Four Hot Spots in the Health Care M&A Market

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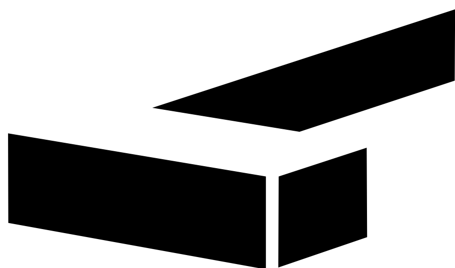

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Introduction

Among the dozen or more sectors that make up the health care services industry, a handful has displayed extraordinary growth in the last several quarters. Activity in other sectors has remained fairly consistent, while a few sectors continue to languish below the radar. In this report, we examine the factors contributing to activity in four of these sectors, and weigh the impact of future legislation, growth and financing initiatives. We begin with a look at the M&A market as a whole.

Overview: The Current State of Health Care M&A

Carsten Beith
I certainly think, as a result of healthcare reform, and to some degree broader trends that really began well before PPACA was even implemented, have sort of been overwhelmingly driving a path of commoditization to the healthcare industry, broadly speaking; and I think most of the sectors are ultimately going to be commoditized to a much greater degree than we currently see.

And I think some of that is certainly driven by the basic need to generate economies of scale and economies of process. And I think really the major theme for the managed care companies is really this whole provider consolidation trend that's occurring and the impact of healthcare reform, combined.

So, certainly we've seen the provider/payer integration is not a new concept, and it's been going on for quite a while. I mean, we referenced some of the provider/payer integration models that exist—Geisinger, UPMC, obviously Kaiser in California. And in fact in California, to a large extent capitation never really went away, so a lot of the providers really had what I describe as really insurance characteristics.

> "We're essentially moving away from a fee-for-service payment incentive."

But the way that we really look at healthcare reform—and I think this is really where there will be, over time, a very significant change—we're essentially moving away from a fee-for-service payment incentive, where every component of the healthcare industry is essentially a revenue center with very few cross-centers, cross-centers being kind of second-tier down the food chain in terms of vendors and so on.

But when you move to a risk-based ACO or population management or some other type of model where you're essentially not getting paid for volume, I think it changes the dynamic pretty significantly. You take essentially a hospital discharge, for instance. There's probably $15-$20,000 at stake with every hospital discharge, the hospital getting $11-$12,000 in professional fees, on the physician side another $2-$3,000, and then the post-acute care, pharmacy and others kind of getting the rest. So when you think about healthcare reform, we kind of distill it down to just one basic notion: It's all about reducing utilization.

So, the question becomes, who gets the economic benefit of that reduced utilization? So if it's a $20,000 sort of revenue number that you're talking about, the restructuring of the industry as we see it is really a function of trying to position your organization to capture some of the benefits of that reduced utilization, and it's obviously going to be very difficult for hospitals, and specialists in particular, who I think are sort of the bull's eye for healthcare reform and cost reduction.

But it also represents opportunities for those organizations that can really position themselves to manage that risk. When you look at the managed care companies, they've been affected pretty dramatically by healthcare reform, in the sense that from the premium side of it, with the 15% cap of administrative fees and profits on large employer plans, and 20% cap on small employer plans, the ability for them to arbitrage medical costs, keeping all the information and data proprietary and essentially leveraging that information to pay off all the providers, many of them having consolidated, most of the managed care companies will say that game is over.

> "When you look at the managed care companies, they've been affected pretty dramatically by healthcare reform."

So they're really starting to look at, how do you essentially get back into the medical arbitrage game in a meaningful way under healthcare reform; and secondly, how do they diversify their revenue base in some sense in fairly dramatic ways? So, we've seen the industry really begin to make some fairly dramatic changes, and I think the Blues, just because of the dominance that they are in so many states—although they're fairly large, sometimes very slow-moving organizations, have certainly shown the way, with a number of different integration models and a number of different ways to start to capture that medical arbitrage.

I think everybody probably heard this morning, Highmark announced that they had managed to convince the bondholders that West Penn wasn't in fact 100 cents on the dollar but 85 cents on the dollar; so here, you're clearly going to have another fully integrated system. But we're really seeing both the payers and the providers across the country really starting to develop different models of affiliation.

I think the question ultimately is can the payers operate providers, and conversely, can the providers operate payers, where you're creating these fully integrated models? But there are certainly some very good examples of success, whether it's Kaiser out in California or Geisinger or UPMC.

And I think, combined with some models out there that clearly are working, and the very significant economic pressures that are coming out of healthcare reform, and to some degree sort of the broader pressures that are being asserted by employers and the consumers of healthcare, I think we'll continue to see pretty significant integration between providers and payers.

I don't think we'll see, at least not yet, the payers get actively involved in acquiring hospitals. To some degree there is still capacity in many, many markets. So I think what we hear from the payers

is that they can still buy it on the spot market. But I think once demographics catch up and you get a larger population insured under healthcare reform, and you start seeing in fact shortages of the hospital resource, and particularly the physician resource, I could certainly see that we'll see the payers get more actively involved in ownership on the provider side, including hospitals. Whether that comes in sort of majority ownership, we'll see. I can certainly envision scenarios where we see the payers starting to buy minority interest in various providers.

So we've outlined sort of a number of what we think are some of the transformational transactions that we've seen over the last couple of years. Certainly United's acquisition of a big IP out in California in Monarch; WellPoint's acquisition of CareMore; and Healthcare Partners/DaVita—which was kind of an interesting transaction, because here you had DaVita, a renal company that essentially is a cost center in the healthcare system, really trying to figure out how do they capture some of that medical arbitrage in risk-bearing models, and they buy Healthcare Partners, which operates essentially a fully capitated model out in California and generates 20-plus percent EBITDA margins, which are obviously dramatically higher than even a well-run hospital, which is lucky to get a 12 or 13% EBITDA margin.

We've summarized some of the diversification transactions that we're seeing the Blues involved in. Whether it's investing in IT infrastructure, communication technologies and so on, a la NaviNet and Availity, or buying travel insurance companies like HTH Worldwide, or TriZetto, which essentially is a big HCIT company that's the backbone of many managed care plans, what we're essentially seeing is sort of these diversification initiatives are both designed for the Blues to have more control over what's called the premium dollars and how they're used, but also for them to essentially diversify into different revenue streams.

> "I think the question ultimately is can the payers operate providers, and conversely, can the providers operate payers, where you're creating these fully integrated models?"

The analogy that I really use is, to some degree the basic premium collection by the managed care companies is going to start to look somewhat commoditized, and to some degree almost like a utility, particularly if the exchanges take off and really become and create a lot of transparency around pricing; then I see the Blues having sort of a business that I would describe as utility, and then the rest of it would be very similar to what we're seeing in the utilities in terms of investing in sort of for-profit, non-regulated subsidiaries. And this is really starting to happen in a pretty dramatic way with the Blues, who are still extraordinarily—or generally, extraordinarily well capitalized and really have the ability to pursue these types of transactions. We're seeing the same thing in the non-Blues plans, whether it's United and so forth, making these types of investments.

On the next slide, we talked about some of the diversification initiatives. Essentially almost every Blues plan that we work with, we've seen them establish various types of subsidiary enterprises that are really oriented toward expanding their ability to capture some of that medical arbitrage that I referred to, but also essentially looking for much larger and diversified revenue streams. So I think this is really one of the trends.

And of all the businesses that are impacted by healthcare reform, at the end of the day, healthcare reform is really insurance reform, and I think the managed care payers are probably going to be impacted more at the end of the day than just about any other sector in healthcare. So overall, we see managed care frankly as a pretty attractive sector with strong membership growth obviously in government programs with Accountable Care. There will certainly be new opportunities with some of the insurance exchanges. We still aren't clear exactly how those orient themselves. And there are other opportunities around much more consumer-oriented healthcare.

As I said, I think healthcare reform ultimately is insurance reform, and so the sector will in fact be impacted pretty dramatically, and we've seen that in some of the subsectors within managed care, in terms of how they're trading and where the real opportunities are. It's clear that with healthcare reform, Medicaid expansion will be significant, and the Medicaid-oriented HMOs are certainly trading at multiples that are significantly higher than the traditional commercial HMOs.

> "To some degree the basic premium collection by the managed care companies is going to start to look somewhat commoditized."

The other piece I think that's still uncertain is Medicare Advantage. It has obviously been significantly curtailed with healthcare reform, but it's an overwhelmingly popular program among the seniors. And certainly to the extent that it really begins to capture the ability to truly manage utilization, which some managed care operators have really been able to do, there's still a pretty significant opportunity in that area. So we see that Medicare Advantage, even though it's curtailed from a reimbursement standpoint, currently probably has some pretty good long-term prospects.

Then you have some dual-eligibles in the Medicaid-Medicare population that's getting increasing focus from the managed care players because they tend to be very complex patients with—or enrollees, often with co-morbidities and significant health challenges; and if the right—let's call it "economic model," works, there should be some pretty significant opportunities to reduce utilization among that population; and by virtue of that, generate some of the medical arbitrage that the payers seek. So ultimately I think the managed care sector is still viewed relatively positively from a valuation standpoint.

I think Steve earlier referenced a couple of sort of blockbuster deals last year, obviously WellPoint buying AmeriGroup, a big Medicaid plan, and a 14.5 multiple of EBITDA, kind of through the stratosphere, if you will. But even Aetna buying Coventry at a pedestrian 7.8 multiple, these are still

pretty healthy multiples for a sector that probably has more turmoil ahead of it than the other sectors within healthcare.

So, just looking at sort of the valuations, they're kind of all over the board, but as with a lot of sectors in healthcare that are directly or indirectly impacted by the federal government, we tend to see kind of these five, six, seven times EBITDA kinds of multiples, and somewhere between six or seven times revenue multiples.

1. Post Acute Care

Carsten Beith
One of the key dynamics overall in the post-acute care sector is that it's certainly expected to grow significantly faster than the acute care hospital sector. And so from that perspective, we see a lot of interest in Wall Street in trying to figure the right plays within that post-acute sector. And we look at, if you look at the lower right-hand corner, it's sort of this pathway in terms of really looking at what happens to these discharges that I referred to earlier, and where did they go, and where are the opportunities?

"One of the key dynamics overall in the post-acute care sector is that it's certainly expected to grow significantly faster than the acute care hospital sector."

So the question ultimately is, how will the federal government, which is sort of an overwhelming payer for the post-acute sector, how will it ultimately structure the payment system? Currently, I sort of described a little bit like the whack-the-mole type of approach, which is not looking at the system in aggregate and saying, we should be venue-neutral, where is the best place to place patients and get the best care, the best outcome at the lowest cost; it's a little bit of which sector in healthcare at any given time is making too much money, and let's cut reimbursement, without really understanding what are the broader implications. I think that's always a risk.

2. Hospitals

Joshua Nemzoff
I always get asked, what exactly is a distressed hospital?

There are three different ratios that we use to look at the market. One is debt service coverage. The other is days' cash on hand. The third is EBIT margin. Just to give you an overview of what a distressed hospital looks like, we have about 2.5 debt service coverage, and if you have about 90 days' cash on hand and you have an EBIT margin of about 8%, you're not quite distressed, but you're getting

there. It's probably time to call a turnaround firm; it's not quite time to sell.

If you have debt service coverage of about 1.5, your days' cash on hand are about 60, and your EBIT margin is about 5%, it's time to sell and it's too late for a turnaround firm. You're a prime target for someone to buy.

If your debt service coverage is 1, your days' cash on hand are 30, if your EBIT margin is 2%, it may be too late for you to sell; you may be starting to think about calling the bankruptcy attorney—unless of course you happen to be located in New York City. If you're in New York City and you have 30 days' cash on hand, you're probably a star performer. That's a very different market.

So that's kind of what the distressed market looks like. It's low coverage, it's low cash on hand, low EBIT margin. They don't get there overnight; it happens over a period of time. It's very, very difficult to turn around a hospital at coverage levels of 1.5 with only 60 days' cash on hand and very little margin.

Then the question is, who's buying these things? There are for-profits, and there are nonprofits. The for-profit companies are in-market buyers, and they're also out-of-market buyers, and they will buy hospitals in markets where it's nowhere near any hospitals they own. There are large for-profits, there are small for-profits. Some of them are public, some of them are private. They're kind of all over the map. They have significant access to capital. They've got access to debt and they've got access to equity. Some of these companies have extremely large capital bases, in terms of the ability to tap into the equity markets and write checks for $100 million, $200 million, $500 million.

> "It's very, very difficult to turn around a hospital at coverage levels of 1.5 with only 60 days' cash on hand and very little margin."

These are very, very large equity firms that own these companies. They're very aggressive. They certainly have the ability to take risk. They're looking typically for a 25% return on investment per year, and they have no fear at all in terms of taking over a not-for-profit hospital or even another for-profit hospital and making a go of it.

Steve Economou
These private equity firms, what do they see as the exit when they make these investments?

Joshua Nemzoff
Primarily, the exit is going public and getting enormous return on their capital. That's sort of the Nashville model, as it's been referred to. But their goal over time is to develop a critical mass of $700-$800 million or a billion dollars in revenue, go public, and then the multiples who go public is their exit strategy.

The nonprofit buyers are a completely different breed. They tend to not be great risk-takers. Their access to capital is exclusively debt; it's very rare that a nonprofit hospital will write a check in terms of cash. They're looking for hospitals that are near their existing hospitals. Except for the very large systems, it's very unusual to see a not-for-profit hospital go buy another facility that's not anywhere near their market.

> "If you've got 10 or 15% market share, you don't have enough leverage to tell an insurance company what to do."

Those are the two main buyers of hospitals, both for-profit and nonprofit. The main difference between the two of them is that the for-profits are much more willing to take risk, and therefore it makes them much more aggressive.

As far as the issue of health reform and the impact that would have on the M&A market, obviously the anxiety level has gone up dramatically in the healthcare industry. There was a period for a year or two where everybody thought that Obamacare was going to save them. I think we're past that now; reality has kind of set in, and what's happened is that the large profitable hospitals are probably going to do even better; the ones that are not profitable will do even worse. It's the rich will get richer, poor will get poorer.

But healthcare reform is not going to be—it's my opinion—the savior for a lot of these hospitals that two or three years ago were thinking that their bad debt problems were going to go away.

Steve Economou
Do you think the hospital market will consolidate into a handful of major players like the payer market?

Joshua Nemzoff
No; the hospital market is too geographically dispersed to do that. Certainly there are large systems and large markets, but there are thousands of hospitals, they're all over the country, obviously. And even if you go into any large metropolitan area, you have very large players in those areas. But you're not going to see the kind of consolidation that you see in managed care, insurance markets, where two players control a huge market, and that happens all over the country. So there's certainly going to be consolidation, but I would not expect it to be as concentrated as you see in the insurance business.

Steve Economou
Do you think smaller communities will be concentrated?

Joshua Nemzoff
Well, I think that they already are. I think that what's happened in a lot of markets is that you end up with one player or two players that are very dominant, and whether it is one player or two players, they have the clout to demand managed care rates, and that's why you see a lot of these hospitals doing very, very well, because managed care companies cannot live without these hospitals.

It’s a question of leverage, and in those markets they have that leverage. So if you’ve got 10 or 15% market share, you don’t have enough leverage to tell an insurance company what to do. If you have 25 or 30% leverage, you’ve got enough leverage to tell an insurance company we need to be more reasonable in terms of their rates. So it’s a market-by-market issue, but I don’t see the hospital market consolidating with the insurance market.

3. Physician Groups

Joshua Nemzoff
I never understood the theory about buying physician groups. I’ve been in the business for a while, as you know, and this is the third cycle of people deciding it would be a great idea to buy physician groups.

The reason hospitals buy physician groups is in order to increase volume and get referrals. So there are two sides to that puzzle. One is keeping the buy-in you have, and buying the physician practices of doctors that already admit to your hospital. That’s not a profitable venture; that’s a zero-sum game because they’re already admitting. The other is to go and try and buy physicians that are in somebody else’s hospital on an increased buy-in, and hospitals are trying to do that also.

But the biggest problem that everybody had in the last two go-arounds was that they would buy the physician’s practice, and the physician all of a sudden, instead of working 50 or 60 or 70 hours a week, was working 40 to 50 hours a week, and they could not get the doctors to perform the way they wanted them to perform.

> “In some sense, it’s a different business model than just the traditional PPM rollup.”

There are a lot of stories about it, and a lot of discussion about it, a lot of concern about it. But the bottom line is that if you’re buying a physician practice with a primary reason of getting him to admit patients to your hospital, and he’s already admitting patients to the hospital, how are you ever going to make money doing that?

I remember about—I think it was five or six years ago, I think it was St. Thomas in Nashville—publically announced that they were simply giving back 200-300 physician practices that they’d purchased a few years before, and they weren’t the only ones. I understand the concept. I don’t think it’s a good idea for these hospitals to think that buying physician practices is going to be a long-run strategy for them, because if everybody’s doing the same thing, they’re just going to neutralize each other and they’ll be right back where they started from.

Steve Economou
Haven’t the deal structures just changed over the two different cycles? Put aside the private equity role of the physician practices, but on the hospital side, hospital acquisitions of physician practices?

Joshua Nemzoff
The structure has changed, but the problem remains the same. Now, the idea of owning physician practices has been around for 20 or 30 years. One of the greatest examples of a success story, which goes back at least 20 or 25 years, is Intermountain Healthcare in Salt Lake City, which owns hundreds of physician practices. They're great at running those practices, and it's worked out very well, and that's fine.

As far as what you pay to doctors and how you share the revenue and how that works out, it doesn't really matter what the model is. If there's no more money coming into the equation, then doctors don't have any ability to increase their revenue, and the hospital doesn't have any ability to increase the revenue. Then, the only way for the hospital to profit from this is that they go and buy a physician practice from a competitor. That physician changes his referral patterns and starts putting his patients in their hospital. That's what everybody's trying to accomplish. If they're successful at it, then it probably would work; but if they're not successful at it, then they're just paying a lot of salaries, and it's not going to impact their bottom line at all.

Steve Monroe
I think one of the things that's happened is that back in the heyday, some of the cardiologists, oncologists, those practices were being sold for—I don't have it in front of me, but let's say $1.5 million per doc; and you just would not see those numbers today. It's not a sale to cash out your practice; it's really more of, how can my practice survive and do better in the future. So I don't think it's as much of a cash-out situation like it was ten years ago.

Joshua Nemzoff
I would agree. The other side of the equation, Steve, is from the doctor's point of view, if you talk to almost any doctor, he'll tell you that they're working harder now than they worked two or three years ago, and they're making 60% of what they were making three years ago. So they see this as a trap that they can't get out of, and if somebody's willing to simply give them a paycheck and they'd make the same amount of money, they're guaranteed that for some period of time, they see that as a way out of a very serious problem they've run into.

Steve Economou
Are you guys confident at all about the private equity rollups of physician groups?

Joshua Nemzoff
I think FICOR years ago kind of paved the way for that one. You could get a positive and also a negative way. I just—I don't see even the folks on Wall Street being willing to take that risk. It's just not a venture that I think is going to work, and they know it, and they've seen it happen before. But there just aren't enough dollars to make the paradigm work.

Carsten Beith
I think the exception to that is probably physician groups that are capable of bearing risk—obviously the Healthcare Partners, DaVita example, and some of the managed care that I'll talk about a little bit later, that have acquired some of these larger IPAs. But in some sense, it's a different business

model than just the traditional PPM rollup where you just take a piece of the compensation that the physicians were getting before and now they've just monetized it in front. So I agree; I don't think that we'll see the traditional physician practice management model for at least a couple generations yet.

Trey Crabb
I agree with that, and I think it's probably more of an issue with the primary care folks that Josh was talking about. Some of the models are out there on a physician outsource basis. The hospitals are happy to have certain specialties be handled in separate companies with contracts.

4. Home Health Care

Carsten Beith
When we look at the home healthcare sector, certainly the demographic and kind of what I describe as the low-cost setting, are significant incentives for investment, and where we see significant growth. The downside obviously for this sector is really what happens on the reimbursement side. Currently, the Affordable Care Act was pretty tough on the home healthcare sector, with some pretty significant reductions slated through 2017—reduced market-basket updates, or MBUs as we refer to it here.

So the question really is how do the significant drivers, in terms of the industry—and it's a highly fragmented industry with lots of opportunities for consolidation, demographics as I mentioned, new patients coming on, on the insurance side—do those, what are called positive drivers offset the regulatory part of it?

I think the consensus that we see, from a lot of investors that have chosen to invest in the home healthcare sector, is essentially that the key drivers will overwhelm the regulatory and reimbursement challenges, because at the end of the day, the home healthcare sector essentially provides lower cost, arguably equal quality or even higher quality care, and that should really be, or that is clearly the intent of healthcare reform. So a pretty upbeat view I think on the home healthcare sector, even though currently, valuations are probably somewhat depressed, reflecting pretty aggressive rate reductions coming out of Washington.

"Fairly meaningful-sized transactions do get done on a regular basis—$150-$300 million kinds of transactions."

I think there was a question earlier in terms of the size of transactions. The ones that there's data on are obviously more meaningful in terms of size than a lot of the home health agencies that are being sold; I mean, it's one of probably the easiest businesses to get into in the healthcare sector. But fairly meaningful-sized transactions do get done on a regular basis—$150-$300 million kinds of transactions, at pretty typical healthcare services kind of valuations. Six to seven times EBITDA, about 0.9 times revenue are the medians for that.

If you look at the public companies, they are a little bit depressed from a valuation standpoint, we think really driven by the reimbursement concerns from a government perspective. But over time, we

would think that this would be a pretty attractive sector. What's pretty clear is that the consolidation trend that I started this discussion out with is clearly one that will impact the home health sector, as the cost of infrastructure, the cost of IT support to give the data that allows cost and quality measures and all of that is very expensive, and we certainly see sort of the sun setting of small mom-and-pop type of home health, to a much larger sort of institutional approach to that.

Summary

At this point in time post-acute care, hospitals, physician groups and home health care are demonstrating growth potential. Signs of significant future growth have begun to become apparent in recent activity. Although there is a fair amount of uncertainty and change that will effect growth in all sectors in the near future, these sectors are currently demonstrating a promising resilience.