



the long view

how the financial downturn will change health care

The last three U.S. economic downturns were relatively kind to health care. This time, the situation looks radically different, but we also may have our best chance to realize fundamental improvements in the nation's healthcare system.

In the 25 years from 1980 to 2005, when the U.S. economy faced recessions, each time healthcare investment, spending, and employment growth helped lift the rest of the economy toward recovery. The current economic crisis, however, promises to be not just a recession, but a more fundamental, longer term realignment of U.S.

and global financial practices. Not only do all indicators point to a significant near-term negative impact, but also the implications for the realignment for health care extend well beyond the point of economic recovery. Healthcare organizations' responses to the crisis should not be limited to adjustments in financing tactics; they should include a broader rethinking of strategies and priorities.

Origins of the Crisis

The conditions leading to the current financial crisis developed over a decade. The story line has now been well documented. Innovative but increasingly risk-taking financial intermediaries—investment banks, banks, insurers, and others—developed increasingly complex financing products, including synthetic collateralized debt obligations (CDOs). Debts were combined from a diverse group of borrowers; computer models were used to disaggregate and remix different forms of risk; and packages of loans were insured against default and were resold to investors. Great creativity was applied in mixing and matching debts; no two debt packages were alike. However, they were all viewed by rating agencies and loan holders as very safe investments.

AT A GLANCE

There are five reasons that today's economic downturn will have a much broader impact on U.S. health care than did past recessions:

- > This downturn is likely to be more severe and last longer.
- > Healthcare organizations are experiencing problems from several directions simultaneously.
- > Healthcare organizations entered this downturn more heavily leveraged and more vulnerable.
- > This downturn is not just a recession, but a major realignment for financing practices.
- > As the realignment occurs and the new financing order sorts itself out, healthcare organizations are not likely to receive the favorable treatment they had in the past.

For an expanded version of this article, with additional exhibits and sidebars, go to www.hfma.org/hfm.

Enchanted with potential of creating debt that was perceived as safer, and thus more valuable, through more sophisticated packaging of individual loans, the finance industry pushed the envelope further and further. Investment banks pushed their own debt-to-equity ratios higher (to 35:1). Insurers reserved smaller amounts to cover losses. New forms of unregulated insurance (credit default swaps) were created, where financial services firms in essence cross-insured each other. Less equity was required of borrowers, and less emphasis was placed on careful evaluation of borrowers' ability to pay. For strong and weak borrowers alike, credit became cheaper and easier to obtain. As the Federal Reserve kept interest rates extremely low, variable rate borrowing became cheaper still. Many of these practices applied not only to housing mortgages, but also to municipal debt, healthcare debt, and other areas.

Taken as a whole, the financing approach of the past decade:

- > Systematically underestimated and underpriced financial risk
- > Was overleveraged (i.e., matched too much debt with too little equity)
- > Was underinsured (i.e., did not reserve sufficient funds for insurance losses and underestimated the "counterparty risks" that insurers and providers of credit default swaps would be unable to fulfill their commitments to cover losses)
- > Became much less closely regulated (with loosened regulations on commercial banks, increased reliance on unregulated investment banks, and unregulated credit default swaps substituted for regulated forms of insurance)
- > Became uncharacteristically reliant on variable rate debt (creating still more vulnerability as interest rates rose)
- > Moved away from requiring that a solid credit analysis be conducted at the point of loan origination (in part because the loan originators

were no longer penalized or held accountable for defaults)

In short, credit was unrealistically easy to obtain and unrealistically cheap, and the nation (and, increasingly, the world) used more and more of it.

The financial sector had become a house of cards, requiring only a gentle push to bring it down, and that push came from the housing mortgage industry. An oversupply of housing, combined with rising interest rates and a high proportion of variable rate loans, led to a modest decline in housing prices. This was enough to produce a growing number of housing mortgage defaults, and a still larger number of threatened mortgage defaults (because many home owners were "under water"—that is, their mortgages exceeded the value of their homes). This situation led to the threat of large-scale loan defaults, leading to a plunging in values of loans and loan packages being held as assets, which in turn led to sharp undercapitalization of financial services organizations (including holders of loan packages and insurers against loan defaults). The resulting crisis in financing led to a sharp curtailing of the availability of credit, which contributed to the economic crisis—slowing sales, rising unemployment, increased firm closures and bankruptcies, increased demand for governments' safety net services, and reduced public revenues. Anticipation of these challenges also led to the plunge in stock values—causing reductions in personal and corporate assets, nonoperating income, endowments, and retirement funds.

Impacts of Other Recent Economic Downturns on Health Care

Like the overall economy, the healthcare industry experiences cycles; however, healthcare activity is driven by different factors. The conventional wisdom has been that health care is immune from economic recessions.

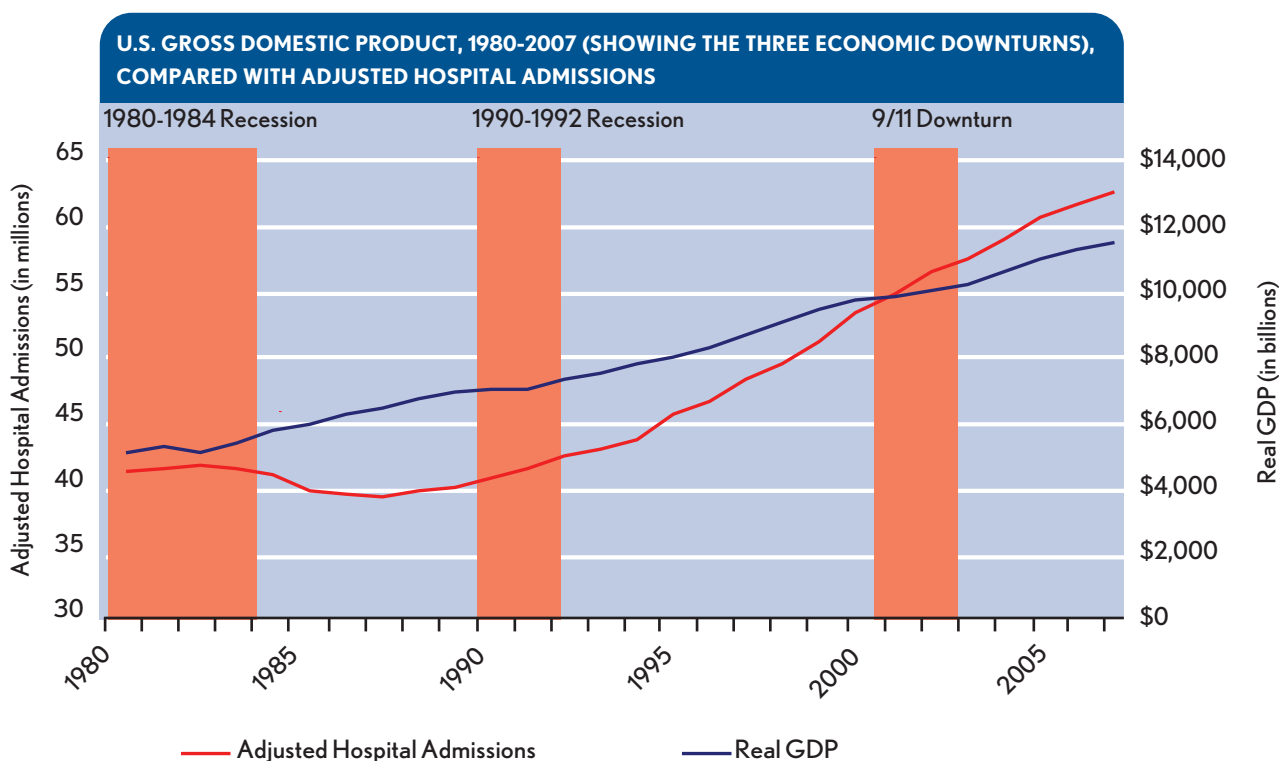
This conventional wisdom is supported by the data from recent economic downturns. The United States experienced three downturns since 1980:

- > The 1980-84 recession (following the Arab Oil Embargo, a prolonged period of “stagflation”)
- > The 1990-02 recession (following the savings and loan crisis and the end of the First Gulf War)
- > The post-9/11 downturn (2001-02)

Despite these downturns, the overall economy experienced relatively steady growth over this time period. Adjusted admissions dropped during the late 1980s—driven primarily by the imposition of diagnosis-related groups (DRGs)

and a period of tightly managed care (including significant use of capitated payments). Subsequently, hospital admissions and other healthcare indicators have shown strong growth.

During and after the post-9/11 downturn, healthcare admissions grew sharply. The “counter-cyclical” nature of healthcare activity has been credited by some economists as an important factor in the post 9/11 recovery. According to the U.S. Census Bureau’s *Statistical Abstract of the United States: 2008*, healthcare employment represented more than one-quarter of net new jobs created in the United States since 2000.



Sources: U.S. Department of Commerce web site, November 2008; AHA Hospital Statistics 2008; McManis calculations.

In this exhibit, the blue line shows the real U.S. Gross Domestic Product (GDP) in 2000 prices. The red line shows adjusted hospital admissions, which follow a quite different pattern. The scale for GDP is on the right of the exhibit, and the scale for adjusted hospital admissions is on the left. Adjusted hospital admissions is the weighted average of inpatient and outpatient admissions.

Why the Current Financial Crisis Is Different

If health care has moved through previous downturns without major adjustments, why not this one? There are several reasons why, in addition to the strong short-term impact we have already seen, this downturn promises to have a lasting impact.

1. There is every reason to believe that this downturn will be more severe and last longer. Total losses within the financial industry are already estimated to be well above those for other recent downturns. George Magnus, senior economic adviser for UBS, the Switzerland-based global investment banking and securities firm, has estimated that U.S. financial industry losses are over

twice the average of previous post-1945 downturns (UBS Investment Research, *The Great Deleveraging Must Still Be Contained*, Nov. 25, 2008). And there are more losses to come. None of the recent recessions has lasted more than two quarters, but this one will.

Getting out of this recession will require a major infusion of capital to replace the losses, and a further major infusion to facilitate massive deleveraging. Financial organizations must work their way back to reasonable debt-to-equity ratios; so must other elements of the economy. This will take time, and governments and central banks (including but not limited to the Federal Reserve) have a series of complex maneuvers

OVERVIEW OF CRISIS PHASES, FINANCING ENVIRONMENTS AND COMMON STRATEGIES

Before the Crisis	During the Crisis	After the Crisis
<p><i>Unrealistically favorable access to capital</i></p> <ul style="list-style-type: none"> > Synthetic CDOs (credit enhanced, “commoditized”) sold at attractive terms > Overleveraged financial intermediaries > Underestimated creditor and credit enhancer risk > Extensive credit use, high leveraging <p><i>Expansive strategies</i></p> <ul style="list-style-type: none"> > Preemptive investments in profitable locations and services > Growing emphasis on quality, service, and IT > High variability in costs > High variability in physician strategies 	<p><i>Unrealistically poor access to capital</i></p> <ul style="list-style-type: none"> > Limited use of CDOs > Shrinking numbers of financial intermediaries, with shrinking capital bases > Tighter, borrower-specific debt underwriting > Growing differences in access to capital between strong and weak healthcare organizations <p><i>Reprioritized strategies</i></p> <ul style="list-style-type: none"> > Capital projects reevaluation and reprioritization > Emphasis on maintaining cash flow > Reassessment of underperforming services > Reemphasis on diversifying capital structure, services, and geography > Cut-backs (for some, “survival mode”) 	<p><i>Realistic (and higher priced) access to capital</i></p> <ul style="list-style-type: none"> > New generation of more transparent CDOs > Cost of credit reflects uncertainty about future healthcare reimbursement > Continued tighter underwriting, with access to and pricing of capital based on credit-worthiness > Ongoing adjustments in capital access based on healthcare reform prospects <p><i>Differentiated strategies</i></p> <ul style="list-style-type: none"> > New importance for lowering the costs of serving a given population > Focus on economies of scale > Focus on physician and care integration > Continuing focus on quality, service, and IT > Priority given to strategies that work with or without healthcare reform

ahead of them if they are to successfully manage “the great de-leveraging” of the global economy without causing still more adverse side effects.

2. Hospitals and other organizations are experiencing problems from several directions simultaneously. On the asset side of the balance sheet, endowments and other investments have fallen with the stock market. On the liabilities side, debt is getting more expensive. Meanwhile, income is falling as patients defer elective procedures, which are usually well-reimbursed in comparison with cost. Nonoperating income has fallen along with assets. Also, fewer patients have commercial reimbursement, and collecting deductibles and copays has become more difficult. Meanwhile, expenses are not falling as fast, since medicine cases—usually not well-reimbursed in comparison with surgical cases—continue at close to pre-crisis rates.

3. Healthcare organizations entered this recession more heavily leveraged and more vulnerable. Like other segments of the economy, hospitals and other healthcare organizations have grown accustomed to easy access to cheap financing. They have taken on more debt than in the past, and a higher proportion of the debt is in variable rate securities. Some of this debt was backed by letters of credit from financial institutions that have gone out of business or that are substantially weakened. Some hospitals’ debt must be renegotiated at higher rates now. Other hospitals are now concerned that they will soon be in violation of bond covenants.

4. As noted previously, this is not just a recession, but a major realignment for financing practices. The first change will be careful underwriting of loans and bonds. No longer will all healthcare organizations have easy access at cheap prices. Looking ahead, as one health system CFO put it, “The underlying credit rating of our organization will determine

whether credit will be available, and if so, how it will be priced.”

5. As the realignment occurs and the new financing order sorts itself out, healthcare organizations are not likely to receive the favorable treatment they have in the past. In the past, healthcare debt was priced similarly to municipal and educational debt. Beyond 2009, there are major questions about the ability of many hospitals to maintain positive cash flow from operations. Expectations are that Medicare and Medicaid payment rates will weaken, followed by more rate pressure from private employers and commercial insurers. Without national healthcare reform, there is concern that the pools of uninsured and underinsured will increase. Holders of new healthcare bonds are expected to price these uncertainties into the interest rates they demand. Together, these factors translate into higher costs of borrowing.

Near-Term Responses of Healthcare Organizations

The previous three economic recessions did not see the wholesale cutting back of hospital capital investment projects that we are seeing this time around. The response of many health system executives we spoke with could be summed up as follows: “We have started a ‘soup to nuts’ review of all budgets, including capital.”

Typical near-term responses include:

- > Delaying capital projects
- > Diversifying capital access strategies (moving to a mix of fixed debt, equity, and less or no variable rate debt)
- > Increasing cash flow (pushing harder on collections and delaying payments)
- > Carefully marshalling available free operating cash flow (operating income less operating expenses and debt payments) as a critical resource

- > Instituting hiring freezes on nonessential personnel and salary freezes or cuts, and shifting more staff to part-time work
- > Pushing for still tighter inventory and supply chain management
- > Looking for additional cost savings; focusing on efficiency
- > Cutting back or eliminating marginally successful service lines
- > Positioning for a merger partner
- > Converting to critical access status (applies only to rural hospitals)
- > Working harder at philanthropy

Moving Through the Crisis

These responses are, of course, only the beginning of health systems' adjustments. The exhibit on page V summarizes key elements of the financing environment and common health system strategic initiatives before the crisis, during the crisis, and during and after recovery. In the current environment, it is unlikely that there is any hospital, health system, medical group, or other healthcare organization that doesn't need a realistic reassessment of its strategy. For most, the emphasis should be not on survival but on coming out of the crisis in the best possible position.

During this early stage of the crisis, many systems have, understandably, shifted their focus from "opportunity-seeking" to "threat-avoiding." However, others are already asking about "the long view." Martin Arrick, a managing director for Standard & Poor's, New York, expressed it this way: "I am trying to look beyond the 'noise in the numbers' of the current crisis and concentrate on the long term. Fundamentals are still fundamentals."

We already see a strong division in strategic focus between the leaders of financially strong and weak health systems. Leaders of systems with poor operating margins are sweating to improve those margins. Leaders of safety net organizations,

which expect to be deluged with patients but not funding, could not be more concerned.

A CEO whose system has a strong market position, but overleveraged itself to get there, said, "I love where we are, but I'm still worried, and I'm frustrated. We are barely meeting our bond covenants, and we are stuck. We are not able to [invest more in and] take advantage of our next opportunities."

Meanwhile, strong systems are looking ahead. A leader of one of the country's strongest systems said, "We've prepared for the downturn. How do we prepare for, and take advantage of, what's next?"

As recovery begins, what will the next healthcare financing environment be like? Let's begin with what central banks and governments will be trying to achieve with capital markets as a whole.

A substantial infusion of new capital into the financial system. Public and private capital infusions are well under way, although most economists say not enough has been committed yet.

A reform of financing practices. There is nothing wrong with sophisticated financing mechanisms that spread risk; but we must return to strong basic lending principles (i.e., careful qualification of potential borrowers and the ability to accurately assess the risk of any loan or loan package at any point in time). For the foreseeable future, each health system that borrows will have to meet closer scrutiny based on its own merits. This will require are building of financing organizations' capability to evaluate healthcare credits.

A careful management of the federal budget.

This will begin with short-term (e.g., two-year) emphasis on economic and jobs stimulus programs in areas of clear long-term need, such as transportation, energy, education, and/or health

care. The economic stimulus should be followed by a sustained period of budget balancing. *It's hard to see how federal budget balancing can be effective without reductions in the "big three" cost areas: military, health care, and retiree benefits.*

In planning for "what's next," we inevitably deal with probabilities, not certainties. However, it is hard to construct a scenario of the post-crisis environment that does not involve the need for much more stringent cost management in healthcare organizations. Employers will be hurting and seeking cost cuts to retain competitiveness. The federal government will be moving carefully but still aggressively out of the capital infusion mode and into a budget balancing mode. State governments will still be struggling mightily with Medicaid costs. Meanwhile, the cost of capital for healthcare organizations will remain substantially higher than pre-crisis levels.

Ironically, this crisis presents the best opportunity yet to move forward with healthcare reform. Employers desperately need cost relief. Safety net providers will soon be "over the top" with unmet needs. Meanwhile, the cost profile associated with most healthcare reform scenarios—i.e., high initial costs followed by a tapering down to a lower level—meets the current need for a stimulus followed by budget discipline. Thus far, the emphasis on healthcare reform has been on universal coverage; the post-crisis emphasis also is likely to include a heavy focus on cost.

At this point, two high-level scenarios dominate the possibilities: We will have healthcare reform, and it will include both a significant move toward universal coverage and significant downward pressure on healthcare costs; or we will have downward pressure on costs, from both public and private payers, without reform. The first scenario offers hope; the second could get nasty. Either way, excellent performance at a lower total cost may well be required for survival.

Strategies Based on the Long View

How does today's leading healthcare system position itself to lead in the post-crisis environment? It has to position itself to deliver higher and higher levels of patient satisfaction, and continue to introduce new technologies, but also lower the cost of serving a given population.

During the crisis, some healthcare organizations are likely to have much greater maneuvering room than others. It is important to use this time to position for post-downturn health care. Answering the following four questions may help.

How can we take further advantage of scale economies? A close look at today's financially successful health systems shows that most of them are already taking advantage of either *systemwide scale* or *regional scale*.

Systemwide economies of scale include the abilities to redesign, standardize, and streamline billing and collection processes; to achieve economies in purchasing and implementing new IT systems; to employ specialized talent and deploy it across the system; and to achieve still more efficient supply chain management.

Regional economies of scale include the abilities to develop three new state-of-the-art cancer programs instead of five; to rationalize the deployment of other new technologies; to implement regionwide branding and brand promises; and to develop a rationalized network of ambulatory services that improve service and accessibility at a lower cost.

In the post-crisis era, successful systems will need to be adept in realizing both systemwide and regional scale economies. It is a given that more consolidations will be proposed, and that stronger systems will be in the driver's seat in selecting partners. Partner selection needs to be based on

more than creating strong balance sheets; it needs to be based on achieving both types of scale.

Today, more Catholic and for-profit systems are configured to achieve systemwide economies, and more community-based not-for-profit systems are configured to realize regional economies. Institutional hurdles will have to be overcome to create systems that are configured to take advantage of all of the opportunities.

The challenge for hospital governing boards and managers, including CFOs, is to look beyond the current crisis and position their organizations for the future.

How can we develop a more integrated care delivery system? A new movement toward physician integration is occurring across the country. It is essential that this movement continue if health systems are to be capable of lowering the total cost of care.

Post-crisis health care, whether it is under reformed reimbursement or simply under cost cutting, is likely to include more physician-physician and physician-health system integration. The key is not only to integrate, but also to develop organizations that can perform well under capitated, episodes of care, or pay-for-performance arrangements.

How does a health system pursue physician integration and realize more economies of scale when different physicians have different needs and preferences? It is almost inevitable that most systems will need to utilize more than one form of physician integration.

How do we develop a culture that promotes cost containment as well as quality, innovation, and service?

Most successful health systems are making huge strides in developing cultures that emphasize and reward quality and service. In many cases, these cultures are reinforced with performance-based pay. These health systems are also making great strides in developing and sustaining “learning communities” where operating units within the system learn from the successes of each other.

These cultural gains now have to be extended to cost reduction. At a recent symposium, Donald M. Berwick, MD, president and CEO, Institute for Healthcare Improvement, suggested that three initiatives can accomplish what he terms the “triple aim”—i.e., improved population health, enhanced experience of care, and lower per capita costs (“The Triple Aim: A New Level of Performance?” Dorsey Hughes Symposium, July 26, 2008).

In the environment ahead, both low quality metrics and high costs represent strategic vulnerabilities.

What adjustments do we make in our push for the optimum market positioning? How does our optimum positioning change as we becoming more integrated and place a higher priority on cost containment? Today’s successful systems became successful in part by identifying the key locations in their service areas and putting the right services in the right locations at the right time. This almost certainly will remain a critical success factor. As capital allocation processes become more constrained, effective decision making on new investments will become even more critical.

This question raises additional questions. How does our optimum positioning change as we becoming more integrated and place a higher priority on cost containment? The optimum market positioning of the future may have more

to do with effective deployment of ambulatory sites and services than it does with hospitals. And how would our optimum positioning change if the most likely healthcare reform proposal is enacted? This is likely to be an ongoing question as we move through the next two years.

A New Shape for Health Care?

In a recent column in *hfm*, Richard L. Clarke, DHA, FHFMA, president and CEO of HFMA, writes that "... we may be at a 'tipping point' that will prompt restructuring of the healthcare industry" ("Interesting Times," *hfm*, November 2008). We agree.

The U.S. economy has been struggling to shoulder rising healthcare costs for some time. This financial crisis may well provide the final impetus needed to set in motion wholesale change. To date, healthcare reform proposals have focused heavily on extending universal coverage. This is appropriate, but as the discussion continues, cost reduction will inevitably also take center stage.

Some of the changes we are about to experience are overdue. The introduction to HFMA's September 2008 report, *Healthcare Payment Reform: From Principles to Action*, begins with a comment on a longstanding reality, that "efforts to enhance health in the United States are thwarted by a healthcare payment system that does not reward the very actions ... that will foster improved health" (www.hfma.org/paymentreform). The incentives simply are not present to control costs.

Other changes will be the results of the financing crisis and economic downturn. The new reality is that many of the healthcare organizations that are experiencing financial stress, or that soon will be as they violate their bond covenants, will not be able to find another organization to acquire them or a government agency to bail them out. The healthcare safety net is in very real peril, and there are likely to be, as a result, serious crises in

many metro areas and smaller communities. The resulting challenges to community and healthcare leaders will be considerable. Meanwhile, employers—in state and local government, school districts, manufacturing, the service sector, and other areas—cannot afford to stand by and allow further cost shifting to continue.

Will this represent a tipping point? There is a good chance that it will. The challenge for hospital governing boards and managers, including CFOs, is to look beyond the current crisis and position their organizations for the future. We haven't talked with anyone in health care who believes that our present system is sustainable. If we—both policymakers and those responsible for delivering care—act wisely in responding to the financial and economic crisis, health care could emerge in a form that has long-term sustainability and better satisfies public needs. ●

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