



Aetna: Key player in US health reforms

by Roger Montgomery

Much has been said about the troubled state of the U.S. healthcare system, whether it be about the perverse incentives that reward the volume of services provided rather than quality patient outcomes, inexorable medical cost inflation, or even anecdotal accounts of those in need of care being turned away. The problem of unfettered medical cost growth is best illustrated by the fact that in 2013, the U.S. spent an incredible 17.4% of GDP on healthcare, the highest amount among high-income nations. It is against this backdrop that opportunities are created for firms that are able to help reduce medical costs and effect a transition towards a system that focuses more on delivering good outcomes for patients at a reasonable cost.

Aetna (AET US) is a US health insurer involved in this transition to “value-based care”, a concept where the providers of healthcare (i.e., hospitals and physicians) are rewarded based on providing a quality outcome for the patient rather than on the quantity of services provided. Health insurers have every incentive to reduce medical costs – they pocket the difference between premiums they take in and medical expenses they pay out to beneficiaries.

Aetna is in the process of transitioning healthcare providers on to risk-sharing contracts called capitation agreements. Under these agreements, the healthcare providers receive a fixed sum per patient, irrespective of the quantity of services the patient receives. In order to effect the transition to a value-based system, health insurers need sufficient scale to pressure the providers into agreeing to value-based contracts. Aetna is the third largest health insurer in the US, with 23.5m members and 2014 revenue of approximately \$58 billion. The company already has 28% of its medical costs running through value-based contracts and is targeting 45% in 2017, a goal that will be aided by Aetna’s scale.

Consolidation amongst health insurers has been topical and Aetna is in the process of acquiring Humana, a health insurer competitor, to give the firm even more negotiating clout with healthcare providers. If anti-trust issues can be resolved, the deal will result in a combined entity with over \$100bn of revenues, which should further improve Aetna’s ability to move providers on to value-based contracts. The deal also increases Aetna’s exposure to the high growth Medicare Advantage segment, given that Humana has 19% share of Medicare Advantage enrolments with 3.2 million members.

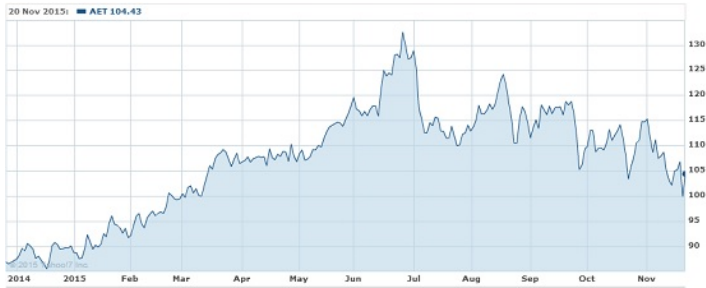
Medicare Advantage is the private health insurance program for over 65 year olds in the US and this program will benefit from an ageing US population. There are an estimated 11,000 individuals that become eligible for Medicare every day and an increasing number of them are projected to choose Medicare Advantage over the “Original Medicare” public health insurance program. Furthermore, of the new enrollees in Medicare Advantage, 61% of them elected plans rated with four or more stars.

The Affordable Care Act established bonuses that are paid to Medicare Advantage plans with four or more stars, where stars are awarded based on performance on measures of clinical quality and patients’ experiences. Aetna has an industry-leading 87% of its Medicare Advantage plans rated as being four or more stars and this provides a distinct advantage, given the drawcard this provides for prospective enrollees, and the bonus payments it receives, which can be reinvested into maintaining those stars ratings.

Aetna is a scale player in a consolidating industry with the foresight and ability to transition healthcare to a more effective model with respect to value and quality. This significant opportunity is only priced today by the market at nine times earnings, before

interest, tax and amortisation, with a long and prosperous path ahead for Aetna shareholders.

Aetna



Source: Yahoo! Finance, 23 November 2015

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