HOW ECONOMIC CONDITIONS IMPACT HEALTH CARE STRATEGIES FOR SUCCESS

7th Annual Orthopedics, Pain Management and Spine Driven ASC Conference – Improving Profitability and Business and Legal Issues

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Agenda

- Health Care Landscape
  - What’s Different Now?
  - What’s The Same?
- Prospects for Health Reform
- Blended Policy Approach
- Role of and Impact Upon ASCs
What We Believed
- U.S. = Highest Quality
- ∴ High Cost O.K.
- Limited Access = Market Economy

What We Know
- U.S. = Quality Varies Greatly
- = Highest Cost By Far
- High Cost + Bad Economy = Decreasing Access
- ASCs Can Do It Better
What’s Different Now?  
Economy No. 1 Issue

- U.S. in recession
- 8.9% Unemployment; Projected > 9% in 2010
- $700+ B rescue (financial industry, auto, small biz, etc.)
- $787 B Economic Stimulus bill; $410 B spending bill
- $1 T public-private bank rescue plan
- $3.56 T budget resolution passed for FY 2010

CBO & Commerce forecast:
- Economy to further contract in CY 2009
- Federal revenues expected to decline by $166 B in 2009

Reference: See CBO, Director’s Blog, Jan. 8, 2009: The Budget and Economic Outlook
Note: unemployment rate for April, 2009
What’s Different Now? Improved Scenario For Legislation

- Arlen Specter party switch gives Dems filibuster-proof 60-seat majority in Senate (if Al Franken seated)
- Budget resolution includes reconciliation instructions that would make reform immune to Senate filibuster
- Senators Baucus (D) and Grassley (R) release “policy options” to control Medicare costs
- 51 Blue Dog House Democrats, wary of huge deficits, obtain Speaker’s PAYGO pledge
- Health care industry groups pledge to help cut costs $2 trillion over ten years
What’s Different Now? Room to Improve Without Harm

Health Care Spending as a Percentage of GDP

- **United States**: 15.3%
- **France**: 11.1%
- **Germany**: 10.6%
- **Canada**: 10.0%
- **OECD Avg**: 8.9%
- **Australia**: 8.8%
- **UK**: 8.4%
- **Japan**: 8.2%

**McKinsey study**: U.S. spends nearly $650 B more on healthcare than expected when compared to other countries, even after adjusting for wealth, but without better outcomes.

- Difference in spending concentrated in outpatient care.
- Excess growth due to:
  - More specialist visits; higher cost per visit
  - Higher prices for technology
  - Patient demand insensitive to price
- Up to 30% of spending is unnecessary, harmful or fraudulent.

What’s Different Now? Questions Re: Value

- Hospital Care
- Variation & Affordability

Health care consumes 16% of the GDP, but independent research confirms: we don’t know what we’re getting for our money.
What’s Different Now?
Hospital Care

Using Medicare claims data, investigators found:

- Where people live, who treats them, and in what hospital – not their illness – determines how much care is given and how much money is spent.

- Hospitals providing more care for one condition have similar patterns for other conditions.

- Level of care intensity likely to apply to commercially insured patients.

Dartmouth research shows: More care and higher spending does not result in better outcomes.

What’s The Same?

- Health care costs are high and rising
- Since 1970, health care costs have grown on average \( \sim 2.5 \) percentage points faster than GDP
- Massachusetts experiment validates expanding access increases costs
- Rising health care costs drive deficits over time\(^1\)

\(^1\) See discussion in Peter R. Orszag, Director’s Blog, Congressional Budget Office, October 13, 2008, 11:00 a.m.
Projected deficit includes:

- Cost of taking over Fannie Mae and Freddie Mac: $238 B
- Net cost of transactions under TARP: $180 B

References: Preliminary analysis of the President's Budget and Update of CBO's Budget and Economic Outlook, March 2009; see also “Budget Gap Is Revised to Surpass $1.8 Trillion,” New York Times, May 12, 2009
What’s The Same?
Rising Health Care Costs Significant Threat To Economy

Projected Spending on Health Care as a Percentage of Gross Domestic Product (GDP)

- 16% GDP
- 32% GDP
- 49% GDP

- All Other Health Care
  (includes private, state and local, and other federal)

- Medicare
- Medicaid

Source: The Long-Term Outlook for Health Care Spending, November 2007, Congressional Budget Office
Note: Amounts for Medicare are net of beneficiaries’ premiums. Amounts for Medicaid are federal spending only.
Agenda

- Health Care Landscape
- **Prospects for Health Reform**
- Blended Policy Approach
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Short-Term: Piecemeal expansion, Not Reform

- Economic Stimulus Bill
  - $87 B to help states pay Medicaid costs
  - $24.7 B for 65% subsidy of COBRA premiums (private coverage for newly uninsured)
  - Also: $19 B for HIT; $1 B for prevention/wellness; $1.1 B for comparative effectiveness research; $10 B for NIH biomedical research

- $32.8 B SCHIP expansion for 4.5 yrs

- “Temporary” expansions will make system transformation more difficult

- Hard to reverse gov’t program expansions

“You never want a serious crisis to go to waste.”

Rahm Emanuel, White House Chief of Staff
Would you be willing to pay more—either in higher health insurance premiums or higher taxes—in order to increase the number of Americans who have health insurance, or not?

Source: Kaiser Family Foundation / Harvard School of Public Health, The Public's Health Care Agenda for the New President and Congress, Chartpack, January, 2009 (Don't Know/Refused responses not included)
Short-Term: Deficit Spending O.K.

Support High If Government Paying

Would you favor the following spending increases, even if it means raising the federal budget deficit?

THOSE IN FAVOR:

- To make health care more accessible and more affordable 76%
- To build and repair roads, bridges and infrastructure 75%
- To develop new clean-energy technology 74%
- To provide financial support to U.S. industries hurt by the mortgage crisis and problems on Wall Street 36%

Long-Term: New Environment for Broader Agenda

No Longer “Unthinkable”

- Public Plan to Compete with Private Insurers
  - Medicaid
  - Medicare buy-in
  - FEHBP buy-in
- Incremental Improvements
  - Payment reform
  - Comparative effectiveness
- “Fed. Reserve” H.C. Board
- Single Payor
  - Medicare-for-all
  - Global budget

Economic Recovery
Campaign Promise
More middle class uninsured

Support for reform / deficit increases
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  - Pragmatism vs. Ideology
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Pragmatism vs. Ideology

Two approaches dominate debate on h.c. reform:

1. Market strategy proponents:
   - Insurance market and tax reform
   - Competition and consumer choice
   - HIT & Transparency

2. Regulatory strategy proponents:
   - Government control of costs / spending caps
   - Leveraging federal programs
   - Establishing best practices

A pure market system or pure regulated system is unlikely in our country

Individual Mandate

Increasing Access
- Automatic Medicaid /SCHIP enrollment
- High risk pools to socialize bad risk
- Medicaid eligibility for poor adults
- Federal subsidies (e.g. refundable tax credits for low-income)

Containing Costs
- Leverage Federal Health programs:
  - Payment for evidence-based medicine
  - Require electronic connectivity
  - Private sector will follow
- Cap or limit exclusion from employee’s taxable income

Improving Quality
- Federal HIT initiatives
- Independent Commission to establish best practice treatment protocols
- Private & public sector P4P programs
- Federally-supported research on comparative effectiveness
- FDA post-marketing surveillance
The rising costs of health care and health insurance pose a serious threat to the future fiscal condition of the U.S.

Without policy change, a substantial and growing number of non-elderly people will go without health insurance.

Policymakers face difficult trade-offs between expanding coverage while controlling costs; steps alone to substantially expand coverage would likely increase total health care spending and raise federal costs.

Solving this problem requires major changes in the financing or provision of health insurance and health care.

Significantly reducing the level or growth of health care spending requires substantial changes in provider incentives.

A combination of approaches is needed.

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Growth in # of ASCs

<table>
<thead>
<tr>
<th>Era of Easy Money and Rapid Growth ’01-’05</th>
<th>Era of Oversaturation ’06-’08</th>
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<tbody>
<tr>
<td>2.7 % LIBOR</td>
<td>4.4% LIBOR</td>
</tr>
<tr>
<td>8.3% CAGR</td>
<td>4.4% CAGR</td>
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Annual Growth Rate

- 2001: 11.3%
- 2002: 6.7%
- 2003: 8.1%
- 2004: 6.4%
- 2005: 8.9%
- 2006: 4.5%
- 2007: 5.5%
- 2008*: 3.3%

Source: CMS’s Provider of Service Files.
Note: 2008 data is through September, 2008.
Fewer Eligible Surgeons to Fuel ASC Growth

- Avg. ASC has 15 partners and 9 non-partner users
- By 2010, it is estimated that there will be only 21 eligible surgeons per ASC

Sources: Deutsche Bank ASC Survey, SDI, American Medical Association, MedPAC, American College of Surgeons, BRP Analysis.
Surgeon ASC Ownership

% of Eligible Surgeons Invested in ASCs, 1990-2010E

Note: Excludes surgeons ineligible for investment, e.g. academics.
Sources: Deutsche Bank ASC Survey, SDI, American Medical Association, MedPAC, American College of Surgeons, BRP Analysis.
Growth in # of ASCs, 1998-2013E

Year-on-Year Δ in # of ASCs (%)

Sources: CMS’s Provider of Service Files, BRP Analysis.
Same-Store Growth Implications

- Pace of growth in # of ASC surgeries expected to slow to match overall surgical case volume growth, due to slower shift from IP → OP and HOPD → ASC

- Growth in # of ASCs also expected to slow, due to lack of financing and diminishing number of non-investor surgeons

- Result = negative to flat industry same-store case growth
ASC Case Volume, 1998-2013E

Year-on-Year Δ in # of ASC cases (%)


Sources: AHA 2008 Trends Affecting Hospitals and Health Systems, Verispan Profiling Data, BRP Analysis.
We believe ASC industry growth continues to decelerate, and weak pricing and physician supply remain the biggest challenges... if capacity continues to outstrip demand and the supply of available surgeons, [same store] volume growth could approach zero. - Deutsche Bank

Sources: CMS’s Provider of Service Files, AHA 2008 Trends Affecting Hospitals and Health Systems, Verispan Profiling Data, BRP Analysis.
Consolidation

› Market generally oversupplied

› Cost inflation (2-4% for labor and supplies) > rate growth (2%) → increasing pressure to enhance margins

› Systemic efficiency improvements require systems, processes, capital investment → increasing advantage for scale operators focused on efficiency

› Consolidation accelerating, expect to continue

› ↑ financial pressure on hospitals → opportunity for operating partners
Industry Consolidation Has Begun

Chain vs. Non-chain Surgery Centers, 2000-2008

% Chain Affiliation by Healthcare Facility Type

- Surgery Centers
- Medical Group Practices
- Nursing Homes
- Cancer Centers
- Hospital
- Imaging Centers

Ownership By Chains

Surgery Center Ownership, 2002-2008

Note: SDI data is for all ASCs, not Medicare-certified only. Chains defined as any company with > 1 ASC.
Historically, healthcare politics have prevented meaningful change. We must transform underlying delivery system to impact quality and costs.

Unless costs are controlled, budget hawks + national security experts will set future health policy by default; expansions without system reform mean uglier choices ahead, including potential swift / massive cuts.

In a crisis, the unthinkable becomes possible.
Conclusion

- As the higher quality, lower cost alternative to HOPDs, ASCs play an important role in future delivery systems.

- Trends in the ASC industry clearly show a move toward consolidation that, properly implemented to leverage cost savings and best practices, will improve the delivery of ASC services.