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US Healthcare Reform: Three Risks Reduce Credit Positives for Not-for-Profit Hospitals

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The US federal government's healthcare reform legislation, the Affordable Care Act (ACA), creates conflicting credit implications for not-for-profit hospitals. The net credit impact for the hospital sector will gradually become clearer following the completion of the open insurance enrollment period for individuals that ends March 31[1].

» **Expanded insurance coverage is the most positive aspect of the ACA.** The scale of the credit benefits this creates for hospitals will depend on a significant net reduction in non-paying, uninsured or poorly insured patients.

The expected net benefit for hospitals has been eroded since the legislation was passed in 2010, first by the Supreme Court granting US states the option to not expand Medicaid insurance coverage in 2012, and now by three emerging risks:

» **Today's high deductibles are tomorrow's bad debt.** Plans with high deductibles will partly offset the benefit of expanded insurance coverage because low and moderate income patients are less apt to pay them in full.

» **Lower insurance company profitability on the exchanges may lower hospital reimbursement in 2015.** In addition, premiums for plans offered on the exchanges may rise in 2015, causing some to drop coverage and further erode benefits to hospitals.

» **If narrow networks are successful, we expect hospital reimbursement to drop**. In narrow networks, hospitals accept lower reimbursement in hopes of gaining market share.

[1] The administration announced on March 25 that it would extend the deadline to mid-April for people who began the application process on the federal exchange, but did not complete applications by March 31

Expanded insurance coverage is the most positive aspect of the ACA

The prospect of additional paying patients has always been the most positive aspect of the ACA for not-for-profit hospitals. When the ACA was being drafted, the hospital industry agreed to more than $150 billion in Medicare rate cuts on the premise that the benefits of a greater pool of paying patients would outweigh the revenue lost due to rate cuts.

Expanded insurance coverage is also positive for hospitals because it is likely to lead to greater use of healthcare and hospital services as previously uninsured individuals gain access to the system. Higher healthcare utilization is important because other industry trends not directly tied to the ACA are reducing patient volumes and revenue.

Some of the factors driving patient volume declines include:

» Medical advances and shifting modalities of care, reducing the need for hospitalization

» Medicare rule changes including Recovery Audit Contractor[2] ("RAC") reviews and the two-midnight rule[3]

» Hospitals, insurers, and other healthcare providers encouraging the use of lower cost settings to provide care

The key result to watch in coming months is the ACA's impact on the overall uninsured rate. The number of previously uninsured individuals obtaining insurance is a key measure in determining the success of the ACA. This indicator is a far more important metric than the headline number of people purchasing insurance through the exchanges because some of those people were already insured and have simply changed where they buy coverage.

Early indications are that the uninsured rate is falling. A recent Gallup poll[4] shows the uninsured rate falling to 15.9% in 2014, down from 17.1% in the fourth quarter of 2013. This is an encouraging sign, especially in light of the fact that the Congressional Budget Office revised its projections of coverage expansion to 6 million from 7 million. The government has not released data or estimates on the net gain in the number of insured people.

Today's high deductibles are tomorrow's bad debt

We believe there is significant risk that people covered by the most popular insurance plans will be unable or unwilling to meet their deductibles. As a result, growth in insurance coverage will not translate into materially lower bad debt exposure for many hospitals, particularly for services where the deductible accounts for a substantial share of the negotiated reimbursement.

High deductible plans have been responsible for an increasing share of bad debt expense in recent years. Exhibit 1 charts the growth in bad debt and incidence of high deductible plans over the last few years. High deductible plans are used to limit premium growth, but because they transfer greater financial risk to policy holders, they expose healthcare providers to bad debt.

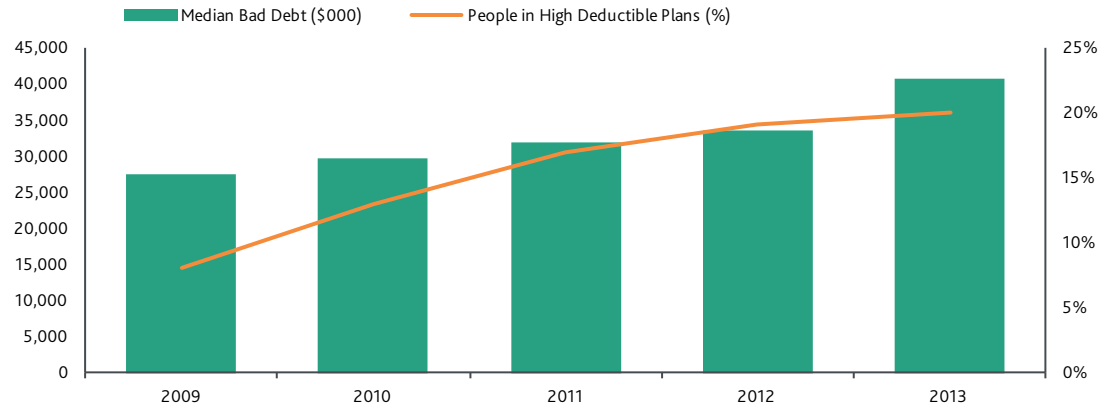
[2] RAC auditors review the medical necessity of Medicare admissions and can clawback payments for admissions not deemed medically necessary

[3] The two-midnight rule is likely to reduce hospital revenue and profitability in 2014. See Moody's sector comment "Two-Midnight Rule Will Reduce Revenue For Most Hospitals"

[4] http://www.gallup.com/poll/167798/uninsured-rate-continues-fall.aspx

EXHIBIT 1

Bad Debt Grows with Popularity of High Deductible Plans



Source: Moody's, Kaiser Family Foundation

Hospitals have few options to address this challenge. For elective procedures, they can require payment upfront or provide financial assistance. However, for non-elective procedures, hospitals often simply absorb the cost.

Over the long term, the financial incentives of high deductible plans could encourage patients to take a more active role in choosing healthcare providers; a small silver lining for hospitals that have strong brand names, or are perceived as low cost or high quality. This element of choice would provide opportunities for hospitals to gain market share for elective or lower acuity services by advertising prices and quality metrics.

To date, approximately 80% of the plans sold have been in the "bronze" or "silver" categories. Plans in these categories have very high deductibles, often at levels twice the national average of deductibles in employer sponsored plans, with estimates in the neighborhood of $5,000 for an individual and $10,000 for a family for bronze plans and $3,000 and $6,000 for silver plans.[5]

Insurance company profitability on the exchanges will impact hospital reimbursement in 2015

The insurance industry's profitability is a key factor in hospital reimbursement because insurance companies tie their negotiations with hospitals to their own expectations of profitability.

Insurance companies will begin pricing policies to be sold on the exchanges in 2015 in the next few months, and negotiations with hospitals will extend through the beginning of open enrollment in November[6].

Given the challenges insurance companies faced in 2014, we expect negotiations for 2015 hospital reimbursement levels to be dynamic, with insurers seeking additional reimbursement discounts and hospitals seeking to offset discounts through risk sharing arrangements that reward hospitals for controlling total medical expenditures, but also expose them to financial losses if medical expenses exceed budget.

[5] There is no national database of the cost of these plans nationwide, although various groups have conducted analyses of the plans sold on state and federal exchanges.

[6] Insurance exchanges are online marketplaces where individuals can shop for health insurance.

An additional challenging factor is that there is a strong chance premiums for exchange products will rise in 2015. This may cause more people to select plans with less coverage and higher deductibles, or simply not purchase insurance at all. Either outcome would be negative for hospitals as it would reduce net gains in insurance coverage.

Although insurance companies typically do not break out profitability by segment, Aetna Inc (Baa2 stable), Cigna Corporation (Baa2 stable) and Humana Inc (Baa3 stable) have all announced they expect to earn negative margins on their exchange business in 2014. We changed our outlook on the insurance industry to negative from stable in January reflecting the various changes to the ACA implemented after insurers had priced their policies.[7]

Enrollment statistics through February show that only 25% of those who have enrolled in the exchange for private healthcare insurance are in the critical 18-34-year-old age group, well short of the 40% target based on the proportion of eligible people in this age group. The way the exchange products are structured and priced, a sizable portion of these healthy individuals must enroll so their lower claim costs can subsidize the higher anticipated claim costs of less healthy individuals.

If narrow networks are successful, we expect hospital reimbursement to drop

Insurance companies are using narrow networks[8] to control costs and offer lower premiums. The risk to hospitals is that they are left out of networks, or accept lower rates in order to potentially gain market share. Hospitals that do join a narrow network suffer if the expected increase in volume does not materialize and the lower rates are insufficient to cover hospitals' fixed costs.

Despite the risks, there are strategies hospitals can adopt in order to succeed under narrow networks. Hospitals can take an active role and partner with insurance companies to market products designed to steer volume to their networks. In a similar vein, some hospitals have started their own insurance companies in order to create proprietary networks designed to compete with insurers directly.

There is also a significant chance that narrow networks will fail to gain traction on the insurance exchanges. A new federal proposal would require health insurers to expand the number of hospitals included in exchange networks, putting a damper on the trend of narrow network health plans.[9]

7 US Healthcare Insurers: Outlook Changed to Negative from Stable

8 Narrow networks refer to a group of hospitals, physicians, or other healthcare providers that have negotiated lower reimbursement rates with insurers. Insurers use them to lower cost and hospitals participate in the hope of offsetting lower payment rates with higher patient volumes.

9 Federal Proposal Helps Essential Hospitals But Discourages Narrow Networks

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» US Not-for-Profit Hospitals: 2014 Outlook, November 2013 (160569)

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» Two-Midnight Rule Will Reduce Revenue For Most Hospitals, March 2014 (165866)

» Health Exchanges are a Modest Credit Negative for Not-for-Profit Hospitals in 2014, October 2013 (159234)

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