# S&P Global Outlook, Trends, and Perspectives

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Suzie Desai
Director
T: 312.233.7046
Suzie.Desai@spglobal.com

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# Agenda

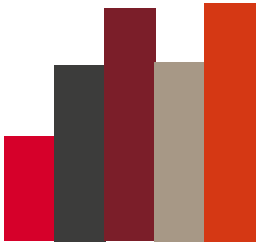
## What is a credit rating and criteria overview

- What ratings mean
- Key definitions
- Criteria overview / thought process

## Discussion of 2017 Outlook

- Sector outlook & emerging pressures

## Discussion of Trends & Perspectives



- Evolution of ACA
- Market driven reform
- M&A

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# What is a Credit Rating? How do you do a Credit Rating?

# Not-for-Profit Healthcare Credit Overview

- **S&P Global Ratings' not-for-profit healthcare group rates variety of acute care providers using two different criteria depending on the type of provider:**
  - Revised standalone hospital criteria: Include all standalone acute care providers including community and academic medical centers, rehabilitation hospitals, cancer hospitals, tax-supported hospitals
  - General healthcare criteria: Everything else that's still acute care but not a standalone hospital including multihospital acute care health systems
- **In our revised standalone hospital criteria, we updated our definition of a multihospital health system:**
  - Three or more hospitals and operating revenue in excess of $1.5 billion; or
  - >= $750 million total operating revenue and at least one of the following characteristics:
    - Three or more hospitals in two or more states;
    - Three or more hospitals in a single state where the largest hospital's operating revenue does not exceed 65% of total operating revenue;
    - Four or more hospitals in a single state with about 15% of total operating revenue from non-acute care businesses including but not limited to psychiatry, rehabilitation, health insurance plan, or long term care; or
    - Ten or more hospitals

# S&P's Global Ratings Scale

| | | |
|---|---|---|
| **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. |
| **Speculative Grade*** | **BB** | **Less vulnerable** in the near term, but faces major ongoing uncertainties or exposure 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** | **Highly vulnerable**; default has not yet occurred, but is expected to be a virtual certainty. |
| | **C** | **Currently highly vulnerable to** non-payment, and ultimate recovery is expected to be lower than that of higher rated obligations. |
| | **D** | **Payment default** on a financial commitment or breach of an imputed promise; also used when a bankruptcy petition has been filed or similar action taken. |

* As considered by market participants

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.

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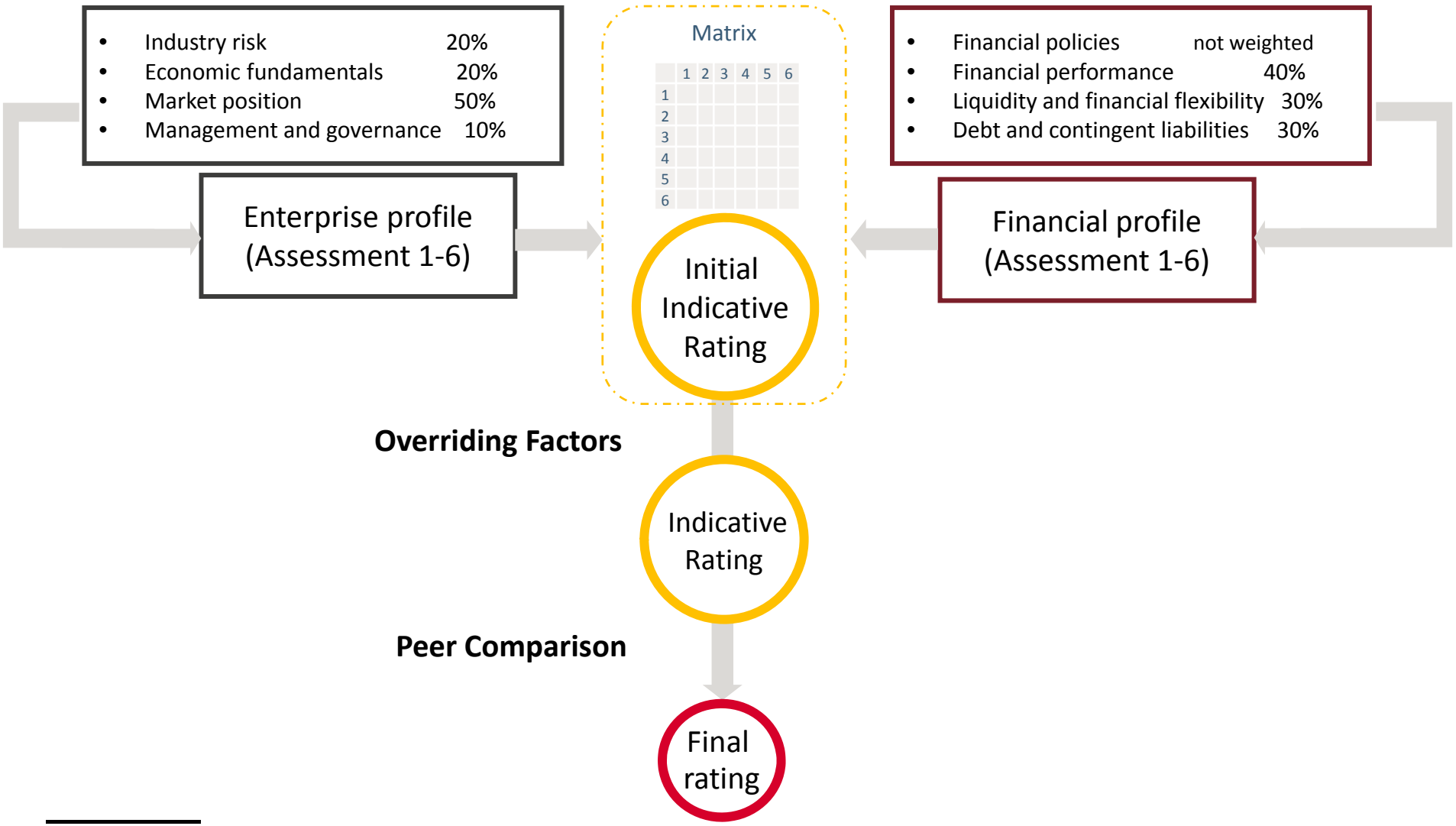
Source: "Standard & Poor's Rating Definitions", Feb. 1, 2016

# Analytical Framework for Standalone Hospitals



# Determining Initial Indicative Rating for Standalone Hospitals

| Enterprise Profile | | Financial Profile: Extremely strong (1) | Very strong (2) | Strong (3) | Adequate (4) | Vulnerable (5) | Highly vulnerable (6) |
|---|---|---|---|---|---|---|---|
| Extremely strong | 1 | aaa | aa+ | aa- | a | bbb+/bbb | bb+/bb |
| Very strong | 2 | aa+ | aa/aa- | a+ | a- | bbb/bbb- | bb/bb- |
| Strong | 3 | aa- | a+ | a | bbb+/bbb | bbb-/bb+ | bb- |
| Adequate | 4 | a | a/a- | a-/bbb+ | bbb/bbb- | bb | b+ |
| Vulnerable | 5 | bbb+ | bbb/bbb- | bbb-/bb+ | bb | bb- | b |
| Highly vulnerable | 6 | bbb- | bb | bb- | b+ | b | b- |

The initial indicative rating results from the interaction between the enterprise and financial profile assessments. Potential adjustments to the initial indicative rating are noted in table 2 of the criteria. The final rating will be within one notch of the indicative rating with the one-notch difference attributable to peer adjustments. For ratings below 'B-' see "Criteria For Assigning 'CCC+', 'CCC', 'CCC-', And 'CC' Ratings", published Oct. 1, 2012.



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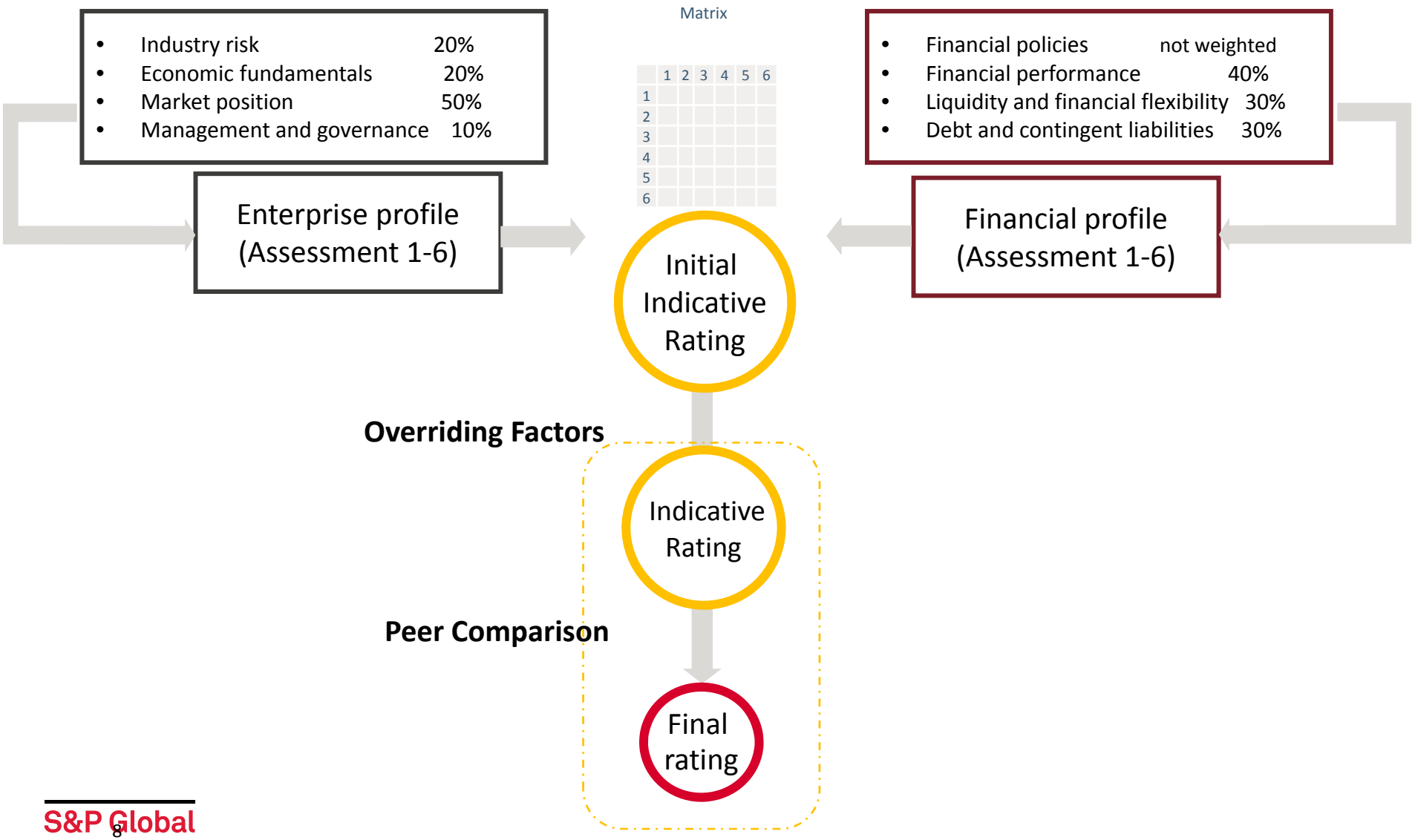
# Analytical Framework for Standalone Hospitals



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# 2017 US Not-for-Profit Healthcare Outlook

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# Not-For-Profit: Stable

**Recent operating softness is beginning to emerge, although stronger non-operating revenues, sound balance sheets and generally stable business positions are supporting the stable industry outlook. We expect balanced upgrades versus downgrades for 2017.**

- Stability supported by several factors:
  - Enterprise profiles continue to evolve but are generally stable
  - Balance sheet strength continues to remain a key credit strength
  - M&A activity has been generally positive & often improving business positions & pace of M&A is expected to proceed at a slightly slower pace
  - Continued implementation of fundamental operational improvement initiatives & strategies

# Not-For-Profit: Stable (cont.)

**Recent operating softness is beginning to emerge, although stronger non-operating revenues, sound balance sheets and generally stable business positions are supporting the stable industry outlook. We expect balanced upgrades versus downgrades for 2017.**

- However…while a combination of the ACA's Medicaid expansion, exchange performance, & management measures supported operating performance, performance is beginning to show signs of weakness as negative pressures are re-emerging:
  - Uneven but clear movement to value continues to lower inpatient use rates by boosting less expensive services. Unclear if this changes now
  - Payor mix shifts are beginning to hurt revenue and profitability (after the initial benefit of the ACA expansion)
    - Aging of America (10K boomers a day qualifying for Medicare)
    - ACA driven swing form uninsured to exchanges (mostly Medicaid)
  - Provider sponsored health plan operations are often dilutive
  - High labor and supply costs including rapid growth in pharma costs
  - Cost of absorbing physician practices
  - A number of large projects/borrowing (strategic spending) also impacting credit quality

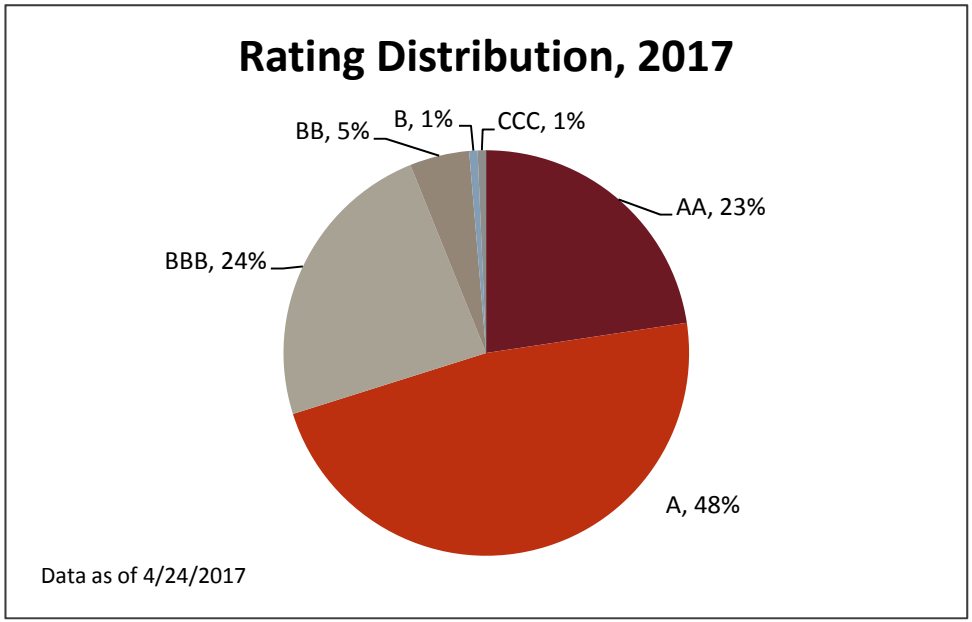
# Not-For-Profit: Stable (cont.)

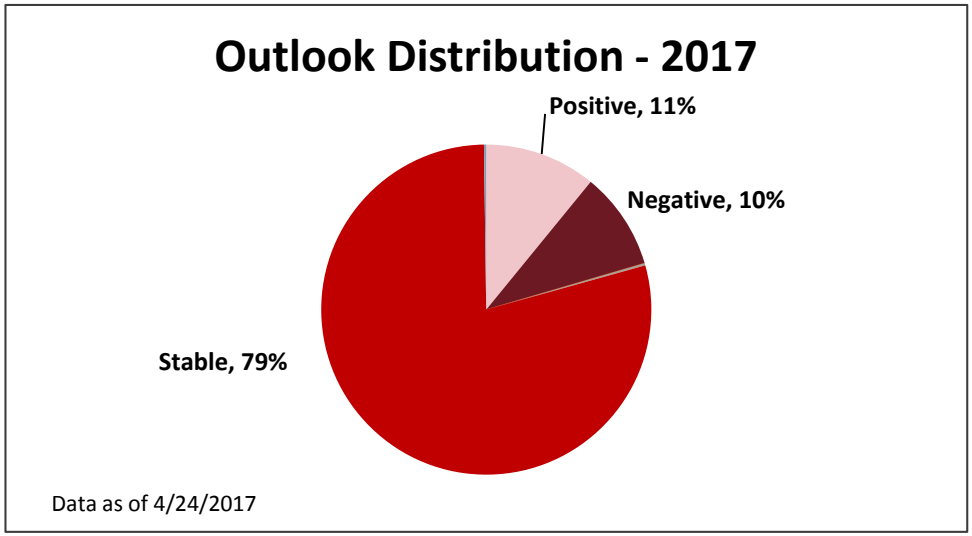
**Recent operating softness is beginning to emerge, although stronger non-operating revenues, sound balance sheets and generally stable business positions are supporting the stable industry outlook. We expect balanced upgrades versus downgrades for 2017.**

- Current efforts to pass AHCA & 'Repeal & Replace" ACA raise serious questions about the near to long-term future of health care reform
- On top of legislative risk, broad market confusion remains (i.e. mixed incentives, uneven pace of change toward value orientation, & strength of exchanges)
- Population health management capacity and ability to manage risk is also emergent differentiator
- A credit gap remains, and is perhaps spreading although all credits are feeling industry pressures (not limited to small or lower rated credits)
  - Size and scale issues, payer leverage, competition, basic demographics

# 2017 Rating & Outlook Distribution

- Ratings:
  - ‘A’ accounts for almost half of our credits
  - ‘AA’ & ‘BBB’ relatively even
  - ~7% non-investment grade
- Outlooks:
  - 79% stable
  - 10 % positive
  - 7% negative
- Current rating and outlook distribution shows relative strength and stability
  - Since 2016 year end, slight increase in negative outlooks through YTD 2017



# 2016 and YTD 2017 Rating Actions Reflect Stability

- Still seeing general credit stability
- **407** total affirmations for the health care sector in 2016 with **126** affirmations through April 2017
- Upgrades outpaced downgrades in 2016 but early indicators from 2017 are beginning to show slight increase in downgrades

| **Upgrades/Downgrades (count)** | Dec 2014 | Dec 2015* | Dec 2016 | April** 2017 |
|---|---|---|---|---|
| Upgrade | 41 | 41 | 43 | 7 |
| Downgrade | 46 | 30 | 37 | 11 |
| **Total** | 87 | 71 | **80** | **18** |

| **Upgrades/Downgrades (percentages)** | Dec 2014 | Dec 2015* | Dec 2016 | April** 2017 |
|---|---|---|---|---|
| Upgrade | 47% | 58% | 54% | 39% |
| Downgrade | 53% | 42% | 46% | 61% |
| **Total** | 100% | 100% | 100% | 100% |

*Dec 2015 results exclude 35 upgrades and 16 downgrades that were due solely to revised criteria and not underlying credit quality

**Rating actions through 4/24/17

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# 2016 and YTD 2017 Rating Actions Reflect Stability

- System with more upgrades relative to downgrades:
  - 18 upgrades
  - 13 downgrades
- Standalones more even:
  - 24 upgrades
  - 23 downgrades
- Positive trend from first three quarters faded in Q4 and generally continued into 2017 with early tilt towards stable trend in 2017

| **Upgrades/Downgrades (count)** | Q1 2016 | Q2 2016 | Q3 2016 | Q4 2016 | Q1 2017 |
|---|---|---|---|---|---|
| Upgrade | 9 | 10 | 13 | 11 | 7 |
| Downgrade | 6 | 14 | 6 | 11 | 9 |
| **Total** | **15** | **24** | **19** | **22** | **16** |

| **Upgrades/Downgrades (percentages)** | Q1 | Q2 | Q3 | Q4 | Q1 2017 |
|---|---|---|---|---|---|
| Upgrade | 60% | 42% | 68% | 50% | 44% |
| Downgrade | 40% | 58% | 32% | 50% | 56% |

# State of the ACA and the Broader Marketplace

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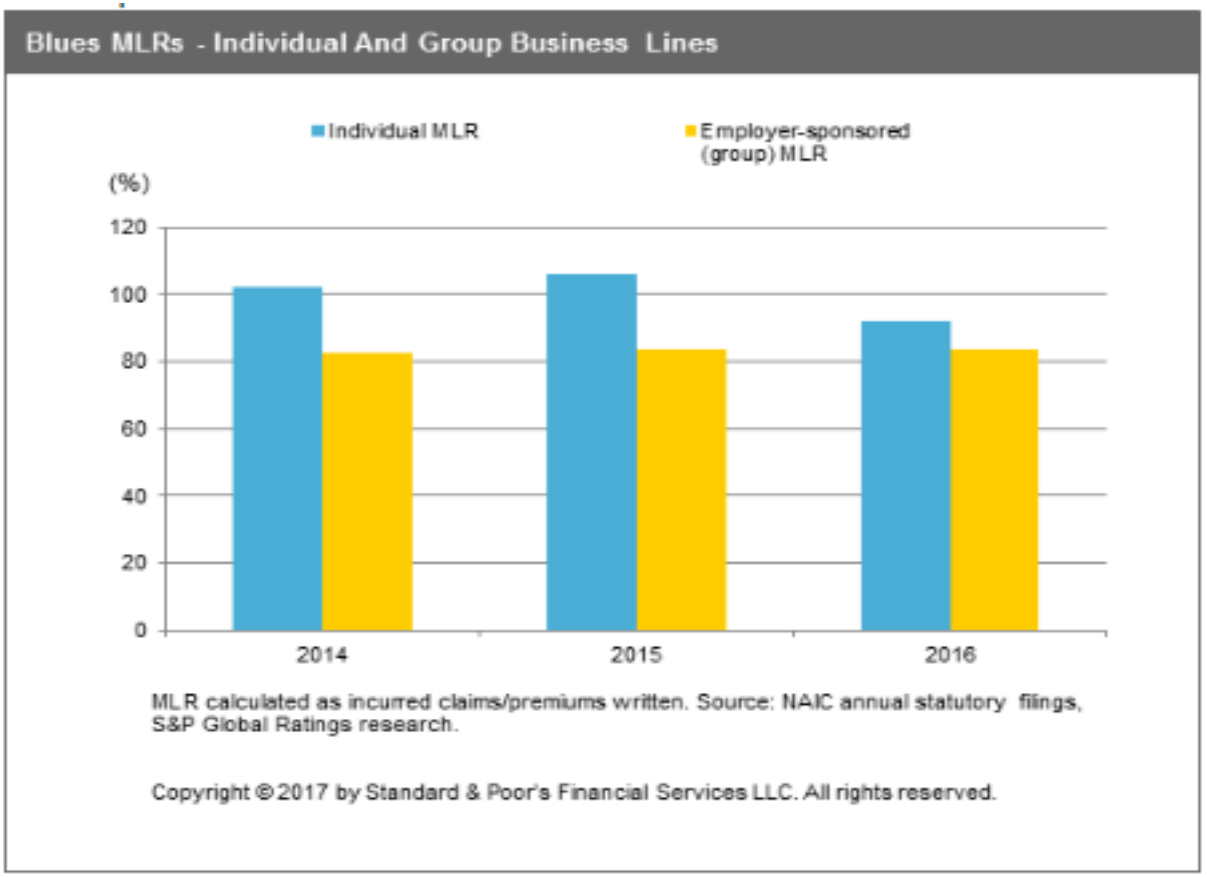
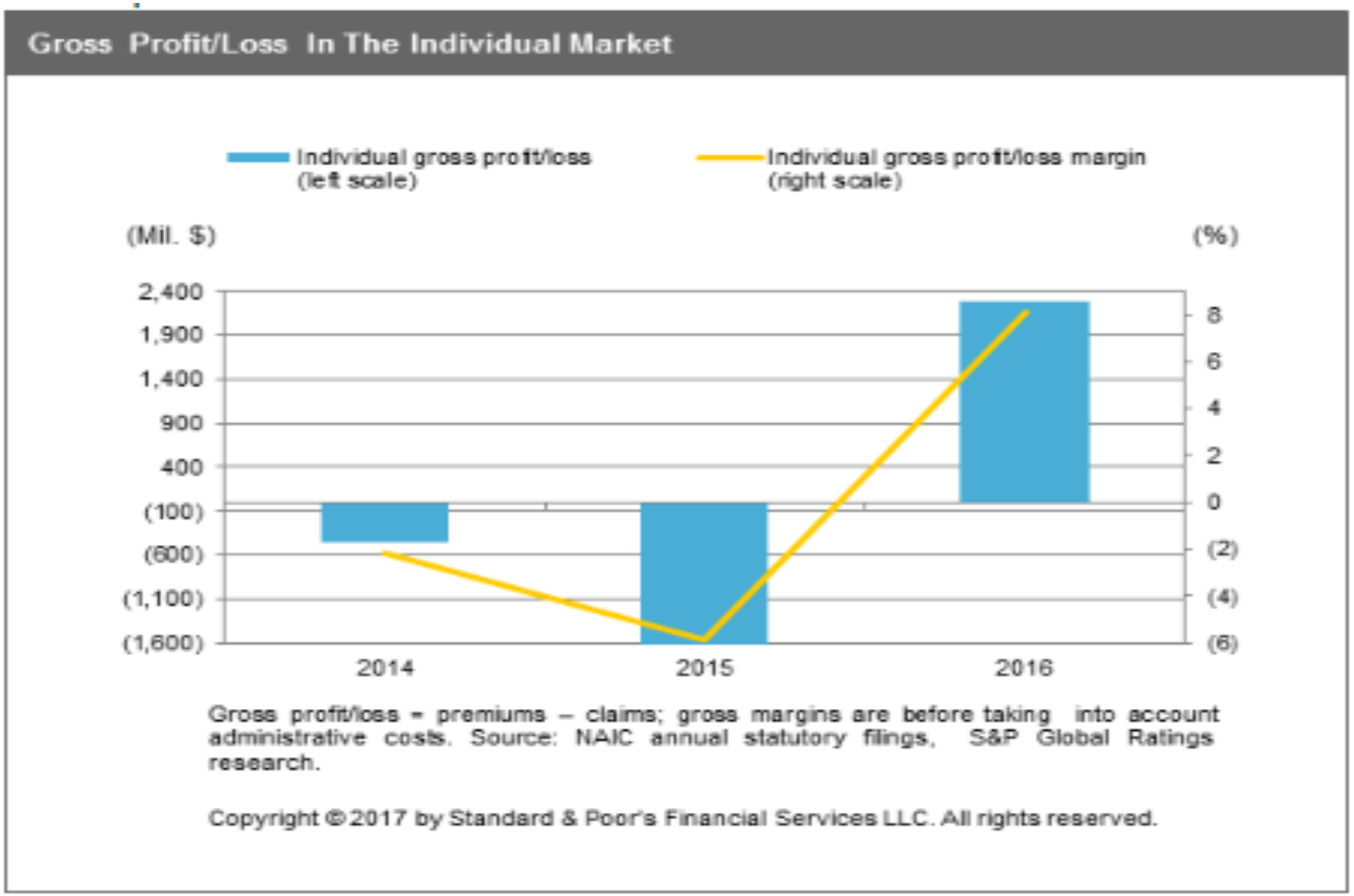
# ACA-Driven Expansion To Date: Providers' perspective

- Initial impact was favorable, particularly in Medicaid expansion states but has generally stabilized:
  - Shift to Medicaid from uninsured depending on location/prior business mix, resulted in incremental contribution to profitability, although uninsured burden remains
  - In 2015, organizations in expansion states vs. non-expansion states saw upgrades far exceed downgrades due to improved financial profiles & utilization growth
  - Expansion had a positive impact on admissions / adjusted admissions, although we began to see this slow down, and as expected, see the re-emergence of sector forces pushing inpatient usage rates down
- If ACA remains in place, going forward we see emerging negatives:
  - Disproportionate share reductions beginning in 2017 (federal fiscal year 2018) will hurt margins for some
  - Broader use rate/inpatient admissions level off and expect declines to re-emerge over time
  - Expectation of adverse changes in some exchange markets could lead to increased levels of uninsured in those states

# BCBS Plan Medical Loss Ratio Trend 2014 - 2016



# BCBS Plan Gross Profit / Loss in the Individual Market 2014 - 2016

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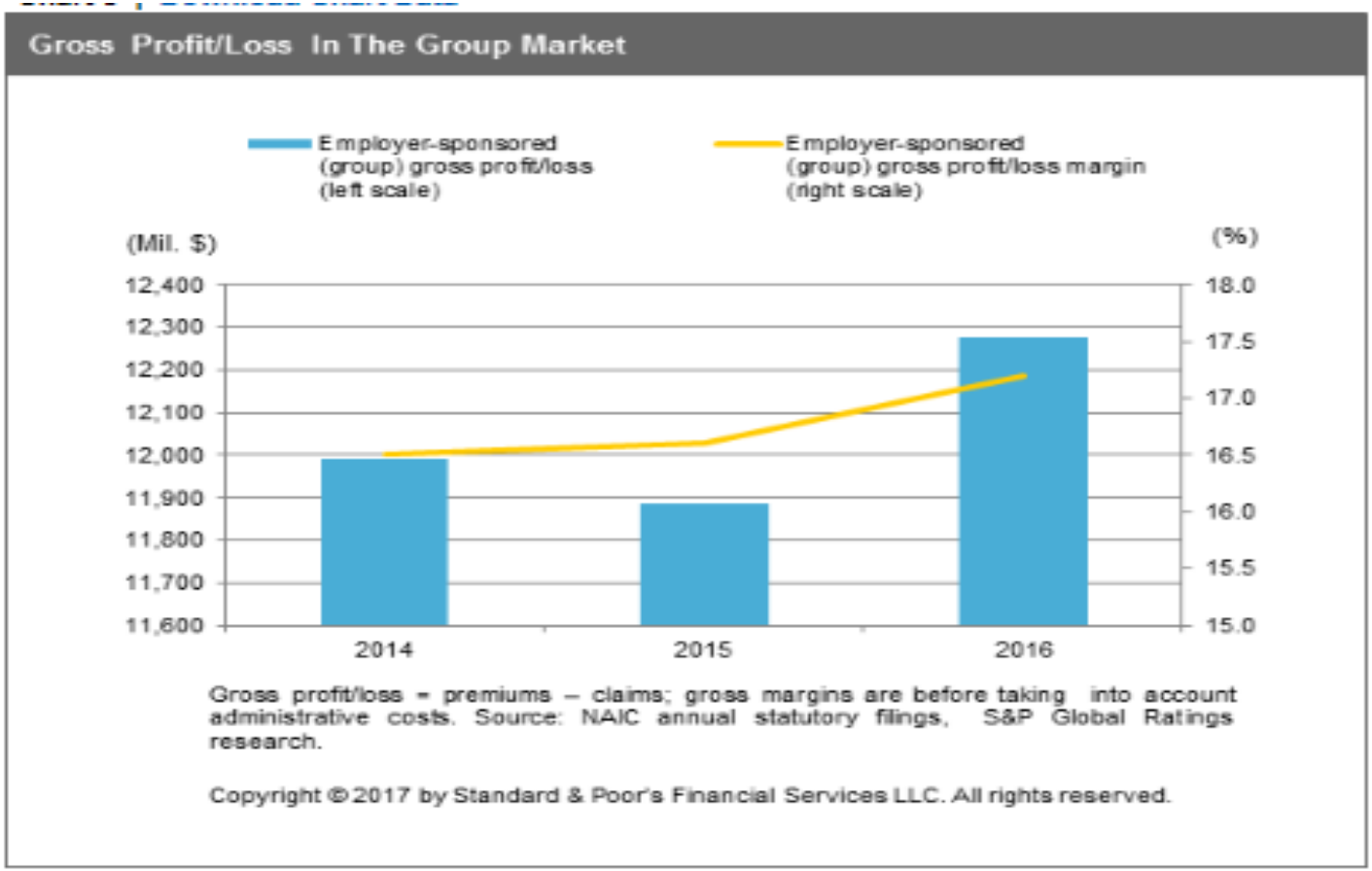
# BCBS Plan Gross Profit / Loss in the Group Market 2014 - 2016

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# Moving From ‘Repeal and Replace” To What’s Next” For U.S. Health Care”

- The AHCA (replacement bill for ACA) was pulled from House floor in March but resurrected in May
  - Any final bill would needs Senate approval, which has indicated intent to potentially revise
- ACA remains as governing law, despite ongoing efforts to achieve legislatively driven change in 2017
- We expect effective dates for any follow-on "repeal and replace" legislation (reflecting significant modification) to extend beyond the 2018 election cycle
- Longer-term credit impact, if any, will depend on specifics of the replacement plan, areas of specific exposure, and mitigating strategies adopted by hospitals to offset any disruptions to their respective markets.
- In the longer term, "repeal and replace" may reduce the size of the ACA individual market and limit future growth in the Medicaid market.
- As a result, the national uninsured rate may increase, but we don't see it reverting to pre-ACA levels as we expect some form of replacement to be implemented along with modifications or repeal of major components of the current law.
- Even if the AHCA does not pass, CMS administrative actions could alter many aspects of the ACA

# Market Driven Reforms

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# Market-Driven Reform

- **Value orientation emerging slowly with market specific variations**
  - Broad provider recognition of need to prepare value orientation continuum, yet movement is slow. Insurers seeking to offer risk exposure with infrastructure support (data management, processing, etc.) to willing and capable providers.
  - Wide range of value arrangements: p4p, bundled payments, shared risk and full capitation
  - CMS role in accelerating change (partly in connection with ACA) less certain
  - MACRA remains an area of bi-artisan support; expect this to continue the move to value
  - We expect long-period of pluralistic models; one size does not fit all providers or markets

- **Growth of high deductible plans and consequences on-going**
  - Currently 40 - 45 million Americans have high deductible plans excluding exchanges, up from about 5 - 10 million ten years ago
  - For providers re-emergence of old bad debt problems as vast increase in retail collections
  - These plans contribute to emerging pricing sensitivity although still limited
    - Important in some “cash based” corners of the market and when purchasing insurance
    - Price sensitivity also contributing to on-going cost cutting
  - Consumerism, high deductible plans and exchanges driving greater use of narrow networks

# Market-Driven Reform

**Consumerism**

- Consumers 'empowered' and are more involved in wide variety of decisions about their own care
- Broader non-traditional distribution channels and personnel, and ways to access care becoming essential including e-visits, phone and photo consults
- Greater consumer 'skin in the game' drives price consciousness, and value orientation, as individuals more involved in decision making

**Competition**

- Heightened competition within and across the sectors and new forms of cooperation
- Continued industry consolidation for providers and re-emerging consolidation for insurers
- Competition for covered lives, changing access points, cross selling opportunities
- Insurers and provider strategies overlapping creating alignment, cross sector collaboration, but also more direct competition as 'integrated delivery systems'
- Physician employment model evolving in generational shift

# Market-Driven Reform

**Strategic Reponses**

- Prolonged and intentional merger and acquisition agenda as providers seek size, scale, skills and surroundings
- Virtual arrangements and other forms of collaboration
- Interest in provider sponsored health plan development,  but also healthy use of the “pause” button
- Increased IT spend, very often significant, in information technology to better link clinical practices (physicians included) with financial costs and outcomes results – tied to broad quality improvement goals
- Goal of tying cost savings and quality together still elusive, but seen as necessary for population health management and addressing on-going federal reimbursement reductions (real and anticipated)
- Private sector innovation both in non-traditional partners, but also in what is often labeled ‘disruptive technologies’ such as mobile medicine

# Mergers & Acquisitions: Partnering and Collaboration

# M&A, Partnership, and Collaboration

- **M&A activity remains at a steady pace but may slow:**
  - Smaller more opportunistic M&A will continue - particularly in decentralized markets
  - Larger mergers will also continue, albeit at a smaller pace and will need to demonstrate the value proposition/benefit of the merger
- **Why merge:**
  - Organizations continue to seek size and scale (traditional cost savings and market heft), as well as diversity or expertise in different services (e.g., health plan, physician management)
  - Widen the funnel strategy - Non-overlapping markets provided for cost savings without negatively impacting volumes
  - Expanding a geographic footprint for longer-term transition to population health management
- **Ongoing observations:**
  - Push back from regulators, particularly in previously consolidated markets and/or where the participants cannot demonstrate the value proposition of the merger
  - Healthy and strong merging with healthy and strong
  - Larger merger systems not immune to overall sector pressures and growing pains could impact credit quality
- **Growth in affiliation strategies in lieu of full M&A and "non-traditionals":**
  - Joint ventures/joint operating agreements; clinical networks – often first step to something more permanent; management contracts – also often first step to something more permanent
  - Affiliations with payers (Allina/Aetna); urgent care/emergent care centers; "disruptive technology"
  - Innovation partnerships

# Ohio credits rated by S&P

# S&P Ratings: Greater Cincinnati Area Market

| Credit | Rating |
|---|---|
| TriHealth, OH | A+/stable |
| UC Health, OH | A/stable |
| Christ Healthcare, OH | A-/stable |
| Cincinnati Children's Hospital, OH | AA/stable |
| Mercy Health, OH | A+/stable |
| Kettering Health Network, OH | A+/stable |
| St. Elizabeth Medical Center, KY | AA/stable |
| | |

- Fairly healthy credit ratings relative to the overall universe of S&P rated not-for-profit healthcare credits
- Mixture of standalone and systems
- Outside of the above: S&P rate a total of 12 additional credits in Ohio & Northern Kentucky which range from large systems to smaller rural providers

# Observations of Ohio Based Provider Credits

- Ohio expanded Medicaid, although expires June 2017
  - 700,000 gained benefits (www.healthinsurance.org)
- Franchise fee tax elimination could pressure state budget (~$1 billion)
- M&A and affiliations are consistent with national trends
  - Some providers maintain health plans, but not necessarily a wide spread move to the insurance arena
- Innovation remains a focus for many providers in Ohio

# Q&A

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