STANDARD &POOR'S

Global Credit Portal
RatingsDirect®

May 13, 2010

Health Care Reform Could Increase Credit Risk For U.S. Not-For-Profit Providers

Primary Credit Analyst:
Liz Sweeney, New York (1) 212-438-2102; liz_sweeney@standardandpoors.com

Secondary Credit Analysts:
Martin D Arrick, New York (1) 212-438-7963; martin_arrick@standardandpoors.com
Avanti Paul, Chicago 312-233-7061; avanti_paul@standardandpoors.com

Table Of Contents

Health Care Reform Could Increase Credit Risk For U.S. Not-For-Profit Providers

Many details of the Patient Protection and Affordability Act and related Health Care and Education Affordability Reconciliation Act of 2010 (together known as the Health Care Reform bill) remain uncertain pending detailed implementation plans and regulations from the U.S. Department of Health & Human Services (HHS). Nevertheless, Standard & Poor's Ratings Services believes that health care reform poses increased credit risk for not-for-profit providers in the next three to five years, when many of its key provisions are scheduled to go into effect. Despite these concerns, however, our outlook is for relative credit stability in 2010 after a significant period of negative credit trends in 2007-2009 (see "U.S. Not-For-Profit Health Care Sector Moves Toward Stability, But its Long-Term Outlook Is Uncertain," published Feb. 18, 2010, in Ratings Direct on the Global Credit Portal). This is largely because we have seen many providers improve their operations and strengthen their balance sheets over the prior year.

Health care reform will have a dual impact on U.S. not-for-profit health care providers arising from the combination of insurance expansion and changes in how providers deliver and are paid for health care services under the health reform package. For instance, the bill reduces the number of uninsured Americans through subsidies and mandates and by making it harder for insurance companies to deny coverage. We expect that the expanded insurance coverage will create winners and losers among providers, based on their existing and future payor mix, their ability to meet demand from newly insured patients, the impact on disproportionate share funding, and the impact on commercial health care insurance availability and rates.

In our opinion, delivery system reform, another major aspect of the bill, will likely result in increased credit risk for providers even as the bill aims to improve the quality of care for Americans. We believe increased credit risk stems from the fact that, under the bill, a greater share of providers' revenue will be at risk based on the quality of care provided, reductions in the fee-for-service reimbursement formulas, potentially lower patient volumes, risks related to managing bundled care episodes instead of providing discreet units of service, and risks related to managing entire populations on a capitated basis.

The bill also introduces new players such as a nonprofit patient-centered outcomes research institute, a center for innovation, and an independent payment advisory board. We believe the goals to improve the quality of care and reduce health care costs are clear. Overall, the bill will provide insurance coverage for millions of Americans, offer incentives to both study and address many problems in the health care system, and, we think, potentially reduce the rate of health care cost inflation.

The Two Halves Of The Bill

The health reform bill addresses many aspects of health care insurance and delivery, but we think its 2,000-plus-pages can broadly be viewed as having two parts. The first is insurance reform, which higher taxes and cuts in existing provider reimbursement formulas would largely pay for. This part of the bill, which is less about changing how care is delivered than it is about expanding coverage, dominates the Congressional Budget Office's (CBO) estimates. The CBO projects that the bill will increase federal outlays by $382 billion over 10 years and increase revenues by $525 billion, for a net reduction in the federal deficit of $143 million. Of this amount, $124

billion of deficit reduction would be from health care reform and $19 billion from education programs.

The other half of the bill has received less attention because it doesn't affect consumers directly. It contains the delivery system and payment reform provisions. These provisions directly affect providers, although we think the impact of the provisions will be more gradual as well as uncertain because many reforms will be first introduced in a test phase. For example, the CBO has estimated at $0 the revenues and expenses for many payment reform provisions, such as the National Pilot Program on Patient Bundling or Value Based Purchasing, for the entire 10-year period. (CBO estimates are in tenths of $1 billion, so numbers smaller than $100 million don't appear.)

Nonetheless, we believe payment reforms could significantly affect providers because of changes in care delivery and payment mechanisms. In many ways, we think this part of the bill represents more significant reform. In addition, we think that commercial health plans, which are under various mandates in the bill, including minimum medical loss ratios (which require spending a minimum percentage of premium dollars on medical care) and providing coverage to people with pre-existing conditions, may accelerate similar payment reforms with their contracted providers to contain costs.

Delivery System Reform Could Spur Consolidation

Organizations that have integrated physician staffs, excellent clinical information systems, detailed cost accounting capabilities, vertically integrated components, and strong management teams will, we believe, be best prepared to handle changes. Systems and single-site hospitals with limited integration may see reduced revenue or slower revenue growth and are likely, in our opinion, to have a harder time managing the challenges of some delivery system reforms such as bundled payments and accountable care organizations (ACOs).

Given that the objectives of delivery system reform in the bill include lowering costs and minimizing inappropriate admissions and services, we believe the impact on the sector's revenue could be significant. In our opinion, providers will have to be nimble in adjusting their costs because these changes could result in lower utilization and a drop in revenue, even for those best prepared to adapt.

If delivery system reforms succeed in reducing hospital business volumes in pilot and demonstration programs and are then implemented broadly, we believe they could result in more consolidation among providers, particularly in regions with the highest medical use rates. We think that hospitals will also need to work extensively with health plans, physicians, and ancillary providers, setting up relationships that could encourage consolidation. Those that are able to successfully forge appropriate partnerships and lead consolidation efforts in their markets may, in our view, even boost their credit strength, while the unsuccessful ones are likely to face downward pressure on their ratings.

Insurance Reform Introduces Uncertainty

The benefits and disadvantages of insurance reform for providers will depend, in our view, on a complex dynamic that will be unique to each provider and market, but at its essence boils down to the benefits of having fewer uninsured patients versus the disadvantages of slower growth in Medicare rates and less disproportionate share revenue, as well as the uncertainty over whether existing commercially insured business will migrate to lower-payment-rate products. (See the article, “Credit FAQ: The Credit Impact Of Health Care Reform Will Take

Hold Slowly," published March 23, 2010, in RatingsDirect on the Global Credit Portal.)

While many aspects of health care reform target Medicare and Medicaid, the size, importance, and visibility of these programs to the sector make them examples for commercial insurers. If cost containment measures in Medicare and Medicaid prove effective, we believe the entire sector will quickly adopt these methodologies.

A Testing Period Will Precede Implementation

We expect that the impact of delivery system and payment reform efforts will be slow, given that many of the reforms will start in pilot or demonstration programs, while others, at least initially, will be in voluntary programs. Also, many of the delivery system and payment reform pilots could undergo significant alterations or end altogether after the testing period.

In addition, since the bill leaves program design largely up to the HHS, we cannot yet determine the details or assess the associated risks and opportunities. However, we believe the large number of Medicare and Medicaid initiatives point to a move away from traditional fee-for-service programs, a hallmark of the delivery system for decades, toward more risk-based approaches. We expect that these changes will come in the form of reduced payments for low-quality outcomes, increased risk to providers and physicians for the bundling of care episodes, greater use of population management techniques, including capitation, and community-based wellness programs to reduce the need for expensive hospital-based treatments.

Because we think these reforms will likely reduce inappropriate utilization of hospital services, the accompanying decline in revenues could, in our view, increase providers' credit risk, especially if they do not act quickly to lower costs and form integrated networks with strong ties to physicians. However, we recognize that the projected negative impact on business volume may just be one side of the story. As more Americans receive coverage -- the individual insurance mandate becomes effective in 2014 -- many hospitals will likely experience growth in volumes. As a consequence, for some capacity-constrained providers, we project that the lower patient volumes resulting from delivery system reforms may obviate some of the need for expensive capital projects due to volume growth related to the newly insured. This scenario is an example of the complex interactions that we believe will likely result from health care reform, underscoring the difficulty of predicting the ultimate impact on providers.

Many Small Measures But One Main Goal

The health care reform bill includes numerous provisions to improve the quality of care, increase access, improve the efficiency of health care delivery, and encourage the development of new patient care models. Each provision by itself is relatively small, and CBO estimates for the fiscal impact are often negligible over 10 years. However, looking at the delivery system reform provisions in aggregate and in conjunction with the payment reductions that will result from Medicare Advantage rate cuts to insurers and the annual inflation (market basket) reductions to providers, we think the bill aims to chip away at the traditional fee-for-service platform.

The government is approaching that change from a number of directions. For instance, we read the bill as providing two major testing vehicles — pilot programs and demonstration projects. Without congressional approval, HHS can scale up pilot programs and use them to accelerate change. But demonstration projects are subject to Congressional approval before a nationwide rollout. As a result, providers are paying particular attention to such pilot programs as payment bundling, as well as voluntary programs such as accountable care organizations. While the credit risk and

opportunities of some reform efforts ultimately depend on their yet-to-be-determined design, Standard & Poor's initial assessment is that the reform bill increases credit risk in the medium and long term.

Altering The Fee-For-Service Platform

As noted above, we read the bill as aiming to alter the traditional fee-for-service model in which hospitals and other providers charge for the nature and quantity of services provided regardless of their efficacy and the quality of the outcomes. We see the bill as doing this in a number of ways, the most significant of which we think are:

- Reductions in annual updates to Medicare fee-for-service rates, beginning in fiscal 2011 and totaling $196 billion over 10 years (CBO projection for fiscal 2010-2019). The reductions include a market basket reduction and a productivity adjustment; and
- Restructuring and reductions in payments to Medicare Advantage plans, setting differential payments to the plans with larger reductions to regions that have higher utilization rates. The Medicare Advantage reductions total $136 billion under the CBO's 10-year projection. We believe that lower reimbursement to health plans will likely translate into reduced reimbursement from insurers to hospitals.

These two changes are not payment reforms, just payment reductions. However, in our view, they reduce the attractiveness of the traditional fee-for-service business for providers by lowering reimbursement outright or by reducing the rate of growth in reimbursement below cost increases. We read other aspects of the bill as seeking to lessen the attractiveness of fee-for-service by reducing volumes through community-based wellness programs and home care projects. Some examples are:

- A pilot program on community-based prevention and wellness starting this fiscal year. It will include public health interventions, community preventative screenings, and treatment of chronic diseases;
- A demonstration project for individualized wellness plans aimed at at-risk populations that use community health centers. The goal is to reduce risk factors for preventable conditions;
- A demonstration project to provide high-need Medicare beneficiaries with primary care services in their homes in order to improve health outcomes, reduce hospital readmissions, and improve the efficiency of care;
- The establishment of the National Prevention, Health Promotion and Public Health Council to coordinate federal wellness, public health, and prevention activities; and
- Grants and incentives to employers for establishing wellness programs.

In our view, the net effect of these activities could reduce hospitals' revenue and volumes if the pilots and demonstration projects are successful. We believe the challenge for hospitals will be to reduce costs in order to remain profitable and to try to participate in programs that provide incentives to coordinate care and improve outcomes. Given that most hospitals depend on fee-for-service business and have high fixed costs that are very difficult to reduce, we think that many will have a hard time making the transition to lower volumes and less reimbursement per encounter. Still, we believe there could be a silver lining for providers who are now capacity constrained because some costly expansion projects may become unnecessary.

Improving Quality Of Care: A Few Incentives And Many Penalties

The bill includes several measures aimed at improving the quality of care delivery and increasing the federal government's perceived value for its health care dollars. While some measures will include incentives for providing

excellent clinical care, the incentives are small. We consider payment reductions for poor care to be more significant. For example, the bill instructs HHS to implement a value-based purchasing program in fiscal 2013 for Medicare, something that was already under development. The program will be a zero-sum proposition as reductions to low-quality providers will offset increases in payments to high-quality providers, however defined. Most of the other quality-based programs in the bill seek to reduce payment for activities perceived as poor quality, such as preventable readmissions. On a net basis, the quality programs will reduce payments to providers while also potentially reducing volumes as hospitals rein in readmissions and seek to prevent adverse outcomes. Highlights of the quality payment reforms include:

- Value-Based Purchasing (VBP) for acute care will go into effect in fiscal 2013, while next year Congress will receive an assessment for other providers such as home health care, skilled nursing, and physicians. The program will offer relatively small incentives or reductions in fee-for-service rates starting at 1% in fiscal 2013 and maxing out at 2% in fiscal 2017, which it will pay to hospitals based on methodology that HHS will determine. Although VBP will still represent fee-for-service payment, it is a modest step away from paying purely for volume regardless of outcomes.
- Reductions in payments for hospital-acquired infections. Payments for certain hospital-acquired conditions will drop by 1% beginning in fiscal 2015.
- Penalties for high readmissions. According to "Promoting Greater Efficiency in Medicare", the Medicare Payment Advisory Commission's 2007 report to Congress, 18% of Medicare admissions represent readmissions within 30 days of discharge, resulting in $12 billion of potentially avoidable cost. Medicare rates will drop for hospitals with the highest readmission rates starting Oct. 1, 2012, reaching $1.5 billion in cuts annually by 2019.
- The creation of a nonprofit Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research. The goal is to determine best clinical practices, reduce variation in clinical treatments, and identify procedures, interventions, and protocols that do and do not work. While the institute's findings will not represent mandates, in our opinion, a high-profile nonprofit institute can be effective in encouraging the quick dissemination of best practices among hospitals and physicians.

As with most of the payment reform provisions in the health reform bill, each of the quality provisions is in our view relatively modest. However, we expect that a provider with already-thin operating margins that is lacking in high-quality outcomes and whose largest payor is typically Medicare could see its profitability decline significantly from the combined impact of VBP, hospital-acquired infections, and preventable readmissions. In addition, commercial payors are already instituting similar reimbursement programs, changes we believe the bill will likely accelerate. This would mean a greater share of hospitals' revenues will be vulnerable to reduced reimbursements if the quality of care doesn't meet designated goals. In our view, hospitals and health systems that are already highly focused on quality of care and patient safety and are responsive to data about readmissions and adverse outcomes will be in the best position to minimize the impact of quality-based payment methods.

Pilot Programs And Demonstration Projects Will Test The Waters

In our view, all of the quality initiatives are meaningful in aggregate but represent only incremental changes within the traditional fee-for-service care delivery model. However, the delivery system reforms -- via pilot programs, demonstration projects, and voluntary programs -- will require providers to partner extensively with health plans, physicians, and post-acute care providers in ways that they haven't done before. This is despite the fact that most hospitals already have relationships with health plans, many employ physicians, and many either own or have

strong ties to post-acute care providers.

In many of these programs, we see the risk shifting to the providers, which we believe is necessary in aligning incentives to provide high quality, cost-effective care. In our opinion, many providers are ill-equipped to take on that risk. In addition, we believe that hospitals will shoulder much of the risk on behalf of their provider partners, particularly their physicians. In our discussions with hospitals and health systems, we found that many were interested in participating in these programs, if only as a learning experience before the programs ramp up in scope. In our view, several payment reform elements could have a significant impact.

A national pilot program on payment bundling for Medicare

A Medicare bundling program will start in 2013, and HHS will evaluate it for expansion in 2016. It may begin with a limited set of diagnoses that HHS determines. Provider groups will agree to accept a fixed bundled payment for an episode of care beginning three days before a hospitalization and include hospital services, physician services, and post-acute services such as home care, nursing home, and physical therapy for a period ending 30 days after discharge.

The pilot's stated goals are to improve quality of care and reduce cost. Providers will need to coordinate with each other to provide appropriate care and avoid costly outcomes such as readmissions and hospital-acquired infections since providers will be at risk for managing the cost of all care covered under the episode. The provider groups will need to figure out among themselves how to allocate the bundled payment.

While the bill doesn't specify which entity among the various providers should be the manager of the bundled payments, we believe that the hospitals, as the largest and often the wealthiest of the participants, will naturally take on that role. In our discussions with hospitals and health systems, we found that many of them favored the incentives to provide appropriate care rather than simply more care. But we also believe that most hospitals do not have the financial and clinical information systems to fully understand the costs of a bundled episode of care, since hospitals typically do not control the non-hospital costs of care, or do not have the systems in place to link clinical events like readmissions to other aspects of care within the episode in order to understand the true cost of the bundled episode.

Although many hospitals employ physicians, the employment strategy typically revolves around securing a referral base to the hospital and stabilizing the medical staff complement. Hospitals usually compensate the physicians they employ largely on productivity, according to an encounter-based business model. We have found that very few hospitals have been able to fully integrate their employed physicians into a single multispecialty group with a unified clinical information system and have centralized professional management to coordinate care for groups of patients.

In building a team of providers to accept bundled payments, we expect that negotiations with physicians will be tricky. Many hospitals only started hiring physicians recently and, given the shortage of doctors in the U.S., we think they may find it difficult to implement bundled payment arrangements that put physicians' incomes at risk. However, some health systems that are highly integrated, particularly those that have their own health plans, and therefore know the costs of care across a continuum of services will, in our view, be well positioned to manage bundled payments. Geisinger Health System, for example, already contracts for bundled payments for certain diagnoses.

Accountable Care Organizations

The bill includes a shared savings program beginning in 2012 under which groups of providers and perhaps health plans will agree to provide all of the care for a minimum of 5,000 Medicare fee-for-service beneficiaries. ACOs will need to meet certain access and quality standards and will be accountable for the overall care of their patients. As an incentive, the ACO will receive a percentage of the savings that Medicare accrues over average costs for comparable Medicare populations. This will be a voluntary program.

Compared with bundled payments, which still represent episodic payment, we see this structure as shifting more risk to providers because they will accept a single payment per beneficiary and be responsible for all of the care of that person. This is very much like the function of a health plan, and, in our view, the ACO program is explicit recognition by Medicare that health plans need clinical partners that have the proper incentives to, among other things, provide preventative services, in order to manage patient care at reduced cost.

Although providers can theoretically form ACOs without a health plan partner, in our discussions with providers, most see a role for health plans in ACOs as administrative entities, while the providers manage clinical care. We see this as representing a shift in risk away from health plans and toward providers and, in our view, the hospitals will bear the lion's share of that risk. Some providers told us that they are interested in joining or creating an ACO, mostly as a learning tool, but they also talked about trying to negotiate risk limitations in the structure before agreeing to volunteer.

The Innovation Center

With a budget of $5 million for 2010, $10 billion for 2011–2019, and $10 billion for each subsequent 10-year period, the bill will create and fund an Innovation Center within the Centers for Medicare and Medicaid Services, which will test several new payment models, including promoting payment and practice reform in primary care.

Examples of this include patient-centered medical home models and models that shift primary care practices away from fee-for-service toward comprehensive payment or salary-based payment. Another is contracting directly with groups of providers and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment. Others include supporting care coordination for chronically ill individuals at high risk of hospitalization through a health technology-enabled network that includes care coordinators, chronic disease registry, and tele-home health technology; and allowing states to test systems of all-payor payment reform for residents.

HHS must submit a report to Congress in 2012 and can expand the time and scope of the payment models. Many providers have told us that they see the center as an incubator for rapid delivery system change and its funding level is an indication to them of the federal government's commitment to testing payment reform in many ways.

Medicaid bundled payment demonstration project

Starting Jan. 1, 2012, and running for five years, eight states, chosen by HHS for their potential to reduce costs and improve care will participate in a Medicaid bundled payment demonstration project. Each state will choose one or more diagnoses to include in a bundled payment. In our view, this project will likely have similar risks and opportunities as the Medicare bundled payment project but is smaller in scope because Medicaid is a smaller payor than Medicare and the project is limited to eight states.

Medicaid global payment demonstration project

Scheduled to start in 2010, a Medicaid global payment demonstration project will allow five states selected by HHS to adjust their current fee-for-service payment model for safety-net hospitals to a global capitated payment structure in which the providers' will receive a per beneficiary payment to cover all of the care for each beneficiary. The safety net providers that we spoke to like the idea, but we think that much depends on the states it will include and how it will structure payments.

The project is relatively small but, in our view, could result in a significant change for participants. Like any payment model that moves from fee-for-service to global capitation, the risk will shift to providers. We believe it will be a challenge for states to design a program that truly shifts significant risk to providers already recognized as critical providers to underserved populations. As a result, we believe that most states will not find it in their best interests to design a program that could have a significantly adverse financial impact on providers who misjudged the risk of global capitation.

A Watchdog Will Keep Costs In Check

The legislation creates the Independent Payment Advisory Board, which will present Congress with comprehensive proposals to reduce excess cost growth and improve the quality of care for Medicare beneficiaries. The board will set target growth rates, and if the chief actuary projects a higher growth rate than the target beginning in 2014, the board has to submit a proposal to Congress to reduce the growth rate. The board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. We believe that the board's role is a long-term concern for providers, given its mandate to monitor and recommend cost of care reductions.

Credit Stability For Now But Uncertainty Ahead

All of the possibilities make it difficult to ascertain the exact impact health care reform will have on particular not-for-profit providers. If delivery system reform initiatives are successful and become broadly implemented, we believe they could lower costs by reducing inappropriate services and encouraging preventative services that would result in fewer admissions. This could reduce providers' revenue streams and pressure the margins of even successful organizations. However, although margins and ratings could come under pressure over the long term, we think that those in any given market could improve their business positions by their relative success or through consolidation. Indeed, while we expect health care reform will likely ultimately result in more downgrades than upgrades, we think that much will depend on the circumstances of individual providers, as well as the skills of each in navigating the changing environment. But the big changes still lie ahead, and for 2010, we expect relative credit stability for not-for-profit health care providers.