Payers and Providers: The Lines Continue To Blur Following Recent Acquisition Activity

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The Trend and Rationale Behind It An emerging trend over the past 12 months has been the acquisition of companies who provide medical care by those who pay for it – blurring the lines between two groups historically at opposite sides of the healthcare spectrum.

The deals signal the growing reach of the insurance industry as carriers diversify outside their traditional commercial health-coverage business. They are also making longer term strategic bets on an integrated approach that ties together the insurance carriers with the providers. With health care spending spiraling, insurers and providers are seeking ways to cut costs and are encouraging non-traditional relationships in an effort to become – and make the health care system – more efficient.

In addition, as profit margins come under attack from the federal health care law, health insurance industry players are also focusing on acquisitions that boost their Medicare population. Though the health care law limits government payments to insurers for Medicare plans, the Medicare business overall remains desirable to insurance companies. It will also expand as Baby Boomers age – and as an increasing portion of Medicare beneficiaries select private plans. Finally, insurance companies view reimbursement as "relatively predictable to lock-in" since future Advantage payments are tied to how much is spent in traditional Medicare, as well as select quality benchmarks.

Diversification also allows insurers to spread their costs over a larger base and increase their role in Medicaid programs. The health care law will expand Medicaid and grant lower-income Americans federal subsidies to buy coverage in 2014.

The Acquisitions: Humana Acquires Concentra

In December 2010, Humana (2011 revenues of $9.06 billion) acquired Concentra, a privately-held, Texas-based company, for ~$790MM in cash. Through its affiliated clinicians, Concentra delivers occupational medicine, urgent care, physical therapy and wellness services to workers and the general public from more than 300 medical centers in 42 states with annual revenues of ~$800MM. In addition to its medical center locations, Concentra serves employer customers by providing a range of health advisory services and operating more than 240 worksite medical facilities. A Humana executive commented that Concentra "reinforces our core businesses while providing both revenue diversification and opportunities for strategic expansion longer term". Once part of Humana, Concentra then acquired four NextCare urgent care facilities in Atlanta.

In 2012, Humana is seeking to stake an even larger claim in the market for senior-focused health plans. The company "sees further growth opportunities in Medicare and, more broadly, in continuing

expansion into adjacencies related to lifelong well being". Humana also confirmed its interest in the market for so-called "dual-eligible patients", or people who qualify for both Medicare and Medicaid.

Highmark Acquires West Penn Allegheny Health Systems

Around mid-year 2011, Highmark (an independent licensee of the Blue Cross and Blue Shield Association with $14.6B of revenue and 3.1 million members in western PA) announced a deal to acquire West Penn Allegheny Health Systems, the second-largest hospital chain in its region. Under the plan, not-for-profit Highmark will invest as much as $475MM into the five-hospital West Penn System, which has been losing money for each of the past five years and has about $800MM in debt. Highmark plans to move away from traditional fee models that reward providers for delivering higher volume health care leading to overutilization. Instead, Highmark would pay salaries to physicians – but offer them incentives if certain quality and efficiency goals were achieved. In addition, Highmark would rely on primary-care doctors to coordinate patients' care with a focus on preventive efforts.

UnitedHealth Acquires Monarch Healthcare; Seeks To Acquire XL Health

In H211, UnitedHealth announced its intention to acquire the management arm of Monarch Healthcare of California, an association that includes approximately 2,300 physicians in a range of specialties. A price was not disclosed. United's Optum Health Services Unit had previously acquired the management arms of two smaller southern CA groups – AppleCare Medical Group and Memorial HealthCare Independent Practice Association. A United Optum spokesperson said that his company "shares Monarch's commitment to bringing patients, physicians, hospitals and health care payers closer together in the mission to increase the quality and affordability of health care".

In late 2011, UnitedHealth also agreed to acquire XL Health, a privately-owned, MD-based company and sponsor of Medicare Advantage Health plans with a primary focus on Medicare recipients with special needs, such as those with chronic illness, and those also eligible for Medicaid.

WellPoint Acquires CareMore

In Q411, Wellpoint (an independent licensee of the Blue Cross and Blue Shield Association with 2011 revenues of $59.8 billion) unveiled its deal for closely held CareMore Health Group for approximately $800MM. The deal expands WellPoint's footprint in Medicare Advantage (currently 555,000 Medicare Advantage beneficiaries), the private-plan version of the federal program that covers the elderly and disabled. It also makes WellPoint a more significant provider of medical care, since CareMore (54,000 Medicare Advantage beneficiaries) owns a network of 26 clinics in California, Arizona, and Nevada that specialize in preventive services and managing the care of frail and chronically ill seniors. CareMore's annual revenue are approximately $750 to $800MM. A WellPoint executive said the acquisition was "an integrated approach……that is increasingly fashionable with health care policymakers". WellPoint expects to more than double the CareMore network of clinics over the next two or three years, focusing on states like New York where WellPoint has Blue Cross and Blue Shield plans. The Company may also

consider using the CareMore clinical approach for other populations like Medicaid and commercially insured consumers.

Cigna Acquires HealthSpring

In early 2012, Cigna closed a $3.9B deal to buy Medicare carrier HealthSpring. The acquisition represented a change for Cigna which has been primarily focused on employers but will now also be a major source of Medicare prescription-drug plans and Medicare Advantage coverage. Cigna has revenues of $21.3B vs. HealthSpring's $3.1B. However, HealthSpring has greater presence in Medicare (340,000 Medicare Advantage enrollees vs. 46,000 for Cigna).

HealthSpring was also viewed as a desirable target due to its strong margins resulting from a payment structure that revolves around incentives for doctor groups that reduce costs and achieve quality measures. A Cigna executive confirmed that HealthSpring "was attractive because it expands our presence in the Seniors and Medicare segments and how it forges relationships with physicians". Cigna plans to expand HealthSpring's model through a growing Medicare Advantage footprint and its commercial business.

Potential Issues Voiced Re: Insurer/Provider Consolidation

Critics have been voicing their concerns regarding the insurer/provider consolidations. Key among them are the potential for: limiting patient choices, restricting physicians autonomy and services, control of prices by "big hospitals" and/or insurance companies and an overall increase in health care costs. Other concerns mentioned include:

"Insurers don't have the skill set for managing physicians" "Most commercial payers (excluding Blue Cross and Blue Shield) have market shares of between 5 and 25% in a given market. Even if payers employ physicians directly or through a management agreement, large hospital systems may still maintain a position of strength. If a payer negotiates too hard, a "big hospital" may threaten to drop out of the payers network"

"This kind of approach has been tried before and backfired, most notably at Humana which spun off its hospitals in 1993 after rival health plans steered patients to competing providers and again in the 90's after consumers revolted against integrated HMO models that were seen as curbing their choices of providers" "With its focus on increasing Medicare (and Medicaid) population, the health insurance industry will have the US government as a more significant piece of its balance sheet. Demographics and stable reimbursement will provide opportunities; political and economic pressures at the state and federal levels will add risk to the insurers model"

Local and regional challenges exist for carriers and providers as well. Examples include:

A combined Highmark-West Penn will be pitted against the University of Pittsburgh Medical Center (a 19-hospital network and owner of a health plan with 1.6 million members with revenues of $8 billion). The University's contract with Highmark expires in June of 2012 and it does not plan to seek an extension if the acquisition is successfully concluded. The loss of the contract would negatively impact Highmark, which would need to persuade customers to buy insurance that requires them to pay out-of-

network rates for U. of Pittsburgh – the region's biggest provider. Highmark would also need to convince patients that its cost savings efforts won't hurt care or reduce access to specialists.

Monarch is currently in an arrangement with United competitor WellPoint to create a cooperative accountable care organization (ACO) with the objective of reducing health care costs and improving quality. The Department of Justice signaled that it wants help from physicians to identify anti-competitive practices by insurers and hospitals, especially in small-group and individual markets

Potential Opportunities For Insurers/Providers

Although payers and providers have regularly battled each other about quality-of -care versus cost-effective care, it is clear that mergers between the two groups are gaining momentum. By acting as a "combined entity", payers and providers are seeking to align incentives to lower costs by avoiding overutilization while still providing quality health care. Payers are looking to increase efficiency of care by integrating their payment systems with provider's delivery systems.

Aside from the recently concluded – or announced – transactions by Humana, HighPoint, UnitedHealth and Cigna, Aetna has mentioned an interest in making acquisitions that would boost its Medicare population. In addition, Highmark may also acquire or invest in other providers, including doctor practices.

Trend to Watch

Look for the trend to continue as insurers step into the business of providing health care directly via acquisitions – and the lines between insurance companies and health care providers continue to blur.

Impact to Device Companies

Given the premiums paid by insurers to acquire providers, the integration-related challenges (including making synergies happen), the "promises" made regarding removing costs (other than supplies) and improving quality of care, and their quest to adapt to the new federal health care law, carriers will likely have their hands full over the next several years. As a result, the impact on physician preference products will likely be negligible in the short term.

However, device executives should remain proactive. Since the biggest challenges facing the MedTech industry are staying innovative, demonstrating value and fueling growth, device executives can at least partially address these challenges by lifting a page from the insurers' playbook – fostering relationships and collaborations with non-traditional partners, including those companies in the managed care sector.

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