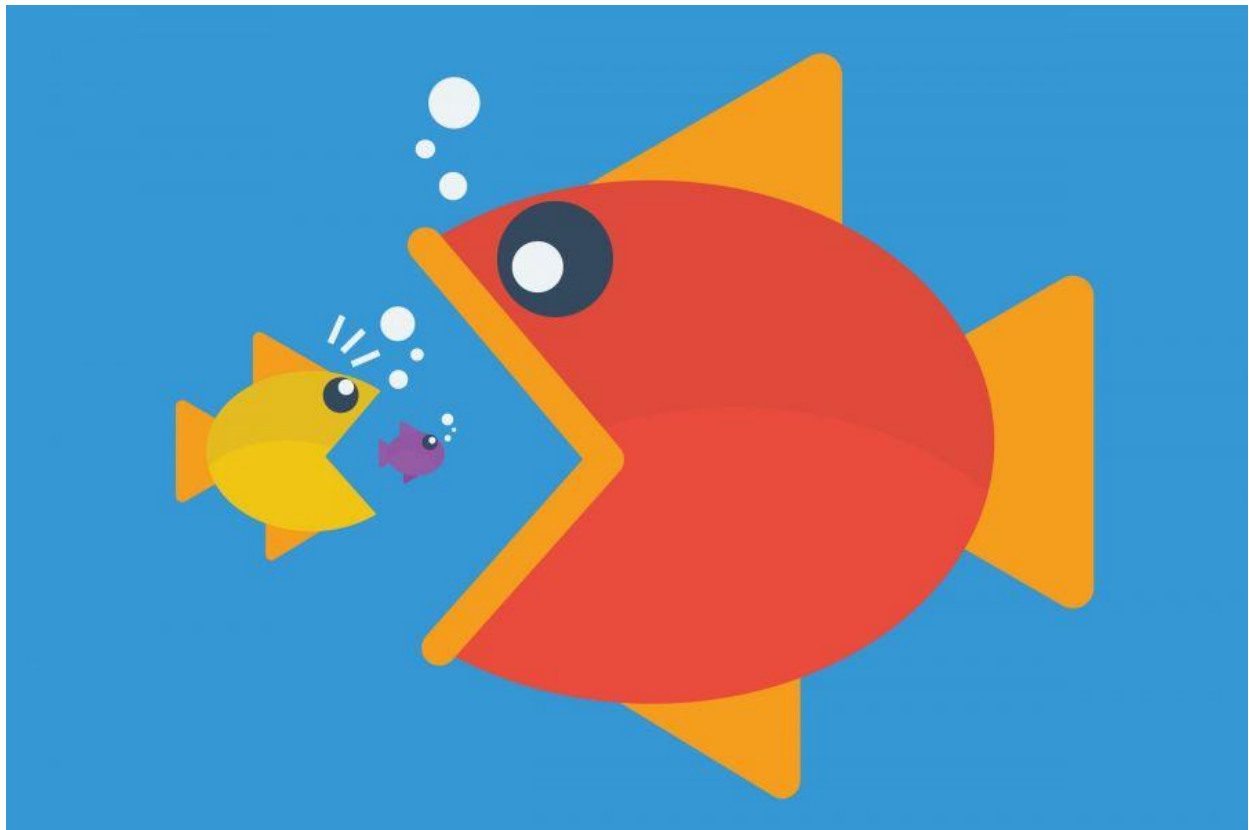


Insurers on a Shopping Spree For All Sorts of Providers

Vertical integration may make sense in the era of value-based care. But will the combinations limit patient choice—and pass antitrust muster?

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The wavy, fuzzy line between payer and provider continues to get wavier and fuzzier.

For about a year insurers have been on a provider shopping spree. UnitedHealth Group, Humana, Centene, and Anthem have announced billions of dollars of deals to acquire primary care practices, hospice providers, and home health care companies. The insurers' foray into provider territory comes as the traditional contours of American health care are in flux. Some large mergers and acquisitions will fundamentally change who does what for whom. The Department of Justice has given go-aheads to CVS's acquisition of Aetna and Cigna's acquisition of Express Scripts. There are rumblings that Walmart wants to acquire Humana. Insurers gobbling up providers is another moving part in a health care system in motion.

483 deals and counting

Last year, the number of mergers and acquisitions in the health care sector totaled 967, with a combined value of \$175.2 billion, according to PricewaterhouseCoopers. While the number of deals was down by 2.5% compared with 2016, the value soared by almost 146%, driven by CVS's acquisition of Aetna.

During the first half of this year, 483 deals in the health care sector were announced, according to PwC's tally. The combined value was almost \$100 billion. The lion's share came from Cigna's proposed acquisition of Express Scripts, for \$67 billion.

Insurers have developed a taste for owning providers for a variety of overlapping reasons. With value-based care, they stand to keep—or at least share—a larger proportion of the premium dollar if they have a provider in the fold. Insurer-provider amalgamations also make good economic sense with value-based payment arrangements that offer incentives for keeping people healthy and, therefore, are supposed to align the financial interests of insurers and providers. The growth of Medicare Advantage—which seems likely to continue as baby boomers age—is another factor. Insurers offering Medicare Advantage plans are getting more enmeshed in managing the delivery of health care, not just paying the bills. These are boom times for for-profit hospice care, as evidenced by the increase in their numbers. In 2000, there were 672 for-profit hospices, according to a MedPAC report earlier this year. By 2016, that number had more than quadrupled, to 2,938. Meanwhile, the number of not-for-profit hospice providers dipped slightly, from 1,324 to 1,273.

"If you can control all of the delivery systems, it gives you an advantage in being competitive," says Hank Osowski, cofounder and managing partner of Strategic Health Group, a health care consulting company in Burbank, Calif. Moody's published a report on vertical integration in health care earlier this year that said insurer ownership of physician and nursing companies could, theoretically, translate into more cost-effective health care. The report envisioned greater emphasis on prevention and incentives for referring patients to ambulatory care clinics instead of hospitals.



Hospice care is seen as a profitable venture if the buyer can control all the delivery systems that need to be involved, says Hank Osowski of Strategic Health Group.

But insurers are also buying up providers simply for their own tactical, defensive reasons. As providers combine and grow larger, owning a provider group is one way an insurer can penetrate a market that has otherwise been sewn up.

There's also a battle underway for patient hearts and minds. An insurer that owns providers may be able to build a stronger relationship with members who are now also its patients.

Insurers buying providers

Buyer	Provider	Type of service	Value	Status
Optum	DaVita Medical Group	Primary and urgent care	\$4.9 billion	Under FTC review
Humana, TPG Capital, and Welsh, Carson, Anderson & Stowe	Kindred at Home	Home health and hospice	\$4.1 billion; Humana's share is \$800 million	Finalized in July
Humana, TPG Capital, and Welsh, Carson, Anderson & Stowe	Curo Health Services	Hospice	\$1.4 billion; Humana has a 40% minority stake	Finalized in July
Humana	Family Physicians Group, Orlando, Fla.	Primary care	Not disclosed	Finalized in April
Centene	Community Medical Group, Miami-Dade County, Fla.	Primary care	Not disclosed	Pending
Anthem	Aspire Health	Non-hospice palliative care	Not disclosed	Finalized in June

Source: MANAGED CARE

Six major transactions involving insurers and providers have been announced since late last year. Three are insurers buying primary or urgent care providers and three involve home health and hospice providers.

The biggest deal is Optum's \$4.9 billion purchase of DaVita Medical Group, the primary and urgent care division of DaVita, which also operates kidney dialysis centers (Optum is part of UnitedHealth Group). The DaVita Medical Group has about 300 clinics in six states serving 1.7 million patients. The Federal Trade Commission is reviewing the transaction. In announcing the deal, Andrew Hayek, CEO of Optum, said the company will work with DaVita Medical Group "to combine our capabilities and, supported by the data analytics and technology capabilities of Optum [to enhance] patient care and the value we provide to the communities we serve."

Medicare Advantage is Humana's strong suit, so the acquisition of Family Physicians Group in Orlando, which serves more than 20,000 Medicare Advantage patients—and about that many patients with other kinds of coverage—makes perfect sense.

Humana is also making a major move into the growing for-profit hospice business. It teamed up with two private equity firms in December to buy a division of Kindred Healthcare that provides home and hospice care services. In April, with the same private equity partners, it bought Curo, a North Carolina hospice company.

Meanwhile, Centene is acquiring the Community Medical Group in Miami, which has more than 70,000 patients. Centene started the year as the largest Medicaid managed care organization in the United States, with more than 12 million members, according to the company's 2017 annual report. Centene is also the largest player in the ACA exchanges, with 1.6 million members—a 35% increase from 2017.

In announcing the acquisition of Community Medical Group, a statement from Centene Chairman and CEO Michael F. Neidorff said that the medical group “shares our focus and commitment to government-sponsored programs and creates a foundation for future growth.” Despite its focus on the Medicaid and Obamacare markets, Neidorff said in a second-quarter earnings call that Centene is “not out there buying all the practices we can and all the clinics that we can.”

Putting payer and provider under one roof means tapping into richer data and offering better care coordination, says Gary Young of Northeastern University.



Anthem joined the shopping spree in June when it acquired Aspire Health in Nashville, the largest non-hospice, community-based palliative care provider in the country, serving patients in 25 states.

Transactions that put payers and providers under one roof places insurers “in a better position to coordinate care” by giving them “access to a much richer data set that can be used for predictive modeling,” says Gary Young, director of the Northeastern University Center for Health Policy and Healthcare Research in Boston.

Osowski believes insurers are drawn to purchasing providers such as Aspire because home health care “can be very effective in reducing readmissions.” And hospice providers are attractive to insurers, “given the spending in the last six to eight weeks of life. They are trying to manage the quality of care for the patient as well as reduce costs.”

Demographics almost certainly guarantee an increasing demand for end-of-life care. In 2016, 49 million Americans were 65 or older; by 2030, that number is projected to be 73 million. Trends for the “oldest old” are headed in the same direction. The number of Americans who are 85 and older is expected to climb from 6.4 million in 2016 to 9.1 million in 2030, according to the U.S. Census Bureau.

Vertical is the way to grow

Insurers are pursuing vertical integration, Osowski says, partly because they have hit a dead end with integration in the other direction: “Horizontal integration is going nowhere.” Plans to merge Humana and Aetna, and Cigna and Anthem, were blocked in 2017 by federal judges who cited antitrust concerns. But Osowski is skeptical of how financially successful the new tie-ups between payers and providers will be. “I don’t know if they can get the kind of performance out of these acquisitions that I think they’re anticipating.” He also wonders if providers that have been acquired by insurers will continue to serve patients who have insurance coverage through other payers. Another challenge may arise if insurers try to expand to providers beyond their existing markets. “What works in one market may not necessarily work in others,” Osowski says.

Pursuing vertical integration fits with payers’ “desire to have vertical integration funds flow within the family,” says Sean Hartzell, associate principal at ECG Management Consultants. Provider consolidation has whetted the payer appetite for providers, in his view. Payers would “rather be on the inside, helping

move people through the continuum of care.” That includes figuring out how to “structure and use big data to help manage care in an appropriate manner,” says Hartzell. By acquiring providers, it also helps reduce the administrative burden and increases the integration of electronic health records, he says.

Young, the Northeastern health policy expert, adds that if an insurer can identify which patients are at risk for developing, for example, diabetes, they can suggest that patients make certain lifestyle changes, such as improving their diet and increasing exercise. By keeping them in better health and avoiding emergency room visits, it can help to contain costs.

“Certain insurance companies already do this quite effectively, particularly Humana with its Medicare Advantage patients,” says John Quelch, dean of the University of Miami’s Business School. Still, Quelch and others see problems with the payer-provider deals. “These are two different types of business with few synergies,” he says.

But “the patient is left out of the equation,” adds Quelch, author of the 2018 book [*Choice Matters: How Healthcare Consumers Make Decisions \(and Why Clinicians and Managers Should Care\)*](#). “If anything, the acquisitions that force patients to use providers owned by the insurer limit consumer costs and don’t necessarily reduce costs.”

Insurers need to be cautious that they don’t appear to be telling providers how to treat patients, given the reputation of HMOs in the ‘90s, Hartzell says. “They have to understand what happened in the past and prevent that from happening in the future.”

Antitrust still an issue

Keep in mind, though, that these spate of acquisitions may yet run into antitrust problems; vertical integration is not immune to scrutiny of federal antitrust regulators. “If you acquire too big a chunk of the provider market, you disadvantage your rivals,” says Thomas “Tim” Greaney, a visiting professor at the University of California Hastings College of Law in San Francisco and an expert in health law and anti-trust law. AT&T’s merger with Time Warner is an example of a vertical integration. A federal judge in June approved the \$85.4 billion deal, but the Department of Justice is appealing the decision. When it comes to health care, the concern would be that if an insurer acquires a provider, “in any given market, the dominant hospital or specialty group would foreclose other insurers” by giving them unfavorable terms, Greaney says.

Case law on vertical mergers has been limited since the 1970s. As a result of the AT&T–Time Warner merger, the government might develop new guidelines regarding vertical mergers. “There’s not a lot for judges to hang their hat on in vertical integration,” Greaney says.

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