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Private Equity and its growth in healthcare

Atul Gupta
University of Pennsylvania

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What is Private Equity (PE)?

Private:

- Target firms are not publicly listed on a stock exchange
- No transparency on ownership or financial performance for those outside the deal

Equity:

- PE partners raise funds from investors: pension fund managers, endowments, sovereign funds, and wealthy individuals
- Combine this equity with debt to acquire controlling stakes in target firms
- PE partners and investors keep profits from the sale of this stake when they "exit" in 5-8 years

PE partners have three revenue streams:

- Annual management fees, taken from the fund (1-2% of capital)
- Share of profits from exit, usually 20% (known as "carried interest")
- Annual "monitoring" fees, taken from the target firm

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The PE playbook: How do they obtain profits?

Financial engineering:

- Deal is financed 60-90% using debt, hence the term, "leveraged" buyout[1]
- Debt is placed on the balance sheet of the target firm, not the PE firm
- The use of debt helps reduce tax liability and increases return on equity
- Sale of real estate unlocks capital even before exit from the deal
- Dividend recapitalization – more debt on the target firm to return capital to PE

Governance engineering:

- Change the managerial leadership, rejig the board; change performance incentives

Operations engineering:

- Costs: layoff staff, realize scale efficiencies (e.g., procurement)
- Revenue: renegotiate higher prices, expand volume (e.g., referrals), increase treatment intensity, upcoding

Notes: 1. Kaplan and Stromberg (Journal of Economic Perspectives, 2009).

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How does PE differ from conventional for-profit ownership?

Private Equity

- Target receives relatively little capital infusion due to large share of debt
- Short-term horizon: Increase firm value within 5-7 years for resale
- Moral hazard: PE firm can do well even if the target suffers
  - Debt on target's balance sheet
  - Loss limited to (minimal) equity investment
  - Minimal hit to reputation

Conventional

- Transaction does not add to target's debt burden
- Going concern: Exit is not needed to make a payoff from investment
- Fortunes of investor and firm are intertwined, even more so if publicly listed

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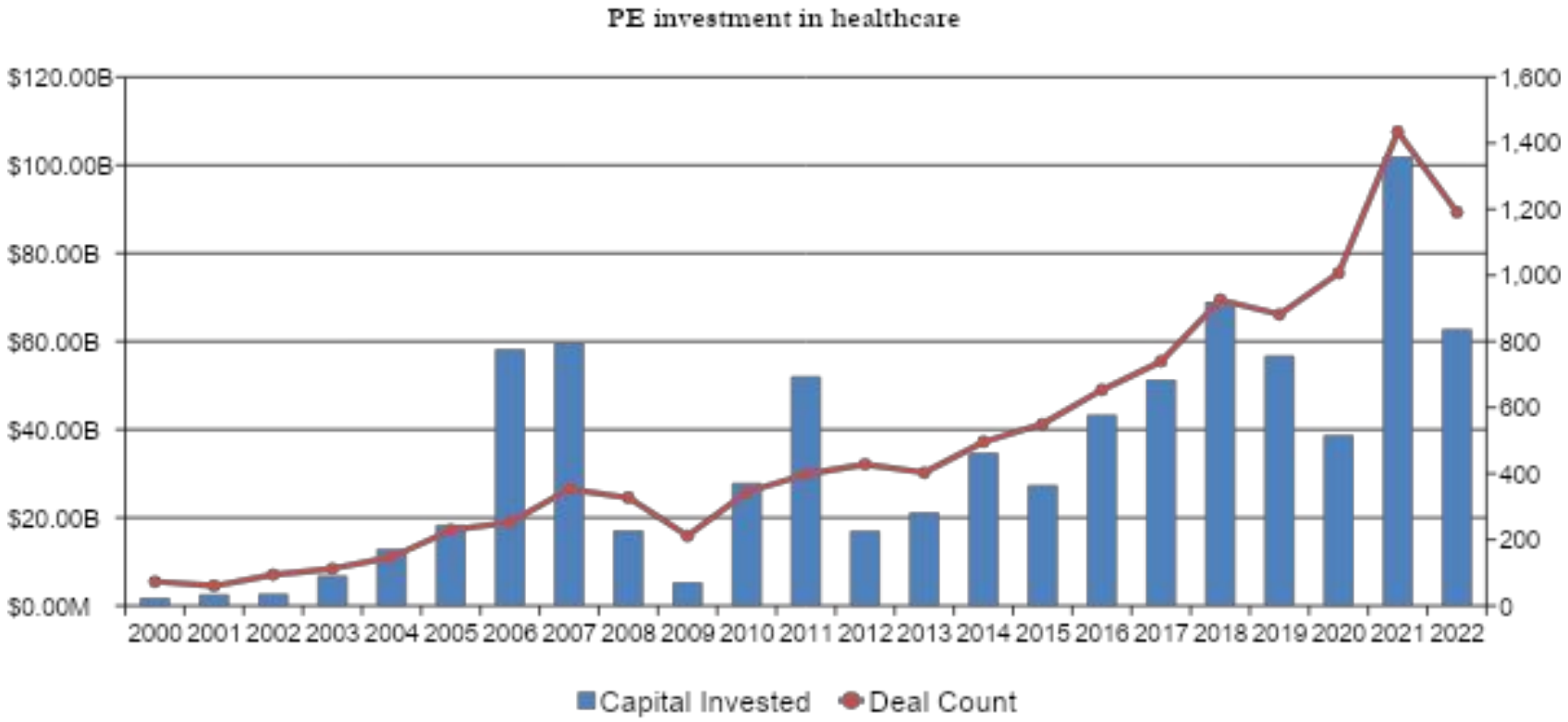
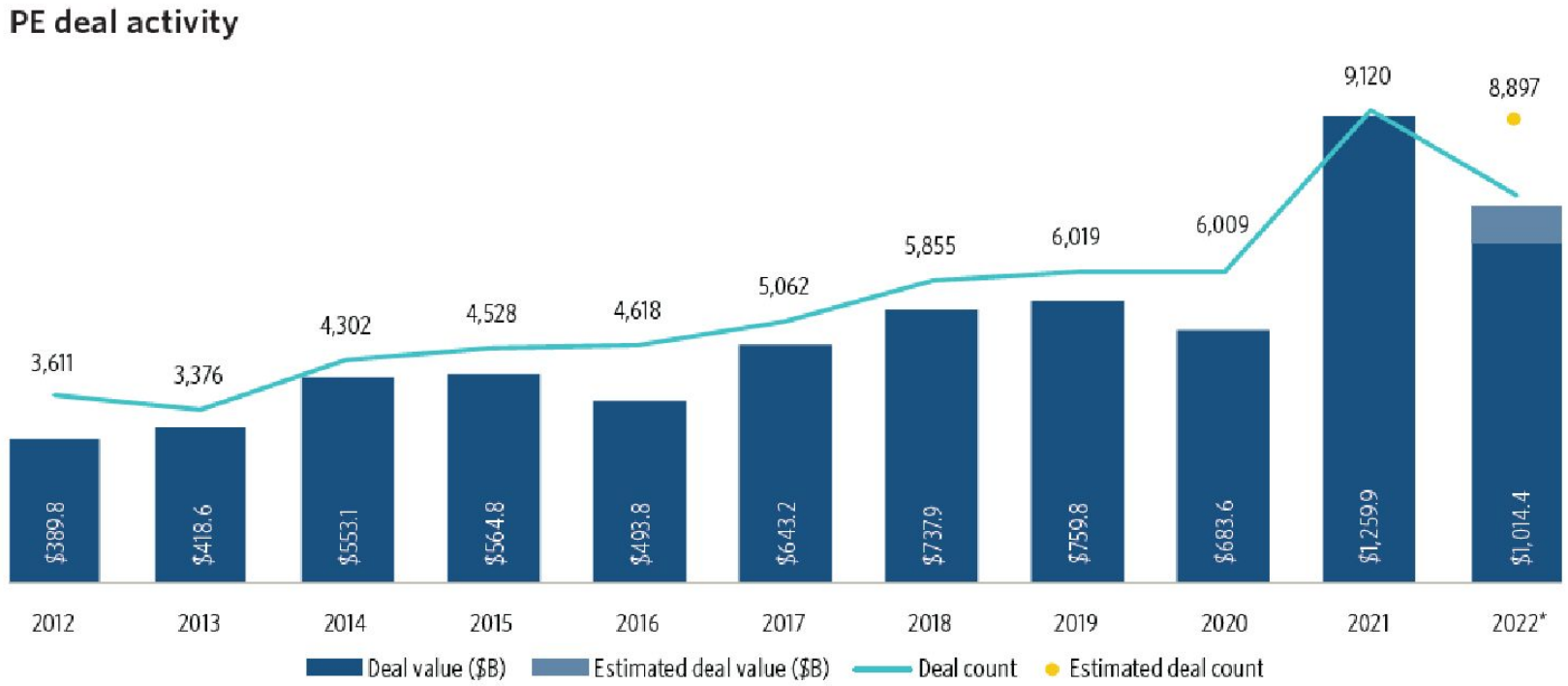
PE investment in healthcare has grown dramatically in the last decade



Notes: Figure 1, Howell and Liu (working paper, 2023). Data sourced from Pitchbook

Healthcare accounted for about 12% of total PE deal value in 2021, up from 5% in 2012



Notes: 2022 annual US PE breakdown. Pitchbook, Inc. Available at https://pitchbook.com/news/reports/2022-annual-us-pe-breakdown

Why has PE investment grown so rapidly in healthcare?

Supply side

- Cheap debt
- Favorable policies: corporate practice of medicine laws relaxed, limited antitrust scrutiny
- Macro factors: recession-proof, aging society, govt. subsidies
- Micro factors: (nearly) inelastic demand, provider fragmentation, opaque quality and uninformed consumers

Demand side

- Providers are looking for capital infusion to survive or scale up
  - Manage regulatory burdens
  - Afford IT and marketing costs
  - Negotiate higher prices
  - Defend against competitors
- PE typically nimbler than publicly listed firms and non-profits

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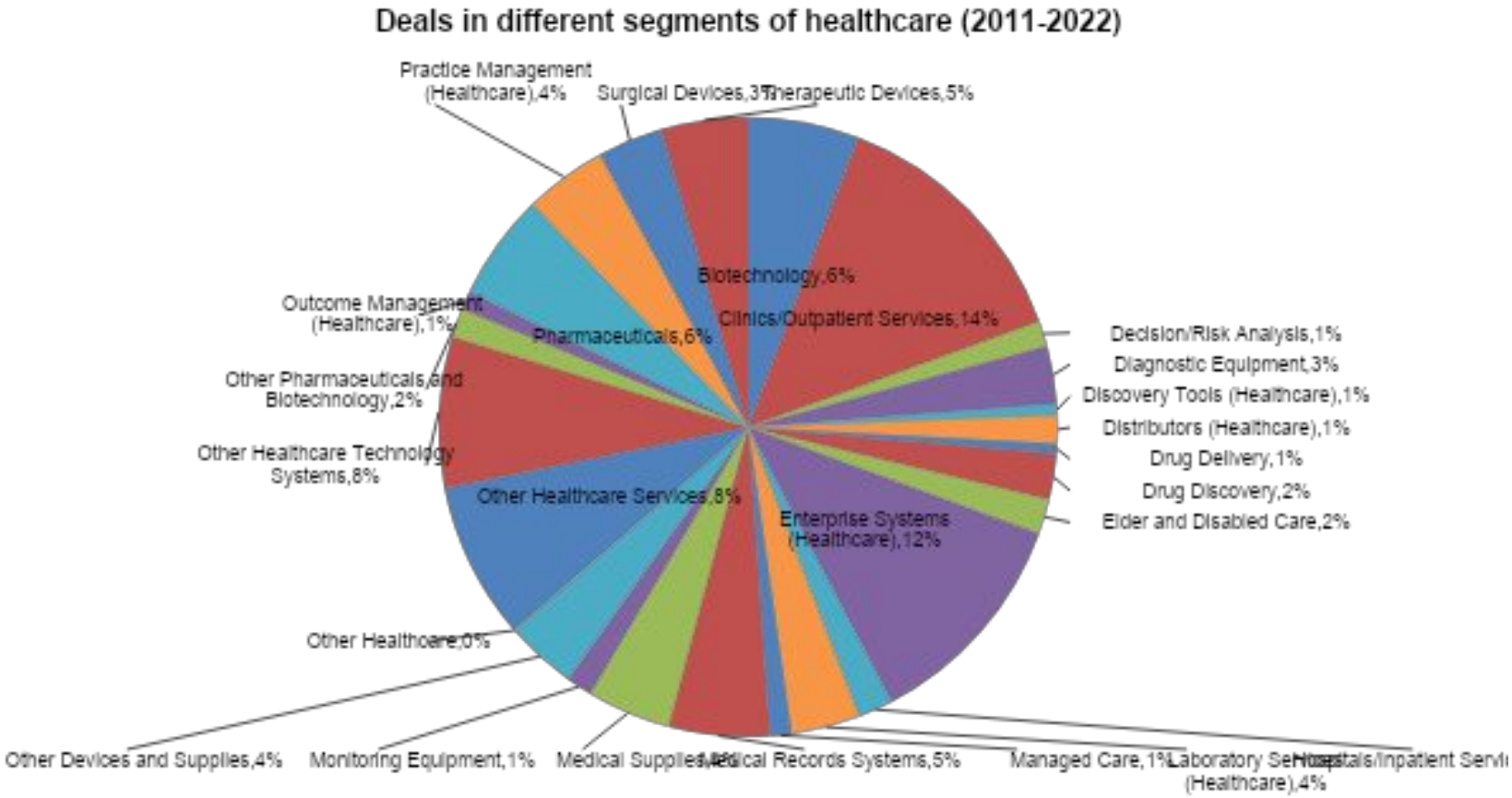
PE firms are focusing on providers and new technology/therapeutics



Notes: Figure 2b, Howell and Liu (working paper, 2023). Data sourced from Pitchbook

What is the concern over PE involvement in healthcare?

Evidence from other sectors is generally positive:

- PE ownership increases firm revenue, reduces costs, increases use of IT, in some cases increases service levels/quality (e.g., restaurants[1])
- PE ownership also leads to staff layoffs. But since it increases growth, overall employment increases[2]

But healthcare markets have some uniquely dysfunctional features:

- Low quality providers are difficult to identify and rarely punished by the market
- Consumer demand is relatively insensitive to price and quality
- Extensive government subsidies and fixed/inflexible prices
- Markets for some services are concentrated (e.g., hospitals, dialysis), and in general, very far from perfectly competitive

Notes: Bernstein and Sheen (Review of Financial Studies, 2016). 2. Davis, Steven J., John Haltiwanger, Kyle Handley, Ron Jarmin, Josh Lerner, and Javier Miranda (American Economic Review, 2014).

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