Taxes, capital, and mergers in rural healthcare

By John Fox | January 3, 2018

In November 2017, as the U.S. Tax Cuts Act worked its way through Congress, the American Hospital Association (AHA) sent a flurry of letters to representatives and senators pleading with them to preserve hospitals' ability to borrow money tax-free.

Early drafts of the bill would have eliminated "private-activity bonds," which allow nonprofit hospitals to borrow money at cheaper rates because their investors don't have to pay taxes on their earnings.

The borrowing mechanism was ultimately preserved in the reconciled bill signed by President Trump, but experts say the entire debate highlighted the precarious state of many small hospitals' balance sheets – and the need to consider carefully which capital expenditures to undertake in the future.

In today's low-rate environment, the advantage of access to a tax-free debt market is small. The average spread between the Bloomberg Barclays Taxable Municipal Bond Index and the Bloomberg Barclays Municipal Bond Index from November 2016 through October 2017 was just 126 basis points (1.26 percent), according to a recent Bond Buyer article.

'Already on edge'

The fact that the debate received so much attention from the AHA and others shows just how many rural, critical access hospitals are "already on the edge," Frank Beaman, CEO of 17-bed Faith Community Hospital in Jacksboro, Texas, told *athenainsight*.

Large hospitals usually have strong credit ratings, so it's mostly small community hospitals with credit ratings of BBB or below that consider raising money on the tax-free market, Beaman says. And many of those facilities were built in the 1950s and are long overdue for replacement.

But even with private-activity bonds preserved, the tax bill will still strain struggling hospitals looking to borrow money for capital improvements. Because the bill will reduce the corporate tax rate from 35 percent to 21 percent, the after-tax yield investors receive on tax-exempt bonds will be less attractive than taxable yields, according to an analysis by HFA Partners, a capital-markets advisor to healthcare providers. Investors will therefore ask for higher yields, making tax-exempt borrowing more expensive for hospitals.

At least 26 nonprofit hospitals are currently in default or distress, meaning they've notified bondholders of financial troubles that make bankruptcy more likely, according to data compiled by Bloomberg.

"You could see a death spiral for many hospitals," Faith Community's Beaman says, pointing to rising costs and decreasing revenue, particularly from government payers. "When hospitals' finances go south, it makes it harder for them to raise money to make the capital improvements they need as part of their efforts to turn themselves around."

A strategy for survival

Even with scarce access to capital and cash, small hospitals must see past their day-to-day struggles and formulate a strategy for survival, says Stephen Klasko, M.D., M.B.A., president and CEO of Philadelphia-based Thomas Jefferson University and Jefferson Health.

Before looking to raise funds for major brick-and-mortar projects, says Klasko, hospitals should consider if a "light and lean" approach would better position them for the future.

For example, rather than constructing large, inpatient facilities in a strategic landscape that already has too many hospital beds, hospitals should consider building ambulatory clinics and "microhospitals" – small, fully licensed inpatient hospital facilities that typically house eight to 10 inpatient beds along with emergency treatment and triage rooms that send more serious cases to larger facilities.

"You need to ask, 'Where do I want to be in 20 years?' Klasko says. "And I think the answer for most hospitals isn't going to be old-school inpatient. Part of a smart capital expenditure strategy is recognizing that we don't need the same healthcare infrastructure that we currently have."

Another benefit of a light and lean approach to capital expenditure is that many ambulatory clinics can now be built without debt, Klasko added. For example, several development companies will build microhospitals and other small facilities in return for a guaranteed portion of the operator's earnings before interest, taxes and amortization (EBITA) until the debt is paid off or a balloon payment takes effect.

CFOs at smaller hospitals can also consider alternative nontraditional ways of raising money for unavoidable capex, including mechanisms such as EB5 loans and public-private partnerships, says Klasko. "Going to the debt market is an old, increasingly obsolete way of financing, anyway."

'Let's merge'

Beaman agrees that executives of cash-strapped hospitals can avoid far more capital expenditures than they realize. They can, for example, turn to the leasing market for expensive equipment and partner with technology companies that offer software as a service with no major upfront costs. "Software is currently one of the largest sources of capex for hospitals, when you take into account the total cost of ownership. You want to make sure you aren't needlessly spending on big-ticket items that will quickly become obsolete," he says.

Beaman adds that a first step for CEOs considering any capital expenditures is to get their financial house in order. When Beaman took over Faith Community seven years ago, the hospital was on the brink of closure. The facility was 50 years old and desperately needed to be repaired or replaced. "Our accounts-receivable days were up to 180; we weren't even sending out bills. So, the house had to be cleared up before we could even consider going to lenders. We ultimately found a great bank to partner with — but our story begins with change management."

Even smart management and innovative financing may not be enough to save many rural hospitals, Klasko warns. He believes that critical access hospitals and other small facilities should take note of consolidation going on elsewhere in the industry and merge to form a national rural health network that could harness economies of scale. Even geographically dispersed facilities can find more success together than by going alone or selling out to existing, multistate networks, he says.

"The whole discussion around tax reform is equivalent to spitting in the ocean — critical access hospitals need to do something drastic if they are going to survive, and smart consolidation may be the answer," Klasko says. "If I were a CEO of a struggling rural hospital, I would call nine or 10 other executives of critical access hospitals that I knew were in the same situation and say, 'Let's merge.'"

John Fox is editorial director of athenaInsight.