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Healthcare Focus

DRESNER PARTNERS
INVESTMENT BANKING

America's Greatness and "Real" Healthcare Reform

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Introduction. In this article, we review the current state of the healthcare landscape, the fundamental causes of how we got here, and the legislative response. In addition, we offer a view to the likely future direction of the healthcare sector, in particular the respective roles of the public and private sectors.

First, some history. From 1969 to 2008, the total public federal debt as a percentage of GDP has, on average, hovered around 40%, never exceeding 50% (with the exception of 1992 to 1995 when it touched 50%). In 2008, for the first time since 1969, the total debt as a percentage of GDP exceeded 50%, reaching 57% in 2010. The primary reason: exploding federal deficits, which grew from $400 billion in 2008, to $1.3 trillion in 2010.

According to the Government Accountability Office (GAO), total public federal debt is likely to touch approximately 120% of GDP by 2019 with a prolonged upward trend expected thereafter. At this rate, by 2019, approximately 93% of federal revenues will be spent on Medicare, Medicaid, social security, and interest payments, with the remainder left over for other public goods, namely education, energy, defense, law enforcement, and scientific research, among others. As a percentage of total healthcare spending, Medicare, Medicaid and other public programs made up 47.4 percent of the total $2.3 trillion healthcare spending in 2008, of which Medicare alone made up 20.1 percent, or $462.3 billion.

It is clear why the series of major legislative responses—the Balanced Budget Act of 1997, to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, to the Deficit Reduction Act of 2005, to the Patient Protection and Affordable Care Act of 2010 (ACA)—all have taken aim at the main "cost" of healthcare, i.e. entitlements, particularly Medicare. While legislation progressively has incorporated fundamental reform measures in addition to payment curtailment, reform ultimately will be the burden of the full spectrum of stakeholders—the federal government, states, providers, businesses, and individuals, with information technology as the primary enabler.

This "real" reform will be the result of rapid, incremental changes focused on simultaneously improving outcomes and efficiency, rather than on the reactive philosophy of attempting to induce positive change throughout the delivery system by attenuating payments.

We believe that pursuing *value,* i.e. maximizing clinical outcomes per dollar spent, is the only rational course of action, particularly in the context of crippling budgetary constraints, and should be the central principle of any process to effect reform. How would this come about? Following is a discussion of each stakeholder's role and how "real" reform, rather than *ad hoc* tinkering, would bring about sustainable value-creating change.

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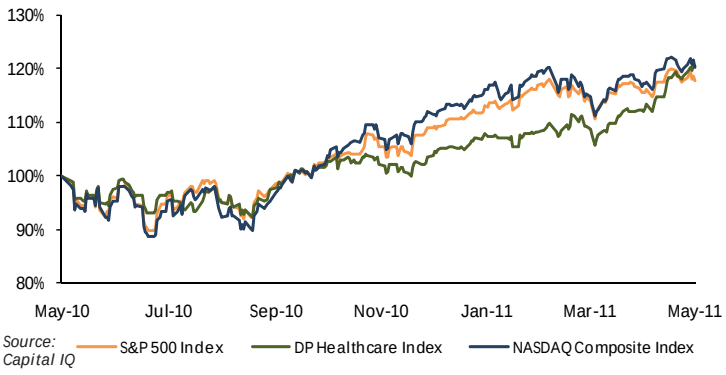
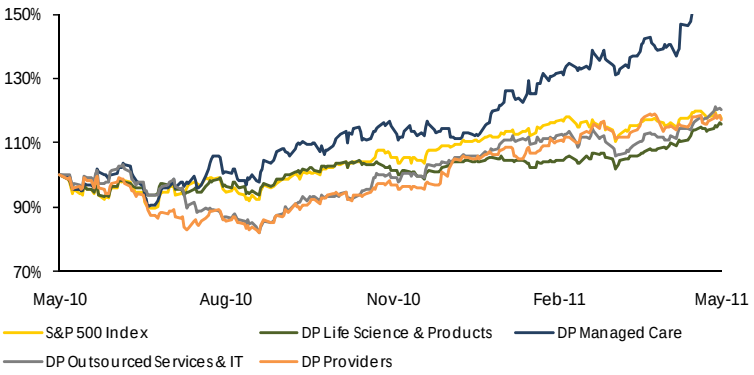
Healthcare Public Market Trends

Industry Returns



Source: Capital IQ

Sector Returns



America's Greatness and "Real" Healthcare Reform (cont.)

Federal Government. Recognizing that Medicare has become replete with waste and inefficiency, successive federal governments, in assorted ways, have attempted to "reform" Medicare, as discussed above. In recent years, however, the idea of premium support has emerged. The concept was first explored in 1995 by Henry Aaron, Senior Fellow at the Brookings Institution, and Robert Reischauer, President of the Urban Institute and former head of the Congressional Budget Office. In 1998, then-Senators Bill Frist (R-TN)) and John B. Breaux, (D-LA) tried vigorously to advance the idea as separate legislation, and in November 1999, Senators Frist, Breaux, et al introduced the Medicare Preservation and Improvement Act of 1999 (S.1895). Then-President Clinton's National Bipartisan Commission on the Future of Medicare incorporated S.1895's core principles in its proposal; however, President Clinton ultimately did not support the Commission's proposal.

The fundamental concept behind the Frist-Breaux bill is to restructure Medicare using as a model the Federal Employees Health Benefits Program (FEHB), which covers nine million federal employees, retirees and their families. Under the FEHB, enrollees are offered a choice of private insurance plans in addition to Medicare Fee for Service, in sharp contrast to the current Medicare model. The government provides on average 72 percent of the premium charged to enrollees by their chosen plan. FEHB was begun in 1960 and has materially lower administrative cost per enrollee than Medicare. S.1895 embodied the key elements of the FEHB structure.

On April 5, 2011, House Budget Committee Chairman Paul Ryan (R-WI) unveiled a plan that is a direct derivative of S.1895 and provides unprecedented choice to Medicare beneficiaries, while reducing the government's payment burden. While details, not the least of which include structure, extent of premium support and potential rate increases, would emerge eventually, the plan (or some future derivative thereof) would also create a larger pie for the private insurance sector and potentially introduce long-overdue competition among private insurers.

An emerging model for this structure is Medicare Part D, where the government provides basic premium support and provides oversight of the marketplace. Enrollees select their insurance and care delivery model, paying out of pocket for higher-coverage choices.

States. 2010 was the year of the largest state budget shortfall in history: $191 billion (up from $110 billion in 2009). Despite this situation, governors are faced with the daunting task of implementing the ACA's key provisions, most notably health insurance exchanges. Under the ACA's mandate, states have the option to establish and administer online insurance exchanges that offer consumers a choice of in-state private insurance plans or, if the state chooses, to instead allow the federal government to do so. The deadline for establishing a functioning exchange is January 1, 2014.

Given many states' constrained resources, some states view the startup costs and administrative burden for establishing insurance exchanges as prohibitive. Last month, Louisiana decided against a state-run exchange, thereby transferring the responsibility to the federal government, as allowed by the ACA. At the other extreme, Utah and Massachusetts had exchanges in place before the enactment of the ACA, with decidedly mixed results.

Most states, however, are still undecided. Aside from the availability of requisite resources, a key criticism of the insurance exchange idea is that due to the ongoing consolidation of the payer sector, the risk of a single monopolistic payer emerging in a given state (particularly in smaller states) is too great. The net effect of this would be that consumers would eventually have less, rather than more, choice, and this obviously would be the opposite of the intent of the ACA. Moreover, there is concern that an exchange would quickly turn into an inefficient government bureaucracy, thereby placing a new burden on state taxpayers.

A possible solution: create a uniform regulatory structure across all states to allow payers to compete across state boundaries without misaligning payer incentives with consumer goals. This provision is not part of the ACA. Enabling inter-state competition among payers would certainly allow more consumer choice, and hence more favorable pricing and coverage. In turn, payers would have access to new markets.

Providers and Payers. No longer can the provider-payer partnership remain adversarial. While pure "operating" efficiency is essential for any provider, it does not by itself constitute a process for creating value. Historically, providers have been fixated (largely as a result of declining reimbursement) on non-clinical metrics such as average length of stay, census, admissions and outpatient visits. Real reform should focus on the patient and doctor, rather than on the physical facility where healthcare is delivered. Value creation can only be accomplished through a patient-centered, consumer-driven model where the primary care physician is the quarterback.

(Continued on page 3)

America's Greatness and "Real" Healthcare Reform (cont.)

Under the current system, commercial payers (due mainly to their origins in the indemnity industry) fundamentally are risk managers employing actuarial methods which (by definition) rely on historical and current, rather than future, events. This fundamentally ignores *value*, i.e. the *best* clinical outcomes, at the *lowest* cost, while *preventing* adverse future events. The payers' model, therefore, would need to change from rewarding providers for volume, to rewarding providers for value.

For providers to create value, their delivery model would need to shift from a volume-based one-size-fits-all model to a patient-centric system in which care is customized for each patient based on his/her unique conditions. The primary care physician would be the central element of a system of real-time assessment, customization of care algorithms (including preventive care protocols), and interaction with specialists and other caregivers, regardless of the site of care.

Businesses. According to the U.S. Chamber of Commerce, healthcare is the most expensive benefit paid by U.S. employers. This is starkly illustrated by the fact that healthcare adds $1,500 to $2,000 to the cost of every vehicle General Motors produces and Starbucks spends more on worker benefits than on coffee.

The good news is that investment into initiatives such as workplace wellness programs can have a significant positive impact over the long term. While there exists controversy over the return on investment (ROI) of workplace programs, there are clear examples of success: Dow Chemical saved more than $70 million over 10 years from a healthy workplace program. The scholarly literature also supports the concept: in a review of 72 published articles, the ROI (mostly from increased employee productivity) from workplace programs is $3.40 to $4.80 for every dollar spent.

Individuals. The internet has become the primary source of information for consumers (vs. doctors and family). This ability to access information rapidly and directly has empowered the consumer as never before—"consumerism" clearly affects the behavior of doctors and hospitals. As a result, providers increasingly are viewing individuals as informed consumers and true partners in care, rather than a set of symptoms to be treated. Additionally, this has resulted in healthcare becoming more and more continuous and less episodic.

Additionally, healthcare is becoming increasingly "personalized". It turns out that most drugs, whatever the condition, are effective for only about half the people who take them. Advanced screening methods give physicians more evidence for tailoring treatments directly to the individual receiving it, potentially improving care and saving money, i.e. creating value. Personalized medicine goes even beyond that by determining which drug is best for which patient, rather than continuing to treat everyone in the same manner in the hope of benefitting the fortunate few.

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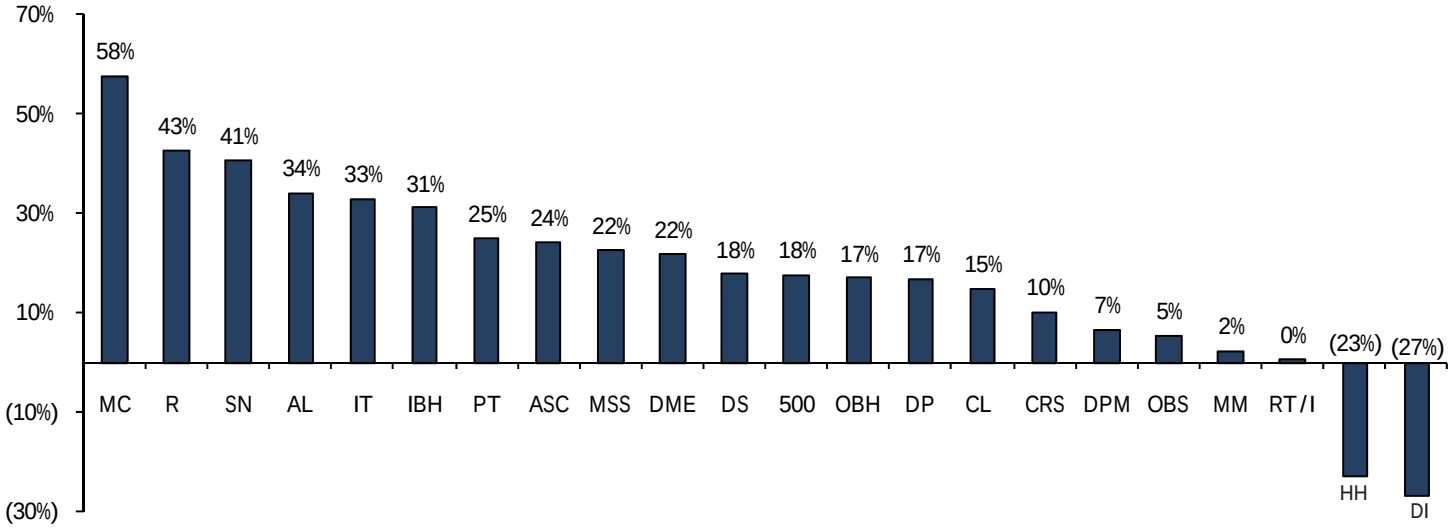
1-Year Stock Returns by Sector

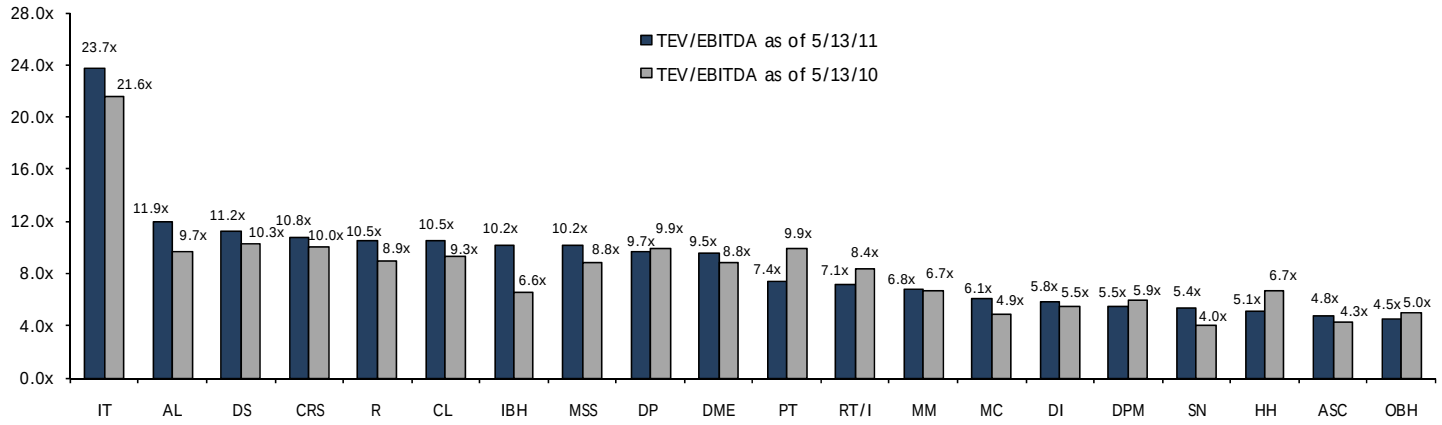


500 - S&P 500	DI - Diagnostic Imaging	DS - Dental Supplies	MM - Medical Management	R - Renal
AL - Assisted Living	DIA - Dialysis	HH - Home Health	MSS - Medical & Surgical Supplies	RT/I - RT/Infusion
ASC - Ambulatory Surgery Centers	DME - Durable Medical Equipment	IBH - Inpatient Behavioral Health	OBH - Other Behavioral Health	SN - Skilled Nursing
CL - Clinical Labs	DP - Diagnostic Products	IT - Healthcare IT	OBS - Outsourced Business Services	
CRS - Clinical Research Services	DPM - Dental Practice Mgmt	MC - Managed Care	PT - Physical Therapy	

Source: Capital IQ
Data as of 5/13/11

HEALTHCARE INDUSTRY DEVELOPMENTS

Public Company Multiples



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Recent U.S. Healthcare Transactions

Source: Capital IQ

Announce Date	Target	Buyer	Enterprise Value (TEV)	TEV/ Revenue	TEV/ EBITDA	Sector
5/1/11	Cephalon Inc.	TEVA Pharmaceuticals USA, Inc.	$6,238	2.1x	5.8x	Biotechnology
4/27/11	Synthes Inc.	Johnson & Johnson	$19,525	5.3x	12.3x	Healthcare Equipment
4/18/11	Prism Pharmaceuticals, Inc.	Baxter International Inc.	$338	-	-	Pharmaceuticals
4/10/11	American Medical Systems Holdings Inc.	Endo Pharmaceuticals Holdings Inc.	$2,715	5.0x	15.6x	Healthcare Equipment
4/7/11	Manor Care, Inc.	HCP, Inc.	$960	-	-	Healthcare Facilities
4/5/11	Inspire Pharmaceuticals, Inc.	Merck & Co. Inc.	$327	3.1x	-	Pharmaceuticals
4/4/11	Capsugel, Inc.	Kohlberg Kravis Roberts & Co.	$2,375	3.2x	-	Pharmaceuticals
3/28/11	Rural/Metro Corp.	Warburg Pincus LLC	$679	1.2x	9.6x	Healthcare Services
3/18/11	Cephalon Inc.	Valeant Pharmaceuticals International	$5,446	1.9x	5.2x	Biotechnology
3/17/11	Celera Corporation	Quest Diagnostics Inc.	$330	2.6x	-	Biotechnology
3/8/11	Walgreens Health Initiatives, Inc.	Catalyst Health Solutions, Inc.	$525	-	-	Healthcare Services
3/7/11	CaridianBCT, Inc.	Terumo Corporation	$2,625	5.0x	14.4x	Healthcare Equipment
2/28/11	Plexxikon, Inc.	Daiichi Sankyo Company, Limited	$935	-	-	Biotechnology
2/24/11	Athena Diagnostics, Inc.	Quest Diagnostics Inc.	$740	6.7x	-	Healthcare Services
2/21/11	Clinical Data, Inc.	Forest Laboratories Inc.	$933	54.6x	-	Biotechnology
2/21/11	Calistoga Pharmaceuticals, Inc.	Gilead Sciences Limited	$600	-	-	Biotechnology
2/15/11	US Seniors Housing Portfolio	Health Care REIT Inc.	$910	-	-	Healthcare Facilities
2/13/11	Emergency Medical Services Corporation	Clayton, Dubilier & Rice, Inc.	$2,968	1.0x	9.5x	Healthcare Services
2/7/11	Rehabcare Group Inc.	Kindred Healthcare Inc.	$1,266	1.0x	7.7x	Healthcare Services
2/6/11	Beckman Coulter Inc.	Danaher Corp.	$6,853	1.9x	8.6x	Healthcare Equipment
2/4/11	DSI Renal, Inc.	DaVita, Inc.	$689	1.9x	-	Healthcare Facilities
1/28/11	Taligen Therapeutics, Inc.	Alexion Pharmaceuticals, Inc.	$478	-	-	Biotechnology
1/24/11	BioVex, Inc.	Amgen Inc.	$1,000	-	-	Biotechnology
1/20/11	Paddock Laboratories, Inc.	Perrigo Co.	$540	2.7x	-	Pharmaceuticals
1/19/11	Atritech, Inc.	Boston Scientific Corporation	$375	-	-	Healthcare Equipment
1/6/11	Interlace Medical, Inc.	Hologic Inc.	$354	-	-	Healthcare Equipment
12/31/10	Brandywine Senior Living, Inc., 19 SNFs	Health Care REIT Inc.	$605	-	-	Healthcare Facilities
12/20/10	Martek Biosciences Corp.	Royal DSM N.V.	$1,024	2.3x	8.3x	Biotechnology
12/12/10	Dionex Corp.	Thermo Fisher Scientific, Inc.	$2,129	4.9x	20.6x	Life Sciences
12/10/10	HCP Ventures II, LLC	HCP, Inc.	$863	10.3x	11.0x	Healthcare Facilities
12/7/10	Medicity Inc.	Aetna Inc.	$500	-	-	Health Care Technology
11/22/10	Ardian, Inc.	Medtronic, Inc.	$1,048	-	-	Healthcare Equipment
11/19/10	Concentra, Inc.	Humana Inc.	$805	1.0x	-	Healthcare Facilities

HEALTHCARE SECTOR SPOTLIGHT

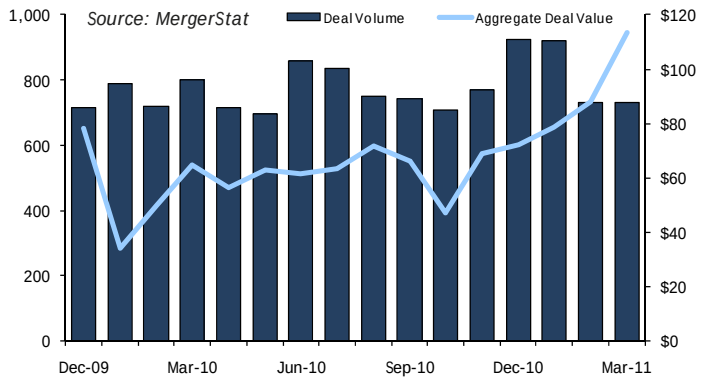
Public Company Trading Statistics

5/13/2011	Enterprise Value to:			
	Revenue		EBITDA	
Sub Sector	LTM	2011E	LTM	2011E
Ambulatory Surgery Center	1.7x	1.6x	4.8x	4.6x
Clinical Labs	1.9x	1.7x	10.5x	9.4x
Clinical Research Services	1.5x	1.5x	10.8x	10.4x
Dental Practice Management	1.0x	1.0x	5.5x	5.5x
Dental Supplies	1.8x	1.8x	11.2x	10.4x
Diagnostic Imaging	1.6x	1.5x	5.3x	5.0x
Diagnostic Products	2.7x	2.5x	9.7x	9.0x
Durable Medical Equipment	2.7x	2.8x	9.5x	10.3x
Healthcare IT	5.0x	4.5x	23.7x	14.2x
Home Health	0.8x	0.7x	5.1x	5.7x
Independent and Assisted Living	2.0x	2.1x	11.9x	13.3x
Inpatient Behavioral Health	1.5x	1.2x	10.2x	7.9x
Managed Care	0.5x	0.5x	6.1x	6.5x
Medical and Surgical Supplies	1.8x	1.7x	10.2x	9.3x
Medical Management	1.1x	1.2x	6.6x	6.8x
Other Behavior Health	0.4x	0.4x	4.5x	5.0x
Outsourced Business Services	5.1x	4.0x	17.2x	9.9x
Physical Therapy	1.2x	1.1x	7.4x	7.3x
Renal	2.1x	1.6x	10.5x	8.2x
RT/Infusion	1.9x	1.8x	7.1x	6.7x
Skilled Nursing	0.3x	0.3x	4.8x	4.6x

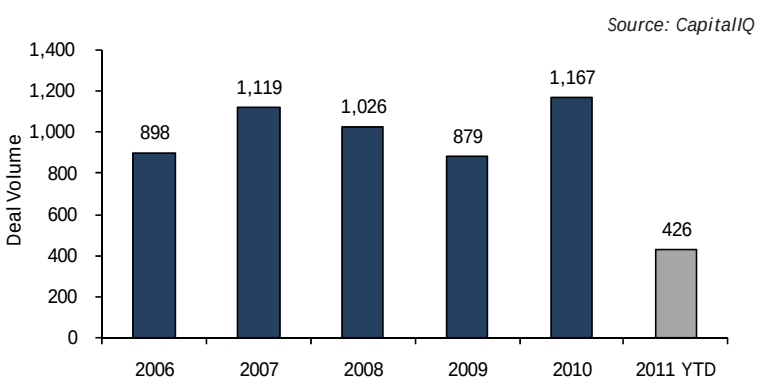
Source: Capital IQ

Capital Markets

U.S. M&A Activity (All Sectors)



U.S. Healthcare M&A Volume (Closed Deals)



America's Greatness and "Real" Healthcare Reform (cont.)

Information Technology. The role of Healthcare Information Technology (HCIT) will be pivotal in bringing about perpetual value-creating change. Currently, the main thrust of HCIT development is devoted to workflow and care management through (1) the seamless connectivity of all caregivers involved in a given patient's care, (2) the ability to electronically store (thereby eliminating paper-based records) and access patients' clinical information in a uniform format (also referred to as Electronic Medical Records, EMR), (3) the centralized storage of clinical information and the ability to move and access it across disparate healthcare information systems (also referred to as Health Information Exchanges, HIE), and (4) the automation of non-clinical protocols. For the most part, these efforts address the vast inefficiency in the overall healthcare delivery system and will result in a robust future foundation for a value-based delivery system.

More importantly, HCIT will play a key role in clinical decision making and the evolution of Evidence-Based Medicine (EBM, the application of the best-available data obtained from advanced screening methods to facilitate clinical decision making). With the development of advanced diagnostic methods such as genomics and proteomics, the sheer volume of variables and data required to facilitate effective clinical decision making is beginning to overwhelm human cognitive capacity. Without a substantial and sustained future investment into the development of sophisticated decision support systems, it is unlikely that long-term value creation-creation efforts will advance much beyond operational "fine tuning". It is alarming to note that the overall information technology spending per employee in healthcare is only $500, compared to *over $8,000 in the financial services sector*.

As an example of the impact of the use of decision support systems, an initiative at the Vanderbilt University Medical Center to reduce the number of Ventilator Acquired Pneumonia (VAP) cases yielded highly encouraging results. In 2009 (vs 2008), the number of VAPs prevented was 108, which resulted in 16 avoided deaths, 1,055 avoided hospital days, 431 avoided ICU days, and $4.3 million saved.

Conclusion. The ACA is now the law of the land. While not perfect, it does generally embody the concept of *value,* and can be built upon. Can (and will) it be repealed? Unlikely, although parts of it may be changed materially or entirely removed (such as the individual mandate, which is likely to be ruled unconstitutional by the Supreme Court). The final legislative outcome is difficult to predict.

What is certain and predictable, however, is that the single-largest threat to the greatness of America will continue to be the exploding debt driven by accelerating entitlement spending. The only way to break the cycle is to drastically reduce the need for entitlements, and the only way to accomplish that is to build a value-based healthcare delivery system that has the pursuit of value as its central element.

Dresner Partners Healthcare Group

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As a financial advisor we provide independent and objective advice, and seasoned execution. Please contact one of our Healthcare Group leaders to discuss how our experience can help you

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