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Health Plan Week

Strategic Business, Financial and Regulatory News of the Health Insurance Industry

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UnitedHealth Group May Invest Deeper Into Workers' Comp PBM Through Helios Buy

Industry sources tell *HPW* that UnitedHealth Group is on the verge of buying Helios, a privately owned provider of workers' compensation and PBM services to large health insurers and third-party administrators (TPAs), handling more than 7 million prescriptions per year. While the reported price tag of $1.6 billion to $1.7 billion raised a few eyebrows, sources say the logic of such a move, if it comes to pass, makes sense considering UnitedHealth's laser-like focus on growing its Optum unit to even greater heights.

UnitedHealth would not comment on the possible purchase of Memphis, Tenn.-based Helios from its current owners Kelso & Company and Stone Point Capital LLC, first reported by Bloomberg on Oct. 28. *HPW* learned from an industry source the deal could happen in the next few weeks, while news reports suggest the deal could be announced in the next few days.

"The price startles a little," Henry Loubet, senior vice president and chief strategy officer for Keenan in Oakland and former CEO of UnitedHealthcare's Western operations, tells *HPW*. But the prospective move, which he has no prior knowledge of, is a nod to the fact that workers' comp is a good niche for making money in a less-regulated sector, he says.

"I believe that in the broader health care space, there is an underappreciation of the whole workers' comp medical opportunity and that this may be an indication that more health companies are paying attention to workers' comp," Loubet explains. "United continues to focus on its Optum brand and opportunities outside the health plan area."

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Aetna, Anthem Portray Rocky Road for ACA Exchange Lines, but Total Results Are Solid

Aetna Inc. and Anthem, Inc. posted fundamentally strong third-quarter 2015 earnings, beating Wall Street estimates as has become the norm in the last few years for the large publicly traded insurers. But while most business lines, especially the government segments of each carrier, are delivering strong results, both carriers raised more concerns about the individual Affordable Care Act (ACA) marketplaces, which have developed a darkening cast about them in recent weeks.

Anthem led off the negative talk on exchanges on Oct. 28 during a review of third-quarter earnings, when it said total individual membership fell to 1.7 million people from 1.9 million a year earlier for the same period. "Individual membership declined by 99,000 during the quarter as we continue to see contraction in exchange lives and some attrition off-exchange," Anthem CEO Joseph Swedish said during an earnings conference call.

"Our exchange membership declined by an additional 69,000 lives to 824,000 members. Year-to-date, our individual business has declined by 48,000 lives, meaningfully behind our original growth expectations for this year, as we have discussed previously."

continued

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One of the main reasons for coming to Emblem is the company's value-based care focus, which will help reverse its recent fortunes, she explains, adding that Emblem's "unique" delivery system through AdvantageCare Physicians is also an attraction.

Emblem formed AdvantageCare Physicians in 2013. The affiliated corporation is made of four independent physician groups employing 400 multi-specialty physicians in some 40 locations scattered around New York City.

"It is very similar to a Kaiser, a Geisinger and an Intermountain and all of those," Ignagni says. "And this plan is actually, in this community, the market leader in value-based health care, meaning that approximately two-thirds of our arrangements with health care providers are value-based."

She also says she was drawn to Emblem's commitment to the underserved with chronic conditions and health care disparities.

Wider Industry Issues Still Have Her Ear

Even as she heads a private-sector insurer, Ignagni says many of the issues she worked on at AHIP are shaping her priorities in New York. For instance, like many CEOs of health plans she beats a loud drum for changes in the opaque way pharmaceutical companies operate, which aids their ability to charge what insurers believe are exorbitant prices for specialty drugs. Emblem, with its strong presence in low-income areas, has been hit hard by costs tied to hepatitis C drugs as an example.

"In the end, every part of the health care ecosystem has to step up and participate in the question of affordability," she says. "And this includes calls for transparency in the pricing of pharma products, which will have very positive results and create downward pressure on a pricing strategy that heretofore has been about everything you can get away with," Ignagni says. "I think pharma companies will be called on like health plans, which is to disaggregate the components of pricing to be very transparent about that and be prepared to discuss the rationale behind pricing. I think that trend toward transparency and calls from the political arena will be crucial to opening up the cover of the black box."

On another hot-button issue, consolidation, she says people should be concerned not about insurer mega-mergers but hospital combinations. "We have a unit cost problem now and if hospital systems are gobbling up the lower cost community hospitals and increasing costs as a result of that, that means everyone's costs go up. Rates go up and consumer costs go up and it has implications on the delivery system, pricing, and our ability to delivery affordable products," Ignagni declares.

With her work shaping the Affordable Care Act (ACA) during President Obama's first term, Ignagni became known for helping to bring the law to life. While she praises what the ACA has done to bring millions of new lives to the insurance marketplace, there is at least one part of the law that has gone unfulfilled: the risk corridors payments. This is key because the funding shortfall for the program has caused almost half of the 23 Consumer Oriented and Operated Plans (CO-OPs) to close and pressured the bottom lines of insurers across the spectrum (see brief, p. 8).

"I think that the legislation was very, very clear. The regulatory structure was clear and where there are commitments that are made that plans relied on to price products and deliver affordability to consumers, it was because of the expectation this was going to work very similar to Part D," she continues. "I think most plans would tell you that they strongly believe those commitments needed to be honored. Because the reason for risk corridors as they were developed for Part D and the same reason that existed in ACA is anytime you bring a broad array of new products for so many individuals there needs to be some measure of predictability. That was the story of Part D and the same rationale here."

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UnitedHealth Seeks Workers' Comp

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UnitedHealth's move on Helios comes after it paid $12.8 billion for PBM Catamaran in a deal that was announced on March 30 *(HPW 4/13/15, p. 1)* and closed on July 23, and which brought an immediate boost to Optum's bottom line. In its latest quarterly results filed on Oct. 15, UnitedHealth said Optum experienced a robust third quarter with revenues up 61% year-on-year to more than $19 billion out of the $42.5 billion the overall UnitedHealth Group accumulated. To put that Optum number in perspective, Aetna Inc. on Oct. 29 said its revenues

Additional News of the Week

Coverage of these health plan developments was included in this week's issue of *Spotlight on Health Insurers:*

- BCBSM Donates $1.2M to Safety Net Clinics
- Shareholders Greenlight Centene, Health Net Deal
- Florida Blue Glitch Denies Patients HIV Medicine

Links to these additional news stories can be accessed at www.AISHealth.com/enews/spotlightonhealthinsurers.

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for the third quarter of 2015 were just under $15 billion (see story, p. 1).

PBM Space Could Be an Optum Sweet Spot

Other observers agree a Helios buy would support UnitedHealth's overall strategy. "It seems to make sense. They add PBM business to their now growing PBM base (it is hard for an insurer to sell its own PBM services to other insurers), but the workers' comp element takes that problem out of the equation," Bill Sullivan, principal consultant for Specialty Pharmacy Solutions LLC, tells *HPW*. "Also, bundling workers' comp into the United menu of solutions expands their base and it looks like Helios had built a pretty strong presence in that category."

And the Wall Street view is much the same. Top UnitedHealth analyst Sheryl Skolnick, Ph.D., managing director and director of research for Mizuho Securities USA, tells *HPW* the acquisition is "kind of interesting since it is also focused on the middle-market employer, similar to Catamaran."

She also says Helios has a technical bent much like Catamaran and would seem to be a good match in that regard with the Catamaran platform as a base. "They want to be big and fully at scale in that business," she adds.

UnitedHealth Was Not Always Comp Crazy

The Catamaran acquisition put Optum into the workers' comp business in a sizable way. That is because right before UnitedHealth consumed the PBM, Catamaran purchased Healthcare Solutions, which serves as a workers' comp PBM and claims management resource for workers' comp and auto insurance carriers, TPAs, health plans and self-insured employers.

That was not always the case, though, according to a Sept. 3 posting in the Managed Care Matters blog. Writing on his blog well before anyone mentioned Helios, Joseph Paduda, the Madison, Conn.-based principal of Health Strategy Associates, said UnitedHealth previously had avoided workers' comp but that changed with Catamaran coming into the fold.

Congressional Budget Deal Would End ACA's Auto Enrollment Trigger

A two-year budget deal that has passed both the Senate and House includes a small number of items related to health care, among them a provision that strikes down Section 1511 of the Affordable Care Act (ACA) related to auto enrollment.

The Bipartisan Budget Act of 2015 (H. Res. 495), reached a few days prior between House Republican leaders and President Obama, gives a final victory to former House Speaker John Boehner (R-Ohio) and a first win to new Speaker Paul Ryan (R-Wis.), who was voted in the day after the House approved the measure on Oct. 28. The Senate voted to approve the legislation early on Oct. 30. President Obama is expected to sign the bill.

Section 1511, which was opposed by business groups, would require employers that have 200 or more workers and provide health insurance to automatically enroll new employees in a plan, subject to legal waiting periods. It also mandates that employers give their employees notice that they can opt out of the plans in which they are auto-enrolled any time they like.

"This is a 'nudge' provision, intended to reverse the course of inertia and encourage enrollment in coverage by employees who might otherwise forgo doing so if they had to initiate enrollment on their own," according to Timothy Jost, law professor at Washington and Lee University, in an Oct. 27 blog post in *Health Affairs*.

Among other health care-related matters, the budget deal would:

◆ ***Maintain 2016 Medicare Part B premium and deductible levels consistent with actuarially fair rates***. Without this measure, monthly Part B premiums would soar from the 2015 level at $104.90 to $159.30 next year.

◆ ***Apply an inflation adjustment to the Medicaid generic drug inflationary rebate.*** "Currently, single source and innovator multiple source drugs pay an additional rebate if the price of the drug has increased faster than inflation. The inflation-based rebate, however, does not apply to generic drugs," the outline of the legislation said. The measure would apply the rebate to generics.

◆ ***Codify the CMS definition of provider-based off-campus hospital outpatient departments*** as those locations that are more than 250 yards from the main campus of a hospital.

Read the budget deal at http://tinyurl.com/qhsgtnu.

"Catamaran (now OptumRx) has substantial share in the workers' comp PBM space, with total Rx revenues likely in the $650 to $750 million range, spread among its network rental business, PBM Cypress Care, Ohio BWC services and other governmental work. Adding Healthcare Solutions' other services pushes total work comp revenues closer to the billion-dollar mark," he wrote. While UnitedHealth had some bad experiences in the workers' comp space in the 1990s and had sold off related business over the last few decades, the business is more appealing now.

Paduda noted that the health reform law put even more regulation on the back of health plans. "In contrast, work comp regulatory risk, while significant, is limited to what individual states do. If one state makes a change, it has zero impact on the others, thereby minimizing regulatory risk." He says other "nice things" about UnitedHealth's workers' comp business include that it "is a fee business, without insurance risk; margins are pretty healthy, a lot higher than group/governmental programs; it has scale; when all the dollars are combined it's a substantial player; minimal investment is required as the businesses are mature and operating pretty successfully with experienced management and solid brands."

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HEALTH PLAN BRIEFS

◆ **Anthem Inc. unit Anthem Blue Cross in California on Oct. 27 agreed to pay back around 50,000 customers a total of $8.3 million to settle a class-action lawsuit concerning accusations it increased premiums mid-year,** according to the plaintiffs' representative Consumers Watchdog and a news story in the *Los Angeles Times*. Anthem did not admit guilt in the matter, and spokesperson Darrell Ng tells *HPW* the insurer is pleased the matter is settled. In the newspaper article, Dave Jacobson, one of the plaintiffs, recounted his troubles after he enrolled in a PPO Share $500 individual plan. "In April 2011, he received medical services and Anthem Blue Cross acknowledged that he met his deductible and paid 70% of his bill. When he went back for follow-up tests three months later, he was told he needed to pay $50 more toward his deductible before the insurance company paid its percentage for his care," the *Times* said. "According to the lawsuit, the midyear change to Jacobson's yearly out-of-pocket maximum increased to $5,850 from $5,000. His annual prescription drug deductible increased to $275 from $250." Consumer Watchdog said the average settlement amount would be $167. Visit http://tinyurl.com/q8ulj2v for the Consumer Watchdog release and http://tinyurl.com/pn6pgnj for the newspaper article.

◆ **The Chinese hacked U.S. health insurers like Anthem, which suffered a massive computer attack earlier this year, to learn about American health care and help the country manage its aging population,** according to a story in the *Financial Times* on Oct. 28. The article also said software company Symantec traced the Anthem hack back to a cyber espionage group called Black Vine, which has connections to a Beijing-based IT security company. Anthem did not respond to *HPW*'s request for comment. In January, Anthem said it experienced a computer hack of its databases, exposing the personal information of more than 80 million customers *(HPW 2/16/15, p. 1)*. Visit http://tinyurl.com/nhqpowm.

◆ **On Oct. 27, Centene Corp. released earnings that showed the strength of its Medicaid managed care focus and which toppled Wall Street's expectations.** Centene reported third-quarter 2015 net income of $93 million, or 76 cents per share, up from $81 million, or 67 cents per share, in last year's third quarter. Earnings, adjusted for one-time gains and costs, were 84 cents per share. Analysts had expected 78 cents per share. The insurer posted revenue of $5.82 billion in the period, also above the analyst call of $5.81 billion. Centene said its managed care membership was 4.8 million as of Sept. 30, up 24% from the third quarter of 2014. Centene CEO Michael Neidorff, speaking after the earnings release, said the insurer's $6.8 billion acquisition of Health Net, Inc. announced on July 2 *(HPW 7/13/15, p. 3)* remains on track to close in early 2016. Visit http://tinyurl.com/npe3m4e.

◆ **Molina Healthcare, Inc. on Oct. 29 said its net income from continuing operations was $46.3 million, or 77 cents per share, for the third quarter of 2015, versus $16.1 million, or 33 cents per share, in the same quarter of 2014.** On an adjusted basis, earnings were 89 cents per share, well above the Wall Street expectation for 69 cents per share. Molina's medical loss ratio was 89.3% in the third quarter of 2015, down from 90.6% in the third quar-