

Strategies in Capital Finance

V o l u m e 5 6

FAREWELL TO A TIME OF PLENTY?

**Health Plan Strategies for Growth in a
More Challenging Market**

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EXECUTIVE SUMMARY

Health plans are emerging from an exceptionally good seven-year run of managed care growth and financial performance that has generated significant capital for both for-profit and nonprofit health plans. The strong economic results over the last seven years have built up sizeable reserves, particularly among the nonprofit Blues, which are being drawn down via more aggressive price competition (and therefore reduced margins). Commercial sector margins and membership growth rates are under pressure. The Medicare sector, which has been the source of significant recent growth, is quite likely to face reimbursement reductions, although it still represents an opportunity for membership growth. And the Medicaid sector will be influenced by potential, but uncertain, government health reform initiatives to extend coverage for the uninsured and shift portions of the remaining fee-for-service enrollment into managed care products. The political environment will be an increasingly meaningful factor in the next few years, especially for government focused entities as the results of the 2008 national elections impact the likelihood of market opportunities in Medicare and Medicaid.

Strong cash generation during the past seven years, attractive valuations of acquirers, and access to debt has fueled an active M&A market, resulting in significant consolidation. However, we expect transaction volume and valuations to moderate, as there are simply fewer plans available for consolidation, and debt markets have become less favorable subsequent to the credit crunch of the summer of 2007. Mid-sized transactions of \$50-\$500 million will likely be the norm with buyers focusing on filling out product line and technology capabilities and expanding intra-regionally as opposed to pursuing pure in-market “book of business” consolidation.

We expect the more consolidated market to reward scale plans that can adjust their strategies to take advantage of the opportunities this environment will present. Health plans will need to focus more closely than in the past on excellence in care management and operations execution for sustained competitive differentiation. We have identified four strategic priorities that respond to the challenges arising from the current market environment:

- Enhance and integrate care management,
- Grow and build out market capabilities in the individual/non-group sector,
- Build products with transparency and consumer engagement, and
- Increase scale and/or competitive differentiation in an increasingly consolidated market.

INTRODUCTION: GLASS HALF FULL OR HALF EMPTY?

Historically, in the typical underwriting cycle, health plans have experienced two- to three-year periods of growth and positive financial performance that have often been followed by several years of financial challenge. In contrast, health plans are now emerging from an exceptionally good seven-year run of managed care growth and financial performance. This extended “up” period has generated significant capital for both for-profit and nonprofit health plans. Investors in public companies have experienced significant increases in shareholder value, and nonprofit Blues plans have accumulated balance sheets that are bursting at the seams.

Some industry observers caution that these positive trends will not continue. Growth through acquisition may be challenging, because aggressive consolidation over the last few years now leaves fewer high quality regional plans to acquire. The huge Medicare Part D revenue growth experienced over the past few years is effectively over, as there are now more than 25 million seniors enrolled in Part D Medicare plans, and 38 million seniors now have prescription drug coverage.¹ More fundamentally, a recent credible analysis by The Medicare Payment Advisory Commission (MedPAC) shows Medicare Advantage plans are receiving a 12% “subsidy,”² and this and other similar studies are likely to add to Congressional pressures to mandate Medicare Advantage pricing cuts. Premium increases in the commercial sector will be under pressure while publicly traded health plans and, in particular, the Blues “spend down” built up reserves in a market where overall membership is not growing. A Democratic Congress, which has historically been less-than-supportive of the managed care industry, may also prove even less friendly in a national election environment where health care is among the top two or three domestic policy issues. Together, these factors describe the future health plan glass as half empty.

Others point to indicators that suggest in the near term the health plan glass is half full. The sustained positive financial performance of the large health plans during this decade has been longer and stronger than the up and down fluctuations usually experienced in the classic health insurance underwriting cycle. Many believe that the underwriting cycle has been permanently muted as a result of risk-based capital requirements having been adopted in a majority of states and consolidation having taken weaker, less disciplined plans out of the market. Opportunities for growth in revenue and membership include Medicare managed care in such areas as chronic special needs plans and reimbursement expansion proposals for uninsureds through programs such as S-CHIP. Revenue growth opportunities also include managed care initiatives for Medicare-Medicaid dually eligible as well as aged, blind, and disabled (ABD) persons. Opportunities for margin preservation or expansion are also available through improved cost management such as through greater generic drug substitution, with patents relating to 5% of drug spending expiring in 2007 and 2008, better predictive modeling tools, and second generation disease management programs that may permit improvements in both cost and quality management of high cost cases.

...we believe that successful companies will be those that do an excellent job in product innovation, care management, and operational execution.

Despite the challenges facing the industry, we continue to see the glass as more than half full for the near term, but we believe the “all boats rise” market of recent years is likely to be replaced by one in which companies will need to work harder to compete successfully than in the past. In particular, we believe that successful companies will be those that do an excellent job in product innovation, care management, and operational execution. Those that can successfully differentiate themselves in a more competitive environment will have opportunities for growth.

As health plans and specialty companies pursue these strategic objectives, we expect the M&A market will also be positive during the next two years, but less so than in recent years. Valuations driven in the past by excess private equity cash and “cheap debt” are correcting back to historical levels. Successful companies, however, will selectively pursue acquisitions that create administrative efficiency, geographic and product breadth, and new products that meet the needs of the market. The results of the forthcoming 2008 national elections and subsequent political environment will inevitably change the particular market opportunities available for health plans. The

¹ Enrollment in Medicare plans from CMS as of April 7, 2007. Seniors with prescription drug coverage from Mike Leavitt, “Secretary’s Progress Report IV on the Medicare Prescription Drug Benefit,” Department of Health and Human Services (June 14, 2006).

² “MedPAC Report to the Congress: Promoting Greater Efficiency in Medicare” (June 2007) Table 3-1.

Medicaid sector and programs to expand coverage for the uninsured might be positively impacted in the event of a Democratic victory, but Medicare privatization could be constrained by a Democratic victory. If Republicans hold the White House, the reverse might be expected.

In this *Strategies in Capital Finance* white paper we examine the factors driving this more challenging managed care market. We identify four strategic managed care priorities for health plans to respond to these market dynamics and their implications for M&A.

HEALTH PLAN MARKET SUMMARY

U.S. HEALTH BENEFIT MARKET

The health plan sector has shown remarkable strength during this decade. Figure 1 shows returns and equity prices of publicly held plans since January 2000 and illustrates the impressive and sustained positives in this industry over this time period. We believe it is now, however, time to reassess market positions and strategies in light of underlying market trends that will be discussed below.

Figure 1. Extraordinary Seven-Year Run for Public Managed Care Plans

	2000	2001	2002	2003	2004	2005	2006	12 Months Ended 9/30/07
Publicly Traded MCOs								
Pre-Tax Margin	3.3%	4.2%	5.5%	6.8%	7.7%	8.3%	8.3%	7.8%
Net Margin	1.9%	2.7%	3.6%	4.3%	4.9%	5.3%	5.5%	5.2%
Return on Assets	4.3%	5.3%	6.4%	7.6%	8.0%	7.5%	8.2%	7.1%
Return on Equity	16.5%	19.4%	21.7%	25.4%	25.5%	20.1%	20.7%	19.5%

Managed Care vs. S&P 500
January 3, 2000 – December 31, 2007

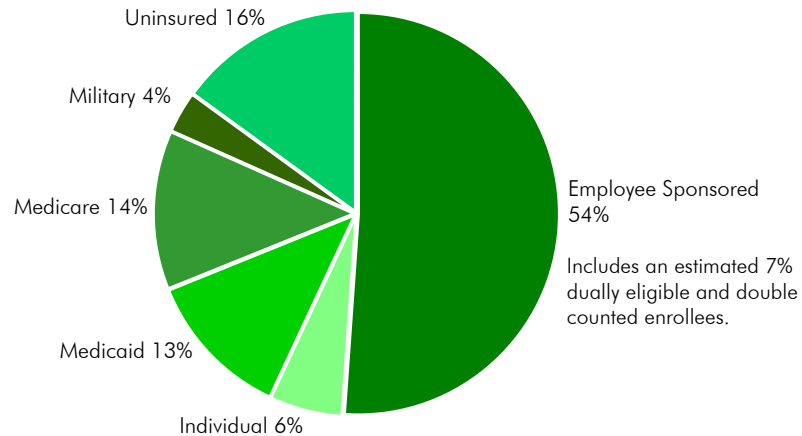


Normalized for extraordinary items.
Market cap weighted. Managed care stocks include Aetna, AMERIGROUP, Centene, CIGNA, Coventry, Health Net, HealthSpring, Humana, Molina, Sierra Health, UnitedHealth, Universal American, WellCare, and WellPoint.

Source: Company Documents and Capital IQ.

Figure 2 shows the type of health coverage for U.S. residents. In the last few years, there has been a decrease in employer sponsorship, some increase in individual coverage, but also a growing number of uninsured. Overall Medicare enrollment has held steady recently, but is expected to grow significantly over the next decades as the elderly grow from 13% to 17% of total population in 2020³ due to the aging of the baby boomer generation.

FIGURE 2. U.S. Health Benefit Coverage by Type of Health Coverage



Source: 2006 U.S. Census Bureau, Employee Benefit Research Institute, and Cain Brothers Analysis.

We consider trends within the commercial, Medicare, and Medicaid sectors individually below.

COMMERCIAL

In 2006, there were 180 million people under the age of 65 covered by private health insurance, with 164 million covered by employer-sponsored plans and 17 million by individually purchased plans.⁴ However, the commercial market is mature and shrinking, employer sponsorship of health benefits is decreasing, and retiree enrollment is declining as employers withdraw from sponsorship of (expensive) retiree health insurance. Six trends within the commercial market sector are described below:

■ Decline in Employment-Based Coverage Continues

While most non-elderly U.S. residents continue to be covered by health insurance offered by their employers, the percent of employers offering health coverage has declined from 69% in 2000 to 60% in 2007.⁵ Figure 3 shows that there has been a similar decline in the portion of the non-elderly U.S. population covered by employer-sponsored health coverage. Reasons contributing to this trend include the rising costs of health coverage, employment downsizing in industries with strong employment-based health coverage, growth in the number of early retirees who are not yet eligible for Medicare, workforce shift from large to small employers, workforce shift away from

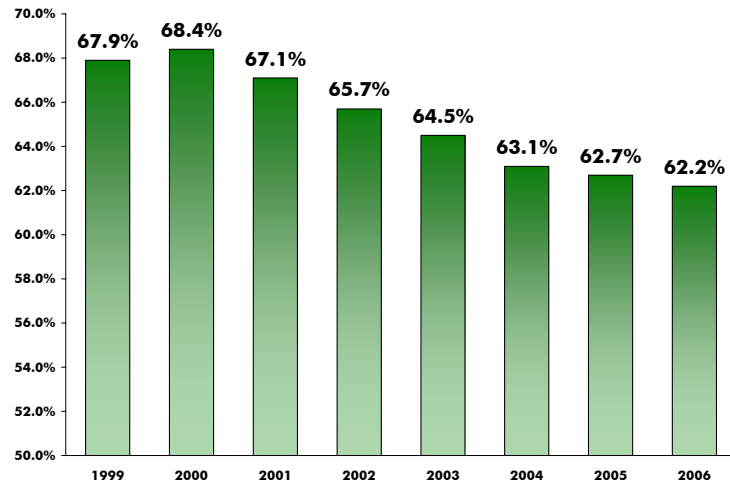
³ U.S. Census Projections.

⁴ Carmen DeNavas-Walt, Bernadette Proctor, and Jessica Smith, U.S. Census Bureau, Current Population Reports, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, U.S. Government Printing Office, Washington, DC, (August 2007): 63. (Note: The estimates of type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.)

⁵ Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits Annual Survey," (2007) : 32.

manufacturing to the service and retail sectors, and an increasing immigrant population. While some of the decline in employment-based coverage was picked up by public payors during the first years of the decade, more recently, the decline has resulted in growth in the number of uninsured.

FIGURE 3. Percentage of Non-Elderly Population with Employment-Based Health Coverage



Source: Employee Benefit Research Institute, Issue Brief No. 310 (October 2007) Figure 1.

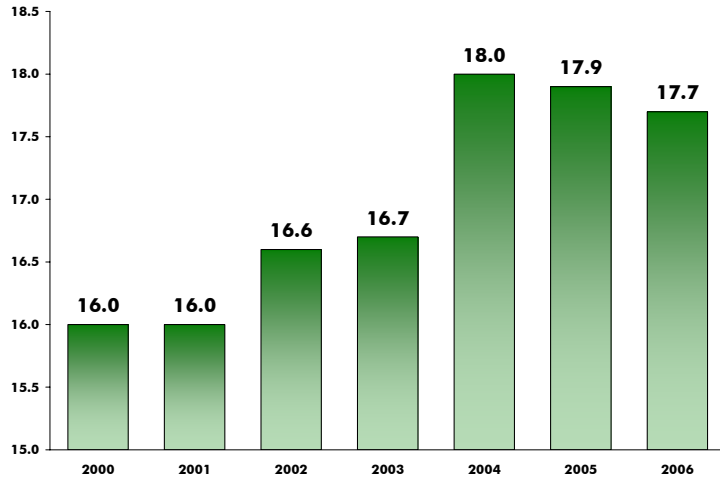
■ Individual/Non-Group Insurance Stable Recently, But Expected to Grow

Some of those no longer covered by employer-sponsored health benefits now purchase health coverage in the individual/non-group market. The individual market has increased from 6.5% of the non-elderly population in 2000 to 6.8% in 2006.⁶ Figure 4 shows that the number of non-elderly enrollees in individual coverage has increased from 16.0 million in 2000 to 17.7 million in 2006. Despite its stability in recently reported years, many industry watchers expect the individual market to grow as employer sponsorship of benefits continue to decrease, baby boomers without employer-sponsored health benefits take early retirement and purchase health insurance to “bridge” them to Medicare, and states such as Massachusetts turn to mandated coverage through individually purchased plans. Changes in the tax code to remove the current incentive for employer-sponsored coverage have been proposed by President Bush and have been supported by several Republican presidential candidates. If enacted in some form over the coming years, these proposals could substantially increase the size of the individual market.⁷

⁶ Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey,” *Employee Benefit Research Institute Issue Brief*, (October 2007): 5.

⁷ See, for example, Citigroup Global Markets Equity Research, “Health Insurance: Our Analysis of the Individual Market Opportunity,” *Citigroup Industry In-Depth* (September 13, 2007).

FIGURE 4. U.S. Number of Non-Elderly Enrollees in Individually Purchased Commercial Health Insurance (in millions)

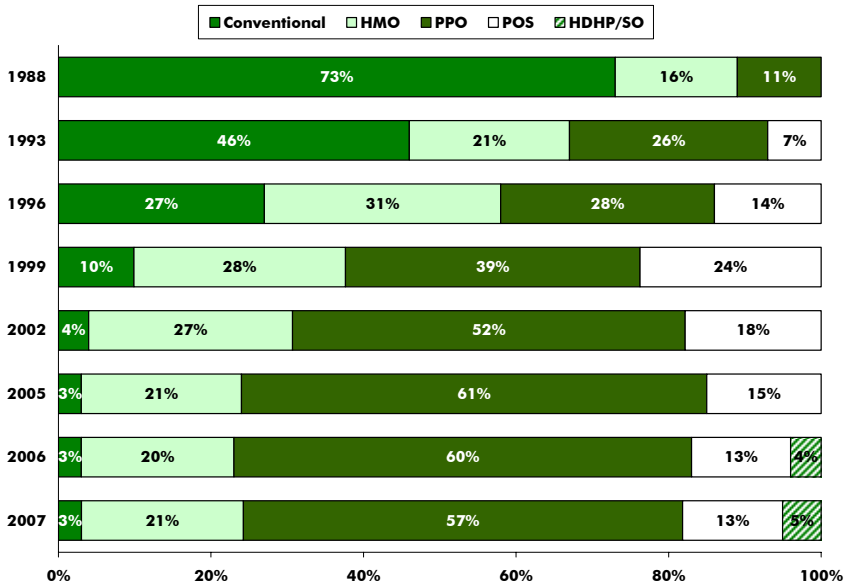


Source: Employee Benefit Research Institute, Issue Brief No. 310 (October 2007) Figure 1.

■ PPOs Predominate with HMOs Diminished, But Holding Steady

Figure 5 illustrates the significant changes that have taken place in employer-sponsored health plans over the last 19 years, with indemnity (conventional) health insurance dwindling to a very small percentage by 2002. HMO coverage grew most rapidly to replace indemnity through 1996 and then began to shrink. Preferred Provider Organizations (PPOs) and Point of Service (POS) plans have become the mainstay over the past three years, and HMO plans have held steady at about a 20% market share. High Deductible Health Plans with Savings Option (HDHP/SO) plans were first reported in the Kaiser/HRET survey in 2006 and now are 5% of the enrollment.

FIGURE 5. Distribution of Health Plan Enrollment for Employer-Sponsored Health Plans by Plan Type, 1988-2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, September 11, 2007.

■ **Risk Business Is Declining, Less Profitable ASO Business Is Growing, and Margins Are Softening**

Commercial health plans are also seeing a shift away from risk-based contracts towards Administrative Services Only (ASO) contracts, where large employers bear the risk for health expenditures. In ASO contracts, health plans do not take risk and only administer the health program, including claims payment, on a contractual basis. A Lehman Brothers analysis estimates that, between 2001 and the Second Quarter of 2007, overall commercial membership among the group of large publicly traded companies it follows went up by 5.3 million members. That overall increase in commercial members, however, contained a material shift from risk business to ASO business as total ASO increased by 10.5 million members, and risk membership decreased by 5.2 million.⁸

Commercial ASO growth...is really a “rob Peter to pay Paul” story, when higher priced, fully insured commercial accounts convert to self funding.

ASO, or self-funded business, can be profitable and is not subject to underwriting cycles or unilateral government premium cuts. At the same time, because it is essentially a transaction processing product, the revenue and margin upside is materially lower on a gross dollars basis than risk business, and the business is highly competitive with firms like UnitedHealth, CIGNA, WellPoint, Aetna, and regional Blues plans competing aggressively for large ASO accounts. Some growth is likely in the ASO portion of the commercial market, but it is really a “rob Peter to pay Paul” story, when higher priced, fully insured commercial accounts convert to self funding.

Commercial sector margins are now decreasing. The only real source of recent commercial membership growth has been this “share shift” to ASO business, with its inherent lower profitability. With healthy balance sheets from the aforementioned strong multi-year run, some of the commercial sector margin softness also results from large nonprofit health plans limiting premium increases via a purposeful spend-down of reserves, effectively sharing past years’ gains with current policy holders.

■ **Consumer Directed Products are Growing, But More Slowly than Many Had Anticipated**

Federal legislation has supported the development of high deductible health savings accounts (HDHP HSAs), often more broadly called consumer directed health plans (CDHPs). These portable, tax-advantaged plans linked to savings and investment accounts expose consumers in substantial ways to the health care choices they make. Annual deductibles in these plans are at least \$1,100 per individual and \$2,200 per family, and are often higher. There has been good year-over-year growth in HDHP HSA enrollment as shown in Figure 6, but the membership is still only 1.5% of overall U.S. population. Health Reimbursement Accounts (HRAs) offer a similar approach to benefits, anchored by a personal spending account. HRAs are also linked with HDHPs but do not offer the savings and portability benefits of HDHP HSAs. HDHP HSA enrollment grew from 1.3 million in 2006 to 1.9 million in 2007.⁹

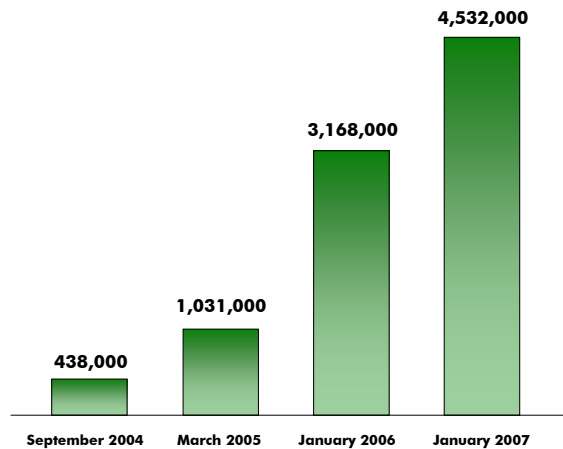
Many in the marketplace add Flexible Spending Accounts (FSAs) to the category of consumer directed health plans. FSAs are employer-sponsored plans that allow employees to set aside a portion of their earnings in an account to be used to cover medical expenses without those earnings being subject to payroll taxes. FSAs have been used most often to help employees with medical services not covered by

⁸ Joshua Raskin, “Managed Care 2Q07: A Calm Second Quarter?” Lehman Brothers Managed Care (August 22, 2007): 6.

⁹ The Kaiser Family Foundation and Health Research & Educational Trust, “Survey of Employer Health Benefits: 2007,” (September 11, 2007): Exhibit 10.

conventional health benefits, and they do not offer savings/portability benefits of HDHP HSAs.

FIGURE 6. HDHP HSA Enrollment



Source: America's Health Insurance Plans: January 2007 Census (April 2007) and "An Overview of Preliminary Market Research," (June 2006).

In our view, the primary and sustaining impact of the "consumerism" trend is greater transparency regarding the cost and quality of health care and greater engagement by consumers in their own health care decision making.

Some analysts have predicted continued rapid growth in CDHPs, but there have been recent indications that enrollment is likely to be more tempered in the near term. Lower overall health premium increases for 2008 are likely to retard strong CDHP growth, giving enrollees less incentive to switch to these products. Further, it is still not clear whether CDHPs will appeal to lower income enrollees. Early experience is that those selecting CDHPs and related HSAs tend to have higher incomes than those covered by traditional plans, with 51% reporting an adjusted gross income greater than \$75,000 per year.¹⁰ Slow enrollment growth may also be partially based on low satisfaction thus far by consumers. A September 2006 Hewitt survey showed that only 30% of HSA enrollees understood and were satisfied with their health coverage, and 48% said they would not re-enroll next year.¹¹

Hewitt research also finds, however, that these plans are gaining traction with employers as a way to control costs. Over 20% of companies offer, or plan to offer, a CDHP by the end of this year, and almost half are considering offering one at a future date.¹² Other analysts see a restructuring of the industry for consumers as inevitable. For example, Goldman Sachs estimates that the number of lives covered by consumer-directed health plans will grow from under 4 million in 2005 to 49 million by 2010.¹³

In our view, the primary and sustaining impact of the "consumerism" trend is greater transparency regarding the cost and quality of health care and greater engagement by consumers in their own health care decision making. We believe this trend will impact the industry in profound ways, whether there are 49 million or 4 million people enrolled in specifically defined CDHP products during the next few years.

¹⁰ GAO, "Health Savings Accounts: Early Enrollee Experiences with Accounts and Eligible Health Plans," Statement of John E. Dicken, Testimony Before the Subcommittee on Health Care, Committee on Finance, U.S. Senate (September 26, 2006): 6.

¹¹ "Hewitt Survey Finds Employees Struggling to Effectively Manage Their Health Care," Press Release (September 9, 2006).

¹² "Hewitt Associates Data Reveals Rate of Increases for U.S. Health Care Costs Declines for Fifth Consecutive Year," Press Release (September 24, 2007).

¹³ "Diamond/Goldman Sachs Symposium Finds Consumerism, Technology Reshaping U.S. Health Care System in Unexpected Ways," Press Release (October 13, 2007).

Many industry analysts believe that competitive differentiation based largely on proprietary approaches to discounts and reimbursement, care management, network participation, and quality improvement are giving way to a much greater emphasis on cost and care transparency and differentiation on overall value and service. For example, the recent New York Attorney General settlements with CIGNA, Aetna, UnitedHealth, Empire BCBS, and Group Health will bring increased transparency to the process of physician rankings and the weight given to physician costs in pay for performance models. Fifty large employers through the HR Policy Association have brought increased transparency to pharmaceutical benefit management by a codified set of pharmaceutical purchasing principles.

Consumer engagement in health care decision making is not singularly produced by cost sharing or plan benefit design. It is also facilitated by access to easy-to-understand clinical information and supportive health coaches. There has been dramatic growth in “shared decision making” and care management models that focus on preference-sensitive conditions in which the consumers of services much more actively manage their own treatment decisions. The market has begun to adopt, and will increasingly incorporate, a shift in how health benefit services are delivered, with a growing competitively differentiating emphasis on transparency and multi-faceted consumer engagement. We believe these trends will continue regardless of the pace of growth of specific CDHP products.

■ Market Share Shifts to Large Nonprofits and Mutuals

Overall the commercial market has seen a shift towards large nonprofits.

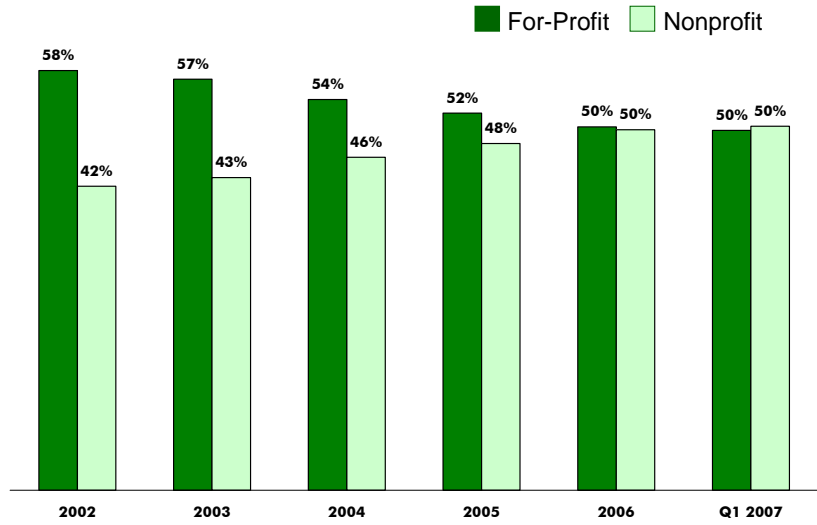
Overall the commercial market has seen a shift towards large nonprofits as shown in Figure 7. Eight of the top ten largest commercial insured membership gains in 2006 were by Blue Cross Blue Shield (BCBS) plans.¹⁴ BCBS plans make up approximately 31% of the U.S. health insurance market, with publicly held WellPoint at 12% and nonprofit and mutual BCBS plans at 19%. There are currently over 60 million enrollees in nonprofit BCBS plans. In 32 states, nonprofit BCBS plans hold a higher market share than all of the publicly held plans combined.¹⁵ These nonprofit plans still enjoy “best in market” provider discounts in most markets, and they generally have very strong balance sheets. The “Blue Card” program, whereby the 40 BCBS plans “combine” the networks within their respective local markets to create a powerful national network, permits companies with employees in multiples states to access the BCBS provider discounts in all U.S. markets, providing a BCBS based national account alternative to companies like UnitedHealth, Aetna, and CIGNA. In fact, the publicly owned for-profit managed care organizations’ organic enrollment growth from 2003 to 2007 was estimated at only 1.4%.¹⁶

¹⁴ “Managed Care Stat Check,” Bear Stearns Equity Research (July 2007): 16. Based on Highline Data LLC, National Association of Insurance Commissioners, state insurance departments, company reports, and Bear Stearns estimates.

¹⁵ “An In-Depth Look at Commercial Market Share,” Goldman Sachs Americas: Managed Care (August 27, 2007): 11.

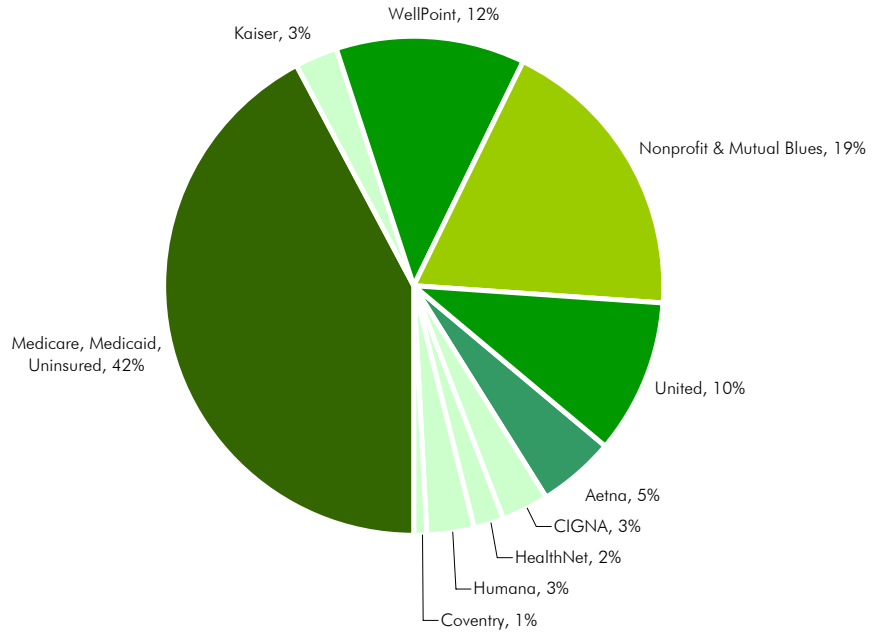
¹⁶ Lehman Brothers Global Equity Research, *2007 Managed Care Guidebook: A Complete Reference Guide for Investors*, (January 25, 2007): 15.

FIGURE 7. Commercial Share Shifts to Large Nonprofits



Source: "Managed Care Stat Check," Bear Stearns Equity Research (July 2007): 16. Based on Highline Data LLC, National Association of Insurance Commissioners State Insurance Departments, Company Reports and Bear Stearns estimates.

FIGURE 8. U.S. Health Benefits by Market Share (2006)



Source: Citigroup Investment Research, "Health Insurance: Our Analysis of the Individual Market Opportunity" (September 13, 2007) based on various company reports, Blue Cross Blue Shield, Kaiser Family Foundation, U.S. Census Data and Citigroup market research.

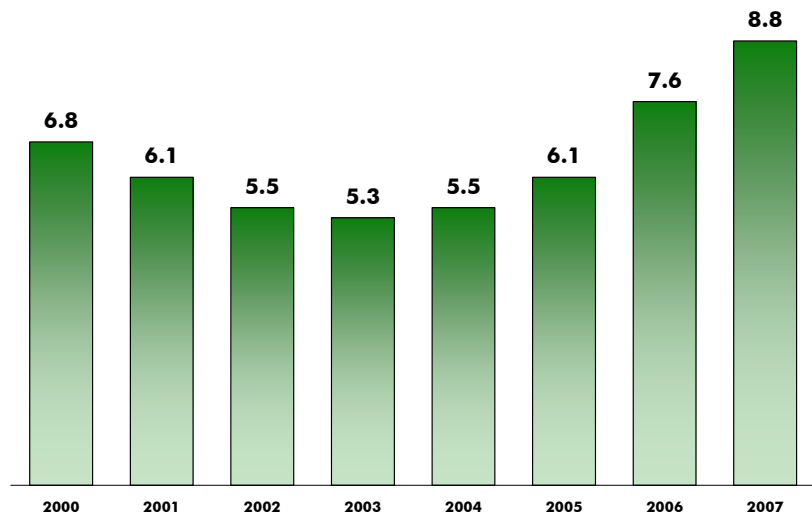
All of these trends have resulted in a market with a few publicly held companies and the BCBS plans holding large national market shares, as shown in Figure 8.

MEDICARE

Given the various pressures on the commercial sector, most of the revenue growth seen in the national managed care market the last few years has been from Medicare Advantage (the Medicare managed care program) and Medicare Part D prescription drug coverage. The stimulus of this growth was the passage of the Medicare Modernization Act (MMA) in December 2003. The number of Medicare Advantage enrollees had grown to 8.8 million as of October 2007, a compound annual growth rate of 13.5% from 2003, and the number of plans offering Medicare Advantage products has more than doubled since the passage of MMA to a total of 602 plans in 2007.¹⁷

Figure 9 illustrates the strong growth in Medicare Advantage enrollment, since the passage of MMA in 2003.

FIGURE 9. Medicare Advantage Enrollment (in millions)



Source: CMS, Kaiser Family Foundation, updated June 2007 and October 2007.

The economic implications of this growth can be seen in Figure 10, which provides a high level estimate of the amount of the monthly CMS payments and beneficiary premiums that have entered the managed care industry over the last few years. Cumulatively, the managed care industry has received over \$40 billion in new revenue associated with Medicare that is not associated with “share shift.” Most of this revenue can be attributed to the stimulus associated with MMA. This dramatic increase in revenue (and to a lesser extent enrollment) has provided much of the fuel for the strong financial results of much of the industry during the last three years.

¹⁷ Kaiser Family Foundation, *Medicare Advantage Fact Sheet* (June 2007).

FIGURE 10. Managed Care Industry Revenue Impact of Medicare Advantage

	2004	2005	2006	2007
Average Part A&B, PMPM	\$660	\$690	\$721	\$729
Average Part D, PMPM			67	62
Average Monthly Premiums	<u>20</u>	<u>18</u>	<u>22</u>	<u>17</u>
Total Premium	\$680	\$708	\$810	\$808
MA & MA Part D Enrollment (millions)	5.5	6.1	7.6	8.8
Annual Revenue (\$millions)	\$44,800	\$51,826	\$73,872	\$85,325
MA Industry Revenue Increase		\$6,946	\$22,046	\$11,453
Cumulative			\$28,992	\$40,445

Source: Cain Brothers estimates for illustration purposes based on CMS and Kaiser Family Foundation data.

The Medicare managed care market faces some headwinds.

The Medicare managed care market faces some headwinds, however. MedPAC and Commonwealth Fund findings confirm that there is a premium paid for all types of Medicare Advantage products versus conventional Medicare fee-for-service. For example, MedPAC found that in 2006, compared to Medicare fee-for-service, local HMOs were paid a 10% subsidy, local PPOs were paid a 17% subsidy, and private fee-for-service (PFFS) plans were paid a 19% subsidy.¹⁸ It is estimated that perpetuation of this subsidy will reduce the life of the Medicare Trust Fund by two years,¹⁹ and cutting the Medicare Advantage benchmark to 100% of fee-for-service would save \$149 billion over ten years.²⁰ Most experts believe that the dollar size of this impact means that some level of payment reduction is virtually inevitable.

The size of potential funding cuts is impossible to predict, but several analysts forecast payment reductions to Medicare Advantage plans in 2009 or 2010 of \$15-\$30 billion.²¹ Since most Medicare Advantage plans provide additional benefits beyond those of the Medicare fee-for-service program, funding cuts are likely to result in benefit reductions. If there were a cut of greater than \$30 billion, it would be difficult for Medicare Advantage plans to provide any differential benefits compared to Medicare fee-for-service and keep up with cost inflation, and profitability would be negatively impacted.

Another challenge facing plans in the Medicare sector is a growing concentration among large Medicare companies. Figure 11 illustrates that over half of the Medicare Advantage enrollees are covered by UnitedHealth, BCBS plans, Humana, or Kaiser. Humana and UnitedHealth, for example, have strategically committed to the Medicare line of business, believing that long-term viability and competitive advantage comes with the kind of scale that allows them to develop specialized medical management, marketing, and sales resources, as well as to develop risk adjustment expertise and invest in government relations.

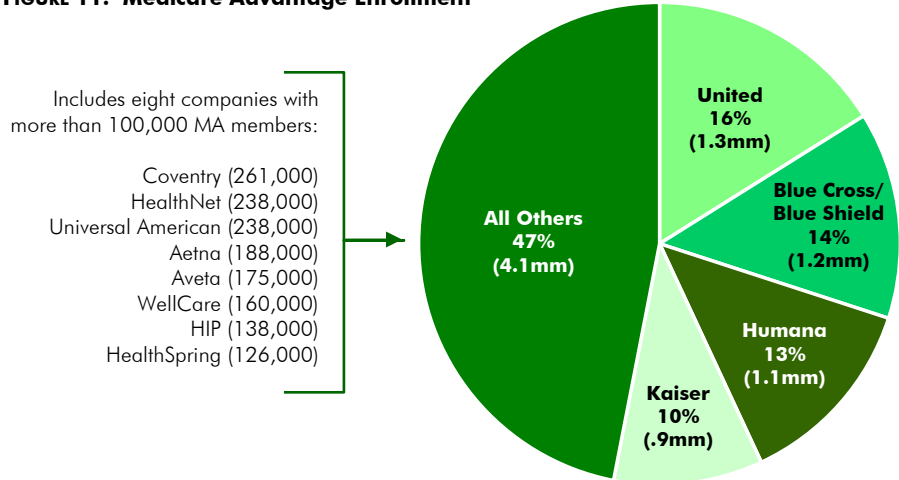
¹⁸ MedPAC, "Report to the Congress: Promoting Greater Efficiency in Medicare" (June 2007): Table 3-1. Also see: Brian Biles, Lauren Nicholas, Barbara Cooper, Emily Adrion, and Stuart Guterman, "The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised," *The Commonwealth Fund Issue Brief* (November 2006).

¹⁹ Kaiser Family Foundation, *Medicare Advantage Fact Sheet* (June 2007).

²⁰ Edwin Park and Robert Greenstein, "Private Plan Overpayments Weaken Medicare's Financing and Hasten the Program's Insolvency," CBO (April 20, 2007).

²¹ See for example: Credit Suisse Equity Research, "2Q07 Managed Care Earnings Preview: Medicare Advantage: The Great Debate of Fiscal '08" (July 12, 2007).

FIGURE 11. Medicare Advantage Enrollment

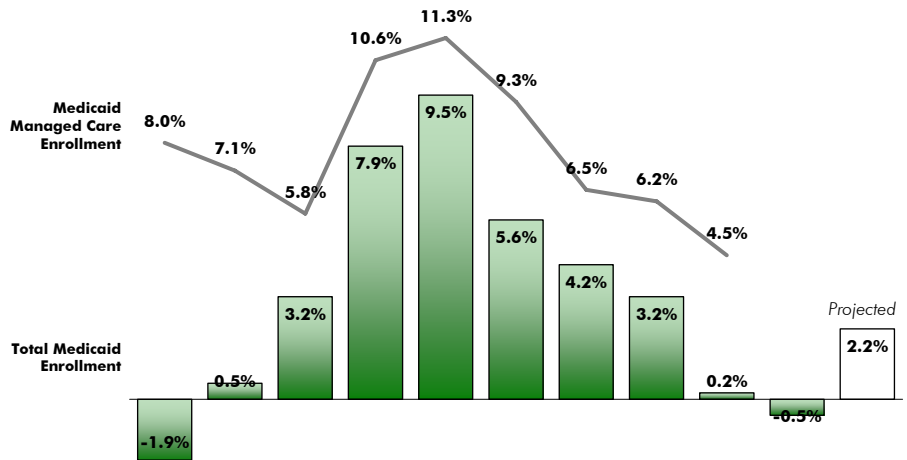


Source: Company filings, CMS as of September 2007. Market share data not adjusted for pending acquisitions.

MEDICAID

The Medicaid program provides health coverage to 46 million enrollees through traditional Medicaid programs run by the states and through a variety of managed care approaches administered by health plans. Figure 12 shows that since 2000 the patterns of growth in total Medicaid enrollment and growth in Medicaid managed care enrollment have been similar. While the growth rates in both increased through 2002 and the growth rates have been lower since then for both, Medicaid managed care has consistently grown at a higher rate.

FIGURE 12. Percentage Change in Medicaid Enrollment 1998-2008

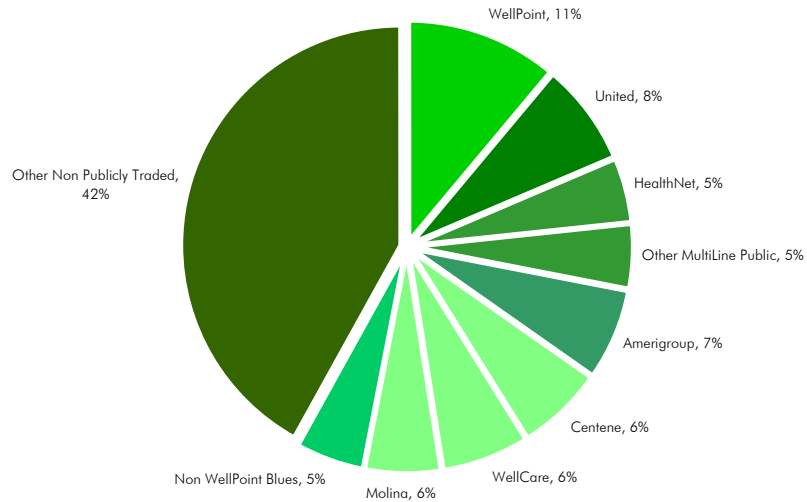


Source: CMS Medicaid Managed Care Enrollment Report as of June 30, 2006, for Managed Care Enrollment, Kaiser "As Tough Times Wane," report October 2007 for U.S. Medicaid Enrollment.

Over this period, states have moved an increasing number of enrollees to traditionally managed HMO plans in an attempt to control costs. As of December 2006, all but three states had at least one form of managed care for Medicaid enrollees, with two-thirds of managed care enrollees in a prepaid, risk-based HMO or a health insuring organization that provides for a comprehensive array of services. Additional near-term enrollment growth is projected via eligibility expansion; new access to managed care

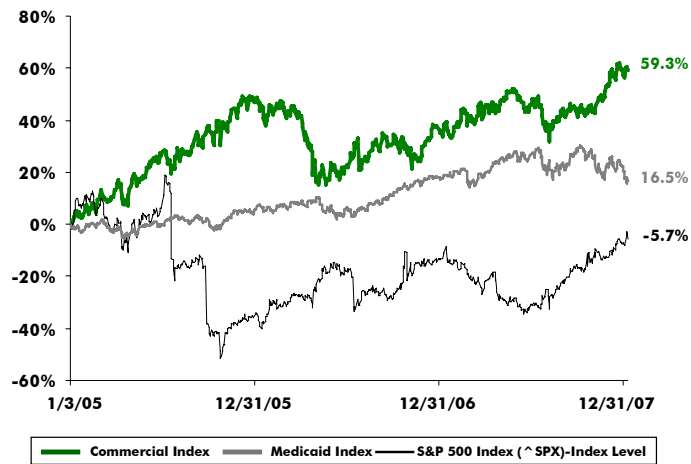
for aged, blind, and disabled populations; and states such as South Carolina mandating managed care for the first time. Sustained growth over the long term will be difficult, however, as managed care programs already address a significant majority of total Medicaid beneficiaries, which makes it unlikely that the dramatic growth seen in the early part of this decade can continue. Further, state procurements are likely to increasingly resemble the “share shift” process experienced in the commercial sector, putting pressure on margins.

FIGURE 13. 2006 Medicaid Market Share by Companies Having More Than 500,000 Enrollees.



Source: Lehman Brothers estimates, January 2007 and Cain Brothers Analysis.

The market rewarded Medicaid enrollment growth during the early part of the decade, but the stocks of companies specializing in Medicaid have performed relatively poorly compared to the rest of the publicly held managed care companies since 2005, as shown in Figure 14. Until recently, the Medicaid sector’s performance was led by WellCare, which is a publicly held company specializing in both Medicaid and Medicare managed care. WellCare’s market capitalization fell precipitously in October 2007, when the FBI unexpectedly visited the company’s offices and seized documents. Regulatory and legal risk is a significant factor for health plans operating in both the Medicaid and Medicare sectors. We have excluded WellCare from the Medicaid specialty index in this figure, because these events obscure the underlying performance of Medicaid-focused public companies.

FIGURE 14. Publicly Traded Medicaid HMO Stocks (excluding WellCare) vs. Commercial HMOs vs. S&P 500 (Jan 3, 2005 – Dec 31, 2007)

Commercial Index includes Aetna, CIGNA, Coventry, Health Net, Humana, Sierra Health, UnitedHealth, and WellPoint
 Medicaid Index includes AMERIGROUP, Centene, and Molina

Source: Capital IQ and Cain Brothers Analysis Market Cap Weighted

MANAGED CARE STRATEGIC PRIORITIES

A major characteristic of the managed care industry this decade has been consolidation. While M&A activity in 2006 was not as active as many analysts had expected, 2007 was active in all market segments. During 2007, high profile acquisition targets such as Sierra (UnitedHealth), Great-West (CIGNA) and Vista (Coventry) agreed to be acquired. The recent consolidation trend has been caused in large measure by larger plans seeking in-market and new market expansions, product expansion, and enhanced technology capabilities. Strong cash generation of the past seven years and its associated free capital has helped to fuel the trend, but the ability to execute some of the big acquisitions has been aided by aggressive use of the debt markets. For example, UnitedHealth announced it could move its leverage ratio from 28% to 40% as it took on \$1.6 billion in debt in November 2007 for share repurchases, repayment of existing debt, and to fund acquisitions.

While some of the market conditions driving M&A during the past few years are still present, several have changed. Debt markets, which are a significant source of acquisition cash, have become less favorable subsequent to the credit crunch of the summer 2007. With “cheap debt” unavailable, financial buyers, who participated vigorously in managed care company auctions and often drove up valuations, are retreating to more conventional transactional behavior and leaving the transaction market disproportionately to strategic buyers.

Beyond the United/Sierra and Cigna/Great-West transactions, we expect to see few blockbuster transactions in the near term and believe transaction volume will moderate, because there are simply fewer plans available for consolidation. Mid-sized transactions of \$50-\$500 million will likely be the norm as buyers focus on filling out product line capabilities and expanding intra-regionally. Small and mid-sized plans will need to develop strategies to compete effectively in the next few years or consider whether to sell or partner with a larger and more product-differentiated company. There will also be a market for opportunistic government-focused managed care transactions among companies with long-term commitments to Medicare and/or

We believe managed care mergers and acquisitions for the rest of the decade are likely to increasingly focus on expanding geographic breadth and product and technology capabilities expansion versus pure “book of business” consolidation.

Medicaid managed care. The political environment, state as well as federal, will be an increasingly meaningful factor, especially for government-focused entities.

We believe managed care mergers and acquisitions for the rest of the decade are likely to increasingly focus on expanding geographic breadth and product and technology capabilities expansion versus pure “book of business” consolidation. Companies that deliver either product expansion or specialized capabilities, particularly technology-based functionality that can improve administrative productivity, provide consumer tools, or empirically lower costs, will be merger and acquisition objectives for health plans. In particular, disease management, unique information technology offerings, consumer directed capabilities, specialty businesses, and niche competencies will be active targets in the transaction market as they permit health plans to improve execution excellence.

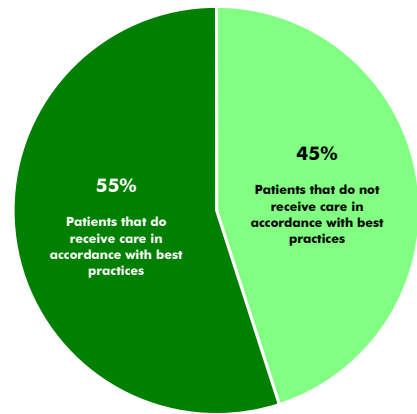
These trends point to four strategic priorities for operational and capital investment in the managed care industry during the next few years:

ENHANCE AND INTEGRATE CARE MANAGEMENT

Health plans, particularly in the Medicare and commercial sectors, have responded to market pressures and moved away from plan designs that heavily “manage care.” Restrictive policies have been abandoned in many cases, because consumers and providers identified them negatively as simply cost-cutting strategies. The potential for better care management that can improve the quality of care patients receive has not yet been realized. A significant percentage of the U.S. population is not currently receiving optimal care management, as shown in Figure 15.

FIGURE 15. Significant % of U.S. Population Not Receiving Optimal Care Management

Percent of Recommended Care Received	
Hypertension	64.7%
Congestive Heart Failure	63.9%
Colorectal Cancer	53.9%
Asthma	53.5%
Diabetes	45.4%
Pneumonia	39.0%
Hip Fracture	22.8%



Source: Elizabeth McGlynn, et. al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine* (2003)

A Commonwealth Fund survey of health care consumers shows that they also perceive many problems with their care. During a two-year period, 17% of those surveyed reported a medical, surgical, medication, or lab test error, and 19% reported that a provider failed to supply important medical history or test results to another doctor or nurse. Across the board, those surveyed endorse the importance of well-coordinated care with 96% stating it is very or somewhat important.²²

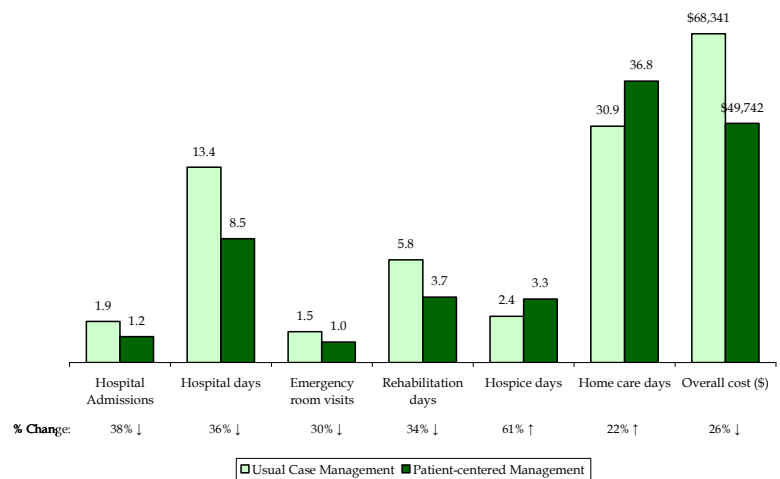
²² Cathy Schoen, Sabrina How, Ilana Weinbaum, John Craig, Jr., and Karen Davis, “The Commonwealth Fund Commission on a High Performance Health System: Public Views on Shaping the Future of the U.S. Health System” (August 2006): 1, 8.

Coordination of care particularly applies to the treatment of chronic illnesses. An estimated 75% of the nation’s health care spending goes to treating chronic conditions,²³ and approximately 48% of the population, or 135 million people, have at least one chronic illness. 80% of Americans aged 65 and older have at least one chronic disease, and almost 95% of health care expenditures for this age group is for chronic diseases.²⁴

Most health plans have had case management systems in place for many years that target members who are at risk for particularly large medical expenditures. These conventional case management approaches, while certainly better for all stakeholders than no intervention at all, can be considerably enhanced with newer, more focused interventions aimed at specific chronic diseases.

An example of this type of effort studied the implementation of a patient centered care management (PCM) regimen in addition to the health plan’s usual case management program. The PCM involves “comprehensive patient-focused collaboration that includes end-of-life and pain management, education, provider coordination, and patient advocacy. It emphasizes the selection and coordination of services from the patient’s perspective and considers all of the patient’s circumstances.” The study compared 756 HMO patients with life-limiting diagnoses (75% with cancer). The study controlled for benefits and blindly screened patients into intervention (“patient-centered management”) and a control group (“normal” case management). Each PCM patient had a complex care team consisting of a care manager, team manager, and physician. Team members spent an average of 10 hours per patient per month. These patients received initial home evaluation with the complex care team. The team determined specific treatment goals and held weekly meetings. The study reviewed utilization for 18 months. The average patient duration in PCM was four months. The study measured actual utilization of patients in the study, but applied an average cost per unit to estimate cost.²⁵ Results are shown in Figure 16.

FIGURE 16. Comparison of Average per Patient Utilization: Usual Case Management vs. Patient-Centered Management



Source: *American Journal of Managed Care*, February 2007 (Sweeney et. al)

²³ U.S. Centers for Disease Control and Prevention, *The Burden of Chronic Diseases and Their Risk Factors* (Atlanta: CDC, 2004): 3.

²⁴ Centers for Disease Control and Merck Company Foundation, “The State of Aging and Health in America 2007” (2007): 5.

²⁵ Latanya Sweeney, Andrew Halpert, and Joan Waranoff, “Patient-Centered Management of Complex Patients Can Reduce Costs Without Shortening Life,” *American Journal of Managed Care* (February 2007): 84-92.

**Care management
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The study concluded that PCM appeared to change patient behaviors and reduce the frequency of inpatient admissions associated with uncoordinated care. Patient's lives were not shortened. Gross savings in utilization was more than three times the cost of providing PCM. The study demonstrated that comprehensive PCM can sharply reduce utilization and costs over traditional management without shortening life. Additionally, satisfaction was very high among those who received PCM.

Plans need to consider the depth and breadth of their disease management and complex care management capabilities across diseases and market sectors. Although almost all payors have some disease management capability, only 21% of those surveyed had disease management for all five of the most common diseases usually managed (diabetes, asthma, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease), and there are many other conditions that could benefit from highly focused disease management approaches aimed at chronic illnesses.²⁶

Care management has broadened beyond management of care for beneficiaries with specific diseases or chronic conditions to include general health promotion and wellness. Health plans are therefore challenged to provide care management across this spectrum to respond to employer and consumer demand. Acquisition and strategic partnerships are both options to develop disease management capabilities. A Credit Suisse report estimated that the disease management and wellness market opportunity in the United States could be \$21.2 billion at the high end of their range.²⁷

A cousin to disease management, the health and wellness market is currently fragmented and in need of leadership. Employers and consultants are increasingly focused on integrated health and wellness across the full continuum of care, providing sophisticated outcomes-oriented reporting and evidencing an ability to effect cross referrals and transfers to disease management and case management programs. No supplier has achieved a full integration across the service spectrum, with Healthways closest to achieving this goal after its acquisition of Axia.

For disease management, large scale managed care organizations have mostly used an in-sourcing approach. Both Aetna and WellPoint gained at least partial control of disease management capabilities through acquisition, while others such as UnitedHealth have focused more on organic capability growth. The disease management sector is increasingly consolidated and other mid-sized health plans have used a contracting approach with companies such as Healthways and Matria as a differentiator from the bigger companies. The strategic models for success in managing disease are still in flux.

Acquisition interest in health and wellness and disease management companies is high, with a range of potential consolidators. In addition to health plans and stand-alone disease management purchasers, consumer focused health care companies such as WebMD and pharmacy benefit managers, distributors, and providers have made acquisitions. For example, Inverness Medical Solutions, a health care diagnostic and care management company has recently acquired Alere Medical, a company with care management services for patients with chronic illness and Paradigm, a provider of high cost and catastrophic disease management services. Inverness's acquisitions illustrate the fluidity of the sector participants and strategies companies are employing around care management.

²⁶ David Matheson, Anne Wilkins, and Daphne Psacharopoulos, "Realizing the Promise of Disease Management: Payer Trends and Opportunities in the United States," *BCG Report* (February 2006): 14.

²⁷ Credit Suisse Equity Research, "Disease Management: Solving Problems in the Healthcare System" (May 4, 2007): 29-32.

WellPoint's 2007 acquisition of AIM, a radiology management company, is another example of a strategy in this area designed to increase transparency, quality, and build out care management in the specialty and imaging areas.

GROW AND BUILD OUT MARKET CAPABILITIES IN INDIVIDUAL/NON-GROUP SECTOR

Growth in the individual health insurance market has been hindered by high administrative costs, differences among state requirements, community rating vs. medically underwritten standards and other regulatory requirements, resulting in high costs of individual coverage. Consumer preferences, national and state policy initiatives, and infrastructure cost innovations will dictate the pace of development of the individual market; but plans need to pay attention to their ability to compete as the historical commercial group market shrinks and the individual market grows.

Ironically, state health care reform initiatives for "universal coverage" using mandates will also increase the individual market. For example the Massachusetts plan that mandates employer health coverage for larger companies also mandates individual health insurance purchase and creates a state clearinghouse for the purchase of individual and small-group insurance plans. The clearinghouse sets standards for these policies, and health plans expect some of the negative underwriting impact endemic in the individual market will be mitigated by the universal coverage requirement and state clearinghouse. While this initiative is too new to be evaluated, it could have the impact of exposing a larger number of people to insurance in the individual market, potentially increasing the attractiveness of that form of health coverage over time.

As plans build out their capabilities to respond to the needs for a retail-oriented consumer-to-provider payment system for CDHP offerings, they are also increasing their capability to serve the individual health insurance market. Almost a quarter of the people covered by HDHP HSAs, or 1.1 million people, purchased those plans in the individual market. While most of those enrollees were replacing prior coverage with their HDHP HSA, 27% were individuals who previously did not have health insurance. These plans are covering people across the age spectrum with 27% (mostly dependents) under age 20, 27% age 20-39, 40% age 40-59, and only 6% over age 60.²⁸

The estimated 47 million uninsured in the U.S. are a fertile market for product expansion. Many of these individuals have sufficient incomes to afford health insurance. These individuals represent a potential market for low cost, simply designed, non-group health care products that include some preventive services coupled with fairly high deductibles. Products that could be effectively marketed to this population could materially reduce the ranks of the uninsured. A few BCBS plans have rolled out such products with premiums as low as \$50 per month, for example.

²⁸ AHIP Center for Policy and Research, "January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans" (April 2007): 5-6.

Focusing on the individual market could be an opportunity for a platform company in the health insurance/benefits business with meaningful scale and infrastructure.

Products to meet the needs of the currently uninsured are probably not high deductible health savings accounts, which are, despite many advantages, fairly complicated. The complexity of these plans is a material barrier for most people needing low monthly premiums. To secure widespread adoption, products that meet this demand will need to use quite different distribution methods than conventional brokers and agents. Community and other resources used by the currently uninsured will need to be developed. While state reform could force this kind of product development, health plans can, and should, accelerate introduction and marketing of these products into existing communities and targeted work environments.

Baby boomers now moving in larger numbers into the early retirement ages present a growing need for a “bridge” or supplement to Medicare. Health care costs are a significant concern for these baby boomers, and individually purchased supplemental coverage that addresses this need represents a market opportunity.

We estimate that overall there is currently a \$50 billion potential individual market, which with even modest growth assumptions could reach \$70 billion in five years. While individual nonprofit BCBS companies have the largest position, the balance of the market is highly fragmented. Focusing on the individual market could be an opportunity for a platform company in the health insurance/benefits business with meaningful scale and infrastructure. Materially different approaches to benefit design, enrollment, and service must be developed to lower the historic administrative load and cost burden. Internet-based tools and other information technology tools to market, underwrite, enroll, service and pay claims are important ingredients. Predictive modeling tools have improved significantly within the last five years. Partnering or acquisitions that change the distribution model from the traditional broker/agent market to more of a small group retail distribution model are essential. CIGNA’s 2006 purchase of Star HRG for its individual market capabilities is an example of a targeted acquisition to meet this strategic priority.

BUILD PRODUCTS WITH TRANSPARENCY AND CONSUMER ENGAGEMENT

Continued premium inflation, even if moderated from levels earlier in the decade, and disappointment with managed care’s ability to impact those trends have increased interest in making the consumer the nexus of the health care cost equation. One avenue for this is additional cost sharing. Forty-two percent of employers report they are very or somewhat likely to increase the amount employees pay for office visit copays or coinsurance during the next year.²⁹

There is also a growing awareness of the impact of consumers’ unhealthy behaviors (e.g., smoking, poor diet, and/or inadequate physical activity as related to obesity) or “modifiable health conditions,” estimated to account for 27% of the rise in health care spending between 1987 and 2001.³⁰ One approach is to offer health and wellness programs, which a growing number of employers are doing. Another is to penalize those who persist in unhealthy behaviors. In a 2007 Pricewaterhouse Coopers survey, 62% of employers said employees with unhealthy lifestyle behaviors should pay a larger portion of their health benefits costs. This was up from 48% in 2005.³¹ As consumers become more aware of the cost of their unhealthy behaviors,

²⁹ Kaiser Family Foundation, “2007 Annual Survey” 186.

³⁰ Kenneth Thorpe, “The Rise in Health Care Spending and What to Do About It,” *Health Affairs* (November/December 2005): 1438.

³¹ Pricewaterhouse Coopers, “Tailoring the Approach: Employer Attitudes and Healthcare Strategies Address Distinct Issues,” *Health Research Institute Health Brief*, (April 2007): 5.

demand for both wellness and disease management products aimed at meeting consumers', not insurers' needs could increase.

A third approach is to convert health benefit offerings to specifically designed consumer directed health plans, usually spending-account-based such as the HDHP HSAs as described in the Managed Care Market Summary of this paper. Putting additional transactional responsibility, additional decision making, and higher cost sharing on the consumer is a trend that is likely to continue through conventional managed care products, even if specific HDHP HSA products grow slowly. The technology implications of this shift away from the focus on the managed care plan/provider relationship to the consumer/provider relationship are significant. The immaturity of current technology solutions is one source of the much cited frustration by early CDHP adopters.

One major challenge posed by these consumer-interfacing products is that they all increase the need to transform the current inefficient consumer-to-provider transaction payment system.

One major challenge posed by these consumer-interfacing products is that they all increase the need to transform the current inefficient consumer-to-provider transaction payment system. Technology-based improvements that self-adjudicate, make transactions more automatic and timely, and assure payment to providers, will enhance participation and create value. Similarly, more efficient, technology-centered tools for consumer-initiated enrollment, plan design elections and changes, provider screening and selection decisions, spending account monitoring, immediately accessible account information, expeditious dispute resolution, and access to personalized health information all require fundamental infrastructure investments that today very few health plans have even begun to make.

Among payors, only UnitedHealth Group has full end-to-end CDHP solutions, although Aetna and WellPoint have most of the ingredients in place. Most plans have partnered with financial services firms to manage spending accounts as well as informatics companies, such as Subimo or CareGain, to provide web-based, consumer decision support. However, none that we have seen are linked or integrated into a seamless, easy-to-use, consumer-tested set of capabilities. Add the growing demand for transparency on price, provider quality and value rankings, and other market characteristics once considered proprietary, and it is clear that managed care plans will need to make meaningful capital and human investments to adapt to these market forces and compete as they take hold.

UnitedHealth's announced acquisition of Fiserv's health-related businesses is an example of an insurer expanding capabilities such as overpayment recovery. Fiserv is also an example of a financial services firm that attempted to leverage its transaction processing capabilities into the health care field but decided to change course and exit. Fiserv will retain its workers' compensation and CareGain technology businesses. We expect this kind of activity to continue as financial services firms and payors enter the managed care market, attempting to develop strategic models to serve consumerism's demands for transparency and multi-faceted engagement.

IBM Global Business Services has identified the need for health plans to shift from a business-to-business to a retail mindset and business model by 2015, and to lead the way in a transformation of the health care environment.³² Strategic partnerships and direct investments in technology and processes that are scalable and not necessarily linked to a particular infrastructure will be necessary in such areas as telemedicine, medical data analysis, transparent ratings of providers on quality and cost, medical care credit cards, medical search technology, and web portals populated with clinical information, to name a few.

³² IBM Global Business Services, "Healthcare 2015 and U.S. Health Plans: New Roles, New Competencies" (2007).

INCREASE SCALE AND/OR COMPETITIVE DIFFERENTIATION IN AN INCREASINGLY CONSOLIDATED MARKET**■ Large Scale Companies**

As the managed care market has moved from one that was highly fragmented and regional just ten years ago to one that is now much more consolidated on a national level, the large national plans have used their access to capital to develop economies of scale in an increasingly commoditized transaction-based industry.

Large players focused on the Medicaid sectors have the scale to develop a specialized infrastructure and a dedicated expertise that allows them to respond to government requirements. Aetna's 2007 acquisition of Schaller Anderson is an example of the acknowledgment of the need by a national company to acquire this specialized capability. Medicaid managed care has diverged from the commercial sector in that it has retained many of the traditional HMO features while PPO-type plans have become the norm in the commercial sector. Economies of scale can bring administrative productivity. Legal and regulatory risk in Medicaid is high, so scale Medicaid companies can invest in deep regulatory and compliance resources and diversify regulatory risk across many states. National plans specializing in the Medicaid sector (Amerigroup, Centene, Molina, and WellCare) have strong balance sheets and are in a good position to compete in this sector and pursue additional growth opportunities. National plans with strong Medicaid lines such as WellPoint, UnitedHealth, and HealthNet also have the scale to compete over the long term. Opportunistic government managed care transactions in areas such as Special Needs Plans and S-CHIP are likely to be the focus of future acquisitions.

Consolidation will also continue among and between the growing number of multi-market Medicare focused companies such as HealthSpring, Aveta, Universal American, Bravo Health, Arcadian, Scan, CareMore, WellMed, and Windsor Health (among others). We believe that there will continue to be exploitable growth opportunities in the Medicare sector and that these companies are, therefore, likely to participate in the M&A market as either buyers or sellers. If CMS makes large cuts in Medicare Advantage payments, M&A activity is likely to be greater as more small plans become sellers.

Large scale and broad geographic presence can also increase access to national commercial customers. Recent examples of geographic breadth transactions include Coventry's acquisition of Vista in Florida, CIGNA's acquisitions of Sagamore Health Network (Indiana's largest PPO) and Great-West, Multiplan's acquisition of Private Healthcare Systems, Viant's acquisition of Texas True Choice, The Parker Group's acquisition of Interplan, and UnitedHealth's acquisition of Sierra Health Services in Nevada.

Expansion to increase scale through deeper and broader product capabilities will also continue. Recent product capability expansion examples include Humana's acquisition of CompBenefits (dental and vision) and UnitedHealth's acquisition of the student insurance business from HealthMarkets.

Some continued activity to increase scale and achieve broader geographic presence by the larger plans will no doubt continue, but we believe that managed care M&A is likely to increasingly focus on product and technology capabilities expansion, not pure consolidation. Specialty businesses and niche competencies that increase the competitive differentiation of larger plans will be the increasing focus of M&A activity.

■ Small and Mid-Sized Companies

Small and mid-sized companies need to position themselves to realize the highest possible value in this more competitive market. They will need to differentiate themselves with value-added service to members that leverage their regional advantages and to reach sufficient scale to achieve transaction efficiency. If the plan has competitive advantages in a particular region or specialized or sector excellence, it may be able to achieve this position and thrive. Plans that choose to compete as independent regional companies will need to continuously invest in new products that keep them competitive and manage medical loss ratios and operating expenses as tightly as possible. They may be able to achieve these objectives through acquisition or strategic partnerships.

***The best time
to sell a plan
is when the
news is good,
not bad.***

One example of a strategic partnership is a non-acquisition marketing alliance with one of the national companies that has the marketing, product, and infrastructure scale to augment a health plan's current offerings. This kind of strategic alliance could permit access to other products, regions, and networks, minimizing the out-of-network negative marketing factor a regional plan holds in the national account market. A strategic affiliation could also involve transfer of some infrastructure such as claims processing or call centers to the partner or support of operating functions such as prescription benefit management, behavioral support, or disease management. Precedents for a strategic alliance include CIGNA with Tufts, Health Alliance Plan, Health Partners of Minnesota, and MVP Health Care. UnitedHealth Group has also undertaken strategic alliances with Harvard Pilgrim and Medica.

Absent a regionally distinct and competitively positioned product suite and/or cost structure, many local, unaffiliated health plans will have to consider the option of a sale. Unfortunately, many smaller plans resist considering sale options until financial results make the status quo untenable. The challenge with this approach is that the value of the plan may have been so depleted by then that a sale is harder to execute successfully. Distressed sales can be achieved when the seller can be positioned as an underperforming asset, but this is not possible in all cases. The best time to sell a plan is when the news is good, not bad.

In the case of a nonprofit seller, proceeds would go to the nonprofit owner or a new foundation organized to fulfill the charitable mission of the seller in a different way. The sale could be pursued with multiple selected parties or via an "auction," which often results in the highest value for the business. However, there are some circumstances where preemptive, exclusive negotiations with one party may be the preferred approach.

When the selling company has insufficient scale to excel in one or more of its lines of business, a sale of a part of the company may be the best option. When competitors are better positioned and capitalized, a sale of Medicare or Medicaid business can allow the seller to monetize a vulnerable asset while attractive valuations are still achievable. Then the infusion of capital from the sale can allow the selling company to restructure itself as a more focused competitor in its remaining lines of business.

CONCLUSION

Those who invest in and lead health plans today can look back on the last few years when membership and revenue growth, widening margins, and acquisition strategies led to extraordinarily strong financial results for many plans. That “all boats rise” period may well be behind us, and, over the near term, we expect the more consolidated market to reward only those plans that can achieve excellence in operational execution and excel at product innovation and care management. As M&A activity shifts from pure in-market “book of business” consolidation to acquisitions of companies that deliver geographic breadth, product expansion, or specialized capabilities, there will be opportunities for both larger scale plans and regionally focused plans that can successfully differentiate themselves to grow and thrive.

ABOUT CAIN BROTHERS

Cain Brothers is an employee-owned investment banking and financial advisory firm that focuses exclusively on the medical services and medical technology industries and their related businesses. Cain Brothers has one of the largest teams on Wall Street dedicated to the health care industry, with bankers and traders who possess experience in all facets of the industry.

Cain Brothers is all about ideas and direct senior banker involvement with the firm's clients. Our philosophy is to roll up our sleeves and work side by side with our clients to produce innovative, market driven solutions for the many opportunities and challenges they face.

The firm's client base is primarily composed of nonprofit and investor-owned health care service providers, third-party payors, medical technology companies, and companies that provide services to the health care industry such as information technology and real estate companies. The firm was formed in 1982 based on the belief that health care organizations have unique needs that can be best addressed by professionals with a focus on the health care delivery system as a whole. The firm has grown to become one of the nation's preeminent investment banking and advisory firms to the health care industry.

Cain Brothers research scans the health care industry environment to identify client challenges, trends, and solutions. Through our *Strategies in Capital Finance* series of white papers, the firm communicates substantive strategic perspectives to senior management teams and board members. The firm also keeps its clients up to date on industry developments, interest rate changes, and equity price trends through its two newsletters, *Industry Insights* and *Senior Health and Housing Weekly News*. These publications are available on our website.

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