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U.S. Not-For-Profit Health Care Sector Outlook Revised To Stable From Negative, Though Uncertainties Persist

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U.S. Not-For-Profit Health Care Sector Outlook Revised To Stable From Negative, Though Uncertainties Persist

Standard & Poor's Ratings Service has revised its outlook on the U.S. not-for-profit health care sector to stable from negative. We made this revision in light of operational improvements driven by the Affordable Care Act (ACA) Medicaid expansion, including a stronger-than-expected boost in volumes and payor mix reflecting clear declines in the number of uninsured people, management initiatives that are delivering on their early promise to improve performance, increasing balance sheet flexibility with generally higher unrestricted reserves, and continued operational benefits from merger and acquisition (M&A) activity.

Our previous negative outlook had anticipated modestly more downgrades than upgrades over the course of 2015. As recently as December 2014, however, we mentioned that there was "a glimmer of relief" for health care providers. The glimmer emerged faster and stronger than projected, as the historical changes sweeping the health care delivery system are taking root slower than expected allowing providers' responses to a broad array of pressures to take hold. Although we expect broad industry pressures to continue and even grow over time, most notably the movement toward a value versus the current fee for service orientation, we believe ratings for the vast majority of providers will remain the same over the remainder of 2015 and 2016, and upgrades and downgrades will remain balanced. Therefore, Standard & Poor's revised its outlook on the U.S. not-for-profit sector to stable.

Overview

- ACA Medicaid expansion has helped improve utilization and payer mix.
- Operational benefits continue to emerge from M&A activity.
- Systems are weathering industry challenges better than stand-alone hospitals.
- The number of uninsured and the related burden for providing uncompensated care has lessened as a result of the ACA and Medicaid expansion.
- Year to date rating action trends favor credits that reside in Medicaid expansion states.

The outlook revision is based on our assessment of recent sectors strengths and our expectation that operational strength will continue to drive the sector until at least the end of 2016, including:

- Broad improvement to the sector's financial performance as noted in our recent median reports (see "U.S. Not-For-Profit Health Care Stand-Alone Ratios Signal Continued Stability Through Next Year Despite Industry Pressures" and "U.S. Not-For-Profit Health Care System Median Ratios Likely To Remain Stable Through 2016 Despite Industry Pressures" published Sept. 1, 2015, on RatingsDirect) and our current year to date observations, as negative pressures ease and longer term positive countermeasures are having the intended effect;
- The positive impact of the ACA on providers via improvements in volume levels and payor mix and reductions in uncompensated care, though this remains state, market, and provider specific; and
- Sustained, even improved, unrestricted liquidity positions over the last year, although it is too soon to assess recent volatility in investment markets on the sector's credit quality.

Although stable, our assessment of the sector considers the many ongoing and ample challenges, including:

- The credit gap--specifically between large providers with specific market competencies and differentiators as compared with smaller providers unable to leverage their more limited size and scale;
- Expectation of longer term revenue pressures--particularly as seen in operational forecasts that call for conservative margins and the likely reemergence of volume pressures as the recent improvement in volume and payor mix is baselined;
- Potential for additional capital expenditures and associated debt increases after years of more modest spending, which could limit future financial flexibility and adversely affect debt related metrics; and
- Continued uncertainty in the sector on multiple fronts, including the imprecise nature of the pace of change to a value model, the role of price and cost consciousness among consumers, potential volatility in non-operating income levels in light of recent significant fluctuations in the equities markets, and the unknown effects of political changes on state and federal health care policy due to future elections.

Despite these ongoing challenges and the inherent uncertainty in the industry, the sector has responded well, as demonstrated by the results from both our annual median reports for stand-alone hospitals and systems and our internal mid-year rating round up, both of which indicate broad stability, and for many metrics, measurable improvements in the sector.

The 2014 Medians

Though the recent median reports look backwards and used 2014 audited information, they indicated stable to incrementally improved operating margins and continued balance-sheet improvement in the majority of rating categories and key metrics (see table 1) relative to the prior year--a sharp contrast from when operating margins were broadly on the decline. We believe that stand-alone hospitals have continued to implement cost savings while also increasing overall outpatient business to drive slightly stronger margins and cash flow. ACA driven Medicaid expansion has also emerged as a positive force for the sector although we expect the financial effects will be more profound in 2015 than 2014. We expect that credit quality for stand-alone hospitals should remain generally stable for the near term as providers continue to manage the implications of health care reform and prepare for more risk based payor contracts, although we expect a pluralistic model will emerge as the norm in most markets.

Table 1

Stand-Alone Hospital Median Ratios By Rating Category--2014 versus 2013

	AA		A		BBB		Speculative Grade	
Fiscal Year-End	2014	2013	2014	2013	2014	2013	2014	2013
Sample size	34	29	155	169	112	127	35	38
Statement of Operations								
Net patient revenue (NPR; $000)	873,336	896,415	408,424	400,581	174,975	205,581	100,694	122,598
Salaries and benefits/NPR (%)	56.3	57.0	55.4	55.6	56.3	56.0	54.9	55.0
Maximum annual debt service coverage (x)	6.5	6.4	4.8	4.3	2.9	2.9	1.8	1.7
Operating lease-adjusted coverage (x)*	5.4	4.6	3.7	3.4	2.5	2.3	1.7	1.5
Debt burden (%)	2.4	2.6	2.8	2.9	3.5	3.5	4.2	4.1
EBIDA ($000)	149,317	207,552	51,238	50,782	20,653	22,808	8,407	8,223

Table 1

Stand-Alone Hospital Median Ratios By Rating Category--2014 versus 2013 (cont.)

Nonoperating revenue/total revenue (%)	3.9	4.2	2.8	2.5	1.7	1.6	1.4	1.4
EBIDA margin (%)	15.1	14.9	12.9	12.2	10.8	9.8	7.7	6.3
Operating EBIDA margin (%)	11.9	12.1	10.5	10.0	8.6	8.2	5.9	4.9
Operating margin (%)	5.2	5.6	3.3	3.0	1.3	1.3	(3.9)	(2.3)
Excess margin (%)	8.7	9.4	6.1	5.1	3.1	2.7	(0.8)	(0.8)
Capital expenditures/depreciation and amortization expense (%)	125.2	149.9	109.5	119.5	90.2	101.1	52.2	81.9
Balance Sheet								
Average age of plant (years)	10.4	9.7	10.7	10.5	11.9	11.3	11.6	11.5
Cushion ratio (x)	36.5	34.4	22.1	21.0	12.0	11.6	5.0	6.0
Days' cash on hand	378.5	338.7	261.6	235.9	160.3	149.0	86.8	97.9
Days in accounts receivable	50.9	51.4	49.2	48.3	48.0	48.5	53.3	52.7
Cash flow/total liabilities (%)	26.4	25.3	19.1	18.4	14.2	13.5	7.3	6.6
Unrestricted reserves ($000)	796,202	900,805	260,998	251,905	80,397	82,350	25,766	29,827
Unrestricted reserves/long-term debt (%)	296.2	257.7	182.0	176.5	112.2	112.3	58.3	57.1
Long-term debt/capitalization (%)	21.4	22.7	29.4	29.0	34.6	36.9	48.5	49.8
DB pension funded status (%)*	84.7	77.3	82.2	84.5	79.0	78.4	73.2	76.7
Pension-adjusted long-term debt/capitalization (%)*	24.1	24.8	31.2	31.4	37.3	38.8	51.5	51.4

*These three ratios are only for organizations that have defined-benefit (DB) pension plans or operating leases. The fiscal year 2014 sample represents 99% of hospitals currently rated by Standard & Poor's.

The financial performance of our rated health care systems has been generally stable to improving over the past year (see table 2). Operating margins are a bright spot with improvement across almost all rating levels. With ongoing multi-year pressure on the sector, we believe management teams have responded well by taking advantage of increased revenue opportunities where available, working to lower costs through system operating synergies, and increasingly integrating with other acute and non-acute care providers as well as physicians. Many managers at our large system credits report adopting more centralized operating philosophies to drive improved operating performance.

Table 2

Not-For-Profit Health Care System Medians By Rating Category--2014 versus 2013

Fiscal Year-End	AA		A		BBB		Speculative Grade	
	2014	2013	2014	2013	2014	2013	2014	2013
Sample Size	59	56	67	65	10	14	4	3
Statement of Operations								
Net patient revenue (NPR; $000)	2,216,150	2,171,100	1,594,812	1,466,365	1,089,690	989,013	1,203,972	1,230,875
Salaries and benefits/NPR (%)	57.3	56.6	57.6	57.4	62.1	58.6	64.0	63.7
Maximum debt service coverage (x)	5.9	5.5	4.1	3.7	2.5	2.5	1.8	1.8
Operating lease adjusted coverage (x)*	4.2	4.2	3.1	2.8	2.2	2.1	1.5	1.5
Debt burden (%)	2.2	2.3	2.7	2.8	2.6	3.0	2.5	2.2
EBIDA ($000)	409,213	426,100	220,303	166,388	92,823	100,018	51,832	46,365
Nonoperating revenue/total revenue (%)	3.2	3.2	2.1	2.2	1.5	1.9	2.2	1.9

Table 2

Not-For-Profit Health Care System Medians By Rating Category--2014 versus 2013 (cont.)								
EBIDA margin (%)	13.8	13.4	11.4	10.3	8.5	9.4	4.4	5.2
Operating EBIDA margin (%)	10.6	10.4	9.4	8.5	6.2	8.4	2.0	3.4
Operating margin (%)	4.0	4.1	2.7	1.4	0.6	1.3	(2.9)	(2.4)
Excess margin (%)	7.4	7.7	4.8	3.5	2.7	3.4	(0.4)	(0.5)
Capital expenditures/depreciation and amortization expense (%)	133.5	156.2	118.7	115.3	131.9	119.7	78.2	82.8
Balance Sheet								
Average age of plant (years)	9.7	10.1	10.9	10.6	10.9	11.5	13.3	14.8
Cushion ratio (x)	27.9	28.1	17.5	16.7	11.9	12.2	6.5	9.4
Days' cash on hand	292.7	285.4	181.7	182.0	137.7	143.2	82.1	100.8
Days in accounts receivable	49.3	52.2	47.7	50.4	49.0	49.1	50.2	45.6
Cash flow/total liabilities (%)	19.5	20.4	15.1	13.7	9.6	11.2	3.9	4.3
Unrestricted reserves ($000)	1,894,038	1,768,800	892,281	782,832	518,620	493,375	236,438	222,643
Unrestricted reserves/long-term debt (%)	206.5	200.8	137.5	118.7	131.7	106.7	46.9	69.2
Long-term debt/capitalization (%)	27.2	27.7	37.8	39.4	44.6	46.2	85.4	91.4
Defined-benefit pension funded status (%)*	82.0	86.4	82.9	83.7	79.9	80.2	76.4	60.1
Pension-adjusted long-term debt/capitalization (%)*	29.5	29.3	42.2	41.6	47.2	51.9	85.9	95.9

*These two ratios are only for organizations that have defined-benefit (DB) pension plans. The fiscal year 2014 sample represents 100% of health care systems currently rated by Standard & Poor's.

Mid-Year Rating Round-Up For Health Care Providers

The mid-year rating round up, by comparison, is more real time in nature, and indicates not only credit stability, but that upgrades are outpacing downgrades. In keeping with historical trends, some credit rating actions are due purely to M&A; however, this year's ratings actions also include upgrades and downgrades based on implementation of our revised stand-alone hospital criteria (see "U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals – Methodology And Assumptions" published on Dec. 15, 2014 on RatingsDirect), which affects about two-thirds of our existing portfolio of rated credits, and by applying our existing Group Rating Methodology (GRM; see "Group Rating Methodology" published Nov. 19, 2013, on RatingsDirect). Even after eliminating the effects of these three factors, fundamental credit strength is generally stable to improving among our rated entities.

As of June 30, 2015, there have been 45 upgrades compared with 32 downgrades and 215 ratings affirmations for the entire health care sector including stand-alone providers, health systems, senior living, and human service providers. Although year-to-date rating changes are mostly positive, the pace is significantly moderated once adjustments are made for the revision to Standard & Poor's criteria for stand-alone hospitals, the application of our GRM, and the very limited effect from M&A. After adjusting for these factors, our year to date upgrades are 23 compared with 19 downgrades for the same time period (see table 3).

Table 3

Not-For-Profit Health Care Rating Changes 2015 from Jan. 1, 2015, through June 30, 2015*

	Upgrades	Downgrades	Affirmations
Total rating actions	45	32	215
Rating actions excluding M&A, GRM, and revised criteria	23	19	N/A

*Includes stand-alone hospitals, health systems, senior living, and human service providers. N/A--not applicable.

The upgrade to downgrade trend, however, is not equal when comparing our stand-alone hospitals and system credits because the health system credits have a more favorable upgrade to downgrade ratio. Year to date through June 30, there have been 33 upgrades compared with 27 downgrades among stand-alone hospitals. After excluding the upgrades due to M&A, GRM, and ratings changed solely due to the criteria revision, downgrades would actually modestly outpace upgrades 14 to 11 (see table 4), demonstrating that the criteria revision is behind the majority of stand-alone hospital upgrades (19 upgrades compared with 13 downgrades).

However, in contrast to the stand-alone credits, there have been 10 system credit upgrades compared with just three downgrades with none of the rating changes affected by the revised stand-alone criteria. The rating trends indicate an equal number of upgrades and downgrades for long-term care and human service providers. Our views on long-term care providers are updated annually. (See "U.S. Not-For-Profit Senior-Living Sector Remains Stable Despite Mixed Financial Results" published Oct. 6, 2014.)

Table 4

Not-For-Profit Health Care Stand-Alone Hospital Rating Changes from Jan. 1, 2015 through June 30, 2015

	Upgrades	Downgrades	Affirmations
Credit quality	8*	12	N/A
Revised criteria	19	13	N/A
Combination of both credit quality and revised criteria	6	2	N/A
Total stand-alone rating actions	33	27	126

*Includes three credits upgraded due to merger & acquisition and group rating methodology. N/A--not applicable.

Additional highlights from the year to date rating changes through June 30 include:

- About three-quarters of our upgrades occurred at the upper end of the rating spectrum in the 'A' or 'AA' categories;
- About two-thirds of our downgrades occurred at the lower end of the rating spectrum, at the 'BBB+' rating or lower;
- About one-quarter of our upgrades were systems while less than 10% of downgrades were systems; and
- About three-quarters of our upgrades were stand-alone hospitals; however, 84% of our downgrades were stand-alone hospitals.

After affirming 215 credits through June 30, which represents about three-quarters of the rating actions for this time, we believe the overall portfolio of credits is currently in a stable state, although there is a mixed message of improvement in the system segment versus stability in the stand-alone sector if one excludes the upgrades due to the criteria revision, M&A, and GRM. This highlights a long-observed industry trend of an existing and perhaps now widening credit gap between our two industry sub-sectors. We believe that current year-to-date trends suggest fundamental credit strength continues to accrue to our larger system credits with size, scale, and synergies while the

stand-alone credits generally are exhibiting flat to even performance. The credit gap also indicates greater strength and positive trends in higher rated credits versus lower rating credits whether or not they are systems or stand-alone providers, which are finding it harder to improve operational performance.

Key Industry Trends Regarding The Outlook Revision

Improvements to utilization and the payor mix

Many of our not-for-profit credits have reported a rise in Medicaid patients and a decrease in their uninsured patient volume since mid-2014, which they attribute to Medicaid expansion. Even non-expansion states saw increased Medicaid enrollment as previously uninsured, but qualified people, have signed up for coverage in light of the publicity surrounding the ACA. At times, this has been remarkably significant and is reflected in a notable drop in the level of uninsured care for some providers. In addition, there's been little evidence so far that the new Medicaid patients overall are generating unusually high medical costs, although there have been a few anecdotes to the contrary. Although this shift is favorable--getting paid something is better than next to nothing--there is some question whether the improved operating performance can be maintained over the long-haul, given our expectations for continued adverse changes in reimbursement facing the industry. Moreover, as greater value orientation continues to grow in the sector, we expect the number of hospital admissions and hospitalization use rates to continue to come down over time after the wave of Medicaid expansion is incorporated into the overall statistical baseline. These longer term risks remain issues for the sector.

Year to date the trends favors credits that reside in Medicaid expansion states. For the first six month of calendar 2015, through June 30, 2015, Standard & Poor's upgraded 30 acute care providers primarily residing in expansion states, versus only 15 downgrades in those two states, for an upgrade to downgrade ratio of two to one. And in non-expansion states, downgrades actually outpaced upgrades 15 to 13 (see table 5) by a narrow margin. Although we have reviewed almost twice as many credits in Medicaid expansion states as in non-expansion states, the percentage of upgrades significantly exceeds the percentage of downgrades in expansion states while the percentage of downgrades in non-expansion states exceeds, but by a lesser margin, the percentage of upgrades. Even when accounting for upgrades to downgrades related to Standard & Poor's criteria revision, the trends stay the same.

Table 5

Not-For-Profit Health Care Stand-Alone and System Rating Changes Through June 30, 2015, by Medicaid Expansion Status

	Upgrades	Downgrades	Affirmations
Medicaid expansion states	30	15	124
Non-expansion states	13	15	69
Total system and stand-alone rating actions	43	30	193

In addition to the shift from uninsured to Medicaid, which is boosting volumes, many of our not-for-profit credits are reporting an unrelated general increase in volumes--both on a 'same-store' basis, but also through active M&A activity--with minimal disruption to their payor mix or reimbursement from the public exchanges.

This increase in utilization can be attributed to many factors including growth in population, aging of population,

working more collaboratively with physicians, pent up post-recession demand, and increased coverage through Medicaid expansion and health exchanges. In addition, we believe that shifts from inpatient admissions to observation visits have recently stabilized and at times have begun to swing back toward inpatient admissions. The recent uptick in volumes represents a fundamental change from recent years when declining inpatient activity was the norm. In addition, while many of our not-for-profit providers were very concerned over a potential negative effect financially from the exchanges--either from too many people signing up for lower tiered plans, or from participants lowering pricing to garner market share in a 'race to the bottom' strategy--most are reporting that not only did participants sign up for higher level plans, but pricing has held relatively firm, thereby preserving or improving in many cases overall payor mix and reimbursement. Although we remain concerned that public exchange products may eventually have a depressive effect on reimbursement levels, there has been minimal affect to date and, as of now, we do not believe this will accelerate as a negative trend.

Mergers & Acquisitions

M&A continues to affect the sector as many not-for-profit health care credits view mergers as an opportunity to strengthen operating and financial profiles. For the past several years, many of the mergers and acquisitions have been between smaller and weaker stand-alone hospitals and larger health systems. While typically smaller hospitals may be prime candidates for M&A, they haven't been the only ones. Almost all hospitals experience financial pressures to some degree, and in recent years we've also seen mergers that involve major university and teaching hospitals as well as smaller city and rural providers. And while these mergers almost always improve the business profile, there is also the risk that they could burden the stronger partner with additional debt, challenged operations, or with commitments to fund capital or operations for a given period of time, although recently significant downward pressure has been muted.

Market participants that have engaged in consolidation often benefit from:

- An increasing ability to reduce expenses;
- Improved volumes, often through buying physician practices, an improved ability to attract and retain physicians as part of a larger system, or keeping referrals within network;
- Ability to design new health care delivery models, which may allow them to better meet consumers' needs, improve quality of care and reduce clinical variation (by some estimates, as much as 30%-40% of clinical treatment is unnecessary);
- Stronger management depth and breadth;
- Access to more comprehensive and often better information technology;
- Broader market coverage to implement population health strategies; and
- Traditional factors such as market leverage.

The underlying rationale for mergers, in our view, is evolving: originally a strategy to gain market clout and leverage with payors has evolved into one of gaining economies of scale to ultimately developing the best geographical, diversified footprint for the effective health management of a given population, although this remains somewhat prospective for many providers. It is the current effects of size and scale however, that are improving financial performance and providing balance sheet stability to our rated credits, particularly during this current period of time where most reimbursement in the U.S. is still on a fee-for-service basis and has not yet moved to a risk based orientation.

Management initiatives and no regrets strategies are producing results

Right now our rated credits continue to implement a series of "no regrets" strategies, that is, strategies that will work under traditional fee-for service, during the transition to population health under a pluralistic model, or even ultimately under some form of broad population health. No regrets strategies include improving the bottom line, conserving unrestricted reserves where possible and migrating toward, but not making a full jump into, population health. All of these are combining to improve the credit strength of our rated organizations, specifically among our rated systems.

Longer term, the transition to value-based reimbursement from fee-for-service reimbursement is the single most significant manifestation of health care reform, after the ACA coverage expansion. The ultimate goal of improving quality of care often involves lower costs as using evidence based medicine to get it right the first time also involves shifting the emphasis to keeping patients healthy by paying providers for stronger preventive care and early disease detection, rather than paying them to treat an illness through episodic care as they would under fee-for-service models. This trend has yet to fully mature, but is likely to dramatically change the health care delivery landscape. Improved quality can be expensive at first, but less expensive over time as patients stay healthier and as unnecessary care is reduced.

This value orientation brings with it a whole new set of requirements and a number of providers are experimenting with and starting their own provider sponsored health plans (see "The Growing And Evolving Role Of Provider-Sponsored Health Plans In U.S. Health Care" published June 8, 2015, on RatingsDirect) to accomplish this end, although this is not the only path to value. However, despite a few visible exceptions, this transformation is still in its infancy, in our view, and even as industry leaders embrace the new paradigm we fully expect to exist in a pluralistic market for an extended period of time.

Stable Outlook Reflects Current Improvement Despite Underlying Pressures

Despite remaining risks, Standard & Poor's has seen a discernable improvement year over year based on our recent median reports and current credit quality trends. Our year to date information, while mixed in some regards, generally confirms that credit strength is returning and arguably has returned at larger health system providers that are leveraging their size and scale. We also believe the ACA-driven Medicaid expansion will continue to get larger over time as more states adopt expansion. Although we believe the full benefits of the expansion will be even more apparent in the fiscal 2015 medians, we remain cautious about the sustainability of the improved operations as benefits of the improved payor mix will have been absorbed, creating a new higher baseline, and additional gains will be hard to duplicate in the years ahead. In addition we believe the widespread installation of electronic medical records will usher in a great capacity of health care management teams to optimize the right amount of care at the right time in the right place under evidence-based best practices.

Combined, all these measures and trends lead Standard & Poor's to revise its outlook from negative to stable on the sector. However, while we are stable, and credits are responding well to numerous pressures, Standard & Poor's acknowledges that numerous pressures still exist and that the industry remains in the midst of significant transformation.