Seven Strategies for Improving Your Hospitals Capital Structure

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By Andrew J. Majka

HOSPITAL AND HEALTH SYSTEM EXECUTIVES SHOULD BE DOING EVERYTHING THEY CAN TO BOLSTER THEIR ORGANIZATIONS' LIQUIDITY POSITIONS GIVEN BALANCE SHEET DAMAGE FROM THE ECONOMIC DOWNTURN AND PENDING UNCERTAINTIES OF HEALTHCARE REFORM. THIS MEANS MAXIMIZING REVENUE FROM CURRENT CONTRACTS, FOCUSING ATTENTION TO ACCOUNTS RECEIVABLE IMPROVEMENT, AND STRICT EXPENSE CONTROL. IN ADDITION TO THESE APPROACHES, CAPITAL STRUCTURE IMPROVEMENTS ARE VITAL. SEVEN STRATEGIES CAN BE INSTRUMENTAL IN THIS REGARD.

PROTECT YOUR BOND RATING

The competitive and financial health of providers nationwide depends on the preservation of the highest possible bond credit ratings. With limited or no availability of credit enhancement, hospitals are now only as strong as their own credit ratings. In a tight credit market, a hospital's rating largely determines whether it has access to capital, the cost of that capital, and the required covenants and security provisions.

Hospital executives should plan carefully to attain the highest credit rating possible under the circumstances. In some cases, this could involve an upgrade, but in most cases, it will involve protecting the current rating or stemming the loss to only a one-notch downgrade. This will require a delicate balancing act amongst difficult trade-offs to keep the financial house in order from both balance sheet and income statement perspectives. Setting and achieving targets to surpass minimally acceptable credit performance benchmarks, as defined recently by Moody's Investors Service, will be a critical starting point.

For example, Moody's recommends that A rated hospitals should maintain an operating cash flow margin of at least 7.5 percent and at least 115 days cash; for Baa rated hospitals, that margin should be at least 6 percent and days cash at least 90. (For more specifics, read a Q&A with Moody's vice president Lisa Goldstein.) Maintaining performance at these levels, however, may not be enough to protect the credit rating and support competitive capital needs.

REEVALUATE RISK

The right mix of debt products continues to be entirely organization-specific, depending on the organization's bond ratings, liquidity, investment policy, changing interest rates, and attitude toward risk.

With fixed-rate debt, the hospital borrower is insulated from most major risks, including fluctuating interest rates, credit quality deterioration, and worldwide events impacting marketability of fixed-rate

bonds. Variable-rate debt exposes the borrower to higher risks, including rising interest rates, credit risk, "put" or remarketing risk, bank renewal risk, and others. But, historically, variable-rate debt has provided borrowers with a lower total cost of capital. Variable-rate debt supported by a highly rated bank or a borrower's exceptional credit and liquidity has traded below 0.5 percent for most of 2009, with a longer-term average cost of debt of approximately 3 percent prior to enhancement costs.

In times of changing market conditions, hospital board members and management teams have added impetus to ensure that they are fully informed of factors that increase risk, have a clear definition of the level of risk the organization can assume given its financial position, and proactively manage to achieve the right level of risk.

DEBT MIX

Executives must be actively reshaping their hospitals' capital structure. Given the new risk environment, the optimal, "right" balance of fixed-rate and variable-rate debt has changed for most organizations. Additionally, such balance now is considerably more difficult for hospitals to achieve than it was just 18 months ago. As a result of the auction-rate securities meltdown in February 2008, hospitals lost a major form of variable-rate debt, leaving one widely available product in the public markets-variable-rate demand bonds (VRDBs).

VRDBs generally can be accessed only by hospitals with strong credit ratings through a highly rated bank or based on a hospital's own credit and liquidity. Other variable-rate options exist, such as direct private placement with banks and fixed-receiver swaps, and should be considered depending on market conditions and availability.

The limited ability to diversify variable-rate debt has significantly increased hospitals' risk and cost associated with such debt. As a result, many hospitals are now rebalancing their debt portfolios by deleveraging from uncommitted, underlying variable-rate capital structures and moving their debt into natural fixed-rate products (as opposed to synthetic swap-created structures). Moody's guidance is that AA rated organizations should not have more than 50 percent variable-rate debt; the percentage declines for lower-rated organizations.

PLAN FOR HIGHER COST OF CAPITAL IN RESHAPING DEBT MIX

As hospitals reshape their debt mix to balance risks, higher interest costs will have a material impact on operating expenses. Hospitals that were using variable-rate debt instruments to achieve all-in capital costs of 2 percent to 3 percent in 2008 and earlier years may now be moving their debt into fixed-rate bonds with all-in costs of 6 percent to 8 percent. Depending on the size of the hospital's debt portfolio, the 4 percent to 5 percent increase in cost of capital can amount to millions of dollars on an annual basis.

As executives reshape the hospital's debt mix, the borrowing and operating plans should reflect the expected higher costs of capital from the greater proportion of committed, fixed-rate debt. Fully funded debt service reserve funds, which increase the overall borrowing amount by about 10 percent, are generally required for all but AA hospitals in the fixed-rate market. For those organizations able to access bank letters of credit for VRDBs, such letters come at higher costs and shorter renewal cycles,

leading to more pricing uncertainty. Executives must ensure that operating plans include the impact of all such costs.

CONSIDER ALTERNATE PRODUCTS

Hospital leaders should be considering all sources of available capital, both traditional and nontraditional, including direct bank lending (or private placements), and operating leases. For organizations that are not 501(c)3 organizations (i.e., generally public hospitals and health systems), Build America Bonds are also an option.

BBB and some lower-rated A category credits may wish to consider Federal Housing Administration supported financing. In essence, it provides an AA insurance policy on fixed-rate debt. Section 242 of the HUD program has been revamped to allow HUD financing to be used by hospitals for refinancing of debt, without conditioning such refinancing on new construction or renovation. Hospitals wishing to secure Section 242 financing must meet minimum financial requirements and satisfy other conditions.

MONITOR COVENANTS

Hospital and health system leaders are closely watching their bond and bank covenants as a result of declining financial performance due to operating deterioration, investment losses, defined-benefit pension funding requirements, swap collateral postings, and other calls on capital.. Many organizations are in danger of breaching such covenants. Some have already done so and remediation needs are increasing.

Bond and bank covenant expectations are much higher in today's market and compliance risk is becoming a major concern. If a hospital is close to breaking its covenants, early conversations with the relevant creditors are a very good idea. Covenant violations are not as difficult to remediate if the hospital's operating performance is solid. When a hospital has technical covenant violations and operating problems, remediation can be very complicated, requiring new forecasts and other documentation. Hospital executives must be very familiar with definitions in their bond and bank documents, particularly the debt service coverage ratio, and know when a covenant breach could occur.

RECONSIDER INVESTMENT STRATEGY

Thorough review of the hospital's investment strategy is now more important than ever. Up to this point, hospitals typically have invested liquid cash reserves in short-term fixed-income securities, bank CDs, and money market funds, which generally were considered safe and liquid. Hospitals normally invested pension and board-designated unrestricted portfolios in a mix of longer-term fixed income and equity instruments, with some use of hedge funds and alternate investments.

The collapse of the stock market in September 2008 buckled the firewall that normally protected hospitals and other investors against losses. That firewall had been built through the strategy of investing in a diversity of products that would typically ensure that if one type of investment decreased, the other would be likely to increase. Following the Federal government's decision to let Lehman Brothers fail, stocks and numerous asset classes, such as real estate and bonds, all moved in the same direction, namely downward, resulting in huge losses for hospitals, among others.

Diversification of investments through use of a portfolio approach continues to be a valid risk-reduction strategy. However, as evidenced during the past year, it does not protect against market or event risk created by a severe economic downturn. Asset portfolio allocation decisions must be made with care; products traditionally considered safe, such as fixed income and domestic equity stocks, may now represent additional risk due to possible high variability of their returns in a volatile market. Additionally, liquidity of hedge fund and alternate investment vehicles has come under increased scrutiny, and in some cases, is no longer considered part of board-designated funds.

Additionally, investment repositioning could trigger realized losses due to their inclusion in debt service coverage, and run afoul of covenants, thereby raising many problematic issues.

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