Merge or Close
Obamacare and Local Healthcare
Panel

• William K Snyder, CTP, – Moderator – Deloitte Transaction and Analytics

• Jeffrey D. Benton, CTP, FTI consulting
• Eric D Prezant, Bryan Cave LLP
• Andrew Turnbull, Houlihan Lokey, Inc.
• Matt Brown, McKesson Specialty Health
State of the Industry
Hospital M&A Volume Declines In 2014, Yet Poised To Pick Up

Announced Hospital Mergers And Acquisitions

- Number of deals (includes deals with no announced price)
- Combined deal value, $B (excludes deals with no announced price)

Source: Irving Levin Associates, Inc.

(1) Dollar volume in 2006 was affected by the privatization of HCA, Inc., the largest hospital transaction ever announced.
Health Care System Operating Margins – The Weak Get Weaker

Not-For-Profit Health Care System Medians By Rating Level - 2013

Source: Standard & Poor’s Rating Services
Note: AA+, BBB/BBB- and Speculative Grade ratings all represented small sample sizes (5 or under)
Operating Margin Deterioration Also Expected for Standalones

Standalone Hospital Medians By Rating Level - 2013

Source: Standard & Poor’s Rating Services
Pyramid of Pain
A Pyramid of Pain for United States Taxpayers

- **Total Obligation**
  - $3.7 Trillion
  - $3.5 Trillion
  - $10.6 Trillion
  - $13.2 Trillion
  - $17.8 Trillion
  - $35.3 Trillion
  - $41.8 Trillion

- **Obligation Per Capita**
  - Underfunded Medicare
    - $285,324
  - Unfunded Medicaid
    - $240,055
  - Federal Debt
    - $212,502
  - Household Debt
    - $90,302
  - Underfunded State and Local Pensions and Retirement Healthcare
    - $72,355
  - State / Local Debt
    - $35,236

**Note:**
- Not drawn to scale
- 3. Includes $3.0 trillion of unfunded pension and $5.1 trillion of retire healthcare obligations
- 4. 2014 Social Security Annual Report
- 6. KPMG. Perkin Eastman & Rowes USA Inc
- 7. 2014 Medicare Trustees Report

*Cumulative Per Capita Obligation of $859,355

- HOUliHAN loKEY
Demographic Changes

The U.S. population is aging as the oldest Baby Boomers\(^1\) are now turning 65 . . .

. . . Yet, the “cost bubble” is still to come as utilization does not spike until age 75 . . .


The 65+ age cohort as a percent of total U.S. population is expected to grow from 13% in 2010 to 19% in 2030

Hospital Discharges & Days of Care by Age (2010)

The 90+ age cohort is the fastest growing

Average age of hospital inpatients was ~41 in 1970 vs. ~58 in 2010

\(^{1}\)Defined as those born between 1946 and 1964

Source: U.S. Census Bureau; Claritas; CDC’s Health, United States, 2009; U.S. National Center for Health Statistics; Utilization statistics based on 2010 data.
Demographic Changes (continued)

... But the trending ratio of U.S. workers to Medicare enrollees will not support the current model.

Medicare Beneficiaries and The Number of Workers per Beneficiary

- Number of beneficiaries (millions)
- Number of workers per beneficiary

Key Implications
- Octogenarians → Centenarians
- Move to “de facto” single payer system (Medicare)
- Patients in hospital will be older with more co-morbidities
- Who will be the innovators?

This “upside down” trend also impacts ratio of clinicians to patients
Increased Medicare and Medicaid Volumes Will Make Cost-Shifting to Commercial Payers More Difficult

### HISTORICAL

<table>
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<tr>
<th>Payer</th>
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**Health System Imperatives:**

- Location, Location, Location – go where the paying population is
- Maximize volumes from top payers
- Benchmarking and controlling costs
  - **Must generate positive return on Medicare**
- Pushing payers to increase/maintain rates (those that cannot may consider consolidation)
- Higher levels of collaboration with physicians to create and get paid for value

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*Source: Massachusetts Hospitals: Critical to the commonwealth and threatened in the economic downturn. MHA.*

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Case Study on Massachusetts Medicaid Program (MassHealth): Medicaid enrollment increased from approximately 1M to 1.4M members from 2006-2010 but the payment to cost ratio fell from 82% to 70% in the same period.
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For Illustrative Purposes

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Obamacare Recap
Healthcare Reform

Regulatory reform is attempting to undergo three primary phases to increase access, expand benefits, and decrease costs

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<th>2010 - 2013</th>
<th>2014</th>
<th>2015 – 2020</th>
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<tr>
<td>• Temporary high risk pool created</td>
<td>• Individual Mandate</td>
<td>• Employer Mandate (2015)</td>
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<td>• Dependent coverage until age 26</td>
<td>• Health Benefit Exchange for individuals and small employers</td>
<td>• Health Benefit Exchange for Children’s Health Insurance Program (2015)</td>
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<td>• No preexisting conditions under age 19</td>
<td>• Standardized “Essential Health Benefits”</td>
<td>• Quality of Care reimbursements for providers (2015)</td>
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<td>• Medicare Part D rebate</td>
<td>• Guarantee issue and renewal rules</td>
<td>• States can form healthcare choice compacts (2016)</td>
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<tr>
<td>• Non-discrimination rules for insured plans</td>
<td>• Rating restrictions (family size, geography, age, and tobacco use only)</td>
<td>• 10% threshold for itemizing medical expenses for seniors (2016)</td>
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<tr>
<td>• Limits on insurance premium increases</td>
<td>• No preexisting conditions</td>
<td>• Health Benefit Exchange for all employers (2017)</td>
</tr>
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<td>• Lifetime dollar limits prohibited</td>
<td>• Annual dollar limits prohibited</td>
<td>• Waiver for state innovation if alternative healthcare plan implemented (2017)</td>
</tr>
<tr>
<td>• Annual dollar limits restricted</td>
<td>• Insurance deductible caps</td>
<td>• Federally-regulated multi-state plans available in every state (2017)</td>
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<tr>
<td>• No cost sharing for preventative care</td>
<td>• Waiting period limited to 90 days</td>
<td>• Excise tax on high cost “Cadillac” insurance plans (2018)</td>
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<td>• FSA / HSA / HRA changes</td>
<td>• Mandatory coverage for clinical trials</td>
<td>• Medicaid coverage extended to former foster care youth under age 25 (2019)</td>
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<td>• Medical loss ratio and policyholder rebates</td>
<td>• Implementation of wellness programs</td>
<td>• Medicare Part D “donut hole” closed (2020)</td>
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<td>• Appeals for adverse benefit determination</td>
<td>• ICD-10 code adoption</td>
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<td>• Anti-fraud funding increased</td>
<td>• Medicaid for everyone under 133% of FPL</td>
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<td>• PCORI / comparative effectiveness</td>
<td>• Phase in of two multi-state plans</td>
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<td>• Employer-provided health benefits on W-2</td>
<td>• Tax credits for low income filers</td>
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<td>• Details on administrative expenditures</td>
<td>• 10% threshold for itemizing medical expenses for everyone under age 65</td>
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<td>• Readmissions Reductions Program</td>
<td>• Small business tax credits</td>
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<td>• More generics approved by FDA</td>
<td>• Small business tax credits</td>
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<td>• Annual fee on pharmaceutical manufacturers</td>
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<td>• Excise tax on medical device sales</td>
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Increase access  Expand benefits  Decrease costs
Healthcare Trends

The Healthcare competitive landscape is expected to change dramatically over the next few years

- By 2017, healthcare will consume over 20% of the US GDP at a cost exceeding $3 trillion
- 30M more people will be insured in 2017 vs. 2013
- Medicare coverage will migrate to 59-60M enrollees from current 47-49M
- Inpatient revenue growth will remain flat while outpatient growth will increase to approx. 20%
- Physician shortages will range from 150,000 – 170,000
- 1/3 of hospitals will have closed or be on a path to closure by 2020 (100+ per year)
- Competition will increase as healthcare providers compete on cost and quality
- Three major technologies will dramatically change healthcare: electronic medical records, mobile applications, and genomics
- Innovation and competition will increasingly come from firms outside traditional healthcare boundaries (e.g., retail, web-based firms)
- Reimbursement will transfer from a production model to one predicated on outcomes and population health management
- Employers will be an increasing force in the delivery of preventative services and health care
- Consumer engagement will be an increased focus for payers and providers

Many of these changes are being driven by Healthcare Reform