THE FUTURE OF OPHTHALMOLOGY:

Is PE Here to Stay?

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A look at the markets of the 1990s and today suggests what to expect in the next 10 years.

In the early 1990s, I began working for a startup company called Novamed. By the time the company went public in 2003, it owned 56 clinics, 12 ambulatory surgery centers (ASCs), multiple optical goods companies, an optical laboratory, and a wholesale buying group. Eventually, I left to start my own consulting business and medical real estate investment, which I sold to a private equity (PE) firm early this year.

My consulting and employment experiences with several PE firms and one physician practice management company (PPMC) give me a unique perspective on how the role of PE and its interest in the field of ophthalmology have evolved and what the future may hold.

FLASHBACK TO THE '90S

The '90s was a decade of consolidation driven by PPMCs. These entities acquired multi- and single-specialty physician practices and oversaw services such as back-office operations, call centers, marketing, human resources, and legal services. Many PPMCs also bought ASCs and drove their physicians' surgical cases to those facilities. Refractive surgery volume was booming, so ASCs brought in a lot of business.

Strategically, PPMCs adopted a hub-and-spoke model in which administration was centralized to increase efficiency and capital. Clinics were acquired, and regional business offices were created to manage groups of clinics. Some doctors who sold their practices to PPMCs received cash, but a large proportion of them received all stock. Generally, the goal was to take the entire entity public in 3 to 5 years at a high multiple of stock earnings. In other words, physicians who sold their practices to a PPMC were presented with an opportunity to earn money from increasing stock prices and from their work as employees of the PPMC.

Some physicians did well; others did not. A lot of PPMCs were underfunded for growth, so they borrowed revenue from the physician practices that they acquired. Certain markets proved to be less profitable than others, and an economic downturn in the late '90s led to poor returns for PE and physician partners overall. In the end, most PPMCs in ophthalmology failed. Some went bankrupt, and others sold practices back to the physicians. Unwinding these business arrangements was a long and often litigious process.

Looking back, I think a major contributor to the PPMC failures of that era was how the financial rewards to physicians were structured. Stock options gave the physicians selling their practices the chance of great rewards. It was a high-risk proposition that did not pay off for most of them.

CONTEMPORARY PE MODELS

Decades after PE interest in ophthalmology fizzled, market forces spurred renewed investment. Modern

PE firms can be divided into three main models.

▶ **No. 1: PE as a lender.** A PE firm can be an attractive alternative to a banking institution. Both provide funding, but a PE firm is often easier to work with and receptive to lending more money based on the market space and other factors. PE firms do not have ownership within a practice per se, but they seek a return on their investment. It may be a percentage that is higher than the interest rate offered by a banking institution, but the level of associated risk is arguably lower because PE provides the practice with resources such as people who understand the financial market and consultants to help the practice with insurance, legal services, construction loans, and regulatory matters as well as human resources.

▶ **No. 2: PE for ophthalmology.** Like PPMCs, the PE firm purchases and consolidates ophthalmology practices and ASCs within a given market space. Well-respected practices with a high volume of elective procedures—typically oculoplastics, refractive surgery, and corneal surgery—are targeted.

▶ **No. 3: Multispecialty PE group.** This model blends ophthalmology with primary care and specialties such as radiology, pediatrics, and other medical specialties. Like a hospital setting, this approach attempts to keep a network of patients within a single organizational entity and capture larger patient care.

THE CURRENT LANDSCAPE

For the ophthalmologist. The second model—PE for ophthalmology—is currently the most prevalent. For physicians in the later stages of their careers, a PE deal can be an attractive exit strategy (Editor's note: For more on this topic, see "Life After PE," pg 72). It is not uncommon for surgeons to be offered high multiples for their practices—five or 10 times the practice's earnings before interest, depreciation, taxes and amortization.

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Some ophthalmologists in earlier stages of their careers are also partnering with PE firms (Editor's note: For more on this topic, see "Opening a PE-Backed Private Practice Right out of Fellowship," pg 44). Funding can allow them to be more creative and to grow and build their practices. It can be difficult to start a practice while carrying debt from medical school, residency, and fellowship. A PE firm can assist with the due diligence required for acquiring and expanding a practice. A PE-backed entity can also be attractive to young ophthalmologists who are not interested in owning a practice but prefer to work hours that align with a typical workday.

For the patient. Patients within a midsized, multispecialty PE network can benefit from a single point of care. Problems can arise, however, in markets that are oversaturated with small-capital PE firms. Patients can become frustrated over and confused about which doctors are in network versus which are not.

THE HORIZON

I don't expect PE investment in ophthalmology to fade like the PPMCs of the 1990s. One reason is numbers—there are a lot of PE firms, they have a lot of resources, and a lot of revenue is being generated. As long as ophthalmology practices use an elective cash-paying business model, PE interest should continue unabated. This scenario seems likely given the growth in premium IOLs and diagnostic devices and treatments for ocular surface disease.

One change I predict is consolidation within PE during the next 5 to 10 years. I expect small-capitalization firms (up to $250 million) to merge to become middle-capitalization firms ($250 million–$1 billion) and small- and middle-capitalization firms to combine to create larger entities. I anticipate that this consolidation will favor multispecialty PE to gain an increasing number of patients and thus capture a greater share of the market.

Another potential force for consolidation is a trend toward office-based surgery (OBS). As cataract surgery performed at in-office OR suites becomes more widely accepted by insurance carriers, there will be an uptick in the number of practices that are building these facilities within their clinics to increase revenue. Until that time, we will continue to see an increase in the number of elective procedures that are being performed within the OBS setting; these include refractive lens exchange, oculoplastics, MIGS, and phakic IOLs and other lens-based procedures. This will also contribute to the cash-based structure that is alive and well in ophthalmology. Clinics where OBS is performed within their in-office surgery suites will be highly sought after by PE firms as this business model grows in ophthalmology. ■