

The Credit Impact Of Health Care Reform Will Take Hold Slowly

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The U.S. appears set to enter a new era with the passage of major health care reform—the Patient Protection and Affordable Care Act—which President Barack Obama signed into law. The book hasn't closed on this controversial law yet; it will almost certainly face amendments in the short term, and some of its chief provisions, such as mandatory insurance purchases, will likely come under fire in the courts. Also, it will be months, or even years, before many of the law's chief provisions take effect.

Yet, the fact remains that the passage of this law is a landmark: The U.S. has the potential to achieve near-universal health care coverage for its citizens for the first time.

The addition of millions of new insured people to the health care system will have a direct effect on hospitals, drug companies, and medical device makers. It will also have repercussions for state and local governments and the national economy. As the law evolves, the ripple effects might change. But in the immediate aftermath of today's signing, Standard & Poor's Ratings Services is answering some questions about the new law.

Frequently Asked Questions

Will the new law help cut medical costs or the rate of growth in medical costs?

We suspect that in some instances, medical costs might rise in the short term but level off later after some of the law's key initiatives take full effect. More people with health insurance, for example, means more people with access to preventive and primary care. Insuring them will be expensive, but the payoff could come years later if we see the population's health improve and there are far fewer visits to expensive hospital emergency rooms instead of primary care physicians.

The law also ushers in a period of active pilot projects that could cut costs, such as by bundling payments for patient care into a single bill to cut down costs rather than paying

several providers. That builds on the work many hospitals have already begun to standardize and computerize patient records—another initiative that will cut down on medical errors, improve productivity, and reduce costs. The law also creates an independent Medicare board to make recommendations to help curb spending if the law's current measures prove insufficient.

We believe that, however imperfect, the new law will at least let the country begin to get a handle on medical cost inflation. The Congressional Budget Office predicts that reform will shave \$130 billion off the federal deficit in the first 10 years and \$1.2 trillion in the following decade, while reducing Medicare growth by 1.4% annually, thus extending the solvency of Medicare funding. Although we believe that this forecast might prove overly optimistic, the cost of health care in its present form is rising at a rate we believe is unsustainable for the U.S. economy. Perhaps the new law will prompt lawmakers into taking further action to control medical cost inflation.

What are Standard & Poor's long-term expectations for the rollout of the legislation for health insurers?

We believe that health care reform will result in federal and state programs that continue to work in concert with the private sector. The migration from legislative status to law should, at the very least, enable health insurers to be in a better position to plan strategically and develop the necessary relationships with the providers of medical goods and services to stay viable, or, in some circumstances, to pursue an exit strategy from some lines of business, either in whole or in part. That could ultimately lead to a pickup in mergers and acquisitions or joint ventures to gain scale, operational capability, and competency.

We also expect that the development of specific rules and regulations to implement the new law's provisions will play an important role in how insurers are affected. The health insurance sector will essentially be dealing with a four-year, back-end-weighted phase-in period (full implementation is scheduled for 2014), which could create some interim difficulties for insurers as they seek to reposition themselves for a reshaped market in the midst of a weak, slow-growing economy.

Although the roll-out is not expected to destabilize the existing operational infrastructure of the marketplace, the emerging new partnerships between the government and private health insurers will likely introduce some longer-term risks. Increasing budgetary pressures and economic imbalances at the federal, state, and local levels could crimp financing for public/private programs, including well-functioning state-based exchange systems. Our credit concern is that these conditions could dim health insurers' earnings prospects and compress margins, potentially weakening cash-flow strength and debt-servicing capacity. The expansion of government-sponsored insurance could also make underwriting standards, rate structure, and provider contracting more subject to the political process, which could constitute material risks that would be factored into our ratings.

How does Standard & Poor's factor the reform law into its health insurance sector outlook?

We cited health reform legislation as a factor when we updated and sustained our negative outlook for the health insurance sector in January 2010. Although we continue to believe that there is potential for moderate credit-quality erosion over the long term, we're not expecting the new law, in and of itself, to drive rating actions in 2010. The primary credit factors continue to be the sluggish economic development (as it relates to the level of payroll employment in the commercial sector) and weakened operating performance overall.

What are some of the key near-term considerations that could affect health insurers?

Two big downside concerns for us are the inclusion of minimum medical benefit ratios (the share of revenue spent on medical expenses) and the movement toward a new payment structure for Medicare Advantage. The marketplace, we believe, will begin to feel these changes in 2011.

The reform mandates that insurers writing individual and small-group policies must spend 80% of their revenues on medical costs, while insurers covering large groups must spend 85%. Based on our initial assessment, margins for a cross-section of companies—primarily for-profit, diversified health insurers—could erode moderately. But for us to fully assess the risk, we'll need to see exactly how rules and regulations to be developed in 2010 will lay out how information pertaining to these calculations will be reported (i.e., by operating company, by state, on a consolidated basis, or by some other method) and by which accounting method, such as GAAP (generally accepted accounting principles, SAP (statutory accounting principles), or another approach.

We believe that Medicare Advantage rates will likely be the same in 2011 as in 2010, as the government begins changing the payment structure. We believe the revised funding scheme is likely to result in lower margins in this segment and moderately lower penetration levels for health insurers over the next one to three years. We expect payment benchmarks to vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Health insurers controlled about 23% of the Medicare market in 2009 after a rather strong three-year expansion.

What are the implications of health insurance reform for drug company revenues?

Over the next few years, major patent expirations on high-priced branded prescription pharmaceuticals could shrink revenues for some drug companies. Accordingly, health insurance reform could provide some welcome support, with provisions that close the gap in Medicare coverage for drug expenditures between \$2,700 and \$6,154, commonly referred to as the "donut hole."

This might be reminiscent of the boost in drug spending following the 2006 implementation of Medicare prescription pharmaceutical coverage for the elderly (Part D). However, the closing of the donut hole should be much more gradual, with a rather limited \$250 rebate for Part D enrollees entering the gap in 2010. Thereafter, a 50% discount on all name-brand drugs in the donut hole becomes effective, with additional discounts to close the hole completely. However, that's not likely to occur for 10 years.

Although the additional 32 million beneficiaries could also help raise revenues, the full potential of the opportunity might take some time to realize. First of all, the mandatory purchase of health insurance, which we believe will spur private insurance enrollment, won't kick in until 2014. Although lower out-of-pocket costs for the newly insured could bolster drug utilization, the enrollment of more young, healthy beneficiaries who might not heavily use the benefit could offset some of the potential benefit.

Moreover, until more people have insurance, there could be a timing mismatch between the expected ramp-up in revenues from a gradual increase in enrollment and the incremental cost associated with new drug company fees under the law. (The fees begin at \$2.5 billion in 2011 and subsequently rise to a total of \$85 billion over 10 years.)

How might reform affect the speculative-grade for-profit hospital chains?

For-profit hospital chains, which operate less than 15% of all U.S. acute care facilities, could benefit from more patients and lower costs for uncompensated care. At the same time, however, reform provisions call for more than \$150 billion in Medicare spending cuts over 10 years, and that could especially affect revenues after 2015.

Those more difficult operating conditions could also accompany an increase in private managed care efforts to shift some of their costs to providers. Indeed, managed care plans face major reductions in their Medicare Advantage reimbursement as well as operating restrictions that could cut into profits. If hospitals need more staff to treat patients, they might encounter a tighter labor supply and have to pay higher salaries.

The ongoing reimbursement risk that for-profit hospitals face, and the aggressive capital structures under which they operate, contribute to the predominance of speculative-grade ratings in the sector. Still, the outlooks on HCA Inc. (B+/Positive/—) and HealthSouth Corp. (B/Positive/—) in 2009 benefited from financing that reduced our liquidity concerns stemming from large upcoming debt maturities. An IPO contributed to our upgrade of Select Medical Corp. (B/Stable/—) late last year. Notwithstanding these cases of credit improvement, the failure of hospital chains to prepare operationally and financially for the changes that are likely coming could weaken credit quality as reform efforts take hold. The good news is that these challenges might not intensify for a few years.

How might the law affect not-for-profit hospitals, especially with regard to Medicaid and Medicare reimbursements?

The Patient Protection and Affordability Act and related Reconciliation Act of 2010 do little to change our view that credit quality for these hospitals in 2010 will stabilize, though in our recent outlook, we discussed longer-term cost and revenue pressures that remain despite some improvement in 2009. The new legislation will alter the landscape over time, especially after 2014, when insurance becomes mandatory.

Many of these newly insured people will get their coverage through insurance exchanges that are projected to become operational in 2014, even though some smaller initiatives will increase the number of insured before then. To the extent that the uninsured are already receiving services at a not-for-profit hospital, the provider can now expect to benefit, as insured revenues will rise and the aggregate cost of treating those without insurance declines. It follows that while all hospitals should see some benefit as uninsured levels decline, hospitals treating a greater percentage of uninsured people will likely be the greatest beneficiaries—although they will have to demonstrate an ability to retain these patients, as competition for the newly insured will likely intensify.

This benefit, however, is offset directly by potential reductions in Medicare's annual update factor, in reductions to disproportionate share revenues, and indirectly, by Medicare Advantage insurers that we believe are likely to pass on their funding reductions to all providers, including hospitals. Although the benefits of increased insurance availability are more likely to be skewed to hospitals with high charity care and self-pay burdens, the Medicare funding reductions are more broad based and will affect most hospitals significantly.

How much not-for-profit hospitals benefit from this new law could well depend on the balance between revenue lost, largely from Medicare, versus revenue gained from the newly insured. Much will

also depend on the level of reimbursement provided by the newly insured population, how well it covers the cost of care, and the level of disproportionate funding that is lost.

Another issue that could significantly affect hospitals is the potential for a surge in demand as the newly insured people seek out services that they previously deferred. Although this is generally likely to be positive for hospitals, it raises issues of staffing and space, which they will have to address. And finally, the law has generated numerous pilot projects that aim to change how care is reimbursed and provided. For example, there is clear movement toward bundled payments, which is one payment for one episode of care and includes numerous parties that are now paid separately. Many hospital administrators have indicated they are already preparing for bundled payments though, although it remains to be seen how this will ultimately affect hospital financial performance. The pilot projects also provide incentives for more efficient care, which could lower patient volume. Over time, this could lower overall health care costs but reduce hospital revenues.

Are device fees a concern for the makers of medical products?

We believe that, even with the imposition of medical device fees, the manufacturers of high-margin technological devices are well-positioned for the foreseeable future. The increasing needs of an aging population already bode well for the demand for new procedures and technologies. Reform legislation could strengthen the ability of patients to receive care by virtue of growth in Medicaid and mandated private insurance coverage.

The Congressional Budget Office projects that Medicaid enrollment will grow by more than 40% over this decade, versus 16% growth in the private sector. Accordingly, even as health insurance coverage broadens, there could be a greater proportional increase in less-profitable Medicaid business. At the same time, government budgetary pressures could discourage more expensive and profitable medical treatment. In such a scenario, we believe that more aggressive negotiations with hospital customers feeling the pinch of tighter third-party reimbursement could indirectly squeeze margins for medical device companies. Moreover, regulatory shifts, such as a more demanding new product-approval process, add to the potential for variability in revenues and earnings.

There will now be a 2.3% excise tax on medical devices, scheduled to take effect in 2013. That tax is forecast to raise \$20 billion over 10 years. But to the extent that these fees cannot be offset by higher prices, cost savings, or increased revenues from a larger base of insured people, medical device makers could, in coming years, see some adverse consequences.

How will health care reform affect U.S. states, especially with regard to Medicaid reimbursement?

The new law is not expected to have immediate credit implications for U.S. states, though there are many aspects of the legislation that will affect states down the road. The impact will likely vary in each state, depending on the level of insured residents in a state and the nature of its Medicaid program. Each state determines its own eligibility rules, roster of services, and reimbursement levels, subject to federal minimums, and there is wide variation among states, which we expect will affect the future costs associated with expansion. The new law aims to extend insurance coverage to 32 million currently uninsured individuals by 2019, and we expect a large share of them will be covered by Medicaid.

Since its creation in 1965, states have shared Medicaid costs with the federal government. Those costs, however, have historically risen faster than the rate of inflation and remain one of the biggest

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components of state spending. Although the new law outlines federal reimbursement for low-income Medicaid recipients initially, there will also be a phased-in state cost. Moreover, the uninsured rate varies significantly by state. Because Medicaid caseloads tend to rise when the economy is weak and state revenues are falling, managing this program during economic cycles has consistently been a challenge for the states. It is clear that the new legislation will alter the health care landscape over time, and we will review the fiscal and economic implications on a state-by-state basis as details emerge.

by Robert McNatt

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