HEALTH PLAN VALUATION

Methodologies and Special Considerations

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This is the second in a four-part series on the valuation of health plans and the role valuation plays in due diligence to consummate a merger or acquisition transaction or the postmerger integration process. A flurry of health plan transactions took place from 2013 to 2018; 105 plans entered the market and 104 were sold to a larger plan or ceased operations. The rapid pace of health plan acquisition or consolidation, especially for provider-sponsored health plans, is likely to continue.

In an environment of such significant M&A activity, plan owners need to determine an appropriate purchase price when acquiring or divesting a health plan. In this article, we explain how key assumptions affect a valuation, and describe the importance of reaching an achievable financial forecast.

VALUATION METHODOLOGY

There are three health plan valuation methodologies.

1. The ***income approach*** determines the present value of a health plan's discounted cash flow based on a forecast of its future performance. The income approach is heavily relied upon for profitable businesses; however, not all health plans are profitable.

2. The ***market approach*** determines value by examining the sales of comparable health plans. The market approach is useful for profitable and unprofitable businesses, and most acquirers of health plans are interested in the membership of the plan they are acquiring. Historical financial statements inform the multiple that is used in the market approach, as details about the different lines of business (LOBs) and their profitability are included. ECG's proprietary transaction database breaks out profitability by LOB for target entities to better assist with determining an appropriate multiple.

3. The ***cost approach*** assesses the value of a health plan's underlying assets. The cost approach is not used as often because health plans own minimal assets.[1]

The three methodologies can be used in combination or as a single approach. Each brings nuance to the valuation process, and we will address that further.

[1]The cost approach may be used for a new plan when there are no historical operations, as start-up costs could be considered.

THE INCOME APPROACH: TESTING MANAGEMENT'S FORECAST

A key element of the income approach is management's forecast of the health plan's performance over the next three to five years using a pro forma financial statement. Quite often, health plans are for sale because they aren't achieving the financial performance desired by the owner. The management, however, may forecast that the health plan will achieve substantial improvements during the next few years, and this can directly affect the valuation range. A detailed review of the financial projections is needed to determine their reasonableness and credibility. The valuation expert should have extensive experience with the sources of health plan revenue and the major clinical and operational programs and associated expenses that underlie the pro forma.

To assess the forecast, ECG usually first reviews the key assumptions, along with the supporting documentation, and then conducts management interviews. Below are some of the issues that often merit additional attention.

Plan Information

The Plan's Current Situation

It is important to understand the plan's current situation, how it arrived in that situation, and the change in performance forecast by management. This provides clues to the areas within the forecast that merit closer examination.

Many plans are for sale for a specific reason. For example, a provider-owned Medicare Advantage plan has a relatively small service area and low membership, and management decides operation of the plan no longer aligns with the provider's strategic mission. In other situations, management determines the plan doesn't have the infrastructure capital to scale up the data management and systems that are needed to achieve and support the desired membership. Learning how the plan arrived at its current position can provide insight on where to focus additional scrutiny in the review process.

LOB Performance

Health plan performance can often vary significantly by LOB. Understanding the performance of each LOB can yield further clues to the credibility of the forecast and show where improvement is most needed. After the challenging areas of operation are identified, the credibility of the forecast can be more easily assessed. If solutions are readily available and a typical management team can execute and achieve results, then the forecasted improvements can be quite reasonable.

Revenue

Health plan revenues are substantially affected by many unique factors that apply to particular LOBs, whether those factors are established by state regulators or government programs or are related to market conditions.

The key revenue drivers of a financial forecast are:

- Enrollment.
- Per member per month premium revenue growth.
- Risk adjustment.
- Quality bonuses.
- Other revenue sources, such as behavioral health, obstetrics, etc.

For more in-depth examples on the revenue forecast, see the following explanations; otherwise, skip ahead to the Expenses section on page 8.

Enrollment

Quite often, management will forecast growth in enrollment. The prospects for growth by LOB in a market should be carefully examined. For example, the management forecast could indicate growth in the Medicare Advantage market, but the subject's state already has Medicare Advantage enrollment penetration that exceeds the national average percentage of Medicare-eligible population. The management forecast may then require a testing of assumptions to determine how the plan would achieve the forecasted growth.

In another example, a health plan may have a substantial share of membership and revenue coming from a Medicaid contract that is subject to reprocurement during the forecast period. In this situation, a closer examination of the health plan's performance under the Medicaid contract—including the health plan's quality performance, enrollee satisfaction and disenrollment rates, scope of provider network, or achievement of the state's contract goals—may be warranted to assess the prospects for a new contract to be awarded.

Ultimately, a decision must be reached on whether the enrollment projection that supports the forecast is reasonable in the context of the market and management's plan to achieve growth.

Per Member Per Month (PMPM) Premium Revenue Growth

The PMPM premium revenue for each LOB is governed by rules or market conditions that may call into question management's forecast assumption. A few examples show instances where the management assumptions of PMPM premium revenue growth are not supported by historical precedence, applicable rules, or market conditions.

In the fully insured large-group commercial markets, premium pricing is dictated chiefly by competitive forces. We see the fully insured large-group market continuing to shrink as more employers switch to self-funded plans. In addition, many large groups offer multiple plans to employees, and the health plan that is the subject of the valuation may have only a slice of the account, rather than exclusive status. It is not uncommon to see long-standing accounts offering a plan within the employer portfolio with a combination of rich benefits that drive adverse selection and increasing premiums that drive enrollment losses of the most profitable members, the so called "death spiral." This is a particularly thorny issue for management to resolve. A forecast that projects both enrollment and premium growth in this situation may not be credible.

Government LOBs have defined formulas to calculate premiums, but there are opportunities to forecast improvements. Many Medicaid programs use two-year-old historical data (the "base rate"), trended to the rate year for utilization and unit price changes. This data is then risk adjusted to establish the rate year premium. In some cases, a health plan will experience disallowance of base year costs that depress the rate year premium. A management team that has identified opportunities to correct cost disallowances can reasonably project an improvement in PMPM premiums above normal inflation through better documentation and appropriate reporting of costs.

Finally, Medicare Advantage premiums are driven by a methodology that uses historical Medicare fee-for-service (FFS) costs for each county. It trends those costs forward to the rate year for a number of adjustments to establish a county premium cap. In the bid process, the plan premium must be lower than the county cap. A percentage of the bid below the county cap (with the percentage dependent on the Star rating) is a rebate the plan can use to reduce premiums and cost sharing or offer additional benefits, but cannot be used for plan profit.

Premium increases are feasible but must be tested against the following:

- Current amount of rebate and county cap
- Historical rate of Medicare Advantage county premium cap increases
- Market conditions where premium increases, even if achievable, could affect enrollment

Risk Adjustment

There are different risk-adjustment algorithms customarily applied in Medicare Advantage, Medicaid, and the commercial fully insured individual and small-group markets. In addition to the algorithms, the risk-adjustment methodology is substantially different across LOBs. It is important to validate the management's estimates of risk-adjustment revenue changes and examine how those changes will be realized.

To obtain the best risk-adjustment score per member, the plan depends on the provider's documentation of medical records and coding. If the health plan has identified suspected missing or overcoded diagnoses through analytics programs, it may be reasonable to estimate an adjustment in revenue related to an increase in risk-adjustment allowances. Even with an identified opportunity, the management team should articulate the program by which the plan will realize the opportunity, which can require informing providers of the opportunity for each plan member and may include financial incentives for providers to accurately collect required data.

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Quality Bonuses

Medicare Advantage has a well-defined quality bonus program (the Stars Rating Program), and state Medicaid managed care programs often have similar programs that are designed to address the medical needs of their populations. As with risk adjustment, health plans are dependent on providers to collect much of the data that supports a plan's eligibility for the bonus. One complicating factor is that Medicaid quality programs vary substantially from state to state. That means forecasted improvements in quality bonus recovery will require credibility testing to assess whether the plan will be able to realize those improvements.

Other Revenue Sources

Many Medicaid programs have a host of special revenue arrangements, often related to behavioral health, obstetrical services, HIV services, hepatitis C drugs, and other programs. For health plans serving as a Medicaid managed care organization, careful review of these special revenue programs is recommended to ensure the forecast appropriately reflects the likely future revenue.

The COVID-19 Factor

Where Medicare Advantage and Medicaid use two-year-old data to establish benefit-year premiums, the impact of 2020 as a base year for 2022 rates remains to be seen. Most health plans are experiencing an abnormally low 2020 MLR due to a decline in elective services brought about by lockdowns, with some risk of underpayment in future years as volumes normalize.

[2] In 2017, Medicaid was the funding source for 43.8% of all US births. Source: Joyce Martin, Brady Hamilton, Michelle Osterman, "Births in the United States, 2017" (Hyattsville: NCHS Data Brief, No. 318, August 2018, p.3), https://www.cdc.gov/nchs/products/databriefs/db318.htm.

Expenses

The main areas that drive the overall expense forecast are:

- FFS provider claims.
- Value-based arrangements (VBAs).
- Expense ratios.

For more in-depth examples on the expense drivers, see the following explanations; otherwise, skip ahead to the Taxes and Profitability section.

FFS Provider Claims

Provider claims constitute the largest expense category in health plans, accounting for approximately 85% of all premium revenue. Participating provider agreements are subject to expiration and negotiation, and an evaluation of provider cost risk is recommended in order to validate the forecasting of future claims expense. In selected instances such as Medicare Advantage, a limited provider network scope can affect network adequacy and the plan's ability to achieve enrollment if a provider contract is terminated.

VBAs

VBAs can serve as an important hedge on provider claims cost, while at the same time potentially promoting quality improvement. However, regional markets have very different levels of provider appetite for VBAs, with many still preferring FFS payments. The forecast may indicate a change in the percentage of provider claims subject to a VBA, and this could have an associated impact on the plan's provider claims risk and profitability. A review of the percentage of provider claims that are subject to a VBA, VBA performance, and renewal prospects can improve forecast reliability.

Expense Ratios

It is not uncommon to see subscale health plans with low enrollment have expense ratios that are substantially higher than industry averages. These plans often have low profitability or even negative net income in the most recently completed reporting period. However, plans that forecast credible enrollment growth are likely to experience a concomitant reduction in PMPM administrative expense, substantially improving plan PMPM profitability. A review of the plan's expense ratios during the period of the forecast may indicate that with enrollment growth, the plan is simply achieving industry administrative expense norms, and this supports the forecast credibility.

Another factor is expense trends in aggregate and PMPM. Quite often, a forecast will indicate a slowing of aggregate expense growth and a reduction in PMPM administrative expense; the rationale for this forecast result requires careful examination.

Taxes and Profitability

The Affordable Care Act (ACA) introduced a number of taxes and fees, other than income taxes, that apply to health plans. The federal government has waived such fees for selected years. Forecasts should be reviewed to ensure these are appropriately considered as a cost of doing business.

THE MARKET APPROACH: WHAT TRANSACTIONS ARE COMPARABLE?

The market approach to valuation determines a health plan's value based on market transactions. This approach can be challenging for many reasons, including: (1) how, under the market approach, strategic sale transactions affect health plan acquisition prices, and (2) the identification of comparable sales characteristics and the construct of the market value.

The Strategic Sale

The price paid for a health plan acquisition may reflect the unique strategic value that an acquisition brings to a single acquirer, rather than the value that a typical buyer would place on a plan.

In January 2020, Centene completed its acquisition of WellCare at a value of 19x EBITDA, a very high multiple. The acquisition would enable Centene to expand its offerings of government-sponsored healthcare programs, including Medicaid and Medicare Advantage, and to increase its presence in the ACA individual market while acquiring up to 6.3 million new members. Although Centene had a much larger Medicaid enrollment than WellCare, the acquisition of WellCare's 545,000 members would more than double Centene's 416,900 Medicare Advantage membership. Clearly, Centene saw WellCare as having unique strategic value to its core business with considerable synergies to deliver accretive value, which justified the high EBITDA multiple.

If your health plan has positive cash flow and is contemplating a transaction, of course you would point to Centene's acquisition of WellCare as setting the standard for valuation of your plan. However, it's not that easy. Valuation experts look at several elements of each transaction, including strategic synergies, to determine whether the transaction should be used in a particular valuation engagement or if it constitutes a strategic sale outlier. Recognizing strategic sales and their impact on valuation is an important factor in selecting comparable transactions.

The Characteristics of a Comparable Sale

One of the biggest challenges in using the market approach is that it can be difficult to identify enough comparable health plan transactions on which to base a valuation. Multi-line health plans have a unique mix of members by LOB; a different revenue, risk, and profitability profile within each LOB; and unique factors affecting the purchase price, such as geographic location or the budget status of a state government, in the case of a Medicaid plan.

Simply put, there isn't likely to be an abundance of market-comparable health plans that look exactly like the subject plan.

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Further compounding the challenge is that the publicly available purchase price of market-comparable plans is probably not apportioned by LOB. This makes it difficult to understand how the mix of members in the comparable plan and the performance in each LOB align with the subject plan.

In order to develop a credible valuation, valuation experts must understand how the characteristics of a comparable transaction apply to the health plan that is being valued. Seasoned valuation experts know that several factors affect the price: the mix of membership, size of membership, revenue sources, EBITDA margin, risk by LOB, and unique factors like the service-area location.

Each comparable transaction should be analyzed to determine the value of the members in each LOB based on the key characteristics of the transaction. After the analysis yields a range of values for the members, a valuation can be created for the subject health plan that reflects the mix of members by LOB as well as other characteristics.

Another frequent situation is the acquisition of a health plan where the income approach would produce a negative value of the subject health plan. In that circumstance, the valuation expert must identify comparable transactions—those that involve the same LOBs as the subject health plan that also have negative profit margins. In particular, by learning the acquisition price of specific LOBs operating at a loss, the valuation expert provides insight on the intrinsic value of the membership in the health plan to be acquired.

ADJUSTMENTS TO VALUATION: RISK-BASED CAPITAL AND CAPITAL SURPLUS

After the business enterprise value is established for the plan, an adjustment may be needed to account for the requirements of risk-based capital and capital surplus.

As a condition of state licensure or of entering a government contract, the health plan is required to maintain a minimum reserve capital, termed "risk-based capital," to ensure financial solvency and ensure that provider claims for health services will be paid. The amount of risk-based capital the health plan is required to maintain is customarily defined by state insurance regulators or the governmental agencies that administer Medicaid, Medicare Advantage, and other government contracts.

In most states, the minimum requirement is 100% of the risk-based capital. Health plans with less than 200% are subject to insurance regulator financial oversight and development of a remediation plan. In valuations, ECG establishes a normative risk-based capital based on industry-accepted standards. Health plans with less than this normative amount will experience a downward adjustment to value (by the amount that the risk-based capital is less than the target at closing). Health plans with risk-based capital greater than the normative amount will receive an upward adjustment to value (by the amount that the risk-based capital is greater than the target).

Fair Value

Valuation of health plans requires both valuation expertise and a deep understanding of the health insurance industry. Unique financial reporting rules in the industry and wide disparities in premium revenue, medical costs, administrative and compliance requirements, and profitability by LOB can dramatically affect the range of value in a valuation. A valuation expert who understands these nuances will promote a fair value that enables the buyer and seller to arrive at a common understanding of a health plan's value and finalize a transaction.

Part one of our ongoing series explores the US health plan market. **Part three** explains how the valuation process can inform the due diligence review. **Part four** discusses how the valuation process can shape the merger integration plan upon the closing of the transaction.

Read the rest of this series on the ECG Blog.

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