Reducing Balance Sheet Risks and Managing Overall Capital Costs

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Presentation Topics

• Case Study: GSHS Debt Re-capitalization Strategy
• Current topics affecting health care providers
• Overview of current capital markets and health care financings
• Framework for making capital markets decisions
• Rating agency perspectives and common questions asked by analysts

Appendix
• Brief overview of health care reform and sector trends
GSHS Debt Re-capitalization Strategy

Good Shepherd Health System ("GSHS") is a three-hospital regional system based in East Texas; also, GSHS has five medical office buildings, 31 clinics, 10 EMS locations and 2 provider networks. It is rated "Baa2/Stable" and "BBB+/Stable". Total revenues (net of bad debt) in 2011 of about $360 MM

Key goals: Reduce capital-related risks on Balance Sheet, manage overall cost of capital and fund new projects

**Capital-related risks and opportunities facing GSHS**
- Existing mix of fixed to variable debt was 61% to 39%
- Minimize risk to variable rate underlying; swaps underwater $21MM
  - Collateral posting of $18MM resulting in lower DCOH
  - Risk of lower-rated counterparty meeting cash flow requirements
- 61% of existing debt exposed to volatility and increased costs due to fragile banking industry
- Potential risks in renewal of existing LOCs:
  - Higher costs
  - Possibility of non-renewal
  - All LOCs with one bank
- Market risks if credit/product events occur outside of GSHS’ control including put risk
- Attractive interest rate environment

**Objectives of multi-phased financing plan**
- Reduce risks in current capital structure (interest rate, LOC renewals, bank and counterparty credit ratings)
- Take advantage of low fixed rated to fund new projects
- Strengthen cash position by releasing funds in swap collateral accounts and existing DSRF
- Bring recently merged hospital into the GSHS Obligated Group
- Streamline MTI, reporting and financial covenant structure
- Ensure maximum flexibility for future financings

**GSHS Existing Debt Profile Before Re-Capitalization**

<table>
<thead>
<tr>
<th>Series</th>
<th>Par ($000)</th>
<th>Call Date</th>
<th>Final Maturity</th>
<th>Credit Enhancer (Expiration)</th>
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<tbody>
<tr>
<td>2002A</td>
<td>8,960</td>
<td>10/1/2012</td>
<td>10/1/2029</td>
<td>N/A</td>
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<tr>
<td>2002B (Tunable)</td>
<td>4,465</td>
<td>Non-Callable</td>
<td>10/1/2015</td>
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<tr>
<td>2004</td>
<td>13,730</td>
<td>Current</td>
<td>10/1/2015</td>
<td>5/25/2012</td>
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<tr>
<td>2005A</td>
<td>10,000</td>
<td>Non-Callable</td>
<td>10/1/2016</td>
<td>N/A</td>
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<tr>
<td>2006B</td>
<td>42,500</td>
<td>Current</td>
<td>10/1/2029</td>
<td>3/6/2013</td>
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<tr>
<td>2006C</td>
<td>42,500</td>
<td>Current</td>
<td>10/1/2029</td>
<td>3/6/2013</td>
</tr>
<tr>
<td>2010</td>
<td>40,595</td>
<td>7/1/2013</td>
<td>7/1/2020</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>$162,370</td>
<td></td>
<td></td>
<td></td>
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</table>

*Swap counterparty rated "Baa1"
GSHS Debt Re-capitalization Strategy

Phase I: Replace LOC

Phase I: Replace expiring Letter of Credit ("LOC") backed Variable Rate Demand Bond ("VRDB") to secure a higher rated bank, reduce fees and match LOC renewal date with final maturity

- Existing LOC bank exited the LOC business and had lower credit ratings resulting in higher rates to GSHS
- Process: Conducted RFP process for bank LOC and Bank Direct Purchase ("BDP") interest. Needed multiple banks in order to secure sufficient bank capacity for both LOC and BDP transactions ($100MM)
- Issues: Timing of securing LOC bank commitment coincided with finalization of year-end audit. Needed to negotiate with two banks and their counsels on financial and reporting terms to finalize audit
- Result: Secured more highly rated bank (from "A3/A-" to "Aa3/A+"), reduced annual LOC fees by 20 bps which immediately resulted in better rate performance. Expected annual savings of $126,000

Phase II: Convert LOC-backed VRDBs to BDPs

Phase II: Convert LOC-backed VRDB with BDP

- Re-evaluating risk profile of capital structure in light of external factors such as declining bank credit ratings and thus, higher interest costs
- Process: Educated the Board as to the risks of VRDB compared to BDP including mechanics of BDP structure
- Issues: Managing business requirements of banks for new business and securing aggressive terms. Protracted negotiations with banks and their counsels regarding financial covenants and terms including importance of staggered renewal dates
- Result: Elimination of VRDB related risks, maintained interest rate swaps, all-in attractive net rates (after swaps) of 5.26% and 5.32%, no renewal issues until 2016 and 2019
Phase III: Novate swap and increase collateral thresholds

- Re-evaluating risk profile of capital structure in light of external factors such as counterparty credit ratings. Existing counterparty was rated “Baa1”. Under existing swap, collateral posting threshold of $2.5MM with termination costs of approximately $21MM
- **Process:** Conducted swap competitive process to seek interest by more highly rated counterparties at reasonable pricing and better collateral thresholds
- **Issues:** Finding sufficient capacity and more highly rated counterparties agreeable to higher collateral threshold
- **Result:** Secured interest from two banks rated “Aa3/AA-” and “Aa3/A+”, replacing lower rated swap counterparty while eliminating basis risk. Increased collateral threshold resulted in release of $5MM. Due to current interest rates, GSHS can continue to take advantage of synthetic structure and make decision to terminate swaps when more feasible to do so

Phase IV: Issue fixed rate bond issue

- **Process:** Traditional fixed rate financing followed bank deals including credit rating agency reviews, due diligence, updating Appendix A and disclosure documents
- **Issues:** Weighted average life of assets being financed was a constraint. Tax requirement resulted in separation of bank deals from fixed rate offering. Decision regarding extending life of existing bond issue
- **Result:** Locked in fixed rate financing for new money and generated net PV savings of $1.2MM from refinancing of existing bonds. Consolidated into one MTI for GSHS and newly merged entity. Streamlined reporting and compliance.
GSHS Debt Re-capitalization Strategy
Execution of Financing Plan

Accomplished goals

✓ Reduced risks in current capital structure (interest rate, basis, LOC renewals, put, credit ratings)
✓ Funded new capital projects with attractive fixed rates
✓ Brought recently merged hospital into the GSHS Obligated Group
✓ Restructured swaps that reduced counterparty risks and/or increased collateral thresholds
✓ Strengthened cash position from swap releases and existing bond issue
✓ Structured documents to provide ample future flexibility

Current Topics Affecting Health Care Providers

• Health care spending ($2.7 Tn or 18% of GNP in 2011) at slowest growth rate of 3.9% (compared to 7.6% in 2007 and double digits in 1990’s)
  — Factors include recession, growth of consumer out-of-pocket spending
• Medicare spending rose from 4.3% in 2010 to 6.2% in 2011
  — One-time jump in SNF payments and increased use of physician services
• Medicaid spending growth declined from 5.9% in 2010 to 2.5% in 2011
  — Budget tightening by States
  — Medicaid is top State budget concern
  — Implementation of state exchanges and potential costs to consumers
• “Fiscal Cliff” agreements will mean more cuts for hospital industry
  — $15 Bn in new hospital cuts
  — $10 Bn in "coding creep" and $4.2 Bn in rebasing disproportionate share payments
  — “Docs versus hospitals”
Current Topics Affecting Health Care Providers

- Changes to financial institutions and tax code that could impact providers’ market access and cost of capital
  - Banks win 4 year delay in meeting liquidity coverage ratio
  - Possible limitation on income-tax deduction for tax-exempt bonds and potential impact on investors and providers’ cost of capital

- Administration may use Medicare reform as “incubator” for broader health care change—Tanden’s proposed policies: “The Senior Protection Plan” from the Center for American Progress entitled “$385 Billion in Health Care Savings Without Harming the Beneficiaries”. Highlights include:
  - Competitive bidding for all health care products and Medicaid managed care programs
  - Form “accountable care states”
  - Accelerate use of new payment methodologies
  - Use FEP to reform delivery system
  - Reform GME and workforce
  - Reduce excessive payments for inpatient and outpatient services
  - Cut administrative costs and improper payments

Key Economic Indicators
National Trends 2002 - 2012

- National Unemployment
- US Debt as % of GDP
- Consumer Sentiment Index
- S&P 500 Index

- (1) US Bureau of Labor Statistics
- (2) www.usgovernmentspending.com
- (3) University of Michigan
- (4) Bloomberg
Key Economic Indicators
National Health Care Trends 2002 to 2012

- US Health Care Spending % of GDP
- US Medicare Spending ($B)
- Gross National Health Expenditures ($B)
- Per Capita Health Care Spending ($)

(1) www.cms.gov (2) OECD Health Data 2011, Source year 2010

Capital Markets Trends
Historical Yield Analysis

(1) The Bond Buyer Revenue Index consists of revenue bonds of 25 issuers with a 5-year final maturity and an average rating of AA/A.
(2) Securities Industry and Financial Markets Association Index - Previously called the Bond Market Association Municipal Swap Index.

Source: Bloomberg
Capital Markets Trends
The Non-”Whitney” Effect

- Contrary to Meredith Whitney’s 2010 prediction, sizeable defaults did not materialize, healthy fund inflows returned in Q4 2011 and have continued into 2012
  - Strong investor demand and the low interest rate environment have led to historically attractive fixed rates for borrowers
- In 2012, the municipal long-term bond market has posted inflows 48 out of 52 weeks for an aggregate inflow total of $27.401 billion, indicating that buyers are making a strong return to the municipal bond market
- In recent weeks, bond funds have seen outflows due to concerns over the Fiscal Cliff and the possibility that municipal bonds could lose their tax-exemption

(1) Sources: The Bond Buyer and TM3.com

Capital Markets Trends
Current Health Care Yields and Key Indicators

Health Care Yields

<table>
<thead>
<tr>
<th>Maturity</th>
<th>AAA-BBB</th>
<th>Treasury</th>
<th>A</th>
<th>Baa</th>
<th>NR</th>
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<td>1</td>
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<td>2</td>
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<td>0.25%</td>
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<td>5</td>
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<tr>
<td>7</td>
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<tr>
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<tr>
<td>10</td>
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<tr>
<td>15</td>
<td>0.80%</td>
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<tr>
<td>20</td>
<td>1.00%</td>
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<tr>
<td>30</td>
<td>1.20%</td>
<td>1.20%</td>
<td>1.20%</td>
<td>1.20%</td>
<td>1.20%</td>
</tr>
</tbody>
</table>

BBRRBI

SIFMA

(1) Rates provided by Bloomberg
(2) Rates provided by Bloomberg
**Capital Markets Trends**

**Historical Spread Analysis**

![Spread Analysis Chart]

- "AAA" Spread Over "AAA"
- "AA" Spread Over "AAA"
- "A" Spread Over "AA"
- "BBB" Spread Over "A"

**Source:** Cain Brothers

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**Capital Markets Trends**

**Municipal Bond Issuance Volume**

![Issuance Volume Chart]

**Health Care Tax-Exempt Bonds as Portion of Total Tax-Exempt Bonds**

- **2006:** $336 bn
- **2007:** $368 bn
- **2008:** $326 bn
- **2009:** $351 bn
- **2010:** $343 bn
- **2011:** $262 bn
- **2012 YTD:** $316.15 bn

**Source:** Bond Buyer; 2012 Year to Date, data excludes December 2012 results
Financial Structure Trends
Health Care Bond Issuance by Structure
(Excludes Bank Placement Issues)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Par Amount ($MM)</th>
<th>Fixed</th>
<th>Variable</th>
</tr>
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<tbody>
<tr>
<td>2008</td>
<td>$24,778</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>2009</td>
<td>$32,006</td>
<td>72%</td>
<td>28%</td>
</tr>
<tr>
<td>2010</td>
<td>$25,091</td>
<td>86%</td>
<td>14%</td>
</tr>
<tr>
<td>2011</td>
<td>$20,636</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>2012</td>
<td>$24,207</td>
<td>81%</td>
<td>19%</td>
</tr>
</tbody>
</table>


Rating Agencies Perspective
Health Care Outlook

**Outlook: Negative**
- In 2011, downgrades exceed upgrades 36 to 25
- Low revenue growth projections over the next 18 months due to significant reimbursement pressures from both government and commercial payors
- Sluggish economic recovery has negatively impacted demand and payor mix
- A growing population over 65 is expected to be a source of demand
- Increase in the number of insured patients expected to partially offset lower reimbursement rates
- Regulatory uncertainty exists due to the ability of states to opt out of Medicaid expansion under the Supreme Court ruling
- Increased acquisition of physician practices creates additional financial burdens and can not be financed with tax-exempt debt
- Expect movement towards greater alignment between providers

**Outlook: Stable/Challenging**
- In 2011, upgrades exceeded downgrades 50 to 31
- Pending federal budget sequestration, reform implementation, and state budgetary pressures will make the future environment challenging
- Despite strong revenue growth in 2011, margins remained flat due to increased physician employment and EMR system costs
- Health care reform remains controversial with no major impact expected until 2014
- Revenue sources will be constrained due to Medicare, Medicaid and commercial insurance rate reductions
- CMS is expected to continue unabated, including stable single-site facilities that have previously opted to remain independent
- Increased physician integration is expected to continue through 2012

**Outlook: Stable**
- Downgrades have outpaced upgrades, 10 to 9 during the first six months of 2012
- Affirmations are expected to be the predominant rating action in hospital sector during 2012
- Operating performance is predicted to remain stable due to shared service consolidation, supply chain improvements, and operating efficiencies
- Capital expenditures are expected to remain muted
- Hospitals will continue to move certain services into outpatient settings to take advantage of lower costs
- Elements of health care reform scheduled to take effect in 2012 should have minimal impact on financial performance
- An increasing number of stand-alone providers will realize the need for size and scale to drive efficiencies

Sources:
- Moody’s “U.S. Not-For-Profit Healthcare Mid-Year 2012 Outlook”, August 21, 2012
- Moody’s “U.S. Not-For-Profit Health Care System Rations”, August 11, 2012
- S&P “U.S. Not-For-Profit Standalone Hospital Ratings”, August 13, 2012
Rating Agencies Perspective
Health Care Ratings Upgrades to Downgrades

Agency Upgrades/Downgrades

2008 2009 2010 2011 1st Half 2012
Upgrades 27 21 41 24 21
Downgrades 55 56 46 36 23

Rating Agencies Perspective
Capital Access

Larger systems are generally rated in higher rating categories compared to stand-alone hospitals

2012 Distribution of Not-for-Profit Providers Across Bond Rating Categories

Rating Agencies Perspective
Not-For-Profit Health Care Median Trends
Free-standing hospitals and single-state health care system medians for all rating categories

Cash-to-Debt (%)
Net Patient Revenues ($000)
EBIDA ($000)
Debt-to-Capitalization (%)

Rating Agencies Perspective
Not-For-Profit Health Care Median Trends (Cont’d)
Free-standing hospitals and single-state health care system medians for all rating categories

Operating Margin (%)
Maximum Annual Debt Service Coverage (x)
Days Cash on Hand (days)
Average Age of Plant (years)

Source: S&P’s U.S. Not-For-Profit Stand-Alone Hospital Ratios (July 13, 2012)
Capital Markets Decision Making
Common Questions from Rating Agencies and Investors

• What is the strategic vision and mission of the organization?
  – Is your organization engaged in affiliation/merger discussions?
  – What investments and improvements are being made?
  – How will the organization achieve the vision/mission?

• What are the potential impacts of Health Care Reform on the organization?
  – How prepared is the organization to adopt the changes?
  – Any legislative issues that may negatively/positively impact operations?

• What is the competitive climate?
  – Market share of PSA and SSA trends
  – What is the organization’s competitive edge?
  – Volume/utilization trends

• What are the payor mix and physician strategies?
  – Is the organization profitable under Medicare?
  – What is the profitability of managed care contracts and status of any ongoing negotiations?
  – What are the organization’s physician strategies (recruitment/retention)?

• How is the organization managing its operations and cost structure?
  – What are cost containment initiatives underway?
  – What IT systems are being used or implemented?
  – Is organization properly configured to meet changes in clinical practice patterns?

• How effective is your organization’s fund raising efforts?

Range of Financing Options
Strengths and Considerations

<table>
<thead>
<tr>
<th>Fixed Rate</th>
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<tbody>
<tr>
<td>Typically 30 year amortization with 10 year call</td>
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<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>Lowest risk – transfers all financial risks to bondholders</td>
</tr>
<tr>
<td>No interest rate, renewal, bank credit risks</td>
</tr>
<tr>
<td>Increasing market for taxable issues</td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
</tr>
<tr>
<td>Higher cost</td>
</tr>
<tr>
<td>Limited flexibility prior to call date; can be important if future plans change</td>
</tr>
<tr>
<td>Extensive disclosure required</td>
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<tr>
<td>On-going disclosure requirements</td>
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<table>
<thead>
<tr>
<th>Variable Rate Demand Bonds (“VRDB”)</th>
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<tbody>
<tr>
<td>VRDB structured with Bank Letter of Credit (“LOC”)</td>
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<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>Attractive low rates and LOC fees</td>
</tr>
<tr>
<td>Renewal flexibility in advance of expiration</td>
</tr>
<tr>
<td>Structural flexibility</td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
</tr>
<tr>
<td>Interest rate: May rise</td>
</tr>
<tr>
<td>Renewal: Must be renewed periodically</td>
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<tr>
<td>Bank Credit: Rate will increase if bank credit is downgraded</td>
</tr>
<tr>
<td>Likely additional covenants</td>
</tr>
<tr>
<td>Ancillary commercial banking business potentially required</td>
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<table>
<thead>
<tr>
<th>Bank Direct Purchase (“BDP”)</th>
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<tbody>
<tr>
<td>Bank purchases bonds and holds for specific time</td>
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<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>Attractive direct placement rates</td>
</tr>
<tr>
<td>Initial terms up to 10 years</td>
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<tr>
<td>No credit exposure to direct placement bank</td>
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<tr>
<td>No remarketing fees</td>
</tr>
<tr>
<td>Fixed rate possible</td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
</tr>
<tr>
<td>Higher cost than VRDB</td>
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<tr>
<td>Amortization potentially shorter than traditional tax-exempt debt</td>
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<tr>
<td>Likely additional covenants</td>
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<td>Some commercial banking business potentially required</td>
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<table>
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<th>Floating Rate Notes (“FRN”)</th>
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<td>FRNs rate structured as spread to SIFMA</td>
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<tr>
<td><strong>Strengths</strong></td>
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<tr>
<td>Attractive variable rates</td>
</tr>
<tr>
<td>Initial terms 3 to 7 years</td>
</tr>
<tr>
<td>SIFMA index plus spread</td>
</tr>
<tr>
<td>No bank needed</td>
</tr>
<tr>
<td>No VRDB exposure</td>
</tr>
<tr>
<td>No new covenants</td>
</tr>
<tr>
<td>Maximize average life</td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
</tr>
<tr>
<td>Slightly higher cost than LOC &amp; BDP options</td>
</tr>
<tr>
<td>Depending upon term, hard put</td>
</tr>
<tr>
<td>Newer market than LOC, VRDB and BDP for health care issuers</td>
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Capital Markets Decision Making
Key Financing Considerations

- What is the risk tolerance of the organization? Risks include:
  - Balance Sheet management
  - Product type
  - Bank exposure
  - Capital markets volatility and perspective
- What is appropriate mix of fixed and variable?
  - Board perspective
  - Credit rating implications
  - Bank capacity
  - Current market conditions
- Are there any future capital projects that need to be financed?
- Are there any challenging financial covenants?
- Does the organization have bank capacity (both liquidity and line)?
- If pursuing bank options (VRDB or BDP), are there any additional covenants and ancillary business requirements?
- What is the current level of debt capacity?
- What is impact of incremental debt on key financial ratios and credit rating(s)?

Appendix:

Brief overview of health care reform and sector trends
Health Care Reform
Key Provisions

Health Care Reform ultimately became Insurance Reform and will significantly impact systems/hospitals

- **Hospitals**
  - Medicare reimbursement to hospitals reduced by $150 BN over 10 years; more cuts under recent Fiscal Cliff legislation
  - New reimbursement models (bundled payments) will lower reimbursement to hospitals
  - New payment penalties for hospitals with high readmission rates

- **Insurers**
  - Individual mandate to obtain health insurance
  - Extends dependent coverage to children up to 26 years of age
  - Employers with 50+ employees required to offer insurance
  - State insurance exchanges to be established
  - Insurers cannot deny coverage due to pre-existing conditions
  - Medicaid eligibility will be expanded to 133% of the poverty line
  - More aggressive review of rate increases

- **Funding for Health Care Reform**
  - 59% would be funded by provider cuts
  - Remaining 41% would be funded by tax increases

Health Care Reform Major Goals

- **Increase Access**
  - Medicaid expansion
  - SCHIP expansion
  - Subsidies for low income households
  - Long-term care expansion (new)
  - Insurance reform (e.g., pre-existing conditions, lifetime limits, premium reviews, health exchanges)
  - Expansion of community health services & primary care

- **Reduce Costs**
  - Comparative effectiveness
  - Medical home
  - Preventive health
  - Bundled payments
  - Accountable care organizations (ACOs)
  - Center for Innovation
  - Value-based purchasing
  - Administrative simplification
  - Fraud and abuse surveillance
  - Leverage government purchasing power
  - Independent Medicare Payment Commission

- **Improve Quality**
  - Comparative effectiveness
  - Essential benefits: HHS
  - Electronic health records (EHRs)
  - Workforce re-design
  - Delivery system integration
  - LTC expansion
  - Connect health & human services
  - Focus on under-served populations
  - Overhaul FDA and CMS

Source: Deloitte Center for Health Solutions, Health Reform
Health Care Reform
Implementation Timetable

- Elimination of pre-existing coverage exclusions for children and lifetime coverage limits and rescissions
- Dependent coverage through age 26
- Medical Loss Ratio (MLR) minimums for non-grandfathered plans
- Medicare Part D (senior pharmacy benefit) gap narrows; Medicare Advantage (MA) rates frozen, bonuses available, beneficiary relates, free preventive care
- Temporary high-risk pools
- Fee on brand-name pharmaceutical manufacturers
- Hospital facing penalties for avoidable re-admissions within 20 or 30 days of discharge

**Major Expansion of Coverage (2014)**
- Mandates on individuals
- Employer penalties for those that do not provide coverage (some exceptions apply to small businesses)
- Health insurance exchanges
- Small employer and individual subsidies
- Health insurer industry fee
- Guaranteed issue, rating bands and risk adjustment
- Medicaid expansion (~16 million new covered beneficiaries)
- Disproportionate share payment reductions to hospitals

**Bending the Cost Curve (2015 - 2020)**
- Penalty for not adopting electronic medical records (EMRs)
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax (“Cadillac plans”)
- Medicare Part D “doughnut hole” closures
- Reduced payment for hospital-acquired conditions

**Health Care Reform Potential Impact: Positive for Providers**

- Higher utilization due to increased number of insured lives starting in 2014
  - Medicaid and SCHIP ranks to increase by ~16 million beneficiaries, but some offset by Supreme Court of the United States (SCOTUS) ruling
- Exchanges to provide coverage to ~24 million beneficiaries less ~8 million decline in employer-sponsored, non-group and over-coverage
  - Lower bad debt from self-pay population (should improve margins and cash flow)
  - Independent Medicare Advisory Board cannot affect hospitals until 2020
Health Care Reform
Changing Reimbursement Structure

• Move to fee-for-value via carrot-and-stick approach
  – ACOs – shared savings relating to patient populations
  – Bundled payments – payment for episodes of care, demonstration pilots
  – Value-based purchasing – payment for quality outcomes starting in 2013
  – Re-admission penalties starting October 1, 2012
    o MedPAC recommends including post-acute providers too
• Pushes hospitals and physicians closer together to manage populations and achieve lower costs and cost savings from care coordination
  • Bigger scale required
    – Clinical and financial IT is expensive
  • Consolidation continuing
    – Industry consolidation is in full swing with payers looking at providers and vice versa

Health Care Reform
Challenges Facing Providers

• Increasing Medicare population (“Baby Boomers”)
  – Medicare margins are low, need to adjust infrastructure and operating costs
• Increasing Medicaid population
  – Medicaid covered ~57 million lives and is projected to increase by ~68 million by 2014
  – PPACA projected to add another ~26 million to Medicaid and SCHIP by 2019
  – Medicaid margins are even lower and are constrained by state budget deficits
  – Lower disproportionate share hospital (DSH) payments
    o PPACA reduces funding for the Medicaid DSH program by $17.1 billion between 2014 and 2020
• Quality reporting
  – Need to stay out of the lower quartiles
  • Shortages of medical professionals
    – Physicians: 160,000 in 2025 (Est.)
    – Nurses: 260,000 in 2025 (Est.)
Health Care Reform

Key Aspects of Supreme Court Ruling

On June 28, 2012 the Supreme Court upheld the key provisions of PPACA by a 5-4 decision

- **Individual Mandate**: Upheld
  - Should benefit providers, especially hospitals, which have bad-debt expense exceeding 10% of revenue, on average
- **Medicaid Expansion**: Upheld, more or less
  - Positive for Medicaid plans
  - Congress cannot compel states to participate in expansion by withholding funds for current Medicaid programs
  - Puts decision making at the state level with 37 current Republican governors
  - State incentive – Federal government fully funds the Medicaid expansion for first three years

Key Issues

State Medicaid Shortfalls

State economies are still struggling but effective budgeting helps to reduce the pressure

- States economies were forced to dramatically increase FY2012 state spending for Medicaid by 28.7% (due to Medicaid stimulus funds that expired June 2011)
- Compared to 2011, adopted budgets for FY2012 assumed total Medicaid spending growth of only 2.2% (near record lows) as well as slower enrollment growth
- For FY2012, majority of states experiencing Medicaid spending and enrollment growth equal to or below original growth projections, and 10 states reported mid-year Medicaid cuts

- While Texas has an $8 billion reserve, it is still facing a $4.3 bn Medicaid deficit

Source: Kaiser Family Foundation, February 2012
Hospital transactions have been exceptionally strong over the last two years.

Over the past 15 years the average number of deals was 72 annually.

Among major 2011 & 2012 transactions include:

- Catholic Health East merges with Trinity Health
- Vanguard’s joint venture with Valley Baptist Health System (Cain Brothers’ client)
- HCA purchase of Catholic Health East’s Mercy Hospital in Florida
- Jewish Hospital & St. Mary’s Healthcare merger with Saint Joseph Health System
- Emory’s joint venture with Saint Joseph’s Health System in Atlanta (Cain Brothers’ client)
- Lahey Clinic’s affiliation with Northeast Health System (Cain Brothers’ client)
- Beaumont Health System’s merger with Henry Ford Health System
- Baylor and Scott White signed an agreement of intent to merge

Joint-ventures with for-profit health care systems are increasingly used to address key challenges

- Capital constraints
- Market consolidation

Not-for-profit systems continue to have a significant role in transaction activity

- 79% of all transactions since 2001 have involved a not-for-profit system as either a target, acquirer or both