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Association News

IVCA Feature: Summary of the IVCA Luncheon, 'Affordable Care Act's Impact on Healthcare Investing'

July 18, 2012 11:59 PM -

CHICAGO – The decision by the Supreme Court regarding the Affordable Care Act (ACA) to uphold the law with a 5-4 vote, has not quieted the debate about the viability of implementation. The IVCA wanted to put the Act under another sort of microscope, as in how it will affect healthcare investments. The education luncheon on July 10th – "Affordable Care Act's Impact on Healthcare Investing" – brought together legal analysis, provider representation and investors.

Sponsoring the event was the law firm of Greenberg Traurig with the firm's own Gary Silverman moderating the discussion. The discussion began with expert overview of the ACA, provided by Eric Hargan – also of Greenburg Traurig – who served in the U.S. Department of Health and Human Services under the Bush II administration.

The panel participants included the investors –Kerry Byler of BlueCross BlueShield Venture Partners, Eric Larson of Linden LLC and Aaron Lillybridge of Baird Capital Partners. The healthcare provider side was ably represented by Dr. Larry J. Goodman, CEO of Rush University Medical Center in Chicago.

ANALYZING THE AFFORDABLE HEALTHCARE ACT

In 2009, Congress debated and President Obama signed into law the Affordable Care Act, restructuring and executing healthcare access opportunities. After being challenged in courts on several levels across the country, the Act came up before the Supreme Court, which ruled 5-4 that the law was constitutional.

Eric Hargan has experience at both the legal and governmental level regarding healthcare implementation. As a member of the Bush administration, he participated in the implementation of "Medicare Part D." His overview of the ACA included three salient points...

The Individual Mandate: This is the requirement for all Americans to buy health insurance or face a penalty, re-characterized as a tax by the Supreme Court decision. It's a relatively small tax. The incentive mandate will not be that high.

The Employer Mandate: This is for companies or businesses with 50 or more people, they will be required to provide healthcare insurance. The opt out tax for this is $2000 per employee per year. There have been a lot of predictions that employers will take people off their healthcare and simply pay the fine.

Medicaid: The threshold for this program was raised to 133 percent of the poverty level, a significant increase, designed to be permanent. Instead of coverage for specific categories, it will cover individuals and children. There are many state governors that are rejecting that increase in Medicaid, and litigation will rise accordingly.

Caps on Medicaid and Medicare payments are another sub-feature of the legislation, which it was posited will cut costs once they reach a certain level. According to Mr. Hargan, the Chief Actuary is questioning the sustainability of this tenet of the Act, because the law doesn't affect the beneficiaries. The impact on providers could possibly be a cut to reimbursements and coverage.

In conclusion, in this election year the Senate Minority leadership and the Speaker's office in the House has been mum on which parts of the law they will try to rescind, and the presumptive Republican nominee Mitt Romney has promised to overturn the law if he takes office. On the Supreme Court Ruling, one of the litigators on the conservative side, Gary Barnett, opined that the decision was "flimsy" and would not stand the test of time. It was too narrowly based, in the reading of taxation powers. Finally, the spending clause in setting up the Act within individual states, may be subject to litigation.

IMPACT ON HEALTHCARE INVESTING AND PROVIDER SERVICES

Gary Silverman moderated the next portion of the luncheon, a discussion with the panel in a question-and-answer format.

Q: Which sectors of the healthcare markets will be the winners and losers under the Act?

Kerry Byler of BlueCross BlueShield Venture Partners: We are in a unique position with our venture funds, with our sub-sector focusing on health care. The winners we see will be a shift from the more commercial insurers to a more retail, consumer-oriented group of payers. From an investment perspective, that funding shift would go to those retail groups.

Eric Larson of Linden LLC: I just want to make a couple comments on Eric Hargan's overview, to answer the question. One, I'm gratified to hear that there is uncertainty regarding the law, because that's how we feel. Parts of the bill will survive, and that's our job, figuring out which things we should focus on.

I participated in a webcast after the decision was made, and one panelist commented that every sector of the healthcare industry would benefit from this Act. More insured will mean more sales of drugs, devices and services. As the industry goes from 17% of the GDP to 20% of the GDP, that's a rising tide that will lift all boats. I would comment that in any industry there are always losers, so it may lift all boats except the ones that already have leaky holes in them.

Dr. Larry J. Goodman, CEO Rush University Medical Center: I like that assessment that everything will get better, although I don't quite share it. In looking at it from the provider side, pre-existing large systems that have employed physicians have an advantage going in. I think the huge risk will be the rush to form large systems, and the requirements that will be involved.

In contracting together, there will be a culture mix of different organizations who have to understand the difference between an episode of care and the entire management of care. This will not only be doing a good job when the patient walks in the door, it will be the responsibility including the financial risk of that entire episode of care, with owned and unowned care previously provided. That rush to provide large systems, if not accompanied by technology and other informational steps, could result in some crashing and burning.

On the pharmaceutical side, generics will gain a huge advantage, but a lot of investigators will move toward industry-sponsored research, which they weren't doing before. There will be a path there, but it won't be an easy one.

Lastly, the public hospital systems: those who don't have the large care infrastructure, (and many do not) and have not figured out Medicaid (and many have not) are in real trouble. That could really impact public healthcare systems and processes.

Aaron Lillybridge of Baird Capital Partners: I will reiterate what Eric Larson said, the theme of the day is that investors in this sector are paid to separate the wheat from the chaff, figure out what is going to survive. As I usually tell the lawyers when I get frustrated, let's try to figure out the 'spirit' of the law – such as cost reduction intentions. Exactly what will happen, well, there are still a lot of questions.

Most of the healthcare companies we're involved with have said they think it will be a huge boon for their

business. I think for 80% of the businesses it will cause a lot of noise for awhile, and then may eventually be a good thing, but a lot of people are hanging their hats on fat times for healthcare. However, if there is anything we're reading regarding the spirit of the law, is that more will have to be done with less. That means revenues may go up, but earnings may come down. Yes, there will be more patients, but if they come in at a Medicaid rate, I don't know many people making money at a Medicaid rate.

Q: Turning again to our healthcare investors, has the ACA already made an impact on your portfolios?

Lillybridge: We invest in healthcare industry sectors, stages and geography across the country, as well as the UK and international funds. It's as important to know who you are, as well as who you are not. As far as our portfolio, we have a revenue cycle business that focuses on emergency room [ER] space, there are a lot of patients who come in that just don't pay. For us, it's about revenue collection, so that business should do better, because the patients that didn't pay before now will, through the providers.

One of the businesses that I think is sort of interesting is the pharmaceutical outsource business. That business has been rocked by drug shortages. Since they are an outsource model, customers have been coming to them during the shortages, but they have a hard time making money on that, because they have the same problems with more pharma manufacturers limiting production, and picking the winners and losers among their client base. You'd think that these businesses could mitigate the costs during shortages, but that is not the case.

We own device-based businesses, and one of the big issues is the medical device tax. Is that going to hold? We'll see, we are putting models together. That is the unfortunate answer for investors. 'We'll see.' You have to prepare for the worst and best.

Larson: I will build off of what Aaron said, all the way down through our portfolio companies, even to the workers, all are curious and worried as to the effect regarding the ACA. To not be able to have clear answers is really troubling. Subsequently there is a veil of uncertainty as to what we do. We are primarily a life science and healthcare buyout firm, so everything we do is within the industry.

Linden's approach is to buy mature companies, fundamentally strong businesses that may have neglected or under-resourced by their current owners. Our job is to bring together operating and financial resources for each of the companies we buy. It's a collaborative opportunity to create a creative growth plan with the management team. We're a boutique, we look to do one or two investments a year, and having uncertainty about the future is a really challenging part at the outset.

I talked to executives and operating partners in portfolio companies that we own, to gain a perspective from their side...

We own a behavior health business in Nashville, there has been a very positive result in the ACA regarding mental health. In 2008, the Mental Health Parity Act was passed, which was part of the TARP act, but that provided a certain level of coverage. What the ACA plan provides is universal coverage, and that is viewed as a positive trend in the mental health field, offset somewhat by whatever happens at the state level for Medicaid funding.

We own a cluster of businesses that are in the clinical lab and life sciences area. The medical device tax is relevant here, and one of our CEOs answered that in 80% of the clinical diagnoses that is done, a test like this are provided, but represents only two percent of the costs. Particular to our companies, many already focus on cost reduction, and one of the main focuses of the ACA is to find ways to reduce costs.

The last point regarding our portfolio is to be nimble. Part of the benefit of Private Equity and Venture Capital is to provide nimble guidance for these small and medium size companies. I think of them as 'ankle biters.' We can really change small aspects of sectors in the healthcare economy. We just sold a physical therapy company based in Pennsylvania, and they are subject to government reimbursement costs, and their revenues had fallen off dramatically. But with guidance from our board there, they figured out a way to retrench, because everyone else in that industry was facing the same thing. By being nimble, they ended up have a nice growth story.

Byler: We have two funds now, raised in the last couple of years. BlueCross Blue Shield covers about 90 million Americans currently; one out of every three, with a well recognized system and healthcare brand.

Our goal is to drive innovation from the payer perspective, and to obviously increase quality and improve efficiencies.

Three companies illustrate that for us...

One is Bloom Healthcare, that was formed within the new funds and was sold last year. Going back to my point about shifting from commercial markets to a more consumer/retail focus, it helped that transition through the employer level to allow for them to shift responsibility to more client contributions.

The second and third companies focus on existing large provider systems. We have a company called ZeOmega, that really enables those providers to implement the Patient Centered Medical Home primary care system model, efficiently and effectively. And the third company is called Merits Health, which helps large provider systems implement care assist models, transitioning from fee-for-service to pay-for-performance. That's where our investment thesis is, with respect to performance.

Q: Before we turn to the provider side again, do you as investors overall the ACA will be a good thing for you, a bad thing for you, and what sectors of the healthcare industry do you think will heat up as a result?

Larson: I think it will be generally good for Linden, and generally good for the industry. There will be some inevitable losers. Since I've been in the Private Equity industry, since the mid-1980s, whenever I've seen regulatory or legislative changes, it's generally been good for Private Equity and Venture Capital, because we have nimble investment and management strategies. I think of this as an opportunity to bring creative destruction to the healthcare industry, which it needs. We see the pressure on the big pharmaceutical companies, and it may force them to rationalize the portfolio of non-core assets they have. The hospital consolidations may create opportunities for us to either look for collaborations or spin offs. The intense focus on cost reduction with quality improvement really plays well with companies we're already invested in, and what we continue to look for in every opportunity we pursue.

Lillybridge: For us, I go back to the spirit generally as well. I think one of the biggest benefits I see and can comment upon, is that a lot of people are spending a lot of time on tools, a lot of them IT enabled tools that we didn't have in the managed care evolution in the past. In earlier attempts to reign in costs, we didn't have the tools we have today. We're amazed on how many people are out there – despite the turmoil surrounding the ACA – are creating opportunities, and they do see where it's going. Computers, smartphones and home visits are all contributing to lower cost ways in coordinating care. We see a lot of that innovation getting stronger, regardless of where the healthcare model goes.

There is a portion of society that is getting A-plus healthcare that may not continue to get A-plus care, especially if they're not willing to pay more. And in that we also see all kinds of opportunities. Healthcare needs to be treated more like a business, it's amazing how the payer, the consumer and the person who makes health decisions are all different people. That's a problem, and has created the issues in healthcare in the past. Do I think the Act is going to magically change that? No. Some of the tenets need to be fully thought through, for it's not one-size-fits-all. But that's exciting for us, I look forward to the next 10-15 years. I think there is going to be some real opportunity, especially in newly created models.

Byler: As far as the question of net benefit versus non-benefit, I think it's yet to be determined. There are just too many balls in the air right now. If you look at community rating requirements and guaranteed issues, there has not been much implemented yet, which is difficult to manage from a payer's perspective. If you add in the health exchanges, obviously there will be some net benefits for payers. I will add from an investment perspective, it's really helped jumpstart innovation. That's a great thing for a venture investor.

Q: Turning to the provider side: Dr. Goodman, can you give us a little perspective from Rush University Medical Center side, the biggest impact both good and bad regarding the ACA?

Goodman: Rush is a University Medical system, we're four colleges, 2,000 students, a medical school, a college of nursing, a college of health sciences and a graduate school. We have about $80 million in externally funded research, most of which is from the National Institute of Health. We have about 8500 employees, a hospital, senior care and the Rush system, which includes four suburban hospitals. We have a mixed model of salaried and private physicians, the 17-year-old Rush system can accept pay-for-performance and monthly payments, and that model has both the private and salaried positions on the faculty, so there is no 'town and gown' department chairs. That's the background.

As far as looking ahead, not just at the Act, but more broadly. The goals of healthcare reform, and the drive of the economy and technology, it might be easiest in the triple aim of access, quality and cost – where those aims are going, and at least how they are impacting the provider side. The most positive aspect of this is quality. There has never been a way to uniformly measure quality. Quality is easier to shake out now with the electronic record. We can do data mining more quickly, and we know what's going on, as do the payers and the government. Plus soon the public will follow. That is a big deal, a big positive thing.

That difference, between merely having an electronic record, and actually using it to drive quality, and later tying it into a payment methodology – with pay-for-performance and eventually risk acceptance – is critical. When the quality side starts to demarcate, with all those positive things, something else can happen.

The best hospitals are not necessarily the best in risk adjusted quality outcomes, or on patient satisfaction. A gall bladder is a gall bladder, and if the survival rate is the same whether you go to the Mayo Clinic or the place around the corner, and if the place around the corner is cheaper, that's the place you can go to. That shift of choice based on the combination of economics of the individual, with higher co-pays, and will drive the sea change. We can now measure physicians, preventative care including nurses and other providers, plus costs associated with all that as well.

The last is least well addressed in all of this, which is access. There is a assumption if that more people have insurance, that will solve it. Already In California, physicians are refusing both Medicare and Medicaid patients. Medicaid pays physicians 18-22 cents on a dollar of cost, with hospitals like Rush it's about 70 cents on the dollar of cost. If a patient is empowered with a Medicaid card to go down the road to another hospital, that facility's Medicaid percentage could shoot up to a point where there can be a 'tip-over' event. Access remains a huge challenge in all this.

Everyone is struggling to get costs down. To do it across a continuum requires those partnerships, and that is where the management between primary care, the hospital stay, the nursing home and the rehab facility are all preparing for a time beyond pay-for-performance, and towards acceptance of risk: That's something most large systems are most wary of, and are not adept at. Whenever I see people doing things that they are not used to doing, most likely they're not going to do it well. That's the phase we're moving into, and the first responders jumping into this, unless they are very clever, will have some problems.

Q: Back to the political side of the Act. Mr Hargan, can you handicap some different scenarios that could result from this fall's elections – whether the act can be repealed, what the vulnerabilities are and whether the act can even be repealed at this point?

Eric Hargan: If the Republicans pick up 49 seats in the Senate, Romney is elected and the House is held, the bill is dead in the water. ACA will be repealed. Something will take its place. But for Republicans, the bill is toxic. If they get in, this Act will be gone.

Q: Depending on what media outlet you listen to, this Act will either save healthcare or will be an act of Armageddon. It's a mass disparity of views. Will anyone like to weigh in on whether this will be, cost-wise, a net positive for the country or a net negative?

Lillybridge: I think all of this is going to evolve. Healthcare, as much as I think change will be quicker in the next ten years than the last ten years, it still takes a long time. It will all play out. I think calls of Armageddon are absolutely characterizes not thinking about it. Is there going to be uncertainty and increase risk for a time period? Yes. But I think increased uncertainty and increased risk can also create more opportunity.

Goodman: I don't think the costs will necessarily go down, but the rate of rise will go down, it has to. All this stuff underneath the ACA is not a lie, these costs are taking up a huge amount of the economy of the United States, it's not a sustainable future. In the U.S., certain age demographic costs are not much different from other developed nations, until we hit the group of ages 50 and up. That's when our curves go way up. This is the part that will shake down. The question is, who will get hurt and how rapidly will the rate-of-rise stabilize. There is a lot of room to bend that curve, if it's done at the right pace. The rapidity of the change is worrisome, but I do believe that rate-of-rise will come down.

ATTENDEE Q&A

Q: Will 51 votes in the Senate be required to overturn the newly defined "tax" or the whole ACA bill?

Hargan: That is an unknown. The Senate Minority leader has refused to discuss it. The bill was initially passed in reconciliation. Which means, will the entire bill be under attack or will pieces of it remain? If the tax is overturned, the healthcare industry would certainly be in front of the legislature looking for complete reform. In any case, I think parts of this bill will survive, but a lot of this bill would be doomed if the mandate is ripped out.

Q: There are many smaller sized and medium sized companies that don't provide healthcare. What will those companies do after the ACA is implemented?

Hargan: If they have 50 or more employees, they will be subject to the law. They will either pay the fine or pay health insurance. How will they adapt to it? Some may pay think paying the $2000 a year fine is worth it, rather than providing insurance. One of the interesting elements of the law is, will employers cherry-pick employees? Are their salaries so low that they qualify for federally funded insurance? There might be a worse case privacy moment in that scenario. There is potential for businesses to look more closely – and ask more questions – of their employees.

Lillybridge: The people in the insurance business have said that their actuarial law has shown that unless there is an incentive, or if the penalty is less than 50% of the premium amount, that it won't drive any action.

Q: How do you see the post-acute providers who are not owned by the Accountable Care Organizations (ACOs) interfacing with the ACOs?

Goodman: Initially they can contract as they do today, with the next level up of sharing data, and beginning to participate in the pay-for-performance. The problem is when we get into risk sharing for real, and the interest is on one party or the other in a contract, the people will need to look at other models that meet the legal criterium of contracting across those entities. That's where you'll see all sorts of models. It's a selection process on what entities can do to be a desired partner.

Q: If President Obama is re-elected, what will the Republican's options be?

Hargan: There will be funding battles if they maintain the House and win the Senate. Depending on how the election turns out, and if Obama wins, I doubt there will be a lot of effort put into defunding by the Republicans. There still will be skirmishes and fights, but it will be tested.

Q: For Dr. Goodman, do you see ten years from now that health insurances companies will be not be the intermediator, and effectively the larger systems in cities will control healthcare dollars, and you'll be in charge of taking care of it?

Goodman: I think insurance companies won't go that route, but there can be some fundamental changes. I think you will see from large systems some direct-to-employer contracting. On the other side, providers will look at larger employers and say, let's just put a product out there and exchange ourselves. That might happen.

There are two differences from the old HMO model. The data underneath the changes are very different, I wouldn't underestimate the value of that. And the role of the consumer in this is the sea change. I really think they will drive this change.

For those organizations that cannot distinguish themselves by the highest quality, then the demarcation of successful organizations are minute. They will have to develop a product. This exchange will be the interesting spot, to see what products are there and what are the other services that can be provided, either to employers directly, or in partnerships between providers and insurers, including to the Medicaid population. It will be different for all these sectors.

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