Report 3

hfma's **financing the future III**

# Managing Unfunded Liabilities: Will Your Hospital Be Prepared?

hfma
healthcare financial management association

In partnership with

GE
Healthcare Financial Services

**Financing the Future III**
**Report 3**
**Managing Unfunded Liabilities: Will Your Hospital Be Prepared?**

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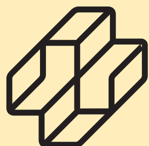
Healthcare Financial Management Association
Two Westbrook Corporate Center, Suite 700
Westchester, IL 60154-5700
www.hfma.org
www.financingthefuture.org

Correspondence: resourcecenter@hfma.org



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# About Financing the Future III

Since 2003, HFMA's Financing the Future project has given healthcare providers the information they need to help their organizations deliver the necessary resources to provide safe, high-quality care to their communities.

The first Financing the Future series featured six reports that brought together key stakeholders to share knowledge about and produce empirical evidence of healthcare capital needs, availability, and factors associated with access. One of the key findings was a growing gap between "have" and "have-not" hospitals with respect to financial condition. Further, the reports found that "have-not" hospitals are growing in number at a greater rate than are "have" hospitals. This series was led by HFMA in partnership with GE Healthcare Financial Services, with research conducted by HFMA and PricewaterhouseCoopers.

The second Financing the Future series identified best practices of capital planning and access. The cornerstone principle, carried through in each of six reports, was that adherence to a rigorous corporate finance process is critical to a hospital's ability to increase access to capital, make wise investments in the organization's future, and improve financial performance. Thus, the goal of Financing the Future II was to define, provide examples of, and encourage the implementation of a successful, corporate finance-based approach to financial management in healthcare organizations. HFMA's partners for Financing the Future II were GE Healthcare Financial Services and Kaufman, Hall & Associates.

This report is part of the third—and in many ways the most ambitious—Financing the Future series. HFMA, in partnership with GE Healthcare Financial Services, has set out to identify key industry trends that affect hospitals' capital position and ability to fund important future initiatives. The reports focus on the following:

- *Payment trends,* including pay for performance, impact of consumerism, and coping with the consumer's rising financial stake in paying for healthcare services
- *Healthcare technology spending,* including technology purchasing, funding, and optimizing investments
- *Unfunded liabilities,* including pensions, malpractice insurance, and other enterprisewide risk
- *New hospital construction,* including integrated planning, design, construction, and financing that reduces costs and enhances efficiency and quality, with areas to be addressed include workflow redesign, workforce change, and efficient layout of space that can improve patient safety.

The Financing the Future project embodies the goal of HFMA and GE Healthcare Financial Services to give healthcare providers the business tools they need to be thriving assets to their communities.

# About this Report

In this latest Financing the Future report, focus shifts to unfunded liabilities. As obligations for which cash must be found at some undefined prospective date, unfunded liabilities, such as those involving defined benefit pension plans and medical malpractice claims, are key considerations for CFOs as they engage in strategic capital planning. To provide an understanding of the scope and effect of unfunded liabilities, HFMA, in partnership with GE Healthcare Financial Services, recently interviewed hospital financial executives, ratings agency representatives, and various financial and accounting authorities. In this report, these experts provide their perspectives on the present and future status of unfunded liabilities and offer advice for hospital executives looking to balance fund obligations with portfolio risk.

# Managing Unfunded Liabilities: Will Your Hospital Be Prepared?

When Cathy Jacobson took over as the senior vice president of strategic planning and finance, CFO, and treasurer for Chicago's Rush University Medical Center, five years ago, she inherited two major unfunded liabilities.

The hospital's defined benefit pension plan was underfunded under the Employment Retirement Security Act (ERISA), which drives the amount of money that must be put into a pension plan. The pension plan also was underfunded according to the accounting valuation of pension liability. As a result, the hospital has had to funnel almost $170 million into its pension trust over a five-year period to avoid incurring ERISA penalties while still dealing with the significant liability on its balance sheet.

At the same time, the hospital saw its medical malpractice deductible balloon from $4 million to $15 million per case. The organization had previously established a trust to fund its future malpractice claims. However, with the increase in risk that was retained by the hospital, the required funding to the trust increased significantly. The hospital consequently has had to absorb a significant increase in the amount of cash it needs to fund future malpractice claims and an increase in reinsurance premiums despite the additional risk absorbed by the organization. To shore up its medical malpractice self-insurance program, the hospital has been setting aside almost $30 million a year.

"We had to face the funding of both of these trusts at the same time we were trying to build our cash balance of 50 days cash on hand to 100, which is still remarkably low for the industry," says Jacobson. "We were also dealing with years of deferred capital that we had to start to address. We had to do all of that despite all of the money that had to be funded into these two trusts."

Rush University Medical Center's experience isn't unusual. Since 2000, many hospitals have had to transfer large sums of cash from operations to support defined benefit pension plans and medical malpractice insurance programs. What's more, these demands on cash could not be coming at a worse time. Just in the past few years, hospitals have started to put increasing amounts of capital into expanding, renovating, and upgrading their facilities. Hospitals in fact are in the midst of one of the biggest construction booms they've seen in more than 40 years. A 2004 report showed capital spending to be expected to increase by 14 percent a year for five years.[1] The need to fund medical malpractice insurance captives and pension plans is siphoning money away from needed capital improvements.

# The Crisis in Pension Funding

Defined benefit pensions plans have been declining in popularity over the past 20 years because of the high risk they pose for corporations and hospitals. Pension obligations are huge, returns on plan assets are volatile, and annual costs are variable. In the past five years, pension funding has reached a "crisis" level for providers as a result of several factors:

- The baby boomers have been approaching and entering retirement, and fewer younger workers have been entering the workforce.
- Initially small pension obligations have grown large after decades of compounding.
- Market interest rates have persistently declined.
- Pension fund assets have moderated.
- Large numbers of pension plans have been poorly managed.[2]

Many healthcare financial executives are examining strategies to help their organizations deal with these significant unfunded liabilities. When doing so, it's useful to consider trends related to defined benefit plans in corporate sectors and specific factors that will influence options available to healthcare providers.

## The Vanishing Defined Benefit Plan

Today's corporate environment provides a glimpse of what may be in store for the healthcare industry. The number of Fortune 1000 companies that have frozen or terminated their defined benefit pension plans has more than tripled since 2001. In 2006, 113 Fortune 1000 companies had either frozen or terminated a defined benefit plan or they announced plans to do so. In 2004, that number was 71, and in 2002, it was only 39.[3]

A survey by Towers Perrin concluded that nearly half of corporations with more than $100 million in pension assets will refuse to offer pensions to new hires or will restrict benefits for present workers if funding for the plans cuts into capital spending. According to Towers Perrin, 62 percent of companies will consider freezing their plans in the face of tightened legal and regulatory funding requirements, and 72 percent will do so if the Financial Accounting Standards Board (FASB) decides to eliminate the practice of spreading the estimated value of pensions out over time to counter rate volatility.[4]

McKinsey and Co. estimates that up to 75 percent of defined benefit plans will be frozen or terminated by 2012 as a result of accounting, market, and regulatory forces and at least $1 trillion in pension assets will be invested in different products and solutions, including fixed income, hedge funds, and private equity.[5]

## The Situation for Hospitals

Since the stock market turned bearish in 2002 and 2003, hospitals have had to make up for a shortfall in pension funding. Defined benefit pension plans typically rely on equity investments for 60 percent to 70 percent of returns. When returns on investments shrunk four to five years ago, sponsors of defined benefit plans were socked with an estimated 6 percent to 7 percent increase in annual pension liability.[6]

The Pension Funding Equity Act of 2004 helped to ease the escalation in pension costs for hospitals by replacing the 30-year Treasury rate as the means of calculating annual and quarterly contributions to defined benefit plans with the corporate bond index beginning in 2004 and 2005. The historic lows in 30-year Treasury bond interest rates, which began in 2001, had been forcing plan sponsors to assume artificially low rates of return on their pension obligations and to funnel millions of additional dollars into their plans.[7]

However, pension liability was a concern for hospitals in 2006 because of a decreasing discount rate and suboptimal investment returns. Although

a discount rate of more than 6 percent improved the funding status of pension plans in 2006, Fitch Ratings notes that many hospital pension plans were still seriously underfunded.[8]

While hospitals with underfunded pension plans may have been able to limp along since the stock market downturn, the Pension Protection Act of 2006 is forcing them to bring funding levels up to 80 percent beginning in 2008 or face increased volatility in both fundings and income. The act, which seeks to bolster funding of existing defined benefit plans, requires that plan sponsors accelerate the time period over which they can fund their obligations.

The new pension legislation will not allow sponsors of defined benefit plans to spread out their fundings over a long period of time. If they are underfunded, they are going to have to do something about that in the next five years. At the least, the pension legislation may affect investment strategies. It is generally thought that companies will take the money that has been set aside to fund their pension obligations and invest it more conservatively because they will not want to have to worry about investment volatility on top of funding volatility.

"If the Pension Protection Act requires upfront funding of a large portion of a pension plan's unfunded balance, that could impact some credits, depending on how large the unfunded status is," notes John Wells, analyst with FitchRatings.

A growing concern is that sponsors of defined benefit plans will shift cash flow from operations and capital planning, move investments from equities into fixed income securities, or borrow money to meet obligations. Additional borrowing should not affect credit ratings as long as pension plan sponsors exchange pension-related debt for contractual debt, according to Moody's. However, if pension debt erodes the cushion that supports existing covenants or prompts waivers to existing credit agreements, it could threaten credit ratings.[9]

Wells estimates that 70 percent to 80 percent of Fitch's credits have defined benefit plans, and the vast majority of them are unfunded to some degree. "It really depends on the credit whether an unfunded balance would have an impact," he adds. "Most of the credits we rate are in pretty good shape with their pensions. Most are funded in the 80 percent to 85 percent range, which is something we're comfortable with.

"If they start to get down to 75 percent or 70 percent," he says, "that's when we would start to get a little concerned. In some cases, credits may issue debt to fund their pension plans, which obviously adds risk. But we look at these things case by case."

Reform of sponsors' accounting for postretirement benefits by FASB may significantly affect earnings and the balance sheet. FASB Standard No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans,* represents the first phase of that reform. It will have taken effect by the end of 2007 for virtually all sponsors, moving information about the overfunded or underfunded status of the plan (i.e., fair value of plan assets minus benefit liabilities) from the footnotes of financial statements to the balance sheet.[10]

The change in reporting was made by FASB to improve employers' accounting for pension and other postretirement benefits, says Peter Proestakes, manager of FASB's Pension and Other Postretirement Plans Project. The accounting guidelines in use since the 1980s were the result of a number of compromises. Jeffrey Mechanick, project manager for not-for-profit organizations for FASB, says that by moving unfunded liabilities from the footnotes to the balance sheet, the new accounting standard makes the magnitude of the overfunded or underfunded status of the plan more visible to users of the financial statements.

However, coming on the heels of the Pension Protection Act, FASB Standard No. 158 is a double whammy for pension plan sponsors. As Jacobson, with Rush University Medical Center, notes, providers are feeling the pressure.

"At about the same time that accountants came up with new rules about how to disclose the liability and put it on the balance sheet, the federal government changed the rules in terms of funding with the Pension Protection Act," she says. "With two independent movements toward the same goal, we have to put more cash into our pension plan even more quickly."

## Strategies for Funding Defined Benefit Pension Plans

Mirroring corporations, increasing numbers of hospitals are freezing their defined benefit pension plans or changing the formula by which defined benefits are determined. Fitch notes a continuing gradual shift in the industry from defined benefit pension plans to defined contribution plans, which is viewed favorably as it adds predictability in planning for future funding.[11]

In the short term, hospitals may want to consider a financing vehicle that will sustain their pension obligations. One option is a revolving line of credit that is secured by accounts receivable, can be drawn upon to fund pension plans, and can be paid back over time as cash is generated from operations. Such a strategy would allow a hospital with an underfunded defined benefit pension plan to meet requirements of the Pension Protection Act.

Another option is a term loan, which may be thought of as taxable long-term financing. Hospitals cannot use tax-exempt money because funding a pension plan does not qualify as a legitimate use of tax-exempt bond funding. But while a loan would be taxable, it would be structured like a tax-exempt bond in other ways. So the loan would have the same collateral and the same legal structure as a tax-exempt financing, but it would have a taxable rate of interest.

Hospitals that have frozen their defined benefit pension plans may obtain a loan to purchase an annuity from a life insurance company and outsource the ownership and management of the pension liability. "They would effectively take their defined benefit liability and say to an insurance company, 'Here is my defined benefit portfolio. These are the employees in it. This what we expect to pay out.' They then would buy an annuity to match the forecasted revenue stream," notes Michael O. Lincoln, managing director of the Strategic Relationship Group, GE Healthcare Financial Services.

Admittedly, such a strategy is expensive. However, it gets the pension liability off of the balance sheet, and it trades pension liability—which is often uncertain—for a loan that is paid back over time and that is much less volatile. It also allows the hospital to eventually get out of the defined benefit pension business altogether, Lincoln adds.

Still another option is for hospitals to obtain tax-exempt financing to reimburse themselves for capital projects for which they paid cash and then use the proceeds from that financing to fund their pension plan. In a well-publicized case, Ascension Health, St. Louis, issued $612 million in subordinate bonds to help reduce a $1.4 billion pension deficit and at the same time free up cash, saving an estimated $387 million over 10 years.

The bond issue had a senior/subordinate structure, which made existing bondholders senior to ensure they would be paid first in the event of default. Bonds were issued through three state financing authorities—in Alabama, Indiana, and Michigan—and the bonds were serial mode or multiannual with terms extending from 2007 to 2012.[12]

Generally speaking, subordinate debt tends to be reserved for hospitals with AA or higher credit ratings. However, it may be a tactic for other hospitals that need capital for specific purposes, such as pension plan financing. These smaller-size, low-end investment-grade hospitals may contemplate such a move when looking for funds so substantial (frequently in the range of $20 million to $30 million) as to be no where near their bottom lines—so funding the pension plan through operations isn't an option.

# The Medical Malpractice Environment

The medical malpractice environment is highly unpredictable. Medical malpractice premiums rose 15 percent nationwide between 2000 and 2002, which outpaced the growth of per capita health-care spending in toto by a factor of two, according to the Congressional Budget Office. In states that had not passed tort reform legislation, the jump in medical malpractice premiums was far higher. Medical malpractice premiums in these states rose as much as 45 percent from year to year.[13]

Malpractice claims as well as jury awards during this period also were rising. According to Jury Verdict Research, hospitals were paying claims in 50 percent of court cases, and they were paying a median of $500,000 in awards to plaintiffs per case.[14] With such high payouts, many insurance carriers decided to abandon the medical malpractice market, which reduced hospitals' access to insurance coverage and led to even higher premiums.

Since the early 2000s, the overall medical malpractice climate has improved. Rate increases have allowed medical malpractice insurers to catch up with losses, and premiums have reached acceptable levels relative to costs. The cost of medical malpractice insurance also has decreased or at least stabilized over the past few years.

But while fewer medical malpractice claims have been filed, the dollar amount per claim has risen. The average size of claims is increasing at a rate of 6 percent. Added to that, the amounts paid to plaintiffs increased 3 percent, and the cost of defending against liability claims jumped 17 percent.[15] Reporting in November 2006, the Hospital and Healthsystem Association of Pennsylvania noted that the cost of medical liability coverage in the state had increased 93 percent since 2000.[16]

## Strategies for Funding Medical Malpractice

To decrease the overall rate cost or the rate of growth of malpractice insurance, many hospitals have reduced the limits of their coverage and raised their deductible payments. This not only increases risk to the hospital and may lead to greater year over year expense depending on occurrences of malpractice liability, but it also makes hospitals more vulnerable to pressures from commercial insurance carriers, according to a Standard and Poor's 2004 report.[17]

Other hospitals have responded to the mercurial medical malpractice market by insuring themselves for malpractice liability through captive insurance companies. These companies are created primarily to insure the exposures and risks of their owners and affiliates. Owners/insureds dictate the captive's underwriting and investment policies. As such, they are given control over coverage design, cost, and administration, with perceived benefits being greater control over rates and potential to leave a risk pool that includes higher-risk facilities. In essence, these insurance vehicles provide an opportunity to smooth out insurance cost volatility and maintain a long-term fluid investment. In some instances, captives may be the only way a hospital can obtain insurance at a reasonable price. Also, tax advantages, such as deductibility of premiums and deferred taxation of insurance income, may be available to both onshore and offshore captives depending on how they are structured.[18]

The significant downside to captives is that self-insured hospitals tend to retain more risk, particularly if they have trouble finding affordable reinsurance. Also, prices in the commercial market may increase when lower-risk members leave the pool. Reinsurance, which covers loses above a specified threshold, may provide protection by allowing self-insured hospitals to transfer risk away from an insurance captive.

Nevertheless, the insurance climate has added volatility to the balance sheet and financial planning, as actuarial estimates have varied significantly from year to year.[19]

Also of concern for some is the means of meeting the fiduciary obligations of the captive. When funding these programs, hospitals have predominantly relied on equity. Insurance regulators typically require hospitals to fund their medical malpractice programs at very high levels, setting aside enough cash to cover future medical malpractice liabilities for between five and 10 years. As such, hospitals often end up parking cash in the programs for an extended time.

One strategy for hospitals to meet the fiduciary obligations of a captive without continuing to fund it with cash and premiums is to use contingent capital in the form of a letter of credit. A hospital with a mature insurance captive that has built up excess reserves will likely have an investment portfolio in excess of what it actually needs. A letter of credit can be used to satisfy insurance regulators by providing a mechanism for accessing additional capital in the event of an unforeseen malpractice claim.

A letter of credit also may be used to fill the gap when obligations come in far higher than what was expected from actuarial projections. The letter-of-credit concept may allow a hospital to fund its insurance captive to a flat static level for the next projection period. A hospital therefore may be able to earmark $10 million in its insurance captive for the next five years and turn to the letter of credit to make up the difference if actuarial estimates indicate the amount should be $12 million or $15 million.

# The Changing Investment Portfolio

To get the kinds of returns that are needed to support pension plan benefits and medical malpractice exposure, some hospitals are looking to the world of investment alternatives. “Organizations are matching assets and liabilities, increasing their bond portfolio to an extent to annuitize their liabilities for retired lives with bonds that match up in duration and interest rate payments to pay for these benefits. At the same time they are looking for more alpha, so they are looking to the world of alternatives to get returns from private equity and hedge funds,” says Mike Cosgrove, president and CEO of mutual funds for GE Asset Management and trustee of the GE pension trust. GE Asset Management is headquartered in Stamford, Conn., and has total assets of $197 billion under management, including $61 billion in the pension trust.

There is the perception, however, that, like other institutional investors, hospitals may have taken on unnecessary risk by moving into hedge funds and private equity. “One of the potential risks, if one is looking to boost returns in order to deal with an unfunded liability, is that the investment strategies that are used to get higher returns within an investment program may introduce greater risk and volatility,” notes Lisa Zuckerman, treasurer at Catholic Healthcare West, who manages the organization’s $4.7 billion investment portfolio. “A down year would not only affect the value of the portfolio, but also cause a significant reduction in earnings and cash flow for the organization. We’ve had a great run in the market, where 8 percent to 12 percent returns—or more—were typical, depending on an organization’s asset allocation. But if you go back and look at

financial trends, in say 2001 to 2003, you'll see that investment earnings dried up. For many organizations, that's a significant part of their bottom line."

Institutions that target higher investment returns may have greater swings in performance and be more at risk for cash flow and income volatility in the near term, notes Zuckerman, who previously served as a director at Standard and Poor's Corporation. "But it also depends on the diversification of the portfolio, and how well the program is hedged by investing in a broad range of non-correlated asset classes," she says. "This often means accessing 'alternative' asset classes, where there may be balance sheet ramifications, primarily because these are less liquid assets."

Organizations that pursue alternative investments, such as private equity and hedge funds, should recognize they do carry risk. Hedge funds that have lockout periods, for example, may restrict a hospital's ability to convert the investment to cash. Alternative instruments also have higher monitoring costs, and they may not end up achieving higher returns.[20]

Nevertheless, according to Fitch, as long as investments in alternative investments are offset by cash flow and liquidity, the shift to alternative investments may be a smart move because of their potential to achieve higher returns over time.[21]

In addition, there is an enormous difference in returns between the top quartile private equity firms and the median or lower performers. So it is not that the asset class doesn't perform well. It is the variability of performance of members within the class that is of concern. "Because of the variability of manager skill and strategies within alternative asset classes, it's even more important to understand philosophy and approach, as well as their track record," notes Zuckerman. "Are they using a lot of leverage? What sort of risk profile do they have and what level of returns do they target? Part of the idea of investing in a hedge fund, for example, is to invest money in parts of the market that don't move in the same way as equities or fixed income. But there are many kinds of hedge funds—some take huge bets, while others take a true 'low volatility' strategy. And there are fund-of-fund structures, which introduce a significant level of diversification to reduce volatility. So it's hard to use a broad brush and automatically assume a hospital is taking on a lot of risk simply by getting into these asset classes," says Zuckerman.

"Over time," she adds, "these strategies, when executed successfully, can be a great diversifier in a portfolio and contribute to reduced volatility and more stable long-term returns."

While the move to alternative investments is an effective strategy when done prudently, it can increase the risk profile if it is not well planned and balanced with other investment strategies. A hospital therefore should have institutional depth on the investment front to understand how to construct a portfolio so it is not just blindly chasing after the latest hot performer.

## Will Your Hospital Be Prepared?

Healthcare financial executives should remain vigilant in anticipating the demands of their organizations' unfunded liabilities. While it is easy to become immersed in the day-to-day challenges associated with managing the financial demands of the healthcare organization, leaders should stay committed to successful practices in strategic capital planning. By staying abreast of today's top trends and strategies in regard to pension planning, enterprise risk associated with medical malpractice, and investment alternatives, leadership will be best positioned to understand potential effects to the hospital's capital position and support the organization's ability to fund important future initiatives.

# Case Study Report

## How unfunded liabilities can compound financial problems in a troubled organization

It was right around 2002 when the perfect storm occurred for defined benefit pension plans, recalls Cathy Jacobson, senior vice president of strategic planning, CFO, and treasurer for Chicago's Rush University Medical Center. Returns from investments tanked because of the bear market, and the interest rate by which liabilities are valued was low. "So the value of the assets to support our liabilities dropped because our investment holdings dropped. At the same time, the liability was valued higher and higher because the interest rates were so low," she says.

In 2002 and 2003, the medical malpractice environment was equally ominous, with a rising number of malpractice claims and a contracting medical malpractice insurance market. "We had to become self-insured to $15 million per case with no aggregate. So if a single case bloomed, we were limited to $15 million exposure. If we had more cases, we had no aggregate protection," says Jacobson.

### Pension Plan Funding

"We were starting out with a precariously low cash balance—under 50 days cash on hand—and had to figure out how we were going to fund our pension trust. That significantly impacted anything else we could do," says Jacobson.

Rush University Medical Center began by working with its actuaries on projections of the amount of cash that would be needed for the pension plan down the road. "The remedy was to get a handle on what our projections were under different scenarios, because the discount rate valuation of the liability has an immense impact in terms of how much cash you need to put in to the pension trust and how it will be valued on your balance sheet. A very small move in the discount rate can double or triple or drop in half what your contributions are as well as the impact on the balance sheet," she explains.

Rather than view projections on an annual basis, actuaries for Rush University Medical Center took a longer term view and ran five-year projections and sensitivity analyses in terms of the ranges that would be involved if the liability was valued in different ways. "By looking further out, we were able to see what was coming three years down the road and to start funding for that now," she says. "Instead of having to have a massive call on cash from year to year, we were able to start smoothing things out."

Rush University Medical Center also renegotiated debt covenants. "When the pension liability goes on your balance sheet, it is a direct reduction to your net assets, and it can negatively impact your bond covenants," notes Jacobson. "So we talked to our bond insurer about renegotiating our covenants to avoid the unanticipated impact that we had on our financial statements."

Once the hospital started having positive bottom-line results, it refinanced its debt. The refinancing transaction dropped interest costs from $10 million to $8.5 million. The hospital also has looked at issuing new debt in order to be able to cover capital needs. "We really couldn't do that because this pension liability was sitting on our balance sheet and constraining our debt capacity," she says. "We were in a bind because we had to put cash into the pension plan and, because that liability showed up on our balance sheet, no one wanted us to borrow money." So it really took improving the cash flow of the organization and improving the cash balance while keeping up with the other obligations to be able to prepare to borrow debt again.

In 2003, the hospital changed its defined benefit pension plan formula. "We realized that the market had been moving away from defined benefit pension plans and more to defined contribution plans," says Jacobson. "We couldn't afford to fully fund the plan and buy it out in 2003." So the organization froze the old benefit calculation and went to a defined contribution formula combined with a straight contributory plan going forward. "We stopped the defined benefit pension plan before the pension liability could grow worse, but we have been left with a significant tail to fund."

Even after these steps, the hospital's pension plan is still underfunded from a balance sheet perspective.

To catch up, Rush University Medical Center plans to contribute another $70 million over the next three years and is projecting an additional $140 million over four additional years before it is fully funded.

### Malpractice Insurance Funding

When Rush University Medical Center went from a $4 million malpractice insurance deductible to a $15 million deductible in one year, its actuaries' estimates of liability were "like throwing darts at a dartboard," says Jacobson. "When you are dealing with that level of exposure in a highly volatile medical malpractice market, the ability to make estimates on exposure becomes virtually impossible. You get a mathematical calculation, but the reliability is questionable," she adds.

In the face of operational problems and low levels of cash, unfunded liabilities hit doubly hard. "We were funding the lowest levels we could, and then all of a sudden we had this balloon in projected liability, and we had to come up with the cash," she recalls.

In more recent years, there has been a dampening effect on medical malpractice. The state of Illinois has passed tort reform legislation. Although the legislation has not yet been tested in court, it is believed among other factors to be contributing to an overall improvement in the medical malpractice climate.

Nevertheless, the hospital's annual expense on malpractice self insurance is about $40 million on a discounted basis, and it funds about 75 percent of that amount through operations. And if Illinois' tort reform law is tested and overturned, Jacobson believes the malpractice environment will worsen.

### Gradual Turnaround

Although it still is grappling with huge pension and medical malpractice liabilities, Rush University Medical Center is improving its financial picture. It has built its cash balance from 50 to 140 days on hand. The hospital has instituted efficiency measures internally and expanded its market position. It has enjoyed increases in Medicaid reimbursement and restructured managed care contracts. Once it got enough cash to invest, the hospital has seen gains in investment returns. "We worked to improve operations and have moved beyond [our pension fund problem] and our malpractice experience has come down," says Jacobson. "But it's just these types of things that can hit a troubled organization and make it even harder to pull itself through a turnaround."

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[21] *2007 Nonprofit Hospitals and Health Care Systems Outlook*, FitchRatings, p 3.

# Financing the Future III

Since 2003, HFMA's Financing the Future project has given healthcare providers the information they need to help their organizations have the resources necessary to provide safe, high-quality care for their communities. The project began with a series of reports highlighting strategies hospitals and other healthcare providers could use to improve access to capital. The series was a partnership between HFMA and GE Healthcare Financial Services with research conducted by HFMA and PricewaterhouseCoopers. Following the success of these reports, a second series took the concepts identified a step further by exploring best practices in capital management and providing practical tolls and strategies hospitals could use for financial improvement. This series was a partnership between HFMA, GE Healthcare Financial Services, and Kaufman, Hall & Associates. With Financing the Future III, HFMA, in partnership with GE Healthcare Financial Services, sets out on its most perhaps its most ambitious effort to date: identifying key industry trends that affect hospitals' capital position and ability to fund important future initiatives. For each trend, a report will identify the current state and implications for the future. For more information about Financing the Future III and to access the complete archive of project reports, visit www.financingthefuture.org.

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