

What's Driving the M&A Frenzy in Health Care IT?

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Information technology is at the core of building the new 21st-century health care system. Yet transforming health care won't be as easy as it's been for many other industries that have experienced change through technology, such as financial services and manufacturing.

This is because health care providers must comply with a host of new government regulations that are

pushing them to create a smarter, more efficient care delivery system that advocates stronger connections, better data, and faster, more detailed analysis. However, along with the new laws and mandates, the government is providing substantial financial stimulus to the medical community to spur the technology transformation.

The reasons are clear: Health care

information technology (HIT) is the principal means by which providers can address the new health care laws. Therefore, increasing the adoption of new HIT systems is crucial in the short term in light of the tight deadlines for demonstrating "meaningful use," which is required in order for providers to receive financial reimbursement for the cost of the IT systems. It's also critical that providers not only implement the new technology.
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LETTERS TO THE EDITOR

If you have questions or suggestions regarding the News and its contents, please reply to dpeel@healthcarenewssite.com.

Letter from the Publisher and Editor



Dear Reader,

Many organizations are beginning their annual financial budget exercise. For calendar year companies, this can entail periodic meetings with staff and board committee members for the next few months culminating with efforts to gain board approval of the budget sometime between October and December. This is the time to review the past and project the future.

The Supreme Court decision to uphold the ACA adds a new dimension to 2013 staffing. Providers must be ready to serve hundreds of thousands of new patients on January 1, 2014 as Medicaid expands and individuals are required to buy health insurance.

There is currently a very tight market for direct care providers and administrative staff. This will reach crisis levels in mid to late 2013.

As you prepare your 2013 budget, allocate extra funds for recruitment costs. At the same time, review your vacancy factor estimates given your competitors will be hiring from the same shallow pool. Until next month,

David Peel, Publisher and Editor

Washington Healthcare News 2012 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2012	Hospitals	December 1, 2011	December 26, 2011
February 2012	ASCs	January 3, 2012	January 30, 2012
March 2012	Hospitals	February 1, 2012	February 27, 2012
April 2012	Insurance	March 1, 2012	March 26, 2012
May 2012	Clinics	April 1, 2012	April 30, 2012
June 2012	Human Resources	May 1, 2012	May 28, 2012
July 2012	Hospitals	June 1, 2012	June 25, 2012
August 2012	Hospitals	July 2, 2012	July 30, 2012
September 2012	Clinics	August 1, 2012	August 27, 2012
October 2012	Human Resources	September 3, 2012	September 24, 2012
November 2012	Hospitals	October 1, 2012	October 29, 2012
December 2012	Clinics	November 1, 2012	November 26, 2012

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ogy but also transform clinical operations to maximize the utility of the new HIT systems.

In particular, the electronic health record (EHR) incentive program, which began in 2011, reimburses physicians and hospitals that install EHR systems to help providers improve communication and documentation and cut down on duplicate screenings and tests. More than 76,000 physicians and over 2,200 hospitals had adopted EHR systems through March 2012, and Medicaid and Medicare paid out more than \$4.5 billion in incentive payments just in the past year to cover the costs and implementation of these new systems. This is out of a total \$23 billion earmarked by the government for HIT financial incentives. Another estimated

140,000 providers, or 46 percent of primary care providers nationwide, are already on track to implement HIT systems during 2012.

Built-In Demand

With the onslaught of new government mandates that started with meaningful use and continue with the hospital readmissions reduction program, accountable care organizations (ACOs), and ICD-10, health care providers are having a difficult time keeping up. Since each successor HIT stage builds on its predecessor, it's imperative for organizations to realize that success will be defined by effective adoption of EHR systems first. Beyond that, providers need business intelligence systems and data analytics to produce effective clinical workflow and provide outcomes—otherwise they run the

risk of bogging down a very expensive tool with bad processes that won't yield the benefits.

Having the appropriate HIT systems in place is also key to implementing the mandate to form ACOs. To date, more than half of all hospitals and health systems have started down the ACO path. In April 2012 there were 27 new ACOs representing 375,000 Medicare beneficiaries across 18 states that began to receive up-front savings to assist with the costs for building the infrastructure to get their ACO up and running. Another 150 ACOs are slated for start dates in July.

The continued support and financial incentives to help with building the EHR and ACO infrastructure

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have been major drivers behind the quickened pace of change. As new HIT systems are added, the data necessary to support performance improvement is becoming more available and more clinically

robust, giving ACOs the ability to measure and communicate value to their patients and payers.

For example, Advocate Health and Blue Cross Blue Shield of Illinois, the state's largest hospital and health insurer, formed an ACO in

2010 and can now show meaningful results after two years of building the network and infrastructure. With six months of relevant data in hand from newly installed HIT systems, the organization has shown a drop in admissions of 10.6 percent and a 5.4 percent reduction in emergency room visits.

Rising Fortunes

With the dramatic increase in demand by health care providers for IT systems to respond to new regulations, HIT companies have seen a jump in sales and profitability over the past year and expect it to continue. Publicly traded HIT companies have seen sales growth expectations for the next 12 months (NTM), which were at a moderate 11 percent in November 2011, rise to a current growth expectation of 17 percent. Profitability expectations have also increased, with expected NTM EBITDA growth of 34 percent in December 2011 more than doubling, to 79 percent, today.

Not surprisingly, much of the growth—and the most aggressive land grab—is happening in the physician EHR market, which will likely continue to drive HIT growth in the short term, since new entrants can stake a claim without needing the legacy infrastructure and relationships to support the bigger hospital and health system conversions. In the past year, EHR sales to physicians grew at 22 percent, with a total of 57 percent of office-based physicians now using some form of EHRs. In addition, the financial payback to publicly traded hospital management companies has translated into more than \$400 million of additional revenue in 2011, with the expect-



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tation that full-year numbers for 2012 will be up to three times higher, or \$1.2 billion in additional revenue, as more HIT systems are put in service and government incentives are redeemed.

Overall, the HIT market is estimated at close to \$40 billion and is expected to grow at an average annual rate of 13 percent over the next five years, with select niches growing at rates as high as 18 to 20 percent per year. This level of growth has caused a tremendous surge in the HIT sector, with over 8,000 companies or divisions now calling themselves IT vendors to the health care industry in some way and almost one quarter of those companies having formed in just the past three to five years. Many of these new vendors, such as Medstreaming, NextGate, Apixio, and Deep Domain, were created to respond

directly to health care mandates or to targeted provider issues.

There's also a flood of small to midsize technology companies, such as Agnity, CloudPrime, AeroScout, and InfoStretch, that began selling into multiple vertical markets but have found immediate traction within the health care market and are now using it to quickly establish product credibility and a market foothold. Many of these IT players bring fresh technology, use cloud-based systems that bypass the need to create custom connections with legacy systems, and use software-as-a-service (SaaS) pricing structures, which provide a low-cost alternative to licensing and make it an easy return-on-investment proposition for providers.

Enter the Whales

In addition to the influx of new

vendors, many large technology companies have taken a closer look at health care as a viable and fast-growing vertical market for expansion, and they've been busy making acquisitions. The simultaneous expansion of the overall market with the addition of new vendors and resulting consolidation through acquisition is dramatically redefining the HIT sector.

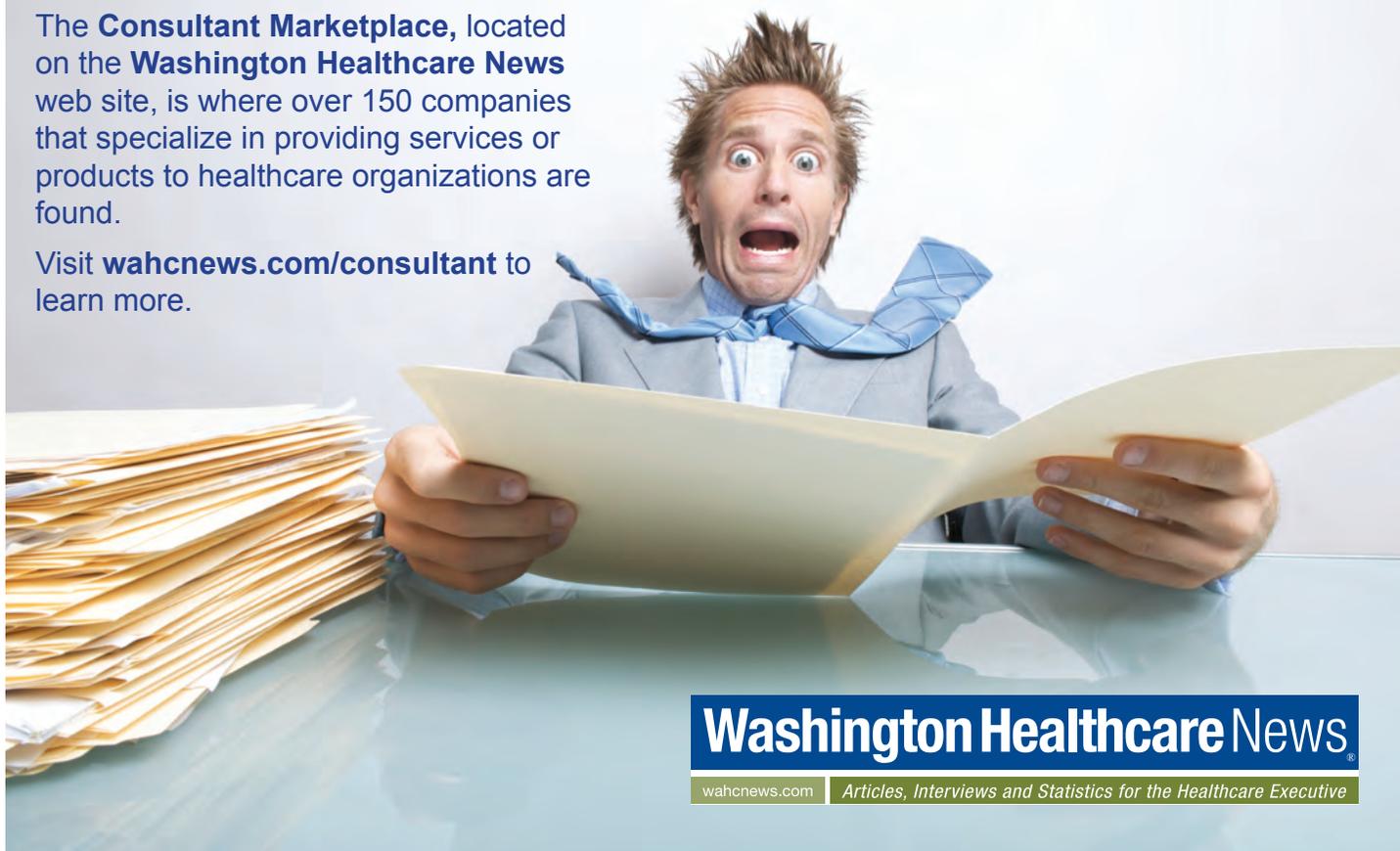
For example, the software application company Oracle acquired ClearTrial, a maker of SaaS-based clinical trial tracking systems, while the semiconductor giant NantWorks has jumped into HIT by picking up a number of diagnostic testing, telehealth, and analytical imaging companies over the past 10 months. Even large medical technology and supply manufac-

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Time to bring in outside help?

The **Consultant Marketplace**, located on the **Washington Healthcare News** web site, is where over 150 companies that specialize in providing services or products to healthcare organizations are found.

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The image shows a man in a grey suit and blue tie, looking extremely overwhelmed with a wide-eyed, open-mouthed expression. He is sitting at a desk, holding a large, thick stack of papers that is overflowing. The papers are piled high on the left side of the desk, and he is holding a single sheet of paper in front of him. The background is a plain, light-colored wall.

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turers that have historically played on the fringes of HIT are now coming in full force, with CareFusion acquiring the enterprise inventory management company Phacts to pick up 200 new health care clients and Alere expanding its health care equipment business into HIT by purchasing eScreen, a Web-based drug screening technology firm.

Along with strategic buyers, greater volumes of capital are coming into the sector from private equity firms, and many are now willing to consider more strategic valuations in order to get into the market. A recent example is Genstar Capital's \$414 million acquisition of eResearchTechnology, a health outcomes research company that was valued in the transaction at

a substantial 38 percent premium over its 90-day trading range.

Traditional HIT firms still play a significant role within many hospital systems and provider groups, having an installed base and long-standing relationships, but they're now under pressure to stay ahead of the regulations as well. This has further accelerated consolidation, with traditional players like Cerner acquiring Clairvia for its advanced resource management software and investing in Sotera Wireless, a maker of software that monitors patient vital signs.

AthenaHealth has also been in the market recently to pick up cloud-based order workflow capabilities from Proxsys. Even a midsize legacy vendor to physician groups, Medical Transcription Billing,

has been actively acquiring companies to address new mandates, purchasing GlobalNet for its EHR systems and United Physicians and Better Billing to expand its customer footprint for revenue cycle management.

The Bottom Line

There's no doubt about it: HIT M&A transaction activity has heated up. There were 258 health care-related IT deals in 2010, increasing to 273 in 2011, and we're on track to see an estimated 300 deals this year. The rampant activity has pushed overall valuations of HIT companies up as well, with deals getting done at an average of 2.5x trailing 12-month (TTM) revenue but with a very wide range of 1-8x TTM revenue. Deals have averaged 15.7x TTM EBITDA, with a range

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spanning 9–94x. This vast spread reflects the different perceived values based on technology, pricing model, installed base, and target market of the company acquired.

The expansion in valuation and the surge of interest in the sector has brought many new parties to the table. HIT companies have numerous alternatives for growth and combination right now. Many have received unsolicited acquisition offers, and others are looking for ways to expand quickly in the current environment without giving up substantial equity.

The result? There are many strategic alternatives to be evaluated right now, including outright sales, strategic partnerships, growth capital, private equity investments, marketing partnerships, and technology sharing. These are all means for fast-growing HIT companies to further boost growth and maximize value while market timing is ripe.

What's eminently clear is that this isn't the time to do nothing. The IT sector is the hottest real estate in the health care industry, and now is the moment to know your options.

Roberta Hurst has more than 18 years of experience advising health care and IT clients on a variety of strategic advisory transactions, including private placements and mergers and acquisitions.

Blair Bautista has over 20 years of experience providing consulting services, including ICD-10 implementation and assessments of EHR applications, to a multitude of health care providers.



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Electronic Medical Records and Cyber Liability

By Janet Jay

*Agency Sales and Service Representative
Physicians Insurance Agency*



The electronic medical record (EMR) at its best is a great tool for medical providers needing to access patient files from wherever they are. A family practice physician can instantly send a patient's chart to an emergency room physician, who can then get instant access to results of an MRI from the radiologist so that important decisions about the patient's care can be made in a timely manner.

EMR has the potential to allow access to thousands of patient records at once for researchers to determine and predict trends, to see what treatment is or is not working for patients with similar fact pat-

terns, and to assist in the diagnosing of new diseases and the tracking of new pandemic trends.

EMR is also the cyber criminal's dream. Medical records contain all sorts of data that could be valuable to a criminal looking for credit card numbers, patient medical histories, employee records, insurance information, addresses, and even social security numbers. In the days of paper files, someone trying to access patient files would have had to bring a large trailer and make multiple trips in and out of a clinic to get away with a fraction of the patient files that can now fit on a keychain jump drive.

Increased Regulation

Each year millions of medical records are inappropriately released. Some are due to the work of cyber criminals, while most are due to simple negligence. Legislators have responded to this alarming trend by increasing regulation. The HITECH (Health Information Technology for Economics and Clinic Health) Act has been enacted to promote the use and standardization of electronic medical records while maintaining patient privacy. It extends certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to third parties,

such as EMR vendors, and mandates patient notification in the event of a data breach.

The HITECH Act calls for increased HIPAA violation penalties, both criminal and monetary. It also gives Health and Human Services (HHS) the authority to audit for HIPAA compliance. HHS has recently acted on this authority with a new pilot program that will audit up to 150 covered entities between November 2011 and December 2012. The pilot program will give HHS a broad assessment of HIPAA compliance issues, and through identifying and correcting HIPAA concerns found, HHS hopes to share what it learns and develop tools to help covered entities better protect health information.

Tools for Your Practice

While it is unlikely that your group will be one of the 150 entities audited this year, the new laws are a good reminder for your office to brush up on patient privacy. If you are a member of Physicians Insurance, you have access to HIPAA privacy tools on the Risk Management section of our Web site, www.phyins.com. In addition, you or any member of your medical office can register for our no-cost risk management seminars, many

of which currently review the new HITECH provisions of HIPAA.

Your office may also benefit from a new planning tool that the Federal Communications Commission (FCC) recently released at <http://www.fcc.gov/cyberplanner> to help small businesses develop a cyber security plan. In addition, the FCC has a wealth of information, tips, and other cyber security resources published at <http://www.fcc.gov/cyberforsmallbiz>.

Insurance Options

Cyber liability, network security, and data compromise policies vary greatly. When purchasing a policy, it is important to know what type of risk the policy affords. Some policies simply help you notify your clients of an inadvertent release of their private information. This coverage might include assistance in determining which records were released and provide your clients with credit monitoring services. Other policies are more comprehensive and can include additional features such as:

- Third-party liability coverage for claims alleging financial loss due to a network security or privacy breach;
- Coverage to replace your data that gets damaged, erased, or corrupted;
- Expenses associated with cyber extortion threats;
- Business interruption and extra expense for your loss of income due to a covered loss;
- Claims alleging copyright infringement; and
- Fines/penalties associated with

HIPAA and the HITECH Act.

Whatever type of policy you choose, you and others in your office who may need to access the coverage at some point (e.g., IT personnel) should be aware of what the policy covers, as well as its limitations.

Janet Jay is the Agency Sales and Service Representative for Physicians Insurance Agency. She can

be contacted by e-mail at janet@phyins.com or telephone at (206) 343-7300 or 1-800-962-1399.

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Cheating Death Through Taxes: Chief Justice Roberts and the ACA

By **Anthony R. Miles**
Partner
Stoel Rives LLP



On June 26, Chief Justice Roberts once again demonstrated the wisdom of the nation's founders, joining with separate groups of four Justices to fulfill Benjamin Franklin's oft-quoted aphorism: "[N]othing can be said to be certain, except death and taxes."ⁱ The Court majorities ruled that although sitting at home doing nothing may be bad for your health, it's not commerce and Congress can't regulate your inactivity.ⁱⁱ Congress can tax it, however; so the Patient Protection and Affordable Care Act of 2010 (the "ACA") is constitutional.ⁱⁱⁱ Much has been written and said about the survival of the individual mandate, but too little

attention has been devoted to the other significant part of the decision—striking the ACA's mandatory expansion of Medicaid—and how the Court's analysis of Congress's powers to tax, spend and to regulate commerce will affect Congress's options in further reform efforts.

Medicaid Expansion

In declining to uphold the mandatory expansion of eligibility for Medicaid, the Court articulated a limitation on Congress's ability to attach conditions to new grants that expand existing programs. More interestingly, Congress's ability to attach conditions to its provision of federal funds to states may be limited by how much the states have come to rely on those funds.^{iv} For example, one could read the Chief Justice's opinion as imposing a limitation on losses for noncompliance with new requirements at 10% of a state's budget.^v This has the paradoxical result that the more the state needs the money, the less control the federal government subsequently can exert over the state's spending policies.

The Court made clear that states must be able to decline expansion of their programs without the

threat of losing funding for their existing programs. By effectively treating the expansion as a new program, the Court's opinion will affect future reform efforts. It creates uncertainty about Congress's authority to impose new conditions on historical spending when those conditions might require the receiving state to change its policies. While some undoubtedly hope this uncertainty will move Congress to adopt a block grant approach, the ruling readily could lead to more national programs.

Many observers anticipate that all states will accept the expansion, but some governors already have expressed opposition.^{vi} If states do opt out of Medicaid, questions of significant importance to providers may arise. For example, could a state that expands its own Medicaid program include a minimum residency requirement for eligibility to avoid having to accept increases in its rolls due to in-migration of residents from states that have declined the expansion?^{vii}

This question is not purely academic. Without in-migration, Washington State's Medicaid expansion is expected to result in the addition of 330,000 more beneficiaries, 100,000 more inpatient bed

days and increase total healthcare spending by \$840 Million.^{viii} Although Washington State has pursued early implementation of the expansion, which is supported by both gubernatorial candidates, providers must remain vigilant about implementation for these and other reasons. For example, the state plan is scheduled to be amended in 2013 with regard to the “newly eligible group.”^{ix}

Implications of Congressional Powers Analysis

By authorizing Congress to tax individuals’ choice to obtain coverage, while limiting Congress’s authority to influence state policy through federal spending and to act independently to regulate behavior under the commerce clause, the decision substantially limits Congress’s options for future reform. As Justice Ginsberg’s dissent notes, the Court’s opinion may have the effect of precluding Congress from preserving a role for private payors in subsequent reform legislation enacted under the commerce clause.^x

The Chief Justice’s analogy of health insurance to broccoli or cars and his statement that “regulation of the uninsured as a class is, in fact, particularly divorced from any link to existing commercial activity” ring false.^{xi} As a society, we build healthcare infrastructure, price services and allow individuals to take all manner of risks partly on the assumptions that providers will care for them when they get injured. All of this is activity and most of it is directly or indirectly commercial. None of this means that the Commerce Clause authorizes Congress to require in-

dividuals to purchase insurance, but a more nuanced discussion of these issues would have provided Congress with meaningful guidance in trying to preserve a role for private payers and state governments. Ironically, the limitations on Congress’s powers under the Commerce and Spending clauses from the Court’s decision combined with the broad construction of the taxing power could steer Congress toward something closer

to a single-payer approach in future stages of health reform. While that result may appeal to some, there is good reason to question whether it would be good for the country.

Tony Miles is a Partner at Stoel Rives LLP who focuses his health-care practice at the intersection of healthcare regulation and technology. He counsels providers and

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Washington State Health Plans Report Lower First Quarter 2012 Net Income

By David Peel
Publisher and Editor
Washington Healthcare News



Fourteen of the largest health plans in Washington State recently reported first quarter 2012 financial reports and the results were generally disappointing when compared to the same time period in 2011. Nine plans reported a lower underwriting gain (or greater loss) and ten reported lower net income (or greater loss) than the same period in 2011.

Our report, shown on page fourteen, shows total revenues, net underwriting gain (loss), investment gain (loss), other income and net income (loss) for the fourteen domestic health plans for the quarters

ending March 31, 2012 and March 31, 2011. We also present member months, the combined total of month ending membership for each twelve month period. When the financial figures are divided by member months, a monthly average (per member per month or PMPM) over the period is obtained that is valuable in comparing one plan to another. Financial statement users can then make apples to apples comparisons of health plans.

All information in this report was obtained through publicly available reports filed with the Washington State Office of Insurance Commissioner (OIC). Information not required to be filed with the OIC (self-insured and some Washington insured business from smaller, non-domestic carriers) is not included in this report nor is it referenced in this article.

Comments from Industry Representatives

We asked representatives of the plans to provide insight into their financial results. Some plans chose not to reply to our request. However, others provided valuable comments and these follow, sorted by plan size in descending order.

Premera & LifeWise Health Plan

Premera's affiliate, LifeWise Health Plan of Washington, didn't fare well with lower figures in the underwriting gain and net income categories. Spokesperson Eric Earling said, "LifeWise's results get to an incredibly important issue to understand about today's individual market: every local health plan selling individual coverage is losing money and has been doing so since last year. In LifeWise's case, our membership grew significantly based on the popularity of our products. At the same, a significant increase in medical costs for our individual members means LifeWise is now operating at a notable loss in serving our individual customers. Filings through the end of 2011 showed similar financial results for other local health plans in the individual market. This is a significant issue for policymakers to understand as the state prepares for the Exchange in 2014, since sustained losses across the individual market have potentially serious implications for the stability of that market for individual consumers in 2014 and beyond."

Strong financial results continued for Premera Blue Cross although there were decreases in net underwriting gain, investment gain

and net income.

Of significance was a large increase in member months (approximately 280 thousand) and lower per member per month total revenues. Earling explained, “Changes in Premera’s reporting from last year are due primarily to a change in reporting to align with federal MLR reporting standards (specifically, dental membership is now included in the count, where it wasn’t before). This is the primary driver of the increase in member months, which likewise brings down the PMPM figure since dental members have a lower PMPM than medical members. Absent the change in reporting for dental membership, Premera saw a slight increase in medical PMPM over 2011.”

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Full Service Medical Plans Only - Sorted by Total Revenues - 000's Omitted²
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Health Plan Name	Member Months ³			Total Revenues			Net Underwriting Gain (Loss) ⁴			Investment Gain (Loss) & Miscellaneous			Other Income ⁵			Net Income (Loss)			
	03/12	03/11	Change	03/12	03/11	Change	03/12	03/11	Change	03/12	03/11	Change	03/12	03/11	Change	03/12	03/11	Change	
Dollars																			
Premiera Blue Cross	1,991	1,711	280	624,433	606,435	17,998	19,213	30,332	-11,119	10,422	14,227	-3,805	828	399	429	26,258	34,242	-7,984	
Regence BlueShield	1,783	1,906	-123	550,764	556,145	-5,381	-4,176	13,121	-17,297	13,889	23,504	-9,615	-596	-837	241	8,615	33,820	-25,205	
Group Health Cooperative	1,077	1,113	-36	530,644	519,197	11,447	3,128	15,046	-11,918	5,119	16,311	-11,192	0	0	0	8,247	31,357	-23,110	
Group Health Options	665	707	-42	255,077	251,605	3,472	-1,934	4,510	-6,444	1,337	1,163	174	0	0	0	-1,965	3,434	-5,399	
Molina Healthcare of WA	1,067	1,034	33	227,953	195,092	32,861	8,900	2,710	6,190	283	345	-62	0	0	0	5,392	1,833	3,559	
Community HP of WA	841	843	-2	189,724	171,380	18,344	-9,705	-4,494	-5,211	763	546	217	-468	-30	-438	-9,409	-3,979	-5,430	
UnitedHealthcare of WA	161	164	-3	129,771	131,672	-1,901	5,116	7,231	-2,115	805	678	127	0	0	0	-1,525	4,820	-6,345	
Arcadian Health Plan	127	129	-2	106,058	106,040	18	4,880	3,293	1,587	285	2,423	-2,138	0	0	0	3,750	4,364	-614	
LifeWise HP of WA	328	289	39	80,837	68,896	11,941	-4,356	1,035	-5,391	1,014	947	67	-11	99	-110	-2,276	1,278	-3,554	
Asuris NW Health	213	236	-23	62,521	63,875	-1,354	6,905	1,145	5,760	577	712	-135	-36	0	-36	4,875	1,284	3,591	
Columbia United Providers	184	173	11	36,105	32,346	3,759	814	1,391	-577	13	42	-29	0	0	0	538	1,040	-502	
KPS Health Plans	78	92	-14	29,130	32,644	-3,514	396	2,640	-2,244	24	-85	109	-113	-4	-109	319	2,552	-2,233	
SoundPath Health	49	34	15	29,021	9,954	19,067	446	210	236	79	38	41	-10	-54	44	515	194	321	
Timber Prod. Mfg. Trust	40	35	5	7,330	6,318	1,012	964	549	415	24	-7	31	0	0	0	988	541	447	
Per Member Per Month⁶																			
Premiera Blue Cross	1,991	1,711	280	314	354	-41	10	18	-8	5	8	-3	0	0	0	13	20	-7	
Regence BlueShield	1,783	1,906	-123	309	292	17	-2	7	-9	8	12	-5	0	0	0	5	18	-13	
Group Health Cooperative	1,077	1,113	-36	493	466	26	3	14	-11	5	15	-10	0	0	0	8	28	-21	
Group Health Options	665	707	-42	384	356	28	-3	6	-9	2	2	0	0	0	0	-3	5	-8	
Molina Healthcare of WA	1,067	1,034	33	214	189	25	8	3	6	0	0	0	0	0	0	5	2	3	
Community HP of WA	841	843	-2	226	203	22	-12	-5	-6	1	1	0	-1	0	-1	-11	-5	-6	
UnitedHealthcare of WA	161	164	-3	806	803	3	32	44	-12	5	4	1	0	0	0	-9	29	-39	
Arcadian Health Plan	127	129	-2	835	822	13	38	26	13	2	19	-17	0	0	0	30	34	-4	
LifeWise HP of WA	328	289	39	246	238	8	-13	4	-17	3	3	0	0	0	0	-7	4	-11	
Asuris NW Health	213	236	-23	294	271	23	32	5	28	3	3	0	0	0	0	23	5	17	
Columbia United Providers	184	173	11	196	187	9	4	8	-4	0	0	0	0	0	0	3	6	-3	
KPS Health Plans	78	92	-14	373	355	19	5	29	-24	0	-1	1	-1	0	-1	4	28	-24	
SoundPath Health	49	34	15	592	293	300	9	6	3	2	1	0	0	0	1	11	6	5	
Timber Prod. Mfg. Trust	40	35	5	183	181	3	24	16	8	1	0	1	0	0	0	25	15	9	

Notes:

- All information from the Washington State Office of Insurance Commissioner web site.
- 000's omitted means the last three digits of each figure is removed. For example, the number 1,000 becomes 1.
- Member Months is the combined total of each month's ending membership. For example, to get Member Months through December is added together to get a combined total.
- Net Underwriting Gain (Loss) is Net Income prior to Income taxes, Investment Gains and Losses and Miscellaneous revenues and expenses. It is a thought to be an accurate measure of the adequacy of premium revenue and can be a good predictor of future premium increases or decreases.
- A negative Other Income number means it was an expense.
- Per Member Per Month is any of the financial figures divided by Member Months for the particular plan.

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Regence BlueShield

Regence was profitable but reported lower results in every category except other income when the first quarter 2012 results are compared to first quarter 2011 results. Spokesperson Georganne Benjamin summed it up this way, “Regence BlueShield had significant membership in the small group and individual market, those hardest hit by the economy. As a result, as the economy remains sluggish, we continue to lose members in proportion to our participation in those markets. However, we remain committed to serving the individual and small group market.”

Benjamin continued, “Additionally, several groups have migrated from being fully funded (which reports membership to state) to self-insured (which is not reported as membership), so to that extent, the state report doesn’t capture all our members.”

She concluded, “Looking at the rest of 2012, our retention rate is 92%, the highest it’s been since 2004. Additionally, we’ve written more large-group business in the first 6 months of 2012 than we have since 2004, even though groups aren’t as large as they used to be – because of the economy, many companies have fewer employees than they did before the recession.”

Group Health Cooperative

Group Health Cooperative was also profitable but reported lower results in every category except total revenues and other income.

Scott Boyd, Vice President of Finance, explained, “The decline in performance between years for GHC is about equally split between underwriting performance and investment performance. The investment performance is indicative of the current state of the financial markets (most carriers have experienced declines). The underwriting performance is our ongoing work to align revenues and expenses and bring value to the market - though performance was stronger during Q1 2011, performance over the later quarters in 2011 was weak and we are still working on rebalancing and restoring profitability, which resulted in minimal Q1 2012 results.”

Group Health Options, a Group Health Cooperative affiliate, reported lower results in the member months, underwriting gain and net income categories. Boyd said, “The decline in performance between years for GHO is about the underwriting performance - similar in nature to that described for GHC - the loss is small on a percentage basis.”

Concluding Comments

This type of across the board decline in financial results would historically be considered a normal dip in the underwriting cycle. However, since healthcare reform is in full implementation it must also be considered a factor.

Look for plan actuaries to continue putting additional margin into premium rates going forward until it’s absolutely clear the costs of healthcare reform are known. Unfortunately, this will require years of verifiable claims history.

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other health industry players in corporate matters, strategic affiliations, technology development and services transactions, and data privacy and security issues involving health information technology. Contact Tony at 206.386.7577 or armiles@stoel.com.

This column is not to be considered legal advice or a legal opinion on specific facts or circumstances. The contents are intended for informational purposes only. If you need legal advice or a legal opinion, please consult with an attorney.

ⁱIn a letter to Jean-Baptiste Leroy dated November 13, 1789, following ratification of the U.S. Constitution, Franklin wrote “Our new Constitution is now established, and has an appearance that promises permanency; but in this world nothing can be said to be certain, except death and taxes.”

ⁱⁱSee *National Fed. of Ind. Bus. v. Sibelius*, 567 U.S. ____ (Opinion of Roberts, C. J.), Slip op. at 27, 44.

ⁱⁱⁱ*Id.* at 39, 42 & 44.

^{iv}*Id.* at 51.

^v*Id.* at 52.

^{vi}The governors of Florida, Iowa, Louisiana, South Carolina, Texas, and Wisconsin all have suggested that they will oppose expansion of Medicaid funding in their states. Louise Radnofsky et al., “Some States Balk at Medicaid Expansion,” *Wall Street Journal*, (July 2, 2012) available at http://online.wsj.com/article/SB10001424052702304211804577502912265771898.html?mod=googlenews_wsj (last visited July 9, 2012).

^{vii}The Court previously has held that the privileges and immunities clause of the Fourteenth Amendment includes a right to travel that prevents a state from implementing tiered benefits based on prior state of residence. See *Saenz v. Roe*, 526 U.S. 489 (1999).

^{viii}See Matthew Buettgens et. al., Health Policy Center, The Urban Institute, *The ACA Medicaid Expansion in Washington* 1, 9 (May 2012), available at http://www.hca.wa.gov/hcr/documents/ACA_Medicaid_Expansion_WA_State.pdf (last visited July 8, 2012);

^{ix}See Washington State Health Care Authority, *Affordable Care Act Medicaid Expansion 2014 Implementation Plan*, 1, 10, (June 22, 2012), available at http://www.hca.wa.gov/me/documents/ME2014_Implementation_Plan.pdf (last visited July 8, 2012).

^xSee *National Fed. of Ind. Bus.*, 567 U.S. ____ (Opinion of Ginsburg, J. concurring in part and dissenting in part), Slip op. at 2.

^{xi}See *National Fed. of Ind. Bus.*, 567 U.S. ____ (Opinion of Roberts, C. J.), Slip op. at 25.

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