Current Issues in Health Care

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North Carolina Nonprofit Healthcare Finance

- North Carolina Medical Care Commission ("NCMCC")
  - Statewide issuer; 17 members appointed by the Governor; Staff housed within the Division of Health Service Regulation ("DHSR") of the North Carolina Department of Health and Human Services.
  - Issues tax-exempt bonds for health systems, community hospitals and senior living facilities (e.g., continuing care retirement communities, skilled nursing facilities, assisted living facilities).
  - NCMCC bonds must be approved and sold by the Local Government Commission.
  - Together, the two commissions have conservative policies in place for the issuance of NCMCC bonds:
    - For new money construction projects, borrowers must obtain a GMP contract based on final working drawings that incorporate all comments from DHSR Construction Section and other State or local reviewers, before the LGC will approve and the bonds can be sold.
    - Level debt service, for up to a 30 (or, in certain cases, a 33) year period (the NCMCC will not issue bonds up to the 40-year statutory maximum).
    - No extensions of maturities in refundings.

Trends in North Carolina Nonprofit Healthcare Financing Since 2008

- After the auction rate securities market collapsed in February 2008, North Carolina health systems refinanced their auction rate bonds by early 2009.
- Almost no use of bond insurance by North Carolina nonprofit healthcare borrowers since 2008.
- Bank direct purchases of NCMCC bonds began in September 2009. Since then,
  - banks have directly purchased 61 series of NCMCC totaling almost $2 billion in principal amount, and
  - almost all publicly offered NCMCC bonds have been fixed rate bonds.

North Carolina Medical Care Commission
Publicly Offered Bond Issues

	2009 (Number of Series/ Principal in Millions)	2010 (Number of Series/ Principal in Millions)	2011 (Number of Series/ Principal in Millions)	2012 (Number of Series/ Principal in Millions)	2013 (Number of Series/ Principal in Millions)	Total (Number of Series/ Principal in Millions)
Fixed Rate	4/ 450	9/ 1,038	4/ 157	10/ 1,236	3/ 186	30/ 3,067
VRDBs	9/ 414	-	-	-	-	9/ 414
Other Variable Rate	-	-	1/ 48	1/ 59	-	2/ 107
Total	13/ 864	9/ 1,038	5/ 205	11/ 1,295	3/ 186	41/ 3,588

- After 2009, no new VRDBs, and only one Window VRDB and one FRN, have been issued.
- Of the 30 fixed rate series issued in 2009-2013, 18 of those series, totaling $2.691 billion, have been issued for health systems.

North Carolina Medical Care Commission
Bank Direct-Purchase Bond Issues

	2009 (Number of Series/ Principal in Millions)	2010 (Number of Series/ Principal in Millions)	2011 (Number of Series/ Principal in Millions)	2012 (Number of Series/ Principal in Millions)	2013 (Number of Series/ Principal in Millions)	Total (Number of Series/ Principal in Millions)
Health Systems	1/ 41	1/ 30	10/ 511	7/ 479	2/ 214	21/ 1,275
Hospitals	1/ 10	1/ 22	4/ 71	1/ 23	1/ 45	8/ 171
Retirement Facilities/ Hospices	6/ 124	17/ 257	3/ 46	4/ 89	2/ 33	32/ 549
Total	8/ 175	19/ 309	17/ 628	12/ 591	5/ 292	61/ 1,995

Observations About NCMCC Bank Direct-Purchases

- Of the 61 series that have been directly purchased by banks, 55 of them bear interest at a percentage of LIBOR plus a fixed spread. One series bears interest at the SIFMA Index plus a fixed spread and the remaining five series bear interest at fixed rates.
  - In many cases the use of a LIBOR-based bond interest rate creates a perfect hedge with an existing or new LIBOR-based interest rate swap.
- Many of the direct purchases are refundings/conversions of existing VRDBs.
  - Example: In 2011 and 2012, Duke Health converted all eight series of its variable rate bonds ($516 million) into bank purchases, with holding periods ranging from seven years to final maturity (sixteen years).
- Because the bank that has been providing an LOC or SBPA for an existing VRDB is often the bank purchaser, the terms of many direct purchases have been substantially the same as the bank reimbursement agreements or SBPAS they replace.
  - To make document review more efficient, a comparison of the continuing covenant agreement in a direct purchase against the existing reimbursement agreement or SBPA is often distributed to the working group to highlight whether any changes in covenants or events of default have been made.

Disclosure About Bank Direct Purchases

- Industry white paper issued in May 2013 provides a framework for voluntary disclosure by issuers/borrowers about bank direct purchases.
- The GFOA Committee on Governmental Debt Management has prepared a recommended practice regarding bank loans dated September 2013 which concludes that governments *should* voluntarily disclose information about bank loans. The Debt Committee has recommended this paper to the GFOA Executive Board for approval.
- The focus on voluntary continuing disclosure about bank direct purchases has (positively) affected the disclosure for new fixed rate issues about the issuer's/borrower's variable rate debt.

Future of Bank Direct Purchases/VRDBs

- From 1986 through 2008, banks rarely invested in non-bank-qualified obligations, presumably because the loss of their ability to deduct the carrying cost did not make the pricing of the product competitive for borrowers and/or attractive to lenders.
- Assuming that loan/deposit rates rise back to historical levels, will banks continue to be willing to invest in non-bank-qualified obligations?
- If the SIFMA Index rises back to historical levels, one would expect substantial inflows into municipal money market funds. Unless VRDB issuance ramps back up, how will the demand of municipal MMFs for suitable investments be met?

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North Carolina Has Highly Rated Health Systems

	Moody's	S&P	Fitch
Vidant Health (Greenville) – Academic Medical Center	A1	A+	-
New Hanover Regional Medical Center (Wilmington) (Bonds issued by New Hanover County, subject to LGC approval)	A1	A+	-
WakeMed (Raleigh)	A1	-	AA-
Duke University Health System (Durham) – Academic Medical Center	Aa2	AA	AA
UNC Hospitals (Chapel Hill) – Academic Medical Center (Bonds issued by UNC Board of Governors, not subject to LGC approval)	Aa3	AA	-
Rex Healthcare (Raleigh) (Controlled affiliate of UNC Hospitals)	A1	A+	A+
FirstHealth of the Carolinas, Inc. (Pinehurst)	Aa3	AA	AA
Moses Cone Health System (Greensboro)	-	AA	AA
Wake Forest Baptist (Winston-Salem) – Academic Medical Center	Aa3	AA-	-
Novant Health, Inc. (Winston-Salem and Charlotte)	A1	A+	AA-
The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System (Charlotte) – Academic Medical Center (Bonds issued by CHS directly as a governmental hospital authority, subject to LGC approval)	Aa3	AA-	-
Mission Health (Asheville)	Aa3	AA-	AA-

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Public Relations/Opinion

- *The Charlotte Observer* and *The News and Observer* (Raleigh), both owned by The McClatchy Company, ran a five-part series in April 2012 entitled "Prognosis: Profits" that focused on "extraordinary profits" at North Carolina nonprofit hospitals. Headlines for the series were:
  - "Nonprofit Hospitals Thrive On Profits"
  - "Most N.C. Hospitals Slim On Charity Care"
  - "Hospital Suits Force New Pain On Patients"
  - "Hospitals' Clout In Capital Built With Money, Contacts"
  - "Experts: Hospitals Need Scrutiny"
- These newspapers continue to write stories that are intended to build upon (and cite back to) this series.

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Cap on Sales Tax Refunds

- Perhaps a direct impact of the current climate was the debate in the North Carolina General Assembly during the session that ended in July 2013 about sharply limiting the refunds of sales taxes for North Carolina charitable nonprofit organizations.
- The NC Senate's original plan capped nonprofit sales tax refunds at $100,000 per year, which would have affected about 250 nonprofits, including hospitals, private colleges and universities, churches, retirement communities and hospices.
- Ultimately, H.B. 998 caps these refunds at $45 million per year, which is currently more than any nonprofit receives.
- Carolinas HealthCare System is very close to the cap.
- There is still concern that the cap will be lowered, or the refund eliminated, in future years.

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Health Systems Are Under Pressure to Demonstrate Community Benefits

- The NCMCC has been requiring its borrowers to submit annual community benefits reports for many years.
- Prior to the adoption of Patient Protection and Affordable Care Act (the "ACA" or "Obamacare") in 2010, North Carolina health systems were under pressure to adopt and publicize charity care policies.
- The ACA added Section 501(r) to the Internal Revenue Code, which imposes new requirements on 501(c)(3) organizations that operate one or more hospital facilities. Each 501(c)(3) hospital organization is required to meet four general requirements on a facility-by-facility basis:
  - establish written financial assistance and emergency medical care policies,
  - limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy,
  - make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual, and
  - conduct a community health needs assessment ("CHNA") and adopt an implementation strategy at least once every three years. (These CHNA requirements are effective for tax years beginning after March 23, 2012).
- The ACA also added new section 4959, which imposes an excise tax for failure to meet the CHNA requirements, and added reporting requirements under section 6033(b) related to sections 501(r) and 4959.

Current Charity Care Policies

- Carolinas HealthCare System
  - Uninsured Discount: Uninsured patients automatically receive a 50% discount off gross charges on all medically necessary services, regardless of income level.
  - Coverage Assistance and Financial Assistance: For NC & SC residents who are uninsured and have received hospital inpatient or observation services (or outpatient services that result in balance of $10,000 or more). Patients with income less than or equal to 200% of the federal poverty guidelines will receive a 100% discount.
  - Financial Assistance Scoring: For NC & SC residents who are uninsured and have received outpatient services that result in balance of less than $10,000. Each account is automatically reviewed for a discount prior to billing. Eligibility is based on a financial assistance score from a third party vendor that indicates the likelihood a patient lives in poverty. Patients with qualifying accounts will be extended a 100% adjustment and will not receive a bill.
  - Hardship Settlement. Assists NC & SC residents who have had a catastrophic medical event regardless of their insurance coverage that has resulted in very large hospital bills in comparison to their financial resources. Patients who have incurred a balance of at least $5,000 after all insurance or third party payments that is greater than 20% of their total household financial resources may be eligible for a Hardship Settlement discount.

Current Charity Care Policies (Cont'd)

- Novant Health
  - Free care to uninsured patients with incomes of up to 300 percent of the federal poverty level
- Wake Forest Baptist
  - Uninsured patients from 19-county service area receive a Community Benefit Discount based on federal poverty guidelines. A patient under 200% of the Federal Poverty Level will be awarded 100% assistance.
- Duke Health
  - Medical treatment that is urgent or provided on an emergency basis is eligible for a charity care discount under the DUHS charity care policy. Patients may receive up to a 100 percent discount on eligible services. Discount amounts are based upon a patient's adjusted gross income compared to percentages of the current Federal Poverty Income Guidelines. 100% discount for families with income to 200% of federal poverty guidelines.

Current Charity Care Policies (Cont'd)

- UNC Hospitals
  - Community Care discount that allows any uninsured patient of any income level to receive a 35 percent discount for physician and hospital charges.
  - Charity Care Program that allows a qualifying patient with an income below 250 percent of the Federal Poverty Guidelines to only be responsible for a copay (at least $25 per primary care clinic visit, $35 for specialist clinic visit, $50 per Emergency Department visit and $100 per admission).
  - Catastrophic Care Program that allows eligible patients who do not qualify for charity care and who have incurred significant hospital and physician costs to have their medical debt reduced to 20% of their yearly income.

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Current Charity Care Policies (Cont'd)

- Vidant Health
  - Patients will qualify for 100% assistance based on the following key criteria:
    - Income below 200% of the federal poverty guidelines based on family size,
    - Limited assets and possess no real property other than immediate dwelling,
    - Amounts owed to Vidant Health, and
    - Type of service received (some elective procedures are not eligible, including cosmetic).
  - Patients who have catastrophic medical care bills may receive medically indigent assistance on balances over $5,000 and income over 200% of the federal poverty guideline.

North Carolina 2010 Median Family Income (Source: U.S. Census Bureau)

- State: $45,570
- Charlotte
  - Mecklenburg: $55,294
- Triad (Winston-Salem, Greensboro, High Point)
  - Forsyth: $46,749
  - Guilford: $45,676
- Triangle (Raleigh, Durham, Chapel Hill)
  - Wake: $63,770
  - Durham: $49,894
  - Orange: $52,981
- Eastern North Carolina
  - Pitt: $38,592
- 200% of 2013-14 Federal Poverty Guideline for:
  - Individual = $22,980
  - Family of four = $47,800

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Impact of North Carolina's Rejection of Medicaid Expansion

- North Carolina has rejected the Medicaid expansion called for in the ACA.
- In North Carolina, about 1.5 million residents are uninsured, and about half of them are expected to qualify for insurance subsidies under the ACA.
- About 500,000 of the uninsured earn less than 100 percent of the poverty level - $11,490 for a single person and $23,500 for a family of four. They are not eligible for insurance subsidies, and therefore are not subject to a penalty for not buying health insurance, because the ACA assumed they would get benefits through the Medicaid expansion.
- The annual cost to North Carolina's hospitals of not expanding Medicaid is estimated to be as much as $660 million.
  - $85 million for UNC Hospitals
  - $50 million for Carolinas HealthCare System Charlotte-area hospitals only
  - $37 million for Novant Health
- AND, under their charity care policies, they will still be required to treat these 500,000 individuals without compensation.

Impact of Health Care Reform

- Principal impact is uncertainty.
- Consolidation activity has increased in recent years, although not necessarily in the form of traditional mergers and acquisitions. Examples:
  - Carolinas HealthCare System/Moses Cone
  - Duke LifePoint
- Physician networks continue to expand, and are now seen as a positive.
  - Example: Beginning with the Official Statement for its 2011A Bonds, Carolinas HealthCare System moved the discussion in Appendix A about its employed physician network ahead of the discussion about its hospital facilities.
- North Carolina health systems appear to be taking a wait and see approach with respect to accountable care organizations ("ACOs").

CHS/Moses Cone Management Agreement

- Effective October 1, 2012, Cone Health entered into a Management Services Agreement with Carolinas HealthCare System ("CHS").
  - 10-year term
  - Cone Health remains independently owned and governed by its Board of Trustees.
  - Top 5 senior leaders of Cone Health (CEO, COO, CFO, Chief Quality Officer and Chief Nursing Officer) became employees of CHS.
    - The relationship is "expected to enhance clinical excellence and provide for a broader range and higher level of cost-effective healthcare services through the sharing of best practices, access to healthcare management experts and clinical quality teams."
  - Cone Health had been quietly exploring possible partnerships for several years with a goal of generating economies of scale, as well as ways to advance its quality and safety agenda.
  - In May 2013 Cone Health joined the Premier healthcare alliance, which CHS joined more than four years ago.

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Duke LifePoint

- In January 2011, Duke University Health System and LifePoint Hospitals formed DLP Healthcare LLP, a joint venture designed to strengthen and improve health care delivery throughout North Carolina and the surrounding regions by creating flexible affiliation options for community hospitals.
  - One of the first joint ventures between an academic health system and a hospital operations company, its mission is to own and operate a system of highly functioning community hospitals.
  - The joint venture combines LifePoint's extensive operational resources and experience in successfully managing community-based hospitals with Duke's renowned expertise and leadership in the development of clinical services and quality systems.

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Duke LifePoint (Cont'd)

- Duke LifePoint hospitals include:
  - Maria Parham Hospital, Henderson, NC (80% ownership; 50/50 board composition)
  - Person Memorial Hospital, Roxboro, NC (100% ownership)
  - Twin County Regional Healthcare in Galax, VA (80% ownership; 50/50 board composition)
  - Marquette General Hospital, Marquette, MI (100% ownership)
  - MOU signed: Wilson Medical Center, Wilson, NC (80/20 ownership, with 50/50 board composition)
  - MOU signed: Rutherford Regional Health System, Rutherfordton, NC (shared ownership; 50/50 board composition)

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Physician Networks Continue to Expand

- Carolinas HealthCare System:
  - As of December 31, 2012, CHS had 1,308 primary care and specialty physicians in its Physician Services Group, in 22 NC and SC counties.
- Novant Health:
  - As of December 31, 2012, Novant's employed physician network included 1,123 full and part-time physicians and 417 mid-level providers such as physician assistants and nurse practitioners located at 350 sites in 26 counties across NC, northern SC and VA.
- The challenge: How to move physician compensation from being based on volume to being based on value.

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Update on General Municipal Market Issues

- Threat to Municipal Bond Interest Exclusion
  - Greatest risk: 28% cap
- Detroit Bankruptcy: Proposed Treatment of Unlimited Tax General Obligation Bonds
  - Will this affect how general obligation bonds are viewed/rated/priced?
- SEC Municipal Advisor Rules
  - Will these rules fundamentally change the relationships among municipal market participants?
- IRS Proposed Issue Price Regulations
  - Would these regulations change how negotiated deals are priced?

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Questions?

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