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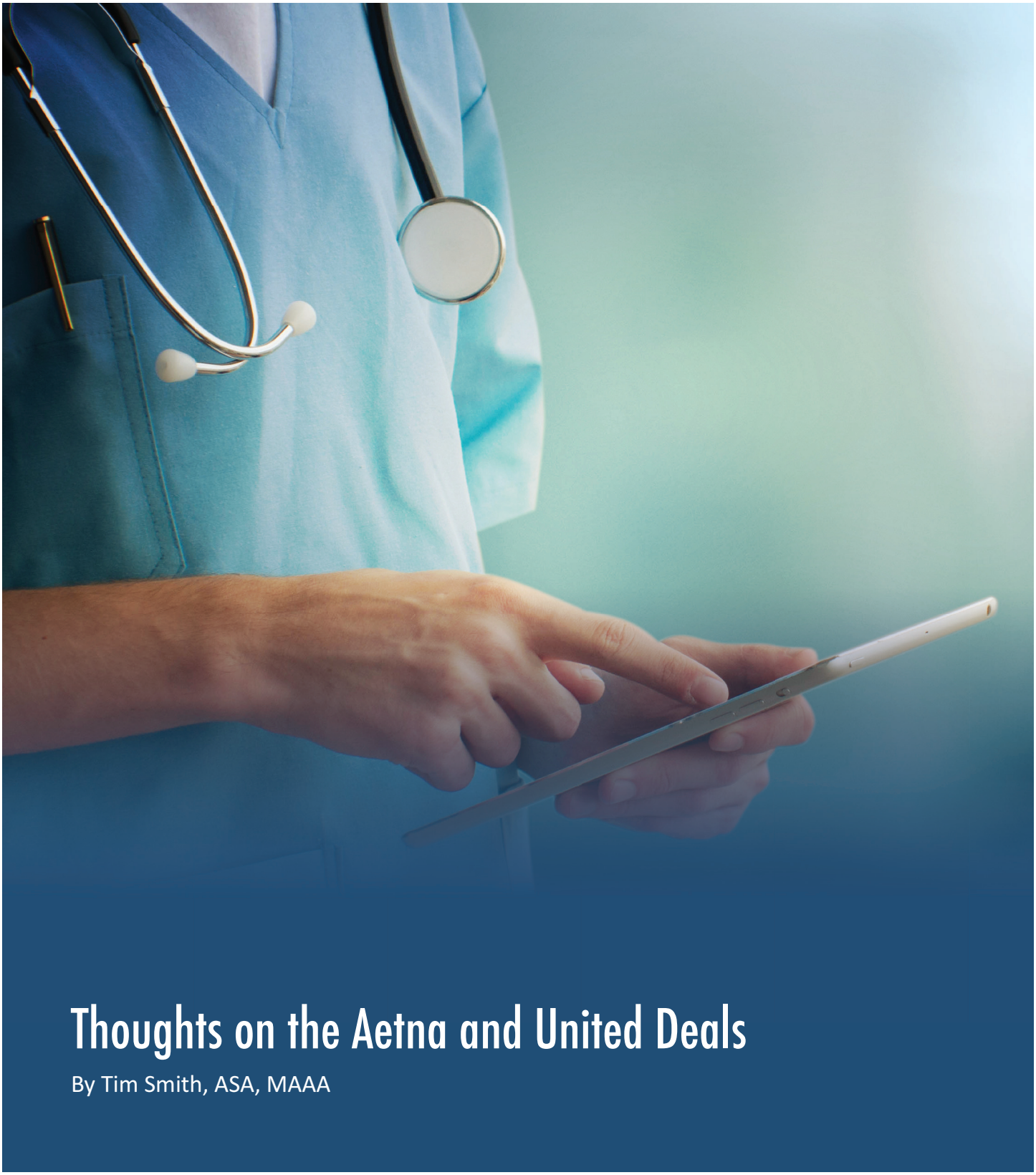

Thoughts on the Aetna and United Deals

By Tim Smith, ASA, MAAA

I have been reading the recent articles about CVS purchasing Aetna and United's purchase of Davita's physician group assets. For the most part, the authors are touting these deals as the future of health care, where value will finally prevail over volume and quality care over the fragmented delivery we experience today. As a consulting actuary actively involved in the space of integrated care, I will offer a fresh perspective by "following the money".

Ultimately, for these deals to "win" for their investors, meaning increased revenues and margins, someone has to "lose". Every author I have read agrees that the loser will be the hospital system. Hospitals have been the target of the nation's health care spending problem for as long as I can remember. But history shows that hospitals have been very resilient at holding their ground. A CDC study I often reference shows US healthcare spending since 1960, and at that time we spent about 33% of our healthcare dollar on hospitals. By 2014, with overall health spending increasing by 8% per year, the hospital's share had only dropped to 32%, even with the prior waves of change such as the HMO movement.

So why will this time be different?

Let's review from the perspective of each player - United, Aetna & the hospital.

United is amassing physicians, by some accounts more than 20,000. Assuming many of these are in primary care, these physicians do have a significant influence over their patient's "doing the right thing". In this case, this might mean staying out of the hospital and instead visiting United-owned physicians and outpatient centers, and taking medications administered by their pharmacy benefit manager (PBM). According to AHRQ, there are approximately 600,000 physicians active in patient care in the US today, of which about 200,000 are in primary care. While United is well on their way to gaining some significant scale, at prices often north of $2M per physician, it will be very expensive to continue this growth to a point where they cover a large portion of their insured populations.

On this strategy of buying physicians, we have seen others attempt this before, only to realize that it is very difficult to monetize. A recent example of someone who tried and exited the market quickly would be none other than the seller in this deal, Davita, who only got into the business in 2012. But it can work for some. Hospitals buy physician groups with the primary purpose of keeping care within their systems. Many show a loss on their books for their physicians, which they make up for with positive margins for the hospital. Before jumping to the conclusion that this is not the right direction for the future of healthcare costs, one could point to the "Kaiser model" and the success of many of the top integrated delivery systems.

But without a hospital to feed, new revenues and margins may need to come through the success of insurance products. This brings us to the CVS/Aetna deal. CVS/Aetna is also making a physician-play with an expansion of their 1,100 or so minute-clinics into their 20K pharmacy locations. Having used a CVS clinic on a few occasions, I must admit it is hard to imagine the investment that would be needed to turn the current "Nurse in a small room" model into a practice transforming the lives of patients with chronic conditions. But time will tell.

For Aetna/CVS to monetize this deal, they need to ensure that the savings from "keeping people out of the hospital" falls to their bottom line, and not to competing insurers or even the government. CVS clinics will need to be tightly aligned around Aetna products. With Aetna today so focused around the large employer, who often demand choice and convenience, convincing these customers to instead use CVS clinics and not their existing physician networks will be a difficult sell, and could lead to animosity with the many physicians not part of CVS.

But an even more difficult sell may develop if relationships begin to go south with local hospitals, who Aetna will still need even as their care model works to move volume away from them. The fact is, insurance buyers may not plan to ever use the hospital, but when making a purchase decision they will want to know that it is there if they ever need it. This provides leverage in a negotiation. And this one way, I believe, hospitals have been able to successfully keep their piece of the health care pie over all these decades of attempts by insurers to keep patients from going to them.

From the hospital perspective, the interesting and ironic part is that they too have embraced this future model of value vs. volume, whether on their own or nudged by the government, and have been working to reduce admissions, re-admissions and ER visits through an improved focus on care management. But in order to survive this future of lower volume, they have also been changing to preserve their revenues and margins by opening more outpatient centers, and working harder to keep care within their systems and away from competing interests.

There are also other worries for hospitals, though. One is the growth of micro-hospitals. These shiny new facilities with an emergency room and small number of beds have low overhead and are often being placed in nice neighborhoods where patients have the highest-paying commercial insurance. Traditional hospitals have significant legacy costs like pensions and buildings, and are often in the not-so-nice parts of town with a significant presence of Medicaid and the uninsured. Another worry with the expansion of competing outpatient centers would be if more insurers follow Anthem's lead in no longer allowing services like high-tech imaging to be received in the hospital. Other coveted service lines could follow this pattern like surgeries and infusion drugs.

How will hospitals react? Those with significant bargaining leverage may react by charging payers like United and Aetna higher prices for their inpatient and specialized services to help make up for lost revenue. For hospitals in competitive markets, they will need to continue to become more efficient, and continue to invest in the outpatient focused care that is emerging. If unsuccessful, they will likely merge and consolidate with other hospitals to gain the leverage, capital and expertise that they need to survive.

Conclusion

Let's take a step back and look at this strategically. Both United and Aetna still have successful insurance operations. Both will now have the highly coveted PBM presence. And both of these organizations have been financially successful for a long time. But as someone who has great interest in the future affordability of health care as a whole, especially as a purchaser of health insurance for me and my employees, we need the overall cost of care to come down, or in the least start to grow at normal levels of inflation.

And from what I read, I am just not convinced that these deals are going to do that.

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