understanding your capital options

As hospitals and health systems plan capital spending that requires financing, they should carefully weigh all their options.

Despite long-term interest rates returning to near-record lows after an increase early in 2011, uncertainty about healthcare reform and future funding for Medicare and Medicaid coupled with concerns about the economy as a whole caused many healthcare organizations to postpone refinancings in 2011. Long-term, publicly issued tax-exempt financing for healthcare organizations was down roughly 15 percent from 2010, with 453 issues totaling $26.8 billion in 2011 compared with 533 issues totaling $31.4 billion in 2010 (source: Thomson Reuters).

Most of this uncertainty continues into 2012, but capital spending can be delayed only so long. Interest rates remain very low, and although healthcare credit spreads widened a bit in 2011, they have narrowed slightly, so now may be a good time for hospitals and health systems to review their capital structures and consider financing-needed capital expenditures.

Rating Agencies’ Outlook on Health Care
In early 2012, the rating agencies offered a somewhat negative outlook for the healthcare industry. Moody’s stated outlook is “negative,” while S&P and Fitch said the outlook is “stable” but had concerns, and downgrades significantly outpaced upgrades. All three rating agencies have expressed concerns about future revenue potential for hospitals and are focusing increasingly on operating margin.

More than ever, hospitals need to achieve a positive margin from providing healthcare services, not just rely on investment income. At the same time, liquidity has come under increased scrutiny for any healthcare borrowers that have debt outstanding that can be put back to them by the holders prior to maturity (“uncommitted capital”).

Traditional Fixed-Rate Tax-Exempt Bonds
Given the rating agencies’ preference for “committed capital” (capital that cannot be put back to the borrower prior to maturity), many healthcare organizations are taking a renewed interest in traditional fixed-rate bonds. Current low interest rates make fixed-rate bonds a reasonable choice under the right conditions for refunding outstanding bonds or financing new projects where the proceeds will be spent quickly. Only one bond insurer remains active in the healthcare industry, and the benefits it offers are marginal to most hospital borrowers because interest rates are low on uninsured tax-exempt healthcare bonds.

AT A GLANCE
When planning capital expenditures, hospitals and health systems should understand the following financing considerations:
> Traditional fixed-rate tax-exempt bonds
> Variable-rate financing alternatives
> Basel III Accord requirements
> Direct tax-exempt bank loans
> Total return swaps
> Taxable financings
> Interest-rate swaps and collateral requirements
The drawbacks to issuing fixed-rate bonds include the growing demand for a debt service reserve fund (DSRF) on A3/A− or lesser credits and possibly a mortgage on Ba1/BBB+ or lesser credits. In addition, because short-term interest rates are so much lower than long-term rates (relatively steep yield curve), bond proceeds in DSRFs, project funds, and refunding escrows cannot be invested at levels high enough to cover the interest cost of the bonds issued to fund them. This results in “negative arbitrage,” which is an additional cost caused by the interest rate of the bonds being higher than the reinvestment rate on bond proceeds that are not spent right away. This added cost can be significant and makes traditional fixed-rate bonds less attractive where there is a DSRF or a project fund that will not be drawn down quickly.

The same is true for advance refundings of outstanding fixed-rate debt where the proceeds of the bond issue are held in an escrow for an extended period of time. The negative arbitrage on the refunding escrow often makes an advance refunding impractical in the current market. This is not true for current refundings, where the bond proceeds are spent quickly to pay off the old bonds that have higher coupons.

Although the retail bond market (bonds sold to individuals) no longer has the impact it had in 2009 and 2010, when it sells bonds today, it still can make a difference in the final interest rates on a fixed-rate issue, so appropriate planning for a successful retail sales effort is important. A successful retail offering may result in more favorable call features on the bonds than an institutional offering and also may eliminate the need for a DSRF. To improve the retail marketing effort on a fixed-rate bond issue, it is beneficial to have a dedicated retail order period just prior to the institutional order period and to add comangers and/or a selling group with retail sales capabilities to increase exposure to more retail buyers.
Variable-Rate Financing Alternatives

Although variable-rate demand bonds (VRDBs) backed by letters of credit (LOCs) or standby bond purchase agreements (SBPAs) are still a viable option for variable-rate debt, we see more and more hospitals choosing to use direct tax-exempt bank loans issued as multimodal tax-exempt bonds instead. DRSFs are not required for either VRDBs or direct bank loans, which reduces the issue size compared with fixed-rate bonds and eliminates the associated negative arbitrage. One reason direct bank loans are becoming popular is that, unlike LOCs or SBPAs, they are not expected to be affected by the Basel III Accord, which is a global regulatory standard on capital adequacy for banks imposed by the Basel Committee on Banking Supervision to strengthen current banking capital requirements.

Basel III Accord

The Basel III Accord, as currently approved, will, among other things, require banks to hold reserves equal to 100 percent of their contingent liabilities, such as LOCs and SBPAs. These higher reserve requirements will increase the banks’ cost of issuing these instruments. Although this particular aspect of Basel III does not go into effect until 2015 at the earliest (other requirements start in 2013), banks need to start building reserves now to be compliant by 2015, so their cost will increase well before then.

The result is that the cost of LOCs and SBPAs will go up, and some banks currently are not offering these options with maturities beyond 2015. Even if a hospital locks in a good rate on an LOC or SBPA today and gets an expiration out beyond 2015, every agreement for these types of facilities includes “yield protection” language, which means the cost to the borrower is likely to go up as it goes up for the bank.

Direct bank loans also include yield protection language, but they should avoid this increased cost due to Basel III because the loans are fully funded and are not contingent obligations of the banks.

Direct Tax-Exempt Bank Loans

Direct bank loans offer comparable, or lower, ongoing interest rates compared with VRDBs and can be issued for longer periods before requiring

HEALTHCARE ISSUANCE BY VOLUME*

* Dollars in thousands
Source: Thomson Reuters.


the bank to renew its commitment (often seven to 10 years for bank loans compared with three to seven years for LOCs or SBPAs). In addition, they typically are quicker and less expensive to issue than VRDBs. Direct bank loans do not require an underwriter, official statement (offering document), or ratings. In addition, the proceeds of bank loans often can be structured to be drawn down as needed, rather than fully funded at closing like other types of bonds, so negative arbitrage in any project fund is virtually eliminated.

Direct bank loans can be issued either as variable-rate or fixed-rate while the bank holds the bonds. There are several applications in which these loans are particularly well suited for healthcare borrowers, including the following:

> To fund construction projects, because the bond proceeds can be drawn down as needed, rather than all at the closing, thereby eliminating the negative arbitrage in the construction fund
> To refund outstanding callable fixed-rate bonds at lower interest rates
> To replace outstanding VRDBs to:
  — Avoid increased cost due to Basel III issues
  — Obtain longer bank commitments than LOCs or SBPAs
  — Avoid put risk for the period the bank holds the bonds
  — Avoid the risk of a bank downgrade
  — Reduce basis risk compared with VRDBs when used to create synthetic fixed-rate debt where variable-rate bonds are issued and the interest-rate exposure is swapped back to fixed
> To cover any orphaned fixed-rate interest rate swaps still outstanding where the related variable-rate debt is gone for some reason, the net result recreating synthetic fixed-rate debt
> To be an alternative to serial bonds (the bonds with the shortest consecutive maturities) in conjunction with a new fixed-rate bond issue

The last application can be advantageous for five reasons:

> Direct bank loans typically have lower interest rates than publicly offered bonds.
> They have lower issuance cost than the publicly offered portion of the financing.
> The overall issue size may be reduced because no DSRF is needed on the bank loan.
> There will be reduced negative arbitrage because the bank loan portion may be drawn down after other bond proceeds are expensed.
> Fixed-rate serial bonds are not callable, but bank loans are, which can be advantageous if rates go down further or other factors change.

**Total Return Swaps and Similar Structures**

Another option to achieve variable-rate exposure is to issue long-term, fixed-rate bonds that are sold to a counterparty and later swap the effective interest rate back to a variable rate for three to five years using a vehicle called a total return swap (TRS). Different bankers offer slight variations on this theme. This structure can result in fixed-rate debt on the balance sheet (seicommitted capital) but with a net variable-rate exposure. There are market risks associated with most versions of these structures when the TRS matures, but with some versions, these risks are not necessarily any greater than the risks posed with other variable-rate structures.

Currently, the IRS is investigating a few TRS deals, so before too much time and effort are expended considering one of these transactions, hospitals should consult with bond counsel and their financial adviser to make sure the proposed structure does not run afoul of tax law.

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For more information on direct tax-exempt bank loans, see Grant Oslund’s and John E. Cheney’s article “Tax-Exempt Bank Loans Still an Option for Providers,” hfm, July 2011, pp. 70-73.
Taxable Financings
An unusual phenomenon has been occurring in early 2012: Long-term taxable rates are right on top of, and occasionally have been below, tax-exempt rates. This situation has made taxable financings a realistic alternative for a few health systems. The advantages of taxable financings include no need to use a conduit issuer or to comply with tax laws for useful life and use of bond proceeds. For example, pension shortfalls are not an eligible use of tax-exempt proceeds, but taxable financings can be used to fund the shortfall in a pension plan.

There are two primary drawbacks to taxable financings. First, if issued on a variable-rate basis, the rates may seem attractive while interest rates are so low, but when rates rise, taxable financings will become significantly more expensive, suggesting that issuance of variable-rate bonds is appropriate in a taxable financing only if it is short-term. Second, the most efficient market is for issues in excess of $250 million, which limits the most significant benefit to very large systems. Smaller issues can get done, but at slightly higher cost than the larger issues.

Interest-Rate Swaps and Collateral Requirements
Many healthcare borrowers entered into fixed-payer swaps (in which they pay a fixed rate and receive a variable rate) to create synthetic fixed-rate debt before the financial market crisis in 2008. As interest rates have dropped, the mark-to-market value on fixed-payer swaps has dropped as well. The result of lower values on the swaps has created the need for many hospitals to post collateral at levels few ever expected. As a result, these hospitals are looking for ways to mitigate the need to post so much collateral on their swaps.

Refund outstanding synthetic fixed-rate debt with traditional fixed-rate debt, and terminate the related fixed-payer swaps. This option is most appropriate where the swap was “integrated” with the bonds for tax purposes with the result that the cost of terminating the swap can be financed with the new bonds. This approach locks in the loss on the swap, but some adopt it to eliminate the uncertainties of swap valuation as well as the periodic renewing of variable-rate debt structures.

“Novate” a portion of the swap portfolio. To novate means, in essence, to terminate an existing swap with one counterparty and enter into a new, similar swap with another counterparty. Most swap counterparties offer what is called a “collateral threshold,” which means the hospital does not post collateral until the value of the swap drops below a negative amount exceeding the threshold, and posting of collateral is required only to the extent the negative value of the swap exceeds the threshold. For example, if a hospital has a collateral threshold of $20 million with its swap counterparty and the value of the swap goes negative by $20 million, no collateral is posted. If the value of the swap goes to a negative $25 million, then $5 million is posted, and so on.

If, however, the hospital novates a portion of its swap portfolio to another counterparty with similar terms, the result could be two different counterparties, each with collateral thresholds of $20 million. Once the novation has been executed, the hospital would not be required to post collateral unless the value of the swaps at each counterparty were to drop below a negative $20 million, effectively increasing its total threshold to $40 million. There is a cost to novation, but some counterparties are willing to cover a significant portion of the cost, so many hospitals and health systems are exploring this option with their swap advisers.
Recoup some swaps. Under this approach, the hospital buys down the fixed-payer rate on a swap so that the negative mark and the associated collateral requirement are reduced. This option can be accomplished at little net cost because the present value of the lower rate equals the cost of the recouponing. In addition to lower collateral requirements going forward, operating margin may be enhanced somewhat due to the lower fixed payments on the swap. The primary drawback is that cash reserves are depleted to buy down the rate. The net effect may be that what was posted as collateral is used to buy down the rate, but the amount of collateral required in the future will be lower by that amount.

Execute a swap on the hospital’s investment portfolio rather than as part of its debt portfolio. This new type of swap structure is much less costly to execute than traditional negotiated swaps, and the swap and its related changes in market value are not reported on the hospital’s financial statements. One drawback is that this structure has no collateral thresholds, but it could be an attractive alternative for hospitals with significant liquidity that want an extremely low-cost way to execute swaps.

As with any derivative or debt option, hospitals should consult their financial advisers on the risks and benefits of any of these options.

Consolidation Within the Healthcare Industry
Healthcare consolidation has increased significantly since the beginning of 2010, and most healthcare analysts expect this trend to continue throughout 2012. Factors driving consolidation include increasing pressure on revenue along with increasing needs for capital, physician alignment, and sophisticated systems, such as electronic health records.

There is no doubt that larger healthcare systems tend to have greater access to capital and at lower cost than smaller healthcare organizations and are therefore better equipped to face the growing uncertainty in the market. Smaller organizations are finding it harder to stay competitive and can often benefit from an affiliation with a larger system.

Evaluate Financing Options
Despite the growing challenges of generating a positive operating margin in the healthcare industry, access to capital remains strong for successful healthcare organizations. Proper planning and execution of financings is more critical than ever as hospitals cannot afford costly mistakes. A well-executed financing plan can allow access to the capital necessary to invest in the assets needed for success under healthcare reform and the other challenges facing the industry.

All healthcare organizations should evaluate the many financing options available in 2012 with their financial advisers rather than merely resorting to what was done in the past, or limiting their options to vehicles offered by their investment banker. The organizations most likely to succeed and thrive will be the ones that acquire and spend capital wisely.

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