To: Senator Virginia Lyons, Chair, Vermont Senate Health and Welfare Committee

From Nancy Kane, Independent consultant

Re: H482 Proposed Metrics of Financial Health

H482 and other testimony are considering two measures of hospital balance sheet health for use as a financial screening mechanism for determining which hospitals might be appropriate sources of emergency funding in the event that Blue Cross of Vermont goes below its minimum required statutory net worth. A third measure – operating margins – will not be discussed, except to say it is best to wait for the audited results before relying on the operating margin metric, because much revenue and expense is not "finalized" until year end, when outside auditors get involved in reviewing estimated settlements.

The first metric , days cash on hand (DCOH), would be calculated as follows: all sources of unrestricted and not legally bound (eg debt service serve funds, self-insurance reserves) financial assets (cash and investments) divided by daily cash operating expenses. For systems, this metric should use System, not hospital-specific data, as it is common practice to report cash and investments managed by a parent entity in the parent balance sheet rather than that of the hospital.

In practice, hospitals and systems operate successfully with a wide range of DCOH values. For-profit hospitals often maintain very low DCOH , eg 6 – 10 days, because their sources of capital do not require them to hold enough financial assets to be able to repay long-term debt[1] from their existing cash resources. The main reason nonprofits seek high DCOH is to maintain credit-worthiness when they issue longerm debt. Creditors like the security of having financial assets available to repay debt in the event that cash from operating activities is insufficient to meet debt service.

Median (50th pctile) values for nonprofit hospitals with credit rating categories above investment grade range from 150 – 320 DCOH (see attached 2023 Fitch Ratings for Nonprofit Hospitals)[2]. Note that UVMHN has maintained a strong credit rating with a DCOH well below those medians. Credit ratings do not generally drop just because DCOH falls below the medians of any rating category. So the range proposed (floor of 125, trigger of 135) is in the range of "reasonable" in that it is unlikely to trigger financial disaster of the System.

The problem with using specific levels of DCOH to trigger emergency financial assistance is that it is not a fixed number over a long period of time, and it is subject to management

[1] https://www.healthfinancejournal.com/index_php/johcf/article/download/265/265.pdf

discretion. It goes up and down daily as hospitals pay vendors and workers, purchase equipment, borrow on lines of credit, collect receivables , etc. Averaging DCOH (eg, rolling average of prior six months) could help capture a more "true" number.

The other issue is that investments are reported at market value so are vulnerable to capital market fluctuations. Such changes can be quite large, as they do not have to be "realized" to affect the reported value of financial assets.

The other balance sheet metric for financial health under consideration is unrestricted net assets (equity) over some minimum number or, preferably, a maximum capitalization ratio (share of total capitalization that is long-term debt) . Net assets are a measure of the cumulative wealth of an organization over time, as it represents the value of earnings over the life of the organization. To determine financial health, it must be adjusted for the size (total capitalization), as $1 billion is a lot of equity in an organization with $2 billion in total capitalization, but it is not so much in an organization with $12 billion in total capitalization (the rest being longterm debt). The Long-term Debt to Total Capitalization ratio is often used to assess the adequacy of equity. This is calculated as "Longterm debt/(longterm debt plus unrestricted net assets (equity)". As the Fitch rating attachment shows, the range among rated hospitals/systems is 30-40% longterm debt (or the inverse, 60-70% equity). It might be helpful to include this metric along with DCOH as a way to insure that financial assets are not entirely financed by debt.

However, unrestricted net assets are also affected by capital market fluctuations because unrealized gains and losses impact earnings. It is difficult to calculate accurately on an interim basis because, as mentioned earlier, the income statement is not usually finalized until year end. Interim income statements include material managerial estimates of revenues and expenses.

Concern about Increasing Financial Uncertainty

The hospital industry is undergoing a period of dramatic financial uncertainty as capital markets fluctuate erratically and the federal government threatens to reduce Medicaid while it has already significantly reduced payments supporting the medical research infrastructure. Adding the possibility of a sudden financial call on cash resources of a health system heightens that uncertainty.

To mitigate (but not eliminate) that uncertainty, it may be worth considering a payment mechanism that creates a cash reserve for BC as claims are paid, rather than legislating a reach-back to capture cash held by the health system. One could do that by requiring a withhold on rates paid by BC to a System; the withhold would only be paid to the System if BC claims for that System stay at or below some target percentage of premium. If claims

go above that percentage, BC keeps the reserve (and may even increase the withhold). If claims stay below, the System gets the reserve. The frequency of settlements would have to reflect the length of time it takes for claims to be processed through the system. But in the interim, the cash would be retained by BC. The cash reserve would have a finite value that both the System and BC could rely on to reduce their financial uncertainty. A withhold system is commonly used in "Value-based" payment systems where a portion of payment depends on a system meeting certain metrics, often quality-related.

This concludes my testimony on the use of financial metrics to determine financial strength of hospitals/health systems for purposes of emergency funding of BC of Vermont.