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Participating Bonds Offer New “Carrot” To Hospitals

The debate between using positive or negative incentives to influence behavior has been around as long as there have been people to influence. Use a “carrot” or use a “stick”?

Like many others, hospitals have struggled with this question in their relationship with physicians. Participating bond transactions (PBTs) may be about to emerge as an important new tool to enable hospitals—especially not-for-profit and public hospitals—to develop new incentives to encourage physician cooperation and discourage lack of cooperation.

McDermott Will & Emery (MWE), which has the largest healthcare law practice in the U.S., has been a leader in developing this new tool. Lawyers at that firm are actively promoting PBTs in their discussions with clients and prospective clients. Other healthcare lawyers and investment bankers are watching carefully to see if PBTs become a wave of the future.

Participating bonds are tax-exempt offerings enabling physicians to participate in the success (or failure) of a hospital or ancillary facility. They are typically secured as subordinated instruments and they have the ability to require physician investors to enter into covenants not to invest in competing facilities.

The real key, though, is the financial incentive. Traditional tax-exempt hospital bonds pay investors a low, fixed rate of interest, probably around 4-5% in today’s market. PBTs, in contrast, are designed to pay much higher rates—10-12% or even more in some cases—and interest on the bonds may be deferred altogether if speci-

fied performance hurdles are not met.

The interest obligation can also be arranged so that physicians are entitled to receive additional compensation from excess earnings or superior performance, hence the concept of the “carrot” versus the “stick.”

PBTs can improve physician behavior in a variety of ways, including:

- PBTs are much simpler transactions than equity joint ventures because they do not involve transferring assets from a charitable to a taxable environment.
- PBTs can be structured to comply with safe harbors.
- At least in theory, they create a sense of shared destiny. Physicians invest significant amounts of their own capital but with more protections and security than in an equity investment; yet they still participate when the hospital and the docs are working effectively together to improve service and efficiency.
- Physicians can exercise more influence over governance and management of the project in which they invest through various legal contrivances, and these techniques appear to be obtaining consistent governmental approvals.

MWE closed the first PBT on June 2, 2003, a transaction that involved an \$8 million ambulatory surgery center located in the southeast. Robert Rosenfield, a partner at the firm, has stated publicly that he expects as many as four deals to close by mid-year although he declined to identify specific projects.

Here’s how a PBT could be used to finance construction of a new ambulatory surgery center (ASC):

The new ASC would be organized as a new, non-profit subsidiary of the sponsoring hospital. Surgeons using the ASC would be appointed to 50% of the Board seats of the new sub. In addition, they would obtain

control over important, day-to-day management through investment in a new limited liability company that would function as a management services organization (MSO).

They would then purchase all or a substantial part of the PBTs used to construct the ASC, and they would participate in higher or lower payments of interest depending on how well the ASC is operated. This interest would be tax exempt versus their distributions if the ownership of the center was held in the traditional joint venture arrangement.

Joint ventures are, arguably, becoming more heavily regulated. While many exist, joint ventures between hospitals and physicians present many legal and regulatory risks. These risks have increased in the past three years. The consequences of failing to comply with applicable statutes and regulations can range from criminal penalties to loss of tax exemption to exclusion from Medicare and Medicaid programs to substantial fines and penalties.

MWE has issued at least two legal opinions in recent months offering their formal judgment that PBTs do not violate any of the applicable federal statutes and that they offer, in fact, the most conservative approach to hospital-physician financial collaboration. Will PBTs replace joint ventures as the industry’s preferred behavior modification technique? That remains to be seen but careful observers are watching closely to see how MWE’s new ideas are accepted both by the government and by the industry.

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