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Healthcare Investment Consulting Practice

Ellwood's Recap of HFMA ANI Conference

From June 26-29, Tim Egan (Senior Consultant and Healthcare Practice Leader) attended the Healthcare Financial Management Association (HFMA) Annual National Institute (ANI) conference in Las Vegas, NV. The conference attracted several thousand HFMA members and hundreds of exhibitors.

The central theme of ANI this year was to think "Out of the Box". HFMA President and CEO Joe Fifer indicated the theme is intended to provide a framework to think about innovation to respond to the challenges and opportunities that lie ahead in the healthcare industry. The Affordable Care Act (ACA) and its current and future impacts also received much discussion among conference attendees. Last year, the ACA was the primary focus of ANI as the Supreme Court was due to rule on its constitutionality. As you know, the Supreme Court affirmed the constitutionality of ACA. As such, this year ANI attendees discussed the impacts felt over the past year and those expected in the future.

For those unable to attend or those whose schedules did not permit attendance at some of the sessions, the following summarizes key highlights from HFMA's Leadership Address and two of the more informational presentations as they pertain to hospital investment programs, including Standard & Poor's: *Industry Trends and Credit Issues*. Feel free to distribute this recap internally at your organization or send externally to anyone you think might find it useful.

Note: The next HFMA ANI conference will be in Orlando, FL from June 25-28, 2017.

REASON FOR ATTENDANCE

As Ellwood's investment consulting Healthcare Practice Leader, my HFMA membership and attendance is predicated on trying to remain apprised of and keeping informed about the major implications of healthcare reform and other prevalent developments that impact our hospital and healthcare clients' investment programs.

Given the continuing uncertainties of the ACA era and the healthcare landscape in general, we know that the growth and stability of our hospital and healthcare clients' investment programs are more important than ever before. As such, Ellwood's ability and knowledge base of the hospital and healthcare landscape is critical in understanding each client's specific circumstances and needs and developing optimal investment program solutions and structures to help guide these institutions forward.

In addition, Ellwood is actively seeking to add new clients to our existing Hospital and Healthcare clientele. For nearly forty years, Ellwood has worked with stand-alone community hospitals, regional medical centers, and large healthcare systems. During that time, Ellwood has developed an expansive knowledge base, resources, and healthcare experience in an effort to enhance hospital/healthcare investment programs. Currently, Ellwood's consulting assets under advisement are in excess of $56 billion, of which $9.6 billion represents hospital/healthcare clients.

Also, since 2006, Ellwood has provided investment consulting services to HFMA National's Operating Reserve and Education Foundation investment programs. We work closely with senior management, HFMA's Audit and Finance Committee, and the newly-formed HFMA Investment Subcommittee which is comprised of senior level financial executives of member institutions.

If you or any of your peers at not-for-profit healthcare systems or hospitals are seeking investment consulting expertise, please contact me at 312-782-5432 or Tim.Egan@ellwoodassociates.com. In addition, please visit our enhanced website at www.ellwoodassociates.com.

HFMA LEADERSHIP ADDRESS

HFMA 2015-2016 Chair Melinda Hancock (Partner, Healthcare, Dixon Hughes Goodman) revisited her theme "Go Beyond" for the past HFMA year. Her message last year quoted 17th century philosopher John Locke who said "no one's knowledge can go beyond their experience" to enthusiastically implore HFMA's membership to continually seek new experiences in order to keep learning. She discussed the healthcare transformation underway and the requirements of HFMA's members to "Go Beyond" traditional roles and responsibilities, current knowledge base and skillsets, and the status quo of the fee for service payment system as the primary healthcare financing mechanism.

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Timothy R. Egan
Senior Consultant/Healthcare Practice Leader
Tim.Egan@ellwoodassociates.com
312.782.5432

She also quoted Albert Einstein who said "once we accept limits we can begin to go beyond them". Perhaps, this quote best sums up the need to embrace rather than fear the transformative change in healthcare. Only then, she stressed, will HFMA and our healthcare system truly "Go Beyond".

Melinda then welcomed incoming HFMA 2016-2017 Chair Mary Mirabelli (Vice President, Global Practice-Healthcare, for Hewlett-Packard Enterprise Services). As Mary announced her theme for the new HFMA year "Thrive" she didn't quote any 17th century philosophers. Instead, Mary conveyed an all-too-real 21st century story of tragedy, hope, and inspiration. She discussed her background and training as an Occupational Therapist and her passion for patients, their medical experiences, and their healthcare financial experiences.

She discussed the inspirational story of a patient diagnosed with breast cancer. This patient contracted breast cancer on both sides and treatment required 7 surgeries and 35 rounds of radiation. As chemotherapy would take all of this patient's hair, she chose to shave it off before cancer could take it from her as her expression of control. She also continued working throughout this ordeal in order to maintain some semblance of control, to find solace, and to maintain a degree of normalcy.

To Mary, this patient's mindset was not about surviving but rather choosing to "Thrive" in the face of adversity, uncertainty, and change. The chronic condition, Mary surmised, presents the opportunity to make treatment decisions, financial decisions, career decisions, and life decisions. She connected this thought to the need to "Thrive" as an industry, in our personal lives, communities, and organizations, and that to do so is both a privilege and a distinct responsibility.

Choosing to "Thrive", Mary implored, has been a hallmark of HFMA going back to the 1980's era of DRGs to new concepts of bundled payments and utilization and the massive legislative changes since. These evolutions required new processes, technology, jobs and roles, and systems. HFMA and its members had to learn new skills and abilities to manage healthcare finance along the way. Today, Mary stressed, is no different as the industry evolves to new payment models, population health management, telehealth, and robotic claims processing of accounts receivable among others. For healthcare to continue to "Thrive" in our communities, Mary told members that HFMA must absorb, adapt, predict and lead the change. Perhaps, Mary summed it up best as she described her definition of "Thrive" for HFMA, which is "to rely on firm roots and branch out to grow".

By the way, the patient described above is Mary Mirabelli. She recently celebrated her sixth cancer-free year. Congratulations Mary!

FEATURED SPEAKER SESSION REVIEW

Industry Trends and Credit Issues – Martin Arrick (Managing Director, U.S. Global Finance, S&P Global Ratings) of Standard & Poor's

Mr. Arrick discussed S&P's healthcare sector outlook, its medians analysis, current healthcare bond market activity, and provided comments on ACA expansion and market reform.

Key Takeaways

Standard & Poor's assigns a "stable" rating to the healthcare sector citing easing negative pressures and a positive response in addressing ACA's challenges. As a result, Mr. Arrick expects a "balanced" upgrade versus downgrade trend for 2016 and 2017, largely based on the following observations:

- Stable margins,
- Balance sheet strength,
- Positive mergers and acquisitions activity,
- Improved overall performance due to Medicaid expansion and improved volume and payer mix, and

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Senior Consultant/Healthcare Practice Leader
Tim.Egan@ellwoodassociates.com
312.782.5432

- Some negative ACA pressures remain and some weaker performance has been observed the effects of which include poor information technology installations, weak investment markets, and cost of integrating physician practices.

While S&P has assigned a "stable" rating for the healthcare sector, Mr. Arrick told the audience that he is optimistic on healthcare for the following reasons:

- The pace of change will be incremental,
- There is a great deal of money in the system (18% of GDP which is the largest for any country in the world; France is second at 12% of GDP),
- Smart management teams in the industry, and importantly
- The healthcare sector cannot be "off-shored".

Highlights

Standard & Poor's (S&P) currently provides credit ratings for 140 healthcare systems and 336 stand-alone hospitals. S&P attempts to update each entity's rating yearly. Generally, S&P's bases its ratings on a two-year forward outlook. As such, a positive outlook from S&P for an entity implies that there is a one in three chance that its credit rating will be raised over that timeframe.

Mr. Arrick acknowledged the disconnect between S&P's two-year rating outlook and the change occurring within the healthcare sector which will evolve over the next five to ten years. However, as the impacts of healthcare reform become more understandable and immediate, S&P will have abundant time to alter its credit ratings accordingly.

Several common themes regarding improved financials, attractive bond market reception toward healthcare issues, and potentially disruptive competition drove the discussion.

Continuing Improvement
Prior to 2015, S&P assigned a negative outlook for the healthcare sector due to deteriorating volumes in the fee-for-service model. The most important aspects of the ACA, primarily Medicaid expansion, began being implemented in 2014. Since then, usage volumes increased and bad debt and charity care decreased as 10-15 million newly insureds sought care. Further, the movement or shift to the healthcare value model and proactive steps by hospital management teams to strengthen their financial and enterprise profiles drove stronger performance.

From a financial perspective, Mr. Arrick indicated that S&P has observed continuing balance sheet strength since the credit crisis of 2008/2009. Some of this strength was driven by reduced capital spending and improved investment rates of return. Merger activity has also benefited on balance as weaker hospitals affiliate with bigger and financially stronger hospitals which improves the credit story.

S&P will publish its 2015 median report in the next few months. Mr. Arrick's preliminary review indicates modest operating margin improvement due to cost controls and merger efficiencies to remove redundant overhead, soft non-operating performance reflective of lower investment income and reduced philanthropy, stable debt coverage ratios, and "meaningful" growth in overall net patient revenues. Net patient revenue growth has been impacted by four primary factors, including:

1. merger activity,
2. general reduction of number of ratings as smaller, weaker entities merge with larger entities,
3. integration of physician practices, and
4. premiums from provider sponsored health plans.

Some of the key preliminary 2015 median ratios discussed reflect financial improvement:

- Unrestricted Reserves/Long Term Debt is 161%; only 104% in 2008

- Debt/Capital is 32%; 39% in 2008. S&P believes this metric may rise given significant debt issuance in 2016 due to low interest rates.

Timothy R. Egan
Senior Consultant/Healthcare Practice Leader
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- Capital Expenditures/Depreciation is 113%; 2008 was 156%. This is reflective of deferring expenditures to preserve cash immediately following the credit crisis. The actual number may be a bit higher as some large investments in information technology are sometimes partially funded with operating cash which doesn't get reflected in this metric.

- Average Age of Plant is 10.8 years. Mr. Arrick indicated that plant age is manageable at 12 years but may result in some competitive disadvantage. Conversely, stand-alones without significant competition in rural areas can manage plant lives of 15-17 years.

Credit Gap
Mr. Arrick pointed out several aspects of a credit gap within the healthcare sector. He indicated that the largest not-for-profit healthcare systems have revenue of about $20 billion and 80,000-100,000 employees. While there has been a movement toward larger entities, S&P thinks that smaller hospitals (revenue of $50 million to $250 million) can "roll on for quite a while" as many own their geography, have a niche, and are controlled locally. Mr. Arrick believes that there is a "place for small providers" but that is generally the area where S&P finds the most weakness. As such, access to credit is slightly more difficult and the cost of debt is higher for smaller entities.

In 2015, upgrades outpaced downgrades following two years of the inverse. In 2016, Mr. Arrick expects a 50/50 split. There has been noticeable growth in the 'AA'-rated category reflecting the larger systems merging and getting financially stronger. States with Medicaid expansion have seen more rating improvement than non-expansion states. Non-expansion states, though, have not been disadvantaged from a rating perspective.

Bond Market Activity
Money flows to money market and bond funds continues an upward trajectory. Mr. Arrick discussed the attractiveness of healthcare fixed income as being perceived as higher risk/higher return. In addition, money flows suggest investors are moving out of equities and following the flight to quality in fixed income. This bodes well for tax-exempt bond issuance, especially following the recent Brexit announcement.

In addition, S&P reports that credit spreads have declined significantly over the past five years. In 2011, 'A'-rated and 'BBB'-rated, tax-exempt healthcare bond credit spreads were 1.20% and 2.25%, respectively. In May 2016, S&P reports credit spreads at 0.75% and 0.50%, respectively.

Market Driven Reform
Mr. Arrick identified and discussed five primary components of market-driven healthcare reform.

1. *Movement to Value Model Emerging Slowly*
   S&P fully expects systems and stand-alone hospitals to be developing strategies and moving toward the value model. Importantly, these strategies must preserve current profitability. Otherwise, ratings will be negatively impacted. Mr. Arrick reports that S&P will be flexible in working with those entities that it rates and expects some profitability pressure. The movement to value is expected to take 5-10 years and, thus, S&P expects several models (fee-for-service, value, hybrid) to be active for a prolonged period of time.

   S&P has a positive view on "big data" that will aid in improving overall care quality. Electronic medical records and other technologies will allow hospital management to reign in cost outliers and deliver improved care. S&P expects the utility of these technologies to be somewhat limited, however, unless management can figure out the reimbursement puzzle.

2. *Growth of High Deductible Plans*
   Today 30-40 million people are enrolled in high deductible plans (only 5 million were enrolled in such plans ten years ago) and S&P expects the trend to continue, especially as employers push in this direction. As such, a greater share of income will be directed toward healthcare expenses. For providers, this could result in a re-emergence of bad debt expense for retail collections.

Timothy R. Egan
Senior Consultant/Healthcare Practice Leader
Tim.Egan@ellwoodassociates.com
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3. *Consumerism*
   As people pay a greater share of healthcare costs, pressure will emerge to better disclose cost data to consumers, which is not readily available today. This will certainly be most prevalent in the high deductible plan space.

   Likewise, increased consumer costs will begin to spur adoption of new devices that empower consumers to identify and understand personal medical conditions.

4. *Exchanges*
   S&P reports that exchanges have had a modest impact on providers. Initially, the expectation was that providers would have to accept a meaningful reimbursement "haircut" to participate in the exchanges. The reimbursement rate, to date, has only been modestly lower.

5. *Competition*
   Mr. Arrick began this discussion with a quote regarding healthcare competition that says "when there is less food at the table competition gets tighter and manners go out the window". Mr. Arrick posited that providers that previously operated within a 100 mile radius are now extending to 200-300 miles into the backyards of other providers. Cleveland Clinic and, to some degree, Mayo are doing this nationally. In general, S&P reports that competition is intensifying to the benefit of the large, financially strong, nationally-recognized providers.

Merger/Acquisition Activity
In addition to the merger activity already described in this piece, S&P notes a significant increase in joint venture-type/joint operating agreement activity. Here, some independents are entering into virtual mergers by sharing/splitting service lines and sharing income statements, while maintaining ownership independence.

Whether or not these arrangements result in credit enhancement is evaluated on a case-by-case basis. Mr. Arrick was quoted "if you have seen one JOA, you have seen one JOA" indicating that these structures can vary widely. Key factors that S&P evaluates include total cost of investment, market share impact, ability to better compete with larger providers, and cash distribution mechanics.

BREAKOUT SESSION REVIEW

Federal Policy Update – Andrew Bressler, Managing Director, Bank of American Merrill Lynch Global Research

This discussion focused on the current and prospective state of healthcare reform. Mr. Bressler provided some thought-provoking statistics, including:

- Healthcare exchanges currently have approximately 12.7 million enrollees, far below the 22 million projected by the Congressional Budget office and Obama Administration in 2010/2011. In fact, the enrolled population is expected to decline to 10 million at the end of 2016 as enrollees drop coverage or fail to make premium payments.

- The new projection is for 19 million enrollees by 2019.

- More successful has been Medicaid enrollment of 15 million as projected by the U.S. Department of Health and Human Services. Thirty-one states have expanded Medicaid coverage and several others are contemplating doing so.

- There is increasing concern that insurers will continue to leave the exchanges. There was a modest decline from the 333 plans offered in 2015 to the current 315 plans in 2016. Following significant financial losses, United Healthcare and Humana, which are among the largest health insurers, have decided to leave most markets; others are expected to follow.

Timothy R. Egan
Senior Consultant/Healthcare Practice Leader
Tim.Egan@ellwoodassociates.com
312.782.5432

- Average insurance premiums are expected to increase 20-30% in 2017 with a wide variance among states.

- These and other healthcare reform factors suggest that providers will alter their enterprises to address the new landscape. Specifically, Bank of America Merrill Lynch reports that a survey of hospital executives revealed that many are likely to make acquisitions (27% expect to acquire physician practices, 25% outpatient services, 7% post-acute services, 10% health plans) in response to healthcare reform.

- Medicare reimbursement is expected to rise 0.7% in 2017.

In addition, this session explored the various healthcare reform proposals from the political parties and presidential candidates. No significant change is expected in the near-term. Others topics discussed included drug pricing issues, payment issues, models, and reform.

CONTACT

Timothy R. Egan
Senior Consultant/Healthcare Practice Leader
Tim.Egan@ellwoodassociates.com
312.782.5432

33 W Monroe Street
Suite 1850
Chicago, IL 60603
www.ellwoodassociates.com