

The Latest Key Developments in the Healthcare Industry

HEALTH SYSTEM CHALLENGES, RISKS AND POTENTIAL SOLUTIONS

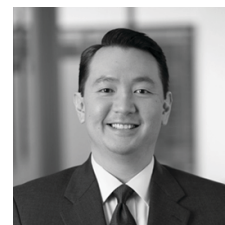
Health systems today face significant challenges, further complicating an ever-changing landscape. Some of the most notable trends we see in the space include:

- Higher interest rates, which impact borrowing costs as well as investment opportunities;
- Efforts to gradually repeal the Affordable Care Act (“ACA”);
- Emergence of value-based payment programs;
- The advent of major vertical integrations such as CVS-Aetna;
- A growing demand for digital healthcare

The following article summarizes these key issues for health systems and, where appropriate, provides some potential solutions.

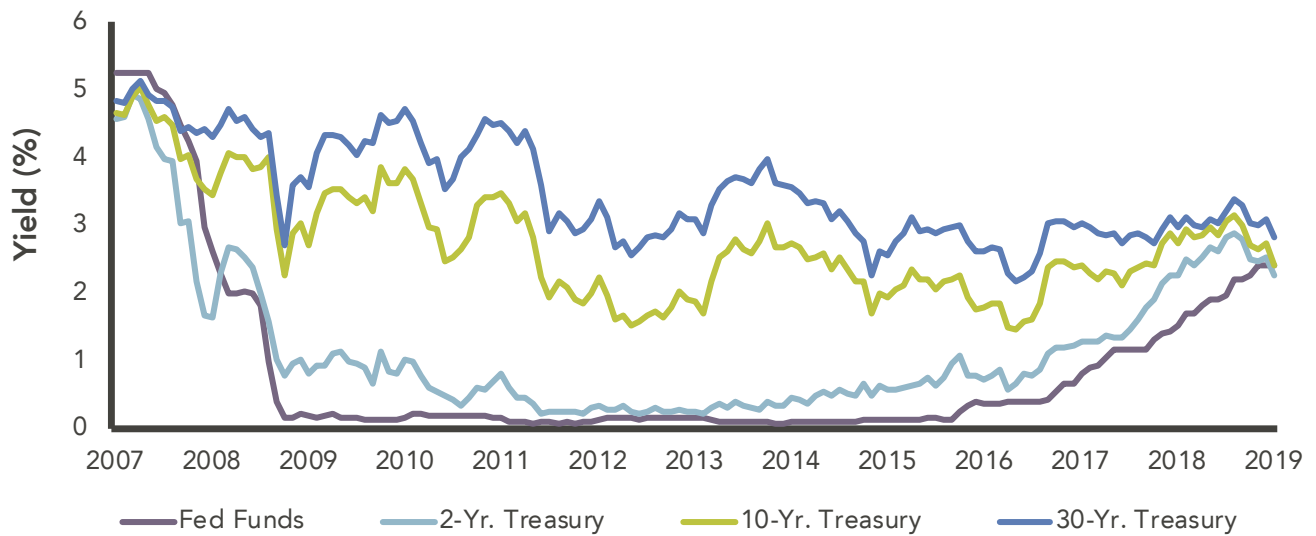
The effect of rising interest rates on health systems’ investment returns and debt costs

The Federal Reserve has hiked nine times since the Great Recession, with the target fed funds rate now at 2.25%–2.50%. Exhibit 1 on the following page shows that short- and medium-term rates rose dramatically over the last four years. Given that most healthcare systems are heavy investors in fixed income, higher yields should equate to higher investment returns and thus more assets to pursue growth opportunities or offset borrowing and operating costs.



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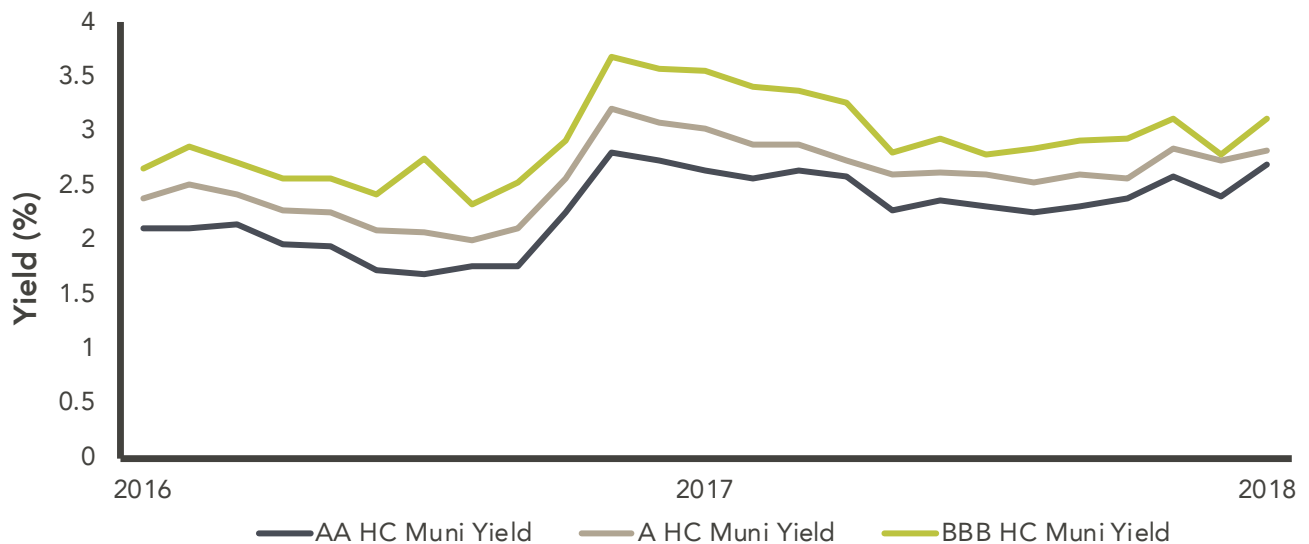
Exhibit 1: Interest Rate Environment



Source: Bloomberg

Given the higher rate backdrop, health systems as debt issuers have seen their cost of capital grow. Exhibit 2 shows interest rates on 10-year maturity fixed rate investment grade municipal debt issued by health systems. Yields for each rating tier are trending upwards, which is not surprising given the overall higher rate environment. So, while investment returns should be higher for healthcare systems, interest expense has also risen for these systems.

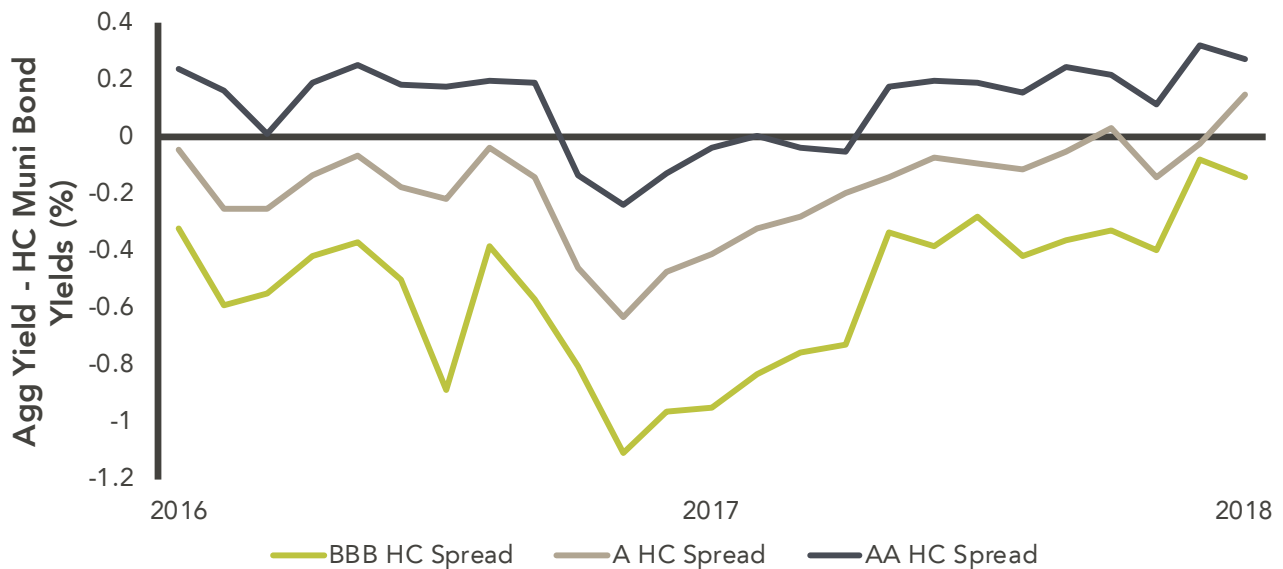
Exhibit 2: Health Care Municipal 10-Year Maturity Debt Yields



Source: Bloomberg; latest data available as of March 2019

Are health systems better or worse off now that both investment yields and debt costs are rising? Exhibit 3 on the following page shows the yield on a low risk, diversified fixed income portfolio — as measured by the Bloomberg Barclays Aggregate Index (“Agg”) — rising roughly in line or slightly above health systems’ debt costs. The asset/liability spread, or investment return/debt cost differential, has been increasing.

Exhibit 3: Asset/Liability Spreads



Source: Bloomberg, latest data available as of March 2019

This shows that in today's environment, health systems do not have to take too much investment risk to adequately offset their debt costs. In other words, an appropriately diversified fixed income portfolio should be able to cover most of their interest expense, rather than relying on higher returning yet considerably more volatile equities to make up for the rate differential.

Beyond rising rates, the other most significant challenge that health systems face is the repeal of the Affordable Care Act ("ACA"), which has wide-reaching effects.

The biggest issue is the ACA — the Trump administration is still working to repeal it.

With the Tax Act's repeal of the ACA mandate requiring health insurance for individuals, the Congressional Budget Office estimates that the number of people with health insurance would decrease by four million in 2019 and by 13 million in 2027.¹ Clearly, the gradual repeal of the ACA provides for an ever-uncertain environment for health systems. If nothing else, this looming uncertainty creates a variety of potential scenarios for which healthcare systems need to be prepared for.

Amidst this uncertainty, many health systems are making a concerted effort to invest in technology, as technological advancement may help a health care provider consistently gain a competitive edge vis-a-vis the ACA wildcard.

Health systems are investing in technology startups or joint ventures with technology companies that could yield products making health care more efficient, and there is rising investment in technology for the millennial generation.

Spectrum Health, a Grand Rapids, Michigan-based health system, recently formed Spectrum Health Ventures, a venture capital fund aimed at investing \$100 million in digital health over the next ten years.² Providence Health & Services, a 160-year-old nonprofit Catholic health system near Seattle, recently formed a \$150 million venture capital fund called Providence Ventures, run by a former Amazon executive who built the Kindle self-publishing business.³ One of these startups is Express Care, an on-demand, consumer-facing healthcare platform that uses secure video technology for patients to receive diagnoses and treatment from their health care providers.⁴

While health systems continue to invest in technology to make their processes more efficient, other participants in the sector are leveraging technology to help their workforces obtain health care in a cheaper and easier fashion. The recently announced Amazon-Berkshire Hathaway-JP Morgan joint venture will be looked upon as a high-profile test case for potentially disruptive healthcare technology.

Potential for disruption: The Amazon-Berkshire Hathaway-JPMorgan alliance and CVS-Aetna merger.

In early 2018, Amazon, Berkshire Hathaway and JPMorgan announced a joint venture aimed at making it easier and cheaper for their combined workforces to obtain health care. The alliance may use automation and artificial intelligence to drive savings, such as with automated health tests, lab work, and data input. The alliance could benefit from lower costs and increased delivery via telemedicine, through which doctors diagnose and treat ailments remotely using video conferencing and mobile apps. It may also aim to reduce drug prices as well as enhance distribution. For example, this initiative may launch an online pharmacy that could potentially displace pharmacy benefit managers (“PBMs”) like Express Scripts or Caremark and ultimately save billions in drug costs.⁵ In a similar vein, the CVS-Aetna pharmacy-insurer megamerger promises to reduce the overuse of emergency departments — which leads to \$38 billion in wasted spend every year⁶ — by channeling Aetna members to CVS clinics.

It is yet to be seen whether these combinations will disrupt healthcare, but there is an industry trailblazer that is already revolutionizing healthcare management and delivery: Kaiser Permanente.

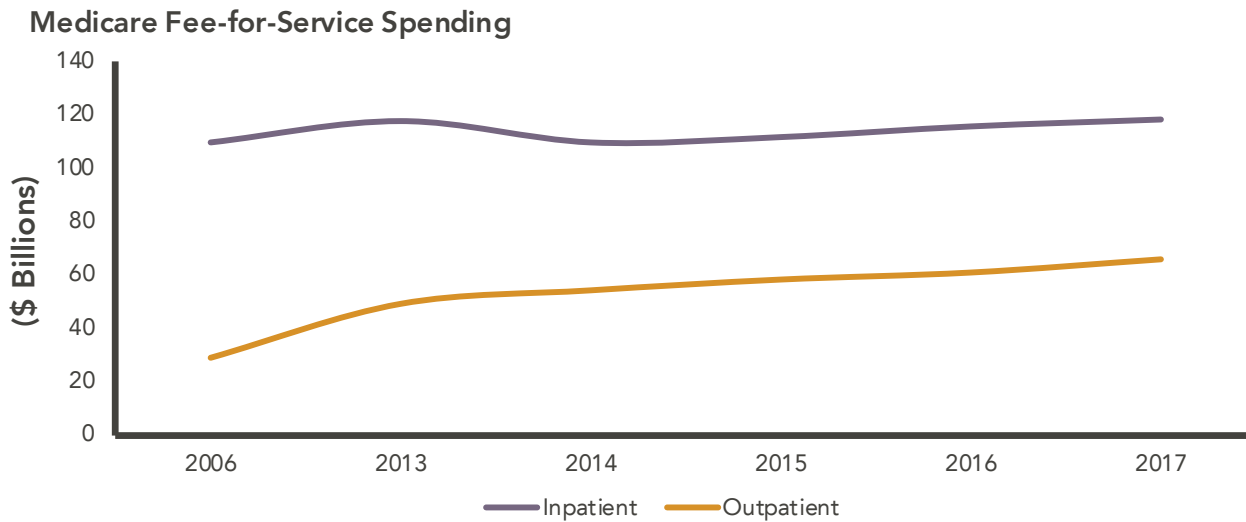
Some health systems have started to emulate Kaiser Permanente, where all units are cost centers.

Kaiser Permanente relies on its comprehensive electronic health record (EHR) technology in conjunction with a vertically-integrated structure to bring about cost efficiencies. They are a nonprofit health system that is more cost-effective than the average HMO. Kaiser is vertically integrated across health insurance, medical groups, and the hospital, as well as horizontally integrated across primary and specialty care in addition to inpatient and outpatient care. 90% of Kaiser’s revenue is prepaid, so Kaiser does not have to worry about reimbursement, and can align incentives with patients’ health and wellbeing.⁷ Several health systems are following suit. Dean Clinic of Madison, WI, and Intermountain Healthcare of Salt Lake City recently began emulating Kaiser with a fully integrated model. Seven hospitals and Anthem Blue Cross recently launched a joint venture called Vivity, an integrated health plan and provider network.

In addition to leveraging some of Kaiser’s approach, health systems may also want to consider focusing on the trend of growing outpatient services versus inpatient services.

The growth in outpatient services over inpatient services continues.

Exhibit 4: Outpatient vs. Inpatient Activity



Source: MedPAC (Medicare Payment Advisory Commission) Report to Congress, March 2019

As shown in the chart above, Medicare fee-for-service outpatient payments more than doubled from \$29 billion in 2006 to \$66 billion in 2017, while inpatient payments were relatively stagnant from \$110 billion in 2006 to \$119 billion in 2017. As this trend continues, health systems must find ways to adapt to more outpatient services demand relative to inpatient services, particularly because outpatient services are considerably less expensive for patients and insurers alike.

Another trend is the rise in the acquisition of doctors' practices. We examine the trends, pitfalls and recommendations pertaining to buying physicians' practices below.

Health systems should be careful of spending sprees to buy doctors' practices where patient revenue does not follow.

A 2016 American Medical Association study showed that less than half of practicing doctors own their own practices — the first time ever that more doctors are employed by hospitals than own their practices.⁸ Buying doctors' practices gives the hospital a wider reach for referrals and more negotiation power through size. It lets the hospital better enforce utilization and referral policies. Furthermore, it enables hospitals to better address the value-based payment model. However, hospitals cannot force referrals, and there are cases of physicians leaving hospitals because they were pressured to refer within the system. Moreover, some health systems are plagued with net negative results from such acquisitions, due to increased physician salaries and benefits or inefficient transitions. The key is efficient care coordination and avoiding unnecessary procedures and costs. Having the best specialists also helps so that acquired primary care physicians will be motivated to refer within the system.

That said, a critical reason why hospitals continue to acquire physicians' practices is to better address the value-based payment model.

Value-Based Payment Programs continue to be implemented by the Centers for Medicare and Medicaid Services ("CMS").

Value-based payment programs rely on patient satisfaction and other value-driven metrics for the health system to receive Medicare payments. The aim is to enhance healthcare quality, minimize costs, and reduce hospital

readmissions, however this goal increases operational risk. The Department of Health & Human Services has a continual goal of linking more and more Medicare payments to the value-based reimbursement model. There are seven value-based programs, ranging from the Hospital Value-Based Purchasing Program that covers inpatient acute hospital care to the Hospital Readmission Reduction Program that covers readmissions. Each of these programs provides incentives in the form of higher pay and penalties in the form of lower pay based on quality metrics ranging from mortality and complications to patient safety and experience to efficiency and cost reduction. However, value-based programs are coming under greater scrutiny, as certain studies released in 2017 showed that despite heart failure patient readmissions declining, their mortality rates rose under the Hospital Readmission Reduction Program. While imperfect, value-based programs and the gradual shift towards adopting them are here to stay but will require more refinement.

Lastly, we close with the prospects of investing in higher-yielding, less-liquid asset classes.

The rise in LIBOR, health systems investing in private credit, and the nuances of variable rates on both the asset and liability sides of the balance sheet.

Health systems typically carry variable rates on the liability side of their balance sheets, especially with growing medical costs and debt issuance. While many systems use swaps to fix some of their variable rate debt payments, private credit may make sense for systems that can handle its illiquidity. Private credit provides the benefits of floating rates in case rates continue to rise, as well as the small-issuer and illiquidity premiums. We noted above that in today's environment, health systems do not have to take too much investment risk to adequately offset their debt costs. However, for health systems that can tolerate the illiquidity, private credit in the form of direct lending, mezzanine debt, or distressed debt could provide yields in the range of LIBOR+600 to LIBOR+1400. With the rise in the fed funds rate over the last four years, LIBOR has risen in the same timeframe, benefiting private credit yields. We are seeing larger health systems use their stronger balance sheets and economies of scale versus smaller systems to invest in such higher-yielding, less-liquid asset classes.

It must be noted that private credit is a Level III asset, removed from days cash on hand. Moreover, President Trump recently signed a partial rollback of Dodd-Frank regulations that may affect private credit. Under Dodd-Frank, banks with over \$50 billion in assets were subject to stricter capital requirements and higher regulatory scrutiny, making it difficult for them to engage in direct lending, causing the specialty direct lending fund cottage industry to grow. The signed bill increases that threshold from \$50 billion to \$100 billion and will raise it to \$250 billion after 18 months. The number of banks in this group will fall from 38 to 12, which may reintroduce competition for direct lending firms. This shift is expected to be gradual, and it may take perhaps several years for banks returning to the direct lending business to begin displacing some direct lending firms. Private credit may make sense for systems that can manage the illiquidity and thus take advantage of the attractive yields and favorable supply-demand dynamics.

CONCLUSION

The U.S. healthcare industry is evolving at a pace faster than that of many other industries. Health systems face numerous challenges including higher interest rates, the roll-out of value-based payment models, the shift towards digital health, the fight to repeal the ACA on Capitol Hill, and physicians' practice acquisition and integration. Going forward, we will monitor and provide insight on these developments as we continue to assist health systems in utilizing their investable assets to ultimately benefit their patients and employees. ■

NOTES

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