

UPDATE ON FINANCIAL TURNAROUND

Albemarle First Boosts New Owner

The fall 2006 issue of *Region Focus* went to press just before an announcement that was pertinent to the article, “The Life and Times of Albemarle First.” In October, Winchester, Va.-based Premier Community Bankshares reported third-quarter earnings of \$2 million. What was notable about those results was the contribution made by Albemarle First, which Premier had acquired July 1.

As readers of the article may recall, Charlottesville-based Albemarle First had struggled in its early years to overcome lending problems and a check-kiting scheme. But more recently a financial turnaround seemed to be taking hold, amid a concerted effort by new management and staff. (A new executive team was put in place in early 2002, starting with the appointment of CEO Tom Boyd.) Premier’s third-quarter announcement appears to support the conclusion that the turnaround was complete: Albemarle First provided profits of \$455,000, the highest quarterly total in the acquired bank’s history.

On Jan. 29, Premier announced it was being acquired by Charleston, W.Va.-based United Bankshares, pending regulatory and shareholder approvals. — DOUG CAMPBELL

BEST PRACTICES

West Virginia Encourages IT Investment in Health Care Industry

Technological advances have revolutionized the diagnosis and treatment of illness. Yet the revolution in information technology, ranging from electronic record-keeping to wireless communications, hasn’t had as big an impact on the health care industry. Doctors still lug around thick folders stuffed with records and x-rays, making it difficult for different practices to share information on the same patient. Verbal and written orders from doctors can be misinterpreted, leading to deadly medical errors in hospitals.

West Virginia is among states trying to change the status quo. Since March 2006, it has facilitated the development of a statewide health information network, which was recommended by a task force created by Gov. Joe Manchin in 2005 and touted in the governor’s last three State of the State addresses.

David Campbell, chief executive officer of the nonprofit Community Health Network of West Virginia, believes this network would support the use of electronic medical records (EMR) and the free flow of information between doctors, hospitals, and insurance companies. “The government won’t build and operate the system, but it does have a public interest in encouraging its development,” Campbell

says. Banking and other industries have used information technology to make their operations more efficient and improve the quality of services. “We haven’t done that in health care.”

Information technology may improve the quality of patient care. Devon Herrick, a senior fellow at the National Center for Policy Analysis, says software could check for contra-indications when a doctor writes a prescription. More important, “massive data mining of EMR systems will, in the long term, help establish best practices and evidence-based treatments,” Herrick adds. “By adopting best practices and coordinating care, quality will hopefully be better.”

Such quality improvements could yield cost savings for providers. Better patient safety would reduce the costs incurred to correct medical mistakes. Fewer duplicative tests would be ordered because medical records would be more accessible.

Health care insurers could save money as well, adds Sallie Hunt, an official at the West Virginia Health Care Authority involved in the creation of the state’s health information network. For example, electronic prescribing of medications would enable insurers to better manage their costs through the use of formularies, preferred lists of drug products that have been deemed to be the most cost-effective. A doctor could use a wireless handheld device to select drug options presented for patients based on their insurance coverage.

So why aren’t health care professionals lining up to buy wireless routers? Some blame the fee-for-service system of health care reimbursement. Third parties pay the same price for medical services regardless of how efficiently they are provided.

“Doctors are not being paid for high-quality care coordination. Rather, they are being paid by the task,” Herrick notes. “When more people begin paying for medical bills directly, such as from a [health savings account], they will begin to demand timely access to their medical information and will want efficient care.”

However, even under the current fee-for-service regime, a doctor could cut costs and boost profits by implementing IT. The problem is it takes time for providers to learn about new technologies and implement them in order to achieve the maximum cost savings. Doctors are always working under a time crunch, so the opportunity cost of the transition may not outweigh the savings, which are in the long run and may not seem as significant or certain. There are also privacy concerns. Once patient records are put into electronic form, arguably they become more vulnerable to being accessed by unauthorized persons.

Finally, it’s not cheap to implement information technology. In a survey of physician groups and individual practices, Robert Miller and Ida Sim at the University of California at San Francisco found that the upfront costs for deploying an EMR system ranges from \$16,000 to \$36,000 per physician.

These expenses include equipment purchases and installation, conversion of existing paper-based information into digital form, and training personnel. They don't include the revenue that is lost during the transition period due to productivity declines.

Hospitals and large physician groups are better able to absorb these costs than smaller groups and individual practices, plus they have the management expertise and organizational scale to make other changes necessary to realizing the full benefits of information technology. For example, the Carolinas HealthCare System began installing wireless access points throughout its 14 hospitals in North Carolina and South Carolina in 2004. This investment will enable doctors to instantly access patient orders, lab results, and other information.

Should states or Uncle Sam help foot the bill for IT investment in the health care industry? A 2002 Institute of Medicine report called for government funding of large-scale demonstration projects to test the implementation of health information networks. But, Miller and Sim believe that governments don't need to directly fund networks or subsidize IT purchases by health care professionals.

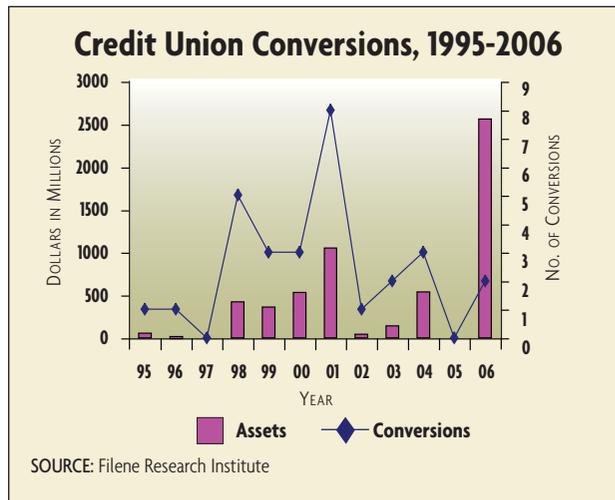
"Our study suggests that most practices can secure capital for purchasing the technology," the researchers note in their March/April 2004 article in *Health Affairs*. "Policy funds could be better used for rewarding quality improvement, for example, than for replacing available sources of capital." — CHARLES GERENA

THE CONVERSION QUESTION

Credit Unions Weigh Costs and Benefits of Converting to Banks

Since 1995, the first year they were allowed to do so, 29 member-owned credit unions have turned into either mutual holding companies or stockholder-owned banks, either through direct conversion or through mergers. In the Fifth District, four credit unions have made the switch. It's usually a two-step process beginning with a membership-wide vote first on whether to convert to a depositor-owned, mutual savings bank, then concluding with another vote on conversion to a stockholder-owned bank. Also required are approvals from regulators.

Generally, conversions are instigated by management and pitched as the best means for the institutions to survive. Lafayette Federal Credit Union of Kensington, Md., was one of the most recent credit unions to undertake the process for conversion. The effort has recently stalled amid concerns about the voting process for conversion of the 16,000-member institution. But before Lafayette Federal withdrew its conversion plan, CEO Michael Hearne explained why he favored the effort. "The name of the game is grow or die. It's increasingly expensive to do business and the only way you pay for additional expenses is to bring in additional revenue, and the only way you do



that is to increase volume," he said. "It's much easier to grow as a thrift than a credit union."

The first U.S. credit union opened in 1909 in New Hampshire. In the early days, credit unions were founded to serve members of a specific organization with small consumer loans. They developed under the premise that their members' common interests and bonds could serve as a substitute for collateral, explains Richmond Fed economist John Walter. In 1932, the average size of a U.S. credit union was just 187 members. "With this knowledge in hand, the credit union loan committee could make a low-risk and, therefore, low-interest loan to a credit union member," Walter writes in a recent article.

This distinguishing characteristic no longer exists so strongly. Today's credit unions can span numerous employers and geographic areas, diminishing old "common bond" insights into lending. At the same time, however, they have gained mortgage lending powers and expanded their business lending.

Most important, as nonprofits, credit unions still maintain their exemption from federal income taxes unlike banks. That tax-exempt status bothers community bankers, who complain that credit unions present unfair competition because they can use their tax-bill savings to undercut bank prices.

So why would credit unions, with their built-in tax advantage, want to convert? One reason may be that some of their original competitive advantages have eroded. Creditworthiness is more easily identified by all financial services players nowadays thanks to innovations in the financial marketplace. Also, even as credit unions have grown to close to 90 million members, they remain smaller in comparison to commercial banks. About half of all U.S. credit unions have less than \$10 million in assets, while only 1 percent of all banks are that small, Walter writes. Many credit unions are looking for growth opportunities, but as they are currently organized, those opportunities are limited.

James Wilcox, an economist at the University of California at Berkeley, has studied credit union conversions. Credit unions have to use retained earnings as their only source for meeting capital requirements, unlike banks which

can raise capital in many different ways. Wilcox says that credit unions that offer superior rates and services probably shouldn't be converting; they can better serve members as credit unions. But he adds that credit unions which offer similar rates and services to banks make for good conversion candidates. "What members ought to figure out is that they own this thing and then whether it's better to cash out now or keep the cash coming," Wilcox says.

However, conversions can be controversial. Usually the controversy stems from how the equity is divided up after conversion. Typically, credit union members are offered the opportunity to buy shares of the new bank before those shares are sold to the public. By law, shares can't be distributed to members in exchange for their claims to retained earnings. Meanwhile, fewer than one out of 10 members end up purchasing shares of the converted institution.

That number would increase, Wilcox thinks, if the rules were changed for how credit union equity is disbursed. He proposes that both credit union depositors and borrowers be compensated for their "lifetime contributions" to the institution. At the very least, it would be a fairer system than the present. "Life is messy, and half a loaf or two-thirds a loaf is better than none," Wilcox says.

In late December, Lafayette Federal's board and management thought it had overcome equity concerns in winning a membershipwide election to convert to a mutual savings bank. But given the balloting problems, the Lafayette Federal board said it would terminate the conversion plan and anticipated "no immediate changes in our operations."

Hearne, Lafayette's CEO, says the board tried to allay equity issues by pledging, in the event of such a conversion, to not accept stock grants, options, or any payments and buy stock under same considerations as other members. "I don't know what else could have been done to say that this shouldn't be an issue," Hearne says. "But that's the most visceral issue here. I understand why." — DOUG CAMPBELL

RAISE THE ROOF

Tunnel Clearance Could Open Access to Southern West Virginia

Twenty-eight rail tunnels, four in Virginia and 24 in West Virginia, are getting taller. Starting this summer, the tunnels will be modified to accommodate double-stacked railcars that move goods inland, mainly to Chicago and other Midwest cities, from Hampton Roads port terminals. The project aims to lower costs while speeding the transport of goods.

The price tag for tunnel clearances alone is estimated at \$151 million. At least one tunnel, Big Four # 2 near Welch, W.Va., will be "daylighted," meaning its top will be blasted off. It's a big project, with Norfolk Southern Corporation getting taxpayer help to realize economic benefits sooner rather than later. The improvement wasn't at the top of the railroad's to-do list, from a shareholder perspective, says Mark Burton,



Raising tunnels to accommodate double-stacked containers on trains will move cargo more cheaply and efficiently from Hampton Roads ports to Chicago.

director of transportation economics at the University of Tennessee's Center for Transportation Research.

Burton says railroads are under pressure to increase earnings. "That has really squeezed the level of investment to something below what the railroads would have liked to have seen." Any savings for Norfolk Southern probably will go to keep rates competitive, thus benefiting shippers who could always land at another deep water port and load onto rival rails, Burton notes. CSX, for example, already double stacks on routes from its Charleston, S.C., terminal. "This puts them on equal footing with CSX," he says.

Federal funding is estimated at \$95 million and Virginia will pay \$22.5 million toward the clearance and construction of an intermodal terminal in the Roanoke region. West Virginia is likely to fund most of a terminal proposed for Prichard, W.Va., near the Ohio River.

Construction will begin this summer on the tunnel clearance portion of the project, slated for completion in 2009. The entire effort, which includes a terminal and construction work in Ohio, too, is called the Heartland Corridor.

Double-stacked containers from ships load directly onto railcars at Norfolk, the most efficient way to move containers between Norfolk and Chicago, says Robin Chapman, Norfolk Southern spokesman. Stacked trains currently travel the long way around to Chicago, avoiding West Virginia, Southwest Virginia, and low tunnels altogether. The more direct route clips 233 miles and a day's travel time off the trip to Chicago. The shortcut runs through Roanoke, Va., and Southern West Virginia by way of Columbus, Ohio, a distance of 1,031 miles compared to 1,264 miles.

Double stacking cuts costs nearly in half, Burton says. "Single-stack shipments are sometimes competitive with trucking prices and sometimes not," he says. "Double stacks always generate profit."

West Virginia could win big economically from the increased container traffic, especially if plans for an intermodal terminal in Prichard, W.Va., materialize. Intermodal terminals where trucks, trains, and even barges come together serve as inland ports, giving manufacturers easy, direct access to coastal ports for overseas markets. "What the intermodal terminals do is bring to the regions where they're located the capability for companies in that region to connect more directly to the international markets," Chapman says.

Direct access means business, says Patrick Donovan, executive director of the West Virginia Public Port Authority. “What that does is give Southern West Virginia, Kentucky, and Ohio global reach other than the river system. When you look at our proximity to Midwest markets out of West Virginia, it’s pretty impressive.”

For the state to retain and recruit firms, the intermodal terminal is critical. Container traffic over the deep draft ports — such as Norfolk and New York — has grown by double-digit percentages in all but one of the last 10 years, Burton notes. “The huge growth and importance of container traffic is directly tied to international traffic,” he says. “The reason global markets work, the reason we’re wearing so many Chinese tennis shoes, is that international shipping by container has become remarkably cheap.”

Currently, any manufacturer in West Virginia faces a \$400 to \$600 disadvantage per container. “So firms that want to use containers don’t locate there,” Burton says. Norfolk Southern provided the state with \$1 million for preliminary engineering of the Prichard site.

Consumers may benefit as well. Take beer, a product that ranks high on the inbound commodities list, says Burton. “Somebody who likes to drink German beer would be able to buy it more affordably.”

— BETTY JOYCE NASH

WEST VIRGINIA'S MEDICAID MODIFICATION

New Program to Encourage Personal Responsibility for Health Care Decisions

West Virginia is testing a first-of-its-kind program: providing incentives for the state’s poorest people to accept more personal responsibility for their health. The pilot program has begun with three counties — Clay, Upshur, and Lincoln — asking patients to sign “member agreements” that give access to services not usually covered by Medicaid. Members with diabetes or weight problems, for example, could attend nutritional seminars or meetings with dietitians. On the flip side, beneficiaries who don’t sign the agreements face limits on the number of prescriptions they receive and don’t get access to extra benefits.

As with most states, West Virginia’s funding of Medicaid — the nationwide health care program that covers medical services for the poor — constantly strains the budget. But the pilot program is not being pursued as a short-term cost fix; it is a long-term effort to improve the health and well-being of West Virginia’s poorest residents, officials say. By extension, over time it is hoped the program contains costs. (Other states are modifying Medicaid coverage, too. Kentucky, for example, is restricting the number of prescriptions some beneficiaries can receive. But West Virginia’s program is the first to provide incentives toward improving health.)

The idea was approved by the federal government in the summer and started in late 2006. Initially, the target population is the young and healthy poor, a demographic that at present isn’t a drag on Medicaid expenditures but which

could be if future lifestyle choices make them unhealthy.

“We want these people to make healthier decisions and we want to partner with them to make these healthier decisions,” says Shannon Riley, spokeswoman for the West Virginia Bureau for Medical Services. “If we can eliminate lifestyle-induced diseases in this young and healthy population, that significantly slows the growth of our [Medicaid] program in the future.”

While private insurers and even public health departments have been trying for some time to build incentives for patients to take more interest in their health, Medicaid has never been the ground for such efforts. The federal government pays for about 57 percent of the \$275 billion nationwide program, with states covering the rest.

Robert Helms, a resident scholar on health care policy with the American Enterprise Institute, says the West Virginia program is a good first step. The program is in keeping with recommendations of the Medicaid Commission’s 2006 report, to which Helms contributed, to give states more control and flexibility in administering Medicaid.

In a roundabout way, West Virginia’s “Mountain Health Choices” program helps ease the classic health care problem of those receiving a service not directly paying for it, which creates all the wrong incentives. Recipients agree to keep doctor appointments, only use the emergency room in case of real emergencies, and comply with prescription medications, among other responsibilities.

“I’m very supportive of what they’re trying to do, with the principle of trying to help more people be more responsible,” Helms says. “It’s moving in the right direction. And the cost benefits may even be secondary to improving the quality of these people’s health, preventing them from becoming serious Medicaid patients in the first place.”

While patients who sign up for the program are eligible for enhanced services, those who don’t are relegated to another plan. The “Basic Plan” limits prescriptions to four per month, for example, while the “Enhanced Plan” has no limit. This difference has given rise to some criticism. A short article in the Aug. 24 edition of the *New England Journal of Medicine* questioned whether some Medicaid patients, especially children beholden to their parents’ actions, would be denied necessary medical services under the plan.

But Riley, the West Virginia spokeswoman, says the program is not about withholding care as much as it is about rewarding patients who take steps to improve their health. All Medicaid beneficiaries have the opportunity to sign up for the enhanced plan each year. “Honestly, it’s kind of insulting to insinuate that poor people can’t make good decisions,” Riley says.

In the next year, the state aims to add new features to the program, offering more programs not typically covered under Medicaid, though details still have to be worked out and approved by the federal regulator, the Centers for Medicare and Medicaid Services. The idea is to expand the program statewide, eventually covering a majority of the state’s 380,000 Medicaid beneficiaries.

— DOUG CAMPBELL