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The Financial Crisis Facing America's Hospital Industry: Part I

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Throughout most of 2008, news of the presidential election and America's two pending wars have taken second billing to the world's potentially greatest financial crisis since the Great Depression. America's hospitals, which for many years have operated under significant financial stress and survived on razor-thin profit margins,¹ have felt the impact of the financial crisis in a significant and damaging way. This article will explore the micro- and macroeconomic factors that create financial difficulties for hospitals generally, as well as the impact of the current financial crisis on the capital markets for hospitals nationwide. Finally, the authors offer their prognosis of what to expect from the health care industry in the coming year.



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In the past six months, as the "credit crunch" in America worsened, it has aptly adopted a new name: the "credit crisis." While some think that the hospital industry is insulated from the effects of a weak economy be-

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cause "people need health care even during tough times," in fact hospitals are now especially vulnerable. The obvious challenge is that it is more difficult to obtain credit, and that situation will worsen in the near future. The credit crisis continues to disrupt capital markets, increasing borrowing costs and decreasing the credit availability for all health care borrowers. Nonprofit hospitals, nursing homes and other health

are often propped up by limited supplies of credentialed health care workers.



George D. Pillari

But just as importantly, tax revenues are down dramatically for federal, state and municipal governments²—and those "payers" are still the 800-pound gorillas with regard to health care delivery systems nationwide. They can

delay payments or simply refuse to pay at all, as was the case this past summer in California,³ or decide to recalculate the amount they will pay for various services. Finally, as consumers feel the pressure from the slowing economy, there will inevitably be more bad debt write-offs, more indigent care and fewer discretionary procedures. The net result of this turmoil? Hospitals that were already in financial distress will experience higher costs,

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care providers that frequently raise capital by employing variable-rate interest bonds have felt the impact.



Shane Passarelli

Unlike an airline or other capital-intensive service business, hospitals cannot pass on the rising cost of borrowing to their customers in the form of higher prices: Third-party re-imbursalment rates are set and remain fixed for long periods of time. Moreover, hospitals cannot easily make draconian cuts to reduce costs, such as reducing staffing, because staffing levels are frequently set by statute and wage levels

lower income and increasing financial stress.

The financial prognosis for the hospital industry has been bleak for a while. As the state with the most hospitals, California is often the "early warning system" for the nation's hospitals. Last year, even before the bottom dropped out of the financial markets, newspapers were already writing about the tough financial situation facing California's hospitals. Nearly two dozen private hospitals in Los Angeles and Orange counties, accounting for up to 15 percent of beds in the region, were reported to be

² See, e.g., "Cities, states begin to feel economic downturn," *Business Week*, available at www.msnbc.msn.com/id/25479690 (July 1, 2008); "The next victim of the Real Estate Crisis," *Business Week*, available at www.businessweek.com/lifestyle/content/jun2008/bw20080627_320852 (June 2008).

³ See, e.g., "Budget Crisis in California," available at www.sfgate.com/cgi-bin/article.cgi (May 15, 2008); "A deeper wound for our healthcare system..." available at www.health-access.org/2008/05/deeper-wound-for-our-health-care-system (May 14, 2008).

¹ See, e.g., Evelyn Lee, "New Jersey Hospitals Post Narrower Operating Margins," available at www.njbiz.com/article.asp?alD=72569 (Nov. 29, 2007).

in dire financial straits and in danger of bankruptcy or closure.⁴ Since then, in the greater Los Angeles area alone, 420-bed Brotman Medical Center Valley Health System (a three-hospital health care district) and Huntington Park Hospital have filed for bankruptcy protection and are attempting to reorganize. Century City Doctor's Hospital, located in the heart of the Century City/Beverly Hills corridor, closed and filed for a forced liquidation under chapter 7, causing investors to lose tens of millions of dollars.

For hospitals nationally, the news during the last year has gone from bad to worse. The hospital industry is dominated by nonprofit and governmentally-owned community hospitals; according to the American Hospital Association, investor-owned hospitals account for only 15.5 percent of the total market nationally. However, the number of community hospitals (hospitals with an average length of stay under 30 days) has declined by more than 1,000 to 4,900 during the last 25 years.⁵ Part of this decline is certainly based on overall decline in hospital utilization (more on that later), but part of the decline is also due to the stress of operating hospitals under constant financial difficulties. Alvarez & Marsal's Health Care Industry Group (A&M) published a report in April 2008 that reviewed data for each short-term acute care hospital in the United States with more than 25 beds, approximately 3,861 in all.⁶ The results were gloomy: More than half were technically insolvent or at risk of insolvency. As to A&M's prognosis more than six months ago, "as states and municipalities begin to limit spending in the face of slumping tax revenues and a weakening economy, the financial health of many hospitals is likely to further deteriorate. Many will encounter serious liquidity crises and face the prospect of radically restructuring or shutting doors."⁷ And that was before the especially difficult circumstances of the second half of 2008. The credit crisis is affecting hospitals more significantly than other industries because of ongoing micro- and macroeconomic factors that created financial distress for hospitals even before the current credit crisis arose.

Microeconomic Drivers of Financial Distress

In good times and bad, there are three primary microeconomic drivers of financial distress for hospitals: (1) capital structure, (2) organization and governance and (3) revenue-cycle mismanagement. Many hospitals suffer from an inappropriate capital structure, with capital spending as the most telling metric. A decreasing amount or complete cessation of capital spending can lead to a "death spiral" for a hospital and is a "genetic marker" for lenders and board members that the institution is in distress. Given the lack of free cash flow from operations, investing too much or too little can jeopardize a hospital's long-term survival. In a well-managed hospital, the goal is patient, employee and physician satisfaction, and the avoidance of unnecessary capital spending that leads to a technology arms race with local competitors. Nonetheless, hospital managers frequently will delay capital expenditures first when cash is tight, because they are focusing on surviving today. Because the hospital industry operates with EBITDA margins of 10-12 percent (low compared with other industries) and a necessary minimum capital expenditure of 4-6 percent of net revenues every year (high compared with other industries), balance sheet strength is a key determinant in measuring a hospital's ability to withstand a financial crisis. Therefore, hospital management must be disciplined in its capital planning and budgeting process, ensuring the proper level of capital expenditures, balanced against the need for liquidity (cash on hand, lines of credit, sustained credit ratings) in the context of the hospital's operating performance.

Hospitals with poor organization and governance tend to be questionable credit risks for lenders. In these situations, management is frequently unmotivated as a result of a lack of clear financial incentives and a clear "chain of command" with regard to long-term strategic planning accountability. As a result, management teams frequently focus on uncoordinated incremental change without any strategic planning or overall context, versus coordinated changes as part of a comprehensive strategic plan. Executives often find themselves more worried about preserving their jobs than investing in long-term planning or long-term solutions. Additionally, nonshareholder boards are often appointed without financial incentives, further exacerbating the issue of short-term vs. long-term goals, and further misaligning the interests of the stakeholders and the hospital.

Century City Doctors Hospital is a noteworthy case because it demonstrates the

range and complexity of strategic issues that hospital operators face in today's marketplace. Nearly \$100 million in capital was reported to have been invested in the 142-bed hospital from debt and equity sources. The hospital invested significant capital in property improvements, providing patients with private rooms, Wolfgang Puck cuisine and flat-screen TVs with on-demand pay television services.

However, in this case, the hospital primarily failed because, despite it having a "spa-like" environment, it was unable to pull patients from nearby well-established hospitals. In the end, the hospital discovered that whether one serves Wolfgang Puck or fast food, reimbursement from payors is the same and is dependent on patient volume.

The health care industry is unique because of its complicated billing and collection practices, usually referred to as "revenue-cycle management." For example, unlike most industries, the customer receiving the services is typically not paying for those services. Rather, a third-party payor, such as an insurance company, Medicare or Medicaid, is typically paying the bills. Thus, making sure that the patient is entitled to the service per its third-party payor and that the hospital will be compensated for the services is essential. Additionally, the rate of reimbursement for a health care service will differ depending on the payor. In other words, while the hospital may have a set rate for a procedure, each payor contract may set a different rate for the same procedure. Other examples include physicians that are not properly credentialed with payors, failure to collect insurance information on the front end and writing off a patient claim as uninsured, or improper coding that understates revenue. Unfortunately, there is no easy fix; generally throughout the health care industry the claims adjudication and payment collection process is complex and often time-consuming. Some health care providers have manually intensive, paper-driven systems that tend to compound already existing inefficiencies. Others invest millions in information technology and implementation, embarking upon system conversions in which it is difficult to measure returns. Often one hears in the health care industry that systems conversions "never go well, just hope it's not a disaster." The net result is that while revenue cycle management is an essential element of the financial success of a hospital, the reality of the situation—that many hospitals do this poorly—has led to financial distress in the past for hospitals.

Macroeconomic Drivers of Financial Distress

The macroeconomic challenges facing the

⁴ Daniel Costello and Susannah Rosenblatt, "Financial Woes Jeopardize Area Hospitals," *Los Angeles Times*, Sept. 23, 2007.

⁵ Agency for Healthcare Research and Quality, *Healthcare Costs and Utilization Project*, available at www.haup-us.ahrq.gov/reports-factsandfigures/fcts_figures_2005.jsp#ex1_1.

⁶ Alvarez & Marsal Healthcare Industry Group, "Hospital Insolvency: The Looming Crisis," available at www.alvarezandmarsal.com/en/docs/am_hospital_insolvency_survey_03.2008.pdf (Mar. 2008).

⁷ "More Than Half of U.S. Hospitals Are Now Technically Insolvent or at Risk of Insolvency, According to New Alvarez & Marsal Study," a *Healthcare News* article found at www.alvarezandmarsal.com/en/global_services/healthcare/news.

hospital industry seem to be contrary to logic. The demographic and economic trends all seem to be poised to create an industry that is large, healthy and growing. Health care is one of the largest industries in the nation, and its costs—as widely discussed in the past presidential election cycle—are staggering. Total national health expenditures were expected to rise 6.9 percent in 2007—double the rate of inflation.⁸ Health care expenditures in the United States amounted to approximately \$2.3 trillion in 2007, or \$7,600 per person (about 16 percent of the gross domestic product), and this trend is not projected to slow down in the near future.⁹ To the contrary, health care spending is expected to increase at similar levels for the next decade, reaching \$4.2 trillion in 2016, or 20 percent of GDP. According to NHEA, total hospital expenditures were approximately \$648 million in 2006 (or greater than one-quarter of the total health care expenditure figures). In addition to the immense outlays for hospital care, the aging U.S. population (78.2 million estimated “baby boomers” by the U.S. Census Bureau as of July 1, 2005) is a key demographic trend that is expected to drive overall health care spending nationally.¹⁰

Nonetheless, there are many macro-economic factors that create a bleaker financial picture for the health care industry in general and the hospital segment in particular, which include: (1) increased labor costs due to an acute shortage of registered nurses; (2) the loss of lucrative outpatient procedures to freestanding ambulatory care centers and specialty hospitals; (3) an increase in bad debts, driven by an increase in the number of uninsured patients; (4) an overall decline in hospital utilization because of advances in technology and the use of pharmaceuticals; (5) a decline in employer-based health care spending, as industry tries to control growing health care costs; and (6) the “leverage” of health maintenance organizations (HMO), which can negotiate contracts that are significantly less favorable to hospitals.

The nation is in the midst of a nursing shortage that is expected to intensify as baby boomers age and health care needs grow. Compounding the problem, colleges and universities across the country are struggling to expand enrollment levels to meet the rising demand for nursing care. In some states, insurers are providing scholarships and even funding nursing-education programs. For

example, Independence Blue Cross of Pennsylvania has awarded millions of dollars through its Nurse Scholar program.¹¹ According to a report released by the American Hospital Association in July 2007, U.S. hospitals need approximately 116,000 registered nurses to fill vacant nurse positions nationwide, translating into a national registered nurse vacancy rate of 8.1 percent.¹² One report found that 44 percent of hospital CEOs had more difficulty recruiting registered nurses in 2006 than in 2005.¹³ According to a report published by the U.S. Bureau of Labor Statistics, more than one million new and replacement nurses will be needed by 2016. Based on a projection by government analysts, nursing is the nation’s top profession in terms of job growth, citing that more than 587,000 new nursing positions will be created through 2016 (a 23.5 percent increase).¹⁴ This shortage of nurses creates pressure on wages, increasing labor costs significantly for hospitals nationwide.

The growth in freestanding ambulatory care centers and specialty hospitals has posed a significant challenge to traditional, general acute-care hospitals. Advancement in anesthesia and surgical equipment and techniques has allowed an ever-increasing range of procedures to be performed in lower cost and more convenient outpatient settings. The reimbursement rates for cardiovascular and orthopedic surgery procedures are competitive for freestanding ambulatory facilities and surgical centers, compared to hospitals. Not surprisingly, there has been a proliferation of Medicare-certified ambulatory surgery centers, and the number of procedures performed out of the conventional inpatient hospital setting.¹⁵ As a result, increasing numbers of outpatient surgical procedures are now performed outside of a hospital-owned facility. This trend is significant because hospitals typically report higher operating margins on outpatient and ancillary businesses than they do on inpatient care.

An increasingly uninsured population is pushing bad debt rates higher. According to the U.S. Census Bureau, more than 47 million people lacked medical insurance in 2006 (approximately 16 percent of the population). More than half of those had annual incomes of less than \$50,000.¹⁶ According to some studies, medical debt is the single largest

catalyst for personal bankruptcies in the United States; a recent study found that 50 percent of all personal bankruptcy filings were at least partly the result of medical expenses.¹⁷ With unemployment increasing, bad debts are a growing source of concern for hospitals and their lenders.

Despite the demographic trends discussed earlier, hospital inpatient admissions have remained flat at about 34 million per year and the average length of hospital stays has decreased nearly 25 percent since 1980.¹⁸ This change in hospital utilization is due to many factors, including technology advances and the use of pharmaceuticals that have reduced the need for and length of inpatient medical care. Breakthroughs in cardiovascular care and cholesterol-management drugs have alleviated the need for many hospital admissions. The result is that while there are an increasing number of older Americans, they use hospitals less than previous generations.

Most hospitals are paid by a limited number of “payors.” The largest of these payors are two government programs: Medicare, which generally covers the elderly, and Medicaid, which generally covers the poor. These two programs pay for nearly half of all hospital services. The other large payors are HMOs, which can include entities such as Kaiser Foundation Health Plan, Blue Cross/Blue Shield and HealthNet. About one-third of all Americans are enrolled in an HMO. In some markets, HMO penetration is more than 70 percent. This results in what economists call a “monopsony,” or a market dominated by a few or single purchaser of services. By aggregating millions of patients, HMOs are able to exert collective buying power in price negotiations with hospitals. This dynamic leads to more downward pressure on hospital revenue.

As a result of all these micro- and macroeconomic issues, the hospital industry has been under unrelenting pressure for many years. The current credit crisis, however, adds a whole new dimension to the situation. ■

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⁸ Poisal, J.A., et al. “Health Spending Projections Through 2016: Modest Changes Obscure Part D’s Impact.” *Health Affairs* (21 February 2007): W242-253. The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States, provided by the Centers for Medicare and Medicaid Services (CMS). These amounts are drawn from the NHEA.

⁹ Plunkett Research, Ltd., Health Care Trends, available at www.plunkett-research.com/industries/healthcare/healthcaretrends/tabid/294/default.aspx.

¹⁰ U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Healthcare Survey, available at www.cdc.gov/hchs/data/misc/healthcare.pdf.

¹¹ Nurse Scholars Program, available at www.ibx.com/social_mission/-nurse_scholars/index.html.

¹² Dr. Peter Buerhaus, et al., “The Future of the Nursing Workforce in the United States: Data, Trends and Implications” (March 2008).

¹³ “The 2007 State of America’s Hospitals—Taking the Pulse.” Am. Hosp. Ass’n. (July 2007).

¹⁴ U.S. Bureau of Labor Statistics, available at www.bls.gov/opub/mir/-2007/11/art5full.pdf.

¹⁵ National Healthcare Survey, *supra*, fn. 11.

¹⁶ See, e.g., Medlines, “45.7 Million Americans without Health Insurance,” available at www.medlines.com/2008/08/30/457-million-americans-without-health-insurance.

¹⁷ Melissa Jacoby and Elizabeth Warren, “Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress,” Northwestern Univ. L.R. at 535, Vol. 100 (2006).

¹⁸ AHA Hospital Statistics, 2007, American Hospital Association, Chicago.