

4th Quarter 2009 Update
Hospitals' Overall Economic Situation, Access to Capital and Capital Spending Trends

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I'm Claudia Gourdon and I'm responsible for sales and marketing at Healthcare Finance Group. We're based in NYC, and have been providing financing to the healthcare industry – and only to the healthcare industry – for over 10 years. We cover all sectors of the industry, but focus primarily on middle market, below investment grade companies. Approximately 45% of our portfolio is to hospitals and the balance is weighted towards SNFs and home health providers. Today, we are one of only a couple of private, independent, financing firms. We are conservatively financed, which has enabled us to remain active throughout the difficult last 18 months.

Overall Impact of Today's Economic Situation on Hospitals

For most hospitals, the last 18 months have been very difficult, and their financial situations have deteriorated. The period has been marked by declining revenues, which have resulted from low volumes and low investment income, and by ever increasing costs. Exacerbating that situation was an almost frozen credit market which limited hospitals' access to debt.

This period has resulted in some fundamental changes which probably started in late 2007, but the recent economic dislocation accelerated those trends. That is, the number of acute care hospitals overall has declined by at least 20%, as has the number of physician organizations. These decreases have come from consolidations between hospitals and, -- yes, some liquidations -- as well as from affiliations of doctor groups with hospitals.

This trend will, in my opinion, continue. The weak, struggling hospitals will be taken over, and more doctor groups will align with the stronger hospitals. So the hospitals that survive are going to be in better fundamental shape and I think that the experience of having not been recession proof, which was a shock to many, has made hospital executives and hospital Boards more amenable to new ways of doing business.

But how you look at today's economic environment depends on your timeframe.

In contrast to the last 18 months, the last 2 months look clearly better, with increased access to capital and slightly increasing revenue, as patient volume increases in step with the improving economy.

But if you take a longer viewpoint of, say, the last 5 years, the economic environment today is still very challenging, with high unemployment resulting in higher bad debt, anemic revenue growth, expensive loans and conservative lenders. Further, investment portfolios are still off, charity care reimbursement is still down, days cash is generally low, and there is an urgent need to make facility maintenance investment. Finally, the uncertainty of the changes in Medicare reimbursement, which may become law under Healthcare Reform, is causing hospitals to be very cautious.

So, while the overall environment is somewhat better, it is still weak and the recovery is in its early phase.

However, hospital executives are beginning to make plans -- especially in light of the Stimulus Act, which included \$150 billion for healthcare. Executives are now weighing the impact of the expansions of COBRA and Medicaid, and are planning on how to maximize the money available for IT investment.

Hospital's Access to Capital

Much has been said and written about the credit crisis, so I won't go over that history. Right now, hospitals have more access to funds than during the last 18 months, but nothing like 2 and more years ago.

Let me use HFG's experience to illustrate my point. Today, we have significant money available to lend to hospitals and others for working capital, we have limited money for term debt, and no money for real estate loans. You can contrast that to, on the one hand, 2 and 3 years ago when we did working capital loans, term debt and real estate financings ---- and, on the other hand, a period last year when we only had limited funds available for working capital loans. So, clearly, more money is available more readily now from private lenders like us.

Money is also more available from banks; they are not only making more loans, but are supporting and increasing the accepted leverage levels. Senior debt to EBITDA has increased from about 2x last year to 2.5x now, and total debt levels are at 4x or even 4 1/4x.

There is also robust demand from investors who are buying NFP healthcare bonds – which purchases reached a record high of \$65 million in November.

Finally, refinancings are up, especially those which have a goal of stretching the maturity – as HCA and Tenet did recently.

The refinancing market in general may actually be the majority of the overall market activity for much of 2010.

Bonds due in 2009 totaled \$26 billion, but bonds due in 2010 total \$45 billion – and they total \$120 billion in 2011. The \$165 billion forward refinancing calendar is much larger than in recent memory and, in my opinion, will put a damper on the overall market.

The impact on hospitals will be similar to that felt by other industries -- lenders will have the ability to force better pricing and covenant terms, and they will strongly favor the better credits over the weak ones.

The result will be that the strong credits will have much easier access to capital than the weaker credits in terms of volume, pricing and flexibility. This will serve to further support the ability of the better hospitals to expand, and will put increased pressure on the weaker hospitals.

Hospitals' Capital Budgets

The capital budget wish list at most hospitals is significantly larger than the funds available. The pent up demand is fairly significant.

One area that, in my opinion, will definitely get funding is IT. There are several reasons for this. First, as I mentioned, there's Stimulus money available; 2nd, the Healthcare Reform Act – in whatever form it ultimately takes -- will require better and more complete medical electronic records in order to qualify for government payments; and 3rd, in 2010 most hospitals will face RAC reviews.

First, the push from the Stimulus Act.

CMS just released the definition of “meaningful use” of healthcare IT under the Stimulus Act, in order to provide guidance on how to qualify for the federal incentive payments. In 2010, providers have to meet the so-called Stage 1 requirements. There are 23 criteria for hospitals and 25 requirements for other providers which, in essence, entail electronically capturing health information in a coded format, using that information to track clinical conditions and communicating that information in a coordinated fashion. The implementation of Stages 2 and 3 is required over the next few years, and all Stages must be implemented by 2014. So, to get the Stimulus Act money, hospitals need to be improving their IT capabilities.

The second reason that IT will get funding is the push from the new Healthcare Reform Act.

Many of the proposed regulations in both versions of the Healthcare Reform Bill, require hospitals to submit documentation that is assumed to be electronically based. For example, the hospitals that show high Hospital Acquired Conditions (HACs) will not get 100% of their Medicare payments.

Finally, the third reason that IT will get funding -- and this, in my mind, may be the most compelling driver -- is the RACs.

RACs are Recovery Audit Contractors for CMS who are reviewing the Medicare payments to hospitals beginning in 2007. In particular, they are looking for any upcoding that may have taken place under the DRG system, and hospitals have only 45 days to respond to a RAC inquiry.

It's important to note that the RAC contractors are paid a percentage of the improper payments they collect from hospitals, and the burden of proof is on the hospital. In other words, if the hospital can't prove that it didn't upcode and CMS thinks it did, the hospital is fined, or Medicare simply offsets its current payments against the historic overpayment. Either way, the hospital will experience an immediate decrease in revenues.

It this wasn't difficult enough for hospitals, in the Senate version of the Healthcare bill, RAC is extended to Medicare Part D, Medicare Advantage and to Medicaid. Of course, the final Act may be less far-reaching, but, clearly, there will be a lot of scrutiny on hospitals. So good clinical documentation is not only important and a good thing to do, it's a "must do" for most hospitals.

The other "must do" that I've been hearing about from hospital executives is facility maintenance. For example, if the HVAC system was on its last legs in 2008 and nothing was done in 2009, it is at the top of the list to be fixed in 2010.

Also, the healthcare industry is the 2nd largest consumer of energy in the US and the environmental movement is likely to make hospitals a target for payment penalties if they don't meet certain standards. So facility maintenance, especially related to energy, may be another "must do".

It's only after the pent-up facility maintenance has been completed, that hospitals mention equipment and medical device spending.

Of specific interest to some of you on this call, are the new excise taxes being proposed on medical devices.

The taxes under the House version of the Healthcare Reform Bill begin in 2013; the taxes under the Senate version of the Bill began on Monday. While the Senate version exempts Class I and less than \$100 Class II devices, both versions target this sector. As law, the additional taxes are likely to make an already cautious hospital purchaser even more cautious, which will put more pressure on the medical device manufacturers.

Finally, the Payments Disclosure Act requires the disclosure of all healthcare payments to healthcare providers that are made by medical companies. So, again, there will be more scrutiny of hospitals and therefore caution on the part of hospital executives as they develop their capital budgets.

Future Outlook

The future outlook for hospitals is highly colored by Healthcare Reform and by the overall increased public scrutiny, which goes beyond whatever Act may be passed.

For example, there are new tax forms (990s) that the NFP hospitals have to file --- which will disclose executive salaries and hospital governance policies, for example. There will also be tighter underwriting rules for insurers, which will force both for-profit and NFP hospitals to disclose more information than previously.

That being said, the general outlook for hospitals will be driven by the outcome of the Healthcare Reform Act and, while we don't know what the Act will look like, we do know some of the likely winners and losers, as well as the general direction of reform.

Looking first at the specifics, there are some areas that are relatively clear. Specialty hospitals are not going to be reimbursed as easily or as well as they are currently, and diagnostic imaging and durable medical equipment [and indoor tanning salons of all things], are going to be under pressure through additional taxation.

Looking at the general direction of the Bills, there is also some clarity. If you're a hospital treating the uninsured, the good news is that the government will pay for more than it has in the past; but the bad news is that at least approximately 10%, or \$40 billion per year, will be cut from the Medicare budget.

So, a hospital that isn't overly reliant on government support today, should do well since more patients will be covered. But a weaker hospital, that's reliant on government reimbursement today, may or may not ultimately be better off, depending on how the specifics work out for that hospital. Initially, increased coverage and increased patient volume should be positive for hospitals. But, over time, the Medicare cuts may offset the initial benefit.

Because the long term impacts of any Act are very difficult to predict, many hospital executives are simply hoping that the impact on their hospital won't be too negative, and are focusing more on their local economy and community. However, almost every executive that I've spoken with is very concerned about the disruptions that the implementation of new regulations may have, and are especially concerned about the potential negative unintended consequences.