COMMUNITY AFFAIRS SENATE COMMITTEE

INQUIRY INTO:

Aged Care (Living Longer Living Better) Bill 2013;

Australian Aged Care Quality Agency Bill 2013;

Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013;

Aged Care (Bond Security) Amendment Bill 2013;

Aged Care (Bond Security) Levy Amendment Bill 2013

SUBMISSION BY

THE AGED CARE GUILD

22 APRIL 2013

Executive Summary

The Aged Care Guild (the **Guild**) is an association that was formed in 2012 consisting of the five largest 'for profit' Providers in the residential aged care industry in Australia. The Guild's objective is to ensure a financially stable aged care sector in Australia that encourages investment and further development of aged care services.

The Guild's original members were Bupa Care Services, Domain Principal Group, Japara Holdings Pty Ltd, Lend Lease Primelife and Regis Aged Care. The original Guild members control more than 10% (circa 20,000) of the industry's beds; hold circa $1.6bn of the $12bn industry wide accommodation bond pool; and collectively have been the largest builders or acquirers of beds in the industry over the last five years.

The Guild supports the need for industry reform and broadly agrees with many aspects of the proposed legislative changes. It sees *Living Longer Living Better* (**LLLB**) as an important step of a much bigger reform journey.

While the Guild welcomes the Government making aged care a priority through LLLB, in order to ensure quality aged care services are sustainable in the future there are a number of matters that the Guild believes still need to be addressed.

The most important of these issues is the regime of lump sum bonds. The circa $12bn of bonds (aka capital) underpin the industry and facilitate growth and delivery of new beds as they are effectively an interest free form of capital. This mechanism also allows the sector to access traditional bank debt as they then have the ability to repay the debt. Our other concerns are largely shared by other industry bodies and have been noted in previous discussions that we have had as part of the reform process.

Our submission seeks to inform the Senate Affairs Committee on the impacts of the proposed changes to the bond regime in the following context:

Situation: Proposed legislative reforms will influence consumer behaviour such that the inflow of capital to the industry from bonds is nullified.

Problem: Said decline in bond inflow and by nexus, outflow of existing bond capital will cripple development, reinvestment and improvement which consequently will lead to less consumer choice and lower industry viability. It may potentially also lead to a fewer number of operational beds in the near term.

Complication: The triggers for review and subsequent remedy periods are elongated and any negative impacts from reforms will be near impossible to reverse.

Implication: Unless the legislative framework is amended **prior** to adoption, consumer choice and indeed services will be negatively impacted.

In summary, in relation the bond regime only, we recommend that any amendments proposed that are likely to influence consumer behaviour be withdrawn until such time as an appropriately detailed impact study can be undertaken to accurately determine the impact of the changes.

Rationale:

Bonds have been a significant source of funding for many years, enabling the construction of many new aged care beds as a result. Changes in Bond levels have been incremental as the market has evolved and new facilities have been built. Providers balance sheets, debt facilities and liquidity management strategies are designed for the current funding regime and are in fact, reliant on it.

It is this reliance and on the operating structure that warrants such close scrutiny and analysis as the 'cost' of not proceeding in this manner is the potential decline of services and operational beds which reduces consumer choice in not only where they receive their care, but also how.

Further detail supporting our contention is provided herein and the Guild welcomes any opportunity to further present its' views at a Committee Hearing.
For the sake of clarity the concerns are presented in relation to the elemental part that warrants attention. In this vein, the new proposed terminology when referring to daily fees[1] and bonds[2] is utilised.

1. Choice of payment

At present, the resident agrees the method of their payment for the accommodation be it a RAD or DAP prior to entry. The amounts are negotiated on free market principles and therefore certainty from both the provider and resident perspectives is maintained form the point of entry in relation to either a DAP or RAD. Practically speaking, choice is therefore already present in the system.

Moreover, a provider presently has the flexibility to offer their services on a specific basis in order to ensure compliance with specific debt covenants or other capital structure objectives.

Lastly residents have a 14 day cooling off period in relation to the Accommodation Agreement however, under the proposed legislation this is not a cooling off period (where the contract becomes void), rather it is a choice of payment period which has been extended to 28 days after admission.

Proposed legislation:
Proposed Division 52F-4 expressly prohibits a Provider from requiring a resident to choose how to pay their accommodation fees prior to entry. In fact it is proposed that they have at least 28 days post admission to make this choice (see proposed new section 52F-3(1) (e) of the Aged Care (Living Longer Living Better) Bill 2013).

Issue:
Until such time as the resident decides on their payment method, they pay the DAP and this in of itself will encourage the adoption of DAP's over RAD's as it is something the resident is used to doing from the day of entry – that which is being done and is known is easier to adopt. The default position in the proposed legislation is a DAP rather than a RAD.[3]

[1] Referred to as an Accommodation Bond (**Bond**) under existing legislation and a Refundable Accommodation Deposit (**RAD**) under the proposed legislation. For ease of discussion the term 'Bond' is often used throughout this document in reference to lump sum payments under both current and proposed legislation.
[2] Referred to as a Periodic Payment (**PP**) under existing legislation and a Daily Accommodation Payment (**DAP**) under the proposed legislation.
[3] Proposed section 52F-3(1)(f)

Moreover, this change in the selection of payment method further dilutes the right of a provider to determine how their services and accommodation is paid for. When considered objectively, no other services industry has controls placed on both the demand and supply side of the equation. It is our view that the Provider should determine whether they wish to offer a lump sum or periodic payment or a combination of both, and it is for the customer to decide between Providers as to the offer that best meets their needs. This contention is further supported by virtue of the increased transparency requirements.

Cost of inaction

Unfortunately, the industry has not been provided with any evidence to address its' concerns and thus there is a large element of the 'unknown' in relation to the level of impact these concerns may have. This alone has stagnated development and growth activity in the sector.

Notwithstanding, what we do know is as follows:

- The quantum of Bond cash flows are significant to many Providers and can be multiples of their operating cash flows;
- Providers can no longer control these RAD cash flows;
- There will most likely be downward pressure on providers' RAD pools on existing bonded beds given imposed caps and disincentive to pay RAD's;
- It is unlikely that new RADs on standard High Care will offset all these bond outflows; and,
- Banks may not fully fund the shortfall (see Appendix 1 for further detail).

To further highlight the impact, we have outlined a working example below (please refer to Appendix 2 for additional details).

The example assumes a 100 bed facility that originally required debt funding of $20m to build and make operational. Assume that $15m of RAD's have been collected via 50 bonded residents.

As is the case presently for providers that carry bank debt, all RAD's as and when received are utilised for debt reduction and thus the provider on 1 July 2014 has net debt of $5m.

Furthermore we assume an average operator who generates operational cashflow (defined as EBITDA) of $7,000 per bed[4] and for bank security purposes, the business has an initial value of $100,000 per bed plus another $2m in security assets which is in line with present day norms.

Lastly, we have assumed the common banking covenants for a provider of this nature being 1.75x for interest cover ('ICR') and a loan to value ratio ('LVR') of 55%. Based on these assumptions they are comfortably operating within these covenants (ICR = 2.0x, LVR = 42%) on 1 July 2014.

In order to illustrate the impact, now assume that 60% of new residents choose a DAP instead of a RAD post reform going live and the current unbonded rooms do not attract bonds (based on our contention) then the cash outflows impact the providers debt position as follows.

Debt Metric	2014	2015	2016	Notes / Assumptions
Net debt ($)	5,000,000	9,500,000	12,650,000	Net debt after existing bond pool deducted
ICR	2.0	1.5	1.4	Interest cover ratio covenant 1.75x (breached)
LVR	42%	67%	81%	Loan to value ratio covenant 55% (breached)

[4] Prior to any increase related to additional DAP's.

Aside from banking arrangements being breached, what the example clearly shows is the significant impost on the provider to fund outgoing RAD's.

Clearly this outcome is concerning.

Whilst we acknowledge that this is a hypothetical and that many scenarios exist, we firmly believe that many providers will face cash flow issues for the reasons aforementioned and there are insufficient relief mechanisms available to curtail the negative impact.

In addition, we acknowledge that in theory, there is scope for additional new bonds to be taken on high care beds which were previously unbondable. That said, we do not believe that the quantum of these additional bonds will nullify the negative impacts for the following reasons:

- For facilities that are highly bonded (pure Low Care or Extra Service) there will be few if any new bonds on High Care available;
- Our experience is that only single rooms in good quality facilities can command a bond and a high proportion of our existing standard High Care beds are located in the older style facilities with multi-bed wards that will not command a market driven bond;
- A large portion of existing (and future) high care residents have insufficient assets to allow a bond to be charged that is financially worthwhile;
- If the proposed resident choice legislation is passed, new High Care residents will be more likely pay a periodic payment rather than a bond; and,
- A disincentive to pay a RAD exists because of its' proposed inclusion in the means test (this is elaborated on further below).

While Guild members have the benefit of diversification, the majority of the industry is comprised of single facilities and the changes proposed will impact them the greatest, leaving the industry vulnerable as a whole.

2. Disincentive to pay a RAD

At present, the RAD paid to a provider is excluded from the residents means test in relation to the calculation of resident fees.

Thus, many choose to pay a bond in order to the preserve the equity they have, and fund the cost of their care via pension entitlements and other supplementary income streams.

Proposed Legislation:

The proposed Bill clearly stipulates the inclusion of a RAD in the means test for a resident under section 44-26A(5) of the *Aged Care (Living Longer Living Better) Bill 2013*.

The RAD will be utilised in calculating the value of a person's assets when determining firstly, whether the care recipient is a supported resident, concessional resident or assisted resident and ultimately, the amount of accommodation supplement payable.

This represents a quantum shift from the current operating framework and we believe provides a disincentive for residents to pay a RAD.

Issue:
The impact of such a change compounds the issue highlighted above because the industry's primary form of capital via which it facilitates new beds, reinvestment into existing facilities and improvements in services may reduce over time.

Furthermore, it will lead to a impost of significant proportions on operators cashflows as outgoing RAD's will have to be funded via generated profits and/ or higher borrowings where possible.

Inevitably, this will lead to a severe contraction in building activity, a significant rise in the operational defaults (as cashflow impacts will not be able to be absorbed by the majority of the industry) and a restriction on rationalization/ consolidation by virtue of capital being constrained.

As a consequence, the number of operational beds may in fact decrease in the short term and limit consumer choice.

Time is a critical factor
Unlike many reform agendas, the negative impact of inaction in relation to the concerns raised cannot be adequately unwound or managed if the tenants of consumer choice and a viable aged care sector are to be upheld.

By the time the review is conducted and the findings reported in 2017 the sector will have been irreparably harmed and consumer confidence destroyed as providers will not be able to relieve the financial pressures and as a result solvency issues will occur across the sector.

The sector can ill afford a trial and error approach.

Conclusion
The salient points raised herein lead us to believe that consumer behaviour will change to strongly prefer the payment of a DAP over a RAD.

Consequently, the industry impact is swift and severe as illustrated and will negate the very principles of the LLLB package being consumer choice and improved care via a sustainable aged care system.

Guild Recommendation

Fundamentally, in the absence of detailed modelling that clearly demonstrates the variance of a downside and likely scenario is narrow i.e. the magnitude of any negative impact can be withstood by the sector, the proposed changes highlighted herein should not be passed.

This approach will remove the ambiguity, restore confidence in the sector and enable providers to 're-tool' their businesses appropriately in order to meet consumer demands and provide choice.

This will also seek to enhance the many other positive reform items contained within the LLLB package.

Appendix 1

Capital Structure: Issues for Providers and the Industry

The below points serve to support the contentions raised in the body of the submission and speak specifically to the financial structures and associated impacts on providers.

Fundamentally, the sector is underpinned by RAD's and the mechanism has become an integral and inseparable part of the way the sector structures itself, operators and indeed remains viable.

1. RAD cash flows can be significantly greater and much more volatile, than operating cashflows therefore providers have very limited capacity to fund any significant bond outflows from operating cash flows. i.e. average industry bond is circa $280,000 per bonded bed while the cash profit for the same bed is circa $7,000 per annum (industry average; Grant Thornton document titled "Implications for the residential aged care industry. Caring for older Australians – Productivity Commission Report, September 2011").

2. The lump sum RAD pool today is $12 billion across the sector. Daily charge bonds (currently known as periodic payments) represent less than 10% or circa $1 billion. The resident pays an interest rate being the MPIR[5] (presently 6.95%) on the outstanding amount. This is closer to debt funding costs rather than a weighted average cost of capital (WACC) and therefore is an inadequate rate of return for providers. However given this form of payment represents a low and stable percentage of total bonds this inadequate pricing is able to be absorbed by providers.

   That said, providers will not be able to absorb a material increase in DAP's with a corresponding fall in RAD's. Providers will only be able to absorb the adverse liquidity consequences of a significant shift to DAP's if they are able to set the daily charge at their 12 -14% pre tax WACC on the value of the RAD they would otherwise charge- this also provides sufficient interest cover to enable Bank's to fund any shortfalls. This WACC is the minimum financial equivalent return an operator must achieve to be indifferent to receiving a RAD or a DAP.

3. The proposed new pricing and resident admission regime may likely see the level of RAD's reduce and be replaced by DAP's. This is unquantified downside risk to stability of balance sheets in the industry because there is no alternate capital or cash inflow to replace the RAD.

4. As the inflow of RAD's declines and the related impact on cashflow, Banks will require additional top up equity to replace lost RAD cash flows. This should be self-evident as the price of the daily charge bond at 6.95% approximates a provider's borrowing cost.

   Banks may not provide a $100 loan to replace a $100 RAD outflow that has been replaced by a DAP when the provider's interest cost on the loan is circa $7 annually (7% interest rate) and the DAP is only $6.95 annually – banks rarely lend on less than 1.75 times servicing ratios.

   To further put this in perspective at an industry level;

   a. Current bank debt in the industry is circa $4-5 billion.

   b. Should the $12 billion Bond Pool referred to previously reduce by $3 billion the banks would then require a 40% cash equity ($1.2bn) contribution to offset this reduction.

Where is this to come from? Note that this additional equity will be required to fund existing operational beds as is, not construction to meet future demand or maintain existing beds.

[5] Maximum Permissible Interest Rate

Appendix 2

Worked Example

Debt Metric	2014	2015	2016	Notes / Assumptions
Beds	100	100	100	"100 bed" example
Residents	95	95	95	95% occupancy
Bonds Held	50	35	25	50 single rooms / private ensuite, 25 twin rooms. Ave length of stay 2 years, 60% of new residents elect a DAP rather than RAD.
Average Bond Value ($)	300,000	300,000	300,000	Assume bond capping does not apply downward pressure at all levels
Total Bonds ($)	15,000,000	10,500,000	7,350,000	Total bond pool at 30 Jun
Cost per bed ($)	200,000	200,000	200,000	Total cost assumption for purpose of model
Total Cost ($)	20,000,000	20,000,000	20,000,000	Total funding requirements
Net debt ($)	5,000,000	9,500,000	12,650,000	Net debt after existing bond pool deducted
Interest @ 7% ($)	350,000	665,000	885,500	Interest cost on net debt assuming 7% interest rate
Operating Cashflow / Bed ($)	7,000	7,000	7,000	Simple assumption based on industry data per Grant Thornton report
Operating Cashflow ($)	700,000	700,000	700,000	"Normal" operating cashflow
Additional DAP @ 6.95%	n.a.	312,750	531,675	Additional operational cashflow from residents electing DAP instead of RAD
New Operating Cashflow ($)	700,000	1,012,750	1,231,675	Total cashflow used for debt covenants etc
ICR	2.0	1.5	1.4	Interest cover ratio
Value for Security purposes				
Aged Care Facility	10,000,000	12,085,000	13,544,500	"Good operator" earnings of $15k per bed + additional DAP capitalised at 15%
Other (Equity)	2,000,000	2,000,000	2,000,000	
	12,000,000	14,085,000	15,544,500	
LVR	42%	67%	81%	Loan to value ratio
Security Value per Bed Calculation				
EBITDA	15,000	18,128	20,317	
Cap Rate	15.00%	15.00%	15.00%	
Security Value per Bed	100,000	120,850	135,445	