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## Lessons from the Allegheny Bankruptcy

### Abstract

On July 21, 1998, the nonprofit Allegheny Health, Education, and Research Foundation (AHERF) filed for bankruptcy, with \$1.3 billion in debt and 65,000 creditors. The Pittsburgh-based organization had pursued an aggressive strategy of acquiring physicians and hospitals in the Philadelphia area. Its dramatic collapse prompted the entry of a for-profit hospital chain into the Philadelphia market, as Tenet Healthcare Corp. purchased eight hospitals from AHERF at firesale prices. This Issue Brief chronicles the hows and whys of the nation's largest nonprofit health care failure, and analyzes its lessons for other struggling academic health centers.

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# LDI *Issue Brief*

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## ***Lessons from the Allegheny Bankruptcy***

Editor's Note: On July 21, 1998, the nonprofit Allegheny Health, Education, and Research Foundation (AHERF) filed for bankruptcy, with \$1.3 billion in debt and 65,000 creditors. The Pittsburgh-based organization had pursued an aggressive strategy of acquiring physicians and hospitals in the Philadelphia area. Its dramatic collapse prompted the entry of a for-profit hospital chain into the Philadelphia market, as Tenet Healthcare Corp. purchased eight hospitals from AHERF at firesale prices. This Issue Brief chronicles the hows and whys of the nation's largest nonprofit health care failure, and analyzes its lessons for other struggling academic health centers.

## ***The rise and fall of AHERF***

AHERF was established in 1983 as the parent company of 670-bed Allegheny Hospital in Pittsburgh. By the end of 1997, AHERF had transformed itself from a sole community hospital into Pennsylvania's largest statewide integrated delivery system, with 14 hospitals and more than 300 primary care physician practices primarily in the Philadelphia area.

- 1987: AHERF acquires Medical College of Pennsylvania, and its two affiliated hospitals in Philadelphia.
- 1991: Acquires United Hospitals Inc., a system of four hospitals in Philadelphia. That same year, AHERF acquires Suburban Medical Associates, its first set of primary care practices.
- 1993: Acquires Hahnemann Medical College and its affiliated hospital in Philadelphia, and merged the two medical schools into MCP-Hahnemann (in 1994).
- 1996-97: Acquires Graduate Health System and its six hospitals in Philadelphia. Also acquires three more hospitals in the Pittsburgh area.
- October 1997: Closes Mount Sinai Hospital and lays off 1,700 people.
- March 1998: Offers to sell six nonteaching hospitals in Philadelphia to Vanguard Health Systems for \$450 million, but the deal falls through as the extent of AHERF's fiscal difficulty is revealed.
- July 1998: AHERF files for bankruptcy, as the system loses more than \$1 million a day.
- October 1998: AHERF sells its entire Philadelphia operations to Tenet (eight hospitals, all medical practices and medical school) for \$345 million.

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### ***AHERF failed to achieve its strategic goals***

AHERF's growth was based on questionable strategies that rested upon untested assumptions about the benefits of integrated delivery systems. AHERF sought to:

- develop Pennsylvania's first statewide integrated delivery system (IDS) grounded in academic medicine. But Pennsylvania has few statewide payers (other than Medicaid and U.S. Healthcare) or employers (other than banks) that might wish to contract with a statewide system.
- build regional market share to leverage managed care payers. However, few systems have amassed enough market share to do this, especially in markets such as Philadelphia, which has two large payers and excess provider capacity.
- garner capitated contracts from managed care organizations. At AHERF as well as other systems, this strategy led to low capitated revenues and capitation rates as a percentage of premiums, and resulted in huge provider losses.
- achieve synergies and efficiencies among the hospitals and other acquisitions. Synergies and economies of scale depend heavily on postmerger implementation, little of which occurred at AHERF because its expansion was so rapid.
- use community/suburban hospitals to refer private-pay patients to teaching hospitals and fill their beds. But academic medical centers in Philadelphia have had difficulty persuading wealthy suburbanites to use older teaching hospitals in the city. Meanwhile, suburban hospitals developed revenue-generating services to attract local patients.

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### ***Acquiring primary care physician practices proved to be a financial disaster***

As part of the IDS strategy, AHERF and other Philadelphia systems purchased primary care physician practices. A primary care network was deemed essential for obtaining managed care risk contracts, and held out the promise of increased inpatient referrals.

- From 1991-1997, AHERF acquired 310 primary care physicians in Philadelphia, and 136 primary care physicians and 75 other specialists in Pittsburgh, reportedly at a cost of \$100 million. These practices were purchased at top-of-the market prices, due to a bidding war with other competing systems in Philadelphia.
- AHERF did not capture a majority of the primary care network's referrals, possibly because the practices were acquired without considering proximity to AHERF hospitals, and because of the practices' existing loyalty to other hospitals. Other systems have found that they can command only 25-30% of their primary care physicians' referrals.
- The AHERF physician network lost \$41 million in 1996, \$61 million in 1997, and \$52 million in 1998.

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### ***As AHERF acquired more struggling hospitals, its debt soared***

AHERF's expansion was accompanied by the assumption of debt among its acquisitions and by large amounts of new and refinanced debt floated in the tax-exempt hospital bond market. Bond debt grew from \$67 million in 1986 to nearly \$1.2 billion in 1998. Why did AHERF assume so much debt?

- At times, AHERF refinanced older debt at better interest rates.
  - AHERF refinanced debt of hospitals with lower debt ratings by pooling them with hospitals that had better balance sheets and/or higher debt ratings, to obtain better interest rates.
  - AHERF appears to have disguised its accumulated debt by organizing it into different obligated groups. Debt-rating agencies had a difficult time grading each
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group, since it was hard to know how the fiscal health of one group affected the others.

- There is speculation that AHERF issued debt because it was in a hurry to develop a statewide system. It faced competition for some of the hospitals it wished to acquire, had no access to the equity market, and had purchased hospitals with little or no positive cash flow.

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***The competitive market context compounded AHERF's failures***

AHERF's bankruptcy took place in a Philadelphia market that quickly became unforgiving of its strategic failures.

- Philadelphia hospitals were hit by reductions in payments from their three major payers. The two largest private insurers (U.S. Healthcare and Keystone) began to move their members from indemnity to HMO plans. These enrollment shifts, according to AHERF, led to a 10% decline in the average payment per case. At the same time, Medicare lowered payment rates (as mandated by the Balanced Budget Act of 1997), and Medicaid lowered rates as well.
- Although these reductions affected all area hospitals, AHERF's rapid expansion and cash-flow problems made it particularly vulnerable to sudden revenue declines.
- Philadelphia had five major academic medical centers vying for market share, reputation, and research funding. AHERF's decision to purchase two struggling medical schools and their city hospitals did not bestow any competitive advantage.

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***Oversight mechanisms did not identify nor derail a failed management strategy***

While the market succeeded in holding AHERF accountable for its managerial decisions, other oversight mechanisms—the parent board, external auditors, and bond rating agencies—did not.

- AHERF's board failed to act as a countervailing force against the overly ambitious plans of its senior management. CEO Sherif Abdelhak dominated board decisions, and made key decisions without formal board approval. There were conflicts of interest, a strong alliance between the board chairman and CEO, and a ruling inside clique.
  - Board members tend to rely on accountants and external auditors for financial oversight of an organization. In this case, according to the "chief forensic accountant" hired by creditors to sift through AHERF's finances, financial management was deliberately placed in boxes so that each person or entity within AHERF could see only one small piece of the overall financial position. AHERF did not compile a consolidated financial report for all of its subsidiaries until 1998.
  - Investors who purchase health care bonds rely on ratings services to evaluate the risk of their investment. But AHERF's financial manipulations made it difficult for these agencies to judge its overall creditworthiness. As bond rating agencies began to downgrade AHERF's bonds, AHERF took steps to improve these ratings without improving its underlying financial health: it called in the bonds, refinanced them and reissued them under a pooled obligated group, and insured them. The insured bonds often received a higher rating, reflecting the underlying health of the insurance company to insure that debt. The debt rating agency has since changed this policy, but at the time, bond insurance masked the underlying credit quality of AHERF's bonds.
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## **POLICY IMPLICATIONS**

The hospital system known as AHERF no longer exists, although legal cases against AHERF's officers and directors continue. What can be learned from this saga? Burns and colleagues draw five lessons from AHERF's bankruptcy.

- Growth at any cost does not appear to be the answer for hospitals. Instead, hospitals may be better off forming systems at the local market level, where they can achieve some countervailing market power over managed care and purchasing power to contract directly with large suppliers.
- AHERF's expansion strategies—horizontal consolidation, vertical integration and assumption of capitated risk—are causing problems for other hospitals that have followed similar strategies. More hospitals and health systems are likely to edge toward bankruptcy in the near future.
- Rapid changes in hospital reimbursement and market conditions can overwhelm consolidation and integration strategies.
- Hospital system bankruptcy is not necessarily undesirable when it results from failed managerial decisions in the face of new market forces, but may not be desirable when it results from unethical behavior or lack of due diligence.
- The use of bond insurance and reinsurance may reduce investors' scrutiny of underlying bond ratings, and diffuse financial and market risk throughout the health care system. As risk is diffused, so is the responsibility. In AHERF's case, these mechanisms may have contributed to AHERF's collapse.

**Editor's Postscript:** On January 28, 2000, Tenet Healthcare Corp. announced that City Avenue Hospital—a 228-bed hospital acquired from AHERF—would close as of May 1.

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*This Issue Brief is based on the following article: L.R. Burns, J. Cacciamani, J. Clement, W. Aquino. The Fall of the House of AHERF: the Allegheny Bankruptcy. Health Affairs, January/February 2000, vol. 19, pp. 7-41.*

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