Even before Bear Stearns and Lehman Bros. became shorthand for Wall Street disaster, the Pension Benefit Guaranty Corp. was concerned about hospital pension funds.

The independent, federally chartered guarantor of defined-benefit pension plans saw two challenges with the hospital industry after it undertook an internal study of healthcare pensions, says Suzanne Kelly, a senior financial analyst for the PBGC. (The study has not been released publicly before.)

The corporation completed its study of 1,037 healthcare defined-benefit pension plans, including 802 hospital plans, in March 2008—when the Dow Jones industrial average was in the range of 12,000 vs. about 8,500 today—and found two elements that were problematic, Kelly says.

One is familiar to hospital executives: The hospital industry has a much different profile than most of the industries that the PBGC deals with, Kelly says. It is largely not-for-profit, runs on thin margins and has to provide at least some level of service to all who walk through its doors—something the corporation doesn’t see with any other industry, Kelly says. Its fragmented nature also leaves hospitals more exposed to the fortunes of their local economies than most businesses that the PBGC monitors, she adds.

“We haven’t seen one like this with a tremendous number of plans concentrated in one industry,” Kelly says. “It caught our attention.”

The other concern is also related to that fragmentation: the hospital plans are much more numerous and much smaller individually than any industry that the corporation deals with, Kelly says. That means there are simply a lot of plans, an internal challenge that the PBGC faces in monitoring these plans and the additional burden it would face in taking control of a significant percentage of hospital pension plans, Kelly says.

Small pension plans covering 10,000 participants take nearly as much staff time to handle as plans with a million or more participants, Kelly says, so any changes in the industry’s economics that unsettled hospitals’ already precarious finances could unleash a wave of small plans on the PBGC. Moreover, smaller organizations have less management resources and fewer specialized personnel that they can devote to oversight of their pension plans than large corporations, Kelly says.

The study relied heavily on the annual filings that defined-benefit plans must make with the Internal Revenue Service on Form 5500. At the time of the study, the Form 5500s that were available covered 2004 and 2005, and then the PBGC adjusted those figures to estimate where the pension plans stood as of Dec. 31, 2006, according to the study (See chart).

Hospital pension plans don’t differ materially from other pension plans in one respect—their asset mix, Kelly says. Typical pension plans hold about 60% of their assets as equities, so those have suffered from the drop in the stock market. The Dow closed 2006 at 12,463 and has dropped by nearly a third since then.

To make matters worse from an actuarial standpoint, interest rates have fallen sharply from the level used in the study, Kelly says. While good for borrowers, lower interest rates increase the total liabilities in their defined-benefit pension plans to meet their future liabilities, she says. "Funding ratios are going down across the board," Kelly says.

The study also revealed that there was a geographic element to the problem, Kelly says. Hospital plans in three states—Michigan, New Jersey and New York—had more than $750 mil-

### RUNNING THE GAMUT

A snapshot of 802 hospital pension plans monitored by the Pension Benefit Guaranty Corp.

<table>
<thead>
<tr>
<th>Unfunded benefit liability</th>
<th>Plans</th>
<th>Total unfunded benefit liability ($ in billions)</th>
<th>Percentage of total plan participants</th>
<th>Average funding percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>67</td>
<td>$0</td>
<td>10.0%</td>
<td>107.4%</td>
</tr>
<tr>
<td>Less than $5 million</td>
<td>251</td>
<td>0.55</td>
<td>7.8</td>
<td>89.8</td>
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<tr>
<td>$5 million to $50 million</td>
<td>423</td>
<td>7.19</td>
<td>48.2</td>
<td>83.1</td>
</tr>
<tr>
<td>$50 million to $100 million</td>
<td>40</td>
<td>2.88</td>
<td>14.8</td>
<td>78.4</td>
</tr>
<tr>
<td>$100 million to $250 million</td>
<td>18</td>
<td>2.72</td>
<td>12.8</td>
<td>76.1</td>
</tr>
<tr>
<td>More than $250 million</td>
<td>3</td>
<td>0.86</td>
<td>6.3</td>
<td>88.0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>802</td>
<td><strong>$14.19</strong></td>
<td><strong>82.2%</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: Total percentages don’t add up to 100 because of rounding.

Source: Pension Benefit Guaranty Corp.
lion in unfunded benefit liabilities and a funding ratio below 80%, according to the study. The PBGC spoke with health department officials in New Jersey and New York to make them more aware of the problem and encourage them to discuss it with hospital officials in their states, Kelly says.

Matthew D’Oria, deputy commissioner of the New Jersey Health and Senior Services Department, says his agency’s meeting with the PBGC last fall opened a new source of information for its efforts to stay on top of hospital finance in New Jersey. The department gained new oversight powers under a law that was enacted last year (Aug. 18, 2008, p. 12).

“As much data as we get, there’s not a lot of specific information about the pensions,” D’Oria says. “On the balance sheet, it shows up as a liability, but just one of many. They were able to shed a lot of light on some of our hospitals. We know better now which ones are closer to safe levels for pension funding.”

**Educat ed elected officials**

The contact with the PBGC has been maintained, and that has led the department to educate state and federal elected officials about the effect that pension liabilities can have on some hospitals, D’Oria says. For example, the agency has told state officials that, he says, “A hospital might look good right now, but they have a looming pension liability coming in a few months that will wipe out their reserves.” Health department officials also have spoken with the state’s congressional delegation to recommend some measures, perhaps temporary, to ease the burden of pension contributions in light of the actuarial squeeze of cratering equity returns and sharply lower interest rates, he adds.

Neil Benjamin, director of the Division of Health Facility Planning within the New York State Health Department, says his agency’s meeting a year ago with the PBGC helped smooth the way for a hospital merger in Amsterdam, N.Y. Amsterdam Memorial Hospital and St. Mary’s Hospital were not required to merge under the state’s Berger Commission report (Dec. 4, 2006, p. 6), but they took advantage of a voluntary consolidation program that the department calls “Berger look-alikes,” Benjamin says.

A sticking point was the pension obligation of 39-bed Amsterdam Memorial, which 143-bed St. Mary’s didn’t want to assume, the PBGC’s Kelly says. The health department gave St. Mary’s a $7 million grant that was payable to the PBGC to buy out the hospital’s obligation and, in May, the PBGC assumed responsibility for the plan, according to a PBGC news release.

The health department also helped the PBGC with the data collection that it needs for monitoring plans, Benjamin says. The state’s Medicaid program requires cost reports that include audited financial statements, he says. Within those statements, the auditors have to report on the funding level of the organization’s pension liabilities, he says. The department now provides these cost reports to the PBGC, he adds.

“We’ve established a good basis of communication with them,” Benjamin says. “We’ll continue to talk to them.”

Kelly adds that the PBGC is open to hospital officials directly. “If they think that they are getting into a problem area,” she says, “feel free to talk to us.”

—Vince Galloro