The original release of the Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA) Sec. 242/223(f) refinance program was thought of by participants in the hospital finance industry as a compelling alternative to the traditional tax-exempt bond markets. At the time, the tax-exempt bond markets were challenged by the lingering effects of the financial crisis, including widening credit spreads on fixed-rate offerings, the fallout from bank downgrades impairing letter of credit enhancement and a general tightness of credit within the banking community.

What Happened?

Specifically, bank downgrades weakened the quality and supply of credit enhancement, forcing some borrowers with bank letter of credit supported bonds to restructure at a time when the municipal market was broken. In response to that dynamic, HUD implemented the pilot program FHA Sec. 242/223(f) in 2009. It was seen by some as a compelling new alternative; highly rated, inexpensive capital that could fill a void left in the dysfunctional bond and credit markets. The hope was that the FHA hospital refinance program could offer acute care providers the same incredibly attractive debt restructuring opportunity that its sister program, Sec. 232/223(f), offered to the post-acute care industry after the collapse of the commercial mortgage-backed securities market.

However, two factors quickly dissipated that excitement. First, the new program proved difficult to work through. Few commitments were issued and outcomes as well as timing became very uncertain. Only one hospital received a commitment during the pilot program. Second, the bond markets began to improve; fixed rates steadily declined and credit spreads narrowed, again providing the industry with an affordable fixed-rate alternative across the credit spectrum. Those two dynamics coupled together nearly halted application volume through the new program. Tighter application of underwriting criteria blocked the borrowers that needed debt restructuring while improving bond markets provided fast, predictable and similarly priced alternatives to stronger borrowers.

The pilot expired in early 2011. Since then, the FHA Sec. 242 program has gone through a leadership change and now presents a pro-business, deal-focused message to borrowers and appears hungry to use the program.

What's Changed?

Fortunately, while the program’s rerelease doesn’t contain materially different underwriting criteria or qualification tests, FHA 242 leadership now better understands where the program fits within the spectrum of borrowing options available to acute care providers. The program’s relaunch couldn’t have come at a better time.

The municipal bond markets have been hit hard over the last few months, experiencing record outflows of cash from municipal bond funds and rising yields as we finally enter what appears to be a rising interest rate environment. While certainly not the level of dysfunction experienced in 2008-2009, today’s bond markets have opened the door for a lower fixed-rate alternative to noninvestment-grade and low investment-grade borrowers. With that door open, let’s revisit the revised Sec. 242/223(f) program.

Program Criteria

The refinance program requires that no less than 80% of the mortgage be used for refinancing, with no more than
20% eligible for construction, repairs and equipment. The maximum term for a loan is 25 years, with a maximum of 90% loan to value. For acquisitions, the maximum term remains the same, with a maximum of 90% loan to value of either HUD’s approved market value estimate or actual acquisition cost.

It’s apparent that the fundamentals of the 242/223(f) program have been kept largely the same. However, in response to industry participants’ criticism of the pilot program, internal process modifications were made, aimed at increasing efficiencies and ensuring good projects are not rejected prior to a full consideration.

As with the standard 242 program and the original 242/223(f) pilot, borrowers must pass certain eligibility criteria to qualify for the program. Hospitals are required to have an average debt service coverage ratio greater than or equal to 1.4 times over the last three fiscal years. In addition, hospitals are required to have an aggregate operating margin greater than or equal to zero over the last three fiscal years. Debt service coverage ratios and operating margins must be calculated from the three most recently audited financial statements. Finally, in addition to evidencing financial stability, borrowers are required to evidence a need for the program through a series of additional criteria. Because of the focus on need for the program, borrowers are allowed to recast their last three audited years’ interest expense as if their 242/223(f) loan was in place to help satisfy the core debt service coverage and operating margin criteria.

**Back at Just the Right Time?**

So far, the summer of 2013 has not been kind to the bond markets. In June, comments from the Federal Reserve in support of tapering its bond buying efforts caused a selloff in the markets. In June, comments from the Federal Reserve in support of tapering its bond buying efforts caused a selloff in the markets. In June, comments from the Federal Reserve in support of tapering its bond buying efforts caused a selloff in the markets. In June, comments from the Federal Reserve in support of tapering its bond buying efforts caused a selloff in the markets. In June, comments from the Federal Reserve in support of tapering its bond buying efforts caused a selloff in the markets. In June, comments from the Federal Reserve in support of tapering its bond buying efforts caused a selloff in the markets. In June, comments from the Federal Reserve in support of tapering its bond buying efforts caused a selloff in the markets.

Compounding that dynamic, a key provision of the Affordable Care Act, which would fine businesses for not offering employees affordable health insurance, was delayed by the administration causing even more uncertainty about the financial future of health care providers. As with any investment, increasing uncertainty is usually followed closely by selling activity and volatility. During the first quarter of 2013, municipal bonds have lost 3.1% and hospital/health care bonds are down 3.8%. The sell-off in municipal bonds has been triggered by investors pulling money out of the mutual fund bonds that invest in them—$13.5 billion since June, marking this current flow one of the largest moves out of these funds since 1992. Fund outflows and selling activity translate to increasing interest rates for hospitals seeking financing through the traditional bond markets, thereby making it more difficult and expensive for many hospitals to gain access to affordable fixed-rate capital.

Enter the new Sec. 242/223(f) program. Interest rates for the refinance program are slightly below 5%, including the annual FHA mortgage insurance premium. This is substantially lower than the 30-year BBB Health Care Index of 5.80%, up from 4.26% as of May 1, 2013. That favorable comparison becomes more attractive to noninvestment grade hospital borrowers that qualify for the program as their borrowing cost through the challenged traditional municipal markets will likely be above 6%. Should the new program live up to its pro-business message, it could become much more relevant in today’s market.

While it is very unlikely that FHA Sec. 242, either for construction or refinance, will ever fully compete with the volume of municipal health care bond issuance, it can provide a compelling alternative in challenging markets if FHA leadership makes the program more predictable and accommodating to the threshold investment grade borrowers that need it. In times of capital market distress, those borrowers on the investment grade margin are often the most impacted as investors seek haven in higher quality credits. Sec. 242 mortgage insurance affords those borrowers the opportunity to issue the kind of high quality debt desired by investors in challenging times, providing them access to more affordable fixed-rate capital than otherwise available. It seems that the reissued 242/223(f) program combined with a new regime within the 242 program may have entered the market at just the right time.

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