

# THE PROMISE OF PAYER CONSOLIDATION FOR US HEALTH CARE

By Jon Kaplan, Peter Lawyer, Ozgur Adigozel, Mike Duffy, and Daniel Gorlin

**T**HE JULY 3 ANNOUNCEMENT that private health insurer Aetna is acquiring rival Humana for \$37 billion was the culmination of a frenzy of speculation about consolidation in the US private health insurance industry. Later that month, Anthem announced its long-awaited \$54 billion acquisition of Cigna, a bid that took numerous twists and turns before terms were finalized. Meanwhile, industry giant United Healthcare continues to watch carefully from the sidelines—for now. Industry observers believe it is only a matter of time before the big five are reduced to three or even two.

There are good reasons why these consolidation moves are happening now. Five years after the passage of the Affordable Care Act, and in the wake of the Supreme Court's recent decision to uphold the use of federal tax credits to subsidize the health insurance costs of poorer Americans, uncertainty about the implications of the new law is dissipating. Companies now know the basic outlines of the future health insurance marketplace, and they are

looking to position themselves competitively in the fast-evolving health care ecosystem. What's more, easy access to cheap debt and high market valuations make the prospect of deals financially attractive to buyers and sellers alike. These trends are exacerbated by the shared fear that if any particular company doesn't move fast enough, it risks being left without a "dance partner."

As the potential combinations capture the attention of the industry, analysts, regulators, and the media, a broader question has gone largely unaddressed. What will be the impact of consolidation on the US health care system? The answer depends less on who buys whom than on what any newly consolidated player actually does with its new-found scale and market power.

## Wanted: Cost-Effective, Quality Care

Nearly everyone knows that the US health care system is the most expensive in the world—consuming 18 percent of GDP,

more than any other developed economy. And yet, the system generates health outcomes that lag those of many of its developed-economy peers. (See “Health Reform Should Focus on Outcomes, Not Costs,” BCG article, October 2010.) The basic challenge facing the US health care system is to simultaneously reduce costs (or at least slow their increase) while also improving health outcomes—in short, to improve health care value by delivering cost-effective, quality care. How might payer consolidation contribute to this goal? There are three ways.

**More Efficient Operations.** In the short term, consolidation will make possible the elimination of considerable administrative costs, as new combinations render current systems and operations redundant. Aetna expects to achieve approximately \$1.25 billion in annual cost savings by 2018 as a result of the Humana merger. And Anthem has estimated that it can reap annual synergies of some \$2 billion from a Cigna acquisition. These are big numbers, to be sure, but the likely acquirers are already of a size and scale that savings on administrative costs are unlikely to represent the major source of value in consolidation.

**Stronger Bargaining Power.** Larger entities will also be able to leverage their scale to reduce the unit cost of health care. In some local markets, consolidated national insurers with a greater proportion of lives covered relative to leading local players may attempt to shift the dynamics of rate negotiations with providers. Beyond across-the-board rate reductions, however, increased local scale will make it easier for insurers to assemble dedicated networks of providers that combine additional price discounts with a reasonable degree of choice among providers—an attractive combination for consumers. The initial impact of increased bargaining power will be felt by provider facilities and physicians but may eventually affect other categories, such as pharmacy and diagnostics.

**Better Clinical Management.** Over the long term, however, payer consolidation won’t definitively move the needle on health care

value unless the newly combined health insurers use some of the savings provided by greater scale and increased efficiency to invest in and extend their clinical capabilities. The big innovation in private health insurance in recent years has been a new model characterized by three organizational mechanisms designed to encourage the delivery of cost-effective quality care: a selective network of providers with strong investments in primary care, financial incentives such as risk-based contracting that are aligned with clinical best practices, and active care management that emphasizes prevention in an effort to minimize more costly acute care.

Research has shown that this alternative care-delivery model is less costly than traditional fee-for-service medicine. What’s more, a study BCG conducted in 2013 demonstrates that it delivers better health outcomes as well. In an analysis of claims data for some 3 million Medicare patients, we found that on three internationally accepted dimensions of health care quality—single-year mortality, recovery from acute episodes requiring hospitalization, and sustained health over time—patients enrolled in private Medicare Advantage plans who used this new model had better outcomes than those participating in Medicare on a traditional fee-for-service basis. (See *Alternative Payer Models Show Improved Health-Care Value*, BCG Focus, May 2013.)

Creating the capabilities required by this new model involves considerable investment. Payers need to develop (and, in some cases, actually acquire) the right kind of provider networks. They must build sophisticated IT platforms that support the secure sharing of sensitive patient data, predictive modeling to identify and manage higher cost members, and the systematic collection of health outcomes data to identify best practices for delivering cost-effective quality care. Finally, they have to create new tools to engage members in the management of their own health and wellness.

All these represent important new sources of competitive advantage. Some players in

the industry—in particular, Humana—have already developed valuable assets in these areas. Over time, consolidation and the savings it generates will allow private insurers to invest even more in such capabilities, accelerate the adoption of this value-based model for care delivery, and benefit from new incentives for outcomes-based medicine that have been put in place as part of the Affordable Care Act.

## The Competitive Dynamics of Consolidation

Despite the potential advantages of consolidation, however, its precise impact on the evolution of the health care ecosystem will be anything but straightforward. Although private payers will have an opportunity to extend the new managed-care model and generate major savings as a result of consolidation, they will continue to face major challenges in making it work. Even as they build new capabilities for more cost-effective care management, they will have to win the permission and trust of members if they are to play a more central role in the health decisions affecting their lives. One insurer has a program for sending clinicians into the home to help members manage chronic diseases; however, a majority of the members offered this benefit don't take advantage of it—in large part because it comes from their insurance company, not their doctor. Over the long term, effective clinical-care management will require payers to develop not just a new brand but a whole new identity, perhaps through alliances and partnerships with care providers.

What's more, as insurers try to improve their competitive position vis-à-vis other payers, providers are not standing still. They are undergoing a consolidation wave of their own. Just as payers are moving deeper into the management and, in some cases, the actual provision of clinical care, many providers are experimenting with new payment models and are contemplating moving into insurance—in effect, imitating the integrated payer-provider model of Kaiser Permanente and Geisinger Health System. As they do, they will bring strengths and weaknesses of their own. Al-

though provider brands are relatively strong with health care consumers, it is an open question whether hospital networks that have traditionally relied on maximizing utilization to generate revenue will be able to master the cost management disciplines of the new care-delivery model.

The players most threatened by consolidation are perhaps the smaller local insurers, such as the Blue Cross and Blue Shield plans. Although health care remains largely a regional market, the national insurers' combination of greater scale and capabilities for medical-cost management may represent a new source of competitive advantage that will challenge the local Blues and other local players. They, in turn, may consider consolidation, joint ventures, or other new operating models to increase scale, as well as new models of care delivery to more directly affect the cost and quality of health care. The end game will likely vary across markets in what will continue to be a local business.

## A Dual Agenda for Postmerger Integration

None of these changes, of course, will play out immediately. But decisions that players in the health care ecosystem make now will help determine whether they end up with a leadership role in the more integrated health care system of the future.

As acquirers in the private-payer space contemplate the big challenge of integrating their new acquisitions, we urge them to keep in mind that this is only the first step in a much longer journey. Therefore, they need to pursue a dual agenda: on the one hand, focus over the next 12 to 18 months on delivering the cost synergies that will realize the value of the deal; on the other, use the PMI to strategically position the combined entity for success over the long term as a market leader in clinical management and the delivery of cost-effective quality care. We believe the following four principles will prove to be especially important in maintaining this dual focus:

1. *Don't calculate synergies or develop new*

*strategies in a vacuum.* Given the regional nature of the health care market, there will be no one-size-fits-all solution. The impact of consolidation and the synergies available will vary by market. Acquirers need to understand the limits of national scale, the impact of local market dynamics, and the likely reactions of local market participants.

2. *Define the future operating model.* Use the PMI to define the future operating model of the company and to accelerate the combined company's clinical capabilities by putting them at the center of that new operating model. A key part of this effort will be to identify and retain those people at both the acquiring and the acquired company who are spearheading innovations in care delivery. These will be key players in that future operating model, so make sure they are protected from any job cuts and you understand what it will take to keep them at the company after the acquisition goes through.
3. *Create a new culture.* PMI isn't just about combining boxes on the org chart. It's about creating a whole new culture. In that respect, it is a massive exercise in

change management. Consolidated payers should use the PMI to build an organizational culture focused on clinical innovation and committed to health care value through the cost-effective delivery of improved health outcomes.

4. *Be nimble and prepared to invest.* In the short term, the lion's share of management attention will be on taking out costs. But be ready to shift quickly toward investment—including, perhaps, additional acquisitions to gain new capabilities in care delivery and care management.

**H**OWEVER THE AETNA-HUMANA combination and other potential deals in the private-payer sector play out, one thing is absolutely clear: consolidation is coming not only to private health insurance but to the entire health care system. The winners will be those that both buy wisely and integrate well—with an eye to developing long-term value through the development of new models of cost-effective care delivery.

### About the Authors

**Jon Kaplan** is a senior partner and managing director in the Chicago office of The Boston Consulting Group and the leader of the firm's health-care payers and services team in the US. You may contact him by e-mail at [kaplan.jon@bcg.com](mailto:kaplan.jon@bcg.com).

**Peter Lawyer** is a senior partner and managing director in the firm's Minneapolis office. You may contact him by e-mail at [lawyer.peter@bcg.com](mailto:lawyer.peter@bcg.com).

**Ozgur Adigozel** is a partner and managing director in BCG's Chicago office. You may contact him by e-mail at [adigozel.ozgur@bcg.com](mailto:adigozel.ozgur@bcg.com).

**Mike Duffy** is a partner and managing director in the firm's Dallas office. You may contact him by e-mail at [duffy.mike@bcg.com](mailto:duffy.mike@bcg.com).

**Daniel Gorlin** is a principal in BCG's Chicago office. You may contact him by e-mail at [gorlin.daniel@bcg.com](mailto:gorlin.daniel@bcg.com).

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