Healthcare Consolidation
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Mergers, Consolidations, and Their Affect

• Market Concentration
• 2 Big Mergers: Aetna/Humana and Anthem/Cigna
• Government: Affordable Care Act, Medicare, Medicaid
• Health Systems Consolidation
Payer consolidation impacts EVERY aspect of healthcare.
Market Concentration
Market Concentration

• Few control the many
  • 60% of health insurance market served by 10 plans
  • Commercial Ins.: In 40% of U.S. Metros, 1 Insurer controls half of the market
Market Share of Largest Insurer
# Insurers with >5% Market Share
Market Concentration

• GAO 2014 Study of 3 Segments:
  • Individual market, small group, and large group

• Findings:
  • In each segment, the 3 largest insurers had at least 80% of total enrollment in at least 37 states
    • In more than half of these states, a single insurer had more than 50% total enrollees
    • In 5 of these states at least one segment in which largest insurer >90% enrollees
Figure 2: The Number of States Where the Enrollment Share for the Top Three Insurers Was at Least 80 Percent, by Market Segment 2010-2013

**Individual**
- States where top 3 insurers' share was at least 80 percent
- Total number of states reviewed: 50

**Small group**
- States where top 3 insurers' share was at least 80 percent
- Total number of states reviewed: 50

**Large group**
- States where top 3 insurers' share was at least 80 percent
- Total number of states reviewed: 50
Health Insurers
• New company: 33M members and 2015 revenue of $115B
• Louisville-based Humana began as a single nursing home in 1961, is now the 2nd largest player in Medicare Advantage
  • Medicare’s private managed-care option – enrollment 3x in past decade
  • Will continue to grow with surge of baby boomers entering Medicare
  • Deal gives Aetna access to tech and ancillary services acquired/developed by Humana to manage cost/quality of care for chronically ill Medicare beneficiaries
• Humana is now the most widely available Medicare Advantage option nationally

• The combined company would have 4.34M Advantage members with the addition of Humana’s 3.2M enrollees
Diversified Revenue Base

**aetna**

- Commercial Risk: 13%
- Medicare: 12%
- Medicaid: 26%
- ASC and Other: 49%

2015E Revenue: $61 billion

**Humana**

- Commercial Risk: 4%
- Medicare: 6%
- Medicaid: 18%
- ASC and Other: 72%

2015E Revenue: $54 billion

**aetna + Humana**

- Commercial Risk: 9%
- Medicare: 34%
- Medicaid: 47%
- ASC and Other: 10%

2015E Combined Revenue: $115 billion
A Leading Government Platform

Medicare Advantage Members
- aetna: 4.4M (1)
- aetna + Humana: 1.2M (#4)

Medicare PDP Members (stand alone)
- aetna: 5.8M (1)
- aetna + Humana: 1.4M (#6)

Medicaid Members
- aetna: 2.1M (#6)
- aetna + Humana: 2.4M (#5)

Membership figures as of March 31, 2015
33 states as Medicaid MCO
28 Medicare Advantage Markets
44 states as Medicaid MCO
44 Medicare Advantage Markets
Medicare Advantage Enrollment, by Firm or Affiliate, 2015

- UnitedHealthCare: 20%
- Humana: 19%
- BCBS: 16%
- Kaiser Permanente: 8%
- Aetna: 7%
- Cigna: 3%
- Other national insurers: 3%
- All other insurers: 23%

Total Medicare Advantage Enrollment, 2015 = 16.8 Million
“Medicare Advantage is a very important part of our business because it encourages competition, value-based reimbursement and looking at individual members holistically. It’s a perfect example of where the consumer is making the choice. Providers are incentivized around quality and cost, and that forces integration.”

Bruce Broussard
Humana CEO
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Bruce Broussard
Humana CEO
“The proposed $37 billion merger between rival health insurers Aetna Inc. and Humana Inc. would pose a substantial threat to competition within the health insurance marketplace, particularly its fast-growing Medicare Advantage segment.”

Melinda Reid Hatton
Senior VP and General Counsel
American Hospital Association (AHA)
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Melinda Reid Hatton
Senior VP and General Counsel
American Hospital Association (AHA)
• New company: 56M members and revenue in excess of $115B
• At the heart of the merger is Anthem’s desire to expand their government business, particularly in the Medicare Advantage market
• The combined company would have 1.1M Advantage members (well behind Aetna/Humana’s 4.34M)
• Long term strategy to build its Medicare business through the biggest strength of Anthem and Cigna – their large employer-group business
  • More than 80% of revenue will come from commercial contracts with employers across the country
  • Anthem’s goal: retain their massive pool of workers and their families aging into Medicare
Health Insurer M&A

• How do Health Insurer mergers affect you?
  • Narrower provider networks
    • Response to rising costs
    • Narrowing of physician network now, but same model applies to other networks
      • Home health, DME, custom rehab
      • Narrowing of networks contributes to decrease in patient satisfaction
  • Health Insurers looking to drive costs down
    • What does that do with your rates?
Health Insurer M&A

Mergers won’t stop:

• AHA is fighting Health Insurer mergers, but what are Health Systems doing themselves?
  • They’re following the same M&A trend as Health Insurers
• ACA didn’t initiate this trend, but its policies have certainly ignited it
Health Systems
Health System M&A

Addressing the Costs of Providing Care

• Health Care spending per capita in U.S. 2X other developed countries
  • $2.8 trillion in 2013

• Increasing pressure to contain health care costs and demonstrate value
  • Medicare FFS payments being replaced with emphasis on pay for quality
  • Physicians see more patients - aging population & greater access to the newly insured
  • More patients will be covered through managed care plans
    • narrow networks and value-based payment approaches
  • More patients get coverage through Medicaid (pays less than commercial) and through exchanges
Health System M&A

Adapting to a Realigned Market

- 8 million enrolled in Health Insurance Exchanges (HIXs) during initial 2013-2014 enrollment period
- Estimated totals to hit 16M in 2015 and 25M in 2016
  - 65% selected Silver plan, 20% Bronze (low premiums/high deductibles)
  - Narrow provider networks
- Providers will need to adapt to realignment
  - Smaller players in danger of exclusion from more narrow networks
  - Market-dominant players likely immune from exclusion; can negotiate from a position of strength
  - Dominance comes from being big, which is driving sector consolidation
Health System M&A

Transitioning to Value-Based Care

- Evolution from volume- to value-based care (VBC) is under way
  - Widespread efforts to control & reduce costs
  - Need to improve outcomes
  - Obtain more value for money spent
Health System M&A

Large Systems vs. Community Hospitals

• How well they fare in realigned market depends on their place in the healthcare hierarchy

• Centers of Excellence will continue to proliferate
  • Health systems focusing on children, cancer, hearts, and joints

• Consumers will abandon Community Hospitals
  • If they can’t deliver similar outcomes to Centers of Excellence or large systems, consumers will go elsewhere
Health System M&A

Achieving Scale

• We’re in a period of rapid consolidation among health care providers
• Hospital deal volume increased 14% per year from 2009-2013
  • Regulatory changes, technological innovations, financial pressures, and market dynamics
  • Physicians rapidly moving from private practice to an employed model
  • *Vertical* (physician practices, ambulatory centers, diagnostic centers, home care services, and *DME companies*) and *Horizontal* (hospital acquiring hospital) consolidation happening
Health System M&A

Trends as they pertain to DME

• Reduction of readmissions
  • What are you doing to help ensure that that COPD patient is not readmitted within 30 days of discharge?

• Continuum of Care
  • Work with non-acute entities to help with the continuum of care
    • Home health, outpatient rehab, physician groups, transportation

• Outcomes programs
  • What are you doing for outcomes? Do you provide patient education on COPD? (Breathing techniques, medication management, nutritional, etc...something they can refer back to.)
Health System M&A

Trends as they pertain to DME

• Follow Up Program Imperative
  • Having a follow up program is a must
  • Determine if automated or manual, frequency of contacts
  • Determine what you’re measuring
    • Compliance, patient satisfaction, readmissions, patient well-being

• Data – Collect it and *USE* it
  • Use your data to prove your worth...your value
  • Are you compiling reports for your health system? For physicians? For Payers? Non-Acute entities?
If you’re not showing your **value** as more than just a DME provider, you’ll be *narrowed* out.
How Far Will Health System Consolidation Go?
After consolidation in the next decade,

50% of current health systems will remain.
Managed Medicaid and Medicare
Managed Care Organizations (MCO’s)

- Managed Medicaid by the numbers
- 46M enrollees
- 39 states using private plans
- 267 MCO’s
- $123.6B in Medicaid managed-care spending
Total Medicare Private Health Plan Enrollment, 1999-2015

In millions:

<table>
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<th>Year</th>
<th>Enrollment (in millions)</th>
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<td>2015</td>
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% of Medicare Beneficiaries:

- 1999: 18%
- 2000: 17%
- 2001: 15%
- 2002: 14%
- 2003: 13%
- 2004: 13%
- 2005: 13%
- 2006: 16%
- 2007: 19%
- 2008: 22%
- 2009: 23%
- 2010: 24%
- 2011: 25%
- 2012: 27%
- 2013: 28%
- 2014: 30%
- 2015: 31%
Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2015

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: Authors’ analysis of CMS State/County Market Penetration Files, 2015.
Managed Care Organizations (MCO’s)

**Trends**

- Government Regulation
  - Bigger industry = Bigger government
- State programs to Private plans
- Bundled Payments
- Volume-based to Value-based
Accountable Care Organizations (ACO’s)

• One of Obama administration’s most promising reforms in 2010 health care law

• CMS incentivizes ACO’s to form through lure of bonuses
  • Low risk/low reward – low bonus levels, no financial punishment
  • High risk/high reward options – higher bonus levels, financial responsibility

• Medicare’s projected savings for 2014:
  • Between $10 million and $320 million
Accountable Care Organizations (ACO’s)

2014 Results
• 7% of the 353 ACO’s chose high risk/high reward option
• 196 saved Medicare money
• 157 cost Medicare more than anticipated
• Medicare paid out bonuses to 97
• 3 had to repay Medicare
• 2014 ACO program results = net loss of nearly $3 million
Accountable Care Organizations (ACO’s)

Challenges

• Tough decision for Gov’t to make potential of repayments mandatory
  • Many ACO’s would drop out and new ones wouldn’t join
  • If most continue with no risk of financial repercussions, there’s less incentive to save Gov’t money

• Start-up companies don’t make profits in early years
  • Adding Gov’t risk doesn’t help

• Savings expectations based on national spending averages
What’s VGM Doing?
VGM

• Looking for additional ways to be of help to members
  • Audit assistance through The Van Halem Group
  • Retail assistance through expansion of services and addition of Jim Greatorex
  • Market Data

• Continuing to get more creative with manufacturer relationships
  • Help with challenge of lower reimbursements
U.S. Rehab

• Functional Mobility Assessment (FMA)
  • Provider-focused evidence-based outcomes tool for mobility developed by Drs. Schmeler and Holm with University of Pittsburgh
  • Exclusive license agreement with University of Pittsburgh
  • U.S. Rehab pilot study with group of members currently that will be expanded to entire membership in 2016
• Goals of FMA
  1. Provide CRT industry with measureable data to improve outcomes
  2. Prove worth (value) of the ATP industry
  3. Provide qualitative & quantitative data on CRT to payer sources
OPGA

• Helping DME providers diversify into O&P
• Working with manufacturers to provide good/better/best bundling
• Working with University of Pittsburgh on FMA
  • Define quality of care to quantify value of OPGA members to distinguish themselves from non-licensed providers
• Much closer tie with Government Affairs
  • Use of VGM Government Affairs department
  • Externally working with CMS, HHS, SBA, VA, DOD, and divisions within each
Homelink

- Driving business to VGM members through access to larger networks
- Significant investments in efficiencies
- Simplifying the billing process for quicker payment
- Pursuing opportunities to grow in specialty areas
What Can You Do?
Key Takeaways

1. 3rd Party payers are consolidating
2. Medicare Advantage plans are popping up left and right, leaving traditional Medicare plans
3. To be part of the payer mix, you need to look at different ways to be part of networks
4. Reimbursements are not going up
What can you do?

• Evaluate where you’re at with Government plans
  • Platinum payer mix as % of total gross revenue
    • 46% Government with 20% Medicare, 18% Medicaid, 8% Medicare Advantage
      • (32% commercial, 14% patient pay, 8% other
  • U.S. Rehab payer mix as % of total gross revenue
    • 54% Government with 24% Medicare, 23% Medicaid, 6% Medicare Advantage
      • 26% commercial, 12% patient pay, 9% other
What can you do?

• Specialize/Find new areas
  • Caretailing
• Work with non-acute entities to help with the continuum of care
• Utilize a follow-up program
• Provide data to key partners
What can you do?

• Capture Medicaid dollars
  • Get on the Medicaid HMO panel
  • Invasive mechanical ventilation
  • Apnia monitors
  • Pediatrics

• Stay current
  • Industry news – HME News, Modern Healthcare, Healthcare Dive
  • Industry experts – Joe Paduda
  • Twitter - @healthcaredive, @modrnhealthcr, @paduda, @VGMGroupInc, @hmeliz
What can you do?

• Seek VGM expertise

• Connect with your VGM rep to ensure your records are up-to-date
  • Keeping profile updates helps with web referrals
    • Contact information, locations, product mix
    • Are you the best contact for web referrals?

• Be proactive with Homelink
  • Helps referral volume, referral type
  • 200 Patient Care Coordinators, 1 VP of Provider Relations
  • Sign up for ERA/EFT
  • Backdoor Referrals
Craig Douglas  
VP of Provider Relations  
877-218-2825  
craig.douglas@vgm.com
Optimistically Bright
## Thoughts on the Future

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