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Transcript of the Meeting
of the
Commission on Health Care
Facilities in the 21st Century

Held on Thursday, August 24, 2006
New York City Conference Center
71 West 23rd Street, 2nd floor
Borough of Manhattan

Meeting convened at 1:00 p.m.

P R E S E N T:

Statewide Members
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HOWARD T. HOWLETT
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DR. DAVID SANDMAN

MARK USTIN, ESQ.

Dormitory Authority State of New York
LORA LEFEBVRE
JEFFREY POHL

CHAIRMAN BERGER: I am three minutes late, and I apologize, because while punctuality doesn't mean anything, it does mean that people who come here can assume the meeting will start on time. And that's part of our responsibility.

I would like to welcome you to the meeting of the Commission on Health Care Facilities in the 21st Century, and call the meeting to order. I would like to begin by asking our executive director, David Sandman, to give us a progress report since our last meeting. David?

DR. SANDMAN: Thank you, Mr. Chairman. I am pleased to provide this brief summary of activities.

As previously reported, $269 million in HEAL funding is currently available for hospitals and nursing homes to support restructuring initiatives that are consistent with the goals of the Commission.

Under this capital restructuring initiative, applicants could seek funding, support for physical reconfiguration, the downsizing or closure of a facility, consolidation or conversion of programs in both acute and long-term care beds, and elimination of duplicative services.

The application deadline just passed the other week, on August 15th. And as expected, there was an enthusiastic response to this statewide RFP.

It has been reported that approximately 120 applications have been received by the Department of Health and by the Dormitory Authority, which issued the RFP. In addition, approximately 25 applications have been received under the Commission's own Voluntary Rightsizing procedures. These are from providers wishing to engage in voluntary talks involving various types of consolidations and collaboration, as well as restructuring.

Commission and Department of Health staffs are actively supervising and guiding those talks in each region of the state, and will continue to do so. Commission staff and the regional advisory committees also continue to engage in discussions with providers and other stakeholders within the regions.

In the past month alone, Commission staff has met with approximately 30 more providers; a few of them had previously been nonresponders, despite numerous efforts by the RACs and by the staff to arrange meetings.

With the assistance of multiple trade associations, who I wish to thank for their collaboration, we have been able to successfully reach and schedule all of those providers who have previously been nonresponders, and those efforts do continue with those few who remain.

As always, the Commission is engaged in an active outreach and communications program with various constituencies. Recent briefings of elected officials include the State Senate and the Manhattan Borough President.

And, finally, Mr. Chairman, across the river, New Jersey is planning to establish a commission similar to this one, to examine issues of system capacity in that state. They have reached out to us a few times during their planning efforts, and we are informally providing consultation to their effort.

So, in summary, Mr. Chairman, we are making good progress and are on schedule with the work plan adopted last fall. Thank you.

CHAIRMAN BERGER: Thank you, David. Are there any questions for David from the members? Thank you, David.

By the way, for New Jersey, we don't do

outsourcing. We have enough to do here.

This Commission has the fundamental mandate and charge to look at the institutional structure and institutional network in the state; both in terms of acute care and in terms of long-term care.

But, both in our charge in the legislative mandate and in all of the discussions, it is clear that there are a whole series of what I would call framing issues. Without discussing and without our talking about that, and without putting them on the table, make it very hard to just talk about the institutional framework in a vacuum.

And today we are going to deal with several of these issues, we're going to talk about several of these issues. And we'll continue this at our next meeting in September. And both of the issues that are on the table for us to talk about and to discuss today, are a part of what constitutes the fabric in the network of health delivery in the state.

And they are sort of on two ends of the spectrum. If it has to do with large amounts of money on the capital side, and a lack of funds on the operating side. Both pieces that we have to

understand as we come to deal with some of the issues that we will be dealing with over the next three months from now.

So I would like to begin, I would like to ask David, who has a long background, to open up and begin a discussion with regard to the uninsured in New York State. We've had this discussion before, members of the Commission have asked us to get these issues in front of everybody.

And, so, David, why don't you begin the discussion?

DR. SANDMAN: Thank you, Mr. Chairman. I am pleased to speak with you today regarding the uninsured in New York State. The lack of coverage does remain one of the most serious and persistent health care problems, both here in New York, as well as in the nation.

So I would start today with the basics, including the number and the trends among the uninsured, provide a profile of uninsured New Yorkers, describe some of the barriers the uninsured face in getting health care, summarize the public coverage programs that exist in New York State, some proposals under consideration to further expand coverage, and end up by discussing how the

uninsured, among many factors, have placed financial pressures on our hospital system.

This first set of pie charts show the distribution of health insurance for all individuals, including children and the elderly. Both nationally and in New York State, employer-sponsored coverage remains the dominant source for insured, covering just over half of the population.

In New York State, roughly 15 percent -- the pieces in red -- 15 percent of the total population is uninsured, which is just one percent lower than the national average of nearly 16 percent.

A larger percentage of New Yorkers, 17 percent, has Medicaid, compared to 14 percent nationally, and a very small portion of the population carries coverage bought in the individual markets.

Most often, data regarding the uninsured is restricted to non-elderly individuals, because of the universal coverage provided by Medicare to ages 65 and older. And, thus, these charts indicate the distribution of coverage among non-elderly citizens, or residents.

You can see that the portions of uninsured rise accordingly, so that 17 percent lack coverage in New York State, as do 18 percent nationally. The proportions of employer-sponsored coverage increase, they are identical at 61 percent in both New York and the nation, and the prevalence of Medicaid in New York remains higher than the national average, 18 percent vs. 13.

This next slide drills down a bit deeper. It shows the distribution of coverage in New York City versus the State as a whole. And as you can see, the problem of the uninsured is most severe here in New York City, where one in four non-elderly individuals are uninsured. Also one in four non-elderly residents in New York City have public coverage, compared with one in five statewide.

And, finally, employer-sponsored coverage is far more common on a statewide basis, covering 61 percent, compared with just under half or 47 percent here in the City.

This next slide reveals trends in the percentage of uninsured, both in New York and nationally. The red is New York State and the blue is the U.S. Beginning in 1995, the portion of uninsured in New York State began to exceed the

national average, and this continues through the end of the decade, peaking at 20 percent.

But in the most recent years, the trend has begun to reverse. The proportion of uninsured in New York State has been declining. And you can see that the two bars now cross each other at the far right, so that New York State now actually looks slightly better than the nation as a whole, and the trend here is moving in the right direction, although, the number of uninsured continue to be unacceptable and chronically high.

This slide helps us to understand what has contributed to that movement in that right direction. Between 2000 and 2004, the percentage of the uninsured in New York State has declined, while the percentage nationally has increased.

And the next set of bars makes it pretty clear why that is. The percentage of persons covered by Medicaid has grown at a faster rate in New York State than it has nationally, as we have expanded our program enrollment. And just as importantly, in the third set of bars, our base of employer-sponsored coverage has remained relatively stable, while it has declined and eroded markedly across the nation.

This slide also indicates that New York State has relatively generous eligibility levels for public coverage. We cover various groups, working parents, pregnant women and infants, at income levels significantly higher than the national averages. And our coverage for children is identical, also supplemented by a large Child Health Plus program that kicks in at those income cutoffs.

Let me now turn to a profile of the uninsured. And while the uninsured are a diverse group, they do share certain common characteristics. The first and most obvious feature is that the uninsured tend to be low income.

In New York State, more than one-third of the uninsured live in poverty, based on household income and household size. And another quarter, or 27 percent to be exact, is low income, meaning that they have income between the poverty level and twice the poverty level. So in combination, nearly two-thirds of the uninsured have low income.

The next characteristic of the uninsured is that they are overwhelmingly adults. More than four in five of New York's uninsured are adults. And among those adults are young adults; those ages 18 to 30, who are disproportionately likely to be

uninsured.

Next, three-quarters of the uninsured are either themselves working or the dependent of a worker. Only one-quarter of the uninsured belong to a household where nobody works.

And it won't come as a surprise, that many of these uninsured workers are in small firms. More than half, in fact, are employed in a business with fewer than 25 workers. Fully two-thirds are employed by businesses with fewer than 100 workers.

The bars on the left side indicate a direct correlation between firm size and the likelihood of being uninsured.

So, in a nutshell, the uninsured tend to be what are sometimes called the "working poor." They are not necessarily residing at the very bottom of the socioeconomic ladder. I often refer to the uninsured as people who are playing by the rules but losing. They work, they pay taxes, they are employed by a small firm that does not offer benefits, but they earn just a bit too much to qualify for Medicaid or other public coverage programs, and their low incomes mean that they do not earn nearly enough to buy an individual policy, which tends to be inordinately expensive.

The uninsured also tend to disproportionately belong to racial ethnic minority groups. In New York State, blacks and African Americans comprise 16 percent of the total population and comprise 21 percent of the uninsured.

The imbalance is even greater for Hispanics, who also comprise 16 percent of the total population, but 28 percent of the uninsured. The uninsured are also likely to be non-citizens of the United States, particularly roughly half non-citizens who have been in the country for six years or less, are without health insurance coverage. And these numbers are pretty similar both in the nation and New York State.

And, finally, as a profile, this slide can be interpreted as both good and bad news. The good news is that a large number of the uninsured are today eligible for public health insurance, due to various program expansions that have been enacted by the State.

The bad news, however, is that a large number of these individuals are not enrolled in programs for which they are eligible. In total, 1.3 million of the State's 2.9 million uninsured, nearly half, are estimated to be eligible for some sort of

public coverage program. And among children in particular, where eligibility levels are relatively generous. We could largely solve the problem of uninsured children, if every child was properly signed up for coverage.

So, to recap, so far, New York's uninsured tend to be low income adults, belong to a working family, be a member of a racial or ethnic minority, non-citizen of the United States, and are sometimes already eligible for coverage.

Insurance status really matters. A point which seems painfully obvious, but which always bears repeating. And while there are many types of barriers that prevent people from getting access to health care, the most significant of these barriers tend to be financial. Health insurance is one's ticket into the health care system. And the evidence is overwhelming that the uninsured receive less care than those with coverage.

In particular, they receive less or no preventive and primary care, and they are more likely to experience acute episodes of illness that require advanced and costly care that often was avoidable had there been appropriate access to timely and affordable medical attention.

Looking at some national data, the uninsured are four times more likely than the insured to report having no regular source of care; more than three times as likely to report that they put off or postponed care due to cost; more than three times as likely to report not getting care they needed; and three times more likely to report not filling prescriptions, because they cannot afford them.

These same patterns are true here in New York. Even despite the presence of HHC the world's largest public hospital system that provides substantial amounts of care to the uninsured.

The numbers on this slide are based off of a new analysis performed by Commission staff of the Behavioral Risk Factor and Surveillance Survey conducted by the CDC. It's a particularly large and robust database. And you can see that both in New York State and New York City, there is a yawning gap in access between the uninsured and those with coverage.

The uninsured are twice as likely not to have had a checkup in the past year, and they are four times more likely to report that they could not get or receive care because of cost. And they are

also four to five times more likely to report having no regular source of care.

New York State does have a large and complicated system of public coverage programs, whose growth has helped reduced the number of uninsured residents. The largest of these programs, of course, is Medicaid. New York's Medicaid program has one of the broadest coverage eligibilities in the nation, and it also offers a very comprehensive benefits package, and it is the most expensive Medicaid program in the nation, both in terms of total spending and per enrollee spending.

Medicaid now covers more than four and a half million New York State residents. Of those, roughly two million are children and another two million are adults. It also covers half a million elderly persons. These are often called the duel eligibles, who have both Medicaid and Medicare coverage. As well as 600,000 blind and disabled persons.

In the latter two groups, the elderly, blind and disabled, account for a wildly disproportionate amount of spending within the program. Nationally, the elderly and disabled account for 25 percent of Medicaid beneficiaries,

but they account for almost 70 percent of all Medicaid spending.

Child Health Plus is one of the nation's oldest and largest children's health insurance programs. It covers children up to age 19, and at higher income eligibility levels than Medicaid. And CHIP, as it's often called, has around 400,000 enrollees.

One the newer programs in the State is Family Health Plus. Family Health Plus is a public health insurance program for adults between the ages of 19 and 64 who do not have health insurance, either on their own or through their employers, have income or resources that are too high to qualify for Medicaid.

It is available to single adults, couples without children, and parents with limited incomes. As of last month, the program has more than half a million enrollees.

In addition, we have a program called Healthy New York, that was established primarily to make insurance more affordable and more accessible to workers and small businesses with 50 or fewer employees. It is also available to eligible working uninsured individuals, including sole proprietors.

The program creates a standardized health insurance benefit package that is offered by HMOs in this State, and this program now has more than 100,000 enrollees.

Despite those programs, the number of uninsured remain stubbornly high, and there are some proposals under consideration to further expand coverage.

The first set of proposals is generally known as the fair share approach. Sometimes these were called "pay or play" approaches, sometimes they're called the "Wal-Mart Bills."

But, whatever the name, the essence of the approach is an employer mandate, and the dominate proposal being considered in New York would require businesses with 100 or more employees to pay a $3 per hour tax for all employees. This is the "pay." Or, they could avoid the tax by contributing at least as much to provide their workers with health insurance. The "play" option.

Another approach under consideration, of course, is the recently enacted Massachusetts Model, which has been a shot to the arm and reinvigorated state level reform debates across the country.

The Massachusetts Health Care Reform Plan

promises to provide nearly universal health care coverage in the State. And it combines individual mandates with government subsidies to promote affordability. It mandates everyone in the state to purchase health insurance by July 2007, and would impose financial penalties of up to 50 percent of the cost of a health plan on those who do not, via their income tax filings.

It also includes a requirement that employers with more than ten employees provide health insurance coverage or pay a fair share contribution of up to $295 annually, per employee.

Another central piece of the plan is government funded subsidies to low income individuals, to help them purchase insurance. There will be sliding scale subsidies up to 300 percent of the federal poverty line. And persons with incomes below poverty will not pay any premium.

There will also be Medicaid expansions for both children and adults. And in addition, there will be insurance market reforms, including the merger of individuals and small group markets.

Will this work in Massachusetts? Obviously, the jury is still out, and some major questions do remain, including: Will the health

plans be affordable? The individual mandate is only enforceable if the plans are deemed to be affordable. And achieving that will require that insurers offer plans at substantially lower premiums than exist now.

It is not yet known if those plans will emerge. Another big question is how employers will react. The assessment on employers who do not offer coverage is intended to stimulate them to do so. But the cost is, in fact, much less than the cost of providing insurance.

It is also possible that employers who now offer coverage may decide to drop it and simply pay the assessment, a phenomenon known as "crowd out."

And finally, universal coverage does not come cheap. And there are serious doubts as to whether the plan is adequately financed for future years. So beyond whether this can be made to work in Massachusetts, of course we ask ourselves, "Could it work elsewhere? Could it work here?"

And it helps to understand some of what makes the Massachusetts Health Care Market unique. Massachusetts enjoys an unusually strong foundation of employer-sponsored insurance, supported by a very

expansive Medicaid program. 68 percent of non-elderly Massachusetts residents have health coverage through their employer, compared to just 61 percent nationally.

As a result, only about 10 percent of the Massachusetts population is uninsured; a rate much lower than the nation or New York State. In addition, the Massachusetts plan relies very heavily on federal Medicaid funds to finance it, and other states may not be able to access such financing.

So let me conclude by discussing the financial consequences associated with the uninsured. We have already talked about the adverse impact the lack of coverage has on the uninsured themselves, in terms of their health and their finances. It also puts pressure on our delivery system. People get sick and we provide care to them whether or not they have an insurance card in their wallet.

New York State hospitals provide an enormous sum of uncompensated care to uninsured indigent patients. On an annual basis, New York State hospitals report providing roughly $1.6 billion of uncompensated care through their EDs, outpatient and inpatient services. To

reimburse hospitals for such care, the State allocates $847 million per year in HCRA funding, divided -- $765 million supports the general hospital indigent care pool, and another 82 million supports the high need indigent care pool.

In addition to hospitals, comprehensive diagnostic and treatment centers also provide care to the uninsured and the indigent. Those costs are over and above the $1.6 billion. They are separately reported, and they are also separately reimbursed from a different -- but generally at a lower ratio than hospitals.

Furthermore, one could argue that the State provide significant financial subsidies for care to the uninsured and indigent through many other mechanisms, such as the GME pool, because residents do provide substantial amounts of care to uninsured patients. There are funds transfers to public hospitals.

The ADAP program, which is State funded to provide drugs to uninsured patients with HIV, and there are many, many other public health programs that are targeted to the uninsured.

Mr. Chairman, I would be happy to take any questions.

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CHAIRMAN BERGER: Any questions? The first one.

MS. PROUD: David, in the Massachusetts Model, does the statute include any provisions to guard against, to try and prevent crowd out up front?

DR. SANDMAN: No.

MS. PROUD: So it really is going to depend on what happens in the marketplace.

CHAIRMAN BERGER: And there's some real questions about, if you go out a couple of years, how this gets funded.

MS. WOOD-SMITH: Don't they have a lot fewer of uninsured numbers than we do; dramatically fewer in Massachusetts?

CHAIRMAN BERGER: Yes.

MR. SANDMAN: Yes. 10 percent, which is a lot less.

CHAIRMAN BERGER: It's a lot less. On the other hand, you've got to be very careful. What happens, because, you know, you've got small employers in that state who take a look at this and who are marginally -- the crowding out problem could become very real, and that number could jump.

MS. PROUD: The penalty for them under

the statute could be less than the cost of their currently --

CHAIRMAN BERGER: It is. It is about half, it's about half.

MS. WOOD-SMITH: Is there a fund used in the crowd out fund? Is that funding then used by the State and somehow provides insurance for the unemployed, or does it just go to their general budget?

DR. SANDMAN: Well, their crowd out phenomena would not benefit the State, it would in fact benefit a private employer to drop coverage in order to substitute --

MS. WOOD-SMITH: No, no, I understand that. But you are saying they pay this penalty, the 295 -- where does that money go?

DR. SANDMAN: I don't know if it goes to the general fund or specifically back to the --

CHAIRMAN BERGER: It supports the program. But, you know, if it is costing a dollar an hour and, you know, you pay 50 cents, you are going to distort the economics throughout the entire state.

Part of the reason for spending some time on this is that we will spend more time talking

about issues of reimbursement, and issues of funds flow. Although, I want to remind everybody in our audience, that while that is not our primary mandate, and that will have to be addressed in the future, whatever recommendations we make or anybody else makes will have to be addressed in the fact of both operating and capital needs of health care system in the State of New York.

So part of what we think our responsibility is, this discussion and subsequent discussions to help lay a foundation for long-term discussion, for reviewing both reimbursement patterns, you know, how institutions, how institutions, which are essential to us, build themselves in order to capture funds flow, you know, because it is not necessarily driven by community needs or particular health care needs; but as people who are trying to survive as institutions, build their institutions around available funding, and do not do things which might be very necessary for health care employer, because of the absence of funding.

So in that sense, this all does -- it will all help ultimately fit together, as we come together over time.

The second part of this is -- and the more sort of directly, the issues of the uninsured and reimbursement patterns flow mostly into the issues of the operating budgets of the hospitals. There's the other side, and that is the capital sources of the health care system in the State.

And we can have long debates, and will have long debates, as to the shape of -- the long-term shape and needs of the infrastructure of this State. But there is one thing that is clear, whether it is in repairing those parts of the system which have aged dramatically, or whether it's reinvesting in new kinds of institutions, will new technology and new forms and new shapes, which will meet the needs of the 21st Century, the capital issues are very important.

The ability to raise capital for the future, and in changes that are made, allow and insure that whatever changes we make do not pull the rug out from under the ability of the State of New York or its institutions to raise funds in the capital market.

And to lead us in that discussion, Lora Lefebvre, who is Managing Director of Portfolio Services for DASNY and Jeff Pohl is their general

counsel will talk to us a little bit today about the whole issue of health care restructuring and debt. Thank you.

MS. LEFEBVRE: Thank you very much and good afternoon. Thank you, Chairman Berger and Commission members for the opportunity to speak with you again.

In March I presented an overview of New York State health care market and its capital financing kind of structure. Today I am here with my colleague, Jeffrey Pohl, who is the general counsel to the Authority. Jeff has been an essential and instrumental player in our development to the health care community's restructuring efforts.

We are here to today to discuss, from the Authority's perspective, how we see health care restructuring, and certainly how it affects debt. New York State health care providers have undergone some very significant restructuring activities over the past years, and with your work, we'll undergo more.

All of these efforts have been pursued with the desirable and worthy goals of making health care delivery better for patients and also more cost

efficient.

In light of this, we thought it would be useful to delve deeper into our experiences, largely as an unsecured creditor, with hospitals that have determined to substantially reconfigure or close. For example, when a board decides to close or significantly reconfigure a hospital, after the patient care concerns and community access are taken care of, how does a business close or restructure, and how are the obligations of a hospital taken care of.

Also, what strategies and methods are employed by boards and management to kind of accomplish those objectives. As I pointed out in our last presentation to you all, we believe that restructuring and debt are linked, in that responsible treatment of existing debt is something that will allow for the industry's continued access to capital markets, or continued and necessary reinvestment in the future.

As you are aware, there are many stakeholders and decision-makers involved in hospital restructuring. You, in your role as Commission members, there is hospital management, there are boards of directors, there are patients,

physicians, the Department of Health, creditors, both secured and unsecured.

Although Jeffrey and I are not restructuring experts, we don't hold ourselves out to be that, our observations today are based on the Authority's lengthy lending history and goal as secure creditor to the New York State health care community. And we seek to illustrate some factors, including the various constituencies that come into play when a hospital seeks to close or significantly change its lines of business.

Today we're going to cover a few topics. They're highlighted here on this screen. We thought it would be useful to briefly review the debt and other types of liabilities that a hospital and nursing home must manage when they're implementing the decision to restructure.

We will then quickly review the process of capital financing, in an effort to identify the key players with which the Authority must interact with when we're involved in a restructuring. Then against this backdrop, we will spend most of our time discussing a few examples of restructuring that we have observed, in some detail. Lastly, we will leave you with some elements that we think that you

might want to consider as you continue your deliberations.

Very quickly: My last presentation focused on the formal obligation nearest and dearest to our heart, which is capital debt. But as you can see on this slide, there are many forms of obligations that a hospital or a nursing home may have and must, really, essentially, address when they're restructuring or closing.

Generally speaking, you can imagine that each entity or person that a hospital has an obligation to, will seek to protect their own interest in the event of a restructuring. As it's contemplated, the restructuring is contemplated, all of these things need to be considered and accounted for.

I won't read through the slide, but there is vendor and trade debt. This is very typical for institutions in New York State. It can take anywhere from 30 to 200 days for a hospital or a nursing home to pay their vendors. It depends on the financial situation.

A nervous vendor can refuse to provide essential supplies to a hospital. That is not good. Wages: There are accrued obligations to an

employee, such as sick leave and vacation. If a hospital decides to close or eliminate employees, it would need to comply with collective bargaining agreements and other federal and state laws that govern payment of benefits.

There are also pension and benefit payments that have become a very large issue, not only for the not-for-profit sector, but as we read every day in the commercial sector, with regard to how we are going to fund pension benefits.

Many hospital and nursing homes have had defined benefit pension programs in the past, and they really experienced great difficulty keeping up with their funding requirements. Health insurance is a huge driver of expense, it has become difficult for hospitals and nursing homes to keep up with. The list goes on and on.

So the process that, you know, needs to be dealt with within a restructuring, these obligations -- the point is, these obligations need to be addressed, and the process can be long, complicated and expensive to try to work through those issues.

MR. POHL: As this slide suggests, debt and other obligations provided at a hospital,

nursing home, etcetera, can either be secured or unsecured. The Authority is generally a secured creditor having a mortgage on their hospital or nursing home's gross real estate, and a lien on their gross receipts.

So long as the value of debt is collateral equal or exceeds the debt owed to the Authority, the Authority should, in the end, be able to recover the amount of its loan to the institution.

However, if the institution deems the mortgage property essential to its continued operations, it may seek to defer payment on the Authority's debt, on the basis that the Authority will eventually get paid, but reorganization is the highest priority.

Also, there will be other creditors who are seeking to challenge the priority of our liens or the value of the property that secures them. Our bond holders, unfortunately, expect to get paid on schedule dates, not eventually.

So to avoid a default on the bonds, or claim in on credit enhance, whether it be bond insurance or whatever, we have to work with the institution and other parties to make adequate

arrangements.

The examples that we're going to go through, we'll give you a flavor of how the institution, the Authority and other obligors of the institution have addressed these issues.

This slide shows the various entities to which the Authority is accountable. Most notably, the bond holders. If the institution, as I indicated, doesn't make timely payments due to the bond holders, there maybe a credit enhancer which is obligated to do so.

In any restructuring scenario, the first obligation to the Authority is to make every effort to have the institution to continue to make its debt service payment. But as you saw from Lora's slide, with all those other obligors out there, that may not be their first concern.

If the borrower is unable to do so, the Authority will either seek payment from the credit enhancer, if the bonds have to be credit enhanced, or if they are not, assign the collateral to the trustee, the bond trustee, who will then liquidate them for the benefit of bond holders.

Although the Authority's objective is to avoid a call on credit enhancement, or the need to

provide for the liquidation of the pledged collateral, our ability to achieve this objective depends on numerous factors that are outside our control.

In the end, though, we will act in a manner that is consistent with our obligations to the bond holders, and the providers of credit enhancement, including government mortgage insurers such as FHA and Sonny Mae.

These paramount obligations will limit the Authority's flexibility in the closure work out situations. I gather last time Lora discussed that New York State health care providers rely heavily on FHA and mortgage insurance, and the lack of availability of insurance in New York State.

She also discussed that a repeated pattern of calling on insurance for payments results in either very expensive insurance or no insurance.

Both of these results would, of course, inhibit access to low cost capital for those health care providers, and continue in the future.

MS. LEFEBVRE: So, now that we have kind of like framed what those debt obligations are, and generally who the players are, we want to turn our attention to what we mean when we are talking about

health care restructuring.

You know, restructuring -- the slide up here kind of outlines a few examples, big examples, of what we consider to be restructuring. You know, these are macro level kind of reconfigurations of the system. Because, restructuring can be used -- a terminology used to, I don't know, re-tool your patient registration system.

I mean, that's a significant work flow restructuring. We're not talking about that, we are talking about the macro level. And as I noted in the opening, there are many different decision-makers and stakeholders involved in restructuring.

The Commission has a clear mandate to develop restructuring recommendations for the health care community. The Department of Health has a very significant regulatory role in health care provider oversight, and must approve all closure plans, and, generally, major reconfiguration plans developed by hospitals and nursing homes, to ensure that patient care and community access are taken care of.

For many hospitals, DASNY is a secured creditor and we have interests in the capital debt, along with the stakeholders that Jeff has pointed

out in the previous slide.

Another very key player is the provider's board of directors, that will have to make some very tough decisions regarding how to implement restructuring recommendations, and whether to avail themselves of bankruptcy protection, or proceed outside of bankruptcy.

Typically, bankruptcy is either filed in anticipation of reorganizing a business or liquidating a business. It is important to note at this point that not-for-profit entities cannot be put into bankruptcy by their creditors. Unlike the commercial sector, they need to make a conscious, well-informed decision to seek that protection.

As Jeff and I talk you through some of these examples that are coming, you will see that restructuring, in or out of bankruptcy, is lengthy, is often unpredictable, and it consumes a large amount of human capital and a large amount of dollars. It's very expensive.

We will review a range of these examples that go from extremely complicated and difficult, to those that were not so involved. We also note time frames on each the examples. And we note in our experience, that they are rather lengthy and they

may be instructed to you, but I also would note that the Commission's mandate and extraordinary powers that have been given to the Commissioner of Health, may change or influence those time frames for future recommendations.

So we'll just move on to our first example. Now, we have got a series of examples. The way we've set them up on the slide is, we kind of try to give you a, kind of a little profile of who the hospital is, kind of major characteristics, we've talked about what the institutional action was that was taken, our reaction or action to it, and then the results and time frames.

So, generally, it is all kind of set-up like that. Jeff and I are going to try -- we're not going to read the bullets off for the slide, you can do that. We are going to try to kind of highlight the salient points of each example together.

CHAIRMAN BERGER: By the way, if anybody wants, this will all be on the website. So you could print it off the website later, without sitting there taking notes right now.

MS. LEFEBVRE: Okay. So this hospital, after an attempt at turning around performance, financial performance, for years, not good at all --

attempted to do a turnaround by affiliating with another hospital. And after a few years, decided that that was just not going to assist the weaker hospital in turning around.

So the board decided that they thought the hospital should be closed. In this instance, the board decided not to seek bankruptcy protection. Instead, it entered into an agreement with us as the major secured creditor, to acknowledge the debt that they had to us, and then acknowledge our right to foreclose upon the collateral, which was the hospital real estate, and patient receivables and all the money that came into the hospital.

The hospital developed no plan, that we know of, to address unsecured creditors, such as the vendors and the trade payables that we talked about on the previous side.

MR. POHL: In this case, the amount owed the Authority by the hospital exceeded the value of the property in which we had a mortgage and gross receipts.

The hospital had few other assets, so there really is going to be nothing, in their judgment, available to pay other creditors of the hospital. So the hospital decided not to seek

bankruptcy protection, presumably in the thesis it was going to save significant costs of filing and undertaking such a proceeding, and it left us with no choice, which made it straightforward, to foreclose upon our mortgage.

But then we were left with "How do we deal with the property pending the foreclosure sale?" And there, again, we decided to have a court appointed receiver in the mortgage context, to manage the property, pending the foreclosure sale.

MS. LEFEBVRE: Right. So the responsibility, the maintenance and security of the property after the closure and before the sale, which was a significant amount of time, we went through the winter, we were worried about keeping it heated and keeping it protected, fell to the court appointed receiver.

The cost of that effort was paid out of the patient receivables that we were collecting. We hired somebody to collect those patient receivables and run those down. And, ultimately -- because it was more than that -- paid from the sale proceeds.

We did foreclose our mortgage on that property, and the property was ultimately sold at public auction to the highest bidder. I must note,

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we kind of took it out of sequence, it's on the slide, that the Health Department, obviously, was extremely, you know, active and involved in the process of basically closing the hospital.

The hospital has to file a closure plan with the Department of Health, it has to be approved by them. And so that was a process that was going on as we were kind of moving -- before we move into that process.

MR. POHL: But that was the scramble upon the assets, to cover those costs of closure.

MS. LEFEBVRE: Yes.

MR. POHL: Who was going to pay for medical record storage and all that?

MS. LEFEBVRE: We had a lot of issues with medical record storage. I mean, there were some real serious issues that got addressed, but it was, as I'm going to say, it was a process that really lacked a lot of structure.

We created structure, but there wasn't a lot in the first instance, and it left unsecured creditors unprotected.

MR. POHL: I mean, in this instance, the value of the real estate while exceeding the amount of our debt, really covered most of the debt. So

the decision to proceed with foreclosure, I think was the obvious choice.

And if the value of the collateral had been less, the State would have had to make payments to our bond holders, under a service contract that it had with the Authority. This being under the secured hospital program.

But, because the Authority is not authorized to form subsidiaries, we were unlikely, I think, to bid in on the property at the foreclosure sale, even if that option might have ultimately allowed us to figure out how to remarket or put the property to some other use, you know, in the future.

We just couldn't assume the risk, at least in the view of the current management, to take title to property that would expose the Authority and its assets to of various liabilities that could have been associated with the ownership.

MS. LEFEBVRE: So, the next example is somewhat similar, in terms of its profile. But in this instance, the board of directors chose to seek bankruptcy protection in the first instance.

This board of directors went through a very focused and thorough process aided by outside consultants, to reach that conclusion. And they

embarked upon what I would consider, and Jeffrey would consider a very transparent and communicative process of filing bankruptcy, with all the stakeholders involved. It wasn't, you know, a quick or sudden thing.

DOH worked very closely with the institution to develop and file a closure plan, and make sure that all the patient care concerns were addressed.

MR. POHL: And in this case, unlike the prior case, the value of our collateral exceeded the debt that was owed to us, so there was additional equity available to pay other creditors under a plan of reorganization.

This factor contributed to a decision by the hospital, with the consent of the creditors, representing unsecured creditors, to obtain a loan in bankruptcy, to pay off our mortgage and our bond holders.

Part of the incentive, quite honestly, was, there was also sufficient equity for us, DASNY, with DOH's blessing, to make a loan in bankruptcy, so they could cover some of the ongoing costs during the reorganization in marketing the property and some of these other costs.

But, again, you know, there was enough equity to cover that. And I don't know where that is now.

MS. LEFEBVRE: Well, they are actually just -- they have just, I think, concluded sale of the property. It has taken a while, but they have concluded sale. Patient receivables were used to help fund closing, along with a loan that DASNY and Department of Health made.

Mortgage payments continued throughout this process. There was no kind of standoff over mortgage payments on the this one. The process moved fairly quickly, due to a lot of excellent communication, I would say, and, also, as Jeffrey points out, the inherent value of the real estate. It was orderly.

But, again, bankruptcy is a very expensive process, not only for legal fees, but also for consultants. So this was one that we thought went reasonably well.

The next example is a bit of a larger example. It is a multi-hospital/nursing home system in Downstate, couple different markets, multiple bond issues, multiple lenders involved. This system had been financially underperforming for years, cash

losses begin to mount.

They hire a consultant. The board brings a consultant in and works with a consultant for about nine months: "Develop a turnaround plan and let's implement it."

They were working to develop this plan and implement it, but the cash deficits from operations became so great that it really precipitated the decision by the board to file for bankruptcy. They really were at a point where they couldn't make payroll. I mean, we were at that point with them.

The build-up to that, though, was, HUD and DASNY, in an attempt to kind of assist the turnaround, before they got to that preface, we were releasing bits of security that we had that we felt were reasonable to release, to allow them to get some liquidity.

For example, non-core assets of real estate we would release from our mortgage and let them go monetize to try to bring more cash into the operation, to kind of get through. It didn't work. We got to the point, they hit the wall. The board decided that they needed to file for chapter 11.

There was very little communication with

stakeholders prior to the decision, to make the decision to go into bankruptcy. They also, as they went in, decided not to make mortgage payments. But they told us that they kind of planned to seek larger take-out financing in another six months.

We agreed, in anticipation of that take-out, to make a loan, Department of Health and ourselves, made a loan to basically fund our mortgage payments for six months, because we were clear that we wanted to avoid the largest call on HUD insurance in HUD's history.

I will just say, it was a very large, large thing. So we made that decision. The filing created a lot of difficulty for the institution, in terms of getting supplies delivered. It had an effect on the work force. And, certainly, patient volumes were severely affected by all of this chaos.

The unsecured creditors in this case exerted a large amount of control over the process. And, ultimately, forced changes in management in this institution, in the midst of all this.

In addition, the legal team was changed, in the midst of this bankruptcy. I would characterize the relationship among all of the stakeholders as extremely contentious. But, now

there is a new management team in there, and they are implementing restructuring, including closures and sales of hospitals. And things seem to be going a little smoother, and we are out of it, also.

MR. POHL: Right. And, although, as Lora said, in this case, even though the value of the property mortgage to the Authority exceeded the value of debts owed to the Authority, this was a hair-raising one. In part, because the creditor's committee came up with a variety of legal arguments challenging our mortgages, challenging our method of -- or challenging the way the loans would be -- the mortgages would be allocated, the various loans. It got very complicated.

And their idea was, "Look, while we fight out these disputes, let's authorize them to continue to liquidate the mortgage property they don't need, and we'll put the sale proceeds in escrow, pending resolution of the lien, the disputes."

Well, that may have worked fine from their perspective, but it could have jeopardized, in my view, and others, our right to claim mortgage insurance benefits.

If you start selling the property to which the insured mortgages were late, it was very

unclear what was going to be the status. So we said "No, we are not going to go along with it."

Right up to the wire they kept fighting, and, eventually, they realized that we weren't going to back off, and they ultimately agreed to allow the debtor to go out and get a loan and pay us off.

MS. LEFEBVRE: And I would just point out in closing that this restructuring has cost the institution -- we're a year into the bankruptcy -- has cost the institution a published number, $34 million in legal fees and consulting fees. That doesn't include the expense that we have incurred, or the Department of Health incurred, or HUD incurred, too, to defend, you know, our position. It is a very expensive process.

This is an example of a smaller -- a multi hospital system that has the nursing homes in Downstate, that pursued a bankruptcy filing with the intention of selling the hospital.

They didn't want to close the hospital, they wanted to sell the hospital. They felt it wasn't part of their business plan anymore. They entered into bankruptcy with a very structured kind of work plan on where they wanted to be in the end. The bankruptcy filing did affect patient volumes at

the hospital that they were planning to sell. And it affected some labor stability at the hospital also.

The other thing that this system chose to do is bring all of its affiliates into the bankruptcy also. They weren't necessarily, I think, so concerned about the financial condition of the affiliates, but they brought them in for, I think, additional resources. This complicated the work out, from our perspective.

I think in this instance, as Jeff pointed out, we were lucky to have a purchaser of that hospital who was willing to pay the amount that needed to get paid, and also had enough credit strength to borrow the money to purchase the hospital.

MR. POHL: This was another one where initially it was very contentious with the debtor and their attorney where they said, "Look, you are adequately collateralized. We'll pay your debt service when we get around to it, but you're protected by your mortgage interest" which, of course, if they carry it on too long, it would have required us to assign the mortgage to HUD.

The way we were able to avoid it, quite

frankly, was in the end, we agreed to make a loan that facilitated the debtor's plan of reorganization. They did expect to come out and continue operations.

We felt there was a way to structure a loan that we would be protected and get paid once they came out. So they were able to throw some money at the unsecured creditors, and we avoided an assignment. And I am happy to say that loan has been repaid in full.

MS. LEFEBVRE: In full.

MR. POHL: As part of the reorganization -- this was really directly our issue. The debtor, as Lora mentioned, had determined to sell one of its hospital facilities. But in the end, the perspective purchaser was unwilling to purchase outside of bankruptcy.

I think, in part, there were collective bargain and labor issues that were better resolved through Bankruptcy Court. And eventually that sale was approved and loaned through the Bankruptcy Court.

MS. LEFEBVRE: The next example -- and we will just kind of try to move a little bit quicker here -- is an example of how the reconfiguration can

take a number of different phases. This is a large community hospital system that had two sides in New York City, in what we consider very high need areas.

They were financially struggling. They looked at their operation and they said, "You know what, we would like to turn one of those sites into an alternative health care delivery model, a diagnostic and treatment center."

We had to go through and assess whether or not that business plan made sense for our bond holders, to ensure that our bond holders weren't going to be harmed by them turning into something other than a hospital.

We did that assessment with HUD, based on business plans that were submitted by the hospital, and we went along with it. And so a few years later, the same system -- while a conversion to the diagnostic and treatment center was beneficial, pension, malpractice and pseudoliabilities just overwhelmed this operation.

They felt, the board felt that they needed to take additional steps. The board did make a decision to file for bankruptcy against a very well communicated decision making process by the board to DOH, to DASNY and to HUD, who was the

insurer.

They did commit to continue to make the mortgage payments during this restructuring which was very helpful. But they also needed some assistance on cash flow before they went out and got out this large DIP. We keep referring to this DIP, "debtor in possession financing" to assist them through the bankruptcy. So we did agree, DOH and ourselves, did agree to make that loan to help them out.

MR. POHL: And again, from the hospital's perspective here, it wasn't so much operationally, the bankruptcy was intended to help them restructure the balance sheet. They had a lot of pending malpractice and other claims, that if they didn't take some steps, would have been converted to judgments and become secured claims.

By filing for bankruptcy they got the benefit of the automatic stay and now they are in the position to negotiate with the creditors, the various plaintiffs, and hopefully through a plan of reorganization reduce those claims before they come out of bankruptcy.

MS. LEFEBVRE: The next two examples are examples of restructurings that were done outside of

bankruptcy. This example -- I will just blow through this very quickly -- was not necessarily our borrower. It was a hospital that had borrowed through the local industrial development authority but was linked to our borrower through a parent corporation, so they decided to close one of the facilities, and basically while we were not involved we were standing by as interested parties as they went through that process.

MR. POHL: The lesson here is, here we have two hospitals -- well, even though they weren't jointly and severely liable for, you know, each other's staff, and we had the stronger of the two, what happened when they decided to close the hospital for which the IBA had issued bonds, the way they got themselves out of the situation was, our borrower ended up buying the mortgage from the secured creditors, with the result that, you know, our client ended up being on the hook.

But, again, I think the story there was they owed cents on the dollar.

MS. LEFEBVRE: Cents on the dollar, right. The last example here is a small community hospital that, underperforming financially, needed to do some restructuring, and actually took the step

of developing a business plan, only after affiliating with a larger hospital, in an effort to try to make kind of a go at a relationship with a larger hospital to help turn things around.

Couldn't do it, so they basically revisited their core business and decided that they needed to close their emergency room and convert most of their acute care beds to rehab.

We, as the bond holders, needed to agree -- well, not as the bond holders, but in the bond holders' interest -- needed to agree that that business plan made sense, that they could continue to be a viable entity.

We worked through that with HUD, we all agreed to it. And the jury is still out. I am not sure that is a sustainable model yet, but it was something that they felt they needed to do outside of bankruptcy.

This slide -- you know, we shot a lot of information at you really quickly. And, you know, I hope the slides are helpful when you look at them later.

This slide summarizes some of the points we've gleaned from our experiences. Our examples have focused primarily on the process and the

strategies that boards use, and management uses, to effectuate restructuring efforts.

And although we, to date, have been able to protect the interests of our bond holders without relying on credit enhancement, we recognize that there may be a time when we will not be able to meet this objective.

Very quickly, health care restructuring is very time consuming and resource intensive. Clearly, to find goals going into the restructuring is helpful. I'm sure the Commission's work will be instructive for boards of directors and management.

You can't underestimate the amount of money that's necessary to do these things. It takes a lot. It's not a predictable process. There are a lot of unique circumstances that drive decision-making in different ways.

And I think that that's basically what I'd like to say about that slide. We can go onto the next slide, which --

MR. POHL: There's not really much to be said here, except that, you know, as Lora said, it's expensive, it's time-consuming. And I realize, I guess, that you're not charged with the mechanics of implementing your recommendations, but at least

you'll understand our perspective, for what it is worth.

MS. LEFEBVRE: But I think that some of these things will help you -- you know, inform you as you are kind of working through your recommendations. You know, government is a big issue here. Clarity of goals. The management strength.

There's always changes in the governments and the management teams when you're working through a restructuring. It's sometimes very helpful to have advisors to assist when you are going through this.

Affiliations, restructuring costs, all of these things -- I want to get to the very end here, and the need for additional capital. I think that one of the things that David mentioned at the outset of this meeting was that there are additional funds, in the form of HEAL , available to assist in restructuring, out there right now.

That's true, and I'll get back to that. Because, I think that capital is found in many different ways to assist these restructurings. There are internal funds that the health care system might provide. Probably not a lot given in New York

State health care.

Commercial loans. In the case of, you know, bankruptcy, there are the debtor possession loans that really take the security, both the real property and the receivables, to make loans into.

There have been health care restructuring pool loans that the Dormitory Authority and the Department of Health have made available. FHA has kicked in and assisted and allowed for funds that are held to protect them against an insurance claim, to be used to assist restructuring. They've been very helpful in that regard.

And then HEAL grants, obviously, are available. I would just note that HEAL grants are available for capital expenses for restructuring. HEAL grants are generally not available for the working capital needs to close a hospital, like paying employees off, and so on and so forth. They are really capital grants.

MR. POHL: Can I just make one final --

MS. LEFEBVRE: Yes.

MR. POHL: I mean, if you've seen -- and I don't want to leave you with the impression that we are going to be the lender of last resort. But we don't have unlimited resources. When we do it,

we think there's a strategic reason why.
We just wouldn't lend it if we know they're going to close and go off into the sunset. It's usually because we think it's going to enhance our position, and the position of our bond holders, and the position that's being advocated by our friends at Department of Health. But we wouldn't just throw money into a dark hole.
MS. LEFEBVRE: So I just say in closing, we hope that the considerations that we have given you today will help you and give you a little bit of a framing perspective -- for your recommendations.
And we'd certainly be happy to answer any questions that you might have.
CHAIRMAN BERGER: Thank you. Thank you both very much. Questions?
MR. SEARS: Lora, did I understand correctly that you've never had to rely on credit enhancement for the repayment of dorm issued loans?
MS. LEFEBVRE: Correct. We've never had to call upon credit enhancement to manage a restructuring.
MR. SEARS: And that applies to both bank letters of credit, all forms of bond insurance, et cetera.

MR. POHL: Well, no. I mean, there -- at least I'm aware of one instance where the bank has paid our bonds off through the letters of credit. That was their --

MS. LEFEBVRE: Their call.

MR. POHL: -- their call, based upon their rights under the reimbursement agreement.

MS. LEFEBVRE: There was a default, under their letter of credit agreement, and they said, "We're calling a default and we're taking our money." But we have never had to file a claim, you know, with -- I think that has been our new mantra.

CHAIRMAN BERGER: Somebody once said in his career, a thousand years ago, he was the CEO of a credit enhancement company, the theory was, "We charge so little because nobody would ever use it. And if they never used it, we would never sell it to them again."

Let me just -- I think part of what is important here is that one of the reasons this Commission exists is because it was created in a time when there was not a vacuum. Lora had or Jeff had six or seven examples.

There are more than that out there in our State today, of hospitals which either have filed,

in the process of thinking about it, or are going to be in that position, a financial concern.

And one the lessons that comes out of this discussion is that you do not want to be behind the bankruptcy curve if you can avoid it. That if you can proactively begin to structure your way around -- toward the future, and be ahead of that bankruptcy curve, it is important for financial reasons, it is important for costs, it's important for health care delivery, and it just is less chaotic.

Because, if you'd looked at some of the numbers of years these things drag on -- once you get into that process, it becomes endless. And I hope I am not offending any bankruptcy lawyers in the room, who think I'm taking money out of their mouth.

But, the fact of the matter is, that we would be better served if we could get ahead of this curve. And that's part of the reason we're here.

Secondly, we have to take into consideration the long-term needs of capital formation in the State of New York. People say, "Well, you know, you are not paying the guy delivering groceries, you're not paying Con Ed, but

you are worrying about the bonds."

We worry about everybody. And we've got to worry about the bonds, because the bonds -- people talk about being worried about the bonds as if it's some -- you know, it's sort of some martian kind of place, it is not important.

It is important, because if you do not have capital, we can't do the reinvestment that will change our institutions from, you know, 19th, 20th-century institutions to 21st-century institutions. We need that capital.

We have to have availability of capital, and we have to try not to hit the credit enhancer. Which is an issue, although it may not be permanently possible.

So this is an important part and I thank you all very much. I thank you both very much.

On the future meeting schedule, the next meeting -- and there's a change of date, so I want to announce it, it will be posted on the site -- it will be posted on our website. The next meeting in September will be moved from September 14th to September 15th. It is actually a room availability issue. We will be meeting on September 15th at a different location. It will be posted on our

website. Anything else? Mr. Hinckley?

MR. HINCKLEY: Mr. Chairman, I move that we enter executive session to address in detail the medical, financial and credit history of particular general hospitals and nursing homes that may be subject of Commission recommendations for restructuring, resizing, closing, consolidation or conversion.

CHAIRMAN BERGER: Is there a second vote? Vote all in favor? Any opposed? Okay, this meeting is adjourned. Thank you very much.

(Time Noted: 2:10 p.m.)

C E R T I F I C A T I O N

I, ELLEN SANDLES, a Shorthand Reporter and a Notary Public, do hereby certify that the foregoing is a true and accurate transcription of my stenographic notes.

I further certify that I am not employed by nor related to any party to this action.

ELLEN SANDLES