WELLS FARGO SECURITIES

NFP Hospitals
H2 2015 Update

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Together we'll go far

Some Sector Risks Stabilizing

Political and Legal Challenges

- SCOTUS decision to uphold federal health insurance exchange (HIE) premium subsidies provides stability for hospital strategic and operational planning
- ACA key 2016 presidential election issue; but no consensus on Republican "repeal and replace" plans
- Minor ACA amendments are still being pursued by Congress, but a repeal of 2.3% medical device tax and IPAB would require bipartisan compromises on other priorities

Health Insurance Exchanges

- 2015 effectuated enrollment of 10.2 million (as of March 31) exceeds the 9.1 million HHS year-end target
- Utilization and revenue improvement from the newly insured, but also bad debt from high-deductibles
- Further HIE enrollment growth likely as individual mandate penalties increase
- However, adverse selection risk remains: 1) future competitive premium pricing critical 2) continued lack of consumer awareness and poor health care/health insurance literacy

Medicaid Expansion

- Optional Medicaid expansion has limited implementation - only 28 states and Washington, D.C., have opted in so far (MT plan needs CMS waiver approval)
- However, we continue to believe most states are pragmatic and are likely to eventually opt in
- At least seven state governors (AL, AK, MO, SD, TN, UT, VA, and WY) are currently open to expansion, but may lack sufficient state legislative support

Capital Markets

- H1 2015 hospital bond volume was up dramatically: $17.6 billion (87.5% YoY)
- About 80% was refunding/combined money deals, so issuance pace likely to slow when rates rise
- Technical, rather than credit factors continue to drive market
- Hospital credit risk remains underpriced, but S&P Municipal Bond Hospital Index still outperformed other muni asset classes on a total return basis: 0.83% (YTD), 5.17% (1-year), 12.54% (2014)

Some Sector Risks Still Evolving

Reimbursement Pressures

- Reductions to hospital reimbursement contributing to margin compression:
  - Medicare sequestration, ACA's scheduled Medicare cuts, but Medicaid DSH cuts delayed to 2018
  - State Medicaid rate and/or scope of service reductions; changes in traditional eligibility criteria
- Pressure to increase operating efficiency despite increasing reform-related expenses
- Reduced ability to cost shift; commercial payor pushback

Federal Budget Deficit

- Health care cost-containment remains a priority for all politicians
- Hospitals remain a target for further reimbursement cuts
- Annual health care expenditure growth of 6.0% expected through 2023 (CMS)
- The population, aged 65 or older, is expected to increase by more than 82% by 2039 (CBO)

Industry in Transition

- Challenging transition period, as the industry continues to move away from fee-for-service
- Delivery system reforms unlikely to be reversed regardless of ACA status
- New patient utilization patterns due to HIEs and Medicaid expansion
- Profitability unclear - new HIE and Medicaid revenues may not offset top-line reimbursement cuts

Consumerism

- Price transparency and care quality movements limit patient utilization growth and revenue potential
- Increased cost sharing for ESI and more high-deductible health plans (HDHPs) reduce "excess" utilization but also contribute to bad debt
- Reform-driven delivery system changes and emphasis on value/quality-based care over volume
- Continued shift to greater outpatient service mix and more cost-appropriate care options

Medicaid Expansion Has Helped Hospitals

- **Hospitals in opt-out states more likely to underperform those in states expanding Medicaid**
  - Opt-out states concentrated in the South and Midwest regions
  - Hospitals in the South challenged by: 1) poorer population health status and healthy life expectancy 2) higher poverty and uninsured rates 3) less generous traditional Medicaid eligibility levels and scope of coverage
  - Two-thirds of rural hospital closures over the past five years have been in the South
  - **Estimated 4.2 million more uninsured if no other states expand Medicaid in 2016 (Urban Institute)**
- **Faster than expected Medicaid enrollment pace**
  - 71.1 million total Medicaid enrollments (as of April 2015)
  - An increase of 12.3 million (up 21.3%) over average monthly enrollments prior to ACA's 2014 open enrollment period
  - Slower gains in "oppositional" states

Expansion States	Non-Expansion States
• 28.2% growth in enrollments	• 8.8% growth in enrollments
• 10.9% uninsured rate in 2014	• 16% uninsured rate in 2014
• 4.0 percentage point decline from 2013	• 2.4 percentage points decline from 2013

Sources: U.S. Department of Health & Human Services, Centers for Disease Control and Well Fargo Securities, LLC

- **Positive early effects of ACA expansion - Ascension Health case study (Kaiser)**
  - Hospitals in expansion states benefited more from Medicaid expansion than HIE enrollments
  - Hospitals in non-expansion states experienced noticeably less improvement in payor mix

Expansion State Hospitals	Non-Expansion State Hospitals
• 7.4% increase in Medicaid discharges	• 1.4% increase Medicaid discharges
• 32.2% decline uninsured/self-pay volumes	• 4.4% decline uninsured/self pay volumes
• 8.2% increase Medicaid gross revenues	• 9.4% decline Medicaid gross revenues
• 63.2% decline self-pay revenues	• 2.6% increase self-pay revenues
• 40.1% decline charity care costs	• 6.2% decline charity care costs
• 6.3% net decline uncompensated care costs	• 11.8% net increase uncompensated care costs

Source: Kaiser Commission on Medicaid and Uninsured and Well Fargo Securities, LLC

Hospitals Adapting to Consumerism

➢ **Hospitals must lower their cost structures and reorient their strategies to improve pricing/billing, quality performance, marketing/communications, as well as enhance patient engagement**

Increased patient focus on cost, value and customer service

- HDHPs limit utilization and costs
- More patient engagement, involvement in decision-making, and "shopping" for health care
- **Increased price sensitivity**
- **"Consumer paradox"** - slower historical health care cost growth, yet consumer perception of faster cost growth (employee share of costs growing faster than income)

HIE plan effects

- Less profitable than ESI plans
- Higher cost-sharing requirements (deductibles and out-of-pocket maximums) leading to bad debt
- Affordability remains the No. 1 criteria; 85% of enrollees selected subsidy eligible plans

Newly insured HIE patients showed positive changes in utilization and personal responsibility (HCA)

- 2x more likely to seek outpatient care than uninsured
- More financially responsible ($390 average payment) vs. uninsured (89.6% zero pay)
- Uninsured 3x as likely to use ER as newly insured HIE patients

Narrow networks "work," but threaten high-cost providers like academic medical centers, children's and cancer hospitals

- Effective cost control tool
- High-cost providers vulnerable because low-cost, high-quality hospitals favored
- More highly integrated hospitals better at coordinating care and have continuum to put patients in cost-appropriate setting
- 23% of employers used narrow, tiered or high-performance networks in 2013; more evaluating these plan designs
- Broader network plans had 26% higher prices than narrow networks (McKinsey)

Q&A

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- **Suggestions?**
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