TRUMP, SIR ISAAC NEWTON, HEALTH CARE REFORM, AND M&A

After Donald Trump's stunning defeat of Hillary Clinton – on a platform built in no small part on repealing and replacing Obamacare – the big fat elephant in health care and Wall Street boardrooms across the country is what the fallout might be, and how might it alter investment strategies across the sector.

In thinking this through, we are reminded of Sir Isaac Newton's first law of motion, which broadly states that an object at rest tends to stay at rest, while an object in motion tends to stay in motion.

What, pray tell, could this possibly have to do with health care reform?

Consider that the health care status quo was so thoroughly "at rest," that it repelled efforts to change for 50 plus years. It was so entrenched that it took a Trumpian lift (hmmm) to finally cobble together consequential reform.

Gears that had rusted in place slowly began to grind into motion. Seven years later, like it or not, the Affordable Care Act is pulsing through our health care delivery system – a Goliath (or Kraken, depending on your point of view) with the weight of thousands of pages of regulations, new insurance products, massive Medicaid expansion, innovative payment models, and more, powering its momentum.

So the horse is out of the barn, the train has left the station, the ship has sailed, and health care reform is an object in motion that will tend to stay in motion.

Sure, we will see meaningful changes in the law as it exists now.

But we believe that for the most part, regardless of how they are packaged, these changes will effectively be more iterative in nature then a fundamental retrenching of the program.

Why?

Well, quite simply, **despite the fervor behind "repeal and replace," some of the core elements of the ACA are extremely popular with the American public and health care thought leaders…**

- the elimination of pre-existing conditions as a reason to deny coverage,
- the ability for children to remain covered on their parent's policy until age 26,
- parity laws that provide for mental health benefits "on par" with medical benefits,
- advanced payment models that better align patient, provider, and payor incentives.

Moreover, legislators must be willing to pay a steep political price to knock newly covered beneficiaries off the insurance rolls.

So what may we see instead?

- A reworking of funding mechanisms from government subsidies to tax credits (which could have the added benefit of being positioned as a tax cut).
- A pairing down of benefits included in "base" policies to whittle away at insurance premiums.
- Initiatives to expand health savings accounts (funded again, in part, with tax credits).
- The elimination – or severe curtailment – of the employer or individual mandate.
- A repackaging of Medicaid expansion into earmarked "block grants."
- Initiatives to encourage (require?) states to allow providers to compete freely across state lines.

Will all this yield material reductions in costs?

Perhaps not.

First off, a bit of context:

With all the unknowns regarding participation, demographics, and utilization, the health care exchange products have been extremely difficult to accurately underwrite. So perhaps we shouldn't be so surprised that pricing has been volatile – and will (would?) be subject to great swings over time.

Moreover, it's instructive to remember that traditional employer-based products were experiencing double-digit annual increases in premiums long before health care reform was initiated. That's why the breathtaking deductibles that have dogged the exchange products have been creeping into employer-based coverage as well (and is unrelated to health care reform).

Back to reductions in cost[1]:

Perhaps the most expensive of the reform initiatives – the elimination of the pre-existing condition "gotcha" – is almost assuredly here to stay.

Contrary to traditional Republican doctrine, a new president-elect Trump has publicly stated his desire to leave Medicare programs pretty much intact, so we are unlikely to see significant savings here.

The benefit of insurance companies competing across state lines? Well, at first glance, one would surmise that increased competition would naturally reduce costs. But a detailed study conducted by The Center on Health Insurance Reforms concluded otherwise.

Among other findings, the report concluded that:

"Across state lines legislation was largely unsuccessful because of the localized nature of how health care is delivered. Respondents universally reported the enormous difficulty that out-of-state insurers face in building a network of local providers, and insurers identified doing so as a significant barrier to market entry that far surpasses concerns about a state's regulatory environment or benefit mandates. ***State officials and insurers also noted that across state lines legislation ignores the primary cause of high prices – the cost of delivering care – and fails to account for often dramatic differences in the cost of care between states and regions"*** [emphasis added].

That last sentence is a doozy, and says a lot about the requirements of health care reform.

That's why it is particularly notable that buried in the pages of the Affordable Care Act are a formulary of mandates, incentives, research initiatives, and demonstration projects that have already given rise to accountable care organizations, medical homes, bundled payment models, improved cost and outcomes transparency, and more.

Even though the ACA has not been defined by these measures, they are the ones that are almost assuredly the most consequential.

So, like Kenny from South Park, you can't kill these off.

Given all the above, then, the following are our initial impressions of how "repeal and replace" will alter the current sector and deal making climate:

Uncertainty will do what uncertainty always does.
While the unanticipated election results and the downstream implications for health care creates an initial wave of uncertainty that may put investment strategies on pause, we suspect that given some, or all the above, any disruption will be short-lived.

We sense a subtle descent in hospital census - and, to a lesser degree, utilization of urgent care.
With nearly 20 million newly insured beneficiaries, some of the greatest gains associated with health care reform have been realized by acute care hospitals that have seen steady rises in census and reductions in unpaid claims. It follows, then, that the extent to which changes to the law turn newly covered beneficiaries back into the ranks of the uninsured, we could see downstream reductions in patient census and a rise in write-offs.

The same logic would seem to apply to urgent care as well, except for one big difference. With the most affordable insurance exchange products having such high deductibles, for many newly covered beneficiaries, urgent care has effectively remained cash pay. So, a curtailment of this benefit should have minimal effect on UCCs. The sector, however, is exposed to losses of patients covered through Medicaid expansion. But with many UCCs choosing to steer clear from this segment of the market, these losses will be mitigated.

The unabated rise in health care staffing may abate a bit.
In terms of M&A transaction volume, the health care staffing sector realized record breaking gains from health care reform. With increased census (see above) came increased need for health care providers which drove increased utilization of staffing solutions and a dramatic rise in sector acquisitions and consolidation. As hospitals go, so does, at least to some degree, health care staffing. Consequently, we may see a leveling off of otherwise elevated activity.

[1] Given the limited scope of this marketALERT, we are a focusing on just a few of the challenges facing legislators as they work to re-imagine health care reform and address rising costs.

Behavioral health, home health and hospice, and pharmacy services M&A will largely whistle past repeal and replace.

Behavioral health.

Due in large part to the expansion of mental health parity initiatives, the health care service sector that saw the **greatest**, most **immediate**, and **sustained** acceleration of consolidation activity after the passage of the ACA was behavioral health. As suggested above – and especially in the wake of legislation that was recently passed to increase access to mental health and addiction treatment services – we anticipate that parity will be largely insulated from reform, part deux. So the Big Bertha driver of behavioral health M&A will remain in the bag.

Even a potential rollback in Medicaid or exchange funded spending shouldn't pose too much a problem to some of the sector's high flyers (at least directly, see below).

I/DD and mental health providers that rely heavily on state funding are largely reimbursed through distinct home and community based waiver programs. **Medication assisted treatment** services have a large private pay component. And **autism services**, another hot spot in behavioral health M&A, has been buoyed, in part, by the wide-spread adoption of insurance reforms at the state level. From a reimbursement perspective, then, each are largely outside the ACA's sphere of influence, and hence, the ramifications of repeal and replace.

Home health and hospice.

As stated earlier, Donald Trump campaigned on a promise to leave Medicare – the primary funding source for home health and hospice – intact. What's more, the advanced payment initiatives that have driven new patterns of consolidation in the space (ACO's, bundled payment initiatives, population health management, etc.) are here to stay.

Pharmacy services.

Although we suspect that expectations of increased utilization as a result of newly covered beneficiaries may have tweaked enthusiasm in the pharmacy services sector, we likewise suspect the impact was modest. Moreover, many chronic disease patients, such as HIV, simply moved from Medicaid or ADAP programs to the Exchange. If the Exchange was to go away they would move back to their prior program. In general, the pharmacy world continues to benefit from Part D prescription coverage initiated by W, and regulations that prevent the government from using its purchasing power to negotiate better pricing. While the latter may have been at risk under a Democratic administration (and perhaps a Trump presidency given his love for the art of the deal), we suspect that a Republican controlled congress that has supported these protections in the past will continue to do so.

Medicaid motivated M&A may become muffled.

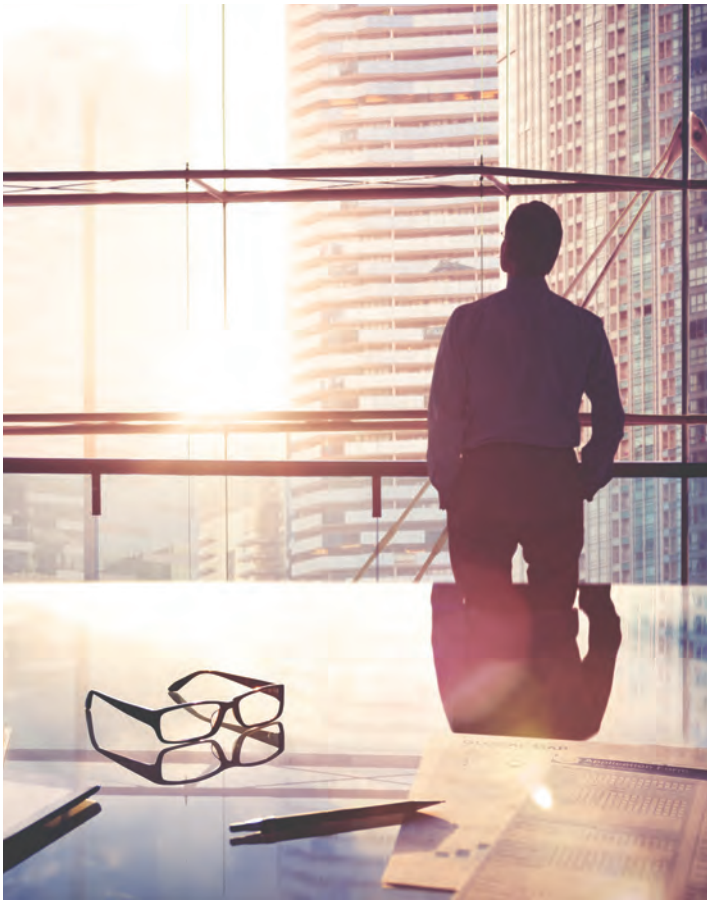
Although in some cases the linkages were soft, several health care service sectors, including home health care and residential and community-based addictions treatment providers, have been boosted, at times, by expectations that Medicaid expansion would not only produce newly covered beneficiaries, but newly or expanded covered services as well, increasing access to, and utilization of, their offerings. Although we suspect that any retraction of expansion is likely to be replaced by some other funding mechanism, we suspect that a reworking of the model could, at least indirectly, dampen a buyer's confidence in this aspect of their investment thesis.

All things considered then, imagine a president-elect Donald Trump addressing a health care investors conference:

"**Don't trust the polls**. Repeal and replace will not be a ***disaster*** for health care investors. ***Believe me***."

And for the most part, we would agree.

Bigly.



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