Chicago area sees hospital building boom

Billions are poured into new facilities, but value of investments is questioned

By Peter Frost, Chicago Tribune reporter

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Rush University Medical Center just completed a massive, $654 million hospital as part of a $1 billion campaign to update its Near West Side campus.

Children’s Memorial Hospital is putting the final touches on an $855 million new hospital in Streeterville that will replace its 50-year-old Lincoln Park hospital.

The University of Chicago Medical Center is spending about $700 million on a new South Side hospital pavilion expected to open in January.

There are new hospitals in Elmhurst, New Lenox and Elgin; plans to add capacity at Edward Hospital in Naperville; and expansions under way at NorthShore University HealthSystem’s Glenbrook and Skokie hospitals. Others, including Northwestern Memorial Hospital, are awaiting regulator approval for projects of their own.

Illinois, particularly the Chicago region, is in the midst of a hospital building boom.

Driven by the need to replace aging facilities, integrate new technology and equipment and, of course, fend off fierce competition, hospital systems spent more than $6.6 billion between April 2009 and April 2011 to build new facilities and update old ones, according to Illinois Hospital Association data scheduled to be released Monday.

The spending spree underscores a race to gain and hold on to market share in one of the most competitive health care markets in the country. It also comes at a time of vast uncertainty in the industry, which faces drastic changes in the way care is delivered and paid for as part of the rollout of the national health care overhaul.

The ramifications for patients, insurers and the hospitals themselves are myriad.

Hospitals’ investments promise to provide better access to more-advanced treatments for patients, as well
as private rooms and more coordinated care. Those upgrades also will help hospitals attract and retain top-quality medical talent.

At the same time, there's a cost for all these gleaming new facilities, nearly all of which feature luxury finishes, such as flat-screen televisions and other hotel-like amenities.

And with nearly every major hospital system in the region investing hundreds of millions into upgrades, it's doubtful there's room for all of them to thrive. Smaller players in particular could be squeezed out.

"The take-away here is people see Chicago as a strong hospital market and one that's worthwhile to invest in," said Allan Baumgarten, a Minneapolis-based health care analyst and author of the Illinois Health Market Review. That's what’s contributing to all the cranes you see on the skyline right now."

To finance the projects, Illinois hospitals accumulated record amounts of debt.

Between 2009 and 2011, hospitals in the state borrowed $6.54 billion through bonds issued via the Illinois Finance Authority. As of Jan. 31, health care organizations had amassed $12.59 billion in outstanding principal on tax-exempt bonds, according to data released last week. That figure includes debt issued by hospitals and other long-term care facilities.

While having first-class hospitals can be a source of prestige and pride for the community, the substantial investments come at a cost, Baumgarten warned.

"Be careful what you wish for," he said. "You can't build new buildings and fill them with exciting new equipment without paying for it."

**Boom begins**

Construction began in earnest in 2008, when the value of health care building starts in the Chicago metro area spiked to $2.6 billion, up from about $659 million a year earlier, according to a McGraw-Hill Research & Analytics report.

In some ways, however, the building spree was overdue. In 2007, the median age of Illinois hospitals was 10.55 years, higher than the national median of 9.77, according to an Illinois Hospital Association study.

That fact was well-known by the region's medical centers, many of which were still using decades-old facilities that were ill-equipped to handle modern technology and evolving patient needs. But many faced the same problem: They didn't have the means to pay for the upgrades.

In the late 1990s and early 2000s, hospitals generally were struggling to make ends meet, largely as a result of a new federal law...
enacted in 1997 that slashed hospital reimbursement rates for Medicare patients.

The legislation, dubbed the Balanced Budget Act of 1997, also established State Children's Health Insurance Programs, which required that virtually all children had access to health care.

As a result, balance sheets of many hospitals deteriorated, squeezing cash flow and depleting capital reserves.

All the while, an influx of high-tech equipment came online and health care delivery and patient expectations evolved.

More procedures are now conducted on a same-day basis, reducing the need for overnight hospital stays. That required hospitals to look at reconfiguring space to accommodate the shift. New imaging equipment, robotics and other devices also require larger rooms and more infrastructure to support.

Meanwhile, patients and their families are no longer willing to share rooms with others for reasons of comfort, privacy and infection-control, a metric backed by medical studies.

With that combination of factors, those hospitals that were able to weather the financial challenges began eyeing overhauls, leading to "an enormous amount of pent-up demand" of new facilities, said Greg Werner, vice president and general manager of Mortenson Construction's Chicago office, one the region's major health care construction firms.

To qualify for tax-exempt bonds to finance expansions, hospitals had to shore up their operations, launch fundraising campaigns and justify to regulators the need for new buildings.

"Some hospitals had aspirations of new facilities, but it took them awhile to build up enough capital to get them off the ground," he said.

Rush University was a prime example.

About 10 years ago, "We knew that we really needed to invest in our campus," said Dr. Larry Goodman, the hospital system's chief executive.

But its balance sheet was in shambles and the hospital was losing money.

"If we're trying to be the hospital of choice in Chicago and be recognized across the country, we needed to do better than just floundering above break-even," Goodman said.

Rush tightened its operations budget and launched a capital campaign in 2004 with a goal of raising
about $300 million.

Within a few years, Rush righted the ship.

The hospital surpassed its fundraising goal by $85 million, fortified its finances, won regulatory approval and secured financing to build its 14-floor, 830,000-square-foot hospital tower, which opened in January.

**Starting from scratch**

Like other major medical centers, Rush opted to build anew rather than update existing facilities, a decision that was based on cost, available space and competition.

Despite the propagation of new structures popping out of the ground, most area hospitals didn't add much inpatient capacity. Nearly all of the new facilities were built to replace old spaces, in many cases cobbled together over years of smaller expansions.

The cost of retrofitting a hospital even 20 years old to accommodate private patient rooms, electronic medical records equipment and advanced medical devices is cost-prohibitive, said Kevin Ryan, a Chicago-based health care attorney with Epstein Becker & Green P.C.

"In light of all those factors, you ask if your buildings are designed to accommodate today's patients and today's equipment," Ryan said. "If it's more economical and better for patients, then it makes more sense to build a new facility."

At the University of Chicago Medical Center, for example, officials designed a 10-story, 1.2 million-square-foot pavilion with flexibility in mind.

To meet the ever-evolving needs of health care delivery and patients, the hospital engineered the interior of the building to easily be reconfigured.

It put 18 feet between floors, up from the normal 14, anticipating the need for additional overhead space to accommodate wiring and other systems introduced in the future. In addition, two of its 10 floors will be left vacant, an open slate for the hospital to outfit as need dictates.

For Douglas Silverstein, president of NorthShore Glenbrook Hospital, the cost of retrofitting the 1977-built hospital to accommodate new equipment and feature all-private patient rooms "was exorbitantly expensive."

Instead, the hospital is spending $134 million to build a new outpatient wing and an additional inpatient floor. Once those projects are complete, the hospital will be able to renovate existing rooms by shifting patients a floor at a time to limit disruptions.

Competition also played a role, a fact that each of the major hospital systems acknowledged — not just for patients but for physicians and other medical care providers.

"Around Chicago, you've got a hypercompetitive marketplace, there's no doubt about it," said Brian Sanderson, a managing partner at Crowe Horwath LLP, an accounting and consulting firm that advises health care providers. "Once one builds, you have to respond."
Battle for market share

The billions of dollars hospitals spent collectively on modernization could push some lesser-capitalized hospitals out of business, unable to compete, industry observers say. It also raises questions about how medical systems that made large investments intend to pay down the new debt.

Jay Warden, a senior vice president at The Camden Group, a Chicago-based health care management consulting firm, calls the spending "a vicious cycle" that will result in a battle among giants for market share.

To pay back hundreds of millions in debt, hospitals must either generate additional patient revenue or redouble efforts to raise money from donors, Warden said.

That's in part because payments from federal and state health care systems aren't likely to increase anytime soon, analysts say. Further, because many private health plans are under pressure from employers who have been hit by rising health care costs and a sour economy, hospitals' ability to pass along the costs to pay for new facilities figures to be difficult, analysts said.

"Those days of being able to build it and recoup your investment through increased billings are over," Ryan said.

The resulting battle for market share could begin siphoning patients away from smaller community hospitals, which might either fold or be forced into partnerships with the large academic systems that have access to capital.

"The big are going to get bigger, and some of the smaller systems are not going to be able to survive," Sanderson said. "It's just like the corner grocery store when the Jewels and Wal-Marts come into town. They just cannot compete."

Others, particularly some of the suburban hospitals, may have taken on too much debt with their large investments in new facilities and could be forced to seek partnerships with the larger academic institutions to remain afloat.

Both Elmhurst Memorial Hospital, which opened a $450 million hospital last year, and Sherman Hospital, which spent $325 million on a new facility in Elgin, posted losses in their most recent quarters.

Because of those hospitals' weakened financial positions, larger hospital systems seeking to expand their footprints west are kicking the tires on possible affiliations, health care analysts and hospital officials said.

Northwestern Memorial HealthCare, for example, is "beyond the talking stage" and conducting due diligence about an affiliation with Elmhurst, said Rob Christie, Northwestern's vice president of external affairs.

Someone must pay

For the region's health care consumers, the results of such industry upheaval are a mixed bag.

Maryjane Wurth, the president of the Illinois Hospital Association, said the spate of new building and expansion "is a great news story for patients" and helps to reposition Chicago as a leader in advanced
medical care.

Others see a likelihood of ballooning costs at a time when many businesses and families can ill-afford them.

"In the end, some portion of these costs have to be built into the rates hospitals are charging," said Baumgarten, the health care analyst. "And a lot of how it's going to be paid for is through additional charges on employer groups and insurance companies."

That translates into higher monthly premiums or higher deductibles for consumers.

Health insurance costs already are on the rise for many Americans, according to a September report from the Kaiser Family Foundation. That study found that the annual premium for family coverage through an employer rose 9 percent in 2011, the biggest increase in six years.

"Everyone is in favor of efficiency, accuracy, speed and access," said Larry Boress, president and CEO of the Midwest Business Group on Health, a nonprofit business coalition. "But it's impossible to know whether all of this brick-and-mortar construction is actually needed or if it's driven by competition."

Whether it's insurers, employers, patients or taxpayers, someone is going to have to pay for the promulgation of new hospitals, he said.

When hospitals demand higher rates from insurers, a consequence is that more and more payers — insurance companies and self-insured companies — may opt to exclude certain hospitals from their networks. The corollary is that access will become more limited for some consumers.

Another option, one which some large self-insured employers already have begun offering, are tiered coverage plans, in which a higher-cost plan may include more hospitals, but at a higher premium.

"We want more efficient hospitals that offer higher-quality care and better use and integration of technology that results in better treatment of patients," Boress said. "But is this just a way to generate revenue and increase market share, or is it adding to the overall costs of the system?"

"I mean, does every patient really need a 40-inch TV in their room?"

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