Payor / Provider Convergence

Understanding Market Trends and Valuation Issues

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AGENDA

I. CHANGING ENVIRONMENT

II. CONSOLIDATION STATUS

III. STRATEGIES TO RESPOND

IV. TRANSACTION MODELS

V. FAIR MARKET VALUE CONSIDERATIONS
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AFFORDABLE CARE ACT ("ACA")

Timeline of Key Events

2010
- Adult coverage until age 26
- Lifetime dollar limits prohibited
- No pre-existing conditions for children until age 19
- Restrictions on member cost sharing for preventative services

2011
- Increased penalty for non-qualified HAS withdraws
- Non-discrimination policies
- Rate reviews

2012
- First medical loss ratio rebates paid
- Quality of care reporting requirements

2013
- Medicare tax increase
- Disproportionate Share Hospital (DSH) payment reductions

2014
- Annual insurance industry tax
- Health insurance exchanges
- Individual employer mandate
- Standardized essential health benefits
- Optimal Medicaid Expansion to 133% of the Federal Poverty Level
KEY PROVISIONS OF ACA

- Creation of Accountable Care Organizations
- Reductions in Medicare Reimbursements
- Coverage Mandates
- Value-based Payments for Hospital Services
- Medical Loss Ratio: 85.0% for large group; 80.0% for small / individual group
- Increased Medicaid Payments for Primary Care
CREATION OF ACOs

Group of healthcare providers who deliver coordinated care and chronic disease management

- Payment is tied to the ACO’s ability to achieve healthcare quality goals and outcomes that result from cost savings
- Operate in both Medicare fee-for-service (Shared Savings Program) and commercial sector
- Healthcare providers are assuming risk for achieving certain outcomes
Medicare ACO structures range from networks of individual physicians to physician groups to hospital/physician partnerships.

Focus on care coordination and engaging patients in their own health.

Twenty ACOs caring for 660,000 Medicare beneficiaries currently bear two-sided financial risk, blurring lines between FFS Medicare and MA.
REDUCTIONS IN MEDICARE REIMBURSEMENTS

Decreasing Reimbursement for Providers – Medicare Payment Risk

**Hospitals**
- In 2015, 5% of hospitals’ Medicare inpatient reimbursement is at risk based on the following programs:
  - Value Based Purchasing (1.5%)
  - Re-admission Reduction Program (3%)
  - Hospital Acquired Conditions (1%)
- In 2016, risk increases to 6%

**Physicians**
- Physicians’ Medicare physician fee schedule payments may be subject to penalties related to the following programs:* 
  - Physician Quality Reporting System (2.0%)
  - Meaningful Use (1.0% to 3.0%)
  - Value-Based Payment Modifier (2.0%)

*Based on 2015 penalty amounts
SHIFT TO VALUE BASED REIMBURSEMENTS

Value-Based Payments – Compensation Models from Fee-for-Service to Risk/Quality Based

◆ Health and Human Service’s goal is to shift 30% of traditional (FFS) Medicare payments to quality or value based payments through alternative payment models by the end of 2016, and 50% by the end of 2018

◆ According to a survey conducted by McKesson Corporation nearly all payers and more than 80.0% of providers are already using some form of value-based reimbursement.
# SUMMARY OF MEDICARE QUALITY/VBP CHANGES

<table>
<thead>
<tr>
<th>Sector</th>
<th>Requirements</th>
<th>Max. Payment Penalty</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospitals</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>FY 2005</td>
</tr>
<tr>
<td></td>
<td>• Hospital-acquired Conditions</td>
<td>1%</td>
<td>FY 2015</td>
</tr>
<tr>
<td></td>
<td>• Hospital Readmissions</td>
<td>3%</td>
<td>FY 2013</td>
</tr>
<tr>
<td></td>
<td>• Value-based Purchasing</td>
<td>1.75%</td>
<td>FY 2013</td>
</tr>
<tr>
<td>Outpatient Hospitals</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>CY 2008</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>• Quality Bonus Payments</td>
<td>Bonus Equivalent to Star Rating</td>
<td>2012</td>
</tr>
<tr>
<td>Ambulatory Surgery Centers</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>2014</td>
</tr>
<tr>
<td>Dialysis</td>
<td>• Meet Quality Benchmarks</td>
<td>2%</td>
<td>2012</td>
</tr>
<tr>
<td>Home Health Agencies</td>
<td>• Report Quality Data</td>
<td>2% max adj. +/- 5% in 2018 and 2019, +/- in 2020, and +/- 8% in 2021 and 2022</td>
<td>2007 2018</td>
</tr>
<tr>
<td>Hospice</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>FY 2014</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>FY 2014</td>
</tr>
<tr>
<td>Long-Term Care Hospitals</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>FY 2014</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facilities</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>FY 2014</td>
</tr>
<tr>
<td></td>
<td>• Meet Quality Benchmarks</td>
<td>4%</td>
<td>2017 2019</td>
</tr>
<tr>
<td></td>
<td>• MIPS</td>
<td>+/- 4% upside/downside in 2019, +/- in 2020, +/- 7% in 2021, and +/- 9% in 2022 and beyond</td>
<td>2007 2017 2019</td>
</tr>
<tr>
<td></td>
<td>A bonus payment of 5% for eligible professionals who participate in approved alternative payment models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>• Report Quality Data</td>
<td>2%</td>
<td>FY 2017 FY 2019</td>
</tr>
<tr>
<td></td>
<td>• VBP Proposed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: “Disruptions and opportunities – primer on value-based care” – Bank of America Merrill Lynch
GOALS FOR PAYMENT CHANGE

Percentage of Hospitals Reporting 10%+ Revenue Tied to Value-Based Contracts

- August 2014: 22%
- February 2015: 42%

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- 2016:
  - 30% All Medicare FFS
  - 85% FFS linked to quality (Categories 2-4)
  - 0% Alternative payment models (Categories 3-4)

- 2018:
  - 50% All Medicare FFS
  - 90% FFS linked to quality (Categories 2-4)
  - 0% Alternative payment models (Categories 3-4)

Source: Kaufman, Hall & Associates LLC
COVERAGE MANDATES

Individual Coverage Mandate

Health Insurance Enrollment in 2017, With and Without Individual Mandate (millions)

<table>
<thead>
<tr>
<th></th>
<th>Affordable Care Act</th>
<th>Repeal Individual Mandate</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Insured</td>
<td>249.6</td>
<td>237.3</td>
<td>-12.3</td>
</tr>
<tr>
<td>Employer</td>
<td>155.8</td>
<td>152.8</td>
<td>-3.0</td>
</tr>
<tr>
<td>Individual (on-/off-exchange)</td>
<td>23.6</td>
<td>17.6</td>
<td>-6.0</td>
</tr>
<tr>
<td>Medicaid and CHIP</td>
<td>58.1</td>
<td>54.8</td>
<td>-3.3</td>
</tr>
<tr>
<td>Other</td>
<td>12.1</td>
<td>12.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Uninsured</td>
<td>28.5</td>
<td>40.8</td>
<td>12.3</td>
</tr>
</tbody>
</table>

Penalties include:

- 2% of yearly household income
- $325 for each individual ($162.50 for children); family max. of $975

Emerging changes in reimbursement models

**Current Environment**
- Fee for Service
- HMO/ Risk-Based Models
- High Deductible Plans
- Quality Incentives and Shared Savings

**New Environment**
- Risk Sharing
- Bundled Payments
- Narrow Networks
- Value-based Purchasing
### Impact on the Marketplace

<table>
<thead>
<tr>
<th>Providers</th>
<th>Payors</th>
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</thead>
<tbody>
<tr>
<td>- Government mandates/reform</td>
<td>- Minimum medical loss ratios</td>
</tr>
<tr>
<td>- Consumer-driven health plans (cost sharing)</td>
<td>- Increased regulatory control over rates</td>
</tr>
<tr>
<td>- Aging population</td>
<td>- Establishment of health insurance exchanges</td>
</tr>
<tr>
<td>- Provider shortages</td>
<td>- Prohibition on certain rating factors (health status, gender)</td>
</tr>
<tr>
<td>- Health insurer/provider business models</td>
<td>- Creation of ratings bands for certain rating factors (age, smoking)</td>
</tr>
<tr>
<td>- Cost containment</td>
<td>- Guaranteed issue/renewability</td>
</tr>
<tr>
<td>- Service delivery (quality)</td>
<td>- Prohibition on preexisting conditions</td>
</tr>
<tr>
<td>- Reimbursement reductions</td>
<td>- Prohibition on lifetime limits/restrictions on annual limits</td>
</tr>
<tr>
<td>- Healthcare claims fraud</td>
<td>- Expansion of mandated benefits</td>
</tr>
<tr>
<td>- Changing technology requirements (HER/ICD10)</td>
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</tbody>
</table>
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Major Provider Consolidations

- Tenet Health
- Vanguard Health Systems
- Trinity Health
- Catholic Health East
- Baylor Health Care System
- Scott & White
- CHS Community Health Systems
- Health Management Associates
- RWJ Barnabas Health

2010

2013

2015
PROVIDER CONSOLIDATION

Increased General M&A Activity

- Deal volume increased after passage of ACA in 2010
- Deal volume in 2015 is trending higher than 2014

Source: Irving Levin & Associates
PAYOR CONSOLIDATION

As healthcare providers have consolidated through various mergers and joint ventures, payors have responded with a wave of consolidation of their own.

- **Q1 2015**: Aetna® and Humana®
  - Awaiting regulatory approval

- **Q2 2015**: Molina Healthcare® and Preferred Medical Plan
  - Finalized August 1, 2015

- **Q3 2015**: Centene Corporation® and Health Net®
  - Expected to close in early 2016

- **Q4 2015**: Anthem® and Cigna®
  - Awaiting regulatory approval
PAYOR CONSOLIDATION

Increased General M&A Activity

- Uptick in activity since 2011
- Trend towards acquisition of targeted small, specialty firms and health plans participating in government sponsored healthcare programs.

Source: Irving Levin & Associates
**2016 HEALTHCARE OUTLOOK**

**Managed Care**

**Regional Consolidation**
Following notable 2015 M&A activity among the largest players, increasing consolidation among regional plans

**Attain Synergies**
M&A focus on key new capabilities like care management, consumer engagement and health & wellness

**Government Programs**
Focus on government programs including dual-eligible and complex populations with exchanges and small group market becoming wild cards

**Convergence**
Further provider/payor convergence
Focus by health systems on organizing physicians and medical groups. Nearly 80% of all costs are directly or indirectly controlled by physicians.

“Care-efficient” model achieved by Group Health in Seattle, managing large commercial and Medicare populations with inpatient days per 1,000 at just 34% and 42% of the national average, respectively.

Focus on government programs including dual-eligible and complex populations with exchanges and small group market becoming wild cards.

New dynamics with more activist employers and price sensitive individuals resulting in greater demand for narrow, custom networks, more transparency on cost and quality comparisons, and alternative and convenient access points.
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III. Strategies to Respond

IV. Transaction Models

V. Fair Market Value Considerations
CONVERGENCE

Payors and providers are “mixing it up”

The line separating payors and providers has become blurred as each has increasingly ventured into the other’s market

The resulting increase in competition has changed the means of supply and demand
WHAT IS “CONVERGENCE?”

The coming together of disparate subsectors of the health care marketplace that heretofore operated separately

Trends of Payor/Provider Convergence

- Population Health Management (instead of utilization management)
- Increases in provider-owned health plans
- Joint ventures for provider networks, population health management and payor affiliations
- Payment reforms, including shared savings, bundled payment & P4P
- Private payor accountable care programs
MOVING TOWARDS PARTIAL CONVERGENCE

There is no one path to success in taking risk

- Medical Home
- Hospital-physician gain-sharing
- Payment for coordination
- Physician & hospital P4P
- Payment adjustment for hospital-acquired conditions, readmissions
- Payment for shared decision making
- Bundled payment
- ACO Shared savings, global payment

Optimize for volume: Risk Managed by Provider
Optimize for outcome: Risk Managed by Provider

Size of circle = ability to bend the medical cost trend curve

Source: Optum Health Plan and Provider Convergence: Preparing for the Transformation
DIVERSE BENEFITS FOR MANAGING POPULATION HEALTH

Three motivators for providers to assume more risk

**Financial Advantage**
- Move away from faltering fee-for-service economics
- Capture greater share of premium dollar

**Market Advantage**
- Attract preferred physician partners
- Secure attractive purchaser contracts

**Clinical Advantage**
- Align financial incentives with mission
- Support investments in better health

*Source: The Advisory Board*
WHERE ARE PROVIDERS IN THE TRANSITION TOWARDS FULL CONVERGENCE?

FFS Transitioning to Shared Savings

Limited Dual-Sided Risk (MA Pioneer)

White-Label Products on Exchanges, Direct-to-Employer

Delegated Risk, Full Capitation

Stand up Provider-Owned Plans

Over 200 MSSP participants; Commercial shared savings contracts expanding rapidly

32 Pioneer, Numerous physician medical groups taking delegated MA risk

More advanced systems standing up direct-to-employer and exchange products

Only a few have demonstrated ability to do so successfully over time

Systems pursuing health plan filings and operations

Source: Optum Health Plan and Provider Convergence: Preparing for the Transformation
HEALTH SYSTEMS OFFERING INSURANCE PRODUCTS

Health Plan Outlook for Healthcare Providers

- 34% Currently Own
- 46% Plan to Own <5 Years
- 30% Do Not Plan to Own <5 Years

Source: The Advisory Board 2013 Accountable Payment Survey Based on 110 Responses
# REASONS FOR CONVERGENCE

<table>
<thead>
<tr>
<th>Providers Interested in Payors</th>
<th>Payors Interested in Providers</th>
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<tbody>
<tr>
<td><strong>Offensive</strong></td>
<td></td>
</tr>
<tr>
<td>- Increase market share and manage utilization through affiliated health system facilities</td>
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<tr>
<td>- Gain market intelligence / better understand populations in potential new markets</td>
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<tr>
<td>- Increase reimbursement through reduced payor margins</td>
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<tr>
<td><strong>Defensive</strong></td>
<td></td>
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<tr>
<td>- Alignment strategy with physician networks</td>
<td></td>
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<tr>
<td>- Off-set potential exclusions from narrow networks</td>
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<tr>
<td>- Response to other health system / payor combinations</td>
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</tr>
<tr>
<td><strong>Strategic</strong></td>
<td></td>
</tr>
<tr>
<td>- Strategy of “arbitrage” and to capture value from efficiency in care delivery and management</td>
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<tr>
<td>- Aligning investment with future payment methodologies (i.e. ability to manage financial risk of value-based contracts)</td>
<td></td>
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<tr>
<td>- While consolidated margins may be lower, top-line revenue is more stable</td>
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<tr>
<td>- Additional coordination of care and management of costs through affiliated provider network</td>
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</tr>
<tr>
<td>- Capture enrollment through health system regional presence and brand</td>
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<tr>
<td>- Diversify sources of profit</td>
<td></td>
</tr>
<tr>
<td>- Protect margins from provider negotiating leverage</td>
<td></td>
</tr>
<tr>
<td>- Avoid disintermediation (direct contracting between employers and provider ACOs)</td>
<td></td>
</tr>
<tr>
<td>- Response to other health system / payor combinations</td>
<td></td>
</tr>
<tr>
<td>- Greater ability to design attractive insurance products with provider network</td>
<td></td>
</tr>
<tr>
<td>- Aligning investment with future payment methodologies (i.e. ACO base structures)</td>
<td></td>
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<tr>
<td>- Limit underwriting risk with ability to better manage health service utilization</td>
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</tbody>
</table>
CHANGING PARTNERSHIPS AND IDENTITIES

To sustain and grow their business, providers and payors are establishing new partnerships and identities to respond to this changing environment.

Source: The Advisory Board

**Health plan acquisition of provider groups**
- **Market share** gains as patients change plans to maintain current provider relationship
- Improved **consumer satisfaction** through expanded provider network
- Improved **operational efficiency** from coordinator between financial clinical aspects of care continuum

**Providers create/sponsor health plans**
- Capture full premium dollar from subscribers
- Manage utilization with benefit design, steer patients to owned or affiliated facilities and providers
- Present credible contracting threat to health insurance companies
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Providers and payors engaged in “partial convergence” are now looking towards “full convergence” transactions

◆ Partial Convergence – contractual arrangements involving sharing of risk around cost management and value-based care
  ➢ Clinically integrated networks contracting with payors for shared savings, risk-based payments, bundled payments, etc.

◆ Full Convergence – investment and ownership in health plan or provider network with vertical integration
  ➢ Providers building or acquiring health plans
  ➢ Payors acquiring provider networks
  ➢ Joint ventures between payors and providers
PROVIDER – DEAL STRUCTURES AND STRATEGIES

Building a Health Plan

◆ Contracts with experts / vendors on health plan capabilities must be developed (e.g., insurer, TPA, PBM, etc., may provide back-office functions)

◆ Board and key management capabilities

◆ Minimum capital and surplus, risk based capital and hazardous financial condition standards

◆ Separation of provider from health plan (e.g., who negotiates managed care contracts)

◆ Separateness of plan data from hospital data

Market Commentary

“Having an insurance base has great potential but it’s a long-term play. You have to grow it slowly. I look upon this as a five-year play before you’re going to see any substantial results. We’ve had ours up for almost a year and a half. That has great potential if you can manage the care effectively and if you get the right membership in your insurance entity. If you have low premiums and high-risk cases, you’re going to be in trouble. You’ve got to watch that all the time.”

“Having an insurance company becomes a huge catalyst in getting the whole organization to think differently about how we should do things. When you collect the premium dollar, you’re going to do all things a little bit differently that when you’re just paid fee-for-service, because of the alignment of the incentives.”

― Michael Dowling, CEO, North Shore – LIJ Health System

NEW PROVIDER-SPONSORED MA ENTRANTS, 2012-2015

<table>
<thead>
<tr>
<th>Provider Sponsor</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor Scott &amp; White Holdings</td>
<td>MedStar Health, Inc.</td>
</tr>
<tr>
<td>Catholic Health Initiatives</td>
<td>Memorial Hermann Healthcare System</td>
</tr>
<tr>
<td>Catholic Health Partners</td>
<td>Mountain States Health Alliance</td>
</tr>
<tr>
<td>CHRISTUS Health</td>
<td>Piedmont WellStar Health Plans, Inc.</td>
</tr>
<tr>
<td>Community Hospital foundation</td>
<td>Premier Health Partners</td>
</tr>
<tr>
<td>FirstHealth of the Carolinas, Inc.</td>
<td>Stanford Hospital and Clinics</td>
</tr>
<tr>
<td>Health Partners Plans, Inc.</td>
<td>Universal Health Services, Inc.</td>
</tr>
<tr>
<td>IJKG Opco LLC/Bayonne Medical Center</td>
<td></td>
</tr>
</tbody>
</table>

- 70% of new MA plans approved since 2008 are provider-sponsored

Source: Avalere analysis of Medicare Advantage enrollment files, 2011-2015
PROVIDER – DEAL STRUCTURES AND STRATEGIES

Acquire a Health Plan

- Acquire an existing plan / shell license transaction
- Stock or asset purchase
- Utilize plan’s existing capabilities
- Assignment of provider network
- Health plan operational capabilities
- Regulatory approvals
  - Insurance & other state regulatory agencies
  - CMS novation; State Medicaid Agency
- Run-out claims & post-closing liabilities

Market Commentary

“Before we had on our strategic list the need for a financing mechanism, because it was our belief that we as providers were going to be taking more and more risk. So we were looking at developing a health plan from within, acquiring one, or partnering with one.”

“We are a growth company. We want to continue to grow. We are going to create a statewide network. That could mean acquisitions, contractual agreements and expansion of its accountable care organization.”

– Joel Allison, CEO of Baylor Scott & White Health

PROVIDER – ACQUIRE/BUILD STRUCTURE

Single Provider Sponsored Health Plan

Health System

Insurance Company

Network Agreements & Delegation Agreements
Medical Management and Other Population Health Management Services

ASO* and Other Vendor Contracts
Large Group Contracts
Small Group Contract
ASO and Other Vendor Contracts

Large Employer Groups
Small Employer Groups

* “Administrative Services Only” – an arrangement where an employer engages an insurance company to handle administrative tasks for their employees.
PAYOR – DEAL STRUCTURES AND STRATEGIES

**Acquire a Provider Network**

- Acquire a health system, practice group or other provider network
- Stock or asset purchase
- Regulatory approvals (e.g. nonprofit acquisitions)

- Potential backlash from other payors and providers in the market
- Sufficiency of provider network capabilities

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Highmark</strong></td>
<td>• Highmark acquires struggling West Penn Allegheny Health System after contentious public debate and regulatory scrutiny –$1B investment including existing debt</td>
</tr>
<tr>
<td>Allegheny Health Network</td>
<td>• Highmark also acquired Jefferson Regional Medical Center in Pittsburgh and St. Vincent Health in Erie</td>
</tr>
<tr>
<td></td>
<td>• Significant ongoing disputes on provider contracting with UPMC</td>
</tr>
<tr>
<td></td>
<td>• Allegheny returned to profitability in first year following transaction</td>
</tr>
</tbody>
</table>
**Partner/Joint Venture**

- Two models: Equity JV & Contractual JV (intermediary or plan controlled risk pool)
- Separate but interdependent collaboration on plan / provider functions
- Allocation of power based upon Board seats and reporting relationship of key management

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Commentary</th>
</tr>
</thead>
</table>
| **aetna** | Commercial JV  
Formed Innovation Health, LLC: 50-50 joint venture  
Insurance holding company system includes HMO and insurer  
Innovation Health offers plans in individual, small group, and self-insured markets  
Inova developed provider network that includes affiliated and independent providers |
| **INOVA** | Medicare Advantage JV  
Formed Veritage, LLC: 50-50 ownership  
BCBS contributed cash, Banner contributed cash and stock in Banner MediSun, Inc. (nka MediSun, Inc. dba Blue Cross Blue Shield of Arizona Advantage)  
Limited to a Medicare Advantage plan only |
| **Banner Health** | **Blue Cross Blue Shield of Arizona** |
PROVIDER/PAYOR – JOINT VENTURE STRUCTURE

Equity Joint Ventures

- Contribution Agreement: Insurer and NewCo
- Co-Insurance Agreement: Captive and NewCo
- “ASO” Profit Sharing Agreement: Health System and NewCo

Health System

Health System Providers

Insurance Company

Holding Company

Existing Employer Groups

Low Provider Rates = Competitive Premiums

Prospective Employer Groups

New Company

Share of Profits & Losses

Participating Provider Agreements

Health System Providers and NewCo

Lower Than Market Provider Rates (Offset by Shared Profits)
Regulatory Considerations

- **Antitrust issues** – HSR filing / FTC review, state antitrust review, firewalls
- **Insurance issues** – state regulatory requirements, risk-based capital requirements, mandated benefits requirements
- **Tax-exempt issues** – implications for nonprofit status / unrelated business income, state agency review of nonprofit acquisitions
- **Federal and state fraud and abuse laws** – Stark Law, Anti-Kickback Statute and other laws implicated by financials relationships involving providers and physicians
- **Other federal and state healthcare laws** – HIPAA / privacy laws, corporate practice of medicine, state licensing, etc.
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STANDARD OF VALUE

Due to the healthcare regulatory environment, valuation issues when considering a prospective transaction need to be addressed

Fair Market Value Standard
STANDARD OF VALUE

Fair Market Value

IRS Revenue Ruling 59-60 is a landmark ruling by the IRS that provides general guidelines for the valuation of closely held companies. We define FMV as established by IRS Revenue Ruling 59-60 as “the amount at which property would change hands between a willing seller and a willing buyer when neither is acting under compulsion and when both have reasonable knowledge of all relevant facts and circumstances.” IRS Revenue Ruling 59-60 calls for examination of the following elements in connection with the subject enterprise:

- The nature and history of the enterprise from inception;
- The economic outlook in general and the outlook for the specific industry in particular;
- The financial condition of the enterprise;
- The earning capacity of the enterprise;
- The dividend paying capacity of the enterprise;
- The goodwill or other intangible value of the enterprise;
- Prior sales of the stock and the size of the block of stock to be valued; and,
- The market prices of corporations in the same or similar specialty areas.
Three Accepted Business Valuation Methods

- **INCOME APPROACH**: Discounted Cash Flow Method
- **COST APPROACH**: Tangible and Intangible Assets
- **MARKET APPROACH**: Guideline Public Company Method and Similar Transactions Method
### Key Balance Sheet Items:

**Cash & Cash Equivalents** – Typically high balances of cash needed to satisfy claims; a relatively smaller amount of operating cash needed for back-office functions.

**Investments** – Premium revenues are typically invested in various liquid assets to enhance health plan total profits.

**Claims Payable** – Includes actual claims amounts owed and “incurred but not reported” (IBNR) amounts; IBNR is a reserve account used to estimated amounts owed to claimants during the reported period.

**Equity** – Amount tested to maintain regulatory compliance.

### Sample Balance Sheet

<table>
<thead>
<tr>
<th>ASSETS:</th>
<th>FYE 2012</th>
<th>FYE 2013</th>
<th>FYE 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash &amp; Cash Equivalents</td>
<td>3,297,700</td>
<td>3,347,100</td>
<td>3,397,300</td>
</tr>
<tr>
<td>Investments</td>
<td>20,501,500</td>
<td>20,809,000</td>
<td>21,121,200</td>
</tr>
<tr>
<td>Net Accounts Receivable</td>
<td>2,323,400</td>
<td>2,198,700</td>
<td>2,198,700</td>
</tr>
<tr>
<td>Prepaid Expenses and Other Current Assets</td>
<td>251,900</td>
<td>328,900</td>
<td>118,300</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>26,374,400</td>
<td>26,683,800</td>
<td>26,835,600</td>
</tr>
<tr>
<td>Other Assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, Plant, &amp; Equipment</td>
<td>150,000</td>
<td>153,500</td>
<td>157,000</td>
</tr>
<tr>
<td><strong>Total Other Assets</strong></td>
<td>150,000</td>
<td>153,500</td>
<td>157,000</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>26,524,400</td>
<td>26,837,300</td>
<td>26,992,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIABILITIES:</th>
<th>FYE 2012</th>
<th>FYE 2013</th>
<th>FYE 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Liabilities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Payable</td>
<td>8,831,600</td>
<td>9,043,600</td>
<td>9,260,600</td>
</tr>
<tr>
<td>Deferred Revenue</td>
<td>4,420,800</td>
<td>4,526,900</td>
<td>4,635,500</td>
</tr>
<tr>
<td>Other Accrued Expenses</td>
<td>431,100</td>
<td>799,500</td>
<td>823,500</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>13,683,400</td>
<td>14,369,900</td>
<td>14,719,600</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>13,683,400</td>
<td>14,369,900</td>
<td>14,719,600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SHAREHOLDERS’ EQUITY:</th>
<th>FYE 2012</th>
<th>FYE 2013</th>
<th>FYE 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Stock</td>
<td>12,841,000</td>
<td>12,467,300</td>
<td>12,273,000</td>
</tr>
<tr>
<td><strong>Total Shareholders’ Equity</strong></td>
<td>12,841,000</td>
<td>12,467,300</td>
<td>12,273,000</td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Shareholders’ Equity</strong></td>
<td>26,524,400</td>
<td>26,837,300</td>
<td>26,992,500</td>
</tr>
</tbody>
</table>
## Key Income Statement Items:

- **Premiums** – The largest revenue category; reflects size of member base and pricing
- **Investment Gains/ Losses** – Typically an operating activity of health plans and included in other revenue
- **Medical Claims Expense** – Amounts paid to providers for services rendered
- **General & Administrative** – Include sales commissions and all other costs associated with operating the health plan
- **Stop-Loss Insurance** – Provides protection in case of catastrophic claims exceeding predetermined levels

### SAMPLE INCOME STATEMENT

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Revenue</td>
<td>84,230,000</td>
<td>85,910,000</td>
<td>87,630,000</td>
<td>93.3%</td>
<td>95.6%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>6,060,000</td>
<td>3,910,000</td>
<td>3,910,000</td>
<td>6.7%</td>
<td>4.4%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Total</td>
<td>90,290,000</td>
<td>89,820,000</td>
<td>91,540,000</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total Net Operating Revenue</td>
<td>90,290,000</td>
<td>89,820,000</td>
<td>91,540,000</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### Operating Expenses:

#### Healthcare Expense:

| Claims Payable         | 76,740,000 | 76,350,000 | 77,810,000 | 85.0%     | 85.0%     | 85.0%     |
| Total                  | 76,740,000 | 76,350,000 | 77,810,000 | 85.0%     | 85.0%     | 85.0%     |

#### General & Administrative

| Salaries, Wages, & Benefits | 8,580,000 | 8,800,000 | 9,060,000 | 9.5%      | 9.8%      | 9.9%      |
| Stop Loss Insurance       | 1,350,000 | 1,350,000 | 1,370,000 | 1.5%      | 1.5%      | 1.5%      |
| Other Operating Expenses  | 720,000   | 720,000   | 730,000   | 0.8%      | 0.8%      | 0.8%      |
| Total Operating Expenses  | 10,650,000| 10,870,000| 11,170,000| 11.8%     | 12.1%     | 12.2%     |
| Total Operating Expenses  | 87,400,000| 87,220,000| 88,980,000| 96.8%     | 97.1%     | 97.2%     |

| EBITDA                  | 2,890,000 | 2,600,000 | 2,560,000 | 3.2%      | 2.9%      | 2.8%      |
SAMPLE OPERATING STATISTICS

Key Operating Statistic Items:

◆ **Per Member Per Month (PMPM)** – Premiums per member per month

◆ **Member Months** – Measures the number of individuals participating in a health plan each month. It’s the product of the number of individuals enrolled in a plan multiplied by the number of months in the health plan policy

◆ **Medical Loss Ratio (MLR)** – Percentage of premium revenue the insurer spends on claims and expenses

<table>
<thead>
<tr>
<th>I. Per Member Per Month</th>
<th>FYE 2012</th>
<th>FYE 2013</th>
<th>FYE 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>$409</td>
<td>$394</td>
<td>$400</td>
</tr>
<tr>
<td>Government</td>
<td>$920</td>
<td>$892</td>
<td>$898</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Member Months</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>105,000</td>
<td>101,000</td>
<td>93,000</td>
</tr>
<tr>
<td>Government</td>
<td>282,000</td>
<td>284,000</td>
<td>306,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Medical Loss Ratio (MLR)</th>
<th>FYE 2012</th>
<th>FYE 2013</th>
<th>FYE 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial - Small Group</td>
<td>82.0%</td>
<td>82.0%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Commercial - Large Group</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Government</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>
GUIDELINE PUBLIC COMPANY MULTIPLES

5 Year Price Performance

Commercial: Cigna, Anthem, Aetna, and UnitedHealth
Managed Medicare: Humana
Managed Medicaid: Molina and WellCare

Source: S&P Capital IQ
GUIDELINE PUBLIC COMPANY MULTIPLES

TEV / Revenue

- Commercial: Cigna, Anthem, Aetna, and UnitedHealth
- Managed Medicare: Humana
- Managed Medicaid: Molina and WellCare

Source: S&P Capital IQ
GUIDELINE PUBLIC COMPANY MULTIPLES

TEV / EBITDA

Source: S&P Capital IQ

Commercial: Cigna, Anthem, Aetna, and UnitedHealth
Managed Medicare: Humana
Managed Medicaid: Molina and WellCare
GENERAL OBSERVATIONS

Transaction Multiples

<table>
<thead>
<tr>
<th></th>
<th>Enterprise Value / Revenue</th>
<th>Enterprise Value / EBITDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>0.42x</td>
<td>9.24x</td>
</tr>
<tr>
<td>Mean</td>
<td>0.52x</td>
<td>9.80x</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>0.15x</td>
<td>6.38x</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>0.70x</td>
<td>13.45x</td>
</tr>
</tbody>
</table>

Fair Market Value Considerations
- Vary by type of plan (IPA, Managed Care, and TPA) and parties involved
- Third-party arrangements post-transaction may need to be incorporated into the valuation
- Comparability of specific deal to precedent transactions when using Market Approach
- When issuing any fairness opinion, auction process used to determine pricing must be heavily reviewed
- Specific regulatory issues impacting the health plan going-forward

Drivers of Value
- Profitability and health of balance sheet
- Type of product (i.e., commercial, Medicare Advantage, Managed Medicaid) have different valuation multiples
- Number and nature (government or commercial) of members
- Growth prospects and population demographic considerations
- Local conditions related to relationships with operators and providers
- Competitive landscape
Final Thoughts

◆ Operational and financial challenges from “partial convergence” and “full convergence” strategies – which models have been most successful?

◆ Is “partial convergence” enough for providers and payors to be successful in the changing healthcare environment or is “full convergence” strategy required for long-term sustainability and success?
Michelle Apodaca is counsel at Haynes Boone, offering business and legal services to healthcare providers including hospitals and health management systems, physician practices, and healthcare payors.

Prior to entering private practice, Michelle served the Texas Hospital Association members as the Vice President of Advocacy, Legal and Public Policy. Early in her career she served as in-House Legal Counsel and Compliance Officer for a Texas health maintenance organization and as a legislative aide in both the Texas State Senate and the U.S. House of Representatives. Mrs. Apodaca is a graduate from Austin College and the Texas A&M School of Law.
James Pinna is a partner with the Healthcare Group of Hunton & Williams in Richmond, VA. He advises healthcare clients on matters involving regulatory compliance (including fraud and abuse, licensure, health privacy and reimbursement issues), structuring of business transactions, corporate governance and tax-exempt status issues. He is a member of the firm’s Health Care Reform Initiative and Pro Bono Committee.

Mr. Pinna is a graduate of Duke University and the University of Virginia School of Law. He is a member of the Virginia State Bar, the Virginia Bar Association, and the American Health Lawyers Association.
Colin McDermott, CFA, CPA/ABV is a managing director with VMG Health. He specializes in providing financial, valuation, and transaction advisory services to clients in the health care industry. His clients have included hospitals, hospital systems, health plans, ambulatory surgery centers, imaging centers, laboratories, physician groups, and other healthcare entities.

Mr. McDermott received a Bachelor of Business Administration in Accounting and a Master of Science in Finance from Texas A&M University. Mr. McDermott is a licensed Certified Public Accountant (CPA) in the state of Texas and holds the Chartered Financial Analyst (CFA) designation.