

Managed Care Puts Some Hospitals in a Credit Squeeze

BY JANE HIEBERT-WHITE

If healthcare reform is not a political activity, it's going to be an economic one," predicted James Bentley, American Hospital Association (AHA) senior vice president for policy, in a conversation. A look at recent hospital trends and an analysis from Wall Street bears this out.

As competitive economic pressures increase in the healthcare system, in large part fueled by the growth of managed care, the way healthcare institutions operate is undergoing dramatic reform. Last month's column examined the growth, diversity, and new trends in managed care. This month I look at how the increasingly competitive managed care environment has affected and will continue to affect hospitals' financial situation, with particular emphasis on the view from Wall Street.

HOSPITAL FINANCIAL TRENDS

A look at some statistics points to a downsizing of the hospital market in the current competitive environment. "The purchasing marketplace of hospitals has really tightened up," said AHA's Bentley. "Hospital detractors say that it's only [the threat of] healthcare reform [that was responsible]. But others say, no, business is bargaining harder. Even with national health reform gone now, we can't shift costs back to Medicare and Medicaid."

William J. Cox, Catholic Health Association (CHA) vice president for government services, agreed with Bentley that "employer groups are causing change and demanding lower premiums." They are "forcing hospitals and doctors to be more efficient . . . and will cause some hospitals to close," Cox noted in a conversation.

It is difficult to tease out of statistics the precise effect that managed care and the competitive marketplace are having on hospitals, however. So far, the data show only the broader trends. Prospective Payment Assessment Commission (ProPAC) executive director Donald Young said ProPAC is seeking out data on managed care and



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its contribution to hospitals' financial situation, but has found it difficult to gain good information on what managed care payers are paying hospitals. He noted two problems with the data on managed care in a conversation: "First, by its very nature, there is not a claim generated. Most of the information we use is from claims. Second, with significant competition, proprietary plans don't want people to know what they're paying, what level of discounts they're getting."

MEASURES POINT TO DOWNSIZING

A variety of measures point to hospital downsizing and smaller profit margins. Data from the *1994 Almanac of Hospital Financial & Operating Indicators* show that hospital profitability declined from a 4.7 percent margin in 1992 to 4.4 percent in 1993. The September 1994 report, released by the Center for Healthcare Industry Performance Studies, Columbus, OH, also showed a decline in hospitals' return on investment: 10.1 percent in 1993, down from 10.5 percent in 1992. The report also noted that the gap is widening between high-performing and low-performing hospitals.¹

Recent AHA statistics paint a picture of a tightening system.² For instance, there were 31,000 fewer full-time-equivalent hospital employees as of the second quarter of 1994 compared with the previous year. Length of stay declined to 6.2 days in the first quarter of 1994, down from 6.4 days in 1993. This 3.1 percent drop was the largest first-quarter drop since the introduction of Medicare's prospective payment system a decade ago in 1984.

Financial data from AHA also point downward.³ Hospitals held their 1994 second-quarter expense increase to nearly half the 1993 rate, 4.2 percent versus 8.2 percent. Overall inflation in goods and services purchased by hospitals was down for the same period: 3.8 percent inflation in 1994 versus 5.6 percent in 1993. But even though hospitals kept costs down, net revenue growth rates were also down: 4.4 percent in the

second quarter of 1994 versus 8.2 percent in 1993. This represents the slowest revenue growth in a decade, according to AHA. It also resulted in declining net hospital margins: 5.9 percent in the 1994 second quarter versus 6.2 percent in 1993.

EFFECTS ON BOND MARKET

An important question for hospitals in the wake of such financial trends is: How do they affect access to financing? To survive, grow, and evolve in the changing healthcare sphere, access to capital is crucial. For nonprofit healthcare institutions, the tax-exempt bond market is a major source of capital. As the healthcare marketplace becomes increasingly competitive, the analysts who rate hospitals and other healthcare providers are asking new questions and scrutinizing the effects of managed care on these providers' financial bottom line.

Fear of Default The pressures managed care places on hospitals raise several key issues for Wall Street, according to Chris Connelly, senior vice president of Lehman Brothers. The first problem is: "As unneeded hospitals go out of business, the debt incurred to build them may default, potentially creating disarray in the tax-exempt capital markets."

Bond Volume Drop The healthcare tax-exempt bond market has averaged over \$19 billion per year since 1988. In 1993 it shot up to \$31.7 billion, fueled in large part by low-interest rate refundings (\$20.6 billion). In 1994, bond volume dropped a dramatic 53 percent to \$13.3 billion.

John Goetz, vice president and manager of healthcare ratings for Moody's Investors Service, in an interview credited the bond volume drop primarily to rising interest rates. He also noted two other factors: "Many hospitals stayed on the sidelines to see what would happen with reform [last year]. Also, changing capital needs in the market [affected the bond volume]. Now hospitals are saying we've got to acquire physician practices and develop PHOs [physician/hospital organizations], which are not as capital intensive. Hospitals may not use tax-exempt bonds for that; they may turn to loans or even the equity market."

Connelly, in his remarks at the August 1994 annual meeting of the National Academy for State Health Policymakers, estimated the outstanding debt issued by not-for-profit healthcare institutions at \$115 billion. Of this, nearly 50

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percent is guaranteed, and almost half is held by individuals (42 percent by households). Mutual funds hold 14 percent; property and casualty insurance hold 11 percent; money markets hold 8 percent; banks hold 8 percent; and others hold the rest, 17 percent. Thus, if the tax-exempt bond market were to face serious disruption, the burden would fall heavily on individual Americans.

Managing Acute Care Downsizing Connelly questioned the stability of this market in the new era of managed care. For instance, he noted, "If you extrapolate HMO use rates, it creates a 75 percent overcapacity of beds. This raises the questions: How do we manage the downsizing of the acute care system? And what do you do with the debt?" He proposed that new policies will be required to reduce financial distress, including such steps as monitoring performance, offering technical assistance, facilitating resolution of financing problems, and recommending solutions. Policies also will be needed for responding to defaults as well, including assisting bondholders in assessing market opportunities for their property, and creating bail-out pools.

Currently, however, the default rate for hospitals' tax-exempt bonds is less than 1 percent. And, Connelly acknowledged, "We don't see the wholesale collapse of the hospital market, but we do see some [hospitals] not being able to respond fast enough to the market." Connelly also noted that bond default rates for nursing homes and other types of healthcare institutions are higher than those of hospitals.

Few Ratings For New Providers This leads us to Connelly's Problem Number 2: "New modalities of care are generally not investment grade; credit criteria are not well established; and few capital programs are available to accommodate them."

Of the nation's 5,300 hospitals, something over 1,500 are rated by Wall Street investment ratings firms. For nursing homes, however, the ratio is much lower; of 17,300 facilities, fewer than 500 are rated. And of the thousands of community service providers, fewer than 100 are rated, according to Connelly.

Lower Ratings Additionally, the newer types of healthcare institutions that are rated typically do not receive ratings as high as hospitals do, according to an October 1994 report by Standard & Poor's analyst Joan Pickett.⁴ "In 1984, the borrowers accessing the tax-exempt markets were

predominantly single-site, acute care hospitals. Over the decade, S&P has seen the growth by multihospital systems, vertically integrated healthcare providers, HMOs, specialty hospitals, rehabilitation institutions, long-term care providers, and physician group practices in the rated tax-exempt market. . . . The growth and increasing diversity of borrowers accessing the capital markets has contributed to the growth in the 'BBB' category and the shrinking 'A' category."

In 1984, S&P's "A" category accounted for 68.1 percent of healthcare ratings. By 1993 the "A" category ratings, while still dominant, had dropped to 46.2 percent. The next largest category rating, "BBB," increased from 24.2 percent in 1984 to 37.4 percent in 1993. The S&P report notes that "10 years ago, most providers with 'BBB' ratings had been placed in this category as a result of downgrades. Today, 61 percent of 250 'BBB' providers were assigned ratings in the category initially, and as borrower diversity has increased, many entities in the 'BBB' category represent less traditional institutions, such as rehabilitation hospitals and long-term care centers."

S&P also points to the growing market pressures and "tougher operating environment" as reasons for the downward trend in healthcare ratings. Moody's Goetz agrees: "Managed care is an increasing risk to hospitals. As a result, it is definitely harder to get a good bond rating. Clearly there's going to be more credit deterioration. And I think managed care will become almost the key rating factor in some markets."

To create a managed care profile in rating hospitals, Moody's now asks hospitals such questions as: What is the level of managed care penetration in the local market? How many managed care plans are there? How many contracts do hospitals have with managed care organizations? What percent of revenue derives from managed care? What type of managed care contracts do hospitals have (are they capitated)? What are the terms of the contracts (one-year, five-year, exclusive, nonexclusive)?

Whether the increased economic pressure on hospitals from managed care will lead to more defaults on bonds or restrict hospitals' access to capital is hard to say. Lehman Brothers' Connelly raised the issue as his third critical problem facing the healthcare financial market. "If significant

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defaults and losses occur for tax-exempt healthcare bond holders, financing new modalities of care without federal or state guarantees will be extremely difficult," he said.

While Moody's Goetz would not go that far, he did say managed care is "going to be a contributing factor to the credit deterioration of the industry. Whether, at end of day, it gets to defaults or lack of access to capital, I don't know." A more likely result is that hospitals will find access to capital more expensive as their ratings are downgraded, he said.

At Moody's downgrades have outpaced upgrades in three out of the past four years. In 1994 Moody's issued 21 hospital bond-rating upgrades and 34 downgrades, according to Goetz. Only in 1993 did upgrades outpace downgrades (17 versus 13). In 1992 there were 18 upgrades to 28 downgrades; in 1991, 11 upgrades to 30 downgrades.

Goetz predicts the downgrading trend will continue: "I think managed care will become an increasing risk factor. It is putting pressure on hospitals not only from the pricing side, but also in reducing utilization and volume. The market is becoming increasingly more competitive. There's competition for patients. You also have the Columbia/HCA merger as a more competitive factor. And Medicare rates are constantly under pressure. But this doesn't mean people can't get upgrades."

Smart Hospitals' Actions Goetz said that, in issuing high ratings, Moody's looks for those smart hospitals taking action to stay competitive in the new marketplace. Such action includes:

- Developing integration strategies with their physicians
- Developing contracting networks
- Focusing a lot of attention on cutting cost

"You've got to be profitable to get into the capital market," said Goetz. And what that means in today's environment is "to really home in on the expense side," he concluded.

ECONOMICS AND CHARITY CARE

A final economic effect of the increasingly competitive market—and one that Catholic providers should watch—is the level of uncompensated care that hospitals offer in the face of new financial pressures. A new study of California private hospitals, led by RAND researchers Joyce Mann and

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HEALTH POLICY

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Glenn Melnick, found that hospitals in highly competitive markets provided more charity care than those in less competitive markets, but that the level of care declined over the decade as the competitive pressures increased.⁵ Also, on average, hospitals could not keep up their levels of charity care. "In 1980, the average private hospital in California provided \$1.2 million of uncompensated care. By 1989, the average hospital provided \$2.1 million of uncompensated care. Had hospitals been able to provide uncompensated care at the same rate in 1989 as they did in 1980, the average hospital would have provided \$2.9 million in such services. This difference represents a shortfall of 36 percent." The researchers attribute nearly half of this shortfall to pressure from MediCal, the state's public healthcare program; 27.6 percent to "competitive pressure"; 21.4 percent to for-profit ownership; and 2.8 percent to pressure from Medicare's prospective payment system.

These findings are particularly telling since California has experienced explosive growth in managed care and selective contracting by both private payers and MediCal. It thus may serve as a "harbinger of trends likely to appear in other parts of the United States," note the researchers. All providers committed to a mission orientation should pay attention to it. □

NOTES

1. *AHA News*, September 19, 1994.
2. "Health Care Barometer," *AHA News*, September 12, 1994.
3. "Slower Growth in Hospital Expenses, Revenues: AHA," *AHA News*, December 5, 1994.
4. Joan Pickett, "A Decade of Health-Care Ratings: Past is Prologue," *Standard & Poor's CreditWeek*, October 1994, pp. 17-18.
5. Joyce Mann, et al., "Uncompensated Care: Hospital Responses to Increased Price Competition and Payment Reform," *Health Affairs*, Spring 1995.

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PUBLIC RELATIONS AND CONSTITUENT SUPPORT

Communications with various constituencies is vital. A communications consultant can help with press releases and communications to the medical staff and employees. An entity's constituencies will have a variety of concerns: Will services be terminated that affect my medical practice? Will there be layoffs? Will I have a different supervisor? Issues like these should be actively addressed in meetings conducted by management and in written correspondence.

The surrounding community may also have concerns: Will the facility we have supported for many years be shut down or sold? Will certain services no longer be available? Will we have to drive to another facility to receive services? Will we continue to have an emergency room or a cardiac center?

MEDICAL STAFF SUPPORT

Obviously, the medical staff is a key driver to the success of a hospital. If, early on, key medical staff leaders do not support a transaction, it will be difficult for the institution to rally behind it. Political or tangential issues will soon surface and become an impediment to resolving or reaching agreement on key issues. Spending time early on with medical staff leaders is important in determining and garnering medical staff support.

Not all negotiations lead to consummation of a merger or affiliation. Nor do all mergers and affiliations lead to successful partnerships. However, careful planning and attention to the factors described above will increase the likelihood of success—or, equally as important, lead to the termination of discussions when the transaction is not in the organization's best interests. □