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## BUSINESS

### Ira Coleman of McDermott, On Healthcare Investment, Consolidation and Value-Based Care

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It's no secret that U.S. healthcare spending topped \$3T in 2014, and remains increasingly healthy, today. By 2018, healthcare is expected to comprise 18% of U.S. GDP. And with the persistent growth of connectivity, transparency, data liberation, and good ole' fashioned middle class emergence in emerging markets, the global healthcare market is aggressively expanding.

While there is huge investment opportunity, Obamacare has dramatically disrupted what was previously an opaque and altogether consumer-unfriendly market, placing immense pressure on providers, in particular. And with cheap and accessible money abound, there was significant consolidation last year — both vertically and horizontally.

With their Health Care Services Private Equity Symposium, McDermott Will & Emery seeks to stay out in front of this deal flow by bringing together some of the biggest private equity HC investors in the country. Below we hear from Ira J. Coleman, global head of McDermott's corporate & transactional practice, about the state of today's healthcare market — including consolidation and investment — and some of the findings from their 10th annual gathering this year. Please see a revised and edited version of our exchange below:

#### On The State Of The Regulatory Environment

Parnell: So, let's start with the regulatory environment. Obviously there is more regulation now, than, say, five years ago. Could you just put some light on that? What's the trajectory of this increase?

Coleman: There's two ways I want to view this: There's regulation that's designed to control fraud and abuse, and there are laws designed to change healthcare. Let's start out with fraud and abuse.

The environment is getting denser. Enforcement's clearly on the rise, and they use new technology. There are collaborative efforts that the government uses now with the Qui Tam action that have changed everything. There's now an individual claim



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that people can bring that goes back to the Civil War days which basically says that if somebody's stealing the government's money, you're allowed to bring these Qui Tam actions against them. And a lot of the plaintiffs bar is using this as a way to get a lot of money. I think there's a 15-20% bounty that they put on the recovery. So, if you get a big case with a billion dollars in fraud, you could get a check for \$200 million. That lights up the plaintiffs bar.

The other aspect of this is the laws designed to change healthcare, like Obamacare. I'm looking at that less from the regulatory side and more as a creative way to change the delivery of healthcare, or the payment of healthcare. Those two sides run a little differently, but the regulatory side of it is changing the way organizations operate, and have compliance plans, and what kind of deals they'll do — making sure that they're cleaner, safer, better. There is a whole lot of work around that. The new laws that are out there that mandate new ways of delivering care and paying for care, those are causing the stress and massive consolidations that we're seeing in the market.

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## **On Momentum In The Consolidation Of The Healthcare Market**

Parnell: So let's talk about consolidation in the market for a moment. How large has the consolidation been, actually?

Coleman: I think 2015 was really huge in the amount of deals going on in the middle market and beyond. We've described last year as "Sell anything that's not nailed down."

I think the reason that the healthcare sector was overweighted — meaning in deal flow in 2015 — is that they did more in healthcare than they've ever done, percentage-wise, going back to the early 2000's. That was because of the consolidation. You had a confluence of events going on: cheap money, good reasons to consolidate, and the cycle of people wanting these high multiples that were going on in the deal flow. So what we saw was a confluence of factors, like the private equity shops could take some money off the table by selling the asset — they were getting a great valuation on the asset — and then they were able to give returns to their investors who would then invest in the new fund. I view it as a one-in-a-million scenario. You never get this confluence of events.

## **On Consolidation In The Near Future**

Parnell: Do you see this happening again? Is it going to continue like this?

Coleman: No. We're already seeing choppiness in the finance market as a result of the choppiness in the overall market; so who knows if money will remain this cheap. You're seeing people who were bidding really high on these auction deals. They're saying, "Look, it's just getting too rich. We're not doing it." Even the ones who were in it forever, in it for the long-haul — "Hey, I'll bid on anything. I don't care. If people say it's too much money, I think I can still make money on it." — I'm watching some of those funds now stay out of it. That's new to me. I believe 2016 will still have a lot of deal flow, but it's going to be a little more moderated, and it's going to be a little more rational, let's say.

## **On The Types Of Consolidation In The Market — Horizontal Vs. Vertical**

Parnell: How would you characterize the consolidation that has been going on? Is it been both vertical and horizontal? What's the nature of it?

Coleman: More horizontal. Let's take the payer deals. These huge payers — HMOs and insurers merging together — that's all horizontal, right? I would describe that as horizontal. It's a payer buying another payer. You are also seeing a lot of vertical movement where payers are buying providers.

I think you're going to see more vertical integration as we delve further into value-based care. We call it pop-health: population management, pop-health play, meaning, "Here's your population to take care of. You're at risk for it. You've got to do everything for these people. Figure it out." With this population health play, which is a sort of value-based care, you're going to have to be vertically integrated to do that.

If I'm a health system and I own beds, I have one part of the care. But if I'm now at risk for the physician side of it and the outpatient or other service side of it that I don't own — let's say I have a contract with other people for that, and that becomes risky — all of a sudden the guys who I had great relationships with are hijacking me on price. But if I own them, I control the price.

You're seeing a lot of the health systems getting vertically integrated. They're buying a lot of physicians and employing them; they're buying a lot of the ambulatory surgery centers, outpatient diagnostics, gastroenterology groups. They know this is where a lot of their funds for population health will have to go to, and they're kind of gussying up and getting ready for that. But in the meantime they have to make money off of it anyway, so it's a little bit of a give and take. You don't want to get all ready for this value-based population health scheme while you're losing your shirt for the next five years until it goes that way.

## **On The Monopolistic Nature Of Healthcare**

Parnell: There's a significant amount of control over what providers can do, and who, where, and what payers will pay for. While it obviously isn't a single entity, the behavior seems monopolistic to me...

Coleman: Let me give you an example. Say there is a major health system with a great name in your local market — Famous Health System — and you happen to be in the right demographic for a large local school system in the area. Most of the school teachers live around one of their hospitals. Now if you're an insurance company and you want to cover this school system, you have to have this particular health system in your plan. What do you think that does for pricing? Famous Health System is going to be able to drive price. They say, "You want to send a patient to our hospital, it's \$2,000 a day," when the normalized hospital day rate is \$700. The insurance provider says, "Well, we can't do that. That's crazy." Then this health system says, "Fine, you don't get our health system."

Now, that's the current way of the volume method. A health system with a good reputation and great geography is able to make more money because they can drive volume because they're going to get not only the local school system, but they'll also get most of the large local employers, too. And they're going to drive price. So they've got that monopolistic approach to it.

But what if we were able to un-package that and say to these large employers, "You guys live around this brand name health system, but let's expose you to who really does the best work. Where do patients have better outcomes? Where do patients have much better experiences? They have heart surgery; they have better results. They have gastric bypass surgery; they have better results. They get colon screenings; they never die of colon cancer." If you're a school system employee, you might be thinking about that. You will probably make your healthcare choices based on these data points. Once we open that up to the general population and people are able to see this transparency, we will see decisions based on quality.

When we're able to make decisions based on quality, guess what happens to Famous Health System's pricing muscle? It weakens, right? Then you look at it and you say, "Okay, if their pricing muscle weakens, then how should we pay them? How do we get them back?" Famous Health System says, "I've got all these great expensive things. I need to make money." The insurance provider says, "Okay, let's measure the true quality of care that you're doing and outcomes, and that's what we'll focus on, and that's how we are going to pay you. We'll pay you the base rate: Everybody gets \$700 per hospital day, or everybody gets \$3,500 to do a gastric bypass, but we're going to give you a bonus

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of up to 50% based on the outcomes and quality measures, and patient satisfaction.” That’s really the story of value-based care.

### **On Dropping The Borders Between The States**

Parnell: This may sound naïve of me, but wouldn’t this just go away if they dropped the borders between states, where insurance is concerned?

Coleman: That’s an excellent question. Do these state regulatory insurance policies kind of prop up these fake monopolies? And I would say no, not really, because most of this is from lack of transparency and the state insurance regulators aren’t the ones holding back on the transparency. It’s just the overall structure.

Are there things that would help? Would removing the boundaries help? Probably. Do I think certain parts of Obamacare helped in regard to transparency? Yeah. But do I really think it’s going to be consumer push that actually makes the changes? Yes, I do.

### **On Foreign Direct Investment — Inbound And Outbound**

Parnell: Foreign money: Are you seeing particular countries that are pumping money into the U.S.? Are there particular countries that you’re seeing U.S. money go to?

Coleman: People are looking at both. I’ve got a few foreign private equity clients making investments in the U.S. in healthcare services. I think China is investing a lot in U.S. healthcare. We’re seeing a lot of interest in Latin America. Bain Capital made a huge investment in Brazil. Yeah, so you’re seeing outbound and inbound investment in healthcare for sure.

### **On Actually Defining “Value-Based” Healthcare**

Parnell: This is a very fundamental question, but can you define “value-based” healthcare? What does that mean, exactly? To the average person receiving healthcare, how would you explain that to them?

Coleman: Instead of just getting paid for a service that you rendered, we’re adding some additional components to it. For example, if you went to the hospital to get your gallbladder out, did it go successfully? Did you stay too long? Did you have a high level of patient satisfaction? Did your visit cause you to get another type of infection?

It’s taking a macro versus an episodic view. It’s looking at the world as something bigger, something from the consumer-patient side of it. What the government is saying is that they want 75% of their care to be based on some kind of value scale. Nobody believes this really is going to happen, but they want it to happen. Instead of paying to treat a Medicare patient for a certain illness, they want to say, “We would like you to keep this patient healthier and not have illness, and we’ll pay you more.”

### **On Measuring “Value-Based” Healthcare**

Parnell: So how are you actually *measuring* “value-based” healthcare?

Coleman: What do we measure? What does value measure? For you, you might say speed matters. “They got me in and out.” I might say, “I’m an old guy. I don’t have anything else to do. I

don’t care if I’m there all day. I care if the nurses are sweet to me and they transport me.” It really becomes data driven. People need the information that is necessary to make choices — the right choices for their individual care. Right now, people work without data. Patients lack the tools to make informed choices. If I told you that you can’t have any transparency about buying a car, you’d say, “that’s crazy.” If I just said, “Yeah, this is a good car,” you would say, “Well let me see the safety ratings. Let me see how many miles to the gallon it gets.”

We don’t take the same approach to making decisions about healthcare as we do with other things. We go to the hospital where our doctor sends us, no questions asked. I always do. I had hernia surgery five years ago, and I went to the surgery center my doctor picked for me. Did he have an ownership interest in it? Yeah. Did I really care? No. Would it have been cool to be able to see how that surgery center compares in infection rates and results and all of this stuff? Yes it would have been better.

### **On The Parallels Between The Healthcare And Legal Communities**

Parnell: You’re on the executive committee with McDermott; I’m sure you’ve seen the parallels here between the evolution of the healthcare market and the legal market. Listening to you talk, the two markets sound very similar, structurally. Both are going through similar changes right now.

Coleman: Exactly. It’s transparency. It’s bringing value to the client. That’s my whole pitch to my clients: We add value. We know your business. Now, if I’m a health system, I tell the patient what my value is to the patient. Are our hospital-acquired infection rates and remission rates lower than our competitors? Do we track that? Can we produce that? Can we show that? This is all starting to come out. There’s a lot of different ways of doing this. There are primary care organizations that think they have it knocked. There are health systems that think they have it knocked. Everybody has a way and a rationale of why theirs is the best. Just like law firms: “We’re big. We’re boutique.”

It is like a moving glacier — it’s not happening overnight. I think it’s going to be driven by results. I think it’s going to be driven by consumerism. The more people pay for their individual healthcare costs, the more they’re going to care about this.

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