

- Implications of the Affordable Care Act
 - Nationally
 - Boston Medical Center as a ‘case study’ for health care reform
 - Credit Implications—as determined by a non banker
- What’s Next

Patient Protection and Affordable Care Act (PPACA) a.k.a. ACA a.k.a. ObamaCare



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a.k.a. Romney Care

When the Website is fixed

The Affordable Care Act will provide peace of mind and access to health care 32 Million Americans

- 16m automatically go into Medicaid
- (earn < 133% FPL = \$29,326/family of 4)

- 16m private insured, largely with public subsidies
- (<400% FPL = \$88,200/family of 4)



Most newly insured will be low-income and...

The Newly Insured Are Currently Patients Of Safety Net Hospitals And Health Systems

Introduction to Boston Medical Center and Boston University School of Medicine



Boston Medical Center is a \$2.5B entity

- **Employs almost 6,000 people, close to 10,000 our campus**
 - 25% live in Boston - concentrated in Dorchester, Roxbury, South End
 - 45% are from racial ethnic minority populations
 - 70 % of employees are represented by organized labor through 10 separate bargaining units
 - Share a campus with Boston University's Schools of Medicine, Dentistry and Public Health
- **BMC HealthNet Plan provides access to health care** and peace of mind to over 350,000 enrollees across Massachusetts and now New Hampshire

BMC's unique role as the largest safety net hospital in New England

Created in 1996 as country's first full asset merger of two public hospitals with a private academic medical center. The merger continues the 100+ year mission of Boston City Hospital to serve all regardless of their ability to pay.

Largest and busiest provider of trauma and emergency services in New England with over 129,000 emergency room visits last year.

Safety Net focus: 150,000 low-income patients/year; 65% of patients from Boston's neighborhoods with greatest levels of mortality and health disparities; specialized programs include grow clinic, child witness to violence, preventive food pantry, social workers and 200,000 translations in 21 languages/year.

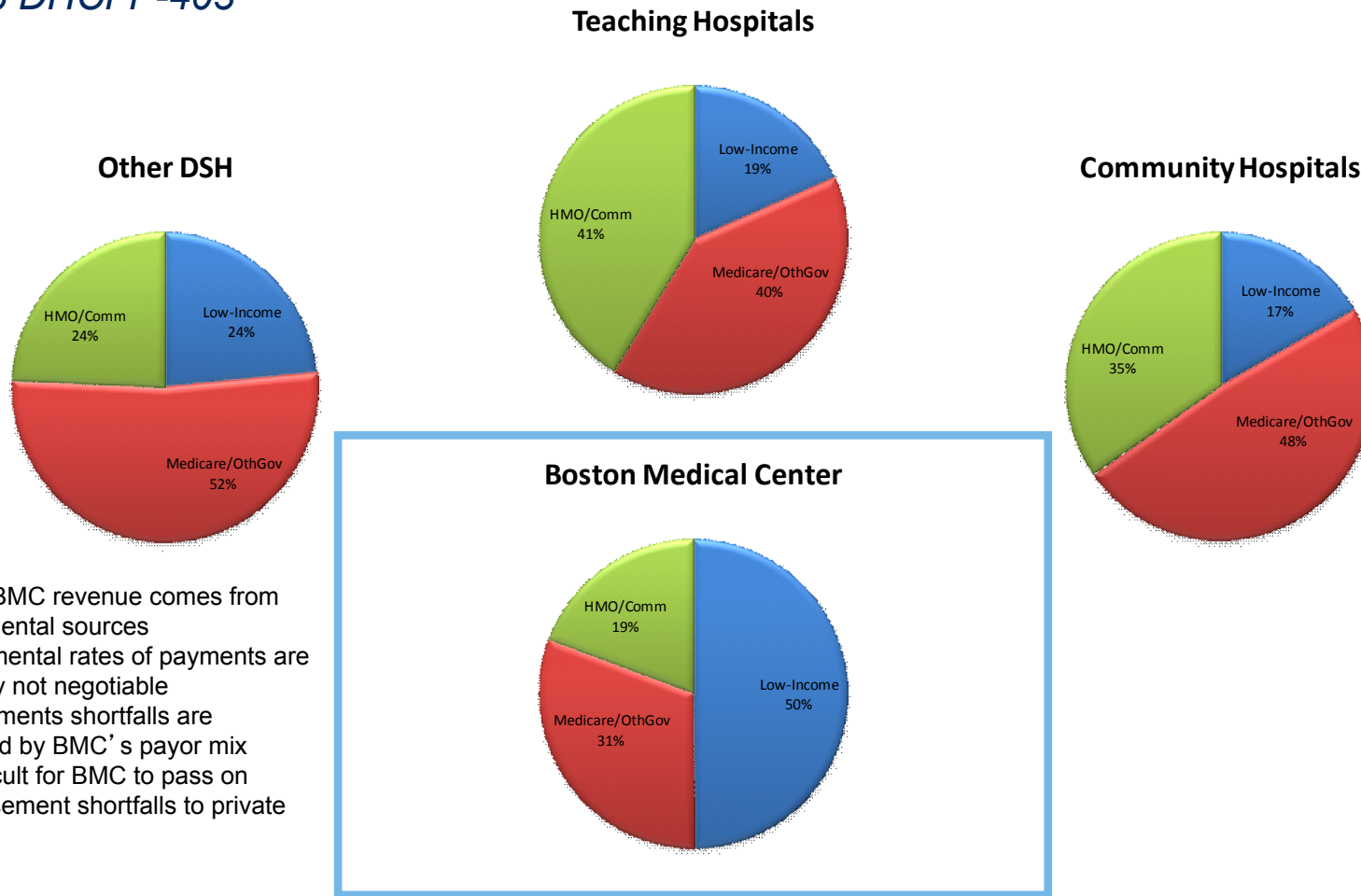
BMC is a leader in medical research and teaching: \$132M in grant awards in FY12 with research specialties including infectious disease, cardiology, Parkinson's disease, geriatrics and endocrinology. **772 residents and fellows** part of 73 residency training programs. Over \$300m of research on campus

Innovative programs that support our mission

- **Enrollment for Cancer Clinical Trials at BMC** includes 14% of newly diagnosed cancer patients, seven times higher than the national average, with rates of enrollment for minority patients greatly exceeding national norms.
- **The Preventive Food Pantry and Demonstration Kitchen (the first hospital-based facility of its kind in the nation)** provides groceries to nearly 7,700 low-income patients and their family members each month – helping to offset hunger in the Boston area.
- **BMC's Patient Transportation Program** provides over 185,000 rides to the hospital each year to those in need – ensuring that patients get the care and treatment they need, including vital clinical services such as dialysis and radiation/chemotherapy.
- **The BMC Grow Clinic is a national model for treating children** diagnosed with Failure to Thrive, or malnutrition associated with poverty, illness and family stress – serving an average of 200 children at any given time.
- **Child Witness to Violence Program** offers trauma-focused counseling and advocacy to children and their families who have been exposed to violence. Social workers, psychologists, early childhood specialists, a consulting attorney and pediatrician work with more than 150 children and their families each year. They also implement national and state-focused training for health care professionals, police, educators and other social service professionals who confront issues of children who witness violence.

Uniquely Positioned to Serve Growing Number of Government Paid Patients

Source: Division of Healthcare Finance and Policy (DHCFP)
FY 2008 DHCFP-403

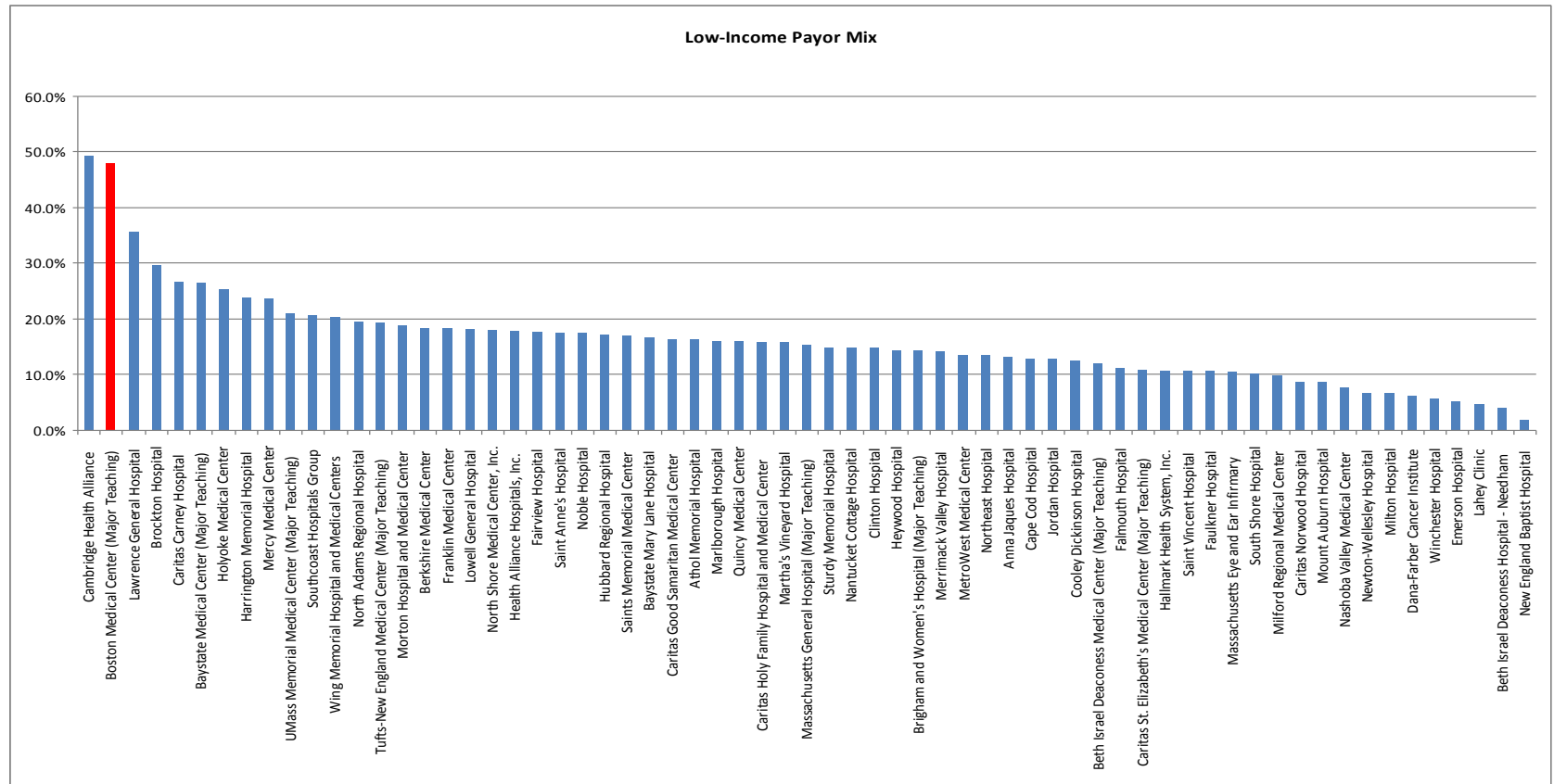


1. 80% of BMC revenue comes from governmental sources
2. Governmental rates of payments are generally not negotiable
3. Any payments shortfalls are magnified by BMC's payor mix
4. It is difficult for BMC to pass on reimbursement shortfalls to private payors

“BMC’s payor mix is **substantially** different than other hospitals”

All Massachusetts Hospitals Low-Income Payor Mix

Source: Division of Healthcare Finance and Policy (DHCFP)



“BMC is a Super DSH hospital with half of it’s patients categorized as Low-Income”.

BMC Role In MA Health Care Reform

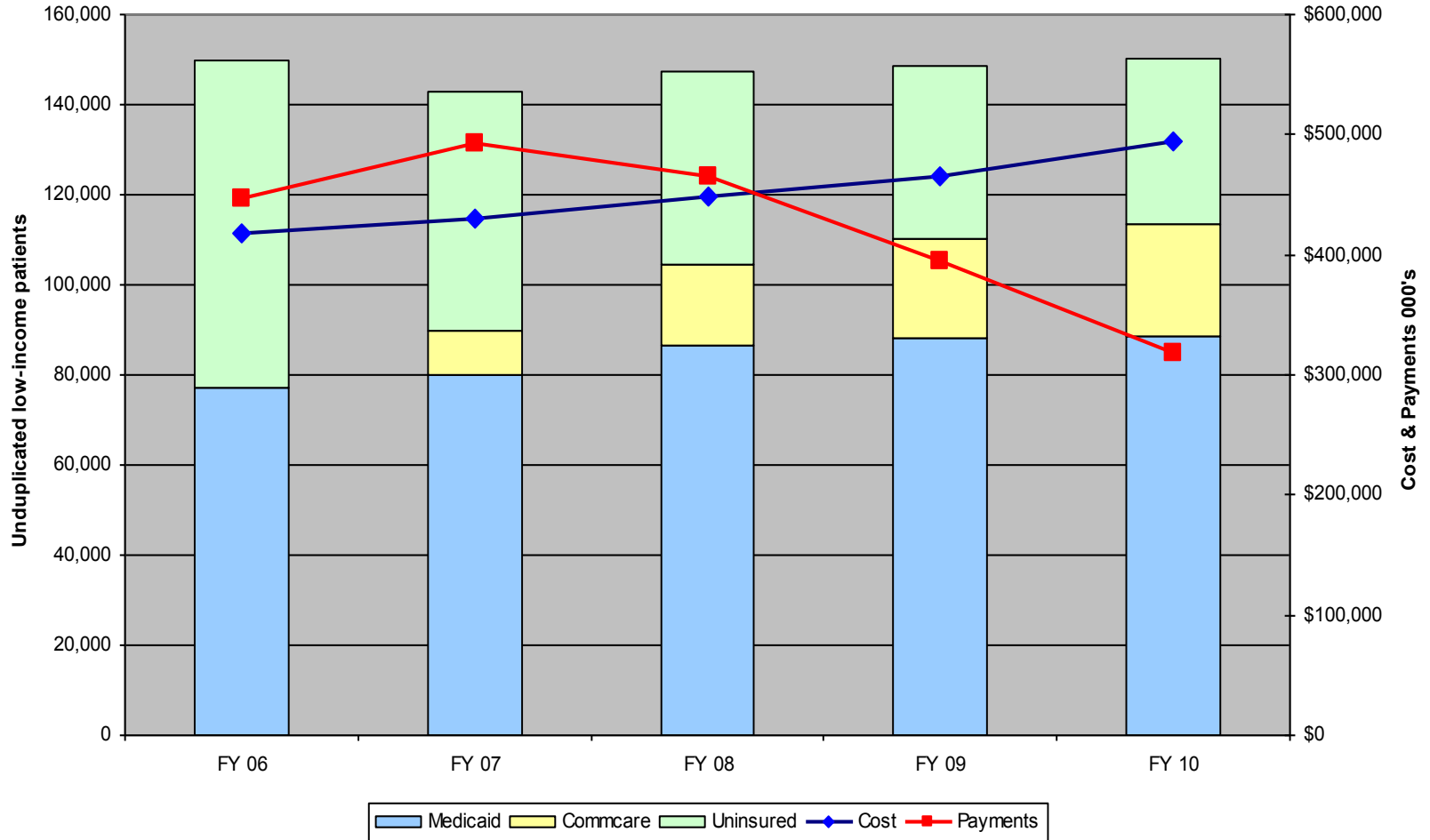
Coverage

- Moved more patients to coverage than all other hospitals in Massachusetts combined
- 150,000 low-income patients served annually
- BMC HealthNet Plan is the largest insurer of care to Medicaid and Commonwealth Care with almost 300,000 statewide members.

Financial Impact

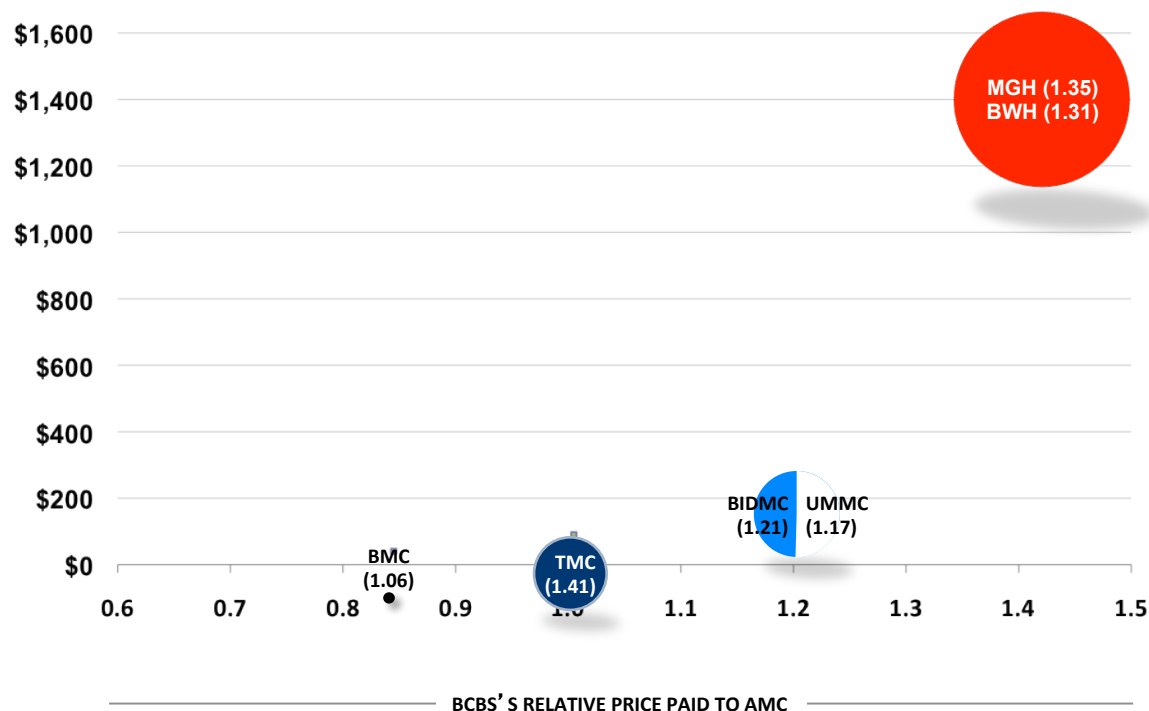
- Since 2008, BMC took a disproportionate share of Medicaid cuts
- \$140m/year decrease in payments to address impact of low Medicaid base rates
- 33% cut in inpatient rates
- Currently being paid lower rates than in 2001

Post MA Healthcare Reform BMC's Financial Health Deteriorated Due to Dramatic Payment Declines from Government Payers



Commercial Rates Driven By the Market Power Are Not the Solution For BMC

SYSTEM-WIDE HOSPITAL REVENUE FROM BCBSMA (SELECTED TEACHING HOSPITALS)
(MILLIONS OF DOLLARS)



The Massachusetts Attorney General found that high prices were related to how “big” a hospital was, in terms of both the total revenue earned by its overarching hospital system (y-axis) and the number of patients the hospital system served (size of dot).

NOTE: The systems' BCBSMA HMO/POS membership in 2008 is indicated by dot size. The hospitals' case mix index is noted in parentheses; Beth Israel Deaconess Medical Center (BIDMC) and UMass Memorial Medical Center (UMMC) are similar in size in terms of BCBSMA membership and also receive similar prices. As such, both hospital systems are reflected in one split dot.

SOURCE: Office of Attorney General Martha Coakley, [Examination of Health Care Cost Trends and Cost Drivers](#), March 2010.

Despite Challenging Circumstances BMC has survived the immediate crisis...

- Post-merger BMC **received appropriate state funding** to deliver on its mission of exceptional care without exception
- MA **healthcare reform** and the **economic downturn** put significant pressure on BMC's revenue
 - Medicaid rates **decreased by 33%** from 2008 to present
 - State supplemental funding **decreased by ~\$140M/year**
- The dramatic reduction in revenue took BMC to the **brink of defaulting** on our debt in 2010
- We survived through a series of measures that generated ~\$100m in improvement
 - Temporary increase in funding from the state
 - Tough cost controls (lay-offs, hiring freezes etc.)
 - Compact with organized labor: deferred wage increases, increased productivity etc.

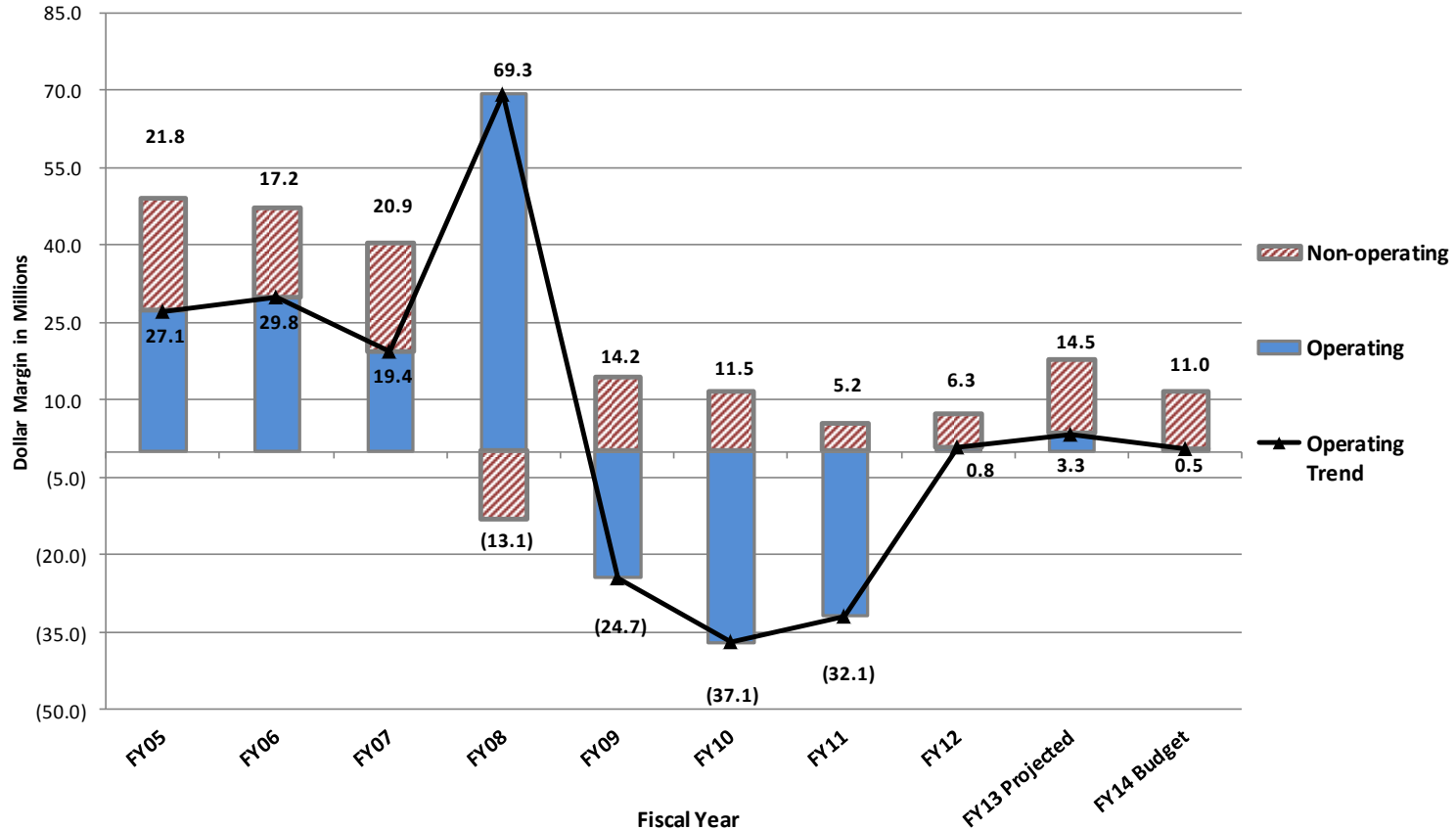
Through a series of specific and strategic actions...

BMC has cut \$100m out of our cost structure and maximized revenue:

- * Implementation of FTI efficiency recommendations
- Emergency Room consolidation
- Close inpatient rehab hospital within a hospital
- * Management salary freeze in FY10; all staff freeze in FY11
- * Hiring freeze, very tight position control and revamping hiring process
- * Clinical and non-clinical supply expense reductions
- * Clinical Effectiveness and Case Management initiatives
- * Revenue Cycle improvements to maximize charge capture
- * Renegotiation of commercial payer rates
- * Securing waiver funding

Hospital Margin Trends – FY05 through FY14

Hospital Operating & Non-Operating Margin Trend



Highlights

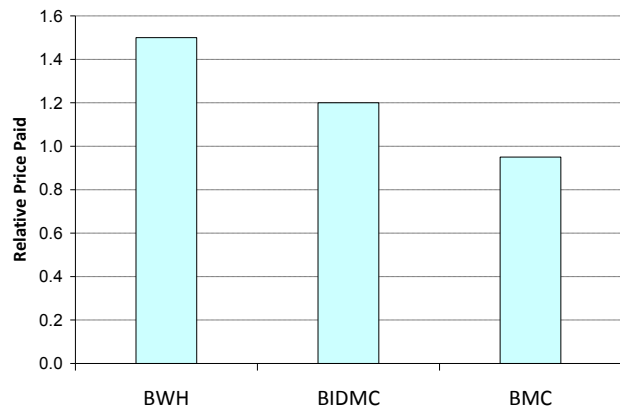
- BMC lost money on operations each year from FY09 to FY11.
- As in FY12, the hospital is projecting to end FY13 with positive operating income.
- FY14 is targeting a break-even budget, the first in seven years, which is a positive reflection on BMC's efforts to improve operating efficiency.

BMC's completes one of the biggest hospital turnarounds in the nation...

- Finished FY12 and FY 13 (unaudited) with a small but symbolically enormous surpluses in each year---and we were able to do this without cutting back on care.
- Implementation of numerous cost savings and efficiency strategies to reduce total medical expense through routine cost reduction and the development of novel programs designed to reduce unnecessary hospitalization, emphasis on prevention and screening:
 - Project RED to cut costly hospital readmissions
 - Patient Centered Medical Home Programs
 - Diabetes management program
 - Yoga for back pain, on campus and at five CHC's
- **We know that access to high quality health care for our patients and our future depends our ability to get people healthy and keep them well**

And has demonstrated our value...

2012 BCBS Relative Hospital Prices



- AG report shows BMC's BCBS price is ~50% lower than BWH's and ~25% lower than Beth Israel's
- DHCFP report shows BMC's commercial prices are 20-28% lower than BI's for key DRGs (severity adjusted)

2012 Leapfrog Patient Safety Ratings



- Named a 2012 Top Hospital by the Leapfrog Group and received an "A" score for safety
- Publicly reported patient safety ratings show BMC performs on par with MGH, BI and BWH and substantially better than Tufts

MA health reform law advances needed cost controls, but BMC's challenges remain largely unaddressed

- Continued downward pressure on Medicaid rates and MCO rates disproportionately affect BMC
 - Federal cuts could total \$40m/year
 - - DME, IME, NIH and sequestration
 - - In 2014 federal reform reduces Medicare reimbursements (BMC's best payer)
- Low commercial rates and no opportunity for cost-shifting
- Projected operating losses in future years will be mitigated by ongoing performance improvement efforts and substantial and complex campus consolidation plan

BUT We Are Not Alone

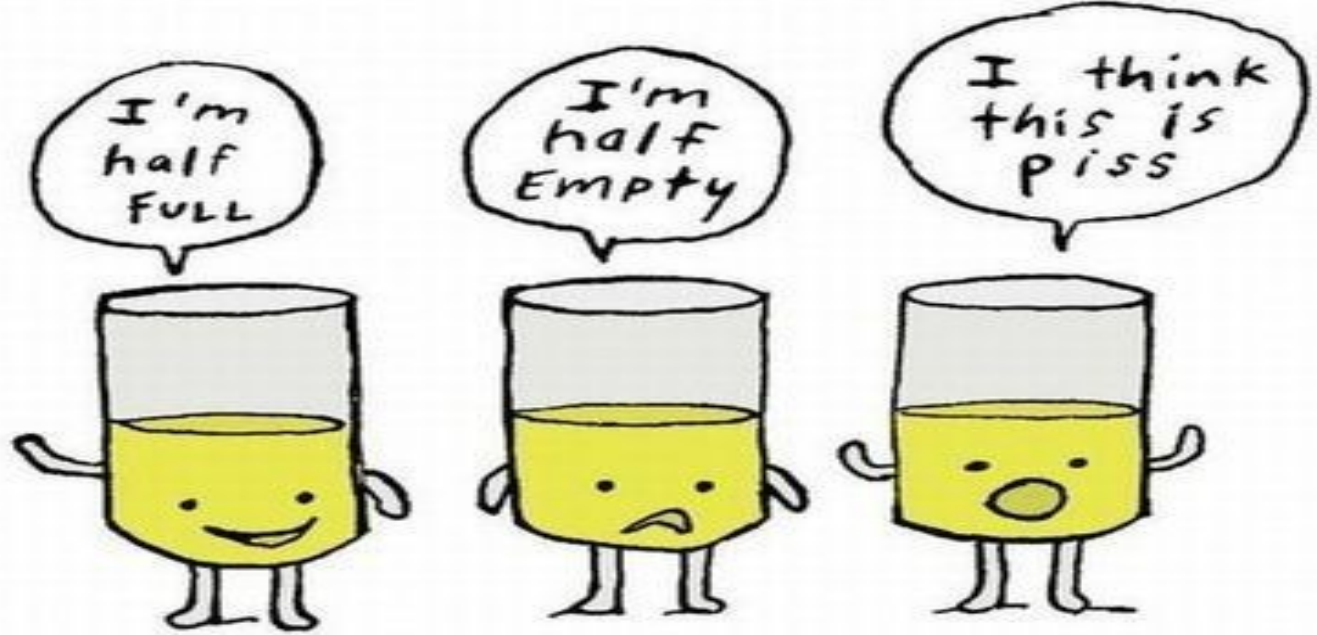
Moody's offered a list of factors that will pose challenges for nonprofit hospitals nationwide, including:

- A 1.3 percent cut to Medicare reimbursement payments
- A reduction in so-called “disproportionate share payments,” which benefit hospitals that serve a high percentage of low-income patients
- Declining inpatient volumes as care shifts to less-expensive outpatient settings
- Shrinking commercial health insurance rate increases (Moody's projects 0 to 5%; Massachusetts will likely be on the low end of that range)
- Big looming expenses such as health IT systems and purchases of doctors groups, in order to better manage large patient populations
- New Obama Care health plans will reimburse hospitals at 20 %t to 30 % lower than commercial plans (though at higher rates than Medicare).

Other Credit Considerations

- While this is a challenging time for hospitals our industry has enjoyed many years of unprecedented growth so strong systems have strong balance sheets—strong systems will thrive and adapt
- Consolidation in a fact of life—despite all the media coverage to the contrary—this trend will continue
- Scale matters (see strong systems point above) as risk shifts from payers to providers and all of us become more focused on the health of the populations we serve
- Physicians will need to come together for scale largely to mitigate HIT costs and risk
- While excess hospital capacity will be created by much needed and ongoing payment reform other demographic trends will push against this—10 million people a day turn 65 every day in America

As We Look to the Future: It's A Matter of Perspective!



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Thank You