

NONPROFIT HEALTHCARE SECTOR

JANNEY FIXED INCOME STRATEGY

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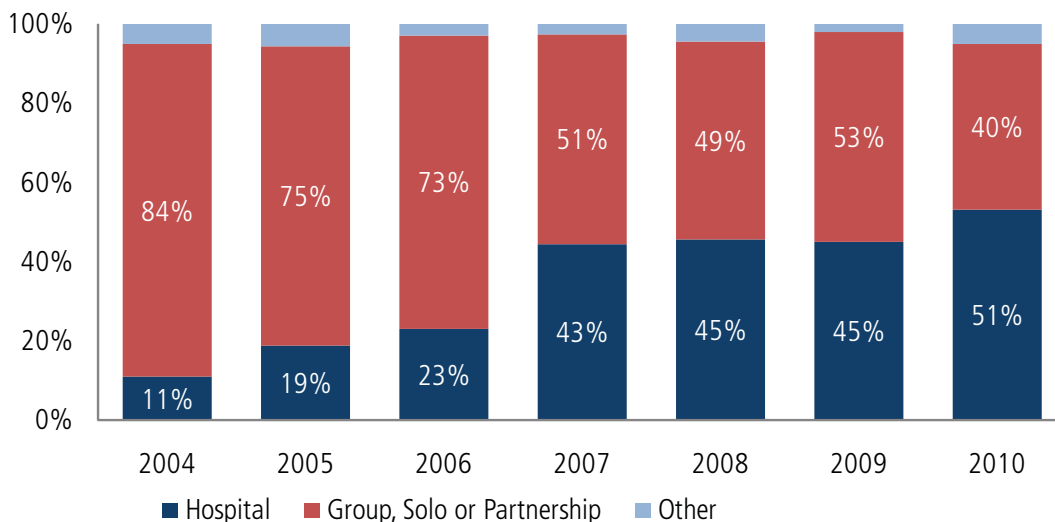
The risk reward proposition in the nonprofit healthcare sector favors large, higher rated issuers over smaller organizations.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

The impact of the Patient Protection and Affordable Care Act (PPACA), signed into law in March 2010, is being felt across the healthcare sector. Although many of its provisions, particularly those directly impacting hospitals, will not be completely phased in until 2014, healthcare organizations, and indeed the entire healthcare industry is racing to prepare for full implementation. Court challenges to many provisions of the legislation are ongoing with as many as thirty states fighting imposition of the law, so uncertainty clouds the future, but with most hospital organizations working under the assumption that the legislation will prevail, they have been preparing for the changes. The US Supreme Court will ultimately weigh in on the law's constitutionality.

Improvements in management and governance are underway in many operations. A recent report from S&P notes that many providers are making their governing boards "smaller and more nimble" to improve decision making. There is a strong trend toward tighter physician alignment, with larger healthcare organizations building and taking over physician practices, providing stronger integration. S&P identifies a growing trend towards closed medical staff models, whereby only doctors employed by the hospital have admitting privileges. According to Moody's, in 2010 hospitals were responsible for 51% of new physician employment, compared to only 23% in 2006.

New Physician Hires - More Doctors Joining Hospitals Than Entering Private Practice



Sources: Moody's; Janney Fixed Income Strategy

ALAN SCHANKEL
Managing Director
215 665 6088
aschankel@janney.com

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A partial outgrowth of the Great Recession and attendant elevated levels of unemployment has been strong focus on cost containment and revenue optimization. Many hospitals saw declines in patient revenue as loss of jobs and health insurance lead potential patients to postpone or opt out of medical treatment, and thus many hospitals were pursuing expense reduction well before passage of PPACA. Provisions of the healthcare legislation will encourage a continuation of cost containment.

ADJUSTING TO CHANGE

Not all hospitals will adjust easily to coming changes. Larger organizations, with sophisticated management, opportunities for economies of scale and the ability to generate funds for capital improvements in physical plant as well as technology are generally best positioned to meet the new challenges of PPACA implementation. Consolidation within the industry will continue and accelerate with larger hospitals swallowing smaller organizations including local community based hospitals as well as second and third tier players in larger competitive markets.

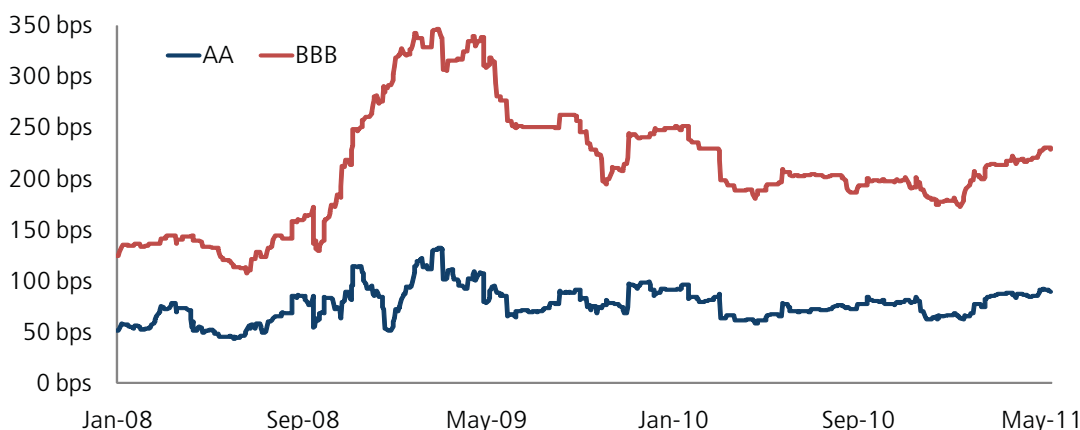
Beginning in January 2012, using Medicare and Medicaid as drivers of change, the federal law will encourage formation of Accountable Care Organizations (ACO), which are networks of doctors and hospitals that share responsibility for assuring favorable outcomes for patients. Members of an ACO will coordinate patient service and care, with a goal of meeting or exceeding benchmarks, and sharing in realized cost savings. Moody's notes that "achieving greater cost and quality accountability will be credit positive for nonprofit hospitals in an era of reform."

In 2013, fixed payments will be introduced, holding hospitals responsible for "episodic" care. Provisions would bundle payments with a fixed amount per medical episode available to cover inpatient and outpatient services, physician services and post acute services beginning three days prior to admission and extending to 30 days after discharge. Under this approach, the risk of managing costs would shift to the hospital. According to S&P, if the Centers for Medicare and Medicaid (CMS) are successful in driving down costs using ACO and fixed payment systems, private insurers can be expected to embrace these approaches. Hospital organizations require adept management and significant investment in information technology systems to manage the processes involved with ACO and fixed payment schemes. Larger, forward looking organizations are well underway in efforts to prepare for 2012 and beyond.

Challenges will persist. Federal and state budget demands will put continuing pressure on Medicare and Medicaid reimbursement rates. Florida's recently adopted FY2012 budget package cuts 12% from Medicaid reimbursements to hospitals. Moody's notes that the median for Medicaid's portion of gross revenues is 12.5% across the 24 Florida hospitals it rates, making the reduction "unquestionably credit negative for the state's hospitals." For many healthcare organizations, pension funding remains a challenge. Those with defined benefit plans have median funding levels of 68% according to S&P.

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Healthcare Debt Spreads Remain Wider than Pre-Recession Levels



Healthcare organizations range from barely investment grade issuers to large billion dollar, multi-facility borrowers. Spreads (yield differential between AAA benchmark and an individual bond or category) for AA rated healthcare bonds have ranged between 43 and 123 bps over the past four years, with widening particularly severe during the general market credit and liquidity crisis in 2008-2009. BBB issuers have seen much higher levels of spread volatility, ranging from 108 to 347 bps in the same period.

CAUTIOUS OUTLOOK BUT.....

Although our outlook for the nonprofit healthcare sector as a whole is cautious we note there is a definite divergence between the larger and more highly rated issuers on the one hand, and smaller, lower rated hospitals on the other. To be clear, there are large organizations with ratings in the BBB range, and smaller hospitals with strong ratings, but these tend to be exceptions. We expect an acceleration of consolidation going forward, with weaker organizations disappearing, primarily through acquisition. Smaller systems will be challenged to adapt to the rapidly changing environment, and those in competitive markets could face declining market share and eventual rating downgrades.

As we go to press, the AA hospital index offers 90 basis points more yield than AAA benchmarks while the BBB group yields 229 bps above the benchmark yield. We see more investor value in the 90 basis points or so of incremental yield available in the high quality segment, than with the wide spread of the BBB portion of the sector. Of course each organization has individual credit aspects that should be considered, but in the nonprofit healthcare sector, bigger is often better, and the risk reward proposition favors the higher rated issuers.

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