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WELLS FARGO SECURITIES

## Municipal Commentary

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# NFP Hospitals Stable, but Showing Signs of Operating Weakness

As the dog days of summer wind down, preparations for implementing major components of healthcare reform continue to heat up. August is also prime time for the release of rating agencies' annual hospital median reports. We maintain a slightly negative hospital sector outlook for the remainder of 2013. Hospitals' defensive liquidity postures have helped cushion against industrywide slowing revenue growth and patient utilization[1] declines this year. Although many of the rating agencies' recently released medians for FY2012[2] showed largely stable hospital performance, this belies the building operating pressures that the hospital industry faces. The weakening of some FY2013 year-to-date financial and operating metrics hint at the sector's growing challenges ahead, in our view. We expect pressures to intensify next year with the start of phased federal reimbursement cuts under the Patient Protection and Affordable Care Act (ACA).

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**Medium-Term Outlook Is Still Negative...**

Our medium-term negative outlook reflects our expectation that hospital financial performance will deteriorate during the initial transition period. Even under ideal circumstances, hospitals will be tested over the next few years. Reduced reimbursement, expanded Medicaid, public health insurance exchanges (HIEs), and the shift to quality and value-based reimbursement are each major changes to simultaneously absorb. One concern is the pace of revenue growth from newly insured patients may not be sufficient to offset scheduled Medicaid disproportionate share reductions or to counter provider reforms designed to drive down excess patient utilization. Uneven state implementation of insurance and Medicaid reforms will likely make adjusting even more difficult for hospitals in certain states. Likewise, multistate hospital systems may need to devise multiple strategies across diverse and evolving state operating environments, particularly in states not fully implementing reform.

We also believe acceleration toward alternative reimbursement models over the next few years is likely, given federal deficit reduction concerns and policymakers' desire to further slow the rate of healthcare cost inflation. Reducing unnecessary and avoidable patient volumes are among the ACA's objectives of more coordinated care and population health management, but quickly moving away from the long-

[1]The combined ripple effects of the slow economic recovery, health plan benefit redesign, and provider-based reforms are influencing consumer behavior, depressing patient volumes and shifting patient utilization patterns.
[2]There is a typically a 120-150 day reporting lag for audited FYE hospital financial and operating data.



standing fee-for-service model will be demanding. Furthermore, there is growing evidence that increasing consumerism, more price transparency and greater consumer cost-sharing under employer-sponsored insurance (ESI) are already beginning to negatively affect patient utilization and hospital profitability.

In our opinion, hospitals may more fully realize returns over the next three to five years on their investments in delivery system reforms and electronic medical records (EMR), and become more adept managing expenses under alternative value-based and population health reimbursement models, but these efforts are likely to reduce revenues. Also, if young, uninsured individuals fail to purchase insurance, it may take longer to reach newly insured penetration targets. In the meantime, hospital sector performance is likely to suffer.

**...but the Long-Term Outlook Remains Positive**

On the other hand, we maintain a positive long-term outlook. We are optimistic about the ability of hospitals to reinvent their business models and to unlock more operating efficiencies over a longer horizon. Hospitals have repeatedly demonstrated resilience to sector challenges in the past, although the ACA's manifold comprehensive reforms are designed to fundamentally transform the industry. There is also likely considerable room for expense improvement, although these gains may be more difficult to achieve after successive years of intense cost containment focus. However, the 10-year timeline to implement the ACA's reform measures and to phase in federal reimbursement reductions gives hospitals a somewhat "softer landing" to adjust to the new operating environment. Early performance results from providers that have already adopted delivery system reforms show promise. For example, 13 of the 32 Pioneer ACO participants were able to achieve bonus payments for achieving cost savings under a population health management model. However, the fact that nine other providers plan to withdraw from the program points to the steep challenges hospitals have to overcome under new business models.

**Stable FY2012 Medians a Bit of "Calm Before the Storm"**

It is encouraging that many hospitals maintained a high level of performance in FY2012, but a closer look at the figures and at FY2013 interims reveals increasing operating and financial weakness across the industry. For example, the rating agencies noted that though hospital expenses increased in FY2012 due to reform preparations, the continued trend of physician employment and more spending on IT, hospitals were able to mitigate the effect on their margins with offsetting cost-containment savings and revenue enhancements. However, each of the rating agencies observed that some new revenues were attributable to nonrecurring EMR "meaningful use" dollars or from hospital provider fees, which are increasingly vulnerable to being limited by the federal government.

***FY2013 interim performance shows further declines in revenues and margins, driven by additional weakness in volume trends.***

In addition, the rating agencies have commented that merger and acquisition activity may have helped to counteract softening or stagnant organic growth. Indeed, Moody's, in a 2012 report, called M&A one of the "positive mitigants to [its] negative sector outlook." The consolidation of acquired companies into the parent hospitals companies' financials, therefore, may have boosted financial metrics, utilization levels and overall revenue growth for some systems. Absent the M&A activity, it is possible that median liquidity levels, for example, could have otherwise eroded.

In some cases, M&A triggered hospital ratings or outlook changes. For example, the rating agencies took several actions in connection with the Trinity Health (Trinity) and Catholic Health East (CHE) merger that closed in May, the largest M&A

transaction this year. In anticipation of the creation of a new consolidated Master Trust Indenture and financials under the Trinity-obligated group later this year, S&P raised CHE's rating one notch to A+, with a stable outlook. Concurrently, S&P affirmed Trinity's AA rating, but revised its outlook to negative. Similarly, Fitch indicated that it would likely affirm Trinity's AA rating and stable outlook, while it would likely affirm CHE's A+ rating and revise its outlook to positive. Moody's, on the other hand, has yet to take action, because the hospitals' credit groups remain separate at the moment, but noted that the deal would be a credit negative for Trinity, which it rates Aa2, stable, and a credit positive for CHE, which it rates A2, stable.

We also believe overall balance sheet and operating profitability medians benefitted somewhat from the reclassification of bad debt pursuant to a change in accounting rules. While the new accounting rules may not have significantly altered overall medians, the classification of bad debt as a contractual adjustment to revenues[3] did have a net positive effect of slightly enhancing operating profitability, as well as days cash on hand liquidity calculations, according to the rating agencies.

**FY2013 Has Been More Difficult**

Year-to-date 2013 interim performance shows further declines in revenues and margins, driven by additional weakness in volume trends. Declining utilization is problematic for hospitals because of the predominance of the volume-centric fee-for-service reimbursement model and the need for hospitals to cut additional costs to offset revenue declines. For most hospitals, inpatient volumes were already flat to declining since the recession, but this year many hospitals are also reportedly experiencing outpatient volume declines. According to Moody's, soft volumes are negatively affecting net income and debt service coverage levels this year.

Weakening sector performance is also reflected by the increase in the number of rating agency negative outlooks and downgrades since 2012. While the vast majority of outlooks are stable and most hospital ratings have remained unchanged this year, a shift in overall sector health is clearly taking place. For example, Moody's downgraded 20 hospital ratings and upgraded just 10 ratings in the first half of 2013, while also assigning nine negative outlooks (though 15 other outlooks were revised to positive). Similarly, Fitch downgraded 11 ratings, upgraded five ratings and made 27 outlook changes (15 to negative) over the same period. Meanwhile, S&P upgraded 11 ratings (six of which were in the AA rating category) and downgraded 11 ratings over the first half.

The rating agencies noted that there was a differential in performance depending on rating level, with some deterioration in the performance of A rated hospitals and the persistence of a significant gap to performance metrics for BBB rated hospitals. The medians also suggest that systems seem to be performing better than standalone hospitals. This may be an indication of the sensitivity of smaller hospitals, many of which are rated in the BBB category, to volume and revenue declines. The operating risk to rural and small hospitals is further highlighted by an August 2013 Department of Health and Human Services recommendation to remove the critical access hospital (CAH) designation[4] for any hospitals that were included in the program under the "necessary provider" provision. According to HealthLeaders, approximately 77% of the nearly 1,300 CAHs in 45 states could be affected by a loss of enhanced Medicare reimbursement. Though it is uncertain

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[3]Reducing both operating revenues and expenses

[4]To be eligible for the CAH designation, hospitals were required to meet criteria such as a maximum of 25 licensed beds, and to be no more than 35 miles from the nearest hospital, or 15 miles from the closest hospital in the case of mountainous terrain.

whether the proposal will ultimately be enacted, a recommendation of this nature supports our view that federal healthcare programs will be increasingly targeted for reductions, given federal budget deficit constraints. For Moody's, virtually all of its downgrades in Q2 2013 were of small hospitals.

**Greater Consumer Cost Sharing May Be Hurting Hospitals**

We believe softening patient utilization is indicative of the fundamental shift in provider orientation related to delivery system reforms and perhaps lasting changes in consumer behavior. Some utilization changes are likely related to the slow economic recovery, but some changes appear to be attributable to new incentives for both providers (to coordinate care and to treat patients in more appropriate cost settings) and consumers (such as ESI benefit redesign that increases cost sharing). The advent of more commercial insurance plans emphasizing narrow provider networks and value-based care is also influencing utilization patterns.

A new Kaiser Family Foundation survey of ESI found that the annual growth rate of insurance premium rates remained modest (only 5% for single coverage and 4% for family plans), mirroring the broader slowdown of healthcare cost inflation over the past few years. According to Kaiser, the slower growth in premiums was partially due to greater cost sharing with employees, including higher co-pay, co-insurance and deductible requirements. While the continued cost-shifting to consumers is a good way for companies to mitigate their healthcare costs, this development will tend to be a negative factor for hospitals in the short term.

There is evidence that greater cost sharing is contributing to the softness in patient volumes, as consumers are reportedly being more selective and cost conscious about seeking care. There is additional anecdotal evidence that high-deductible health plans (HDHPs), for example, are contributing to more bad debt for hospitals as patients are either unable or unwilling to pay balances due on hospital bills. According to Kaiser, PPO plans are still most common (58% of covered workers), but the percentage of HDHPs increased to 20% in 2013, which is more than double the 8% of plans represented just five years ago. Kaiser also found that 78% of covered workers have some form of deductible and 38% of the surveyed employers now have deductibles over $1,000. The study found that 84% of plans have out-of-pocket maximums, but cited a wide variation in limits or what is included in the calculation toward the caps, which means that employees could still be responsible for significant out-of-pocket costs.

Kaiser concluded that its survey "did not find major changes in employer-based health benefits," but the authors suggested that more ESI changes are likely forthcoming. For example, the pending implementation of certain ACA measures, such as the 40% "Cadillac tax," which will begin penalizing employers for offering overly generous health benefits starting in 2018, is reportedly driving health plan benefit redesign for many companies.

***Smaller hospitals and urban, safety net, academic medical centers, which tend to have a higher concentration of indigent and uninsured patients, would be at higher risk for underperformance in the new reform environment.***

**Conclusion**

Hospitals remain well positioned heading into 2014, but the modest worsening in some FY2012 medians and the additional weakening of revenues and utilization in interim FY2013 performance suggest that investors should exercise additional caution. Based on the median data from the rating agencies, we continue to believe that smaller hospitals may be at higher risk for underperformance in the new reform environment. This should be considered in conjunction with our previously

expressed view[5] that there is also heightened risk of underperformance for urban, safety net, academic medical centers in the new reform environment, due to these hospitals' tendency to have a higher concentration of indigent and uninsured patients.

[5]Refer to the *Hospitals Bracing for HIE Final Countdown* report, dated Aug. 14, 2013.

**Additional information is available on request.**

**This report was prepared by Wells Fargo Securities, LLC.**

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