

## OUTLOOK

4 December 2017

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Not-for-profit and public healthcare - US

## 2018 outlook changed to negative due to reimbursement and expense pressures

**Our negative outlook indicates our expectations for the fundamental credit conditions driving the not-for-profit and public healthcare sector over the next 12-18 months.**

We revised the US not-for-profit and public healthcare outlook to negative from stable based on our projections that operating cash flow will contract by 2%-4% over the next 12-18 months. Revenue growth is under pressure because of very low reimbursement rate increases, an ongoing rise in government payors and a continued shift to high deductible plans. We expect rapid expense growth to outpace revenue growth with high labor costs, nursing shortages and rising bad debt.

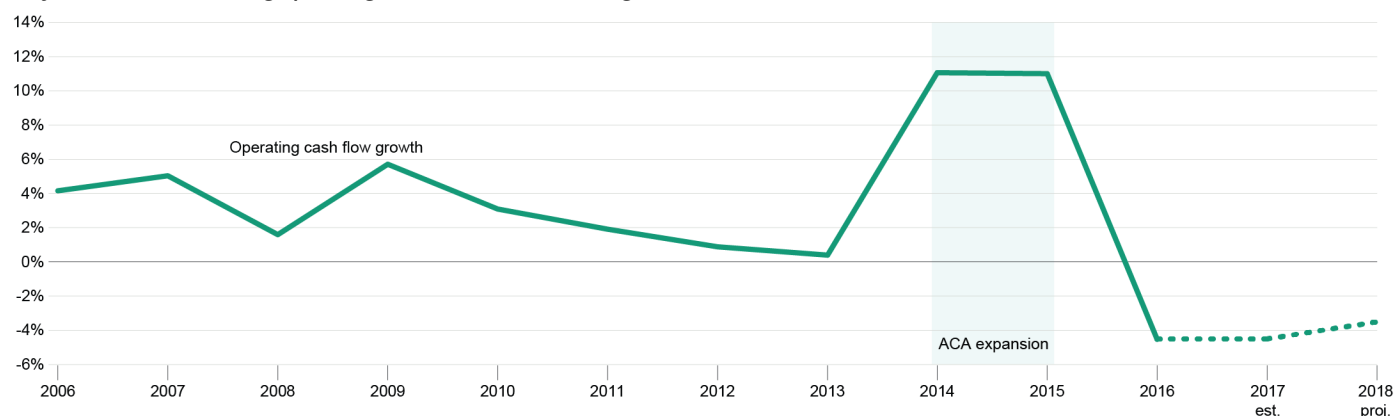
- » **Operating cash flow will contract by 2%-4% in 2018.** Operating pressures are accelerating at hospitals because of low revenue growth and untamed expense growth.
- » **Low reimbursement rates drive slowed revenue growth despite consistent volumes.** Hospitals are unable to translate volume increases into stronger revenue growth because of below inflationary growth of reimbursement rates and rising bad debt.
- » **Expense pressures further compress margins.** Nursing shortages, continued physician and medical specialist hiring, as well as technological investments are accelerating expense growth. Bad debt will grow in 2018 with high deductibles, rising copays, and contracting exchange enrollment because of changes in federal marketing.
- » **Federal policy will have marginal near term direct impact, but continued uncertainty is credit negative.** Federal healthcare policy actions to date will have a negative effect on a small segment of hospitals that we rate. Uncertainty around the Affordable Care Act (ACA) makes it very difficult for hospitals to effectively plan and model long-term strategies. Recent federal tax proposals will also contribute to rising costs for hospitals.
- » **Heightened operating pressure will drive additional consolidations.** We expect that mergers and acquisitions will continue at a rapid pace as smaller and more rural hospitals struggle for financial stability.
- » **What could change the outlook.** Resumed operating cash flow growth of 0%-4% over a 12-18 month period, after accounting for healthcare inflation, could drive a change to stable. A positive outlook could result from expectations of accelerated operating cash flow growth of more than 4% after inflation. Long-term resolution of federal policy or positive regulatory changes could result in a change in outlook.

## Operating cash flow will contract by 2%-4% in 2018

Operating cash flow declined at a more rapid pace than expected in 2017, and we expect continued contraction of 2%-4% through 2018. The cash flow spike from insurance expansion under the ACA in 2014 and 2015 has largely worn off, but cash flow has not stabilized as we had expected because of a low revenue/high expense growth environment (see Exhibit 1). Top-line revenue growth is still strong, but diminished from previous years because of constrained reimbursement rate increases. Margins and operating cash flow will compress as expenses and bad debt continue to rise.

Exhibit 1

### Projections for contracting operating cash flow underscore negative outlook



Source: Moody's Investors Service

## Low reimbursement rates drive slowed revenue growth despite consistent volumes

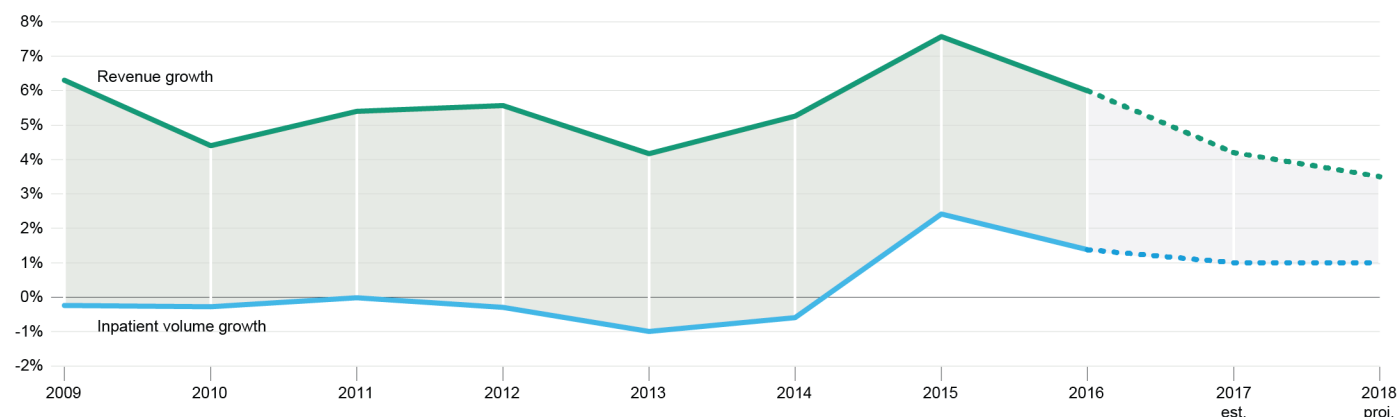
Revenue growth is slowing, and we expect it to remain slightly above medical inflation for hospitals and systems that we rate. Growth will be largely based on expansion strategies founded upon continued acquisitions, including outpatient sites and physician practices, rather than same store revenue growth. This projected level of growth would represent a steady three-year decline in revenue growth off a recent peak in 2015, and the slowest revenue growth since 2013.

Hospitals have not been able to translate relatively stable volumes into stable revenue growth because of lower reimbursement rate increases across all insurance providers (see Exhibit 2). In 2018, inpatient volume growth will remain low as care continues to shift to less costly outpatient services, and patients defer or make alternative choices because of higher deductibles and copays. A small rise in the percentage of uninsured population (see federal policy section) will also contribute to lower inpatient volumes.

*Because our outlooks represent our forward-looking view on credit conditions that factor into our ratings, a negative (positive) outlook suggests that negative (positive) rating actions are more likely on average. However, the outlook does not represent a sum of upgrades, downgrades or ratings under review, or an average of the rating outlooks of issuers in the country or sector, but rather our assessment of the main direction of credit fundamentals within the country, region or sector.*

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Exhibit 2

**Low reimbursement rates compress revenue growth relative to volumes**

2017 is estimated based on year-to-date financials from a sample of hospitals.

Source: Moody's Investors Service

Growth of governmental payors will dampen revenue growth for the foreseeable future due to a rapidly aging US population and low reimbursement rates. Most reimbursement rates will hover below medical inflation, which declined to a low 1.6% in September 2017.<sup>1</sup> Governmental payors, including Medicare and Medicaid, represent 61% of gross patient revenue in 2016 (see Exhibit 3). Medicare, the majority revenue source, continues its multi-year trend of very low reimbursement rate increases, with inpatient admission rates growing by just 1.3% in 2018.<sup>2</sup> Medicare growth has been low, in the 1%-2% range over the last several years, and is not expected to grow substantially in the near term. Medicaid reimbursement rates will vary by state, but with [burgeoning Medicaid expenses](#), many states have begun to make cuts or are delaying payments.

Exhibit 3

**Increasing reliance on government payors will temper revenue growth**

% of gross patient revenue by payor type



Source: Moody's Investors Service

We estimate that commercial insurers, which represent about one-third of gross patient revenue, will raise rates at about inflation and lower insurance coverage. Many are also cutting services or increasing denials to control costs, often squeezing hospitals' higher margin service lines. For example, [Anthem, Inc.](#) (Baa2 stable, P-2) recently announced that it will no longer reimburse for certain MRI services at hospital-based centers due to high costs. Insurers and employees continue to shift costs to the patient through growth in high-deductible plans, which increases hospitals' copay collection burdens and will likely increase bad debt.

## Rapid expense growth and rising bad debt will further compress margins

Expense growth will remain higher than revenue growth, a key driver of operating cash flow contraction. Median expense growth is usually at around 5%-6%, but grew to [recent peak of 7.2% in fiscal 2016](#). The key driver of expense growth through 2018 will continue to be high labor costs. Nursing shortages remain acute — especially in urban centers, medical specialist fees are rising and hospitals continue to hire additional physicians. Recent upgrades of technological platforms and electronic medical records systems are increasingly requiring additional information technology staff as hospitals adapt processes and train staff on new systems. We expect supply costs to continue on a normal growth trend, with the recent spike in [pharmaceutical costs](#) subsiding over the near term. [Pension costs](#) will continue to grow for private hospitals with the federal government's pension guarantee agency (Pension Benefit Guaranty Corporation, or PBGC) premium step ups through 2019.

Rising costs will disproportionately affect small independent hospitals (less than \$400 million in revenues) which represent 23% of the hospitals that we rate. These hospitals are at a disadvantage in negotiating with vendors as well as with attracting physicians. They have fewer financial resources and therefore it is difficult to match the salaries and benefits offered by larger urban systems.

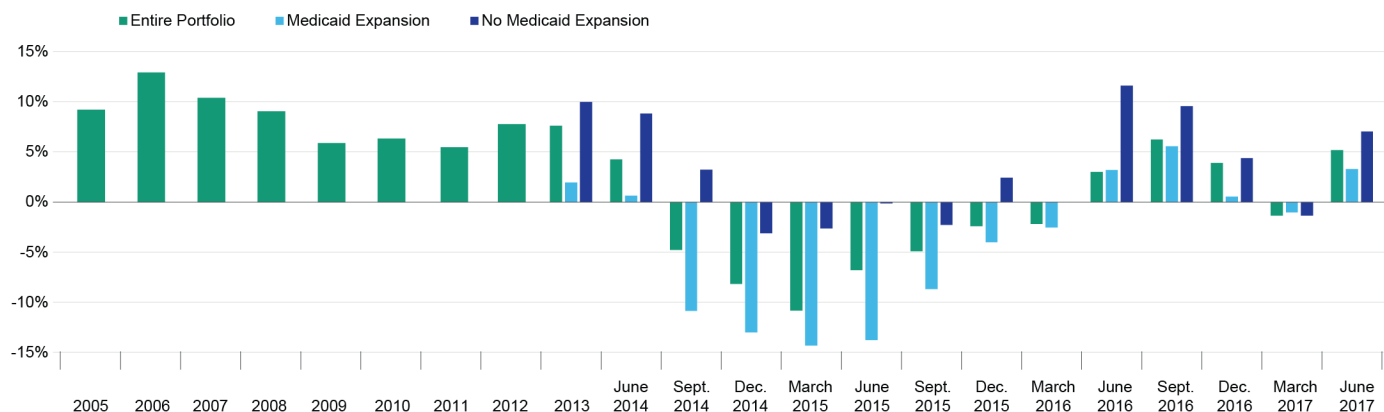
Academic medical centers will continue to have higher expense growth rates than other not-for-profit hospitals, offset by stronger revenue growth. Some factors contributing to elevated expenses at AMCs include: high infrastructure investments to maintain strong research, elevated recruiting costs to attract faculty and medical specialists, and financial transfers to associated medical schools.

## Rising bad debt adds further pressure

We expect bad debt to grow 6%-7% in 2018, up from 5% in 2017, and slightly higher than revenue growth adding to margin pressures (see Exhibit 4). Reduced federal marketing and promotion of the ACA's exchange marketplaces will marginally increase the number of uninsured people, causing bad debt to grow at a somewhat faster pace than last year. Rising copays and use of high deductible plans will increase bad debt for both expansion and non expansion states.

Exhibit 4

### Bad debt is growing as benefits from exchanges moderate



Source: Moody's Investors Service

## Federal policy to date has marginal direct effect, but continued uncertainty and recent tax proposals are credit negative

The Trump administration has issued several executive orders that perpetuate the uncertainty around longer term stability of the individual marketplaces for health insurance, known as the exchanges. The recent actions would be largely credit negative for not-for-profit hospitals, but the immediate effect will be muted because most insurance premium rates are in place through 2018, and the populations affected by these orders are relatively small.

However, although we anticipate that any changes to policy will be rolled out slowly, the prolonged uncertainty around the future of federal policy creates a difficult environment for long-term planning.

The [recent executive orders](#), CMS rulings and legislative proposals are largely credit negative, but with varying effect:

- » **Repeal of individual mandate:** A repeal of the individual mandate has been included in tax reform legislation. A repeal would cause some individuals to forgo insurance; a larger uninsured population would raise uncompensated care costs for hospitals, which is credit negative.
- » **Association health plans and expansion of short-term health plans:** The order to consider proposing new rules or revising existing ones to ease regulations on association health plans and expand the definition of short-term health insurance, which is not subject to ACA rules, will not have an immediate effect. Any changes developed would take several months to draft and enact. However, if introduced, the 10 million to 12 million unsubsidized individuals now in the ACA marketplaces or on the exchange could be swayed to lower cost, less comprehensive health insurance plans. This would have a negative impact on hospitals, driving up uncompensated care costs as fewer services are covered by non-ACA compliant plans.
- » **ACA advertising and promotion:** The shorter enrollment period and greatly reduced marketing budget for the ACA insurance exchanges will result in a modest uptick of uninsured in 2018. A larger uninsured population would raise uncompensated care costs for hospitals, which is credit negative.
- » **Cost-sharing reduction (CSR):** The administration's order would end the federal government's about \$7 billion of CSR reimbursement payments to insurers that provide ACA-mandated subsidies of out-of-pocket costs and deductibles for certain low-income exchange enrollees. About 80% of people on the exchanges are subsidized. This change would primarily affect the 20% who are not subsidized, leading to higher insurance premiums, which is credit negative for not-for-profit hospitals because individuals may choose to discontinue coverage.
- » **Disproportionate Share Hospital (DSH) program:** The Medicaid DSH program was cut by \$2 billion, effective October 1, 2017, with additional cuts scheduled to take place each year over the next eight years. Medicare DSH payments are rising a very low 0.7%. The greatest impact will be felt largely by safety-net hospitals whose uncompensated care will increase.
- » **Children's Health Insurance program (CHIP):** Potential discontinuation of CHIP would impact about 9 million children and mothers. The largest impact would be to children's hospitals, which tend to have very strong fundraising and balance sheets to help offset near-term revenue loss.
- » **Reductions to 340b drug program:** The recently enacted 30% reduction to Medicare Part B drug reimbursement to [340B hospitals](#) will not, on its own, have a material effect on most not-for-profit hospitals. However, the reductions will be a significant challenge for hospitals with low financial flexibility to absorb small revenue changes. We estimate that total 340B savings for all covered entities was about \$6.9 billion in 2016.
- » **Tax proposals:** Recent tax proposals from the House and Senate would be credit negative for not-for-profit healthcare. If enacted, the changes would drive up the cost of capital, contributing to greater merger and acquisition activity. Smaller hospitals would be less able to afford higher interest rate costs in the taxable market, and in order to meet capital needs, would likely look to find partners.

### Heightened operating pressure will accelerate consolidation

Mergers, acquisitions and strategic alliances will [continue at a rapid pace](#), especially for rural or community hospitals and in markets with Medicaid cuts or declining commercial insurers. Healthcare continues to be a crowded and highly regulated market, which heightens competition and revenue pressure. Operating scale and efficiency have become increasingly important as hospitals look for ways to control expenses in light of low reimbursement rates and a continued shift to outpatient services from higher margin inpatient services. Large hospital systems and high-acuity academic medical centers that are associated with strong universities continue to fare better because of economies of scale and brand recognition. Rural hospitals are struggling and are likely to be increasingly acquired by major systems in nearby urban hubs.

Recent consolidation among physician groups and the reentry of physician management companies that are acquiring large independent physician groups will also heighten competitive pressures. As part of a larger organization, these physician companies have greater negotiating leverage with payors and hospitals for contracted rates. Optum, a division of [United Healthcare](#) (A3 stable, P-2) has been buying physician groups and ambulatory centers across the US and in early 2017, purchased Surgical Care Affiliates, the largest operator of free-standing surgical centers in the US.

## What could change the outlook

Our outlook could return to stable if the operating environment improves, bringing stronger revenue growth and stabilization of expense growth. Resolution of federal healthcare policy that leads to more long-term funding certainty could also result in a stable outlook. We would consider changing the outlook to stable if we were to expect resumed operating cash flow growth of 0%-4%.

We would consider changing our outlook to positive with projection of sustained strong operating cash flow growth of above 4%, robust economic expansion, and expectations of material improvement of reimbursement rates or federal policy changes that improve reimbursements.

## Moody's related publications

### Outlooks:

- » [Cross-Sector - Global: 2018 Outlook: Credit conditions improve as healthy economic growth moderates financial stability and political risks](#), November 2017
- » [Global Macroeconomic Update \(2018-19\): Broadening emerging market recovery and stable growth in advanced economies](#), November 2017
- » [Sovereigns – Global: 2018 outlook stable as healthy growth tempers high debt, geopolitical tensions](#), November 2017

### Sector In-Depths:

- » [Cross-Sector - US - FAQ on credit implications of recent executive actions on healthcare](#)
- » [Not-for-profit and public healthcare, Pharmaceuticals - US - Drug price increases abate, but potential 340B change would hurt hospital margins](#)
- » [Not-for-profit and public healthcare - US Medians - Key financial metrics underperform as pressures mount](#)
- » [State Government - US - Medicaid Pressures State Budgets With or Without Federal Policy Changes](#)

To access any of these reports, click on the entry above. Note that these references are current as of the date of publication of this report and that more recent reports may be available. All research may not be available to all clients.

## Endnotes

[1 US Bureau of Labor Statistics — CPI-All Urban Consumers](#)

[2 CMS finalizes 2018 payment and policy updates for Medicare hospital admissions, Centers for Medicare & Medicaid Services, August 2, 2017](#)

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