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Testimony

Legislative Proposals to Improve the Efficiency and Oversight of Municipal Finance

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Statement of
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Introduction
Chairman Frank, Ranking Member Camp, distinguished Committee members. I am Mike Allen, Chief Financial Officer of Winona Health, a 99 bed community owned not-for-profit health system serving over 50,000 residents in the state of Minnesota. I appreciate the opportunity to be here with you this morning representing the Healthcare Financial Management Association (HFMA) in discussing the impact of recent municipal bond financing issues on not-for-profit hospitals.

HFMA is the professional membership organization for individuals involved in the financial management of health care. HFMA's more than 35,000 members work in a variety of healthcare settings including hospitals, long-term care facilities, physician groups, managed care organizations, public accounting and consulting firms as well as other organizations. Our chief financial officers members were heavily involved in developing the following comments.

Why Is Access to Capital Crucial for Not-For-Profit Hospitals?
Providing care in a hospital setting has always been a capital intensive endeavor. However, the need for inexpensive capital has never been greater due to three reasons.

Hospital facilities are rapidly aging. In 1990, the average physical plant was 7.9 years old[i]. Despite the flurry of recent construction activity, the average age has increased 25% to 9.9 years old[ii]. Older facilities pose several challenges to the healthcare system as they:

- Are more expensive to maintain, driving up the cost of care
- Need to be rebuilt or renovated to accommodate advanced diagnostic and treatment equipment which physically requires more space than earlier modalities
- Lack the capacity in many parts of the country to address the healthcare needs of baby boomers

Second, constant advances in diagnostic and treatment technology require hospitals to invest large amounts of capital in new equipment to ensure that patients have access to the most up-to-date care available.

Finally, hospitals are making considerable investments to reduce cost and pave the way for wider health system reform. Implementing fully integrated electronic health records (EHRs) and computerized provider order entry systems (CPOE) will enhance patient safety and increase the efficiency of care provided[iii]. These computerized clinical systems may well be the linchpin of healthcare reform, providing a means of aligning providers to work together in increasing quality and lowering cost, while at the same time providing a rich stream of clinical data on which to base comparative effectiveness studies. While Medicare is funding some of these expenditures, the amount is unlikely to cover the entire cost of a clinical system. Additionally, Medicare funds will not be available until much of the expense has been incurred. In order to bridge these gaps, hospitals must seek external sources of financing.

Financing for Not-For-Profit Hospitals

Few if any not-for-profit hospitals can fund their capital requirements solely though ongoing operations and, due to their tax-exempt status, they are prohibited from accessing equity markets. Traditionally hospitals have had access to capital through multiple channels. However due to economic shocks, funding through each channel is impaired. The list of traditional funding vehicles and their current impairments includes:

- Tax-Exempt and Taxable Debt: Despite the historically low default rate within the municipal bond market, defaults in the sub-prime mortgage bonds have negatively impacted hospitals. In general, sub-prime defaults shook investor confidence causing a flight to quality. Funds flowed out of municipal bonds and into risk free instruments like treasury notes and bonds.

  Exacerbating the situation, financial institutions that provide credit enhancements such as bond insurance and letters of credit were overexposed to the sub-prime market. As a result, credit enhancements that were once widely available and accepted by investors are no longer either available or accepted.

  Limited credit enhancements are still available through the FHA 242 program. However the application process is time-consuming and the collateral requirements are onerous. Additionally, the program requires 20 percent of the debt issued must be used to finance new construction[iv], which is of little help to hospitals whose cost of capital have spiked resulting from an expired letter of credit. Due to these constraints, few hospitals use the FHA 242 program.

- Bank Lines of Credit: Losses in the sub-prime market have reduced bank liquidity, causing banks to tighten lending standards and reduce outstanding lines of credit.

- The Federal Home Loan Bank (FHLB): The FHLB is available for bonds closed on or after July 30, 2008 through December 31, 2010. FHLBs enhance credit by providing either standby/confirming or direct pay letters of credit. Under both structures, the FHLBs never assume any project-related credit risk, which is borne by the member bank – just as on a conventional business loan. To date, only FHLBs in Indianapolis, New York and Cincinnati have used this structure[v].

- Vendor Lease Financing: This option is normally available from vendors who can access capital markets at lower rates than their customers due to the size and strength of their balance sheets (i.e. General Electric). Despite their size and ratings, these companies are not immune to the overall contraction in capital supply, causing their traditional sources of funding to become much more expensive or evaporate. The associated increase in their cost of capital has made these commercial lenders much more selective about the markets and risk profiles they serve.

- Philanthropy: Over 80 percent[vi] of hospitals report seeing a decrease in philanthropic gifts due to losses in investment portfolios and donor concerns about job security.

HFMA Recommendations

Access to an efficient tax exempt bond market is very important to the hospital industry and by extension to achieving the nation's healthcare goals. While current market conditions make it difficult for all hospitals to access the market and for some impossible, there are encouraging signs that the market may be on the long road to recovery. Rates have stabilized (albeit at higher levels than those seen in recent years), the higher rated issues coming to market have found an adequate supply of buyers and retail buyers are returning to the market.

Liquidity Facilities

Based on these encouraging signs our members urge this committee to first do no harm to the fledgling recovery. Liquidity facility solutions that are brought to the market should first and foremost be optional and the preservation of a private market for these facilities should be maintained. This implies that initial pricing of these liquidity instruments should be set carefully to avoid crowding relatively strong, long term providers of liquidity facilities out of the market. Pricing the government offered liquidity facilities at market rates will not offer a great deal of relief for hospitals struggling to afford the higher cost of debt seen in today's market. However, it will create additional capacity for these instruments, providing relief for those good credits who cannot find a liquidity provider with available capacity.

Second, we urge you to keep the scope of the liquidity facility program narrow, perhaps by limiting it to only existing issues. This narrow scope will help to ensure that there is no long term adverse impact to the functioning of the tax exempt bond market. Provision of low cost liquidity facilities on new issues could attract more lower rated credits toward the VRDO market, when perhaps their organizations cannot adequately manage the risks associated with these instruments. Attracting riskier credits to this market increases the risk that defaults will cause investors to demand a higher default risk premium for the entire market.

Municipal Bond Reinsurance

Our members believe a federally backed municipal bond reinsurance program would be beneficial to hospitals if it was appropriately constructed. First the program should be short term, lasting three to five years. This window will give private bond insurers time to recapitalize, establishing the AAA ratings necessary to participate in the market again. Second, federally backed insurance should be provided at market equivalent rates. This will ensure that as private insurers comeback into the market they can compete and also prevents hospitals from receiving an artificial subsidy that is not sustainable long-term. Finally, this program should be available for outstanding debt issues only. We are concerned that opening the program to new issues makes it difficult to sunset and potentially interferes with the recovery of private insurers. Limiting it to existing issues allows hospitals that have experienced a spike in capital costs due to insurer downgrades

or expired bank letters of credit "breathing room" to cost effectively adjust their debt structure while the private sector recovers.

Credit Enhancements

Our members recommend that the underwriting processes, collateral requirements, covenants and usage constraints of the existing FHA 242 program be reviewed and optimized to meet the current needs of the market. While this program has been in place for a number of years, providers have shied away from this credit enhancement option due to the extremely long underwriting and approval periods and the onerous collateral provisions that call for a mortgage on all assets and a two year mortgage reserve fund. Additionally, the FHA 242 program's requirement that at least 20 percent of debt be dedicated to new construction limits its usefulness given the situations facing many of our members. Due to the events in the market discussed earlier, many hospitals need to refinance their existing debt as their current capital structures are cost prohibitive.

While we laud the recent efforts by the Office of Insured Health Care Facilities in reducing the processing time for FHA 242 deals down to 90 days from 9.5 months, we would ask for relief from the collateral requirements that prevent many credit worthy institutions from accessing this vehicle and provide some discretion in meeting the performance standards for the program. Many credit worthy institutions cannot access this program because they happened to have a single year of adverse financial results. Sound underwriting practices should be able to separate a financial event that has been dealt with by a seasoned management team from a long term trend of poor performance.

Our members also recommend eliminating the 20 percent new construction requirement. This will allow hospitals that are faced with onerous capital costs due to the loss of bank backed letters of credit to use the FHA 242 program to refinance at an economically sustainable interest rate.

Finally, we ask that the Federal Home Loan Bank program that granted FHLB members permission to issue standby letters of credit for tax exempt bonds be extended beyond its current December 31, 2010 expiration date and relax the requirement that the participating banks post collateral equal to 100% of the letter of credit amount.

We cannot overstate the impact that the suggested simplifications will have on hospitals, particularly small to mid-sized facilities that are not integrated with a larger health system and therefore have difficulty accessing capital at market-rates.

Financial Advisors

Regarding financial advisors, our members would not recommend additional federal regulation. Some of our members have commented that advisors were somewhat dismissive of the risks inherent in possible worst case scenarios. During these conversations considerable emphasis was placed on the upside of these debt structures while risks were couched in terms of the historical relationships between rates without considering the advent of substantial interest rate volatility similar to what we have recently experienced.

Bearing this experience in mind, we believe that moving forward the financial services industry should have the opportunity to correct problems related to risk disclosure. The committee should encourage the various trade groups representing financial advisors to develop a private sector solution. Potential components might include some or all of the following:

- Well defined standards of conduct
- Specific education/certification for bond enhancements and complex derivative products like interest rate swaps
- A complaint mechanism monitored by the trade groups for use in identifying "bad actors"

If the industry is unable (or unwilling) using the methods suggested above or similar approaches to correct the problems outlined, we would suggest the use of regulatory means to achieve greater risk transparency and disclosure related to derivative products.

Rating Agencies

Similarly, our members would not recommend additional regulation forcing rating agencies toward what may be an artificial consistency between healthcare and other industry credits. In point of fact healthcare business models are fairly unique in that their income statements are extremely dependent on the vagaries of federal and state legislative processes. Further, the industry is about to go through a period of sweeping healthcare reform that is likely to transform these business models in profound ways. To compensate for these income statement risks, rating agencies typically look for stronger balance sheets that will provide some assurance to investors that providers will have the cash to weather these storms and adapt their business models to the new market realities. Do the current ratings accurately reflect the relative risk inherent in healthcare credits? The low rate of healthcare defaults in the tax exempt market would seem to suggest that the ratings are not set too high. As far as lowering the ratings, with the tax exempt bond market just beginning to recover, now is not the time to relax rating agency standards and risk a default that would chase investors out of the market and impose higher risk premiums on all of the issuers in the market.

Concluding Comments/Final Thoughts

Eighty-five percent of all hospitals are not-for-profit[vii]. These organizations play a key role within their communities acting as both a healthcare safety net for the underprivileged and an engine for economic growth. In addition to being a major employer in most communities – directly providing jobs with stable wages and benefits – the American Hospital Association (AHA) estimates that hospitals spend $304 billion annually on goods and services from other businesses[viii].

In order for health care reform to be successful, the nation's not-for-profit hospitals need to be financially healthy. Facilitating access to stable and inexpensive sources of capital funding will reduce the cost of healthcare ensuring access to hospital care for all patients. Further, without reliable funding, it will be difficult for providers to implement electronic health records and take other steps needed to facilitate health system reform.

BACKGROUND DISCUSSION

Fixed Rate Debt and Bond Insurance

Tax-exempt bonds are a crucial source of financing for three-quarters of hospitals[ix]. The credit market meltdown that began during late 2007 has had a significant adverse impact on not-for-profit hospitals. During the spring and summer of 2008 access to capital became more difficult for all but the highest rated credits. From mid-September 2008 to November 2008 the credit market for fixed rate debt was inaccessible for all hospitals regardless of credit rating.

Facilities intending to issue debt in the fourth quarter of 2008 didn't do so until 2009 due to a dearth of buyers. As credit markets loosened somewhat in early 2009 these hospitals brought their issues to market. As a result, the supply of new issuance far outstrips demand. Investors, who are still extremely risk adverse, are taking only the highest quality credits and demanding higher yields. While markets are functioning for quality credits (AA & A), the demand for lower quality investment grade debt (BBB) is variable and non-existent for below-investment grade debt. The situation is exacerbated by the lack of bond insurance.

Prior to the credit crisis, 40 to 50 percent of not-for-profit health care bonds were backed by bond insurance[x]. A lower rated investment grade hospital could "buy-up" to a AAA rating which allowed pension funds and other institutional investors to purchase their issues. Higher rated bonds are also more likely to attract retail investors looking for low risk and tax-free yields. This has the effect of increasing overall demand and driving down the cost of capital.

Reliance on bond insurance however exposed hospitals to the credit positions and market acceptance of bond insurance companies. During 2008 the major bond insurers were downgraded or placed on watch lists by ratings agencies due to their sub-prime mortgage exposure. This had a negative impact on sources of capital for not-for-profit hospitals. Investors exited insured products due to the uncertainty around them. As defaults in sub-prime mortgage bonds accelerated, access to capital was limited to only those with high investment grade ratings (AA – A). By September 2008, the municipal market was closed even to these providers.

Floating Rate Debt

In addition to bond insurance coupled with fixed rate securities, not-for-profit hospitals relied heavily on floating rate debt in the form of auction rate securities and variable rate demand bonds (VRDBs) to access inexpensive capital.

Auction rate securities are debt instruments with a long-term maturity for which the interest rate is regularly reset through a dutch auction. Auctions can fail when demand for securities offered is less than the supply. Prior to 2007 this rarely occurred as banks that specialized in running the auctions would commit their capital to prevent failures. When these auctions do fail, the securities are priced at a penalty rate, typically equal to a state usury maximum or a spread over the London interbank offered rate (LIBOR). As

an example, following a failed auction during the week of February 15, 2008 interest rates on the University of Pittsburgh Medical Center's auction rate debt topped 17 percent[xi].

When the capital positions of auction banks weakened due to sub-prime mortgage losses they became less willing to support the market. As a result investors withdrew leading to widespread auction failures which effectively closed the ARS market in the spring of 2008. Healthcare providers began to seek alternative credit vehicles that they could use to "unwind" their positions in auction rate securities. With the ARS market collapse, VRDBs became the only avenue for hospitals to obtain low cost floating rate capital.

VRDBs are debt instruments that are payable on demand and have an interest rate based on a prevailing money market rate plus a spread. Accessing the VRDB market requires a bank letter of credit for almost all hospitals, except for those with the strongest balance sheets.

As the financial crisis accelerated and bank balance sheets deteriorated, letters of credit became increasingly difficult to secure. Now, when they are available, they are considerably more expensive. By January of 2009, it is estimated that the cost of bank guarantees increased tenfold since the beginning of 2008[xii]. Additionally, the terms and conditions are tighter including more restrictive covenants and termination provisions. Under these circumstances, use of VRDBs increases a facility's capital structure risk as it is now exposed to put risk, renewal risk and credit event risk. As a result many providers have reduced exposure to this financing vehicle by issuing higher cost fixed rate debt.

Interest Rate Swaps

Many organizations paired variable rate debt with interest rate swaps to artificially create inexpensive long-term fixed rate debt. In these arrangements, providers made payments to a swap counterparty based on a fixed rate while receiving floating rate payments based on LIBOR. As credit markets collapsed, LIBOR rates spiked causing negative valuations on "fixed leg" payments, adversely affecting the operating statement of the hospital. As a result, hospitals were forced to post additional collateral putting pressure on already weakened balance sheets and leading ratings agencies to downgrade some facilities that heavily relied on interest rate swaps[xiii].

The Recession

The negative impact of credit market events has been amplified by the economic downturn. Many providers[xiv] report seeing volume declines, particularly in elective surgeries which can account for as much as 75 percent of EBITDA for some providers[xv]. The HFMA Healthcare Financial Pulse survey indicated that inpatient volumes are down in 55% of hospitals with 23% reporting more than a 2% decline in volume. This is a phenomenon that is unique to the current recession. Hospitals have traditionally not experienced decreases in demand during prior recessionary periods. Additionally, expenses for charity care and bad debt have increased as a result of growing numbers of

uninsured and underinsured patients, putting pressure on hospitals already fragile operating statements.

Operating pressures, in conjunction with the capital market turmoil described in the preceding sections have resulted in a number of negative ratings actions. As an example Moody's downgraded 19 hospitals in Q1 of 2009 – compared to eight in Q1 2008 – and 27 in Q4 2008 – compared with 15 in Q4 2007. Additionally, all three ratings agencies have taken a negative outlook on the hospital industry. As a result, the cost of capital has increased for not only downgraded hospitals but for all institutions.

Impact on Not-for-Profit Hospitals

As a direct result of the issues discussed above, interest expense at hospitals increased 15 percent[xvi] in the third quarter of 2008 over the same period in 2007. By January of 2009, many hospitals were forced to replace some or all of what had been inexpensive floating rate debt yielding three to four percent with fixed rate debt costing between six to seven percent for AA rated facilities, six to eight percent for A rated facilities and was widely unavailable for BBB credits and below.

A recent HFMA survey[xvii] finds that increased capital costs are causing facilities to delay or abandon projects necessary to improve the access and quality of care. Seventy-nine percent of respondents report reducing investments in medical technology, seventy-seven report reducing investments in information technology and seventy-two percent report reducing investments in facility construction.

About HFMA

HFMA is the nation's leading membership organization for more than 35,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and longterm care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

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[vi] The Effect of the Recession on Healthcare Philanthropy; Association for Healthcare Philanthropy; December 2008.

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