Rating Guidelines for Health Care Receivables

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Summary
Heightened competition, industry consolidation, and tightening cost controls are driving health care providers — including hospitals, nursing homes, pharmacies, drug and alcohol rehabilitation programs, home health care agencies, and physician practices — to seek lower cost financing. Health care providers are accessing capital through bank lines, sale/leasebacks of medical equipment, receivables’ factoring arrangements, and securitization. This report outlines Fitch IBCA’s criteria for rating health care receivables, describes Fitch IBCA’s servicer review, and highlights the financial and legal structures of health care-backed transactions.

A health care receivable is generated when a bill is prepared for services rendered. However, in the health care industry, the recipient of health care service typically is not the obligor. Instead, the obligation to pay has been contracted to a third-party insurer.

Fitch IBCA’s rating criteria focuses on the health care provider’s or oversight servicer’s historical accuracy in estimating the reimbursable amount of health care receivables. However, even with the most accurate estimation methodology, payments can be denied or delayed. Fitch IBCA develops assumptions regarding the percentage of denied or delayed payments to reflect the provider’s historical experience as well as the desired rating level.

Past experience with Towers Financial Corp.’s transactions (see box at left), which were not rated by Fitch IBCA, has taught the industry that a reliable and experienced servicer with the systems capability to handle the complex requirements of health care receivables is crucial to the securitization effort. As such, Fitch IBCA, using analysts from the asset-backed and health care groups, completes a thorough servicing review to ensure that the servicer has not only an experienced management team and significant equity capital, but also sophisticated management information systems.

Receivables
In a typical transaction, collateral consists of a pool of individual patient accounts receivable, either provided by a single health care provider or purchased by an issuer from a group of health care providers. Providers may include hospitals, nursing homes, pharmacies, drug and alcohol rehabilitation programs, home health care agencies, and physician practices.

A health care receivable is generated when a bill is prepared for services rendered. Unique to the health care industry, but common to virtually all health care

Towers Transactions
Towers Financial Corp., a leading hospital bill-factoring firm, began securitizing health care receivables in the early 1990s. However, allegations of fraud brought forth by the Securities Exchange Commission in February 1993, and Towers’ subsequent default on five health care transactions totaling $196 million, has left investors wary of securities backed by health care receivables.

Fitch IBCA believes that Towers’ situation did not hinge on the securitization of health care receivables, but reflected a lack of oversight. Towers acted as seller, servicer, and collector of payments in the transactions, with no third-party review. This highlights not only the importance of the initial due diligence process but also the necessity of a third-party administrative agent. Fitch IBCA requires that all health care transactions have an oversight servicer, responsible for scrutinizing the payment and collection process, to avoid the lapse in documentation that occurred in the Towers transactions.
providers, the recipient of goods or services generally is not the obligor for the receivable. Rather, the responsibility for bill payment has been contracted to a third-party payor — the patient’s insurer. However, for a small portion of receivables, the individual patient is still responsible for all or some of the bill, including deductible amounts, co-payments, noncovered charges, charges for uninsured patients, and other out-of-pocket expenses.

Third-party payors include federal and state governments under such programs as Medicare, Medicaid, and the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). Payors also include private or quasi-private entities, such as commercial insurers, health maintenance organizations (HMOs), Blue Cross/Blue Shield companies, and self-insured health plans.

Generally, the amount reimbursed by various payors is less than the total bill. Reimbursement methodologies are established by regulation, statute, and/or contracts between payors and providers, and ultimate payment amounts (the net receivable amount) can depend on numerous factors, including the patient’s illness, the procedure, the insurer, and the facility where care was provided. Some of the more common reimbursement methodologies include payment of predetermined amounts based on patients’ diagnoses, per diem payments based on approved costs, and payments based on providers’ actual charges.

**Determination of Receivable Value**

In a health care-backed transaction, each health care provider is responsible for analyzing various payor payment plans, verifying insurance coverage, billing clients, calculating the net receivable amount, and monitoring payments and account balances. In a multiseller program, the issuer, or an affiliate of the issuer, is responsible for the oversight of health care providers, validating providers’ calculation of net receivable amounts, and reconciling account balances with actual funds received.

Depending on the transaction’s structure, Fitch IBCA will focus on the health care provider’s or oversight servicer’s methodology and historical accuracy in estimating the amount of each receivable that ultimately will be reimbursed. To accomplish this, Fitch IBCA will review results from recent procedural audits to ensure compliance with the various reimbursement methodologies.

However, even with the most accurate methodology for predicting reimbursement amounts, unexpected payment denials still occur. These denials result from misinterpretations of payor coverage, documentation problems, failure to comply with managed care requirements, an exhaustion of benefits, a disagreement with the provider, or an after-the-fact payor audit. Fitch IBCA will review the individual health care provider’s or oversight servicer’s historical denial rates for receivables, similar to those that will be sold into the program. Based on this review, Fitch IBCA will discount the net receivable amount by the expected payment denial rate.

In addition, although a large percentage of health care receivables are short term (60–90 days), some accounts may not be resolved after 90 days because of billing errors, payment disputes, audits of unusually large bills, or long processing times. Fitch IBCA performs a static pool and monthly analysis of the health care provider’s or oversight servicer’s historical payment rates to accurately account for those receivables that will not be received in a timely manner.

Fitch IBCA also reviews the targeted payor mix for the program. Typically, Medicare and Medicaid constitute a large percentage of the payor mix while highly rated private insurers, Blue Cross/Blue Shield companies, and HMOs make up the bulk of the remainder. To the extent the program will include receivables that are obligations of speculative-grade or nonrated companies or of private individuals, these receivables will be discounted. The discount for low-rated or nonrated insurers will reflect the payor’s credit, while the discount for private individuals will reflect the health care provider’s collection history for these accounts. Fitch IBCA generally gives no value to accounts in litigation or workers’ compensation claims.

As shown in the box above, the net receivable amount less discounts for
delayed, denied, or unpaid payments, due to poor payor credit, is the amount of receivables’ cash flow under an “expected” case scenario. To stress the portfolio, Fitch IBCA assumes that payments delayed or denied increase by multiples of 2.0–6.0, reducing the amount of bonds that can be rated under the different rating scenarios. Other potential cash flow stress scenarios include defaulting the top one to five providers and/or payors, as appropriate.

In this way, the credit enhancement for the transaction can be derived through overcollateralization, equal to the difference between Fitch IBCA’s estimate of cash flows under an expected case scenario (in line with the provider’s or oversight servicer’s historical performance) as well as more stressful scenarios. Fitch IBCA’s analysis also allows for dynamic credit enhancement, whereby the required credit enhancement will change with pool performance relative to payment denials, payment delays, and nonpayments.

**Additional Credit Enhancement Requirements**

Fitch IBCA requires additional credit enhancement to account for possible government offsets. Medicare, Medicaid, and CHAMPUS are permitted to offset amounts that, through an audit, have been determined to be a government overpayment. To determine this risk, Fitch IBCA reviews the hospital’s historical experience with overcollection based on annual cost reports and audited cost report settlements. This amount times a multiple that reflects the volatility of the provider’s experience will be required as additional credit enhancement.

Depending on the nature of the transaction, Fitch IBCA also may require credit enhancement equal to the maximum amount of funds collected by the provider between account sweeps from Medicare, Medicaid, and CHAMPUS. If the provider declares bankruptcy, these funds would be commingled with a provider’s funds and unavailable to the trust.

**Financial Structure**

The most common financial structure involves an issuer selling health care receivables on a revolving basis to a special purpose corporation, which subsequently pledges the receivables to a trust. Because health care receivables, like other trade receivables, are non-interest bearing, the receivables’ cash flow must be artificially segregated into principal and interest collections. The interest collections, or imputed yield, are used to pay interest, servicing, trustee, and program fees throughout the life of the deal, further discounting the number of bonds that can be issued.

During the revolving period, typically three to five years, principal collections are invested in newly originated receivables. Once the revolving period ends, the transaction begins to amortize, and receivable collections are used to pay principal to bondholders. However, if the seller/servicer declares bankruptcy, there is a material breach of representations and warranties, the servicer defaults, or a significant deterioration in portfolio performance occurs, the deal will begin to amortize earlier.

**Servicing**

Depending on the structure of the transaction, Fitch IBCA, using analysts from the asset-backed and health care groups, will review the servicing operation of the health care provider or oversight servicer, or both. The health care provider is responsible for billing the patient, collecting accounts, and estimating the net receivable amounts. The oversight servicer is responsible for validating the net realizable amounts and reconciling all collections with account receivable balances.

When reviewing an individual health care provider, Fitch IBCA examines the provider’s financials and the strength of its management team. The health care provider must have adequate systems to handle various payor payment plans and verify insurance coverage, as well as to bill and monitor payments and account balances. In addition, the health care provider must have the ability to report to the trustee on the overall performance of the transaction, comparing net receivable amounts to collections. Fitch IBCA relies on continuing servicer audits to confirm compliance with transaction requirements.

When reviewing an oversight servicer, Fitch IBCA considers the servicer’s track record, market presence, and management team to be of critical importance. Management must have significant experience in the financial and operational aspects of the health care industry. Fitch IBCA will review key executives’ resumes and perform background checks, including NEXIS/LEXIS searches, on the company’s principals. In addition, the oversight servicer must be well capitalized and demonstrate a long-term commitment to the business. Fitch IBCA examines financials and performance history as well.

Fitch IBCA also reviews the oversight servicer’s procedures for enrolling and monitoring health care providers participating in the program. Qualification procedures should be conservative, and a program to monitor receivable performance should be in place. In addition, the oversight servicer must have sophisticated management information systems to reconcile the health care provider’s estimate of receipts with its own estimate. The systems must accurately handle various payor payment plans, monitor payments to lock boxes, and reconcile account balances on a timely basis. In addition, once the transaction is completed, the oversight servicer must have tracking and reporting systems to ensure that actual collection rates are in line with expectations.
Fitch IBCA relies on semiannual servicing audits to ensure compliance with the requirements of the transaction.

Legal Issues

Medicare, Medicaid, and CHAMPUS guidelines generally prohibit payment to be made to anyone but the provider of the health care services, subject to certain limited exceptions. These provisions were put in place in the 1970s to deter fraud in the factoring of health care receivables. As a result, government payments must be sent to the provider’s account and under the provider’s control before being turned over to the trust.

To comply with government regulations, Fitch IBCA requires that all government payments be made to a lock box account in the name of the provider and held at the trustee or in a highly rated lock box bank. The trustee, or lock box bank, under instructions from the healthcare provider, is obligated to make frequent sweeps of lock box accounts, limiting the risk of commingling to a minimum, which is accounted for in the credit enhancement levels.

If the hospital declares bankruptcy or defaults on its obligations, government regulations allow payments to be made to a person other than the health care provider, with a court order. Therefore, Fitch IBCA requires that the securitization contain provisions authorizing and requiring the trustee or program administrator, upon bankruptcy or other default of a provider, to request an order from the bankruptcy court to direct payments to a trust account established for the transaction. To the extent all or some health care providers in a transaction are speculative grade, Fitch IBCA may require additional credit enhancement to account for the higher risk of hospital bankruptcy, which could delay the receipt of government payments.

The sale of receivables to the special purpose corporation (with the exception of receivables from Medicare, Medicaid, and CHAMPUS) must constitute a true sale to insulate receivables from the bankruptcy risk of the seller. In all cases, the trustee must perfect its interest in the receivables. Government receivables generally are viewed as part of a social welfare program and, therefore, act as accounts under the Uniform Commercial Code (UCC). Perfection is established by filing a financing statement against the provider.

It is still unclear if receivables payable by private insurers are accounts under the UCC or claims under insurance policies. Therefore, receivables should be perfected under the UCC and common law rules governing perfection of insurance-related rights. This requires filing UCC financing statements against the borrower, as well as ensuring that no prior assignment of receivables has occurred, and providing notice to the insurance company regarding the provider’s sale of receivables.