Collision of Healthcare's Payor-Provider Models

Necessary Pivotal Changes and Innovative Solutions

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Table of Contents

Executive Summary

Thesis

Current Healthcare Marketplace

M&A Landscape

The Fear of Monopolized Healthcare

The Future of Healthcare

Private Equity Opportunity

Conclusion

Defined Terms

Bibliography

Executive Summary

As the U.S. healthcare marketplace continues to proceed down a path of consolidation and increased government regulation, Americans can expect to see further increases in the price of healthcare, a decline in the quality of care, continued growth of healthcare spending, and erosion of both Provider and Payor efficiency. Specific trends are leading the market in this direction and fixing it will require an understanding of those trends and a combination of multiple changes to the healthcare industry, culture, and regulation.

Current Trends:

Mass consolidation and poor allocation of subsidies

- Cause destruction of competition
- Stagnate innovation
- Enable monopsony power

Inefficiencies in the healthcare market

- Payor and Provider failures
- Regulatory Failures
- Uninformed patients with a weak link to true cost

Over-regulation

- Decreases current and future physician quality
- Encourages costly defensive medicine (not preventative)

Current reimbursement models exacerbate negative trends

- Raises insurance premiums
- Forces quantity over quality

With proper regulatory reform, revitalization of competition in the market, and the full and successful vertical integration of a Payor & Provider, the healthcare market can take on a new life without all of the aforementioned detrimental trends

Payor & Provider collision could have a potentially positive or negative impact on the market depending on a variety of contributing variables affecting the success and viability of the combination

Thesis

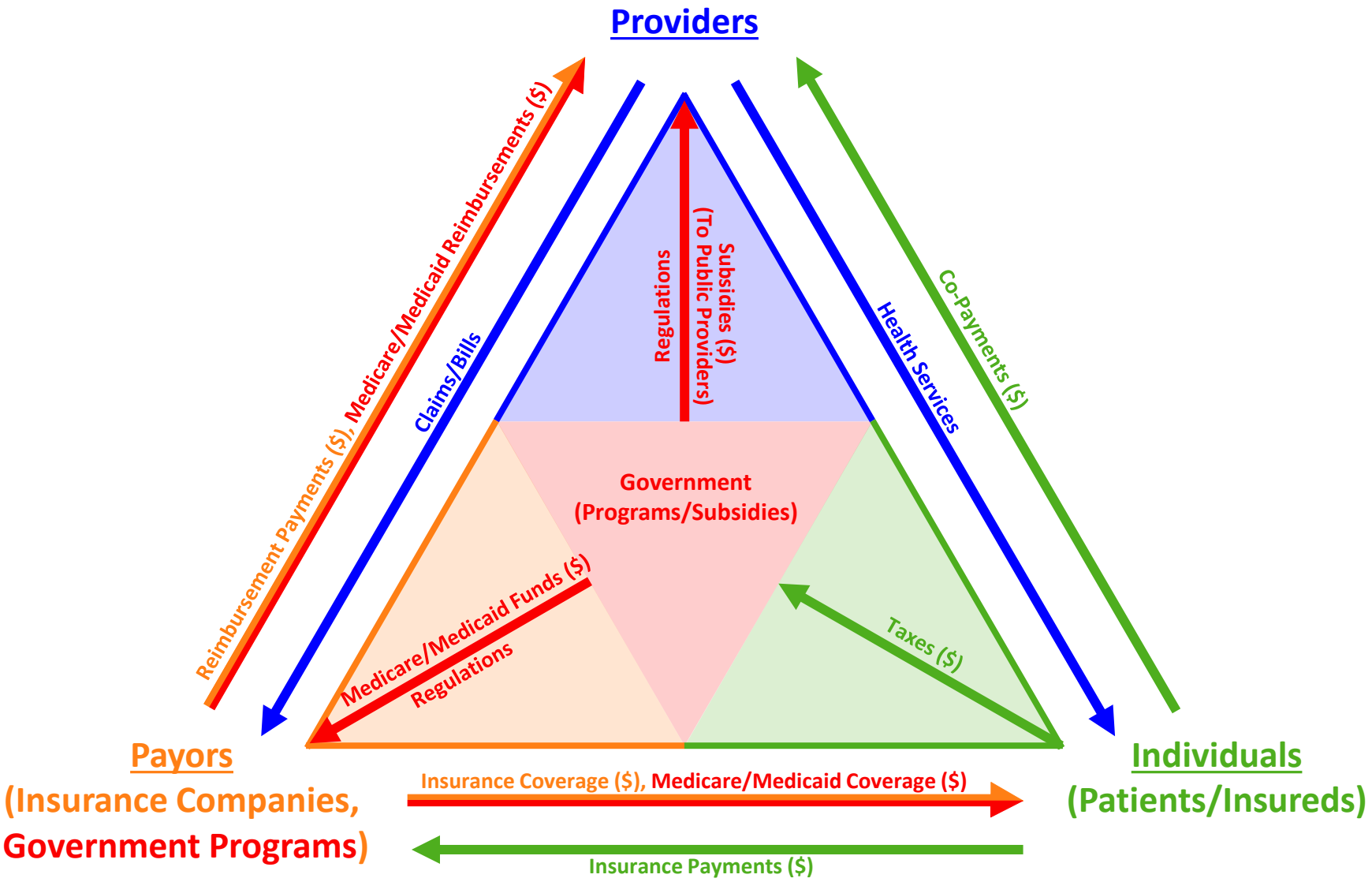
Question Statement

What are the advantages that can be leveraged through the merging of Payors and Providers within the current healthcare and insurance industries and how are these two separate industries approaching the shift towards fewer large players in each? What are the potential advantages of scale associated with cross-industry acquisitions?

Hypothesis

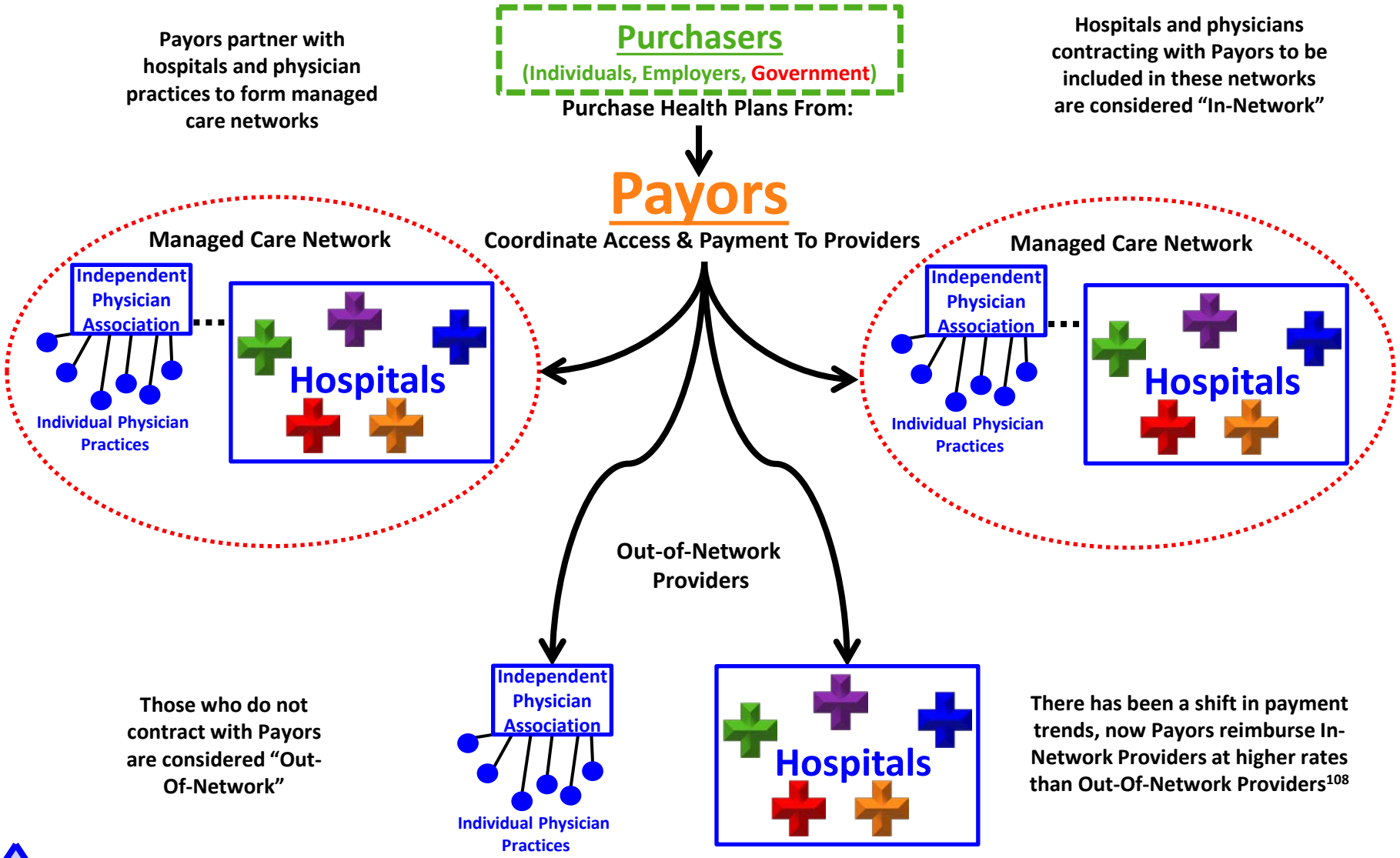
A vertically integrated Payor-Provider model combined with changes in the direction of government health regulations will reduce price burdens on consumers (patients), improve quality of care, reduce business expenses, increase availability of healthcare, and improve market dynamics.

Healthcare Market Structure



The small triangles in the corner have shading relating to the sectors of the healthcare market that are discussed in that slide. Colors match those shown in the full size model and relate to sections shown above

Payors and Horizontally Integrated Providers Currently Interact through Managed Care Systems/Networks



Out-of-Network Providers must make up for the lower reimbursement amounts by "balance billing" patients, resulting in a higher co-payment burden on the insured[110]

The Rise of Mass Spending and Increased Regulation in a Quickly Consolidating Healthcare Market

Misaligned Incentives

Payors

- As a result of strict government regulation, Payors have been forced to operate in ways that are contradictory to any successful competitive business model
- In efforts to cut costs, Payors have created a system that simplifies a complex cost structure, but that has serious repercussions on how medicine is practiced as doctors practice defensive medicine more frequently to adjust for change in reimbursement levels

Providers

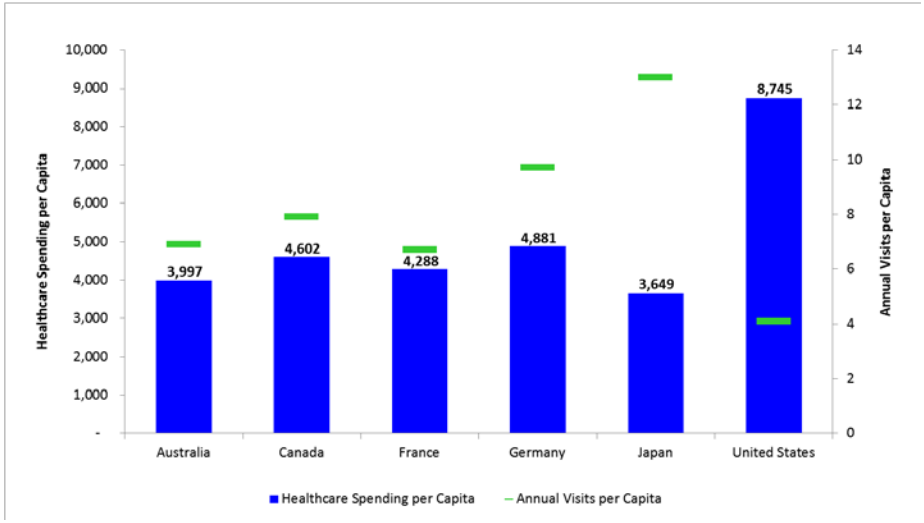
- As a result of Payor reimbursement structures, Providers have created an environment that lacks efficiency and innovation as they try to churn out high volumes in order to profit under the current reimbursement model

Regulation Induced Consequences

- The government has attempted to stabilize a market that was designed to operate freely; while well intended, this has resulted in increased healthcare costs and many other harmful consequences
  - These regulations have also incentivized a series of trends that have decreased the quality of care for both public and privately insured patients
  - Payors and Providers are finding ways to take advantage of a market that has been fragmented by regulation

Why Pay More For Less?

- The U.S. spends more on healthcare per capita than all other developed countries even though the average U.S. citizen visits the doctor fewer times[111]
- The government has attempted to stabilize a market that requires competition to continue to improve and grow
- Eliminating competition has increased the cost of healthcare by allowing inefficiency to run unchallenged



Source: Commonwealth: International Profiles of Health Care Systems

Major Players in the Current Healthcare Landscape

Top Five Payors

Insurer	Total Membership†	Market Cap ($MM)‡	Total Revenue ($MM)†	Managed Care Premiums ($MM)†	# of Employees†
UnitedHealth Group, Inc.	45,900,000	115,400	130,474	115,302	170,000
Anthem, Inc.	38,656,000	39,055	73,874	68,390	51,500
Aetna, Inc.	22,349,000	42,062	58,003	49,562	48,800
Humana, Inc.	21,510,200	27,629	48,500	45,959	57,000
Cigna Corp.	15,952,000	37,110	34,914	20,709	37,200

Capital IQ: †Annualized data as of 12-31-2014, ‡day-to-day data as of 8-14-2015

Largest Providers – Healthcare Facilities & Services

Provider	Healthcare Operational Focus	# of Facilities Operated†	# Licensed Beds†	# of Admissions†	Market Cap ($MM)	Total Revenue ($MM)†	# of Employees†
HCA Holdings, Inc.	General & Acute	279	43,356	1,795,300	37,949	36,918	197,000
Universal Health Services, Inc.	Acute & Specialty	245	26,905	677,675	14,169	8,576	58,700
Community Health Systems, Inc.	General	197	30,137	924,951	6,873	19,491	119,000
Tenet Healthcare Corp.	Acute	290	20,814	791,165	5,195	17,568	95,580
Kindred Healthcare, Inc.	General	199	19,272	95,280	1,881	5,028	50,100

Capital IQ: †Annualized data as of 12-31-2014, ‡day-to-day data as of 8-14-2015

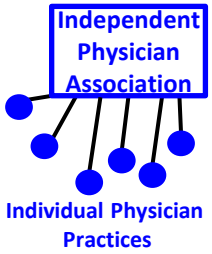
Fragmented Provider Business Models

Management Services Organization (MSO)

- In this model the MSO provides services for its member, client, or subscriber practices
- Usually formed as a for-profit business or as a co-operative
- Can be as simple as a billing service or as complicated as a management company

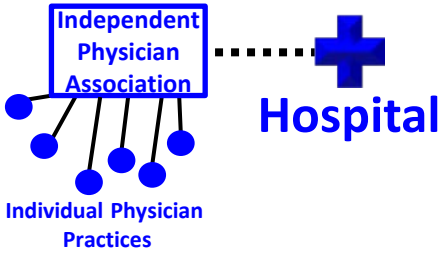
Independent Physician Association (IPA)

- A model used to organize independent practices into contracting entities
- The Independent Physician Association can sign contracts with HMO's to join managed care networks, direct purchasers, and other vendor groups
- Can have a specific hospital affiliation and become part of a Physician/Hospital Organization



Physician/Hospital Organization

- Physicians form an IPA and become a partner with a hospital in a variety of medical related ventures
- While an IPA can operate separately of a hospital, if it is partnered with a hospital the IPA is then considered part of a Physician/Hospital Organization



Group Practices

- Group practice types:
  - **Single specialty group** practices include only physicians of the same specialty
  - **Single discipline (field)** practices include only physicians of one discipline such as primary care
  - **Multi-specialty group** practices include multiple specialties and disciplines and are a purposeful combination of any of the other business structures

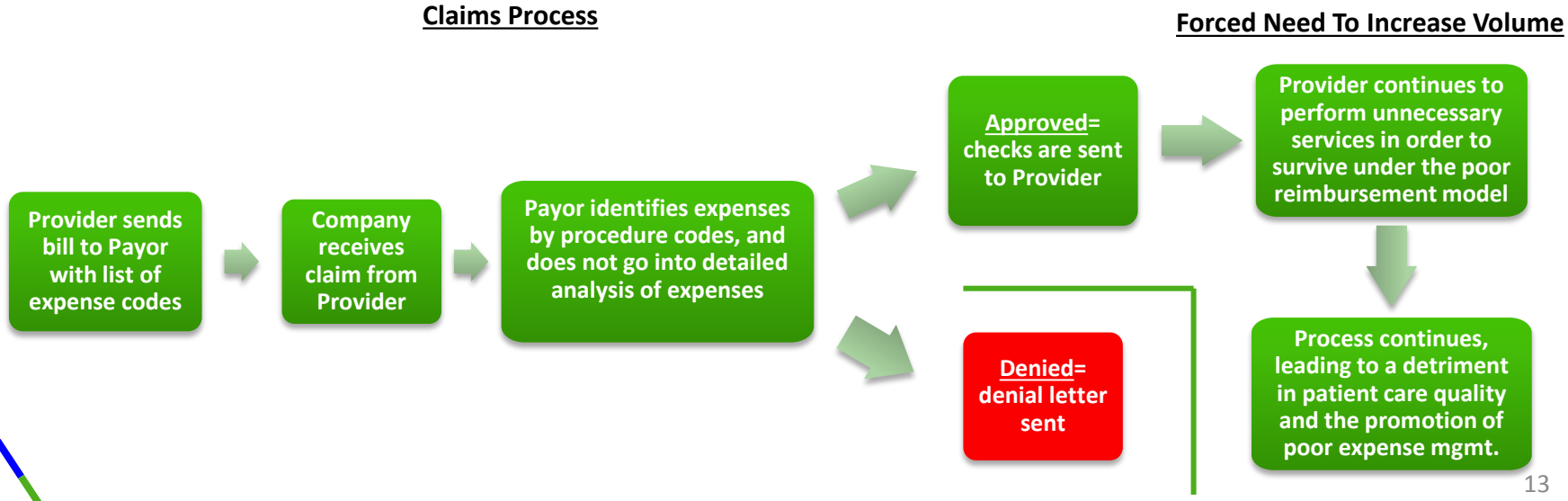
The Payor Reimbursement Model is Riddled With Complications

Problems With Current Process

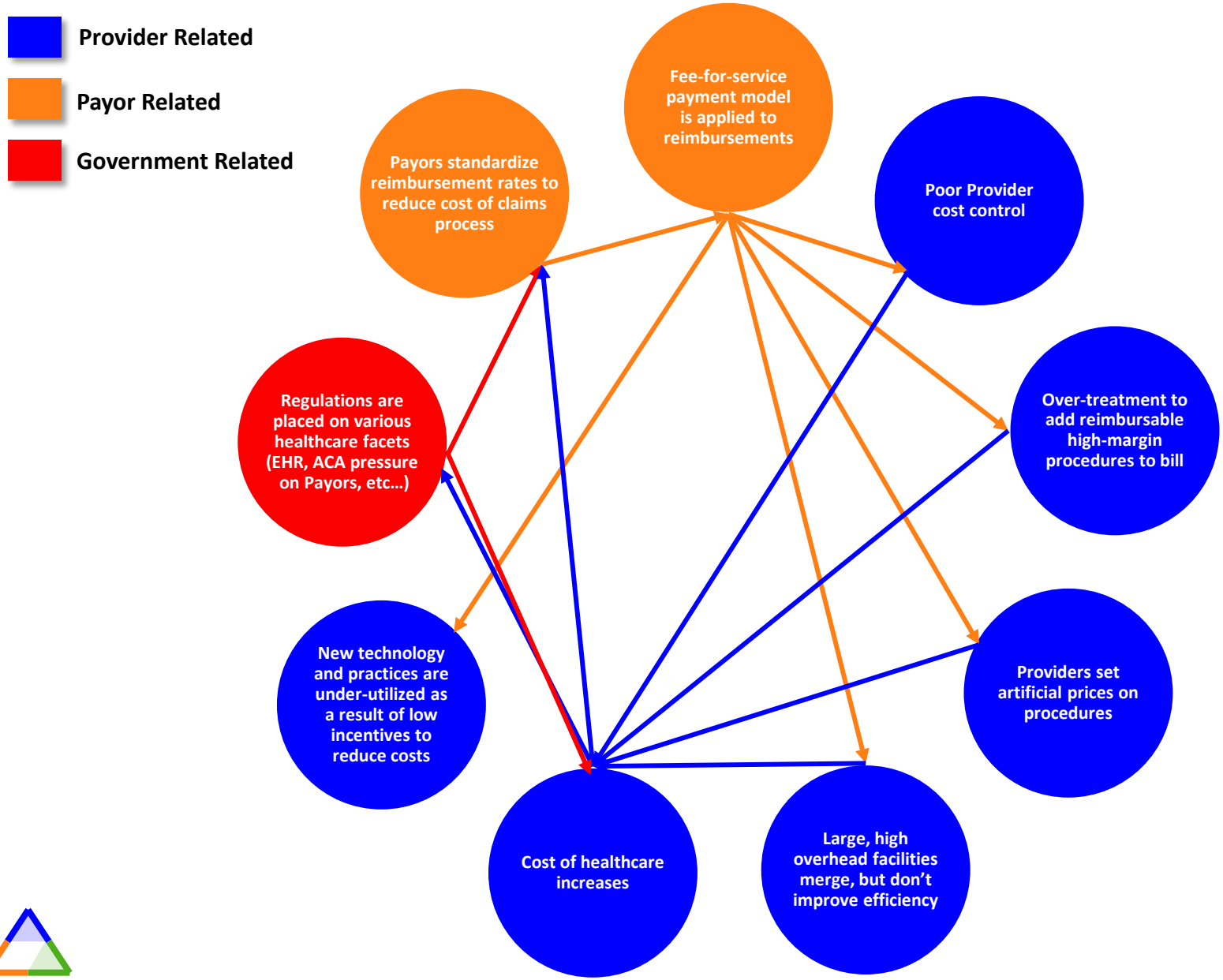
- The most common method of costing currently utilized by Payors is known as the fee-for-service model and exists under the assumption that cases have a designated fixed cost by case type
  - Does not account for variable expenses incurred during a patient's time at the hospital on a per patient basis
  - Creates incentives for physicians to administer unnecessary procedures (MRI, Lab tests, etc..) to increase reimbursement volumes at the expense of the patient
  - Creates an atmosphere that prevents hospitals from receiving any benefit from improved processes and technology

Limited Skilled Innovation

- The fee-for-service reimbursement method eliminates any incentives for the physician or the hospital to operate at a higher level of efficiency, it:[112]
  - Leads to an environment of performance stagnation for physicians
  - Deters the adoption of innovative medical procedures and/or practices due to the high cost of implementation and the long process required to establish a new code for reimbursement for a new procedure
  - Creates incentives for physicians to add unnecessary services to an individual patient's care in an attempt to increase volume and cover the non-reimbursed cost of complicated and more pricey procedures
    - An increase in billable services leads to a higher reimbursement amount received for the procedure



Web of Inefficiencies



Relatively Slow Technological Advancement in the Healthcare Industry Has Left it Behind the Curve

Technology Based Cost Drivers

- Several cost drivers found in the healthcare industry can be reduced with improved technology
  - Communicational failures
  - Over-treatment
  - Administrative complexity
  - Pricing misalignment
  - Preventable conditions/complications
  - High overhead
  - Periodic procedure volumes (periodic checkups, blood tests, etc.)
- Although technology designed to decrease costs associated with these has been improving for the past several years, national healthcare expenditures have continued to rise

Cost Paradox

- Reduced reimbursements rates are forcing Providers to "do more with less" in a market with simultaneous demands for standardization and personalization[113]
  - Technologies designed to decrease current healthcare costs must be adopted into the current model to improve efficiency
  - Many of these cost drivers exist in other industries and have altered how companies apply technology to become more efficient
- The healthcare industry, given incentive, can match the technological progression of other industries in order to reach a higher level of efficiency[113]

Recent HER Implementation

- Healthcare has made significant investments in EHR implementation due to the HITECH laws
  - Partners HealthCare: $1.2 billion
  - Lehigh Valley Health Network: $200 million
  - Lahey Hospital & Medical Center: $160 million
  - Lifespan: $100 million
  - Erlanger Health Systems: $97 million
  - Wheaton Franciscan Healthcare: $54 million
  - Saint Francis Medical Center: $43 million
- This is a good start in improving the technological deficiencies that healthcare is facing, but there is a long way to go before it is caught up to other comparable industries

Stark Law Restricts Certain Provider Business Models

Regulations

The Stark law has three main effects:

1) Prohibits physicians from referring Medicare or Medicaid patients to a facility that the physician (or an immediate family member) has a financial interest in or relationship with
2) Prevents entities from presenting or causing to be presented claims to Medicare or Medicaid (or billing any other individual, entity, or third party Payor) for those referred services
3) Establishes a number of specific exceptions and grants the Secretary of Health the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse

Exceptions to the Stark Law

- Ownership of investment securities which may be purchased on terms generally available to the public, and which are:
  - Listed on the NYSE, ASE, or any regional exchange in which quotations are published on a daily basis, or foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis or traded under an automated interdealer quotation system operated by the National Association Of Securities Dealers
  - In a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous 3 fiscal years, stockholders' equity exceeding $75MM[67]

- Ownership of shares in a regulated investment company if such company had, at the end of the most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding $75MM[80]

Stark Law Violations

Florida Halifax Hospital Medical Center[38]

The Department of Justice reached an agreement with the Provider in March 2014 for the amount of $85 million to reach a settlement on Stark Law case that was filed on June 2009 by a whistleblower who had served as the director of physician services. The case alleged that Halifax's arrangements with medical oncologists and neurosurgeons violated restrictions regarding physician referrals, resulting in an alleged 74,838 false claims and an overpayment of $105 million by government funded Medicare programs

-March 2014, Florida

Tuomey Healthcare System[103]

In October 2013, the U.S. District Court for the District of South Carolina ordered the Provider to pay a massive fine for violating various aspects of the Stark Law and False Claims Act. Tuomey was alleged to have falsified 21,730 claims to the federal government and caused $39 million in damages. In the end, the government was able to successfully request and receive the minimum civil penalty per false claim ($5,500) times the total number of falsified claims, combined with a 3x multiplier that was then applied to the actual amount of damages the government received, totaling to a sum of over $237 million

-October 2013, South Carolina

Anti-Kickback Statute and False Claims Act

Interpretation of the Anti-Kickback Statute

- The federal Anti-Kickback Statute prohibits the exchange, or intent to exchange, anything of value, in an effort induce or reward the referral of federal healthcare program business[41]
- It was originally enacted in 1972 to protect patients and federal healthcare programs from fraud and abuse through criminal persecution[41]
- There are certain payments and business practices that are excluded on a case by case basis, known as "Safe Harbors"

The ACA, through amendments to the statute, has significantly increased the degree of legal exposure that companies now face[41]

Significance of the False Claims Act

- Imposes a liability on any person who submits a false claim to the federal government
- The person does not actually have to have the knowledge that the claim is false, as any person who acts in reckless disregard or deliberate ignorance of the falsity of the information can also be found liable
- The law encompasses a general scope that includes irregular and unfair billing practices, billing for non-FDA approved drugs/devices, and falsified performance records[35]
- The exception to the legislative umbrella covered by the False Claims Act is tax fraud, which is handled by a separate IRS program[35]

Comparison to Stark Law[81]

	Anti-Kickback Statute	Stark Law
Context	Prohibits offering, paying, soliciting, or receiving anything of value to generate or reward referrals to Federal healthcare business programs	Prohibits physicians from referring Medicare patients to an entity with which the physician (or immediately family member) has a financial relationship; the designated entity is also forbidden to submit claims to Medicare for services resulting from a prohibited referral
Referrals	From anyone	From a physician
Items/ Services	Any items or services	Designated health services
Intent	Must be proven (knowing and willful)	No intent standard for overpayment (strict liability) while intent is required for civil monetary penalties for knowingly violating the law
Penalties	**Criminal:** • Fines of up to $25,000 per violation • Up to 5 years in prison per violation **Civil/Administrative:** • False Claims Act liability • Up to $50k CMP per violation • Up to 3x amount of kickback	**Civil:** • Overpayment/refund obligation • False Claims Act liability • Up to $15k CMP for each service • Up to 3x amount of kickback
Exceptions	Voluntary safe harbors	Mandatory exceptions
Fed HC Programs	All	Medicare & Medicaid

HITECH Act was Implemented to Enforce EHR Use

HITECH Summary

- The HITECH Act, enacted on 2/17/09, necessitates the use of national electronic health record (EHR) systems for covered Providers
- The goal was to improve quality, safety, efficiency, increase reporting accuracy, and reduce costs
- The government began mandating several EHR reporting and analytical requirements for covered Providers in 2011

HITECH Registration Trend Shows Adoption Has Become the Standard[115]

Medicare Incentives

- HITECH incentives are available to all non-hospital physicians who treat Medicare patients[114]

HITECH Incentive Payout Over Time

Year of Adoption	2011	2012	2013	2014	2015	2016	Total Paid
2011	$18,000	$12,000	$ 8,000	$ 4,000	$2,000	$ -	$ 44,000
2012		$18,000	$12,000	$ 8,000	$4,000	$2,000	$ 44,000
2013			$15,000	$12,000	$8,000	$4,000	$ 39,000
2014				$15,000	$8,000	$8,000	$ 31,000
2015					$8,000	$8,000	$ 16,000
2016						$8,000	$ 8,000

Tight Government Control

- HITECH increases the potential legal liability for non-compliant Providers
  - Requires implementation of mandatory willful neglect penalties that extend up to $250,000, with repeat violations extending up to $1.5 million[117]
  - Non-compliant Providers have been forced to pay these penalties since 1/1/15, helping to perpetuate the trend of Provider consolidation due to high costs to comply
- HITECH's provisions are vague in many areas[116]
  - Creates an environment in which Providers who treat Medicare/Medicaid patients must closely follow rules that they do not fully understand

Regulation on Provider Processes Results in Inefficiencies and Encourages Only Minimum Standards to Be Met

Pertinent Healthcare Laws[64]

1. **State Licensing Laws**
   - Regulatory requirements must be examined and verified to ensure that a new service line or product offered by a healthcare entity is legally permissible

2. **State and Federal Anti-Kickback Laws**
   - Though these laws are designed to prohibit incentivized patient referrals, the various "safe harbors" that are outlined as exceptions to the law can still be exploited

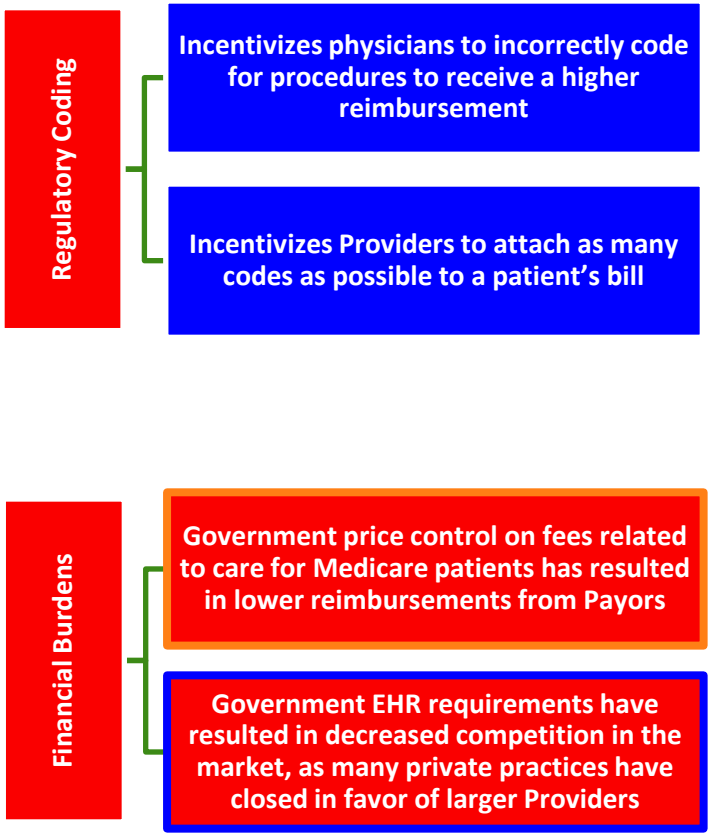
3. **Physician Self-Referral**
   - There are certain cases in which a self-referral could potentially be the most economically sensible treatment option for both the patient and Provider

4. **State Fee-Splitting Laws**
   - There are certain fee-splitting arrangements that create billing scenarios that are constituted as illegal although they may actually be the most sensible; not all states have fee-splitting laws

5. **Medicare and Medicaid Cost Reporting**
   - There are sensitivities that could arise from the business relationship between the Provider and an externally contracted entity that services cost reports filed with Medicare or Medicaid

6. **Medicare and Medicaid Reimbursement**
   - The complex reimbursement rules attributed to Medicare and Medicaid regulations often increase costs due to the complexity of administrative work required

Regulation Created Inefficiencies



Changes in the Healthcare Provider Landscape are Forcing Innovative Deal Structures

Market Overview

- The increasing trend in traditional Provider M&A that occurred between Q1 2009 and Q4 2012 began to slow as Providers began to find it more difficult to adhere to increasing government regulation[118]
- Providers are turning to more innovative and complicated deal structures in order to keep case volumes growing and continue generating a profit. This need is established due to the regulations and reimbursement methods imposed by the government and by Payors

M&A Structures

- Organizations are shifting from traditional structures such as mergers, joint ventures, etc., to more non-traditional structures like joint operating agreements or clinical affiliations[75]
- These more innovative M&A structures allow for more flexibility/interdependence between the individual entities as opposed to more traditional structures
- There has also been a recent trend of not-for-profits and for-profits coming together, as for-profits attempt to focus their resources into different markets[2]

M&A Trends

Merger
- Mutual decision of two companies to combine
- Leadership may be a combination of the two hospitals or from another source
- Hospitals absorb each other's assets and debts
- Goal is to increase economies of scale, improve quality, and increase market share

Acquisition
- Purchase of one hospital by another
- Usually a smaller entity acquired by a larger one
- Goal is to increase market share, footprint, add additional services, and improve financial stability
- Hospitals may continue to function semi-independently or combine structures

Joint Venture
- Mildly flexible
- Used to create something new that may otherwise be overwhelming
- Shared governance between two hospitals
- Contains some form of profit/risk sharing

Affiliations
- Most flexible
- Used to increase geographic footprint, gain economies of scale, exchange best practices, and supplement an already successful set of services
- Doesn't drastically alter management or governance

Joint Operating Agreement
- Assets may be separated, but services are coordinated
- Creation of overarching governing board
- May borrow for capital investments as one organization
- Similar to joint venture, but larger
- Extends past a specific service or activity

Payor M&A is Characterized by the Survival of the Biggest

Overview

- As of December 2014 the five largest Payors (Aetna, Anthem, Cigna, Humana, and UnitedHealth) controlled nearly 50% of covered lives, down from 20 Payors a decade ago[16]

- Three key industry trends have buoyed the demand for consolidation among Payors[78]
  - **Growth in Government Programs:** Medicare and Medicaid programs are expected to grow by 7% annually (faster than GDP) over the next 4 years leading to an increased need to reduce expenses through consolidation
  - **Need for New Risk and Reimbursement Strategies:** Payors currently lack the ability to fully manage Provider costs, which has promoted the emergence of innovative risk-sharing and reimbursement systems that are implemented with Providers to increase accountability and lower expenses
  - **The Search for Adjacent, Higher-Margin Sources of Revenue:** Payors are motivated to find growth outside of their core business, motivated by increasing opportunities in healthcare IT, analytics, delivery, and physician management

Mega Deal Activity in 2015

- M&A activity in the U.S. health insurance industry has rapidly accelerated in order to navigate the uncertainties created by the new regulatory landscape resulting from the ACA passing

Announcement Date	Target	Acquirer	Deal Value ($MM)
24-Jul-15	Cigna	Anthem	$54,200
Anthem announced that it would acquire Cigna in a deal valued at $54.2 billion, which would be the largest health insurance deal to ever hit the industry and create the largest domestic health insurer by membership, surpassing UnitedHealth Group's 45.9 million members by over 7 million [2]			
3-Jul-15	Humana	Aetna	$37,000
Aetna entered into an agreement to buy Humana with a combination of cash and stock for $37 billion, combining Humana's Medicare Advantage business with Aetna's diversified commercial offerings in what will be the second largest health insurance merger ever [1]			
2-Jul-15	Health Net	Centene	$6,300
Centene agreed to buy Health Net for $6.3 billion in cash and stock, consolidating the balance sheets of two smaller domestic health insurers in an effort to realize an estimated $150 million in synergies [3, 4]			

Maintaining a Competitive Edge Amongst the Crowd

Payors have pursued five strategies through M&A to strengthen their market position by increasing bargaining power established by sheer size generation[78]

1. **Extending their geographic presence**
2. **Increasing and diversifying both product and service offerings to target more consumers**
3. **Adding and internally leveraging capabilities such as data analytics & consumer insights**
4. **Managing costs in the care delivery process**
5. **Targeting noncore and international operations**

Desire for Scale Drive Provider M&A Activity

Drivers of Consolidation

- **Large group practices have the potential to realize immediate benefits[120]**
  - Cost savings through economies of scale
  - Ancillary service offerings and the ability to share additional revenues
  - Increased bargaining power
  - Increased ability to hire management expertise
  - Greater ability to invest in data infrastructure, IT, compliance, risk management, accounting, and revenue cycle management resources
  - Ability to assess and share best practices to improve clinical quality and patient care
  - Larger breadth of on-call coverage sharing improves work-life balance for medical professionals
  - Improved ability to negotiate with health plans for favorable terms

Selected Deal Activity in 2015[45]

Announcement Date	Target	Acquirer	Deal value ($MM)
23-Mar-15	United Surgical Partners	Tenet Healthcare	$2,600.0
12-Jun-15	Reliant Hospital Partners	HealthSouth Corp	$730.0
22-Jan-15	Kindred Health	Gentiva Health	$720.0
5-Jan-15	Centerre Healthcare Corp	Kindred Health	$195.0
15-Jun-15	Revera Inc. Nursing Facilities	Genesis HealthCare	$240.0
19-May-15	Valley Care Health System	Stanford Health Care	$85.0
30-Jun-15	Hollywood Pavilion Hospital	Larkin Community Hospital	$24.6
9-Jun-15	Ty Cobb Regional Medical Center	Trinity Health	$12.9
21-Apr-15	Victory Healthcare Houston Hospital	Nobilis Health Corp	$2.4

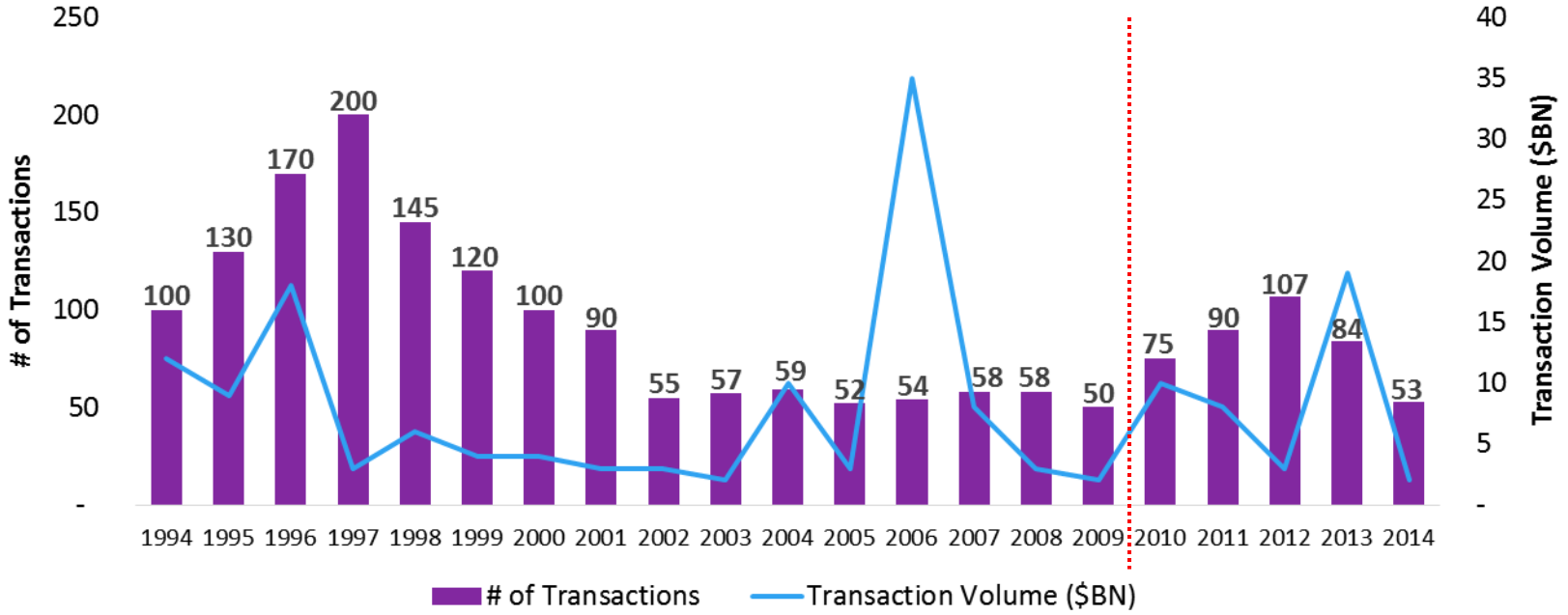
Acquisition Strategies for Providers

Target Markets	Key Success Factors	Description	Performance Metrics	Critical Infrastructure
• Employers • Individuals • Population health managers	• Minimize total cost • Compete on patient outcomes • Increase convenience and expand access • Establish a robust network • Increased patient volumes	• Leverage resources to minimize cost, improve quality, and attract key decision makers • Provide consumers value through better care	• Geographic reach • Risk-based revenue • Total cost of care • Share of wallet • Outcome quality	• Primary care capacity • Care management staff and systems • IT analytics • Post-acute care network • Leverage back office services

Historical Trends in Provider M&A Activity

Deal volume among healthcare Providers has historically seen periods of high activity that has been driven by specific catalysts

- **1994-1996**: Reform to Medicare and Medicaid incites a strong uptick in healthcare M&A as Providers race to combat rapidly rising managed care enrollment rates by engaging in approximately $40 billion of transactions in a three year period
- **1997:** The Balanced Budget Act enacts changes in the Provider payment system in an effort to reduce healthcare spending, which results in a trickle down effect that positions the market to be less investor-friendly, evidenced by a seven year spell of depressed M&A activity
- **2004:** Medicare benefits were expanded through the passage of the Medicare Drug, Improvement, and Modernization Act in late 2013, clearly impacting healthcare M&A desirability as transaction values increased to five times that of the year prior
- **2004-2007**: A leveraged buyout craze is driven by the ease of access to low-cost debt, fueling private equity buyouts and megamergers within the space, consummating in a record year of deal volume in 2006 which roughly doubles the next highest year on record
- **2010-present:** Passage of the ACA creates a demand for companies within the healthcare industry to pursue consolidation in order to save on costs and navigate uncertainties created by the legislature
- **2011:** Proposed rule issued on Accountable Care Organizations (ACO), affecting Medicare payments to Providers



Source: PricewaterhouseCoopers: Succeeding in Hospital and Health Systems M&A
Colliers: Medical Office Highlights - 2015 Outlook

Payors and Providers Explore Innovative Opportunities Through Fully Integrated Healthcare Systems

Motivators of Vertical Integration[23]

- **Reduces overall healthcare expenditures through the amalgamation of essential business functions**
  - Universal access to patient information makes data more accessible and reduces duplicate testing and procedures
  - Ability to better coordinate care for patients and improve efficiency of treatments
  - Reduce non-clinical costs by pooling resources and combining back office and administrative operations
  - Align incentives that are often askew between Payor and Provider
  - Improve reimbursement rates

Providers that have encountered difficulties starting insurance programs on their own have begun turning to M&A to meet their strategic goals of fully integrating in order to provide care and insurance together within an accelerated timeline

Vertical Integration M&A Transactions

Announcement Date	Target	Acquirer	Deal Value ($MM)
24-Dec-12	Amerigroup Corp (Provider)	WellPoint (Payor)	$5,104
30-Apr-13	West Penn Allegheny Health System (Provider)	Highmark (Payor)	$1,000
22-Dec-14	Simply Healthcare Holdings (Provider)	Anthem (Payor)	$800
8-Jun-11	CareMore (Provider)	WellPoint (Payor)	$800
1-Dec-13	APS Healthcare (Provider)	Universal American Corp (Payor)	$281
23-Feb-15	U.S. Health (Payor)	Ascension Health (Provider)	$50
17-Dec-12	Diagnostic Medical Group (Provider)	Florida Blue (Payor)	Undisclosed

Source: 21,37,46,101,122

Considerations of Regulatory Legislature

Antitrust Considerations[120]
Providers that form large groups in order to negotiate better terms with Payors may face repercussions from specific laws that seek to limit the monopolization of an industry

Anti-Kickback Statute[93]
"Safe Harbors" that protect entities from violating the law in regards to investment interests, rentals, and recruitment can be construed by a change in business structure

Stark Law[120]
Pre-affiliation practices must examine how the new relationships that will result as a product of an integrated merger will tie into the existing system of physician referrals and compliance

Many Factors Impact Whether a Merger or Acquisition in the Healthcare Market Will Fail

Sources of Derailment

- **Incompatibility of cultures**
  - Difference between entities can create huge rifts beyond just the executive level, such as when one firm employs organized labor while the other uses contracted services[31]
- **Becoming too big too fast**
  - When the cost of care increases at a rate that is too much to handle; it takes time to realize operational improvements and efficiencies over a wide system following a merger[19]
- **Inability to improve treatment quality**
  - Not all deals consummate as envisioned, service irregularities and disruptions resulting from a poorly executed merger can severely hamper the level of care
- **Loss of efficiencies**
  - Confusion and other issues can result from consummating business lines, increasing costs and time wasted by personnel

Ramifications of Failures

- **Theoretical cost savings not realized**
  - The failure to achieve anticipated reductions in expenses can quickly cripple entities financially, especially if a component of their recent merger involved heavy amounts of borrowing, leading to an erosion in the company's quality of service or even bankruptcy
- **Unpleasant shake-ups resulting from a clashing of cultures**
  - Disagreement between entities can divide executives and board members, essentially crippling a company's decision making nucleus, drive out crucial human capital such as doctors and physicians, and create major disruptions to service lines manned by non-medical staff
- **Disruption of services**
  - Entities that are unable to properly integrate as a result of a merger are likely to experience major issues while trying to serve customers

Ultimately, the consequences of these three significant factors will be passed through to the end user, whether as an insurance customer or patient seeking care, resulting in degraded service or treatment outcomes

Case Studies of Failed Mergers

1997-1999
Penn State's Hershey Medical Center and Geisinger Health System's proposed merger unwound due leadership's failure to recognize challenges of the cultural differences between the two institutions as well as community acceptance between academic and clinic physicians[84]

1998-2010
The merger between Mount Sinai and New York University's medical center collapsed due to preexisting cultural divisions, lack of sustainable support staffing, and inability to realize economies of scale and an improvement in academic performance on a timely basis[34]

2013
Detroit's Henry Ford Health System and Beaumont Health System were unable to consummate a $6.4 billion merger intended to create an integrated system, ultimately attributed to a clash of cultures that could not be resolved in a merger of equals[5]

Private Equity's Investment Into Healthcare

Deal Activity Augmented by Favorable Headwinds

- **The favorable economic environment has facilitated an increase in deal making**
  - Low interest rates have facilitated borrowing, with rates on high-yield debt remaining around 6 percent in 2014[124]
  - High stock market prices along with EBITDA multiple expansion have allowed funds to opportunistically exit healthcare investments
  - Finding value in companies exhibiting stagnation has been bolstered by the ability for private equity firms to creatively infuse capital into weakened balance sheets

- **Strategic M&A activity has been bolstered by healthcare companies that are divesting underperforming and non-core assets to strengthen their balance sheets in order to feed their acquisitive appetite for new growth catalyzers**
  - Strategic buyers have accounted for most of the deals consummated in the $500 million to $5 billion range, contributing $380 billion to all of healthcare M&A in 2014, which was an increase of 90% from the year prior[76]
  - Corporate carve-outs have been headlined private equity's appetite for equipment and supply deals
  - A majority of the largest deals were geared towards increasing scale by introducing new product categories within existing companies or horizontally integrating companies with similar product lines to promote efficiency and synergies

Private Equity Healthcare Deals[124]

Deals by Type	Transaction Count		Announced Deal Value ($MM)	
	FY13	FY14	FY13	FY14
Healthcare Providers & Services	34	33	$462	$1,786
Healthcare Equipment & Supplies	18	24	$58	$5,144
Hospitals	4	2	$35	-
Payors	2	3	$14	$11
Total	**58**	**62**	**$569**	**$6,941**

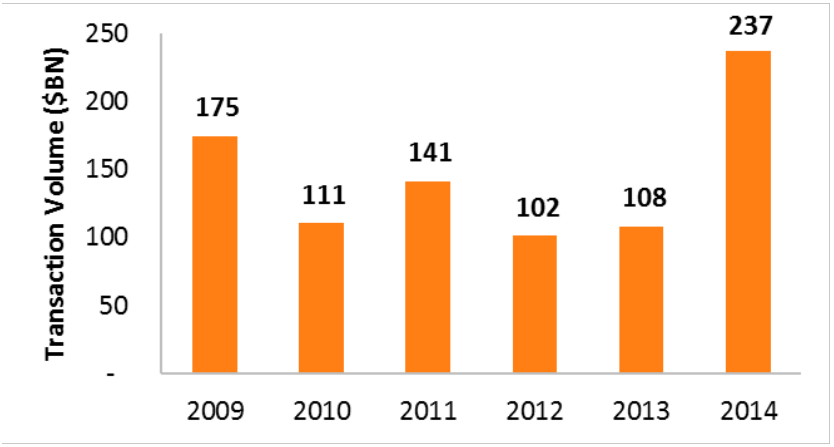
Source: US health services deals insights: Analysis and trends in US health services activity 2014 and 2015 outlook

Numerous Contributors to the Increase in Healthcare M&A

Future Trends

- Consolidation is typically justified by external market factors that must be combatted to remain competitive[47]
- The wave of healthcare M&A, especially horizontal integration, is expected to continue well into 2016 as uncertainties will continue to loom in regards to the ACA
- Vertical integration is still not well adopted and there may be changes in the way that this type of consolidation is handled[47]
- Antitrust concerns remain the biggest threat to healthcare M&A[47]
- The total global profit pool will grow at a CAGR of 4% through 2020[43]
- The demand for home and tele-healthcare will increase[43]
- Increased requests for consumer engagement will alter Provider treatment protocols[43]

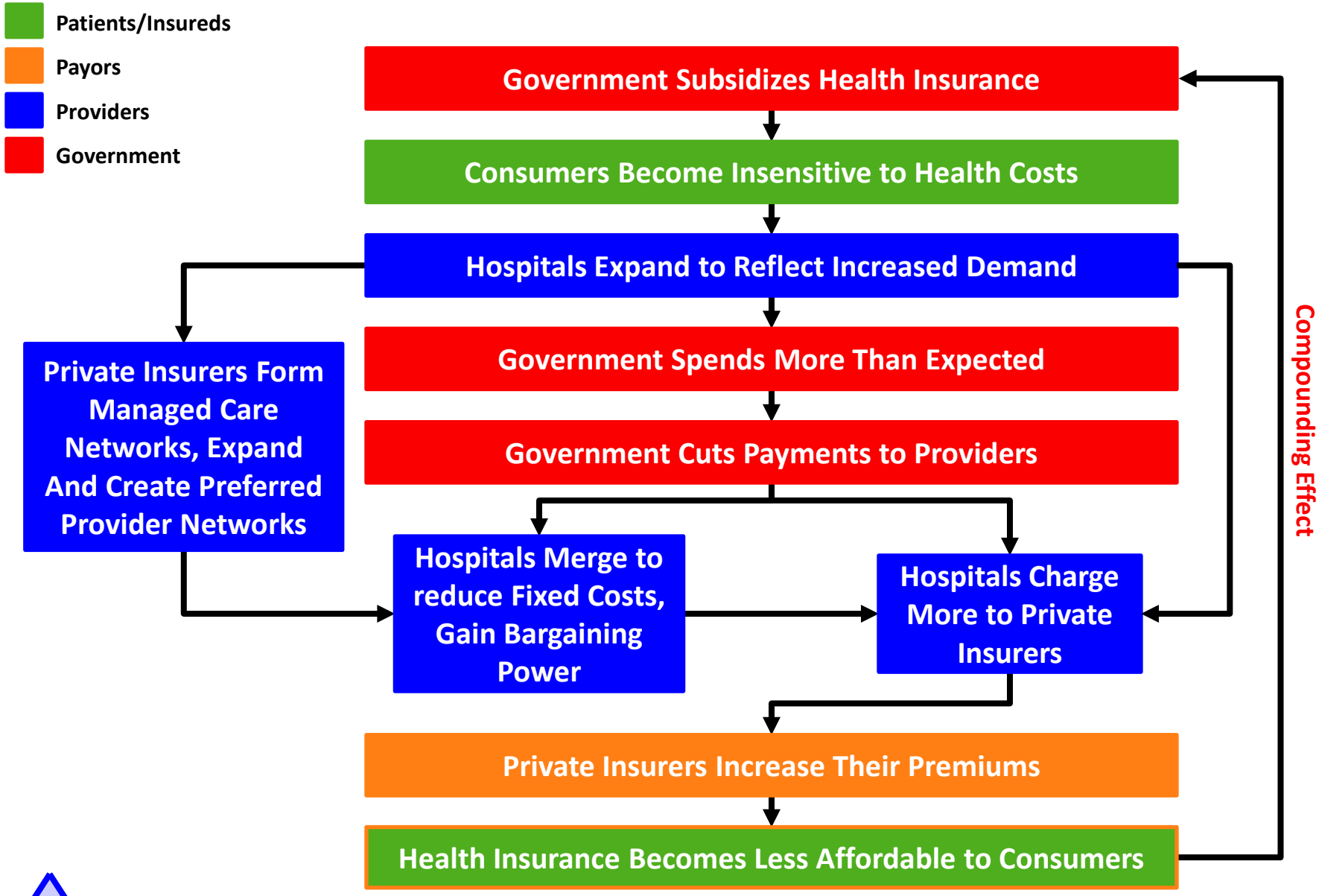
Transaction Value of U.S. Healthcare M&A



Source: Statista: Transaction value of mergers and acquisitions in the U.S. healthcare and life sciences industry from 2009 to 2014 (in billion U.S. dollars)

Initiatives Inciting Consolidation

Cyclical Government Subsidization of Health Insurance Increases Price Burden for the Insured



The Affordable Care Act Gives Government Limitless Potential Control Over the Medical Process

HHS Regulators

Under ACA Section 1311 regulators set "qualifications" that allow insurers to participate in the exchange.[125] The exchange will become the primary way consumers select their insurance, therefore the companies that don't meet the qualifications will likely fail

Section 1311 also gives the government regulators expansive control over Providers through the insurer exchange qualifications.[125] As Providers generally must contract with Payors due to ingrained reliance on third party payment systems, Payors are forced to require contracted Providers to comply with the federally determined regulations

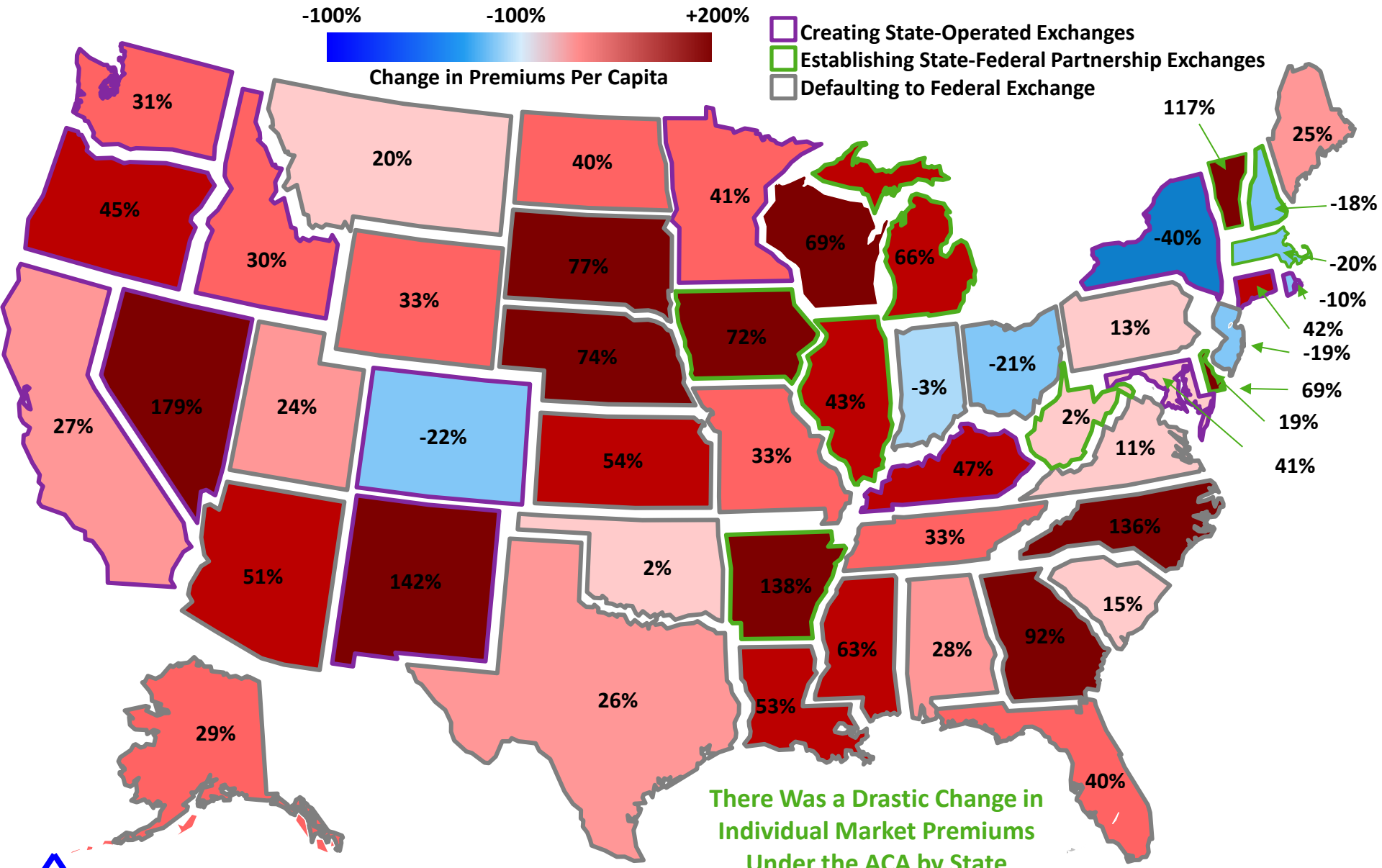
Insurance Exchange Created Under The ACA

These regulations create payment structures that reward and incentivize "quality reporting…chronic disease management, medication and care compliance initiatives…use of best clinical practices, evidence based medicine, and health information technology"[125]

This regulation also gives the Secretary of HHS the authority to develop guidelines to address the aforementioned matters. Starting January 1st 2015, a "qualified" Payor can contract with a Provider "only if such Provider implements such mechanisms to improve health care quality as the Secretary may, through regulation, require"[125]

The ACA will create approximately 159 new committees, agencies, programs and bureaucracies with vast new sweeping regulatory powers[2]

The Affordable Care Act, Particularly When Run at the Federal Level, Results in Increases in Healthcare Premiums



There Was a Drastic Change in Individual Market Premiums Under the ACA by State Between 2013-2014[65]

Source: Obamacare Has Failed To Collapse – But Its Premiums Continue to Climb – Forbes, Wikipedia: Health Insurance Marketplace

One of the ACA's Touted Successes Actually Shows How the Act, Even When Thought to be Working, Inflates Prices

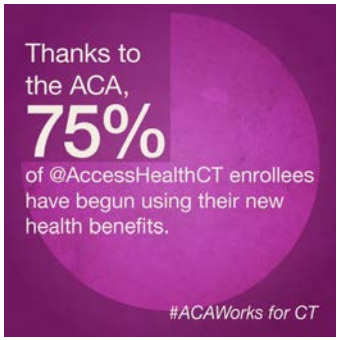
Connecticut Falsely Spun as a Success

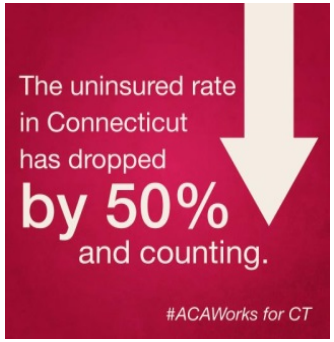
- Claims such as Healthinsurance.org's statement "Access Health CT [Connecticut] has been one of the nation's most successful marketplaces" make it clear that even the best of the success stories of covered lives of the ACA raise premiums by over 42%[65]
- The CMS puts out updates on the progress of the program in Connecticut that ignore the large hike in premium prices all insureds face whether or not they used the ACA exchange to obtain their insurance or not
- The claims to success are made by repeatedly recycling through new phrasing of the increase in the number of insured individuals in Connecticut

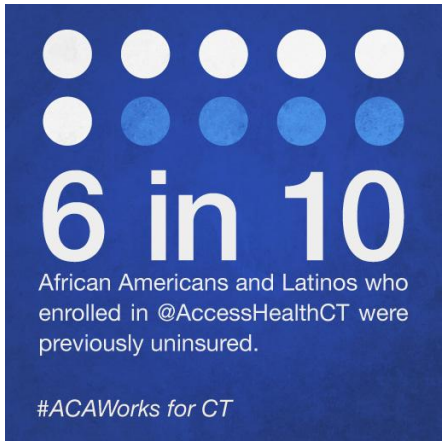
Premium Jump Shows a Clear Failure

Connecticut made the Kaiser Foundation's list of the top ten most expensive health insurance markets in 2014[127]

1)Colorado	6)Wyoming
2)Georgia	7)Mississippi
3)Nevada	8)Vermont
4)Wisconsin	**9)Connecticut**
5)Georgia	10) Alaska







Source: CTHealth: aca works in Connecticut

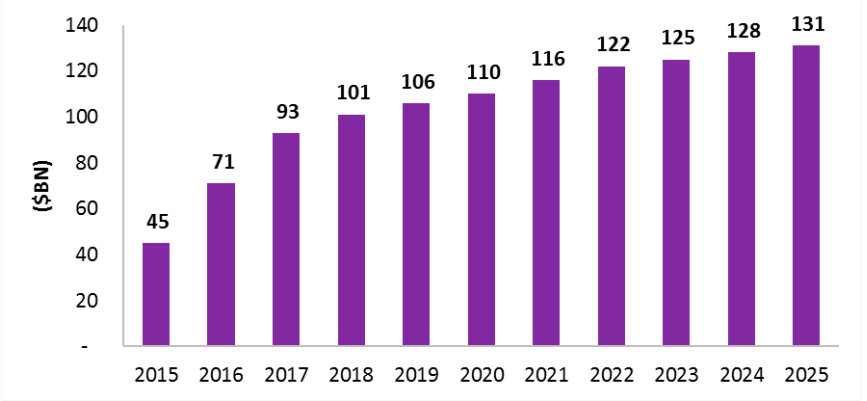
Connecticut's Claims Of Success Ignore the Real Problems Caused by the ACA Exchange

The Constant Growth in Cost of the ACA Does Not Equate to a Growth in the Number Benefitting

Cost Benefit Relationship of Healthcare Spending is no Longer Linear

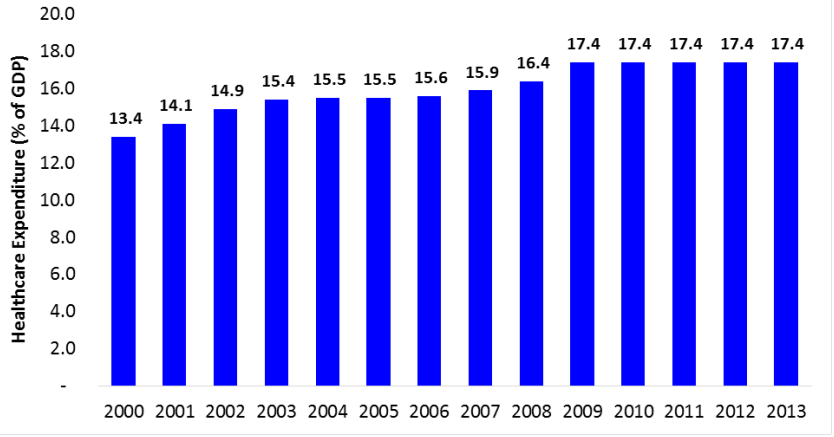
- Under the ACA, government funded expenditures on health insurance exchange subsidies and other related spending is projected to nearly triple from 2015 to 2025
- Conversely, health insurance exchange enrollment is expected to stabilize by 2017 and remain relatively stable through 2025
- The increasing demands of administering care to an aging populous of baby boomers has contributed to the steady rise of national healthcare expenditure between 2000 and 2013
- The intended benefits of the ACA appear to quickly plateau while the overall financial burden continues to mount, signaling inefficiencies and miscalculations in the program's effectiveness

Projected ACA Health Insurance Exchange Subsidies & Related Spending[6]



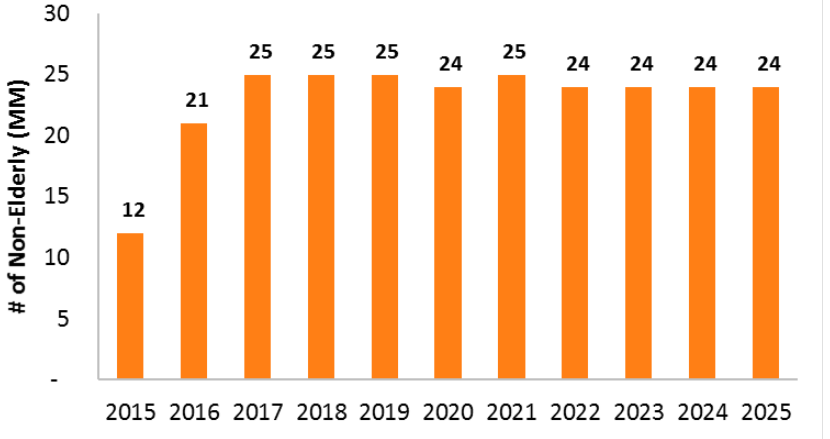
Statista: Projected ACA health insurance exchange subsidies and related spending from 2015 to 2025 (in billions U.S. dollars)

National Healthcare Expenditure[9]



Colliers: Medical Office Highlights - 2015 Outlook

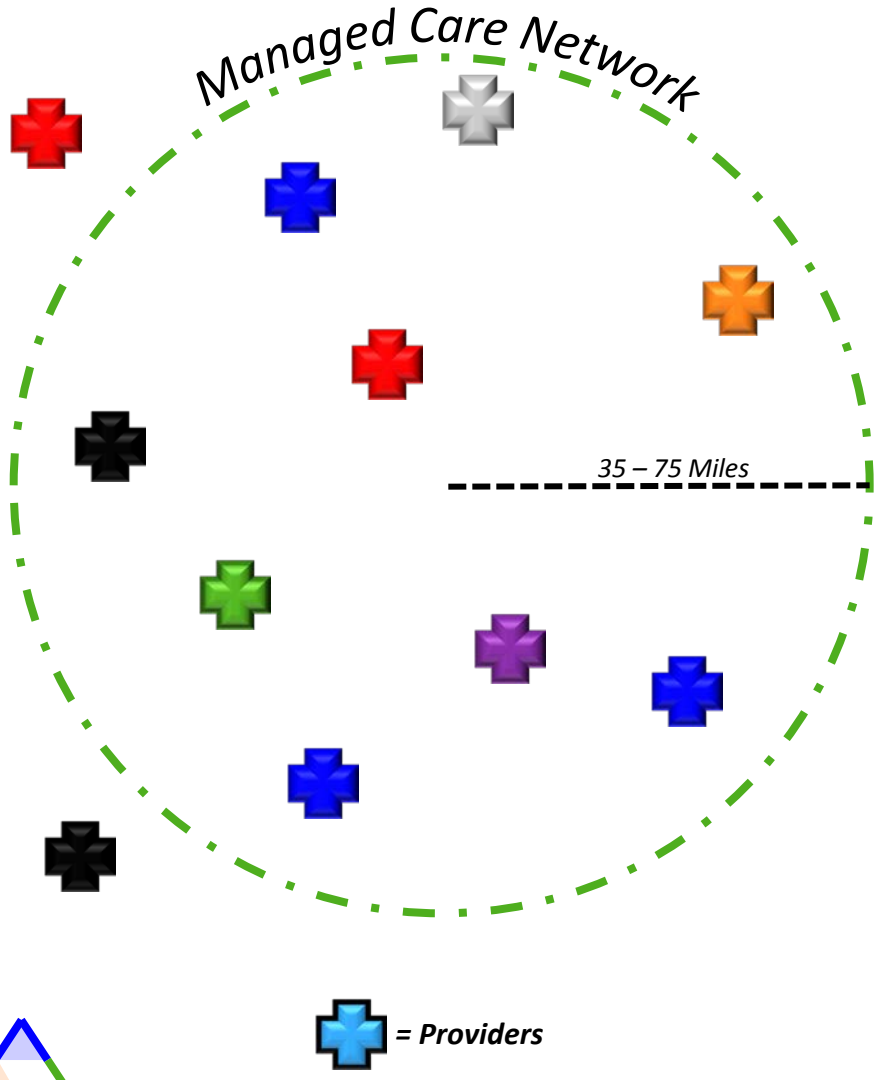
Projected Enrollment in Health Insurance Exchanges under ACA[8]



Statista: Projected number of people enrolled in health insurance exchanges under the Affordable Care Act from 2015 to 2025 (in millions of nonelderly people)

Reduced Competition Gives Excessive Bargaining Power to Large Providers

Payor Network Area Example



Benefits of a Competitive Market

- Before an insurance company's managed care network undergoes a myriad of M&A leading to extreme consolidation, it usually looks similar to the image on the left
- When a network is diverse like this, a Payor is able to negotiate in-network rates with different systems based on that specific system's performance levels and other metrics, encouraging efficiency and cost reduction for Providers
- In a competitive market insurance companies can squeeze payments and Providers can push back appropriately, market forces are more balanced

Process of Consolidation

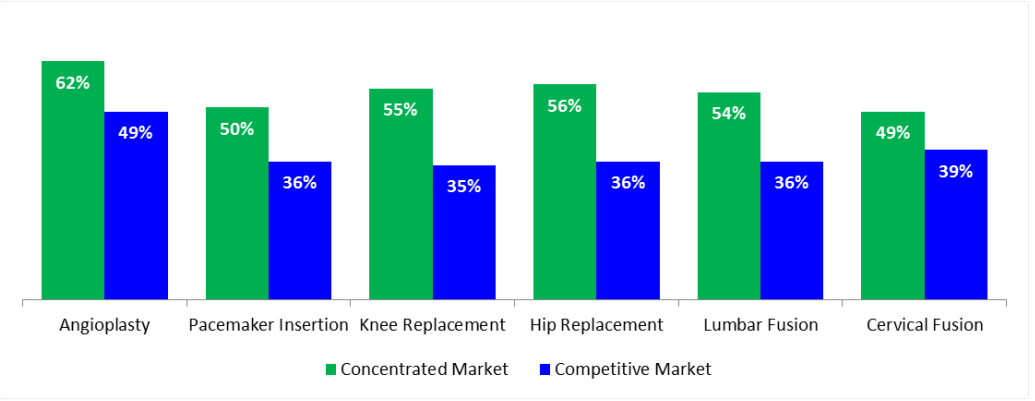
- If the network to the left were to consolidate and the Grey, Green, and Black facilities were acquired by the Blue system, the Blue system would suddenly have an excessive amount of bargaining power in reimbursement rate negotiations with the Payor
  - This is because a Payor is required to provide a certain amount of diversity in Provider options that they offer their insured individuals; therefore, if 6 out of the 9 hospitals in the network were to threaten to withdraw unless offered better reimbursement rates, the Payor would capitulate to the demands
- This power eliminates the need for a Provider to efficiently manage its expenses, and raises insurance premiums as Payors pass increased costs to consumers

Provider's Increased Bargaining Power Increases Their Profit Margins but also Increases the Price Consumers Pay for Care

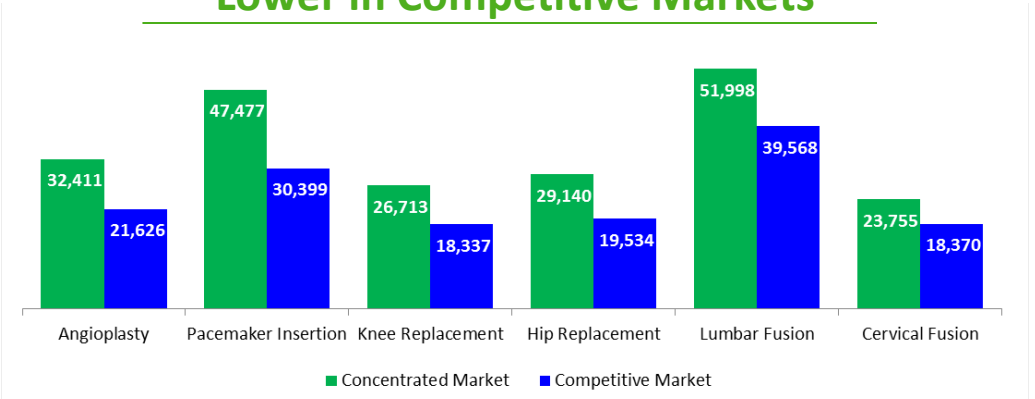
Providers Benefit at Patient Expense

- Inflated reimbursement rates that flow as a result of increased bargaining power and decreased competition allow Providers to increase their profit margins while operating in a bloated, inefficient way
  - Over-compensated staff
  - Under-utilized facilities
  - Lack of spending discipline across facilities
- Unfortunately, the third-party Payor model and a lack of competition desensitizes individuals and Providers to the cost of procedures, therefore they excessively bill Payors. This inflated cost to Payors gets passed on to the insured through increases in premiums in the future
- "Any willing Provider" laws force Payors to contract with even the most inefficient Providers, providing very little incentive for Providers to more efficiently and effectively manage their resources
  - In the case of a large Providers, this law is bad for the market and can exacerbate an already entrenched monopsony situation
  - In the case of small Providers, this law helps protect hospitals from going bankrupt due to Payors ignoring them or pushing rates far below Provider cost levels

Consolidation Induced Provider Profit Margin Increases



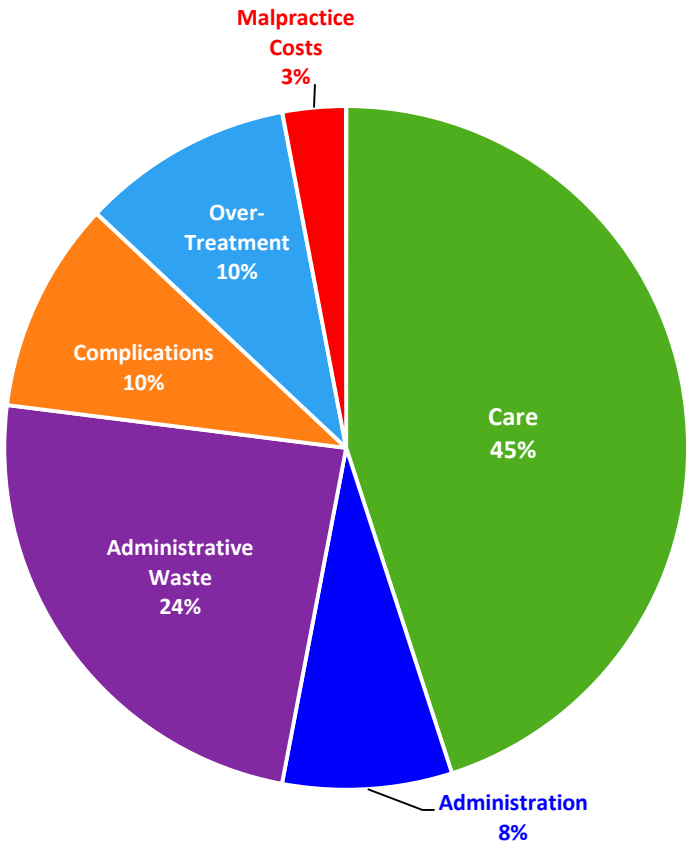
Prices are Consistently Lower in Competitive Markets



Hospital Consolidation: The biggest Driver Of Health Costs That (Almost) Nobody Talks About

Large Provider Inefficiencies Lead to a Tremendous Variance in the Price of Services

Total National Health Expenditures FY 2011



Source: CMS-Medicare Provider Utilization and Payment Data: Physician and Other Supplier

Variance in Medicare Billing FY 2013

Lower Joint Replacement[130]	
Las Colinas Medical Center, Texas	$160,832 ($12,642 reimbursement)
CJW Medical Center, Virginia	$117,000
George Washington University, D.C.	$69,000
Baylor Medical Center, Texas	$42,632 ($14,202 reimbursement)
UM Medical Center, Massachusetts	$36,000
Sibley Memorial Hospital, D.C.	<$30,000
Winchester Medical Center, Virginia	$25,600

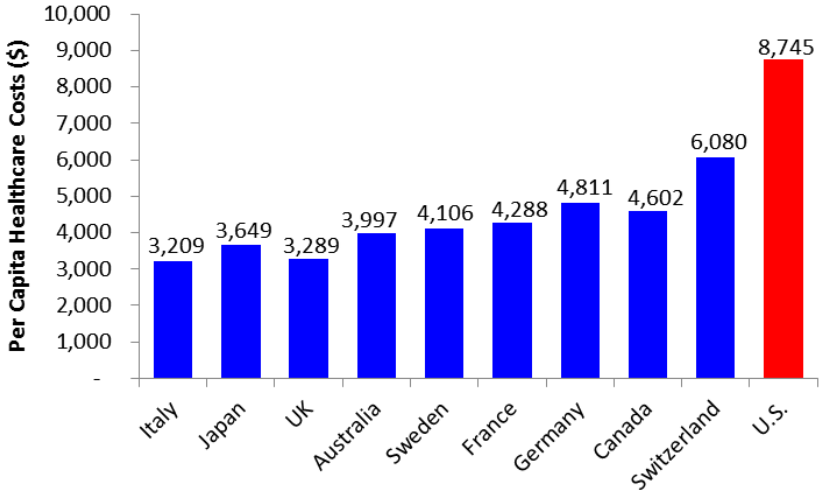
Drivers of Price Disparities

- Lack of transparency with consumers
  - Allows for hidden price variance by making 'price shopping' difficult
- Inflated overhead in large Provider facilities
  - Bloat of many large providers causes variance due to differences in cost efficiency
- Market control due to size of Provider
  - Larger providers can afford to force Payors into higher reimbursement rates

Payor & Provider Lack of Prior Price Transparency to the Insured Makes it Impossible to Have Competitive Choice

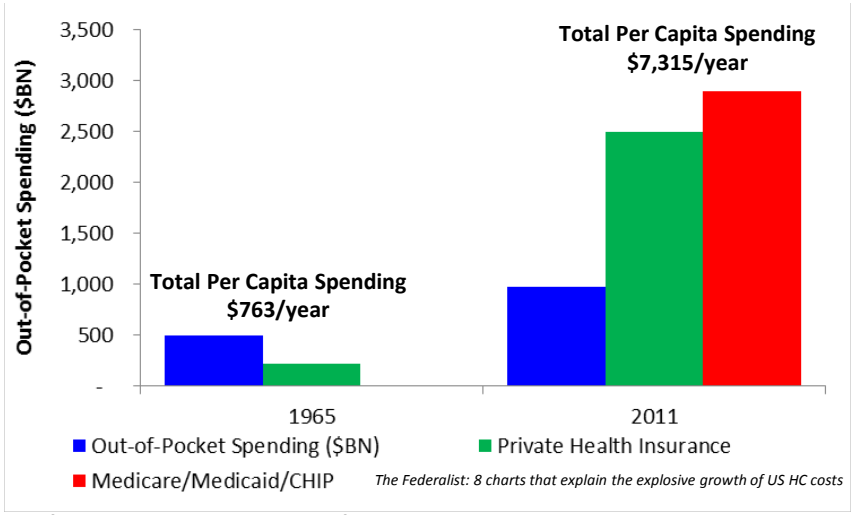
How Today's Consumer is Shielded From the True Costs of Care

- The U.S. healthcare market is completely unlike any other market because patients rarely know the cost they are paying for services until after they are completed
- The third party payment model effectively creates a barrier between the Providers and the consumers, with a Payor acting as the intermediary and assuming the risk burden of offering insurance
- Because of this gap, the only out of pocket payments the consumer pays are co-payments and insurance premiums
- Co-payment amounts are difficult for the average consumer to estimate because of the veiled nature of the actual cost, further distancing the consumer from the price paid for the services they received[131]



Source: Peter G Foundation – Healthcare Primer

Healthcare Spending 1965 Vs. 2011



The Federalist: 8 charts that explain the explosive growth of US HC costs

- Before the establishment of government healthcare in 1965, the majority of healthcare spending was out of pocket, meaning that health consumers were much more sensitive to the costs of their healthcare decisions
- The lack of transparency surrounding costs of care under the modern third-party Payor/government program has led to a lack of concern and interest in the cost of actual care received, instead focusing on the significantly lower cost of insurance premiums

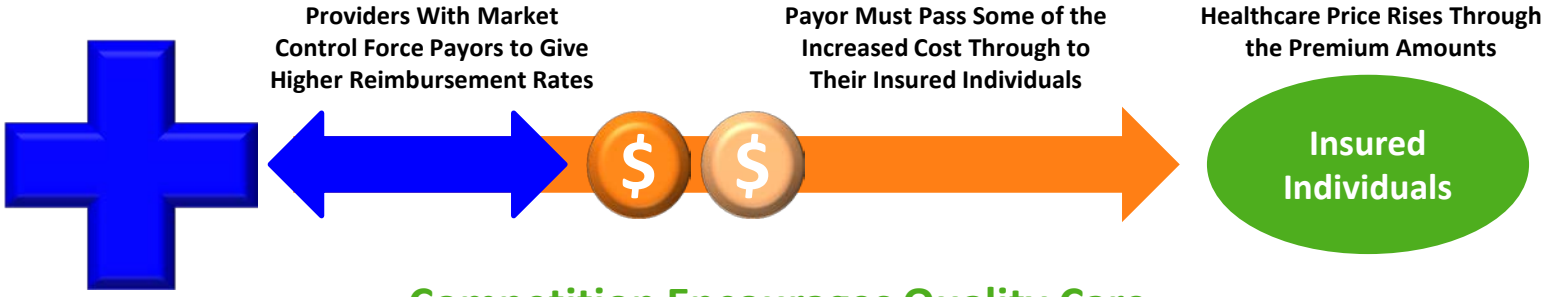
Complete shielding from price prevents customers from "shopping" for the best and most efficient Providers, raising costs by eliminating the need for efficiency as there is no competition in the market

Monopsony Power is a Recipe for Failure in Any Market

Monopsony Power: One Buyer Holds All the Cards

- In a market of quickly consolidating Providers with the power to bully Payors into paying much higher reimbursement rates, forcing the Payors to contract with Providers through a law such as the "any willing Provider" law gives the Providers an unchallengeable monopsony by eliminating any tool a Payor might have to bargain with[132]

- Provider monopsony power leads to increased premiums charged to the insured by Payors as they attempt to pass through some of their increased cost



Competition Encourages Quality Care

- Competition leads to the need inspire and encourage customers to purchase a product in order to stay in business. In healthcare, patients are the customers

- Patients look for two things if given the time and choice when selecting a hospital or Provider of any kind: Price and Quality

- Therefore, rationally operating Providers would work to be as efficient as possible to allow for lower pricing and to offer the highest quality of care to inspire trust within potential patients

- Without competition Providers become bloated and lathargic. This leads to increased cost and a lack of effort to improve quality of care because they have no threatening competition, and therefore, no incentive to improve

Reimbursement Models: Fee-for-Value Model Provides Incentives for Provider Efficiency

Fee-for-Service Reimbursement Model

- Each procedure has a single, set reimbursement amount to be paid out regardless of individual procedure variances
- Creates a Provider emphasis on volume and standardization of procedures
  - Promotes volume over quality, hurting care quality levels
  - Discourages coordinated care
  - Encourages over-utilization of equipment and supplies
  - Decreases incentive for innovative procedures because the increased cost of new technology and procedures is not going to be reflected in the reimbursement amount received

Fee-for-Value Reimbursement Model

- Reimbursement levels under a value-based reimbursement model are subject to penalties or bonuses based on the success or failure in meeting or upholding certain quality and cost-efficiency targets and standards
- Is a step towards allowing efficiency to become a competitive advantage in the healthcare industry
  - Improves coordination of care
  - Incentivizes improved quality of care
  - Incentivizes Providers to utilize new technology to reduce costs
  - Improves competition within the market

Analysis of Reimbursement Models

	Patient is Admitted	Code Determined Cost For Specific Procedure	Applied Overhead	Efficiency Variable	Treatment	Total Cost	Reimbursement
Fee for Service		$10,000	+$1,000	+$2,000	+$2,000	$15,000	$10,000
			Standard Inefficiency as Common in Industry	Overbooked Physician Makes Mistake Due to Lack of Diagnostic Time	Complication leads to Longer Inpatient Stay		Loss = -$5,000
Value Based Care		$10,000	-$1,000	-$1,000	-$1,000	$7,000	$10,000+$2,000
			More Advances & Efficient Processes Lower Overhead Costs	Saves through efficient Shared Services	Quality Care & Accuracy Leads to Quicker Diagnosis & Earlier Discharge		Profit = +$5,000 Quality and Cost-efficiency Targets Met, Bonus Paid Out

When government organizations set the target levels for bonuses and penalties, the fee-for-value model typically causes losses which lead to reduced quality. This is due to a created worry of admitting extraordinarily sick patients, and decreases in price due to penalties resulting from missed target expectations that were poorly set at an unattainable level.

Technology Advances Reduce Cost of Healthcare Management

How Technology can Reduce Healthcare Costs

- Kaiser Permanente, the largest nonprofit integrated healthcare delivery system in the U.S., has relied on extensive application of technological services to become a competitive player in modern healthcare
  - Kaiser invested approximately $4 billion[135] in 2010 to build and implement a new proprietary EHR system that reduced the percentage of patients with bed sores to well under 1% from 3.5%[134]

- Reduced costs associated with Kaiser's improved EHR system highlights a fraction of the potential savings that could be achieved, should the healthcare industry take steps to increase its adoption rate of new medical and back-office technology systems

Technology will help caregivers work as a team

Increase patient-clinic interaction

Shift diagnostic testing into the hands of the patients

Promote self-management of chronic disease

cellscope athenahealth

Digital Diagnostics	Electronic Records	Wearables
• Allow conditions to be diagnosed remotely, and have their records immediately updated on the electronic record network • Lowers Provider outpatient costs	• Lead to better coordinated patient care • High up-front costs result in a permanent efficiency improvement	• Allow consumers to more closely monitor their own health • Wearables help to avoid overtreatment costs by giving consumers real-time health statistics

The future of healthcare is going to be rationing or re-engineering[134]

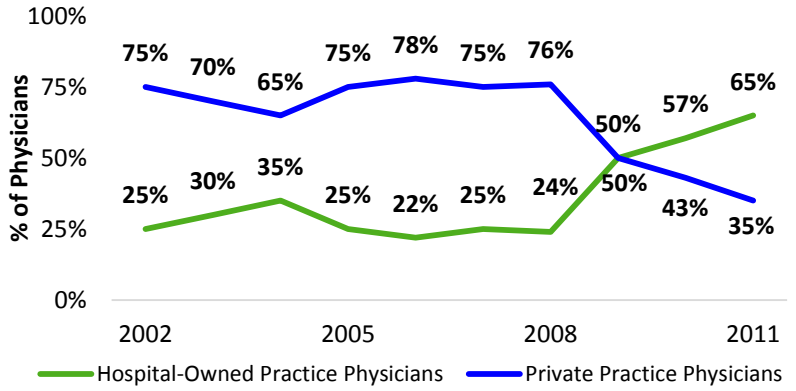
–George C. Halvorson, Former Chairman and CEO of Kaiser Permanente

Decreased Competition Raises Prices and Lowers Quality

Impacts of Provider Competition

- A 2012 Robert Wood Johnson Foundation Report presents some key findings:
  - Hospital consolidation generally results in higher prices across geographic markets[136]
  - When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20%
  - The majority of consolidation was found to have been undertaken primarily for the purpose of enhancing bargaining power with Payors

Employment Dynamics Indicate a Trend



Medical Economics - Monopolizing medicine: Why hospital consolidation may increase healthcare costs

Volume Over Quality Trend Only Benefits High Volume Providers

- This prevents major healthcare Providers from pricing services based on accurate cost recognition
- Providers with a large enough market share in an populated area have a significant level of control over price
- Indirect costs for Providers are increasing based on the cultural pressure to provide state-of-the-art services and facilities, while expecting adequate reimbursement from Payors (culture clash)
- Smaller facilities with effective costing processes in place, that can provide quality service to patients at a lower price, do not receive an advantage in the current system

CPT Code (Medicare Code)	Private Practice Reimbursement	Hospital Reimbursement
99204	$158.33	$254.87
99205	$197.06	$331.33
99211	$19.71	$61.53
99212	$41.45	$100.27
99213	$68.97	$124.40
99214	$102.27	$175.48
99215	$137.60	$235.51

Medical Economics - Monopolizing medicine: Why hospital consolidation may increase healthcare costs

Government Programs, Incentives, and Subsidies Erode the Physician Quality of the Future

Reimbursement Control (ACA Section 3007)

- Creates a value-based payment modifier which adjusts physician reimbursements based on quality of care as defined by the Secretary of Health & Human Services and cost compared to other physicians
- This establishes an arbitrary cut-off for acceptable physician costs, physicians going above this threshold or failing to practice in the ways defined will be penalized

Compromised Care

- Threat of fiscal punishment will further push physicians to practice standardized care rather than care relying on trained best medical judgement, this will lead to compromised care
- The ACA creates pressure on physicians not to order tests, consults, or drugs that their patients may need due to related costs

Reduced Doctor-Patient Access

- "Improvements to the physician quality reporting system" will increase the amount of paperwork physicians are required to fill out, reducing the time that doctors can spend with their patients

Job Dissatisfaction & Increased Fear

- Increased oversight, excessive paperwork, less autonomy, increased malpractice risk due to a regulation-created rush in the medical process, and a diligence reducing cost threshold will lead to high levels of job dissatisfaction
- Without increased malpractice protections, regulations create a paradox by punishing doctors for high costs while consecutively scaring them into the practice of defensive medicine

Multifaceted Decrease In Physician Quality

- Many doctors may not actually leave the profession but they will likely work with less effort and much lower morale
- Upfront investment required to practice medicine and barriers to exit the profession will keep the number of practicing physicians artificially high but not in a way that serves patient's best interests
- Bright young minds will be deterred from pursuing a career in medicine, eroding physician quality over time [91]

A 2009 poll of 1,376 randomly chosen doctors showed that 65% of doctors opposed the new healthcare agenda and that 45% of practicing physicians considered leaving their practice or retiring early if the ACA passed[91]

Accountable Care Organizations (ACOs) Show the Negative Impact of Over-Regulation on an Integrated HC Model

Establishment of ACOs

- The ACA instituted the Medicare Shared Savings Program, and more recently, the Pioneer Program. These programs provided reimbursement incentives to Providers that pursued structural reform and operated according to a rigid set of rules and regulations during and post ACO formation
- ACOs are similar to HMOs in that Physicians, Payors and Providers contract together to form a network of access. The major difference is, in order to receive government program reimbursements, ACOs must follow strict government regulations, new standards and attempt a new pricing model[140]
- The goal of the new pricing model is to spread the risks of cost between both Payor and Provider. It is a promising idea that could work well if not for regulatory interference resulting in a decrease in quality, leading to a lower reimbursement amount, and therefore higher costs[138]

ACOs Show How Promising Vertical Integration Fails With Over-Regulation

- ACOs are a government attempt to cut costs and improve healthcare quality; however, it fails in every aspect of its goal
- Many of the primary 32 ACOs have abandoned the model due to its failure, with only 19 of the 32 still organized as an ACO[139]
- The original goal of ACOs was to decrease cost and improve care quality, instead government involvement and regulation caused the opposite
  - Increased administrative costs to ensure alignment with excessive requirements
  - Decreased admission for the sickest patients due to financial disincentives associated with the risk of failure leading to lower quality of care
  - Lowers physician quality as the best physicians notice the flaws in the system and depart from the model
  - Inflated cost and quality targets that cannot be met result in strict monetary penalization upon failure[140]
  - Fixed per patient budgets, often referred to as “capitation”, lead to greatly reduced quality of care and often result in losses for Providers

ACOs are an example of how a model with potential for success and the makings of a promising pricing solution fails when government steps in and either intentionally or unintentionally prevents competition

Fully Integrated Payor-Provider Models Have Proven to be Successful

Successful Payor-Provider Integration

- One company consisting of both Payor & Provider services, not just contracted relationships, built to form a network. The formed company, through its ability to control all aspects of the healthcare process, can deliver care more efficiently, at a lower cost, and with a higher quality of care
- Consists of a group of primary care physicians, specialists, hospitals and a Payor who merge to form one integrated company with full control over the pricing model at all levels
- Success of the full integration model relies on competition generating the need for these organizations to keep prices down; otherwise, the fully integrated business could potentially price gauge patients
- Requires a significant amount of IT infrastructure support to be effective[138]

Why it is Not More Common

- There are two primary detractors for healthcare entities looking to adopt this model [Vertical integration][138]
  - Cost associated with the consolidation of resources to establish and operate a fully integrated healthcare system
  - Lack of willingness to pursue a radical change due to pre-ingrained market trends, high market control of bloated and government subsidized Providers, and regulatory hurdles to overcome
  - Fear of assuming the risk associated with providing care and offering insurance
  - Many Providers in the market today operate too inefficiently and rely on regulated government reimbursement. This results in an inability to take the first step towards vertical integration

Successful Integration Case Study

- Kaiser Permanente is a fully integrated delivery system
  - Payor, physician groups, and hospitals are one company
  - Care is provided only to those insured by their organization
  - History of strong care coordination and delivery[143]
- Kaiser Permanente's model is a prime example of how a fully vertically integrated model is superior to a contracted relationship that has government-set quality and reimbursement standards
  - Merged to be both Payor & Provider, so that all functions of the system work together to provide quality healthcare at a low cost with positive margins
  - Full integration reduces the control the government has on reimbursements between the private Payor & private Provider, allowing successful adaptation of the pricing model

Kaiser Permanente[142]

- Not-for-profit
- More than 10 million members
- HQ in Oakland, California
- 38 hospitals
- 619 outpatient facilities/offices
- 17,791 physicians
- $56.4 billion in annual revenues 2014

To succeed, the Payor-Provider model must be a fully integrated, privately operated company. Contractually connected networks attempting to implement a new pricing strategy do not succeed due to misalignment of incentives and over-regulation

Challenges Associated With Disrupting the Current Payor/Provider Market Relationship

Regulatory Hurdles

U.S. antitrust laws have played a major role in corralling M&A attempts within the healthcare industry as the FTC has argued that certain attempts at consolidation unfairly eliminate competition[10]

Certificate of Need laws act as a legislative impediment for healthcare facility creation, acquisition, and expansion in 36 states

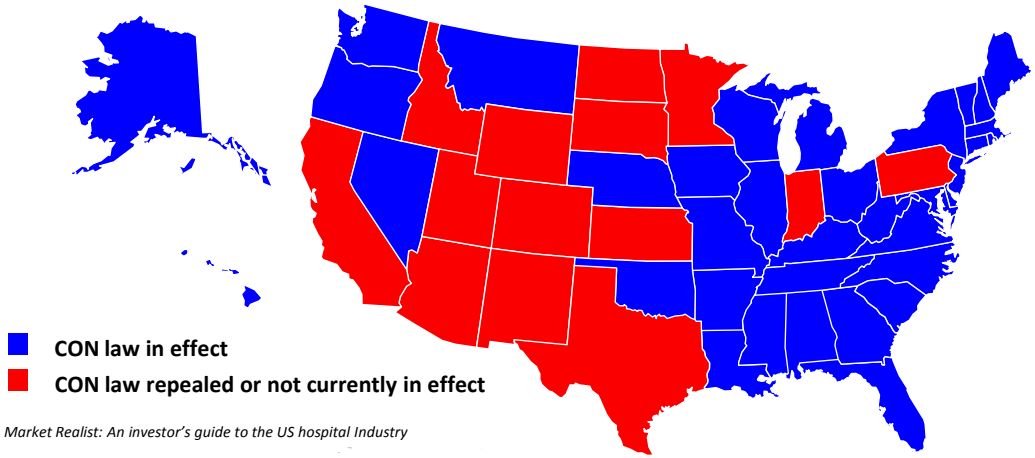
HIPAA and other regulations on the handling of patient medical records have contributed to the issues that obstruct transparency, resulting in increased cost inefficiencies and improper levels of care[62]

Laws governing the mobile health (mHealth) industry make it difficult to integrate new technology (such as telemedicine) into business models, particularly across state lines

Barriers to Entry

- **Shortage of human capital**
  - Less university students are pursuing careers in the medical profession, making it difficult to adequately staff facilities; the U.S. is projected to face a shortage of 90,000 doctors by the year 2025[97]
  - This has been attributed to the arduous education/certification process, and the emergence of occupational substitutes
  - The Balanced Budget Act, originally enacted in 1997, caps funding for medical residencies[91]
- **Intensive capital requirements**
  - Payors must create and maintain large pools of cash to maintain liquidity levels compliant with regulation
  - Providers face the high costs of essential equipment and facilities[104]
- **Large size of giant players dwarf the healthcare landscape**
  - Industry consolidation has created large conglomerates that squeeze out smaller competitors by utilizing economies of scale, access to distribution channels, and strong negotiation leveragability[22]

Certificate of Need Laws by State[80]



Certificate of Need Laws Limit Growth

- Subjects Providers to Government-set constraints on their construction of additional medical capacity
- Meant to reduce overbuilding but results in regulatory-induced erosion of the competitive market environment

Unification of Payor & Provider Incentives Encourage Vertical Integration

Arranging Incentives to Create Benefit

- The fee-for-service system, that has contributed to wastefulness and excessive healthcare costs, can only be eliminated if Payors and Providers are able to share their interests in creating a healthcare model that is targeted at improving patient outcomes instead of reimbursing Providers based on activity alone[69]
- In the current system, Providers control 85% of costs; however, Payors have very limited visibility into the clinical quality of care that is administered by Providers, which results in disputes and underfunded claims. A vertically integrated system can capture the benefits of greater transparency and reduce readmissions[24]
- Payors have access to historical claims data and Providers maintain clinical data, by creating a relationship within which both of these data sets can be openly shared is a powerful tool for the optimization of the overall healthcare business model[96]
- In the traditional healthcare marketplace, Payors and Providers are constantly angling with each other to negotiate more favorable contracts and partnerships; vertical integration creates an economic alignment that eliminates pricing inefficiencies

The current healthcare system is heavily fragmented, resulting in an industry filled with misalignment of incentives, lack of coordination, and lack of trust, ultimately driving up costs for all parties involved and adversely impacting patient outcomes

Cases of Implementation[80]

Cigna and Weil Cornell Physician Organization
Launched a collaborative initiative aimed at improving the deployment of health resources, lowering total medical costs, and increasing patient satisfaction

-January 2012

Highmark and West Penn Allegheny Pursue Affiliation Agreement
Highmark wished to leverage its health plan model with the Provider to revitalize the system's distressed hospitals and outpatient facilities

-June 2011

UnitedHealth Acquired Mgmt. Arm of Monarch Healthcare
Done in order to streamline the administrative support and access to advanced information technology that is delivered to the Provider's primary care and specialty physicians

-August 2011

Humana Acquires Concentra
Goal was to expand the Provider's service areas and provide better service to patients through actionable intelligence tools that provide comprehensive real-time patient information

-December 2010

PE Can Eliminate Current Inefficiencies and Out-Perform Competitors by Blending Payor/Provider Models

Leadership and Guidance

- Private equity firms can monitor the integration of Payor and Provider models from a high-level, allowing them to gain insight that is often overlooked on the "ground-level" among physicians and healthcare executives
- Funds are constantly motivated to seek new ways to maintain and bolster performance, as they have a vested financial interest; an attribute sometimes lacking among management in the typical "eight-to-five" corporate work environment. In addition, funds must exceed performance hurdles to generate returns for both their investors and internally
- The ability to utilize internal contacts and firm resources to survey a wide array of networks and target markets for sourcing transactions allows private equity to be better positioned to correctly align Payors and Providers that can merge successfully
- Synergies can be uniquely realized as private equity firms have the ability to strategically combine portfolio companies and make bolt-on acquisitions to bolster business offerings and create additional value in the integrated healthcare market place
  - *Example: The addition of a business process outsourcing firm to a vertically integrated model can streamline non-healthcare related operations and boost productivity*

Example PE Approach to Integration

1)Locate entities that are complimentary in nature and that could merge together synergistically by performing a deep-dive into each company's operational capabilities, financial health, business model, and projected future performance

2)Survey the regulatory landscape and evaluate risks that could hinder the success of a fully integrated system

3)Consummate the transaction and employ industry expertise to best prepare the company for success

4)Set performance standards and targets that are routinely monitored and evaluated

5)Invoke a change of specific leadership positions if there are sections of the company that are underperforming

6)Implement a calculated marketing strategy to attract new customers as well as explore options to add new service offerings (if profitable) to the existing business

7)Retain existing customers through ensuring that the quality of care that is administered is of the highest quality

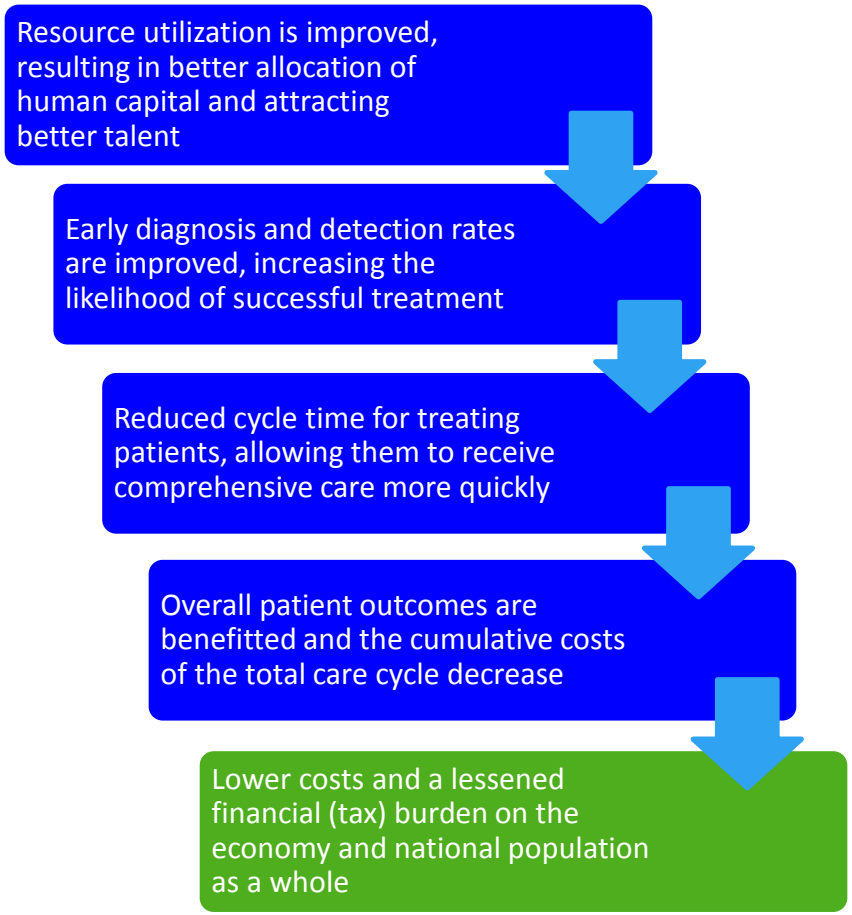
8)Continually evaluate the performance of the integrated system to locate and eliminate any sources of inefficiency and inadequacy that may arise through cyclicality, legislative change, or general shifts in market sentiment

Applying PE Business Acumen to a Fully Integrated Healthcare Model Would Improve Treatment Quality

Advantages of Private Equity's Approach

- The fragmented nature of many healthcare segments plays to the advantage of private equity investors who are looking to utilize a buy-and-build strategy to achieve category leadership[57]
- Private Equity funds have access to a flexible variety of human capital, such as industry experts within specialized fields or management consultants with proven track records, that can be quickly utilized to tie together loose ends and position healthcare companies for long-term success[89]
- Private Equity funds provide access to creative sources of capital and previously inaccessible capital to help healthcare companies grow flexibility and with a lower financial burden (cheaper cost of capital)
- Private Equity's approach tends to result in a leaner operation, creating more cost efficiencies and removing non-contributory aspects of a business that may have dragged it down in the past[85]
- Private investors can revamp existing costing systems that often measure the expenses related to individual departments, services, and support activities independently, which encourage the shifting of costs and create inefficiencies[85]
- Private Equity firms tend to be more tax efficient and have the capability to reduce the corporate tax burden on a complexly blended Payor/Provider model[74]

The Benefits of Increased Efficiency



A Better Government Approach to a Unified Healthcare System

glendonTodd CAPITAL

1 Repeal the Affordable Care Act

- Prevent the crippling outcomes of an essentially government controlled healthcare marketplace
- Avert an erosion in the quality of care by preventing numerous new regulations from passing that harm the patient-doctor relationship, depress the quality of current and incoming physicians, promote volume over quality of care, etc.
- Prevent a large increase in healthcare costs as a result of sections of the ACA

2 Tort Reform

- Large and unpredictable jury payouts encourage frivolous lawsuits
- Excessive Lawsuits lead to defensive or reactive medicine, which leads to poorer care quality
- Legislation that increases malpractice protections would allow doctors to practice medicine more successfully
- Establishment of a panel of practicing doctors with the purpose of screening lawsuits before they are even allowed to trial. Panel has full veto authority

3 Lower Cost

- Promote patient choice through increased competition
- Competition can be created through a true and open national insurance market free of government set conditional regulation
- Standardization of reimbursement should be generally avoided to ensure more specific measurement of true costs
- If code based reimbursement continues, price bands should be established to more accurately reimburse hospitals and physicians

4 Deregulation

- Excessive paperwork and governmental regulation prevents doctors from providing the patient specific, high-quality care that they dedicated a large portion of their lives to learning and honing
- Government set goals, targets, and requirements are often set by individuals with no medical background, this results in unattainable expectations and inevitable financial penalties
  - Leads to an increase in the price of healthcare

5 Protect Physician & Hospital Rights to Opt Out of the Third-Party Payor System

- Protect physicians from being criminalized for opting out of the third party Payor system
- Would reassure those entering the medical profession of their right to practice without over-regulation
- Would protect the right of fully integrated Payor-Provider organizations to operate independently from large third-party Payors

If Subsidization is Inevitable, it Should be Done in a Way That Actually Helps Those it is Intended to Help

Reality

- The largest hospital networks have more bargaining power than their smaller counterparts. For this reason, they receive the vast majority of subsidization from the government. This subsidization is through inflated Medicare payments or publicly funded payment programs that force insured individuals to go to specific hospitals
- Targeted subsidization methods like these shield the big Providers from competition, regardless of standards such as efficiency levels, quality of care, or price of care that these hospitals meet[94]
- By funneling all of these patients to the largest and less efficient hospitals, the government is giving these hospitals the power to demand (and they are receiving) several times the amount typically owed for a procedure that could be performed better and at a lower price elsewhere[85]

Solution

- Public payment systems and policies should be "Provider-neutral". Payments from public systems and regulations should reimburse Providers for providing care, regardless of which Providers the individual receiving the care chooses to go to
- Public systems should not be designed to keep certain Providers in business regardless of the quality, volume, or cost of the treatments they provide
- Individuals should be subsidized directly. This would allow patients to "shop" for the best blend of price and quality. When possible, governments and employers should put patients in control of the funds expended on their care as care is needed and permit them to keep the difference in price between the Provider they choose to use and a competitor, encouraging a search for the more efficient Providers
- Limited government subsidies given to the individuals under direct subsidization plan to primarily necessity based procedures
  - For example is a knee replacement always a needed option, could some individuals without the personal means to afford a knee replacement without a government subsidy use a cane instead?

Current Fear of Frivolous Malpractice Lawsuits is Only Exacerbated by the ACA, Reform is Urgently Needed

Medical Malpractice Facts & Figures

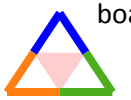
- In a Medscape survey of 3,480 U.S. physicians about their experience with malpractice suits:
  - 31% responded that they had been named in a lawsuit in conjunction with others[145]
  - 9% were sued as individuals
- Physicians sued spend time in trial instead of treating patients, with 28% spending over 40 hours preparing and attending case related meeting even before the trial begins[145]
- 61% of cases take under 2 years to conclude, of the remaining cases, 11% taking over 5 years[145]
- Regardless of the verdict, 29% of physicians no longer trust patients and treat them differently after the suit, 6% even stop practicing medicine[145]

Defensive Medicine

- Defensive medicine is defined by the American Academy of Orthopedic Surgeons as "when doctors order extra tests, procedures, or visits or avoid high risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability"[146]
- These extra tests are often unnecessary but are ordered because physicians fear a malpractice lawsuit should something go wrong when practicing with their best judgement
- Extra tests caused by defensive medicine are very costly and result in increased healthcare prices
- Fear creates a disconnect between patient and doctor due to distrust

Why Reform Is Necessary for an Improvement in the Quality of Patient Care

- Medical malpractice lawsuits have recently become more commonplace in the U.S.. This increase in the number of lawsuits leads to higher medical costs, lower quality of care and eroded physician quality
- The verdicts of medical malpractice lawsuits are determined by a jury who are not medically trained, and trials usually conducted by lawyers, who are also not medically trained. Doctors are not lawyers and lawyers are not doctors, having lawyers evaluating and presenting the choices of a doctor, who made critical decisions mid-surgery, to be judged by a panel of individuals with no medical training is inefficient and illogical.
- The practice of defensive medicine is less efficient and results in poorer outcomes than offensive medicine . The fear of frivolous lawsuits result in physician fear and exits from physicians exiting the medical field, leading to poorer treatment quality overall
- Medical lawsuit settlements and payouts are usually paid by a doctor's medical malpractice insurance or by the hospital where they practice: these settlements inflate the price of treatment as insurance costs are passed to patients by insurance companies who had to pay the settlements
- Reform and/or legislation is needed to create a medical board of non-bias practicing physicians tasked to rotate time commitments in reviewing malpractice lawsuits. Their purpose will be reviewing these cases and determining whether or not they are truly worth sending to trial. This board, through its final decision rights, will weed out the majority of frivolous malpractice lawsuits



CON Laws Must be Repealed at the Federal & State Level to Enable Competitive Market Behavior

Details of the CON Laws

- Currently the Certificate-of-Need (CON) laws subject Providers to government-set constraints on their construction of additional medical capacity
  - The goal of CON laws was to prevent the overbuilding of facilities in a way that leads to increased costs resulting in increased price due to inability of hospitals to fill all of their beds
- The American Health Planning Association (AHPA) is responsible for the regulation and planning related to decisions permitting expansion of any medical facility, decisions are usually based on AHPA analysis of what expenditures are considered "necessary" and on population of the surrounding area

Downsides of the Law Necessitating Repeal: CON Laws are a Con

- The CON law is inherently flawed because it assumes that the AHPA has the ability, knowledge, and right to determine which expenses, treatments, procedures, and costs are "necessary" for a hospital, even at private hospitals
- These legislative restrictions and red tape punish and restrict innovative Providers by not allowing them to expand and establish new, more efficient, and better quality facilities that challenge the current inefficient healthcare marketplace's model
- The law also fails to succeed in performing its primary purpose of reducing the cost of healthcare on individuals. It fails by restricting growing, advanced hospitals from successfully competing in the marketplace by severely limiting expansion capabilities
- Smaller, better run, better quality and less costly hospitals would, in any other market, grow to challenge the larger incumbent rival hospitals resulting in competitive pricing and increased quality as hospitals must compete for patient attention
  - Under the law if opportunity for growth and success does not exist, new and competitive hospitals will not be built
- This competition would cause inefficient, high priced, low quality hospitals to fail and be replaced by a better, more successful, higher quality mix of hospitals. Instead the CON laws further promote inefficiency and lead to high cost and a stagnant, uncompetitive, and poorly managed market

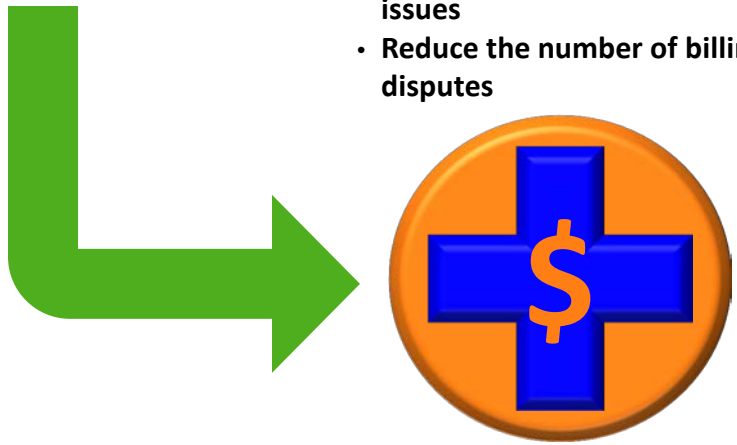
An Integrated Healthcare Company to Leverage the Advantages of Two Unique Business Models

Payor

- Pre-existing insured Network
- Benefits of scale
- Reimbursement system control to keep down costs
- Referral ability and size needed to meet Stark Law exceptions

Provider

- Physician network with patient relationships
- Shared services department
- Benefits of scale



- Emphasis on effective and efficient delivery of care
- More accurate reimbursement rates allowing for successful cost management and lower prices to the patients
- Reduce working capital issues
- Reduce the number of billing disputes

With a competitive healthcare landscape brought about through government reform, a successful shared-services department (benefits of scale), the opportunity for growth, and a strong management team, and integrated Payor-Provider model could successfully capture a larger market share

Conclusion

The healthcare market is on a dangerous path as increased regulation and control lead to the destruction of competition through consolidation and subsidization of inefficient healthcare models and systems. Payor/Provider mergers will be the most effective way of breaking the cycle of miss-aligned subsidization of healthcare. True Payor/Provider combinations will align incentives, lower cost, and increase quality of care for its participants over-coming new challenges presented by a changing market. These mergers can lead by example and help shift regulation and the broader marketplace towards a patient-centric care and payment model. While this model has the potential for success regardless of current obstacles, the true success of the vertically integrated healthcare model depends on the reform of government regulation and the revival of competition in the healthcare marketplace.

Defined Terms

Accountable Care Organization (ACO): Groups of doctors, hospitals, and other healthcare Providers that come together voluntarily to administer coordinated and high quality care to Medicare patients. ACOs are based off of a treatment and payment delivery model that rewards efficient and high-quality care by sharing resulting savings from its Medicare based program

Acquisition: When one entity (acquirer) takes a majority, if not total, ownership interest in another company (target). Acquisitions can be friendly or hostile in nature, with the latter usually incurring uncooperative resistance from the shareholders of the target company. In either case, acquirers will usually expect to pay a figure that is above the market valuation in order to complete their acquisition, generally through a control premium that is required to entice or convince shareholders of the target company to agree to relinquish their ownership interests

Admissions: When a patient is accepted for in-patient treatment or services at a healthcare facility

Affiliations: A type of inter-company relationship in which one entity is a minority owner of another entity's stock or ownership interest. An affiliation can also be defined as a scenario when two or more entities operate as subsidiaries of a larger entity

Affordable Care Act (ACA): A comprehensive federal statute that was signed into law by the Obama Administration in 2010 as a part of a healthcare reform agenda aimed at expanding health insurance coverage eligibility and preventing the denial of coverage due to preexisting conditions. The law was signed under the title of the Patient Protection and Affordable Care Act and consists of multiple provisions that were designed to take effect gradually over time. The ACA is supplemented by a "Patient Bill of Rights" that specifies revamped guidelines for coverage, costs, and care

Balance Billing: The practice of a healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge

Care Management: The practice of administering evidence-based and integrated clinical care activities that are tailored to each individual patient in order to ensure that each patient has his or her own uniquely coordinated plan of care and services that are personalized to improve the quality of treatment

Certificate of Need (CON): A legal document that is required in many states and federal jurisdictions to permit the creation, expansion, or acquisition of healthcare facilities. CON programs are intended to restrain facility costs and curtail overbuilding under the assumption that excess capacity leads to healthcare price inflation

Civil Monetary Penalty (CMP): A punitive fine imposed by a civil court that is intended to punish individuals or organizations for violating a variety of laws or regulations; in many cases these entities will have profited or benefited from an illegal or unethical activity

Claim: An organized and itemized statement of the medical services that were administered as well as the associated costs. Claims are generally submitted from the patient or healthcare Provider to the health insurer

Defined Terms (Cont.)

Compound Annual Growth Rate (CAGR): A measure that captures the growth rate of a certain value over multiple time periods. It is often applied to calculate the mean annual growth rate of an investment or the change in a performance metric over a specific period of time

Consolidation: Generally defined as bringing together smaller, separate parts, to create a larger and more uniform whole

Co-payment: A fixed fee that is required by health insurance Providers as a payment from the patient when he or she visits a medical office, receives a medical service, or completes the filling of a prescription

Corporate Carve-Out: A strategy that can be employed by a company to partially divest a particular business unit while continuing to maintain an equity stake. This strategy is generally a viable option if the particular line of business is not a part of the company's core operations

Covered Lives: The number of people, including their dependents, that are enrolled in a particular health insurance program

Dual-Eligible: Individuals who qualify for both Medicare and Medicaid benefits. Beneficiaries can be categorized as partial-benefit or full-benefit, with partial-benefit dual-eligible individuals often having income or assets that are not low enough to qualify them for full Medicaid benefits in their state

Duplicate Testing: The inappropriate practice of repeating lab, medicine, or other diagnostic procedures and evaluations beyond the allowed threshold provided or allowed by Federal or third party Payors; generally associated with fraudulent billing practices such as knowingly repeating a procedure that has already been correctly performed

EBITDA: Calculated as revenues, less expenses, excluding interest, tax, depreciation, and amortization. It is a non-GAAP measure that is commonly used as a metric to analyze and compare profitability between companies

Economies of Scale: Cost advantages that result from increasing the size or output of an operation due to the inverse relationship between production and the fixed-costs associated with each additional unit that is being produced. Economies of scale can generally demonstrate why larger companies are often more profitable than smaller ones, as per unit costs tend to fall as volumes rise

False Claims Act: A federal law, also called the "Lincoln Law", that imposes a liability on individuals and entities that defraud governmental programs. The law also includes a special provision that allows people who are not affiliated with the government to file suit on behalf of the government through whistleblowing

Fee-for-service (FFS): A payment model where healthcare services are each paid for separately, creating an incentive for Providers to administer more treatments because payments are based off of the quantity of care instead of the quality

Fragmentation (Fragmented Market): A marketplace where there is no single or few established dominant players that can exert the influence required to move the entire industry in a particular direction

Defined Terms (Cont.)

Health Insurance Exchange: A state provided health insurance plan that is subsidized federally in order to provide more people with affordable coverage while spreading the risk between the insurance companies and the state and federal government. Health insurance exchanges cannot exclude individuals due to pre-existing conditions

Health Insurance Portability and Accountability Act (HIPAA): Originally created by the U.S. Congress in 1996, the act was passed as an amendment to existing legislature and is intended to protect the privacy of individuals covered by health insurance by setting clear standards for the storage, accessibility, transparency, and portability of personal medical data

Health Maintenance Organization (HMO): An organization that provides health coverage with Providers under contract, it differs from traditional health insurance by the contracts it has with its Providers. These contracts allow for lower premiums because the health Providers have the advantage of having patients directed to them; however, these contracts also add additional restrictions to the HMO's members accessible treatment options

Healthcare IT: Defined by the HHS Office's National Coordinator for Health IT as, "the application of information processing involving both computer hardware and software that deals with storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision making"

High Reliability Organization (HRO): An organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to a multitude of risk factors and complexity

High-Yield Debt: A bond that pays a higher interest rate than investment grade corporate debt due to its lower credit rating. Issuers of high-yield bonds are generally considered to have a greater possibility of default and must generate higher returns to compensate for the associated risks in order to attract potential investors

Horizontal Integration: When companies or businesses within the same industry come together to combine processes or service offerings that are generally closely associated along the same level of the value chain or production phase

In-Network: Represents the group of doctors, hospitals, and other healthcare Providers with whom the patient's insurance company has contractually partnered with; in-network coverage typically results in more favorable and discounted billing rates

Joint Operating Agreement (JOA): Also referred to as a "Virtual Merger", a JOA allows healthcare entities to maintain their own identities and board of directors while coming together through a variety of operational arrangements that are devised to improve efficiencies and financial health. The main purpose of a JOA is to protect a business from failure while retaining some separation of internal operations to prevent industry monopolization

Defined Terms (Cont.)

Joint Venture: When two or more separate entities come together as a part of a business arrangement that allows them to pool their resources in order to confront a specific challenge or task. Each participant is responsible for the resulting profits, costs, and losses associated with the joint venture. Each entity will continue to maintain its own independent partnership interests

Licensed Beds: Beds at healthcare facilities that are licensed, staffed, and physically available to be occupied by a patient

Managed Care: A system of healthcare in which patients agree to visit only certain doctors and hospitals, and in which the cost of treatment is monitored by a managing company

Management Services Organization (MSO): An organization that is owned by a group of physicians, a joint venture between physicians and hospitals, or investors in conjunction with physicians. The main purpose of MSOs is to ease the administrative burden on physicians by reducing the need to perform non-medical business functions in order to achieve cost savings and improve the quality of care that they are able to administer. MSOs also allow physicians to form a stronger position when negotiating with health plans and healthcare purchasers

Market Capitalization: The total monetary value of a publically traded company's outstanding shares

Medicaid: A joint federal and state program that assists low-income individuals or families pay for the costs associated with long-term medical and custodial care. Although it is largely funded by the federal government, coverage may vary from state to state and the program requires individuals to meet qualification standards based on income, household size, family status, disabilities, and other factors

Medical Malpractice: The improper, unskilled, or negligent treatment of a patient on behalf of a healthcare Provider

Medicare Advantage (MA): A health plan offered by private companies that serves as a substitute for "Original Medicare's" Part A and B benefits by contracting with Medicare to provide access to Preferred Provider Organizations (PPO) or Health Maintenance Organizations (HMO). Other options made accessible through MA include private fee-for-service plans, special needs plans, and Medicare savings plans. Most MA programs also offer prescription drug coverage

Medicare Shared Savings Program: A program that aims to encourage coordination and cooperation among Providers to reduce costs and improve the quality of care for medical fee-for-service beneficiaries

Medicare: A federal health insurance program for certain younger people with disabilities, people who are 65 years of age or older, person's with Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), and people with End-Stage Renal Disease

Membership: Generally defined in the context of an individual who is subscribed to a health insurance plan

Defined Terms (Cont.)

Merger: The combination of two companies that is usually the result of a mutual agreement between both entities. Mergers are usually structured so that the shareholders of one company (target) will be offered securities in the other (acquirer), in exchange for the surrender of the ownership interest in the original company (target)

Mobile Health (mHealth): A term that encapsulates the support of medicine and public health practices through the use of mobile devices

Monopsony: Similar to a monopoly, except that in this case, a large buyer controls a major proportion of a market and is able to wield its buying power to drive prices in the direction they see fit

Multi-Specialty Group Practice: A practice within which there are physicians that can offer a multitude of different medical care specialties within one organization

Network Affiliation: A type of partnership that allows healthcare systems to come together with a low degree of integration to enhance the delivery of their services through collaboration and to access a greater pool of capital. Network Affiliations are seen as "hands-off" alternative to M&A and can boast advantages such as: co-branding of clinical services, mutually beneficial exchange of referrals, and sharing the financial burden of investing in expensive resources and staff

Non-elderly people (person): Defined by the United States Department of Housing and Urban Development as a living person who is under the age of 62 years old

Open Enrollment Period: The period of time during which individuals who are eligible to join a Qualified Health Plan (QHP) are able to enroll in the marketplace. Certain individuals may qualify for a QHP outside of the designated enrollment period if they experience certain Qualifying Life Events such as moving across state lines, significant changes in income, and changes to family size

Out-of-Network: A patient that is seeking care from doctors, hospitals, or other healthcare Providers that are outside of the network in which the patient's insurance Provider is contracted, which typically results in much higher treatment billing as opposed to in-network care

Overtreatment: Healthcare that is deemed as unnecessary or excessive and/or at a higher cost than generally accepted as being appropriate

Payor: Any insurance company or legal entity that is authorized to provide health insurance coverage

Physician Management: A process that encompasses the interaction with individual physicians to provide expertise and support, operational efficiency oversight, organizational advice, employment and recruiting assistance, and leadership guidance

Physician/Hospital Organization (PHO): A management service organization in which the hospitals and the physicians are partners. PHOs legally bond hospitals and their medical staff for the purpose of contracting with managed care plans

Defined Terms (Cont.)

Post Payment Denial: A rebuttal to the settlement of a claim or account balance that is generally issued by an insurance company or government auditor that determined that there was an error during the billing or payment process

Preferred Provider Organization (PPO): A type of health insurance arrangement that allows plan participants relative freedom to choose the doctors and hospitals they want to visit. Obtaining services from doctors within the health insurance plan's network, called "preferred Providers", results in lower fees for policyholders; however, out-of-network doctors are still covered. Coverage requires ongoing payment of premiums by policyholders to the insurance company

Premium: The amount that an individual must pay to the insurer in order to maintain a desired amount of health insurance coverage

Profit Pool: Originally devised as a component of a strategic model by consultants at Bain & Co., a profit pool is essentially the total value chain of activities and services rendered within a specific industry. Each step along this “chain” has a specific size and profitability, which is constantly evolving over time as the landscape of any given industry continues to change

Profit Pool (Healthcare): In the context of healthcare, the total profit pool comprises of the profitability of the entire spectrum of healthcare related business, from treatment and care services, medication, health plans, coverage policies, and everything in between, multiplied by the total volume of each respective activity, product, good, or service

Provider Organizations/Independent Provider Associations (IPA): A legal entity organized and directed by physicians who come together to form an association with the intent to handle the challenges that arise from managed care and to negotiate better terms from Payors on their behalf. IPAs are an important tool for physicians because it allows them to counteract the leverage of large health insurers

Provider: Any doctor, physician, practitioner, healthcare professional, or healthcare facility that is responsible for administering the act of medical care

Reimbursement: A payment made by a third party, usually a health insurer, on the behalf of the beneficiary (patient) to the healthcare Provider that administered a medical service

Revenue Cycle Management: A process that encompasses the entire customer engagement and payment process from start to finish. In healthcare, it is often applied in the context of optimizing the patient’s financial experience along the complete band of duties that address patient care, which can be specified as: contracting and negotiating reimbursement levels for patients among Payors, monitoring the level of care that is administered and then billing for it accordingly, handling the financial implications behind the patient discharge process, settling the balance of the patient’s bill, and dealing with post payment issues such as denials

Single Discipline Group Practice: Similar to a single specialty group practice, except that the focus of the organization is comprised of one specific discipline (such as vision care)

Defined Terms (Cont.)

Single Specialty Group Practice: A practice within which there are at least two physicians that can provide a patient with one specific type of care. In a single specialty group practice, multiple physicians share clinical and administrative facilities, patient records, and employees. Single specialty groups can usually leverage their focus and reputation on a narrow band of healthcare to achieve high quality outcomes and attract and retain patients

Strategic Buyer (M&A): A party that intends to make an acquisition under the presumption that it will create synergies with its existing business, eliminate sources of competition, or apply certain strengths of the target company's operations to its current offerings

Subsidy: A benefit that is a given by the government to specific groups or individuals in order to ease or completely remove a burden that is not in the best interest of the public. Subsidies are usually provided in the form of tax reductions or cash payments

Synergies: The cooperation of two or more entities that produces a combined effect that results in a financial benefit for all parties involved

Telemedicine: The application of telecommunication and information technologies to provide clinical healthcare remotely with the intent to remove distance barriers and improve access to medical services

Vertical Integration: When companies or businesses expand to encompass different points along the same production path or supply chain, usually in terms of goods and/or services, in order to reduce costs and realize efficiencies

Whistleblower: Any individual who purposefully exposes any information or activity that is deemed to be illegal, dishonest, a threat to public interest or national security, or in violation of a company's policy and/or rules

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