LORD ABBETT

Making Sense of Healthcare Reform

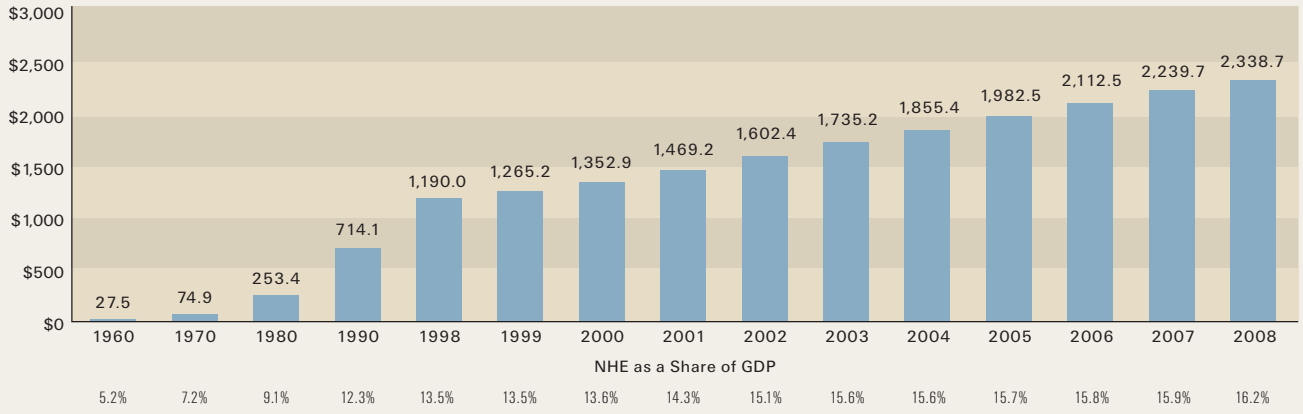
Now that healthcare reform is the law of the land, the multi-trillion-dollar question is, who will prosper and who will suffer? Lord Abbett experts assess the potential opportunities and pitfalls in a complex and sometimes perplexing new environment, where many new rules have yet to be written.

Six months after Congress passed a 2,500-page healthcare reform bill, many Americans have yet to grasp its sweeping prescription for new delivery models, greater accountability, continuous quality improvement, and reduced waste and inefficiency. With the nation already spending one-sixth of its gross domestic product (GDP) on healthcare (see Chart 1) and deeply in debt, the populace worries instead about the price tag: either $940 billion between 2010 and 2019 (the Congressional Budget Office's estimate) or $2.5 trillion (as projected by the conservative Heritage Foundation). And there are worries about higher premiums, higher deductibles, and less choice too.

Whatever the cost, the economics of healthcare are never going to be the same. PricewaterhouseCoopers, the accounting and consulting firm, says healthcare reform will be achieved through primary mechanisms: new coverage (an additional 32 million patients and subsidies for individuals and small businesses to buy insurance); new funding ($508 billion in new taxes and fees); and new regulators (at both the federal and state level).[1]

Healthcare reform also will require $575 billion in spending cuts, but it is feared that a myriad of new rules could add to

Chart 1. National Health Expenditures and Their Share of Gross Domestic Product, 1960–2008



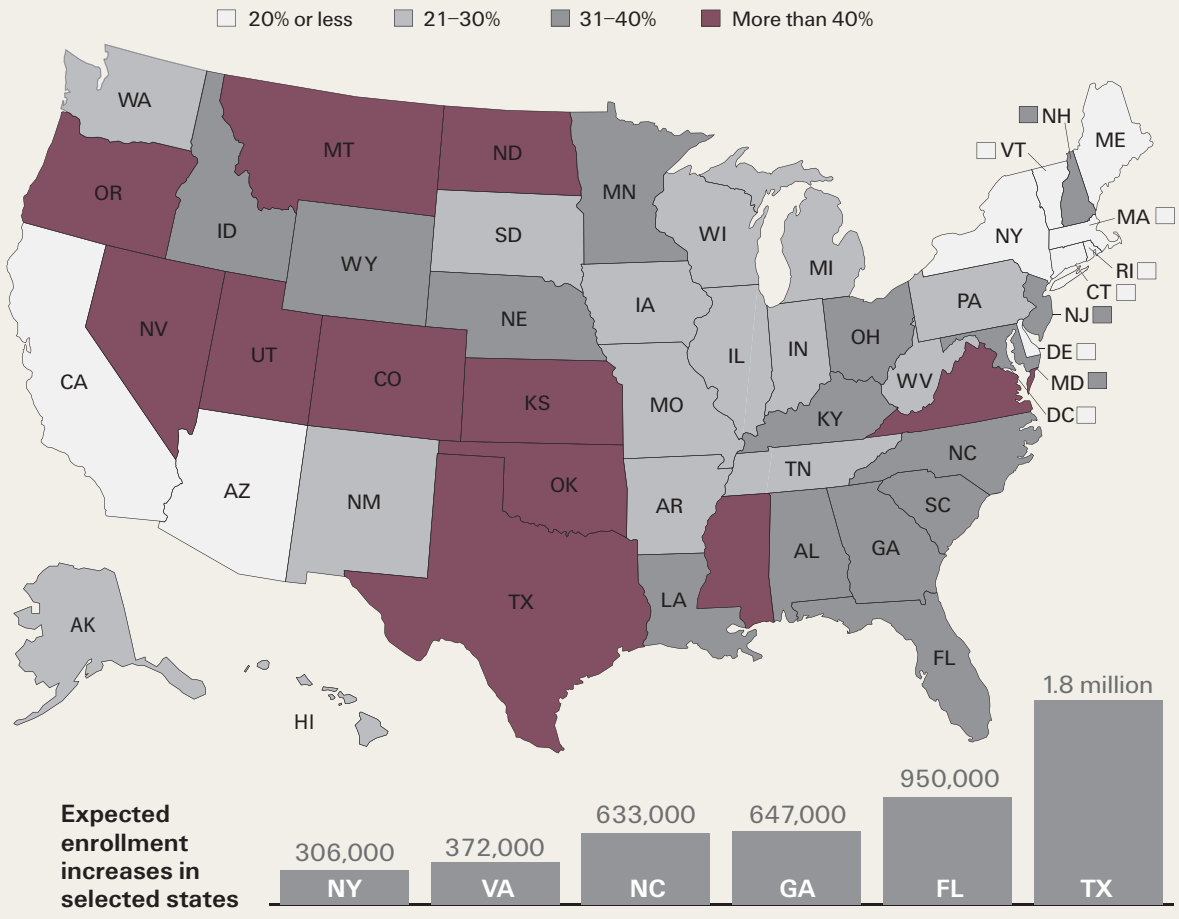
Source: Centers for Medicare & Medicaid Services (the federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program).

costs, at least in the short run. One concern is that healthcare reform will create 159 new federal government programs, bureaucracies, and offices. Another is that health insurers will have to raise premiums to defray the costs of broader coverage under the law, and some may just go out of business. Meanwhile, hospitals and physician practices will have to invest heavily in new technology to chronicle patient information and track outcomes. States will have to invest in infrastructure to comply with various provisions, including the expansion of Medicaid enrollment to 16 million patients, despite a looming shortage of primary care providers. States will have to create exchanges where individuals and small businesses can compare and purchase health insurance online at competitive prices. And they also will have to come up with innovative approaches to Medicaid long-term care lest runaway costs lead to serious budget holes.[2]

Faced with such challenges, attorneys general from 20 states are suing to block healthcare reform on the grounds that forcing individuals to carry insurance is unconstitutional and that it violates state sovereignty. Although various legal experts have cast doubt on such arguments, chances are that litigation on this issue could extend beyond the Obama administration and even make it to the U.S. Supreme Court. There also may be congressional efforts to revise or withhold funding for certain health reforms—all this despite a May 2010 study by the Kaiser Family Foundation that predicts states' financial burden will be relatively small compared with the amount of federal dollars they will receive.[3] (Map 1 shows the states that will be most affected by increased Medicaid population.)

In a recent newsletter, Paul Keckley, executive director of the Deloitte Center for Health Solutions, cited a number of critical questions about healthcare reform: 1) Will the uninsured buy

Map 1. Percentage Increase in Medicaid Enrollment



Source: Kaiser Family Foundation.

insurance? 2) Will hospitals, insurance companies, medical device companies, and prescription drug companies benefit from 32 million newly insured? 3) Will employers pay a penalty, lose their tax deduction for health benefits costs, and walk away from health insurance? 4) Will states be able to establish health exchanges by 2014, and accommodate expansion of Medicaid and children's health insurance programs, while stepping up oversight of health insurance and delivery systems? And 5) Will new integrated healthcare delivery approaches with names like accountable care organizations, the medical home, value-based purchasing, comparable effectiveness, and bundled payments work?[4]

The challenges of converting the current healthcare delivery system to an integrated model of care will be formidable, all right. During the height of the healthcare debate, one expert compared that task to transforming a DC-9 into a 747 while the plane is flying.[5] "Where we are heading here is unknown," said Dr. Mark Werner, chief medical officer for the Carilion Clinic in Rochester, Minnesota, at a recent panel. "We know we have to create a more purposeful solution, [with] more value, [and] less fragmented."[6]

While there are many unknowns, some Lord Abbett funds have overweighted the healthcare sector relative to their respective benchmarks. "A number of those picks have so far been insulated from healthcare reform," said Deepak Khanna, Portfolio Manager for Lord Abbett's Multi Cap Value Equity strategy. "Our philosophy has been to focus on market leaders that we expect will take disproportionate share from competitors over time and also have the dollars left over to innovate and deliver better care."

When it comes to assessing the potential winners and losers under healthcare reform, Khanna breaks down his outlook into two different time frames. The first critical period will be between now and 2014, when companies in the hospital, managed care, pharmaceutical and biotechnology, and medical devices subsectors will pay for healthcare reform in the form of taxes, caps on reimbursement, or reimbursement cuts, and likely see a drop in profits. The second critical period will be 2014 and beyond, when 32 million newly covered patients enter the system, which Khanna believes should have major positive impacts on every industry player.

What follows is a discussion of where various Lord Abbett investment professionals see both short-term and long-term opportunities in the largest healthcare sectors.

TRIAGING THE HOSPITAL SECTOR

Three days before Congress passed healthcare reform last March, a private for-profit hospital company controlled by a major New York private equity firm announced plans to acquire the Detroit Medical Center (DMC), a financially troubled hospital system that some institutional investors found too risky to lend money.

It didn't matter that Detroit's economy was in shambles, or that the DMC's dwindling cash flow made it difficult to finance critical capital improvements. With eight specialty hospitals, 2,000 licensed beds, 3,000 affiliated physicians, and extensive academic connections, DMC is the largest healthcare provider in southeast Michigan. And with a strong management team, greater access to capital, and guaranteed payment for hordes of new patients under healthcare reform, the new investors were confident they could turn DMC into one of the preeminent hospital systems in America.

Several days after the DMC announcement, another private equity firm announced plans to buy Caritas Christi, the largest community-based healthcare system in New England, with six hospitals serving more than 600,000 patients a year. Although it was the private equity firm's first investment in hospitals, it indicated that it wanted to buy more of them in Massachusetts, in order to compete with better-known Boston hospitals and expand nationally.

While both the DMC and Caritas Christi deals are pending, Lord Abbett investment professionals expect much more consolidation of the hospital industry. "Both private equity sponsors and fixed-income investors like hospitals because the earnings are generally stable, which helps explain why healthcare is a meaningful portion of the high-yield index,"[7] said Bill Carpenter, a Research Analyst for Lord Abbett's fixed-income investment team. "Private equity firms typically buy hospital companies with the help of debt financing when their enterprise value multiples[8] are low. Over time they expect that they can improve productivity and efficiency, leading to better organic growth and improved cash flow. Eventually enterprise multiples should improve, which, in turn, should lead to decent returns for participants in these types of equity investments."

Some analysts believe an important bellwether for hospital valuations will be HCA, the largest nongovernmental hospital operator in the United States, which went private in a 2006 leveraged buyout[9] and plans to go public later this year.

Will financial engineers be able to turn around hospitals as Washington rewrites the rules of Medicare and Medicaid reimbursement? One major factor in hospitals' favor is the fact that they will be paid for indigent care services that have long been a drag on their bottom line. Another factor perhaps is their ability to acquire financially squeezed physician practices at attractive prices and then market them to a larger audience.

In a recent interview with McKinsey, Harvey Fineberg, president of the Institute of Medicine (the health arm of the National Academy of Sciences), suggested there is a lot of room for innovation in terms of new business models, technology, and health-delivery methods.[10]

As Tony Paquin, founder and CEO of Paquin Healthcare Companies, put it, "Just as Wal-Mart has brought retail to the healthcare industry, modern hospitals, clinics, and medical practices are bringing healthcare into the retail business," he said in a recent column. "Hospitals once relied almost exclusively on immediate need for their patient base, but that's no longer

true: those patients relying on hospitals almost exclusively for acute care have become consumers, hungry for information, services and products, and hospitals that decline to provide what consumers want will invariably lose business to more accommodating wellness purveyors."[11]

Many hospitals are far behind in using operations management techniques like continuous performance improvement, said Eugene Litvak, president and chief executive of the Institute for Health Care Optimization and an adjunct professor of operations management at the Harvard School of Public Health.[12]

Still, Daniel Solender, Lord Abbett Partner & Director of Municipal Bonds, says tax-exempt bonds issued by nonprofit hospitals are an attractive sector of the market as long as credits are researched intensively before purchase. When it comes to investment-grade healthcare credits, his team typically focuses on large hospital systems that are well positioned in their respective markets or smaller ones which have a dominant position within their competitive area. These healthcare credits have to have good finances and be highly adaptable to change.

Healthcare, broadly defined in this case as nonprofit or government-run hospitals, nursing homes, rehabilitation centers, and the like, have accounted for a good percentage of the municipal bond market issuance for a long time. With more issuance of taxable Build America Bonds (BABs)[13] over the past year and a half (instead of tax-exempt general obligation bonds[14]), healthcare entities have become a bigger percentage of tax-exempt municipal bond issuance.

On the high-yield side, Solender believes there have been a number of good investment opportunities among troubled inner-city hospitals and rural hospitals where there are no competitors nearby, but his team carefully evaluates the risk of each institution given the sometimes inscrutable vagaries of how hospitals get paid for services.

The typical payer mix includes commercial payer plans such as Blue Cross/Blue Shield; government plans such as Medicare and Medicaid; and "private pay" patients. Typically, the combination of government payers is the largest portion of the revenue mix. But nonpayers have been a growing problem. As a portion of healthcare expenses, indigent or underinsured patients cost American hospitals $36.4 billion in 2008 (the latest year for which data are available)—933% more than their cumulative write-offs in 1980. (See Table 1.)

"While healthcare reform will essentially remove the nonpayer component by extending coverage to 34 million uninsured, one of the biggest concerns at hospitals is, will that income produce enough revenue to offset cuts in reimbursements from other sources," said Solender. "From an investment standpoint, a diverse source of revenue is key. If it is too heavy in Medicare [where reimbursement cuts are almost certain], that is probably a reason not to buy a credit."

Table 1. National Uncompensated Care Based on Cost,* 1980–2008

($ in billions)

Year	Hospitals	Uncompensated Care Cost	% of Total Expenses
1980	5,828	$3.90	5.10%
1981	5,812	$4.70	5.20%
1982	5,796	$5.30	5.10%
1983	5,782	$6.10	5.30%
1984	5,757	$7.40	6.00%
1985	5,729	$7.60	5.80%
1986	5,676	$8.90	6.40%
1987	5,597	$9.50	6.20%
1988	5,499	$10.40	6.20%
1989	5,448	$11.10	6.00%
1990	5,370	$12.10	6.00%
1991	5,329	$13.40	6.00%
1992	5,287	$14.70	5.90%
1993	5,252	$16.00	6.00%
1994	5,206	$16.80	6.10%
1995	5,166	$17.50	6.10%
1996	5,134	$18.00	6.10%
1997	5,057	$18.50	6.00%
1998	5,015	$19.00	6.00%
1999	4,956	$20.70	6.20%
2000	4,915	$21.60	6.00%
2001	4,908	$21.50	5.60%
2002	4,927	$31.20	5.70%
2003	4,895	$24.90	5.50%
2004	4,919	$26.90	5.60%
2005	4,936	$28.80	5.60%
2006	4,927	$31.20	5.70%
2007	4,897	$34.00	5.80%
2008	5,010	$36.40	5.80%

Source: American Hospital Association.

*Figures above represent estimated cost of bad debt and charity care to the hospital. However, they do not include Medicaid or Medicare underpayment costs, or other contractual allowances. Nor do they take into account the small number of hospitals that derive the majority of their income from tax appropriations, grants, and contributions.

MANAGED CARE

Managed care companies, which will have to pay an estimated $47 billion toward the costs of healthcare reform between 2014 and 2018, have been in the doldrums amid continuing uncertainty about new rules on reimbursement and the increasing

likelihood of states pushing back on rate increases. One of the biggest questions concerns minimum medical loss ratios (MLRs), which could dampen earnings next year. MLRs refer to the percentage of consumers' premium dollars that insurance companies spend on medical care and quality improvement activities. Under the healthcare reform law, large group plans must spend 85% of premiums on patient care, and small group and individual plans must spend 80%, beginning in 2011.

Such MLRs are considerably higher than states' previous minimums, which has ignited fears that some insurance companies could be forced to curtail coverage or discontinue writing new policies or both. Given such risks, Mila Kofman, Maine's superintendent of insurance, recently asked for a waiver of the MLR requirements for individual-market insurers until 2014, when other reforms, including state-based insurance exchanges, take effect. Kolman wanted to make sure people who have a choice of two companies in Maine continue to have those choices.[15]

Trade associations for both the managed care and hospital industries have become more vocal on this issue. "The medical loss ratio and rebate program … have the potential to destabilize the marketplace and significantly limit consumer choices if the definitions and calculations are too restrictive," said Jane Cline and Therese Vaughan, president and chief executive officer, respectively, of the National Association of Insurance Commissioners. "Equally, the medical loss ratio and rebate program could be rendered useless if the definitions and calculations are too broad."[16]

Despite such uncertainty, Khanna believes Medicaid managed care companies, which fall under state limitations, could also benefit from a loosening of eligibility requirements when 14 million additional patients will be allowed to enter the mix.

PHARMACEUTICALS AND MEDICAL TECHNOLOGY

"Pharmaceuticals and biotechnology companies will feel pain early on," says Lavina Talukdar, a Research Analyst for Lord Abbett's U.S. Large & Mid Cap Equity Research Team. "Top-line revenues are likely to shrink a little. They'll also see some impact to the bottom line. But they should be able to offset the government-imposed price declines through various synergies and cuts in marketing and research and development costs."

With that in mind, Lord Abbett's large cap strategies have traditionally owned some of the largest, most diversified "Big Pharma" names, companies that sold off earlier this year but continued to pay dividends in the 3.5–5% range.

Talukdar has been recommending companies with a strong record of innovation that may fuel growth and maintain pricing in a more tightly regulated environment. But she said there will likely be price pressure on second-tier branded drugs that have cheaper generic alternatives. "If you're taking a cholesterol medication, for example, chances are you're going to be forced to take the cheaper statin because the incremental benefit of the closest alternative at a higher price just isn't there," she said.

According to Talukdar, biotechnology companies with the most advanced technologies and innovative products should continue to get reasonably attractive pricing for drugs that target serious diseases. How government controls costs after 32 million new patients hit the system is another matter. "If costs balloon out of control, chances are the United States will have to move to a tighter system of price controls, which is what most of Europe does already." Talukar said. (Table 2 shows the historical trend in prescription drug costs.)

Table 2. National Health Expenditures on Prescription Drugs, Selected Calendar Years 1960–2008

Year	$ in billions	% increase
1960	$2.7	–
1970	$5.5	7.5%
1980	$12.0	8.2%
1990	$40.3	12.8%
1993	$51.0	8.2%
1997	$77.6	11.1%
1998	$88.5	14.1%
1999	$104.6	18.1%
2000	$120.6	15.3%
2001	$138.3	14.7%
2002	$157.6	14.0%
2003	$174.2	10.5%
2004	$188.8	8.4%
2005	$199.7	5.8%
2006	$217.0	8.7%
2007	$226.8	4.5%
2008	$234.1	3.2%

Source: Centers for Medicare & Medicaid Services.

Even without such headwinds, some big pharmaceutical companies believe emerging markets could be the next big source of growth, particularly as China, India, and Eastern Europe open up their systems to both branded and generic drugs made elsewhere. (See Chart 2.) Whether growth from emerging markets offsets enormous revenue and profit declines from blockbuster drugs that go off patent (that is, "patent cliffs") in the next two years will be a critical test.

But the combination of patent cliffs, population growth, and aging baby boomers will likely benefit generic drug manufacturers with the broadest line of attractively priced products.

"More and more governments around the world are fostering generic utilization," said Yarek Aranowicz, Portfolio Manager with Lord Abbett's International Core Equity strategy. "And while generics are by no means immune from government price controls, the companies with the best economies of scale should continue to be attractive investments."

Other attractive investments might include pharmacy benefit managers (PBMs) that manage the pharmaceutical benefit, drug distributors that distribute generic, specialty, and branded drugs, and healthcare technology companies that help doctors and pharmacies create electronic patient records, said Devesh Karandikar, a Research Analyst for the Lord Abbett U.S. Large & Mid Cap Equity Research Team who covers healthcare services and medical device companies.

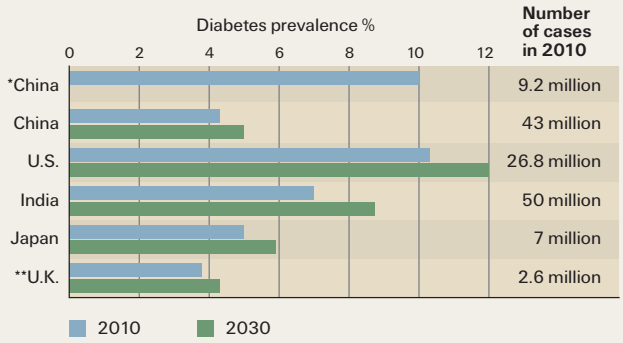
MEDICAL TECHNOLOGY

When it comes to medical technology, Aranowicz believes a vertically integrated company that specializes in kidney disease and related services should do well in both the United States and emerging markets. "In the United States, the trend is toward paying for bundled services, which favors companies that can extract the most synergies," Aranowicz said. "And the potential in China and India is enormous given an estimated 140 million diabetes patients this year alone, and diabetes patients have the highest risk of kidney disease." (See Chart 3.)

With 10 million chronic diabetes patients in the United States, Khanna has focused on a pure play on dialysis, a treatment for patients suffering from chronic kidney failure, also known as end-stage renal disease (ESRD). "ESRD patients require dialysis treatments three times a week, and with the increasing incidence of that disease, the market for dialysis centers should experience substantial growth, though it does not come without reimbursement challenges," said Khanna.

Chart 3. Comparing Diabetes Prevalence, 2010–2030

Comparative percentage calculated by giving countries same age profile

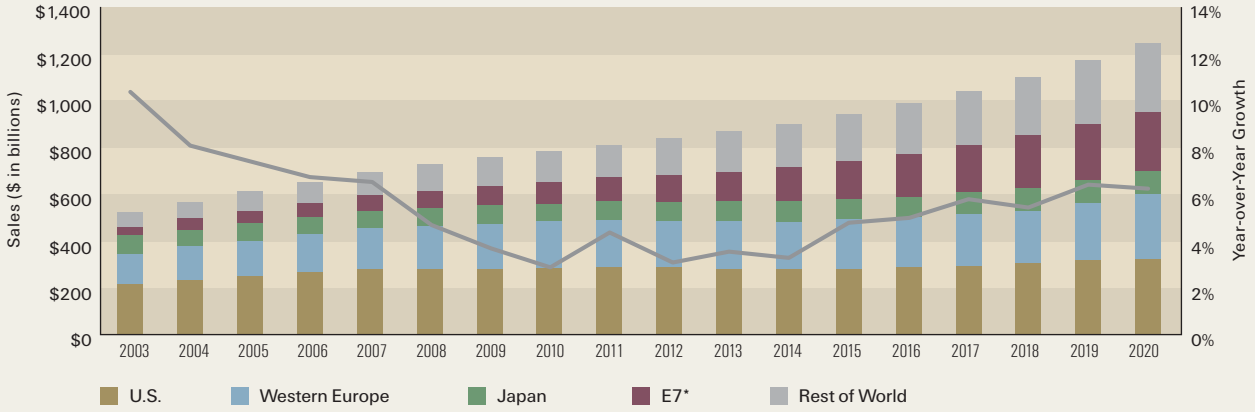


Source: International Diabetes Federation (IDF).

**New England Journal of Medicine*. March 25, 2010, based on a national study from June 2007 through May 2008 to estimate the prevalence of diabetes among Chinese adults. Because of the rapid change in lifestyle in China, the IDF included this higher figure given possible differences in methodology and concern that diabetes may become epidemic.

**Diabetes UK (the charity for people with diabetes in the United Kingdom).

Chart 2. World Pharmaceutical Sales and Year-over-Year Growth, 2003–2020



Source: IMS Health, International Monetary Fund, U.S. Census Bureau, Bureau of Labor Statistics, U.S. Patent Trade Office, and UBS Investment Research estimates.

*E7 represents the seven major emerging economies: China, India, Brazil, Mexico, Russia, Indonesia, and Turkey.

As for medical devices, Khanna has been positive on the long-term prospects for the leading makers of orthopedic implants given projected growth for knee, hip, and other joint replacement as more and more baby boomers become senior citizens. "The market for such devices is expected to grow 4–7% a year, twice the rate of inflation and GDP," he said.

THE BOTTOM LINE

As the midterm congressional elections approach, debate over the potential costs of healthcare reform is likely to grow louder. Some observers argue Massachusetts' costly overhaul of its system signals what could go wrong on a national level. Others fear that the mind-numbing complexity of recently passed legislation could eventually lead to a single-payer system similar to those in the United Kingdom or Canada.

"The larger question is whether healthcare reform will be good for economic growth in the United States," said Rick Ruvkun, Lord Abbett Partner & Director of U.S. Large and Mid Cap Equity Research. "In the end, I am not sure many of us would agree with the premise that premiums will not go up. In return for broader coverage to many, others very well may subsidize them and pay higher medical insurance premiums."

In any case, Khanna believes healthcare reform will have rather serious long-term implications for innovation in the pharmaceutical and biotechnology industries, where $130 billion a year is spent on research and development (R&D) worldwide.

"If I am an innovative company used to spending between 7–10% of my revenues on R&D and suddenly I have a lid on profitability and revenue growth, I'm going to have fewer dollars at my disposal to develop new compounds," Khanna said. "Even a 10% reduction could have a magnified effect."

What, then, should the average investor be most concerned about with regard to healthcare reform?

"I think the average investor has to be cognizant of the fact that over the next two to four years, there will be a major impact on profitability for the majority of companies in the healthcare sector," Khanna added. "You're not going to have the increased earnings growth that a lot of healthcare companies enjoyed in the past, given government controls on pricing, eligibility, and profits. However, if you go beyond 2014, I think there may be potential rewards for longer-term investors. In the short run, one has to be really focused on investment ideas where there is innovation leading to a better quality of life or efficacy, or areas where the pricing controls will not happen or will get muted by secular growth trends." ■

—Reported by Steve Govoni

Healthcare Reform by the Numbers

16%	The percentage of U.S. GDP spent on health in 2007 (more than seven percentage points higher than the average of 8.9% in European countries that belong to the Organisation for Economic Co-operation and Development, or OECD) (Source: OECD.)
48	Where the U.S. ranks globally in life expectancy at birth (age 78.41) (Source: CIA World Factbook.)
44,000–98,000	The estimated number of deaths that occur each year in hospital settings (Source: Institute of Medicine.)
1.7 million	The number of patients who contract infections in U.S. hospitals each year (Source: Centers for Disease Control.)
76%	The percentage of consumers who grade the U.S. system C, D, or F (Source: Deloitte.)
7.3%	The percentage that U.S. employers' average healthcare costs increased per capita in 2009 (Source: ThomsonReuters.)
9%	How much employers can expect healthcare costs to rise in 2011 (Source: PricewaterhouseCoopers.)
$782 billion	How much the U.S. government spent on Medicaid and Medicare in 2008 (Source: U.S. Department of Health and Human Services' Center for Medicare and Medicaid Services.)
21%	State spending on Medicaid as a percentage of their overall 2009 budgets (Source: National Governors Association and National Association of State Budget Officers.)
$127 billion	States' projected deficits through 2012 in total (Source: National Governors Association and National Association of State Budget Officers.)
$210 billion	How much the healthcare system spends each year on claims processing. And according to one recent study, physicians divert as much as 14% of their revenue to ensure accurate payments from insurers. (Source: American Medical Association.)
46.3 million	The number of uninsured people in the United States in 2009 (Source: Centers for Disease Control.)
354 million	The estimated number of doctor visits made each year for acute medical care, more than a quarter of which occur in hospital emergency rooms (Source: *Health Affairs.*)
$10 billion	State and local governments spend more than $10 billion a year to care for the uninsured in hospitals, and provide around $15 billion a year in funding to mental health agencies that serve many of the uninsured. (Source: Center on Budget and Policy Priorities.)
$55.6 billion	The estimated annual cost of the medical liability system, including defensive medicine, in 2008 dollars, or 2.4% of total healthcare spending (Source: *Health Affairs.*)
$940 billion	How much the Congressional Budget Office estimates healthcare reform will cost over a 10-year period

$508 billion	The amount of new taxes and fees expected to help fund healthcare reform (Source: Deloitte.)
$2.5 trillion	The conservative Heritage Fund's estimate of how much healthcare reform will cost over the next decade
$14 trillion	What the nation's total debt is expected to exceed in 2011—about $47,000 for every U.S. resident (Source: Associated Press.)
$143 billion	The Congressional Budget Office's estimate of how much healthcare reform will cut the deficit over 10 years
$47 billion	The amount of new annual fees the health insurance sector will have to pay the government between 2014 and 2018) (Source: Kaiser Family Foundation.)
$16.7 billion	The amount of new annual fees the pharmaceutical manufacturing sector will have to pay the government between 2012 and 2019 (Source: Kaiser Family Foundation.)
$292 billion	How much the United States spent on prescription drugs in 2009 (Source: Medco Health Solutions.)
29.2%	The percentage of the nearly 1,200 doctors surveyed who said they would leave the profession or retire early if health reform legislation was passed (Source: *New England Journal of Medicine*.)
30%	The percentage increase in medical school enrollment that will be needed by 2015 to avoid an acute shortage of doctors given the aging baby boomer population and 32 million more people who will be covered under healthcare reform (Source: Association of American Medical Colleges.)
5,000	The number of hospitals in the United States: 3,000 are nonprofit, 1,000 for-profit, and 1,000 government-owned (Source: American Hospital Association.)
30,000	The number of doctors who have trained as "hospitalists," the fastest-growing specialty in the medical profession. Hospitalists are hospital medicine doctors who supervise the care of other physicians' patients during their hospital stays. (Source: *The Eugene Register-Guard*.)
260,000	The projected shortage of registered nurses by 2025 (Source: U.S. Bureau of Labor Statistics.)
26	The age until which children can remain covered by their parents' health insurance (Source: www.healthcare.gov.)
67%	Percentage of companies that intend to expand or improve wellness programs inside the United States (Source: PricewaterhouseCoopers.)

[1] "Prospering in a Post-reform World," PricewaterhouseCoopers' Health Research Institute, May 2010.

[2] "New Deloitte Report: Medicaid Long-Term Care Is Ticking Time Bomb," press release and full report, Deloitte, June 21, 1010.

[3] Alec MacGillis, "Study: States Will Bear Little Cost of Medicaid Expansion Under Healthcare Law," *The Washington Post*, May 27, 2010.

[4] Paul Keckley, "Health Reform Update," Deloitte, July 12, 2010.

[5] "Medical Homes and Accountable Care Organizations: If We Build It, Will They Come," *Academy Health Research Insights*, Summer 2009.

[6] Deloitte healthcare panel, June 29, 2010.

[7] The Merrill Lynch High Yield Master II Constrained Index tracks the performance of below-investment-grade U.S. dollar-denominated corporate bonds publicly issued in the U.S. domestic market, including 144a issues. Qualifying bonds must have at least one year remaining term to maturity, a fixed coupon schedule, and a minimum amount outstanding of $100 million. Bonds must be rated below investment grade based on a composite of Moody's and Standard & Poor's. Qualifying bonds are capitalization-weighted provided the total allocation to an individual issuer (defined by Bloomberg tickers) does not exceed 2%. Issuers that exceed the limit are reduced to 2%, and the face value of each of their bonds is adjusted on a pro-rata basis. Similarly, the face value of bonds of all other issuers that fall below the 2% cap are increased on a pro-rata basis. The index is unmanaged, does not reflect the deduction of fees or expenses, and is not available for direct investment.

[8] An enterprise value multiple is often used to determine the value of a company. It generally refers to the ratio of enterprise value (the market value of a company's equity plus the market value of its debt, minus cash holdings) to earnings before interest, taxes, depreciation, and amortization (EBITDA).

[9] A leveraged buyout involves the acquisition of another company using a significant amount of borrowed money to meet the cost of the acquisition. The purpose of leveraged buyouts is to allow companies to make large acquisitions without having to commit a large amount of capital.

[10] "Conversations on Healthcare Reform: Harvey Fineberg of the Institute of Medicine, *McKinsey Quarterly*, May 2010.

[11] Tony Paquin, "The Retail Healthcare Revolution," *Voluntary Benefits Magazine*, May 4, 2010.

[12] Julie Weed, "Factory Efficiency Comes to the Hospital," *The New York Times*, July 9, 2010.

[13] The American Recovery and Reinvestment Act of 2009 gave state and local governments the option to issue two general types of Build America Bonds as taxable governmental bonds with federal subsidies for a portion of their borrowing costs. The first type provides a federal subsidy through tax credits to investors in the bonds in an amount equal to 35 percent of the total coupon interest payable by the issuer on taxable governmental bonds (net of the tax credit). The second type provides a Federal subsidy through a refundable tax credit paid to state or local governmental issuers by the Treasury Department and the Internal Revenue Service in an amount equal to 35 percent of the total coupon interest payable to investors in these taxable bonds.

[14] A general obligation ("G.O.") bond is a bond secured by the full faith, credit, and taxing power of an issuer. G.O. bonds issued by states are generally based upon appropriations made by the state legislature for the purposes specified.

[15] "Maine Superintendent to HHS: Let State Off the Hook for Health Reform's MLR Rule," insurancenewsnet.com, July 13, 2010.

[16] "AHA Weighs in with NAIC on Health Care Law's Medical Loss Ratio Provision," AHAnews.com, June 14, 2010.

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