BENESCH
Attorneys at Law

May 2009

Private Equity Bulletin

HEALTH CARE REFORM AGENDA AND STIMULUS SPENDING MAY PRESENT OPPORTUNITIES FOR PRIVATE EQUITY

I. Executive Summary

President Barack Obama and the current Democrat-controlled Congress have begun taking steps to reform the health care system, actions that are consistent with President Obama's promises made on the campaign trail to bring about widespread changes.[1] Recently, President Obama proposed a $634 billion reserve fund for health care over the next decade that could be used to implement President Obama's proposals to lower costs, offer affordable, accessible, universal health insurance coverage, promote prevention and strengthen public health, though significant adjustments may unfold as the proposals work through their way through the legislative process. Additionally, $53 billion has been specifically set aside for health care (along with non-specific ancillary spending bringing the total closer to $150 billion) in the American Recovery and Reinvestment Act of 2009 (the "Stimulus Bill"), the legislation passed in response to the current economic crisis that earmarks $288 billion to tax relief and $499 billion in affirmative federal spending throughout various economic sectors over the next several years. The Stimulus Bill specifically calls for the widespread adoption of standardized health information technology ("HIT") systems, allocates funding to strengthen state Medicaid programs, eases the burden of "COBRA" benefits, and provides financial support for preventive medicine. President Obama's reform agenda also provides a renewed focus on the provision of high quality care in lower cost settings.

These dramatic changes may present private equity funds with investment opportunities in health care. For example, managed care organizations could potentially be a target for dealmakers, as these companies may experience improved enrollment growth prospects from the expansion of health insurance availability. The incentives in the Stimulus Bill may also bode well for companies that provide electronic health records and electronic prescriptions, as $19 billion has been set aside for HIT systems adoption. With $1 billion allocated to preventive care, companies that provide worksite and school site clinical prevention programs could be well positioned. Finally, funds funneled into the system to shore up state Medicaid programs and to help unemployed consumers purchase "COBRA" coverage are only being provided temporarily, but could strengthen portfolio companies that rely on Medicaid reimbursement or that would otherwise have taken a hit resulting from the decisions of consumers to delay or forgo treatment due to the loss of their employer-sponsored benefits.

II. Expanded Health Insurance Availability

President Obama has often cited the statistics that over 45 million Americans lack health insurance, rising costs of health insurance burden employers and two million fewer Americans receive health insurance coverage through their employers than they did eight years ago. The rise in unemployment over the last two years has only exacerbated the problem, causing many Americans to lose their employer-sponsored private health insurance and put certain medical treatments on hold, leading to a decline in the utilization of certain health care services and prescription drugs by some.

In response, President Obama has pledged to provide universal health care coverage by expanding coverage for pre-existing conditions and offering Americans the opportunity to elect to enroll in a new public plan (the National Health Insurance Exchange) or an approved private plan (under which income-based sliding scale tax credits would be made available). This plan calls for a tax credit for small business owners of up to 50% on premiums paid on behalf of employees, and large employers that do not offer meaningful coverage would be required to contribute a percentage of payroll costs toward the costs of the national plan. Furthermore, all children would have health care coverage, and eligibility for Medicaid and SCHIP would be expanded.

Though not as dramatic as the changes proposed by President Obama's plan, and by no means universal, the Stimulus Bill includes measures that increase the availability of health insurance. First, while many terminated employees are

[1] Barack Obama's health care platform is available online at http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.

eligible for COBRA benefits, which allows employees to continue on their employers' health plan for up to eighteen months after the date of termination of employment, for an unemployed individual, COBRA is very expensive and often cost prohibitive, costing up to 102% of the premium, or approximately $12,680 per year per family, according to the Kaiser Family Foundation.

To address this problem, the Stimulus Bill provides over seven million unemployed Americans and their families with a 65% tax credit for COBRA premiums for up to nine months and gives unemployed workers who failed to elect COBRA coverage within the applicable time frame a second chance to elect coverage. The measure is a compromise between the United States House of Representatives and the United States Senate – the House had advocated for the subsidies to last for a full year, while the Senate plan called for a 50% subsidy for a year.

In addition to tax credits for COBRA coverage, the Stimulus Bill provides an estimated $87 billion to states over the next 27 months in the form of a temporary increase in the Federal Medical Assistance Percentage to help maintain current Medicaid programs for some twenty million Americans. Without this allocation, many health care services companies that rely on Medicaid reimbursement would have come under significant pressure.

While by no means a long-term fix, at least temporarily, these two measures are likely to shore up utilization and stabilize revenues of health care portfolio companies where there otherwise may have been a more considerable decline. Moreover, the overwhelming size of the uninsured population likely means that a plan for universal coverage (or greater coverage) could also promote earnings growth in the managed care sector through expanded participation, a sector that otherwise was experiencing limited opportunities to increase enrollment.

III. Health Information Technology

One of the most developed sets of provisions in Stimulus Bill addresses HIT and is consistent with President Obama's promise to invest in the broad adoption of a standards-based electronic health information system. Because federal funds are being funneled into this space, HIT companies could be poised for growth over the next several years and may be candidates for private equity investments.

Initially, the legislation codifies the existing position in the Department of Health and Human Services ("HHS") of the Office of National Coordinator for Health Information Technology ("National Coordinator"). This position was created on April 27, 2004 by President Bush's Executive Order 13335 and largely adopts and codifies the existing program being conducted by HHS through its National Coordinator office.

The Stimulus Bill creates a formal process to harmonize existing HIT standards and to identify and establish standards necessary to fill gaps in the existing standards to permit the development, implementation and maintenance of a nationwide, interoperable HIT system in the public and private sectors. Similarly, the existing HIT advisory groups will be replaced by a HIT Policy Committee and a HIT Standards Committee that will report to the National Coordinator. Both of these committees will be subject to the Federal Advisory Committee Act.

The Stimulus Bill expressly provides that the National Institute for Standards and Technology ("NIST") will test new HIT standards and support the establishment of a voluntary testing program by accredited testing laboratories. In addition, the Stimulus Bill requires NIST to award competitive grants to universities (or research consortia) to establish "Centers for Health Care Information Enterprise Integration". These Centers will be designed to generate innovative approaches to developing a fully interoperable national health care infrastructure as well as develop and use HIT.

The Stimulus Bill also sets forth various incentive programs for the development and implementation of HIT. Although no specific amounts are appropriated for the various programs described below, the Stimulus Bill provides that funds will be appropriated to make these HIT investments during the time period of Fiscal Year 2009 through Fiscal Year 2014.

The Stimulus Bill provides that the Secretary of HHS is to begin to expend funds on various aspects of the HIT program to be used for: (i) HIT architecture to support secure data exchange; (ii) electronic health records not eligible for Medicare/Medicaid HIT incentive payments; (iii) training and dissemination of information on best practices to integrate HIT into health care delivery; (iv) telemedicine; (v) interoperable clinical data repositories; (vi) technologies and best practices for protecting health information; and (vii) use by public health departments. The implementation of these projects is to be conducted in accordance with the National Coordinator's strategic plan.

A second category of funding is designed to create a HIT "extension program" to assist providers in adopting and using certified electronic health record technology. This program will largely be conducted through the creation of a HIT Research Center, together with HIT Regional Extension Centers. These Regional Centers must be affiliated with nonprofit organizations and are designed to provide HIT assistance to providers in their region. The Regional Centers will be eligible for grants for up to four years of funding covering up to 50% of their annual operating and maintenance expenditures.

The Stimulus Bill also provides the National Coordinator with the authority to award planning and implementation grants to states or qualified state-designated entities to facilitate and expand electronic health information exchange. In order to receive an implementation grant, a state or qualified state-designated entity must submit a plan describing the activities to be carried out to facilitate and expand the electronic health information exchange. These grants will be awarded annually by the National Coordinator to undertake activities consistent with the National Coordinator's strategic plan.

The grant activity will be reviewed annually to implement the lessons learned in the subsequent round of awards to ensure that the grants are achieving the greatest improvement in health care quality, decrease in costs, and the most effective and secure electronic information exchange.

Similarly, the National Coordinator is empowered to award competitive grants to states or Indian Tribes to establish loan programs for health care providers to purchase and/or upgrade to certified electronic health record ("EHR") technology, train personnel for the use of the technology and to improve the secure exchange of health information. Any approved loan program must contain matching funds and provide that the loans to providers will be repaid within ten years.

The Stimulus Bill contains a provision authorizing the Secretary of HHS to create a demonstration program for awarding competitive grants to medical, dental and nursing schools designed to integrate HIT into the clinical education of health care professionals. A separate education grant program allows the Secretary, in consultation with the Director of the National Science Foundation, to provide funds to universities to establish or expand medical informatics programs.

In addition to the foregoing incentive programs, the Stimulus Bill contains additional incentives to providers to embrace HIT through the Medicare and Medicaid programs. These incentive provisions largely build upon the previously existing legislative and administrative efforts, such as the Medicare Modernization Act of 2003.

The Center for Medicare and Medicaid Services ("CMS") already administers a number of other programs to facilitate the adoption of EHR. For example, bonus payments are available to physicians participating in the Medicare Care Management Performance demonstration project for using certified EHR and reporting clinical performance data electronically.

In the Stimulus Bill, health care professionals who participate in the Medicare program can qualify for EHR incentive payments upon demonstration that the professional is a "meaningful user" of EHR technology, as defined in the Stimulus Bill. These incentive payments will be available during the period 2011-2016, and will vary based upon a variety of factors including the amount of treatment provided to Medicare beneficiaries by the professional. The highest annual payment is up to $18,000 if the provider's first annual payment year is 2011 or 2012, with the amount decreasing yearly thereafter to $12,000, $8,000, $4,000 and $2,000. Moreover, an additional 10% incentive will be available to professionals located in health professional shortage areas.

These payments will not be available to hospital-based professionals because it is assumed that they will use their hospital's EHR. Similarly, there are significant limitations in the Stimulus Bill on professionals associated with Medicare Advantage plans from qualifying for these incentives.

Subject to certain limitations, each hospital that participates in Medicare's inpatient prospective payment system ("IPPS") will be eligible for EHR incentives beginning in Fiscal Year 2011. To be eligible, an IPPS hospital must meet the statutory and administrative definitions of a "meaningful" EHR user.

The Stimulus Bill provides that there is to be no administrative or judicial review of the determination of an incentive amount. The Stimulus Bill also provides for significant penalties to be assessed to IPPS hospitals that have not succeeded in meeting the "meaningful" EHR user standard, in the absence of a significant, demonstrated hardship.

Contrary to IPPS hospitals, critical access hospitals ("CAH") that are currently paid by Medicare on a "cost-plus" basis will not be eligible for these incentive payments. However, a CAH will be eligible for a separate bonus payment program if it meets the test of a "meaningful" EHR user. Similarly, hospitals associated with Medicare Advantage plans will not qualify for the IPPS incentive payments and will have a more limited opportunity to obtain incentive payments under a different set of calculations.

Finally, health care providers (hospitals and professionals) who provide significant amounts of care and treatment under the Medicaid programs will be eligible for EHR incentive payments. These payments will generally be in lieu of the EHR incentive payments available to providers in the Medicare program. Accordingly, availability of these Medicaid payments will largely be limited to those professionals and hospitals that do not regularly treat Medicare patients such as children's hospitals and pediatricians.

IV. Promoting Prevention, Strengthening Public Health and Improving Quality of Care

President Obama's reform plan also targets chronic diseases including obesity, diabetes, heart disease, asthma and HIV/AIDS. If the plan is any indication of future changes, funding will be available for worksite and school site health promotion programs and onsite clinical preventive services such as vaccinations and exercise facilities to improve employees' health. Financial rewards may also be made available for community based prevention efforts such as sidewalks, biking paths, walking trails and wellness and educational campaigns. Providers who accept federal health care funds would be required to offer patients participation in disease management programs. The Stimulus Bill sets aside a total of $1 billion for clinical preventative services and community-based prevention programs, and companies that provide such programs may be a focal point for private equity.

Private equity funds that have invested in the health care services space should begin to prepare their portfolio companies for increased reporting of cost and quality data such as data on preventable medical errors, nurse staffing ratios, hospital-acquired infections, and disparities in care and costs. Additionally, these companies should be aware of an initiative to align reimbursement and quality and that reimbursement of providers may be tied to achieving performance thresholds on outcome measures.

Additional Information

If you would like further information, please contact us.

James M. Hill
216.363.4444
jhill@beneschlaw.com

Alan E. Schabes
216.363.4589
aschabes@beneschlaw.com

Julie M. Price
216.363.4689
jprice@beneschlaw.com

Frank W. Carsonie
614.223.9361
fcarsonie@beneschlaw.com

Elizabeth A. Dellinger
216.363.4471
edellinger@beneschlaw.com

Jayne E. Juvan
216.363.4636
jjuvan@beneschlaw.com

www.beneschlaw.com