

Evaluating Health-Care Systems

This report describes A.M. Best Co.'s methodology to evaluate a nonprofit health-care system's (the "system") overall creditworthiness, as well as the ability of the system to financially and strategically support its owned or affiliated health (a/k/a health plan) and captive insurance company(ies) and to potentially enhance the stand-alone issuer credit (ICR) and financial strength ratings (FSR) of these regulated subsidiaries. A.M. Best defines nonprofit health-care systems as tax-exempt organizations with one or more hospitals and any complementary entities within their corporate structure.

A.M. Best analyzes the entire system — including individual hospitals, clinics, physician networks, foundations, health insurance companies, captive insurers et al. — to assess its overall financial strength. These evaluations are performed in the course of

assigning a Best's Issuer Credit Rating (ICR) to a system and ICR and Financial Strength Ratings (FSRs) to their regulated subsidiaries or affiliates. Reference Exhibit 1 for Sample Rating Meeting Discussion Topics and Analytical Data Sources.

This report begins by briefly describing the business case for a system to own or affiliate with health and captive insurance companies. The remainder of the report describes A.M. Best's analytical framework, listed below and more fully discussed in the ensuing pages:

1. Health Plan and Captive Stand-Alone Assessment
2. Health-Care System Consolidated Assessment
3. Health Plan and Captive Rating Enhancement Assessment
4. Management Support Agreement Assessment
5. Rating Assignment
6. Monitoring the Evaluation

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Exhibit 1: Sample Rating Meeting Topics and Analytical Data Sources

Sample Rating Meeting Discussion Topics:

- Changes in corporate structure/subsidiaries
- New services being provided or new equipment/technology
- Competition in the service area
- Awards/recognition received by the hospital or system
- Quality initiatives, measures and reported outcomes
- Future strategic plans
- Hospital renovations/expansions — detailed description of the project, including cost and impact to financial and debt service ratios
- Major plant equipment investments in the next one to three years
- Plans to issue additional debt
- Success of contract negotiations with payors
- Bad-debt expense policy, recent policy changes, financial impact and outlook
- Charity care provided (i.e., cost basis) and subsidy amounts received (if applicable)
- Key service lines and competitive advantages
- Strength/scope of referring physician network
- Revenue cycle and supply chain management initiatives
- Pension plan obligation and funding
- Media reports
- Major pending litigation, other than ordinary course of business.
- Governance changes

System-Provided Data Sources:

- Audited Financial Statements including consolidated income statement and balance sheet for past three years and most current year-to-date internal financial statements
- Budget (income statement, balance sheet, cash flow and statistics)
- Operating projections for the next three years
- Corporate structure chart
- Current bond ratings and reports
- Patient utilization statistics for the past three years and year to date (by hospital if applicable)
- Current market share information and service area demographics
- Payor mix
- Top 10 admitting physicians and percentage of patients admitted (based on physician specialty) by hospital
- Number of board-certified physicians (by hospital)
- Average age of physicians (by hospital)
- Capital budget
- Sources and uses of cash for next three years
- Strategic plan/forecasts
- Current investment policy and asset allocation

External Data Sources:

- Medicare Cost Reports
- Independent, third-party quality-of-care comparison reports and awards



Business Case for Health And Captive Insurance Companies

Systems benefit economically from owning or affiliating with health and captive insurance companies. The three primary business benefits for a system to own or affiliate with a health insurance company, collectively referred to as an integrated delivery system, include:

1. Negotiating leverage with other managed care payors — this benefit is increasing in importance as the industry continues to consolidate. Provider-owned or sponsored health insurance companies infuse competition into the market, mitigating the network discount negotiating leverage that large Blue Cross and Blue Shield and publicly-traded health insurers exercise over systems when provider-owned or sponsored health insurance companies do not exist. As the owned or sponsored health insurance company's membership grows in overall contribution to the parent facility's utilization, this benefit strengthens and increases stability in the system's payor mix.
2. Revenue and earnings diversification — insurance contracts provide a more stable, predictable revenue stream than the system's core net patient service revenues from inpatient and outpatient facility utilization. Furthermore, provider-owned or sponsored health insurance companies generate stronger earnings when members' utilization of facilities and provider services is lower, providing a natural hedge to a system's earnings, which improve through overall increased facility utilization.
3. Economies of scale and scope — given the fixed-asset-intensive nature of systems, revenue scale generated by the health insurance company should improve the system's overall operating profitability, financing flexibility and invested asset options and returns. Also, depending upon the level of integration within the system, the entire financing and delivery value chain should become more transparent and cost efficient, owing to the sharing of management and technology resources and alignment of strategic and profit incentives.

Step One: Health Plan and Captive Stand-Alone Assessment

The first step in A.M. Best's evaluation is to assess the health and captive insurance companies' stand-alone financial strength. These evaluation processes are discussed in "Rating Health Insurance Companies (Sept. 8, 2006)" and "A.M. Best's Rating Methodology for Captive Insurance Companies" (Nov. 4, 2005). Economic and analytic issues specific to the integrated delivery system business model are discussed more fully in

Learn More



Methodologies

A.M. Best's Rating Methodology for Captive Insurance Companies *Nov. 4, 2005*

Rating Health Insurance Companies *Sept. 8, 2006*

A.M. Best Co. Methodology

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Step Three: Health Plan and Captive Rating Enhancement Assessment.

Step Two: Health-Care System Consolidated Assessment

As it does in all rating assessments, A.M. Best uses three broad analytical categories to assess the financial strength and flexibility of a system: business profile, balance-sheet strength and operating performance.

1. Business Profile

A.M. Best evaluates the advantages and constraints of the system's operating environment, such as the demographic profile of the service area, competition, payor mix, patient volume and physician profile. The system's presence within a local market is important, as this influences the negotiating power with commercial insurers. The negotiating power of a system is critical to obtaining adequate reimbursement levels for services, especially because commercial payments often cover the revenue deficiencies from government payors and uninsured patients.

• **Geographic and Demographic Considerations:** A.M. Best assesses the geographic service area and demographic factors that can influence the system's provider reimbursement and cost structure. For instance, a rural system may have only a few commercial payors within its region with which to negotiate, versus an urban system with a multitude of competing insurers, permitting the system a stronger stand during negotiation. Demographics, economic status and employment growth in the service area influence costs as well as the types of insurers in the system's service area, and thus impact the system's reimbursement. For example, a significant presence of the aged and poor may increase the system's reliance on Medicare and Medicaid reimbursements, which are generally insufficient to fully cover costs. The presence of large, profitable, high-growth corporations provides a steady growth of high-quality commercial payments.

• **Market Share:** The key importance of market share is the negotiating power it carries with commercial payors, as well as being a good volume/utilization indicator. Market-share trends are monitored closely for increases, decreases and stagnation. Changes, plus or minus, in market share indicate either success at building competitive advantages or management failures, given competitors are outpacing the system in providing quality and variety of services. A.M. Best views the system's market share as an important tool in

gauging the volume of patients that the system serves compared with other systems in the area.

• **Services Provided:** A.M. Best initiates an in-depth inquiry into the breadth and quality of services provided to evaluate a system's competitive factors. A wide breadth of high-quality services can increase a system's ability to contract effectively with managed care players in the market, especially if services are unavailable from other facilities. Specialty services generally receive higher levels of reimbursement for the system. However, if lower-cost specialty hospitals, ambulatory surgical centers or imaging facilities are competing in the area, insurers may redirect patients away from the system.

• **Payor Mix:** A.M. Best's assessment of the system's payor mix looks for reliance on a dominant commercial or government payor for reimbursement and changing trends in payor mix. For example, a high percentage of Medicaid patients in relation to peers could indicate that the system is operating in an economically depressed, high-unemployment service area increasing the volume of uncompensated or undercompensated care and placing more pressure on commercial contracts and ultimately operating margins. A high Medicaid patient mix also is of concern because state-run programs are susceptible to political and fiscal policy changes that could affect reimbursement rates, and Medicaid rates generally do not fully cover costs.

• **Patient Volume:** Growth in commercial patient volume generally is a positive indication of an attractive service area with steady insured population growth and strong market share. Growing patient volume also causes pressure for expansion and drives the need for capital. To determine whether the system is operating at or near capacity, A.M. Best analysts review inpatient volume trends, as measured by the occupancy rate based on the number of maintained beds. This analysis seeks to identify the root cause and implications of growing demand and the service impact and future capital needs. Also, patients' average length of stay in a particular system is compared with industry medians, adjusted for case mix index.

• **Physicians:** A.M. Best views positively physician groups that are owned by the system — despite typically operating at a loss — as they can provide a stable flow of patients. To determine whether the system is overrelying on a few physicians for admissions, A.M. Best requests a list of the top admitting physicians and the percentage of patients they admit. The number of physicians in various specialties is reviewed

to determine the system's strength in offering different specialties. The percentage of board-certified physicians indicates strong competency and knowledge of the services being provided. The average age of the system's physicians and physician turnover rates also are reviewed to determine possible difficulties in hiring or retaining physicians.

- **Management Strength:** To determine the system management's strength of leadership and oversight, A.M. Best looks for a well-conceived strategic plan for the system with a focus on core service lines; board members with diverse backgrounds; clear management performance

goals; and sound budgetary monitoring practices. A focus on continued investment in technology is very important as pressure continues to mount for improved transparency on cost and quality; federal regulations move toward requiring electronic medical records and prescriptions; and pressure continues for compliance with the Health Insurance Portability and Accountability Act. A.M. Best analysts also look at recommendations and scores from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and from patient and employment surveys, as well as employee turnover/vacancy rates, employee satisfaction surveys, and whether quality control is measured and the outcomes monitored.

- **Quality of Care:** A.M. Best incorporates a system's quality-of-care awards and scores from independent, third-party organizations in its qualitative assessment. Owing to the industry's focus on cost versus quality and pay for performance, systems with well-recognized brands and flagship programs should continue to benefit reputationally and, ultimately, financially. Conversely, systems with below-median quality scores in highly competitive markets could be at a distinct disadvantage.

Exhibit 2: Definition of Health-Care System Primary Credit Ratios

In the following table, A.M. Best has defined several primary credit ratios utilized to assess health-care systems. Ratio adjustments to results reported in a health-care system's audited GAAP financial statements have been noted in the Ratio Definitions.

Ratios	Ratio Definitions
Operating Margin	(Net Patient Service Revenue + Premium Revenue + Other Operating Revenue)/Total Operating Expenses. Revenues exclude investment earnings and nonrecurring gains on sale of assets. Operating expenses include interest expense.
EBITDA Margin	(Net Patient Service + Premium Revenue + Other Operating Revenue)/(Total Operating Expenses – Interest Expense – Depreciation and Amortization). Revenues exclude investment earnings and nonrecurring gains on sale of assets.
Debt to Capitalization	Total Long-Term Debt/(Total Long-Term Debt + Total Net Assets). Total Long-Term Debt includes long-term municipal debt, capital leases, notes payable and other debt obligations; and excludes all short-term maturities.
Maximum Annual Debt Service Coverage (MADS)	(Total Operating Expenses – Interest Expense – Depreciation and Amortization)/Maximum Annual Debt Service
Days Cash on Hand – All Sources	(Unrestricted Cash and Cash Equivalents + Short-Term Investments + Long-Term Investments + Board-Designated Funds)/((Total Operating Expenses – Depreciation and Amortization)/365 Days)
Days in Accounts Receivable	Net Patients Accounts Receivable/(Net Patient Service Revenue/365 Days)
Unrestricted Cash and Investments to Long-Term Debt	(Unrestricted Cash and Cash Equivalents + Short-Term Investments + Long-Term Investments + Board Designated Funds)/Total Long-Term Debt
Average Age of Plant	Accumulated Depreciation/Depreciation and Amortization Expense
Bad-Debt Expense as a Percentage of Net Patient Service Revenue	Bad-Debt Expense/Net Patient Service Revenue

2. Balance-Sheet Strength

A.M. Best evaluates the structure of the system's balance sheet to determine whether it is appropriately leveraged, with sufficient liquidity and debt-service coverage. A.M. Best also examines the system's capital investments in its infrastructure to determine whether the facility is able to provide state-of-the-art care and services and generate additional revenue from investment in core service lines.

- **Liquidity:** Liquidity measures are weighted heavily by A.M. Best. Numerous measures are utilized to gauge a system's liquidity. A major factor is Days Cash on Hand, which indicates the number of days that the system can meet its daily operating expenses with cash, invested assets and board-designated funds. When benchmarking a system's Days Cash on Hand result to its peer group, A.M. Best also incorporates the Days in Accounts Receivable and Average Payment Period metrics. For integrated delivery systems that generate a meaningful volume of revenues from an owned or affiliated health insurance company, A.M. Best would expect faster receivables turnover to benefit the system's operating cash flows because of vertical inte-

gration with the health insurance company — enhancing the consolidated credit profile. Regarding the average payment period, A.M. Best identifies systems with an average payment period that is much longer than peer and statewide medians, demonstrating the system is financing its liquidity by stretching out payments to suppliers. In these cases, A.M. Best would adjust the system's financial statements to reflect an average payment period comparable to peer and statewide medians, and estimate the impact to the Days Cash on Hand ratio result to improve comparability among systems. In some cases, this could result in a substantial downward adjustment to A.M. Best's perspective on the system's liquidity.

The ratio of operating cash flow to total debt takes into consideration short-term, as well as long-term, obligations. A low or negative ratio could indicate that the system may have problems meeting its debt obligations. Liquidity should be especially solid if the system has implicit or explicit agreements to support its subsidiaries, or if it has cash-borrowing agreements with its subsidiaries. In addition, any lines of credit the system has with financial institutions are reviewed along with required cash collateralization.

• **Long-Term Debt:** Given downward pressure on operating cash flows, coupled with their tax-free financing advantage, most systems rely heavily on debt financing through the municipal bond markets for capital investments. A.M. Best evaluates Maximum Annual Debt Service, Long-Term-Debt-to-Capitalization and Debt Service Coverage to determine financial flexibility. A schedule of debt-service payments, adjusted to reflect the impact of planned capital projects, is analyzed and stress-tested to assess the system's ability to meet future payments. Covenants are compared with the system's actual experience and a scenario-tested financial forecast to determine the likelihood of default or reduced ability to support regulated subsidiaries.

Furthermore, A.M. Best adjusts a system's financial statements to analyze the difference between the defined-benefit pension plan's unfunded accumulated benefit obligation — and additional dollars reflected on the balance sheet above that threshold — and the unfunded projected defined-benefit pension obligation and other unfunded postretirement benefit obligations. Owing to recent passage of the federal Pension Protection Act, a system's requirement to achieve fully funded status reflects a debt-like obligation. As a result, A.M. Best would increase the system's long-term

debt for the incremental unfunded obligation and assess the system's financial leverage both with and without that adjustment. In cases where the adjustment either has a substantial impact on financial leverage or increases ratio results outside an acceptable range for the issuer credit rating, downward credit rating pressure could result.

• **Capital Expenditures:** A.M. Best monitors a system's investment in the facility, as the system's ability to compete relies on providing state-of-the-art technology, equipment and services. A high level of investment is viewed favorably by A.M. Best, as long as it is backed by sophisticated, well-documented analysis of future returns on investment and debt levels are manageable. A system with a history or forecast of poor operating performance may have restricted access to funding, thus limiting its capital expenditures. At a minimum, A.M. Best reviews a three-year capital plan detailing the expected amount of expenditures along with the sources of those funds, including capital contributions from the system foundation.

A.M. Best compares capital investment with annual depreciation to determine the adequacy of the replacement of obsolescence and the degree of new investment. Current capital expenditures are measured as a percentage of depreciation expense, indicating the amount of spending within the facility. The Average Age of Plant ratio is analyzed to indicate whether a system has older facilities or equipment, which could affect its competitive advantage and indicate the need to finance future capital investment.

To improve comparability among systems, A.M. Best capitalizes all noncancellable operating leases to analyze the impact to the system's financial leverage, debt-service coverage and other affected ratios both with and without this adjustment. A.M. Best would solicit additional information from management when a system demonstrates an increasing reliance on operating leases to finance capital investments, or finances a mission-critical capital asset using this means.

• **Invested Assets:** A.M. Best analyzes the asset composition and historical rate of return of operating (i.e., unrestricted, temporarily and permanently restricted) and defined-benefit pension plan invested assets, the former as a means to complement a system's operating performance and the latter to fund retirement obligations. A.M. Best also stress-tests future rates of return on invested assets. Investment return, excluding realized gains and losses, and portfolio composition (e.g., percentage allocated to equities, fixed-income securities, cash, alternative asset classes,

etc.) are benchmarked against the peer group to assess performance and risk tolerance. Systems with a higher-than-peer-group exposure to equity security or alternative asset classes (e.g., limited partnerships, private placements, et al.) are analyzed further to determine the risk-management programs in place to mitigate the risk of loss, such as a robust enterprise risk-management program.

- **The Foundation:** A.M. Best analyzes the historical trend and future expectations for funds raised by the foundation, whether for restricted capital purposes or for general operating expenses. The system outlines the role of the foundation and future solicitation efforts to maintain or improve fund-raising levels. In cases where there has been and will continue to be considerable reliance on the foundation as a source of external funds to fund general or specific projects, A.M. Best's analysts will inquire further and analyze the likelihood of and competitive pressure against raising this source of capital.

3. Operating Performance

A.M. Best evaluates a system's operating performance based on revenue generation, expense management and the stability of margins. As systems rely heavily on government reimbursement, A.M. Best looks for adequate collection programs in place to receive appropriate payments from all payor sources. In addition, the rising costs of health care and technology — and a growing uninsured or underinsured population — make strict expense-control measures necessary. A.M. Best recognizes that a combination of expense management and strong cash collections is necessary to operate profitably.

- **Revenues and Collections:** A.M. Best evaluates the rate of growth and sustainability of net patient services revenues, especially with reference to the impact of the growing uninsured and underinsured population. While providing uncompensated care is required on the part of a system, A.M. Best reviews the increased amount of charity care reported along with any state uncompensated care programs (i.e., subsidy and/or disproportionate share programs) in order to understand the financial impact to the system. Bad-debt expense or amounts deemed uncollectible from patients (e.g., charity care) are measured as a percentage of net patient service revenue. Other reimbursement challenges associated with Medicare or Medicaid funding legislation are evaluated for future impact on the system.

An overview of the system's revenue cycle management program and strategy for handling aging receivables also is evaluated. It is important for a system to have procedures in place to ensure high collection rates to generate sufficient cash flows to support operations and investments in light of ever-changing system reimbursement.

- **Expense Management:** Expense control is crucial because of narrow operating margins. As such, A.M. Best reviews each major expense line item separately, compares it with the prior year and measures it as a percentage of total expenses. Analysts look for large fluctuations or increases in expenses, especially in salaries, supplies and professional services. The increasing cost of hospital supplies has prompted A.M. Best to evaluate carefully that expense line, in addition to engaging in a discussion of supply-chain management programs. A.M. Best looks for programs in place for retaining employees and managing growth and productivity levels to reduce labor costs. Pension-plan expense, and supporting retirement funding assumptions, also are reviewed to determine the future impact these expenses may have on operating profitability and funding for capital projects.

- **Operating Margin:** Operating margins for systems typically are very modest (i.e., 2% to 4%), owing to strong competition from other hospitals and ambulatory surgery centers, regulatory constraints and a high reliance on state and federal funding, among other issues. In addition to traditional components, A.M. Best's operating margin assessment includes the cost to finance capital projects (i.e. interest expense) and excludes investment interest and dividend income, realized investment gains and losses, and nonrecurring gains and losses from asset sales (e.g., line of business, sale and leaseback, etc.). Underlying drivers of changes, especially margin compression, are evaluated for root cause and proposed corrective actions. A.M. Best assesses past operating-margin trends to determine whether there has been controlled revenue growth and expense management.

- **Excess Margin:** Another indicator of operating performance is excess margin, which — in addition to operating components — accounts for investment interest and dividend income, realized gains and losses and other nonrecurring gains and losses (e.g., proceeds from an asset sale). Given the many constraints placed on systems' operating margins, robust risk-adjusted investment returns and advantages from lower-cost financing of capi-

tal projects are two key drivers for sustained net asset growth and complement the operating-margin analysis.

Step 3: Health Plan and Captive Rating Enhancement Assessment

Rating enhancement for captive insurance companies is discussed fully in A.M. Best's methodology titled, "Rating Members of Insurance Groups" (Jan. 31, 2005 — a/k/a "group rating methodology"). No supplemental rating enhancement guidance for captives is provided in this methodology.

To supplement A.M. Best's group rating methodology and rating enhancement assessment for provider-owned or affiliated health plans, A.M. Best has created a Notching Model to benchmark five rating factors that evaluate the economic interdependence and corporate commitment between a health plan and its system owner(s) or sponsor(s). Model aspects are discussed in the following section and are factored in both the stand-alone analysis and rating enhancement decision for a health insurance company.

Health plans generating higher model scores benchmarked across the peer group could support a tighter notching spread (i.e., could receive more rating enhancement) with the system's ICR. The model provides A.M. Best's analysts, ratings committee and clients quantifiable support to supplement qualitative professional judgment for rating enhancement decisions.

A.M. Best's group rating methodology outlines the approach to provide full rating enhancement, no rating enhancement or some intermediate degree of rating enhancement to a health insurance company that is part of a larger system. Consistent with A.M. Best's group rating methodology, subsidiary rating enhancement is limited to two FSR levels (implied four ICR levels), given that A.M. Best would not assign a "group" rating between a health insurance company and system. Full rating enhancement is when the health insurance company is assigned the equivalent of the system's issuer credit rating.

For health insurance companies that do not qualify for rating enhancement, there is no maximum ratings spread between the health insurance company's and the system's respective ratings. In these cases, the health insurance company's stand-alone rating does not meet the minimum standards for rating enhancement and does not receive any benefit as being owned/sponsored by a creditworthy system, and the health insurance company's stand-alone rating would be the

assigned rating. This is applicable for systems that maintain an owned/sponsored health insurance company's NAIC Risk-Based Capital (RBC) at or marginally above the state regulated minimum, often generating Best's Capital Adequacy Ratio (BCAR) scores substantially below the 110% threshold for a "secure" rating.

As referred to in Best's group rating methodology, a health insurance company's static benchmarked Notching Model score does not systematically determine the level of rating enhancement. The final decision is still subject to quantitative and qualitative analyses by A.M. Best's rating committee, including the benchmarked score's historical trend; scenario testing of medium-term financial forecast based on management's strategy; market forces; and content of explicit or implicit capital support agreements, among other factors.

Health Plan Notching Model — Overview

The model, based on five weighted criteria that generate a benchmarked score between 0% and 100% (i.e., least to most integrated), highlights the importance of A.M. Best's opinion of the system's creditworthiness and the health insurance company's stand-alone risk-based capital adequacy, the latter measured using BCAR. Reference A.M. Best's methodology titled, "Understanding BCAR for Life/Health" (Feb. 9, 2004) for the BCAR calculations, and reference Exhibit 3 of this methodology to review the Notching Model calculations.

Importantly, A.M. Best does not publish model scores because a key component is the system's ICR, and does not designate model score thresholds to determine specific notching spreads. For example, health plans with a score between 75% and 100% do not automatically qualify for rating enhancement to one level below the parent's ICR. Also, as a health insurance company's stand-alone rating increases on the rating scale, each incremental improvement weighs more heavily on a subjective evaluation of the firm's business profile, while still incorporating the quantitative components of financial strength and operating performance measured using the Notching Model.

Notching Model Criteria

Model criteria are discussed below, with the relative weighting listed after each category title.

1. Health-Care System's Issuer Credit Rating: 25%

A.M. Best's analysts conduct full credit analysis on each system with the objective of assigning an issuer credit rating that is privately communi-

cated to client management at this time. This criterion is one of the two largest weighted criteria to determine the level of rating enhancement to a health plan's stand-alone rating, highlighting the importance of this rating to A.M. Best's opinion of the health insurance company's financial strength and creditworthiness. Higher-rated systems could enhance a health plan's rating; weaker-rated systems could place a drag on a health insurance company's rating. A.M. Best's system credit rating criteria are discussed fully in Step 2 of the analytical framework of this methodology.

2. Health Plan(s) BCAR Score: 25%

Sufficient stand-alone capital adequacy is a vitally important aspect of A.M. Best's ratings, and one of the two largest weighted criteria in the Notching Model. In cases where the system has strong creditworthiness in A.M. Best's opinion, very weak subsidiary stand-alone capitalization could dilute the level of rating support in the benchmarked score — even in cases where explicit or implicit support agreements exist.

3. Percentage of Health Plan's Direct Medical Expense Directed to the Health-Care System and Affiliates: 20%

This metric measures the health plan's percentage of total direct medical expense (fully insured) and premium equivalents that are steered to utilize affiliated health-care facilities. Owing to systems' fixed-asset-intensive nature, the effectiveness of a subsidiary health insurance company in steering utilization is a good measure of value. Plans with a very high score indicate a tighter integration with the system, in turn rationalizing corporate commitment.

4. Health Plan's Adjusted Cash Flows as a Percentage of the Health System's Operating Cash Flows: 20%

Although operating cash flows are a strong measure of a health insurance company's operating performance, this accounting measure does not fully capture the economic value a health insurance company generates for its system owner or sponsor. A.M. Best's adjustments reflect:

- Nonrecurring management incentive fees above recurring transfer-priced-based overhead allocations (typically driven by above-budget operating performance).
- Physician quality incentive payments.
- Excess of capitation payments to owner/sponsor or affiliates above the underlying medical cost trend.
- Other nonrecurring and/or performance-based cash payments to the health-care system.

A.M. Best's objective is to gross up accounting-

based operating cash flows for these payments to better reflect cash contribution to the system, improving comparability with the peer group and other health insurance companies with different corporate structures (e.g., tax-paying, publicly traded health insurance companies, Blue Cross Blue Shield plans, etc.). This metric does not reflect system cash-flow benefits from management service fees charged to a health insurance company; inter-company loans to manage working capital; and internal reinsurance contracts to mitigate cash-flow volatility. Importantly, these adjusted results also are analyzed as part of the health insurance company's stand-alone assessment.

5. Health Plan's Total GAAP Revenues as a Percentage of System's Total Revenues: 10%

Measures the revenue scale the health plan adds to the entire health-care system, given the importance of revenue scale to cover a system's high fixed-cost structure. The higher the health plan's revenue contribution to the consolidated system's total, the more uplift the health plan's stand-alone rating receives from the system's ICR.

For example, if a health plan accounts for a large percentage of consolidated system GAAP revenues, A.M. Best believes there is a high likelihood the system would maintain a long-term commitment to the plan and provide financial support when needed. Furthermore in this example, given the revenue scale benefits for health-care systems, A.M. Best believes the system's financial profile could be impacted adversely should it jettison its health plan, which accounts for a large percentage of the total revenue stream. In another case, if the health plan generated a minor percentage of the consolidated system's GAAP revenues, the system could divest itself of the plan and the consolidated credit profile would not be impacted as adversely as in the former case. In the latter case, the health plan's stand-alone rating would receive less rating uplift from the system's ICR on this measure.

Given the continued shift of the industry's mix toward self-insured from fully insured business, the divergence continues to widen between a health plan's GAAP revenues and statutory revenues because of accounting rules. In A.M. Best's opinion, the health plan's GAAP revenue presentation for self-insured business—adjusted to include premium equivalents—provides a more meaningful economic reflection of the plan's contribution to the system's scale for the integrated delivery system industry than does the statutory revenue presentation (i.e., netting of administrative fee revenue and expenses as a miscellaneous item). The Notch-

Notching Criteria

Data source (i.e., statutory blank or other) noted in each data field.

Score Summary:

	Weighting (a)	Calculation Result (b)	Weighted Score
1 Health-Care System Issuer Credit Rating	25%	%	(a*b)
2 BCAR Score - Consolidated for All Regulated Health Care Entities	25%	%	(a*b)
3 % of Plan's Direct Medical Expense (i.e., Capitation and Other Payments) Directed to the Health-Care System and Affiliates	20%	%	(a*b)
4 Health Plan's Adjusted Cash Flows as a % to the System's Operating Cash Flows	20%	%	(a*b)
5 Health Plan's Total GAAP Revenues as a % System's Total GAAP Revenues	10%	%	(a*b)
Sum of Weighted Scores			Sum of Weighted Scores

Note: Calculation Results in Notching Criteria - Score Summary are pulled directly from Supporting Calculation table below.

Supporting Calculations:

Data source (i.e., statutory blank or other) noted in each data field.

	Calculation Result
1 Health-Care System Issuer Credit Rating (Input Percentage from Lift/Drag Scale corresponding to assigned ICR)	
Graduated Health-Care System ICR Lift/Drag Scale	
aaa	100.0%
aa+	90.0%
aa	80.0%
aa-	70.0%
a+	60.0%
a	50.0%
a-	40.0%
bbb+	30.0%
bbb	20.0%
bbb-	10.0%
bb+	-10.0%
bb	-20.0%
bb-	-30.0%
b+	-40.0%
b	-50.0%
b-	-60.0%
ccc	-70.0%
cc	-80.0%
c	-90.0%
2 BCAR Score - Consolidated for All Regulated Health Care Entities	X%
3 % of Plan's Direct Medical Expense (i.e., Capitation and Other Payments) Directed to the Health-Care System and Affiliates	
Total capitation and other payments (Exh. 7, Part 1 - Summary of Transactions with Providers Col. 1, Line 13)	(a)
Total premium equivalents (Company-Provided Data)	(b)
Total capitation and other payments to affiliated providers (Exh. 7, Part 1 - Summary of Transactions with Providers Col. 5, Line 13)	(c)
Total premium equivalents directed to affiliated providers (Company-Provided Data)	(d)
Result (%)	= (c+d)/(a+b)
4 Health Plan's Adjusted Cash Flows as a % of the System's Operating Cash Flows	
Health plan operating cash flows (Cash Flow, Col. 1, Line 11)	(a)
Management incentive payments to system, excluding transfer-price-based overhead payments (Statement of Revenue and Expense)	(b)
Physician quality incentive payments to system (Statement of Revenue and Expense)	(c)
Capitation payments in excess of underlying medical cost trend (Company-Provided Data)	(d)
Adjusted health plan operating cash flows	(e) = (a+b+c+d)
Full-year system net cash provided by operating activities (Health-Care System Audited GAAP Financials)	(f)
Result (%)	= (e/f)
5 Health Plan's Total GAAP Revenues as a % System's Total GAAP Revenues	
Net premium income (Health-Care System Audited GAAP Financials)	(a)
Change in unearned premium reserves and reserve for rate credits (Health-Care System Audited GAAP Financials)	(b)
Fee-for-service (Health-Care System Audited GAAP Financials)	(c)
Risk revenue (Health-Care System Audited GAAP Financials)	(d)
Aggregate write-ins for other health care related revenues (Health-Care System Audited GAAP Financials)	(e)
Total premium equivalents (Company-Provided Data)	(f)
Adjusted health plan GAAP revenues	(g) = (a+b+c+d+e+f)
Health-Care System net patient service revenue (Health-Care System Audited GAAP Financials)	(h)
Health-Care System other operating revenue (Health-Care System Audited GAAP Financials)	(i)
Result (%)	= (g/(g+h+i))

Note: Premium equivalents are defined as claims paid + administrative expenses + stop loss.

Notching Criteria With Sample Data

Score Summary

	Weighting (a)	Calculation Result (b)	Weighted Score (a*b)
1 Health-Care System Issuer Credit Rating	25%	60%	15%
2 BCAR Score - Consolidated for All Regulated Health Care Entities	25%	150%	38%
3 % of Plan's Direct Medical Expense (i.e., Capitation and Other Payments) Directed to the Health-Care System and Affiliates	20%	70%	14%
4 Health Plan's Adjusted Cash Flows as a % to the System's Operating Cash Flows	20%	113%	23%
5 Health Plan's Total GAAP Revenues as a % System's Total GAAP Revenues	10%	41%	4%
Sum of Weighted Scores			93%

Note: Calculation Results in Notching Criteria - Score Summary are pulled directly from Supporting Calculation table below.

Supporting Calculations:

Data source (i.e., statutory blank or other) noted in each data field.

	Calculation Result
1 Health-Care System Issuer Credit Rating (Input Percentage from Lift/Drag Scale corresponding to assigned ICR)	60%
Graduated Health-Care System ICR Lift/Drag Scale	
aaa	100.0%
aa+	90.0%
aa	80.0%
aa-	70.0%
a+	60.0%
a	50.0%
a-	40.0%
bbb+	30.0%
bbb	20.0%
bbb-	10.0%
bb+	-10.0%
bb	-20.0%
bb-	-30.0%
b+	-40.0%
b	-50.0%
b-	-60.0%
ccc	-70.0%
cc	-80.0%
c	-90.0%
2 BCAR Score - Consolidated for All Regulated Health Care Entities	150%
3 % of Plan's Direct Medical Expense (i.e., Capitation and Other Payments) Directed to the Health-Care System and Affiliates	
Total capitation and other payments (Exh. 7, Part 1 - Summary of Transactions with Providers Col. 1, Line 13)	\$500.00
Total premium equivalents (Company-Provided Data)	\$100.00
Total capitation and other payments to affiliated providers (Exh. 7, Part 1 - Summary of Transactions with Providers Col. 5, Line 13)	\$350.00
Total premium equivalents directed to affiliated providers (Company-Provided Data)	\$70.00
Result	70%
4 Health Plan's Adjusted Cash Flows as a % of the System's Operating Cash Flows	
Health plan operating cash flows (Cash Flow, Col. 1, Line 11)	\$20.00
Management incentive payments to system, excluding transfer-price-based overhead payments (Statement of Revenue and Expense)	\$15.00
Physician quality incentive payments to system (Statement of Revenue and Expense)	\$10.00
Capitation payments in excess of underlying medical cost trend (Company-Provided Data)	\$-
Adjusted health plan operating cash flows	\$45.00
Full-year system net cash provided by operating activities (Health-Care System Audited GAAP Financials)	\$40.00
Result	113%
5 Health Plan's Total GAAP Revenues as a % System's Total GAAP Revenues	
Net premium income (Health-Care System Audited GAAP Financials)	\$600.00
Change in unearned premium reserves and reserve for rate credits (Health-Care System Audited GAAP Financials)	\$-
Fee-for-service (Health-Care System Audited GAAP Financials)	\$-
Risk revenue (Health-Care System Audited GAAP Financials)	\$-
Aggregate write-ins for other health care related revenues (Health-Care System Audited GAAP Financials)	\$-
Total premium equivalents (Company-Provided Data)	\$100.00
Adjusted health plan GAAP revenues	\$700.00
Health-Care System net patient service revenue (Health-Care System Audited GAAP Financials)	\$1,000.00
Health-Care System other operating revenue (Health-Care System Audited GAAP Financials)	\$-
Result	41%

Note: Premium equivalents are defined as claims paid + administrative expenses + stop loss.

ing Model's revenue field inventory in this calculation accounts for the various ways systems report a health plan's revenues in their financial statements.

This metric also accounts for consumers who either use competitors' health-care facilities or do not use health-care services during the period. Individuals who do not utilize the system's resources diversify revenue to the system through insurance premiums paid, generating revenues when the system's facilities and services are not utilized. The health plan's revenues provide economies of scale and scope to the organization.

Step 4: Management Support Agreement Assessment

Explicit and implicit capital support agreements are considered at this step, consistent with A.M. Best's group rating methodology. In summary, explicit support agreements are viewed more favorably than implicit agreements. Furthermore, the quality (i.e., content and creditworthiness of the system backing the guarantee) and duration of the support agreement also are evaluated.

The quality and content of support agreements vary widely across the peer group. As a result, examples of explicit and implicit support agreements are provided with A.M. Best's evaluative comments.

Explicit support agreements typically include a risk-based capital floor guarantee measured using either NAIC RBC at the Authorized Control Level (ACL) or BCAR scores, and a contractual commitment to pay all of the health plan's outstanding liabilities in the case of business run-out or insolvency. Explicit agreements are contractual guarantees filed with A.M. Best and, in some cases, with the insurance regulator. In these cases, the system commits that a health plan's risk-based capital will not decline below the predefined floor by guaranteeing an infusion of permanent capital into the health plan in a distressed scenario. Explicit agreements are evaluated based on the system's creditworthiness; the system's ability to infuse permanent capital into the health plan under a distressed scenario; and the guarantee's risk-based capital floor.

Commenting on the third criterion, a health plan's risk-based capital guaranteed not to decline below 400% NAIC RBC ACL would receive more rating enhancement than if RBC were managed to — and guaranteed not to decline below — 200% NAIC RBC ACL, the latter being the minimum amount of capital required to operate and not be placed under regulatory supervision and assuming two systems with similar ICRs. Although these explicit guarantees have not been tested legally,

A.M. Best will continue to enforce these guarantees through rating actions (i.e., if RBC or BCAR falls below the guaranteed floor and permanent capital is not infused within a contractually guaranteed and/or reasonable time period, a health plan's rating would be downgraded).

Implicit support agreements typically include a health plan's ability to use the system's name, a long operating history between the system and health plan, and existence of capitation contracts that transfer underwriting risk from the health plan to the system. Although these are valuable economic assets committed from the system to the health insurance company, they are quite common in integrated delivery systems and lack the extra safety and rating enforceability of an explicit agreement.

Step 5: Rating Assignment

As previously noted, A.M. Best assigns a public FSR(s) to a health-care system's regulated subsidiary(ies). At this time, A.M. Best determines the creditworthiness of the system to assist management in understanding the level of any rating enhancement provided to the regulated subsidiaries' stand-alone FSRs. Importantly, this evaluation is not specific to an individual municipal debt issue or other debt obligation and is communicated privately to client management at this time.

Step 6: Monitoring the Evaluation

A.M. Best will monitor the evaluation of the system and its regulated subsidiaries based on an annual review or on a relevant-event basis. Updates should be provided on the system's capital plans, operations and industry or reimbursement issues annually or when there is a significant change. Updates also should be provided on any topics relating to the system's operations that were discussed in the initial meeting. Information submitted to A.M. Best for the annual meeting will be the same as the information presented in the initial meeting; however, less discussion will need to take place.

Sample Notching Model—Data

	Data
Health-Care System's Issuer Credit Rating assigned by A.M. Best	a+
Health Plan's BCAR Score	150%
Health Plan Total Capitation and Other Payments	\$500
Percentage to System and Affiliates	70%
Health Plan Total Premium Equivalents	\$100
Percentage to System and Affiliates	70%
Health Plan Operating Cash Flows	\$20
Management Incentive Payments to System	\$15
Physician Quality Incentive Payments to System	\$10
Health-Care System Net Cash Provided by Operating Activities	\$40
Health Plan Net Premium Income	\$600
Health-Care System Net Patient Service Revenue	\$1,000



Founded in 1899, A.M. Best Company is a full-service credit rating organization dedicated to serving the financial services industries, including the banking and insurance sectors. For more information, visit www.ambest.com or contact one of our offices.

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