HFMA Maryland Chapter Annual Institute

Healthcare Reform and Changing Dynamics in the Healthcare Industry

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Outline

Credit outlook: 2014 and longer term
Recent credit trends in not-for-profit healthcare
How does healthcare reform impact ratings
Medicaid expansion impact
Case Study – stand alone hospital ratings versus health systems
Maryland hospital ratings and performance vs. U.S.
Why are not-for-profit and for-profit hospital ratings so different?
What A Credit Rating Is And What It Is Not

What It Is
Forward-looking opinions about relative credit risk, i.e., the creditworthiness of an entity or its securities that:

• Strive to be globally comparable across sectors

• Incorporate views on relative likelihood of default that:
  • Refer to the timely payment of interest and principal and,
  • Are applied to entities and securities

And What It Is Not

• Absolute measures of default probability

• Investment advice, a recommendation to purchase, sell or hold securities, or a comment as to market price or suitability for an investor

• A measure of liquidity or market value

• A way of defining “good” or “bad” companies, or a direct assessment of corporate governance

• An audit of the company or its auditors

• A guarantee of credit quality or of future credit risk
Ratings Categories

**Investment Grade**

- **AAA** Extremely strong capacity to meet financial commitments. Highest rating
- **AA** Very strong capacity to meet financial commitments
- **A** Strong capacity to meet financial commitments, but somewhat susceptible to adverse economic conditions and changes in circumstances
- **BBB** Adequate capacity to meet financial commitments, but more subject to adverse economic conditions
- **BBB-** Considered lowest investment grade by market participants
- **BB+** Considered highest speculative grade by market participants

**Speculative Grade**

- **BB** Less vulnerable in the near term, but faces major ongoing uncertainties to adverse business, financial and economic conditions
- **B** More vulnerable to adverse business, financial and economic conditions, but currently has the capacity to meet financial commitments
- **CCC** Currently vulnerable and dependent on favorable business, financial and economic conditions to meet financial commitments
- **CC** Currently highly vulnerable
- **C** A bankruptcy petition has been filed or similar action taken, but payments of financial commitments are continued
- **D** Payments default on financial commitments

Ratings from ‘AA’ to ‘CCC’ may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories.
U.S. Healthcare Spending, % of GDP – very sharp trajectory

Creation of Medicare and Medicaid

Source: Centers for Medicare and Medicaid Services
U.S. Healthcare Spending, % of GDP – but slowed since ‘06

Source: Centers for Medicare and Medicaid Services
High Deductible Plan Membership Soars

Millions of members

Source: Americas Health Insurance Plans – Center for Health Policy and Research. Deductible for single coverage > $1,250 ($2,500 family); out of pocket > $6,250 ($12,500 family)
Medicare $ At Risk – Quality Provisions of ACA

% of hospital inpatient payments at risk

Source: Centers for Medicare & Medicaid Services. VBP = Value based purchasing. HAC = Hospital acquired infections.
Employer-Sponsored Insurance is declining

Source: U.S. Census Bureau
Our View of Health Care Sector Outlook 2013 & 2014

We believe operating environment will be increasingly negative

- Weaker revenue environment
- Renewed competition for patients
- Transition risk issues
- Cost savings harder to find
- Capital pressures building again
- Investment in IT, physicians and integration continue

Could lead to

- Compressed operating and EBIDA margins
- Flat to weaker coverage
- Constrained Days Cash

Source: Standard & Poor’s Ratings Services
Costs of Physician Integration – A Large Community Hospital in PA

Source: Standard & Poor’s Rating Services

physician enterprise loss

Operating income

Admissions

$000s

0
(10,000)
(20,000)
(30,000)
(40,000)
(50,000)

2007 2008 2009 2010 2011 2012

Admissions

Physician enterprise loss

Source: Standard & Poor’s Rating Services
Not-for-Profit Healthcare Rating Trends

10-year total ('03-'12):
Upgrades: 347
Downgrades: 451

31 upgrades:
6 due to merger (4 were 2+ notches)

23 downgrades:
#1: West Penn
#2: UMMS
#3: Temple

* As of Sept 10, 2013. Source: Standard & Poor’s Ratings Services
Bright Spots: Most Measures Rebounded Post-Recession*

Days’ Cash on Hand *

EBIDA Margin (%) *

Capital Exp./ Depreciation (%)

Debt Service Coverage (x)

* 2011 & 2012 ratios adjusted for new bad debt accounting treatment

Source: Standard & Poor’s Ratings Services.
Our View of Health Care Sector Outlook 2013 & 2014

Positives for the sector include:

- Providers’ success maintaining performance despite incremental pressures
- Ongoing yield from existing and new cost control initiatives
- Implementation of new business models to address health care reform
- Meaningful use funding, ability to utilize IT for quality & cost improvement
- New provider taxes (certain states, e.g. PA, NC, CA)
- Credit benefits of consolidation

Source: Standard & Poor’s Ratings Services
Bright Spots: Meaningful Use Dollars Flowing to Providers

$000’s paid to providers

0 2,000 4,000 6,000 8,000 10,000

2011 Program Yr 2012 Program Yr

Professionals include physicians, dentists, optometrists, podiatrists, and chiropractors. Approximately 90% are physicians.

Active Registrations

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Medicare Eligible Professionals</th>
<th>Medicaid Eligible Professionals</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>123,648</td>
<td>49,015</td>
<td>3,077</td>
</tr>
<tr>
<td>2012</td>
<td>237,306</td>
<td>110,149</td>
<td>4,224</td>
</tr>
<tr>
<td>2013 (July)</td>
<td>272,550</td>
<td>132,779</td>
<td>4,510</td>
</tr>
</tbody>
</table>

(Program period is 2011-2016)

Source: Centers for Medicare and Medicaid Services.

Professionals include physicians, dentists, optometrists, podiatrists, and chiropractors. Approximately 90% are physicians.
Ratings likely to remain stable despite weakening operating environment

- Balance sheet strength remains effective cushion; flexibility, time to find next level of cost savings
- Business & financial profiles of weaker credits will deteriorate faster as “credit quality gap” re-emerges
- M&A activity likely to continue at a heavy pace

**** Pace of change not consistent across the country ****

Source: Standard & Poor’s Ratings Services
Growing Exposure & Appetite for Risk Under Reform

Risk sharing contracts & where in organization is risk ‘held’

- ACOs
- Self-insurance exposure
- Direct to employer contracting
- More interest in capitation
- New Medicare rules
  - Bundling
  - Value based purchasing
  - Readmission penalties, HACs

Risk associated with transition to new models of care

Exchanges and Medicaid expansion

Source: Standard & Poor’s Ratings Services
Consolidation Continues

Benefits of consolidation include:

• Scale and negotiating clout with suppliers and private payers
• Increased revenue and geographic diversity

More non-traditional partnering

• Insurance plan acquisitions
• Urgent care businesses
• Non-acute care partnerships

Ratings are shifting upward

• Smaller and lower-rated credits benefit from consolidation
• Larger credits often absorb some acquisition dilution at current rating level

Source: Standard & Poor’s Ratings Services
Medicaid Expansion Map As Of September 3, 2013

Source: Kaiser Family Foundation, kff.org.
What it means for healthcare ratings

- Level of Medicaid and self-pay have always been rating factors
- Is Medicaid expanding or not?
  - Yes: Evaluate it as part of overall payor mix and impact on credit profile.
  - No: What are current underlying payor mix trends?
- Minimal impact expected (at least initially)
- Over time, this will, like most things, impact the smaller and weaker credits first
  - Still in a watch and wait mode
- Broader questions: interplay of exchanges and existing employer insurance base, adequacy of reimbursement, etc.
- On going changes in public support for exchanges evolving state by state
Rating distribution: Healthcare systems vs stand-alones

Source: Standard & Poor’s Ratings Services. Spec. = Speculative Grade (‘BB+’ and lower)
# Stand alone hospitals vs. Healthcare systems

## System ratings are generally higher

<table>
<thead>
<tr>
<th></th>
<th>Stand Alone Hospitals</th>
<th>Healthcare Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td>One or two hospitals</td>
<td>3 or more hospitals</td>
</tr>
<tr>
<td><strong>Revenue base</strong></td>
<td>2012 ‘A’ median: $426 million</td>
<td>2012 ‘A’ median: $1.36 billion</td>
</tr>
<tr>
<td><strong>Economic Fundamentals</strong></td>
<td>Tied to a single local geography</td>
<td>Often have significant geographic diversity</td>
</tr>
<tr>
<td><strong>Market position</strong></td>
<td>May be strong in a single market, but vulnerable to shifting physician loyalties or new competition</td>
<td>May have multiple hospitals in a single market or broadly dispersed geographically</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td>Variable sophistication</td>
<td>Often very sophisticated central office with system-wide services</td>
</tr>
<tr>
<td><strong>Other risks</strong></td>
<td>Vulnerable to a single catastrophic event – flood, hurricane, malpractice lawsuit</td>
<td>Vulnerable to catastrophes, but less likely to impact multiple facilities at once</td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td>Must be strong to offset risks of single site operation</td>
<td>Less vulnerable to declining fortunes of any one facility</td>
</tr>
</tbody>
</table>

*Source: Standard & Poor’s Ratings Services*
Case Study: Stand alone hospitals vs. healthcare systems

<table>
<thead>
<tr>
<th>Two Pittsburgh area credits – both rated ’A+’</th>
<th>St. Clair Memorial Hospital</th>
<th>University of Pittsburgh Medical Center (UPMC)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td>One hospital</td>
<td>21 domestic hospitals, international facilities, senior living, and a major health insurance plan</td>
</tr>
<tr>
<td><strong>Revenue base</strong></td>
<td>$255,703,000</td>
<td>$10,101,600,000</td>
</tr>
<tr>
<td><strong>Economic Fundamentals</strong></td>
<td>Local submarket slightly better than Pittsburgh and region</td>
<td>Multi-year declining population trend in broad western PA market</td>
</tr>
<tr>
<td><strong>Market position</strong></td>
<td>24% in defined primary service area, 2nd to UPMC’s 33%. Third competitor emerging with 19%</td>
<td>60% market share in Allegheny County, 40% in a very broad 29 county service area</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td>Stable, appropriate for hospital size</td>
<td>Stable, excellent depth, leader in financial disclosure, IT, forecasting</td>
</tr>
</tbody>
</table>

Source: Standard & Poor’s Ratings Services
Case Study: Two `A+' not-for-profit healthcare credits

Both are rated `A+', but:

- **UPMC has a stronger enterprise profile**

- **St. Clair’s small size makes it more vulnerable to medical staff or competitive changes**

- **St. Clair achieves the same rating through financial profile**
  - Much stronger margins and cash flow
  - Significantly higher debt service coverage
  - Stronger balance sheet cushion (unrestricted reserves relative to operations and debt)
  - Lower leverage

<table>
<thead>
<tr>
<th>Measure</th>
<th>St. Clair</th>
<th>UPMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating margin</td>
<td>3.3%</td>
<td>2.0%</td>
</tr>
<tr>
<td>EBIDA margin</td>
<td>13.5%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Debt service coverage</td>
<td>8.4x</td>
<td>3.0X</td>
</tr>
<tr>
<td>Days cash on hand</td>
<td>251</td>
<td>138</td>
</tr>
<tr>
<td>Unrestricted reserves / LTD</td>
<td>295%</td>
<td>110%</td>
</tr>
<tr>
<td>Debt to capital</td>
<td>24%</td>
<td>46%</td>
</tr>
<tr>
<td>Average age of plant</td>
<td>12 years</td>
<td>9 years</td>
</tr>
</tbody>
</table>

Source: Standard & Poor's Ratings Services
# Maryland Healthcare Credit Trends

<table>
<thead>
<tr>
<th>Hospital / Health System</th>
<th>Rating</th>
<th>Outlook</th>
<th>Rating action last 12 months</th>
<th>Rating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johns Hopkins Health System</td>
<td>AA-</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
<tr>
<td>GBMC</td>
<td>A</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
<tr>
<td>LifeBridge Health</td>
<td>A</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
<tr>
<td>Peninsula Regional Med. Center</td>
<td>A</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
<tr>
<td>Anne Arundel Health System</td>
<td>A-</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
<tr>
<td>Bon Secours Health System</td>
<td>A-</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
<tr>
<td>MedStar Health</td>
<td>A-</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
<tr>
<td>UMMS</td>
<td>A-</td>
<td>Stable</td>
<td>Downgrade from ‘A’</td>
<td></td>
</tr>
<tr>
<td>Mercy Health Services</td>
<td>BBB</td>
<td>Negative</td>
<td>Affirmed; outlook to negative</td>
<td></td>
</tr>
<tr>
<td>Meritus Health</td>
<td>BBB-</td>
<td>Stable</td>
<td>Affirmed</td>
<td></td>
</tr>
</tbody>
</table>
Maryland Hospitals Track National Performance

Days’ Cash on Hand *

EBIDA Margin (%) *

Capital Exp./ Depreciation (%)

Debt Service Coverage (x)

* 2011 & 2012 ratios adjusted for new bad debt accounting treatment

Bon Secours excluded from Maryland medians

Source: Standard & Poor’s Ratings Services.
Maryland Age of Plant is Younger

Source: Standard & Poor's Ratings Services. Bon Secours Health System excluded from Maryland median
Rating Distribution: Not-For-Profit and Investor-Owned

Source: Standard & Poor's Ratings Services. Not-for-profit includes 550 stand-alone hospitals and healthcare systems. Investor owned includes 17 companies.
## Investor-Owned Healthcare Facilities Ratings

<table>
<thead>
<tr>
<th>Company</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHS Medical Holdings LLC</td>
<td>B</td>
</tr>
<tr>
<td>Capella Healthcare Inc.</td>
<td>B</td>
</tr>
<tr>
<td>Community Health Systems</td>
<td>B+</td>
</tr>
<tr>
<td>HCA Inc.</td>
<td>B+</td>
</tr>
<tr>
<td>Health Management Associates</td>
<td>B+</td>
</tr>
<tr>
<td>Healthsouth</td>
<td>BB-</td>
</tr>
<tr>
<td>IASIS Healthcare Corp</td>
<td>B</td>
</tr>
<tr>
<td>LCI Holding Co LLC</td>
<td>B-</td>
</tr>
<tr>
<td>LHP Hospital Group, Inc.</td>
<td>B</td>
</tr>
<tr>
<td>LifePoint Hospitals Inc.</td>
<td>BB-</td>
</tr>
<tr>
<td>Kindred Healthcare, Inc.</td>
<td>B+</td>
</tr>
<tr>
<td>Prospect Medical Holdings</td>
<td>B</td>
</tr>
<tr>
<td>Regionalcare Hospital Partners</td>
<td>B</td>
</tr>
<tr>
<td>Select Medical Corp</td>
<td>B+</td>
</tr>
<tr>
<td>Tenet Healthcare Corp</td>
<td>B</td>
</tr>
<tr>
<td>Universal Health Services</td>
<td>BB</td>
</tr>
<tr>
<td>Vanguard Health Systems Inc.</td>
<td>B</td>
</tr>
</tbody>
</table>

Source: Standard & Poor’s Ratings Services. Ratings as of August 7, 2013
## Not-for-Profit vs. Investor Owned Healthcare Ratings

### Rating considerations

<table>
<thead>
<tr>
<th>Mission and Community Support</th>
<th>Not-for-Profit</th>
<th>Investor-Owned</th>
</tr>
</thead>
</table>
| Mission to improve health status in community | • Often deep community roots  
• Ability to attract philanthropy  
• Some also receive tax revenue  
• Willing to tolerate low returns or $ losing services  
• Do not pay taxes | Mission to improve health status in community | • Key consideration: maximize shareholder value  
• Must pay taxes (sales, income, real estate) |

<table>
<thead>
<tr>
<th>Business Profile</th>
<th>Not-for-Profit</th>
<th>Investor-Owned</th>
</tr>
</thead>
</table>
| Business position varies widely | • Stand alone hospitals have higher risk  
• May have very strong local support and market share  
• Some multi-hospital systems are bigger than many investor owned | Good at managing portfolio of assets  
• More opportunistic in choosing locations  
• More willing to sell/divest facilities not meeting return targets |

Source: Standard & Poor’s Ratings Services
# Not-for-Profit vs. Investor Owned Healthcare Ratings

## Rating considerations

<table>
<thead>
<tr>
<th>Capital Access and Debt Structure</th>
<th>Not-for-Profit</th>
<th>Investor-Owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost of capital and low rate of return hurdles</td>
<td>• Issue low-cost tax-exempt debt&lt;br&gt;• Long-term fully amortizing debt structures&lt;br&gt;• Very little reliance on short term lines</td>
<td>Riskier capital structures&lt;br&gt;• Access to equity market is an advantage, but&lt;br&gt;• Heavy reliance on short term and bank debt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Policies</th>
<th>Not-for-Profit</th>
<th>Investor-Owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies support long-term survival</td>
<td>• Very high liquidity&lt;br&gt;• Leverage moderate, many are debt-averse&lt;br&gt;• May have large foundations (on or off-balance sheet)</td>
<td>Policies support shareholder value&lt;br&gt;• Cash viewed as low-return asset&lt;br&gt;• Reliance on bank debt for liquidity (rollover risk)&lt;br&gt;• Aggressive growth strategies require financing&lt;br&gt;• Policies raise bondholder risk (dividend payouts, leveraged buy-outs, share repurchases)</td>
</tr>
</tbody>
</table>

Source: Standard & Poor's Ratings Services
For More Information:

- Please visit: www.standardandpoors.com/healthcare

Source: Standard & Poor’s Ratings Services.
Liz Sweeney

- Joined Standard & Poor’s in 1991
- Focus on credit risk analysis in healthcare sector, including hospitals and senior living
- Member of S&P’s criteria committee for US Public Finance, overseeing criteria development and approval
- 5 years prior experience as a trader in derivative markets at EF Hutton and Walsh, Greenwood
- MBA, NYU Stern School of Business. Major in Finance
- BS, Georgetown University. Major in Finance
- Certificate in Healthcare Management, New York University
- Professional societies: National Federation of Municipal Analysts, Healthcare Financial Management Association (Maryland Chapter)
Thank You

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