

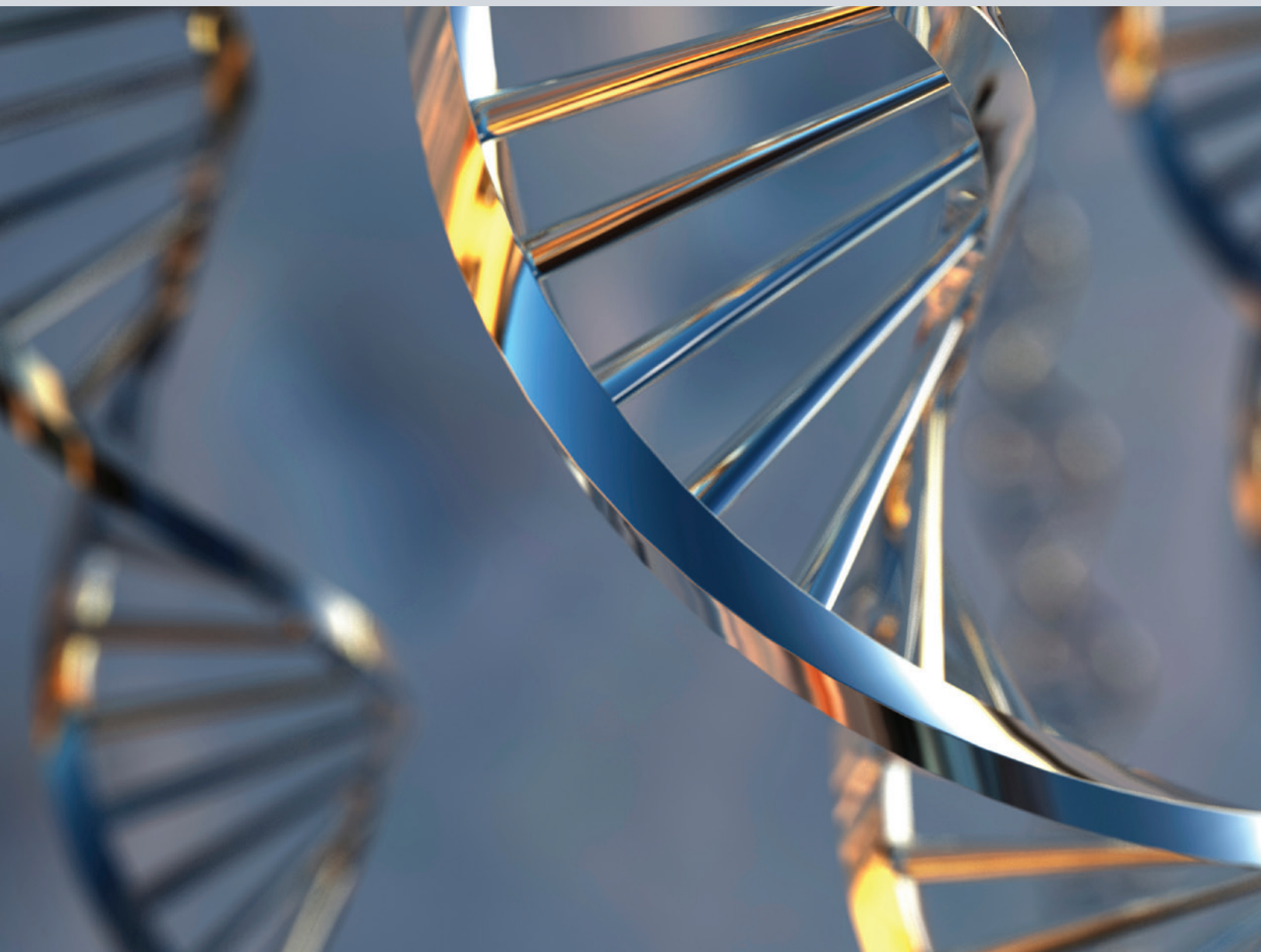


# **THE WHARTON HEALTHCARE QUARTERLY**

**INAUGURAL ISSUE**

**WINTER 2012**

**VOLUME 1, NUMBER 1**



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## **EDITORS' LETTER**

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**Welcome to the Inaugural Edition of *The Wharton Healthcare Quarterly*! We are excited to bring this new e-magazine to the vast Wharton Healthcare Program community.**

The initiation by the Wharton Health Care Alumni Association Board of Directors of the launch of *The Wharton Healthcare Quarterly* was inspired by a desire to stay connected in a fast-paced, often fragmented world. Your enthusiastic response, words of encouragement, and active engagement tell us we're on the right track.

There is a wealth of talent in the Wharton community, making the effort to connect and highlight our alumni well worth it. We hope you will find this offering timely and informative, rich in content, varied in perspective, and highly interactive. Ultimately, we hope it will become a "go-to" resource and eagerly anticipated "must read."

This first edition will help orient you to the basic format, outline the strategic approach, and pilot test the concept in order to gain an initial reaction to the direction we're headed.

We are counting on you to help bring each edition to life and provide the type of insight and feedback which will keep it fresh, relevant, and truly meet the needs of our membership. We look forward to the involvement of our community and receiving new articles, comments, and readership from all of you.

So.....without further ado, welcome to the adventure!

Managing Co-Editors:

**Z. Colette Edwards, WG'84, MD'85**

**Sylvia Tara, WG'05**

*P.S. Special thanks to Hareesh Havnair, Jeff Voigt, David Gerhart, and Gabriela Sanchez for their help in bringing this inaugural edition to press*

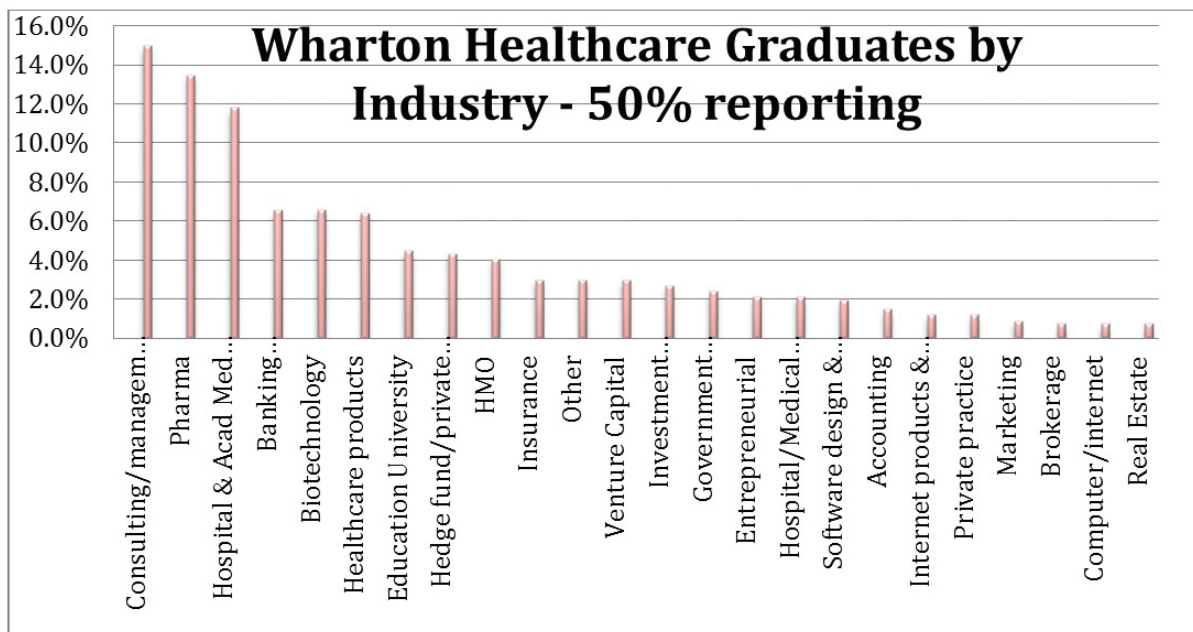
*To learn more about Colette,  
click [here](#).*

*To learn more about Sylvia,  
click [here](#).*

## DID YOU KNOW?

### Healthcare Program Demographics

1. There are 1550 grads and 74 soon-to-be grads in the database.
2. There are 1741 grads/soon-to-be-grads spanning the years of 1971 through 2014.
3. There are 521 joint degree graduates, with MDs leading the way at 305, followed by 82 PhDs, and 24 DDSs/DMDs.
4. The current gender distribution for grads is 59% male:41% female.
5. At the end of 2010, with 50% reporting, grads were located in 28 states plus Canada, the UK, Italy, and Israel.
6. There is great diversity relative to industry sector:



## THE PRESIDENT'S CORNER

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Welcome Fellow Wharton Health Care Alumni and Friends:

I'm thrilled to be contributing to our inaugural issue of *The Wharton Healthcare Quarterly* and want to congratulate our editors, Z. Colette Edwards, WG'84, MD'85 and Sylvia Tara, WG'05, for their dedication to producing this high quality e-magazine. Like all of you, I will look forward to getting quarterly updates on the cutting edge of the healthcare industry, including pieces from Wharton faculty and industry experts, hearing about the personal and professional achievements of our fellow alumni, and reading about the latest news from the Health Care Program office.



Column Editor: Jay Mohr, WG '91,  
Managing Director and Co-Founder,  
[Locust Walk Partners](#)  
To learn more about Jay, [click here](#).

We are at a pivotal time in the healthcare industry with policy reforms impacting all of us – on both personal and professional levels. The 2012 Presidential Elections may render the final verdict on the Patient Protection and Affordable Care Act (PPACA) and it is our hope that this publication, among other sources, will keep you abreast of its many implications.

As health reform evolves over the next 12 months, we also find ourselves at a pivotal time in the evolution of the Wharton Health Care Alumni Association (WHCMAA). Our “base” of **graduates from the Wharton Health Care program is rapidly approaching 2,000 strong**, representing all sectors of the industry – provider, product, IT, policy and payer AND all major continents of the globe! We have a fast growing group of **dues paying members – nearly 400 overall. In 2011, we sponsored or co-sponsored an all-time record of over 35 alumni events**, including our first **Health Care Alumni Conference** and the Annual get-together at the **JPMorgan Life Sciences Investor Conference**. These accomplishments are due, in large part, to a very active and committed Board of Directors.

While we are proud of these numbers, we want to avoid complacency and to continue to enhance what we offer to our member constituents. Meeting the diverse educational needs of a multi-faceted and geographically dispersed group is a challenge, but one that we feel we can meet with **relevant and timely programming** delivered through a range of vehicles, including a greater use of web-based tools and social media.

In order to make sure we meet your needs, in the next few weeks, you will be asked to participate in a bi-annual survey that will ask for your candid input on a number of key questions pertaining to the broader role of the Association, including maximizing the value of our programming; collaborating with the Health Care Program and faculty; and partnering with WEMBA, regional Wharton clubs, and other leading MBA alumni associations. We hope you will give us your input.

The Wharton brand is one that we all wear with great pride! I hope that you will take the opportunity to become an engaged member of our Association. Active dues paying members enjoy a wide range of benefits, including free access to topical webinars, exclusive access to our WHCMAA LinkedIn group, and a range of discounts on other programming. Your dues further enable us to sponsor events, offer scholarships to 2nd year students, and provide stipends for international service trips. If you are already a dues paying member, we thank you for your continuing support and would encourage you to take a more active role – host an event, chair a webinar, or consider joining the WHCMAA Board. We look forward to your involvement!

Feel free to reach out to me or any member of our Board with thoughts and suggestions – we listen to our members!

With best wishes for a healthy and prosperous 2012,

Jay Mohr, WG'91  
President, Wharton Health Care Management



## INDUSTRY TRENDS AND INNOVATION

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### ***New Ventures in Healthcare Conference – Then and Now.... A Reflection on Industry Trends***

Wharton has been a leader in examining the complexity which is healthcare for some time. This year marked the 17th anniversary of our student-organized Wharton Healthcare Business Conference. It brings together all sides of the industry to a neutral forum where students, faculty, and captains of industry drill down on the pressing issues of the day. Given the current national review of healthcare and the anniversary of the conference, we thought it might be interesting to look back at the origins of the conference, touch on a personal journey from one of its founders, and flash forward to the October 2011 Wharton Alumni Association Conference gathering, which also addressed industry trends and was organized by alumni.

Like many Wharton ventures, the conference was conceived on several napkins, facilitated by strong espressos and carried forward by an energetic and highly spirited learning team. Of special note is the extra boost the agenda and effort received from the strong guidance of June Kinney, Associate Director, and Patricia Danzon, Celia Moh Professor of Health Care Management, of the Healthcare Program.

Several notable and influential industry leaders signed up as speakers - Steve Burrill of Burrill & Company, Jesse Treu of Domain Associates, and John Northrup of Eli Lilly. At that time, we examined the value chain in healthcare innovation from idea inception to start-up company formation and from venture stage to IPO, and the varying perspectives of sell and buy side analysts. One of the major highlights was the sparring match between Stelios Papadopolos, a leading biotech banker, and Meirav Chovav, a top-rated analyst of Solomon Brothers, over the state of the industry.

What did we learn then? In 1996, much of the industry seemed poised for growth. The economy was accelerating at a rapid pace (Jeremy Siegel's classroom highlighted GDP growths of 3%+ for the foreseeable future.), the technology boom had begun, and we had the promise of a host of innovative technologies and products, all designed to address unmet medical needs and to allow patients to live longer and more comfortably. There were high hopes for a number of technologies, including gene therapy, artificial organ development for transplantation, tissue reengineering, and a number of minimally invasive procedures using robots, lasers, and computers.

What do we know now? 15 years later, the promises of that era have yielded some unexpected successes, including the routine use of metal stents and implantable defibrillators for cardiac patients, targeted cancer therapies for patients with breast, blood, and lymph node cancers, and medicines focused on fighting the HIV virus that leads to AIDS. At the same time, however, many of the early promises have gone unfulfilled. That disappointment harkened the arrival of the view that medical innovation has stalled in the United States. The focus now is a renewed and aggressive effort on price structures and cost-cutting efforts by businesses and individuals alike. In addition, the accelerating economy of 1996 has been replaced with long-lasting stagnation, the duration of which only speculators are willing to consider.

My own personal experience with healthcare has also morphed quite extensively over the last two decades. I started my career as an Assistant Professor of Medicine and Surgery at the Yale School of Medicine. I served on the front lines of their New Haven emergency room, treating trauma patients suffering from everything from sore throats and paper cuts to gunshot

Column Editor: David Blaustein, WG'96, Managing Director, Healthcare, Suttonbrook Capital  
To learn more about David, [click here](#).

wounds and heart attacks. What really interested me, however, were the new technologies and changing stream of medicines that were available to treat patients. Even in New Haven, a far distance from Silicon Valley or Thousand Oaks, the emergence of the fledgling biotech and medical device industry was alive and starting to form. I wanted to be a part of it, and so came back to Wharton for my MBA, having been a college student there 10 years earlier.

On my 15th anniversary in the industry, I emerge a little bruised, a bit wiser, and cautiously optimistic about the future. I cut my teeth after graduating at Goldman Sachs, and migrated after that experience to the hedge fund world, working for the great U of Penn advocate, Marty Zweig, and his partner, Joe DiMenna. Since then, I have managed healthcare portfolios for a few well-known funds. As both a doctor and an investor, I have witnessed the great promises of numerous technologies, only seeing a handful cross the finish line, with even fewer achieving true medicinal breakthrough status.

So what does it take to innovate and succeed in the healthcare industry, especially in light of the major health reforms taking place under the recently passed Patient Protection and Affordable Care Act (PPACA)?

***Flash Forward - Update from the 2011 Wharton Healthcare Alumni Conference.***

Jeff Voigt, WG'85 and VP of the Wharton Healthcare Alumni Association, reports this subject was discussed in depth at the recent Wharton Healthcare Alumni Association Conference held October 22, 2011 at Huntsman Hall on the UPENN campus.

The conference was attended by 140 participants and included such speakers as Leo Brideau, CEO Ascension Health; Jonathan Bush, CEO, athenahealth; Ezekiel Emanuel, PhD, MD, Diane V.S. Levy and Robert M. Levy University Professor and Vice Provost for Global Initiatives for the University of Pennsylvania; Mark Pauly, PhD, Wharton Bendheim Professor of Healthcare Management; Steve Phurrough, COO, Center for Medical Technology and Policy; and Harlan Weisman, MD, Chief Science & Technology Officer at J&J.



This conference was planned and executed by the Wharton Healthcare Alumni Association with the session leaders all coming from the ranks of the alumni. It was a spirited day of interaction for the attendees who were comprised of Wharton Healthcare alumni members, Wharton PhD healthcare grads, non-healthcare Wharton MBA alumni, and other UPENN graduates, including those from the Wharton undergraduate program.

The Conference title, *“At the Intersection of Policy, Implementation, and Innovation in the Healthcare Industry”* was apropos for the session topics, which included (1) creative policy making, (2) policy implementation, (3) innovative delivery systems and product development, (4) financing, and (5) health information technology. These sessions were bracketed by an update on the Patient Protection and Affordable Care Act (PPACA) and a final debate at day's end on where we are headed with our healthcare system.

Planning for the conference and sessions was undertaken by the following WHCMAA members: Sarah Collins, WG'91 (PPACA); Liz Miller, WG'04 (HIT); Jay Mohr, WG'91 (Healthcare Delivery); Jim O'Connell, WG'07 (Financing); Maureen Spivack, WG'86 (Healthcare Delivery); and Bill Winkenwerder, WG'86 (debate – Healthcare 2020). Despite concern over inertia from the PPACA, it was readily apparent that there are numerous innovations taking place within our healthcare system, and the speakers at the meeting were at the forefront of this change.

There were several key lessons, takeaways, and perspectives expressed:

- Innovation requires not only products and services that improve patient outcomes but also the development of creative policies in order to ensure these products and services see the light of day relative to timely market uptake and reimbursement.
- Turmoil/confusion in markets creates business opportunities for those who are willing to think carefully about the potential consequences/outcomes of shifts in healthcare policy.
- There are numerous and positive sections of the PPACA which are spurring innovation in the areas of comparative effectiveness, benefit design, and value (cost-effectiveness) creation. The Affordable Care Act, while not perfect, is a step in the right direction.
- We should be embracing the parts of the act that positively affect our healthcare system.

Most importantly, the conference brought together, for the first time, Wharton Healthcare alum - with the explicit purpose of talking and networking with each other. There are many talented people who have impacted the field of healthcare in a very positive way who graduated from the Wharton Health Care Program, and sharing our experiences at the conference was invaluable.

This year's Alumni conference is anticipated to be held the weekend of October 27, 2012. Look for upcoming communications on planning and participation in next year's conference. We will need volunteers to plan and present!

And .....don't forget the 18th annual Wharton Healthcare Business Conference "Innovation in a Changing Health Care Environment" to be held February 16 – 17, 2012 in Philadelphia. For more information, visit [www.whcbc.org](http://www.whcbc.org).



## OPEN WIDE

### *Taking a Look at Dental Health*

A funny thing happened on the way to health care reform. The Patient Protection and Affordable Care Act, more commonly known as ACA, actually contains provisions, some fairly notable, concerning dental health. What is going on here? Doesn't everyone brush and floss regularly? Benefit from community water fluoridation? Visit the dentist every six months? Get sealants and braces for their kids? Have dental insurance through the workplace?



Column Editor: Harris Contos, DMD,  
WG'80, Asclepius Consulting  
To learn more about Harris, [click here](#).

With popular advertising focusing on dental implants, cosmetic dentistry, “dentures in an hour,” tooth whitening, and straightening those crooked teeth for both kids and adults, hasn't the “dental problem” been solved in this country? Is it not one of the few segments of health care where we can claim success? At a mere 4% of the total \$2.5 trillion in national health expenditures in 2009, oral health is hardly a driver of health care costs or seen as a prism through which to examine other health care issues such as access, equity, and quality. So what is going on in oral health?

Much can be learned through case study, a centerpiece of a Wharton education, and the “story” does not always have a happy ending. Such was the case involving Deamante Driver, a 12-year-old Prince George's County, Maryland boy who died in 2007 of a dental abscess spreading to his brain. Analysis of this case study reveals a multitude of factors leading to this young boy's avoidable death and the realization that “success” is far from being achieved when it comes to dental health. Adding to the significance of the impact of inadequate oral health on the population as a whole is the link between periodontal disease and heart disease, diabetes control, premature delivery, and stroke.

Significantly, the Driver case was presaged in 2000 with the release of the 332-page “Oral Health in America: A Report of the Surgeon General.” This first-ever report of its type provided a wide-ranging assessment of dental diseases – their epidemiology, their costs, in both debility and dollars, the disparities among racial, ethnic, and socioeconomic groups, the workforce, and other resources available to address these issues. As importantly, it underlined the reality that, despite considerable gains being made in oral health status since the 1960s through fluoridation, technology, and increased access to care, the state of affairs is such that a “silent epidemic” *still exists in this country with regard to dental disease*:

- Tooth decay is the single most common chronic childhood disease – 5 times more common than asthma and 7 times more common than hay fever.
- Over 50 percent of 5- to 9-year-old children have at least one cavity or filling, and that proportion increases to 78 percent among 17-year-olds.
- Poor children suffer twice as much dental disease as their more affluent peers, and their disease is more likely to be untreated and to have worsened in recent years.
- The social impact of dental disease is considerable, with more than 51 million school hours lost to dental-related illness.
- Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits.
- For every adult 19 years or older without medical insurance, three are without dental insurance.
- A little less than two-thirds of adults report having visited a dentist in the past 12 months.
- About 30 percent of adults 65 years and older are edentulous (having no teeth).
- At any given time, about 5 percent of Americans aged 65 and older are living in a long-term care facility, where dental care is problematic.
- Medicare is not designed to reimburse for routine dental care.

So what were some of the contributing factors to Deamante Driver's untimely death? How and why should a young person die from a common, very treatable, thoroughly preventable disease?

- social, economic, and other conditions and attitudes leading to such poor oral health - poverty, failure to select dental insurance even when it is available as a benefit through the workplace, lapses in Medicaid coverage
- a Medicaid bureaucracy through which it is often difficult to maneuver (More than two dozen calls needed to be placed by the Public Justice Center to find a dentist who took Medicaid.)
- the funding and administration of Medicaid programs (in which providers often cite low reimbursement and burdensome paperwork as reasons for not participating)
- the virtual impossibility of seeing a dentist in a timely fashion who took Medicaid patients (At the time, only 900 of the 5,500 dentists in Maryland accepted Medicaid patients, with referral to specialists being especially difficult; in 2005, fewer than one child in three in the state's Medicaid program received any dental services at all.)

Given this context of oral health in this country, a major theme of the Surgeon General's report is succinct in its statement and far-reaching in its implications: - the integration of oral and general health programs is lacking for the population as a whole, and the public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups.

In addition to the implications of the Deamante Driver case, the Surgeon General's report had the central theme that "oral health is integral to overall health," which then begs several questions about the "dental enterprise" in this country and the nation's oral health. Fundamental among them is to ask whether a traditionally private, solo practice, fee-for-service, "cottage industry" business model can sufficiently address the issues of cost, access, and quality facing the rest of the health care in America. Can it respond to developing concepts such as "global budgeting," "bundled payments," and "accountable care organizations (ACOs)," which point to future directions in organization, delivery, finance, and management? Whether some of these approaches "rub off" on dentistry remains to be seen. Some indications say "yes," while others point to a continuing and widening gap between dentistry and the rest of health care, rendering the Surgeon General's theme more slogan than realization.

In future editions of this column, we will take a closer look at a number of issues bearing on dental health, including:

- *Dental coverage* – What does ACA call for in dental insurance? Why no dental coverage under Medicare? What is the state of Medicaid coverage throughout the states? Why can it be so difficult to find a dentist who accepts Medicaid?
- *Costs* – How have dental costs paralleled general health care costs and what are the cost control measures in dental care?
- *Quality* – What are the measures of quality in dental care?
- *Organization of care* – Are there ACOs in dentistry? Does oral health fit into the medical home model?
- *Prevention and Restoration* – Are these competing goals for dental resources?
- *Direct-to-Consumer Advertising* – What questions should one ask about dental implants and cosmetic dentistry?
- *The Dental Workforce* – What is a dental "mid-level provider" and what lessons are to be found in the Alaska Native Tribal Health Consortium dental therapist program to reach underserved populations?

We hope you look forward to examining these and other questions in the months ahead. In the meantime, be sure to keep that winning smile!

## THE PHILOSOPHER'S CORNER

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Welcome to this eclectic standing column which will feature insightful musings, words of wisdom, life lessons, and stepping stones to business success. We'd love to hear from you, so [click here](#) to participate in future editions.



This month's philosopher is David Gerhart, a Senior Project Manager at MedImmune, a leading biotechnology company under the AstraZeneca umbrella. To learn more about David, [click here](#).

### **Life Lessons:**

If I knew then what I know now, I would have taken more risks.

If I knew then what I know now, I would not have remained in the same work role after completion of a major program. In hindsight, my greatest opportunity to market my skills and accomplishments was lost when I took the lead on a follow-up program in the same organization. Instead, I should have been more aggressive in seeking a new assignment beyond what had become my comfort zone.

### **Favorite Quotes:**

"The empires of the future are the empires of the mind." – Winston Churchill

"Eighty percent of success is showing up." – Woody Allen

"Better to remain silent and be thought a fool than to speak out and remove all doubt." – Abraham Lincoln

### **Recommended Reading:**

A Brief History of Nearly Everything – Bill Bryson

The Power of Now – Eckhart Tolle

A Tale of Two Cities – Charles Dickens

The Girl with the Dragon Tattoo – Stieg Larson

Physics of the Future – Michio Kaku

Column Editor:  
Z. Colette Edwards, WG'84, MD'85  
To learn more about Colette,  
[click here](#).

## ALUMNI NEWS: SIMSBURY COUPLE HOLDS WEDDING IN SHELTER

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Lack Of Power Forces Relocation

[Ceremony Will Be 'A Wonderful Memory'](#)

November 01, 2011 – By JULIE STAGIS, [jstagis@courant.com](mailto:jstagis@courant.com), The Hartford Courant

SIMSBURY — Kathleen Dal Santo and Douglas Strachan Arnold were supposed to get married in an intimate ceremony at their home, just the two of them and state Rep. Linda Schofield, who was to officiate.

Instead, Dal Santo and Arnold were married before a room full of strangers gathered at Simsbury High School for shelter after the late-October snowstorm.

## INTERVIEW WITH SUSAN DESMOND-HELLMANN, MD, MPH, CHANCELLOR OF THE UNIVERSITY OF CALIFORNIA

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Over the last two decades, healthcare has emerged as a focal point with a far-reaching impact on the personal day-to-day lives of the American public as well as the health and wellness of the economy. We have seen the relationship between physician and patient reframed to a provider - consumer dynamic, as patients have become more aware and demanding of more control over product choice and healthcare service. We have witnessed the influence manufacturers have within the interactions between payer, provider, and patient. Lastly, we have also witnessed successes with novel drugs, therapies, and devices, the development of “new” delivery systems, and nascent government reforms as well as a number of failed promises.

The model is constantly evolving, especially with the renewed focus on healthcare as a source of funds to help close the widening national deficit. What innovations can we expect in the future to influence the current trajectory?

We have embarked on a series of brief interviews with key players who have agreed to share their unique views and experiences with us.

We are fortunate to be able to launch our first Industry Trends and Innovation column with **Susan Desmond-Hellmann, MD, MPH, the Chancellor of the University of California, San Francisco**. Previously, Dr. Desmond-Hellmann was the **President of Product Development at Genentech**, one of the nation’s leading producers of anti-cancer drug treatments. At Genentech, Dr. Desmond-Hellmann oversaw the FDA approval of a number of the company’s key anti-cancer drugs including Avastin, Herceptin, Rituxan and Xolair.

**DB:** You have had an inspiring career. As an academic and community physician, as a public health provider in Uganda, and as a key innovator of drug development within the biopharmaceutical industry. Let me start by asking “What do you see as the key ingredients in fostering innovation?”

***SDH:** I think the freedom to pursue ideas or initiatives that are not popular is crucial. It’s important to be in an environment that allows for both risk and failure.*

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**DB:** Then do you have a philosophy about work, in particular, and life, in general?

***SDH:** Work should be fun and you should make a difference.*

---

**DB:** I am sure there are many stories, but is there one interesting example about your professional life that you’d like to share?

***SDH:** Yes. It again has to do with the importance of taking risks and of unusual career paths. After medical school and residency in oncology, at the beginning of my faculty career, I left UCSF to work (through a fellowship) in Uganda, doing research and caring for patients. I loved research and academia but underestimated how difficult it would be to return to an academic career. When I came back to the U.S., I wasn’t happy with the options available for an academic position. This led me to clinical practice as an oncologist and then to industry - first Bristol Myers Squibb and then Genentech - and finally now back to UCSF, as Chancellor.*

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Column Editor: David Blaustein,  
WG’96, Managing Director,  
Healthcare, Suttonbrook Capital To  
learn more about David,  
[click here.](#)

**DB:** With that said, is there a favorite quote you might have as a source of inspiration or a favorite book?

**SDH:** *My favorite quote would be “If we did all the things we are capable of, we would literally astound ourselves” by Thomas Edison and my favorite book is “Einstein: His Life and Universe” by Walter Isaacson. You didn’t ask, but my favorite hobby is cycling.*

**DB:** So let me now ask you some of the more academic questions. The first is more a review of the past. What do you think were the top five innovations that have occurred in the past decade? I imagine they are healthcare-related but likely there are others.

**SDH:** *I would say the top five innovations of the last decade have been:*

- 1 human genome sequence completed*
- 2 HIV prevention using antivirals*
- 3 genome-based diagnostics*
- 4 social networking*
- 5 mobile devices*

**DB:** What about the future? If you had to look into your crystal ball, what types of technologies, discoveries, or inventions are you expecting or hoping for in the decade to come?

**SDH:**

- 1 the routine use of information technology to improve health*
- 2 RNA-based therapeutics -siRNA, miRNA*
- 3 malarial vaccine*
- 4 routine use of molecular testing to choose therapeutics*
- 5 the ability to predict and delay neurodegenerative diseases*

*Time will tell.*

**DB:** Thank you. Lastly, I know you are busy with the University and with committees and boards, but looking forward, what are you most optimistic about?

**SDH:** *The next generation of health sciences professionals who are just now beginning their careers. I am so inspired by their global, holistic view and their aspirations to make the world a better place. I am certain that they will do many great things.*



## TAKING THE PLUNGE

### WHC '95 Alum Jamie Richter Seeks New Challenges via Jericho Equity Partners

Wharton alum Jamie Richter recently transitioned from industry to the exciting world of hands-on investment. Richter and partner Eric Schwartz created Jericho Equity Partners, a unique firm that is somewhere along the spectrum between a search fund and private equity. Read on to learn the details of Jamie's transition, the partnership between two Wharton alums, and the fascinating new path they are traveling.



Column Editor:  
Wharton Healthcare Quarterly  
(WHQ)

**Wharton Healthcare Quarterly (WHQ):** Good morning, Jamie, and thanks so much for taking the time to speak with us. We understand you have recently taken the leap to embark on a change in your career that is both exciting and somewhat risky. Could you first give us a brief sense of how your career in health care has transpired to date and what you have chosen to do now?

**Jamie Richter, WHC '95 (JR):** *Sure, and for starters, thanks so much for your interest in my latest endeavors. I hope that my story will be interesting to my fellow alums and perhaps even encourage others to take similar risks. Since graduating from Wharton in '95, I have held operating roles in several health care businesses, cutting across multiple functional areas such as sales, business development, operations, and general management. These positions have included executive roles with a chronic care disease management company (CorSolutions), a leading wireless health technology/service business (CardioNet), and a start-up operating company within J&J's Diabetes Care Franchise. Most recently, I served as CEO of a very early stage wireless health company called Presymtec Medical, which has developed technology enabling early detection of infections.*

*When I left Presymtec Medical, I found myself at a bit of a career crossroads. On one hand, with a broad range of operating experience at an executive level, I was well-positioned to find a new senior management role. On the other hand, I sought a new challenge, something that would allow me to write my own future, exert greater control over key decisions, and take significant ownership. Meanwhile, I did not have that single brilliant idea that drives so many entrepreneurs to start their own companies. Ultimately, I decided that Jericho Equity Partners would be the ideal way for me to pursue an entrepreneurial path without having to build a business from scratch.*

**WHQ:** And for our readers, please provide a quick summary of Jericho Equity Partners – who you are as a firm and what you are hoping to accomplish.

**JR:** *I founded Jericho Equity with a longtime friend and former colleague, Eric Schwartz, who is also a Wharton grad. (He's not a Wharton Health Care alumnus, but I try not to hold that against him.) Eric and I first met back in third grade and had crossed paths at multiple points in our lives. We re-connected several years ago when the two of us ended up working in health care in the Philadelphia area. Eric had been a senior executive with Animas, a diabetes device company, and had stayed on at Johnson & Johnson after J&J acquired Animas in 2006. He recruited me into J&J's Diabetes Care Franchise and it was then that we began discussing future – and more entrepreneurial – career opportunities. Timing in life is everything, of course, and the stars did not align for several years thereafter. Finally, about six months ago, we were both in a position to consider taking some risk, and we resumed our earlier discussions.*

After considering many alternatives, we decided to leverage our operating experience by identifying a small health care business in the Philadelphia area that we could acquire and run on a day-to-day basis. And that is Jericho Equity Partners' mission: to acquire a profitable, growth-oriented health care services business with \$1-3MM in EBITDA. As operating executives, we take a hands-on approach, investing in one business at a time and pairing our operating experience and broad resources with a company's existing capabilities and growth opportunities. We will roll up our sleeves alongside existing employees to run the business. With this model, we do not fashion ourselves as a traditional private equity fund but are closer to what some people in the investment business refer to as independent or "fundless" sponsors. We will be investing our own money, and have also banded together a small group of individual investors who are interested in backing the concept – though we are not ruling out collaboration with a private equity fund, should we come across an attractive opportunity that requires a bit more capital.

**WHQ:** That decision to create Jericho Equity represents a big leap. What process did you go through to make such a difficult decision?

**JR:** *Eric and I joke that this past spring we spent time at every coffee shop within a twenty mile radius of Center City Philadelphia. We discussed all of the things that are so critical for prospective partners to discuss – not just what we wanted to accomplish, but personal factors, too. We compared notes on our work ethic, our values, our priorities in life, our risk tolerance, and how much capital we were each willing and able to bring to the table. We discussed our relative strengths and weaknesses and the roles we would expect to play in the company we ultimately buy. We also gave each other a homework assignment to spend meaningful time with our spouses to make sure they felt comfortable with the scope and nature and timing of the commitment we would be making.*

**WHQ:** How long have you given yourselves to complete the search and transaction?

**JR:** *We committed to each other for a minimum of two years. Of course, we are hoping it will not take that long! We wanted to be sure to give ourselves all the time we needed to make a solid investment decision, and did not want our judgment to be clouded by artificial deadlines. We also recognize that timing and luck can be significant factors in the process, though we believe that we can create some of our own good luck through old-fashioned persistence.*

**WHQ:** In deciding that you wanted to buy and run a business, did you and your business partner consider different models?

**JR:** *Yes, we certainly did. We knew going in that raising a true fund would be a stretch for two guys without a professional investment track record, particularly in this economic environment. Also, we wanted to spend our time looking for great companies rather than trying to raise money. We were not sure what other approaches were viable, so we reached out to others within our respective networks, including some fellow WHC Program alums who had gone out on their own with varying degrees of success. We wanted to understand the various approaches and learn from the experiences and successes (and mistakes) of others. For example, we learned a great deal about Search Funds as an alternative but decided that was not our preferred approach.*

**WHQ:** Why not a Search Fund? Such an approach seems to be gaining in popularity these days.

**JR:** *The Search Fund model is an interesting way for young entrepreneurs to take the reins of a company, but it did not feel like the right fit for us. For starters, we feared that, in the current economy, it might take significant time to find the funding partners and, as I mentioned, we preferred to use that time to find the right company. Second, we want to have a controlling ownership stake in the company we acquire, which runs counter to the Search Fund model. That really gets back to one of the key reasons we formed Jericho Equity Partners in the first place – to control our own destiny. There are certainly advantages to establishing a Search Fund, but for us, the cons outweighed the pros.*

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**WHQ:** Switching gears a bit, a lot is clearly changing these days on the policy side in health care. How does that impact your activities?

**JR:** *The uncertain political environment in health care definitely has a meaningful impact on us and, with any business we have an opportunity to review, we attempt to understand the direct and indirect impact of new laws and/or regulations on that business. Of course, that is not an exact science, and sometimes we are reading the tea leaves. We also have some guiding principles that are a result of the current environment – for example, we have decided that we will not invest in a business whose products or services require FDA approval. Overall, though, we believe that uncertainty and change create opportunities as well as risks, and we hope that our deep operating experience in health care, as well as our continuing efforts to educate ourselves on developments in the external environment, will position us well to take advantage of those opportunities.*

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**WHQ:** Recognizing that you started in June and are early in your search process, as you reflect on the decision to start Jericho Equity Partners, do you feel it was the “right” thing to do?

**JR:** *Absolutely. It has been fun and exciting, and also exhausting and terrifying. We are learning every day, networking with some fantastic people, and getting the opportunity to see many interesting companies. We are continually impressed and fascinated by the way that small business owners have built their companies and managed through an incredibly challenging environment. The prospect of working with these folks to take those businesses to the next level of growth and beyond is what gets us up in the morning! We are thrilled to be doing this.*

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## GROWING IMPORTANCE OF INCORPORATING U.S. PAYERS INTO BIOTECHNOLOGY DRUG DEVELOPMENT DECISION-MAKERS

The power of managed care is increasing because of its role in commercial insurance (typically employer-based) as well as Medicare Part D and Medicare Advantage (Part C, which covers medical and pharmacy benefits for Medicare beneficiaries). The Affordable Care Act will substantially expand managed care's role, both because of the expansion of Medicaid and its role in the new state-based health insurance exchanges which start in 2014.

### Implications for the Development of Biotechnology Agents

Biologics that are in development now and launched in the 2014 to 2018 period will face a greater level of payer scrutiny and more restrictions on access than has occurred to date. Access to cancer agents will be less restricted, but we expect that the payer environment for these drugs may well change as well.

**Thus, there will be four hurdles to a drug's success (Figure 1).** The fourth hurdle, payer coverage and reimbursement, of course affects physician prescribing as well).

Coverage and payment for biotechnology agents, which occur toward the end of a drug's development (Phase III), should not be "taken for granted." Instead, payer needs should be part of the clinical development process and occur at several points in the process (Figure 2).

Developing a very early understanding of payer needs and the reimbursement environment is particularly important for companies that are making "portfolio" selection and allocation decisions. Manufacturers have many opportunities for research, acquisition, or in-licensing, so understanding payer needs and the reimbursement environment is valuable from the perspectives of R&D focus, capital usage, and, ultimately, revenues. Venture capital funding is limited, so identifying biotechnology agents that will have an attractive reimbursement profile is key to the firm's return on investment (ROI).

### Assessing and Planning for the Reimbursement and Payer Environment

We recommend that understanding the payer and the reimbursement environment be incorporated at several points in the clinical program. The first point could be at the time of the investigational new drug (IND) application or immediately after initial clinical data suggested good prospects for a clinical development program. A key reason to do so at that time is to help design the clinical trial program before it is developed and shared with the FDA. From both a manufacturer and a regulatory perspective, it is much better not to launch the expensive and lengthy clinical development process unless the commercial landscape following approval can be anticipated and defined with data that will inform all stakeholders and, specifically, not to make substantive changes to the clinical trial program during Phase III. Also, incorporating this evaluation at the end of Phase I or early in Phase II is more cost-effective for sponsors and will help in designing Phase III trials and outcomes data collection correctly



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Figure 1: The Payer Hurdle in Biotechnology's Future

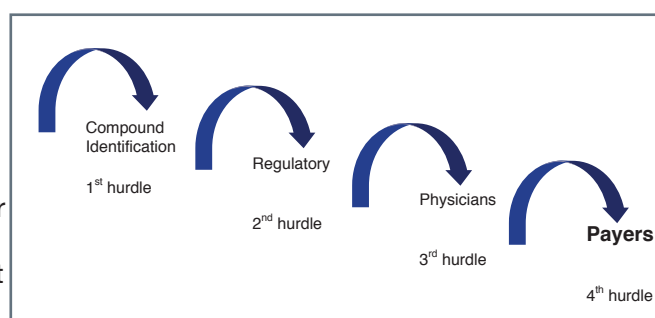
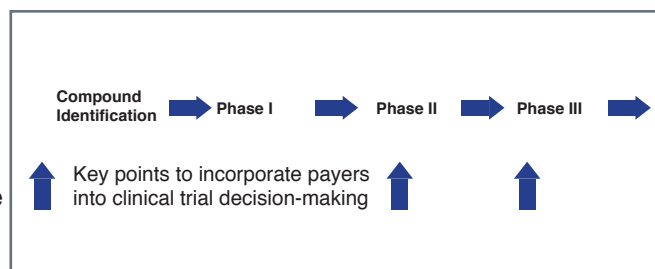


Figure 2: Incorporating Payers into Drug Development



The payer environment and payer perceptions of data (or potential data) related to the product should also be assessed at the end of Phase II. One reason for doing so is that the payer environment is rapidly changing and payers, payment mechanisms, or payer priorities may change. Even if the new data are collected in an additional arm of the Phase III program or outside the clinical program entirely, checking in with payers at this time provides the biotechnology agent's manufacturer with time to develop these data before or shortly after launch. In Phase II and III trials, maintaining the highest possible standards for collecting payer related data (ideally as part of the random controlled trials for regulatory approval), or otherwise in parallel with trials for regulatory approval, is highly valued by payers.

Payers do not equate statistical significance with clinical importance and will critically evaluate the size of a purported effect and its impact across multiple dimensions of clinical care. The Medicare Evidence Development and Coverage Advisory Committee (MedCAC), for example, emphasizes that the improvement in outcomes should be clinically significant and generalizable to clinical practice.

A benefit of having comparative data at launch, rather than in a post-marketing trial, is that payer decision-makers can then use the data in decision-making during their first review, which is typically more in-depth and when perceptions are formed, and it can benefit the drug in early commercialization.

### **The Potential Impact of Comparative Effectiveness Research (CER)**

The Federal Comparative Effectiveness Research (CER) program focuses on comparing different interventions. Accordingly, potentially promising areas for biotechnology target selection include *other types of interventions* that are ineffective, have high morbidity or mortality, or are very expensive.

Federally funded CER is not allowed to include cost in its calculations, but once data for a particular CER priority are available, other groups, such as technology assessment groups or health care policy organizations, can be expected to integrate information about costs into the CER results and publicize these data. Larger and more sophisticated managed care plans or Pharmacy Benefit Managers (PBMs) may also integrate CER results and actual plan costs and use these data in their coverage and reimbursement decision-making.

### **Conclusion**

Orienting R&D programs to payer priorities from an early point is likely to lead to development of agents that have substantially higher volume of use, driven by improvements in payer coverage and reimbursement, patient access, and physician prescribing. Notably, the cost of incorporating payers into the R&D process is substantially less than the potential revenue gain. Additionally, incorporating the development of objective comparative data (versus existing biotechnology agents for that indication or other non-biologic interventions for the disease state) in the pre-launch clinical trial program will also be increasingly important, as payers are likely to use these data in their coverage and reimbursement decision-making.