

# UNITED HEALTH GROUP



## GRIFFIN CONSULTING GROUP

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Wednesday, April 11, 2012



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## EXECUTIVE SUMMARY

UnitedHealth Group (UNH) is a leading health and well-being company, offering diversified products and services to over 75 million individuals in all 50 states and federal and international governments.<sup>1</sup> A healthy enterprise with solid profitability, a strong balance sheet and good cash flow, UNH leads the industry in the health benefits and health services spectrums through UnitedHealthcare and Optum, respectively. While a financial snapshot of UNH indicates excellent financial health, its primary market is undergoing a potential paradigm shift that makes its growth prospects and future health uncertain.

Currently, the United States spends more money on health care than any other country in the world. At the same time, about 20% of Americans do not have health insurance. The federal government has taken action to account for this discrepancy. On March 23<sup>rd</sup>, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA).<sup>1</sup> The Supreme Court is currently reviewing the legislation and will rule on its constitutionality in June of this year. If upheld, this health reform legislation will impact how UNH does business through the individual mandate, predetermined medical loss ratios, Medicaid/Medicare changes, health insurance exchanges and tax increases. While UNH can take advantage of some of these changes, many provisions could inhibit revenue and premium growth rates and increase medical and administrative costs.

Griffon Consulting Group believes UNH can weather the changing health care climate better than competitors, however, thanks to its extensive network of over 754,000 health care professionals, 5,400 hospitals and 61,000 pharmacies.<sup>ii</sup> UNH should continue to run a successful business for individuals and employers by focusing on improving the health care system, maintaining a large network, increasing enrollment and keeping costs low. UNH already works with health care professionals to offer high quality, affordable health care to its employer and government clients and consumers. To sustain its position as market leader, UNH needs to maintain these positive relationships while looking for ways to improve upon them and extend their network to maintain strong financial performance.

In order to reduce the potentially negative consequences of the PPACA, UNH needs to look for ways to take advantage of the individual mandate, which stipulates that everyone must have health insurance; UNH must capture this inflow of previous uninsured individuals looking for health care. Further, UNH should continue engaging in acquisitions and entering new markets with innovative products and services to reduce costs, improve efficiency, and increase growth; UNH has a long acquisition

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<sup>1</sup> See Appendix for a summary of the PPACA



history and needs to take advantage of its strong cash flow liquidity to continue to expand. Identifying and executing effective strategies that address negative consequences of the PPACA, cut costs and force sustainable growth will produce substantial market power and profitability for UNH and its shareholders.

## **COMPANY HISTORY<sup>iii</sup>**

### **1974-1984: EARLY BEGINNINGS**

UnitedHealth Group traces its origins to Charter Med, a small organization founded by physicians in 1974 in Minnesota. In 1977, UnitedHealthcare Corporation was founded and acquired Charter Med; the two organizations were among the pioneers of the HMO (Health Management Organization) concept. The company's first major innovation came in 1979, when it introduced the first health care plan aimed specifically at seniors as an alternative to Medicare.

### **1984-1989: RAPID GROWTH, OVEREXPANSION AND CONSOLIDATION**

In 1984, UnitedHealthcare Corporation made its initial public offering. Previously traded as an over-the-counter stock, the public offering provided an infusion of capital that gave it the impetus to start a program of massive expansion, eventually leading to today's NY Stock Exchange traded giant in the healthcare industry. In 1985, the company acquired the Share Development Corporation, and by the end of the year UnitedHealthcare had grown from offering HMOs in 10 states to 22 states. In 1986, the company acquired Peak Health Care, further expanding its coverage. The growth in patients served was dramatic: from 822,000 enrollees in 1985 to 1.6 million in 1986.

Soon it became apparent that this growth was overexpansion. The company took a loss despite rapidly growing profits and was bailed out by an investment bank, resulting in the bank controlling almost 40% of the company. UnitedHealthcare then began a restructuring, and by 1989 the company was managing one million enrollees and earning \$13.6 million on \$412 million in revenues.

### **1989-1994: VERTICAL AND HORIZONTAL EXPANSION**

As healthcare costs rose rapidly in the late 1980's and early 1990's, UnitedHealthcare was squeezed by its providers. As a countermeasure, the company pioneered several services designed to reduce costs. One example is its pharmaceutical services, a division of the company founded in 1988 and bolstered by the acquisition of PrimeCare Health Plan. The company also created an organ transplant network, a Report Card methodology for ranking providers and a large employee assistance company to



decrease costs and increase customer satisfaction. As well, the company continued its buying spree of smaller health plans; between 1990 and 1993 the company bought no fewer than seven smaller HMOs, considerably expanding its reach and coverage areas.

### **1994-1998: RENEWED FOCUS ON CORE HMO**

In 1994, UnitedHealthcare sold its large pharmaceuticals business for \$2.3 billion. This sale gave it capital to buy the MetraHealth Companies in 1995, further expanding its client base. In 1997, AARP chose UnitedHealthcare as the official provider of its health insurance plans, a huge coup. In 1998, UnitedHealthcare rebranded itself as UnitedHealth Group (UNH). UNH also tried to acquire the healthcare giant Humana but failed after taking a large quarterly loss.

### **1998-2005: SUSTAINED GROWTH AND INNOVATION**

In the early 2000's, UNH began embracing the Internet to connect customers and providers more efficiently. In 2002, with the acquisition of AmeriChoice, UNH also expanded its government services practice, now known as UnitedHealthcare Community & State. The company's highlight during this period was the acquisition of PacifiCare, an HMO, for \$8.8 billion in cash and stock in 2005, the company's largest acquisition in history. This acquisition also coincided with the highpoint in its stock price.

### **2006-PRESENT: CHARTING A PATH FORWARD**

In 2006, senior executives were suspected of backdating options, leading to the resignation of the CEO and a change in leadership and a drop in the stock. A year later, the company extended its agreement with the AARP to include Medicare Part D and Medicare Advantage plans.

### **LOBBYING AND POLITICAL ACTION HISTORY**

UNH emerged in the 1970's into a US healthcare market unique in the developed world. After WWII caps on wages had emerged, and by the founding of the company, most Americans received coverage from their employers. While various universal coverage plans, including Richard Nixon's 1974 proposal, occasionally appeared, the company benefited from the status quo of private coverage.

In 2007, Ingenix, a UNH subsidiary, purchased The Lewin Group, a respected think-tank. This research institution is a fully owned, non-independent subsidiary of UnitedHealth and has maintained a strong reputation. For instance, Senator Ron Wyden used its estimates when creating a proposed healthcare reform.



After the 2008 Presidential elections, healthcare reform gained prominence in the national debate. The PPACA promised to change dramatically the healthcare landscape, and UNH rigorously lobbied to modify the bill. While the legislation ultimately passed, this lobbying contributed to two key victories for the insurance industry: the individual mandate, a statute requiring all Americans to have health insurance or pay a fine, and the exclusion of the Public Option, a government-run plan that would have competed with UNH. The implications of this legislation, and UNH's paths forward, are discussed in the SWOT and Strategic Recommendations sections.

Since 2010, UNH has continued to spend large sums on lobbying federal authorities and contributing to politicians through its Political Action Committee, United for Health. The company has given most of its contributions to Republicans.

## **INNOVATION HISTORY**

Founded by a pioneer of the HMO model, UNH prides itself on its strong history of innovation. Some major changes pioneered by the company are:

- 1979: Institutes first healthcare plans aimed at Senior as a Medicare alternative/supplement
- 1988: Pioneers Pharmaceutical Benefits Management with a large collection of retail locations
- 1989: Creates transplant network to facilitate organ transplants
- 1992: Introduces Report Cards for providers and the industry
- 1998: Allows physicians to compare metrics against national benchmarks
- 1999-2002: Begins to embrace the digital era, both in consumers and by linking physicians to large data networks
- 2004: Introduces consumer-driven (high deductible, with savings) health plans
- 2008: Launches UnitedHealth Continuity, allowing workers to move between jobs with the same health care
- 2009: Creates virtual physician visits software
- 2009: Links patient records to a national, continuous database
- 2009: Adds iPhone app for customers
- 2011: Launches Optum's new hearing aid product



## FINANCIAL ANALYSIS<sup>iv</sup>

### OVERVIEW

UnitedHealth Group is a healthy enterprise with solid profitability, a strong balance sheet and good cash flow. UNH leads the industry in the health benefits spectrum through UnitedHealthcare and runs a successful health services business with Optum. UnitedHealthcare assumes the insurance risk of medical costs and the administrative costs for its customers, who pay a fixed-rate premium or administrative fee. Its three subsidiary businesses include UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community. UNH also offers health services to consumers, employers and physicians through its Optum businesses: OptumHealth (health management, clinical assistance, financial services), OptumInsight (technology, health consulting and business solutions) and OptumRX (pharmacy services).<sup>v</sup> Optum makes the health system more efficient by aligning participants and providing fast information. This technology-based business optimizes care quality by cutting costs and improving the consumer experience.<sup>vi</sup>

Both health benefits and health services businesses have been growing, with health benefits serving over one million people and health services experiencing a 15 percent year-over-year growth.<sup>vii</sup> UNH managed \$135 billion in aggregate health care spending through UnitedHealthcare and Optum in 2011.<sup>viii</sup> UNH Revenues come from premiums on risk-based products; management, administrative, technological and consulting fees; sales of products and services; and investment.<sup>ix</sup> The main sources of revenue are premiums, which come from UnitedHealthcare. These premiums are derived from risk-based health insurance arrangements, where the policy is usually a fixed rate per individual during a 12-month period.<sup>x</sup> Revenues also come from UNH's Optum branch through payment for knowledge-based services. Major costs include medical and operating costs. UNH lowers medical costs through innovative product design and strong negotiations with health care suppliers and providers. At the same time, it cuts operating costs through efficiencies in claim management. Profitability is represented below in Table A.



TABLE A

<b>Profitability</b> - \$ in millions-	<u>2009</u>	<u>2010</u>	<u>2011</u>
Revenue	\$87,138	\$94,155	\$101,862
Premiums	79,315	85,405	91,983
Costs	80,779	86,291	93,398
Medical Costs	65,289	68,841	74,332
Operating Costs	12,734	14,270	15,557
EBIT	5,808	7,383	7,959

Table A indicates growing UNH profits. Both revenues and costs are increasing (with revenue increasing 8% over 2010), and profits have also been on the rise, as shown in earnings before income tax (EBIT). Other key performance indicators displayed in Table B also help illustrate UNH's financial outlook.

TABLE B

<b>Key Performance Indicators</b>	<u>2009</u>	<u>2010</u>	<u>2011</u>
Medical Care Ratio	82.6%	80.6%	80.8%
Operating Expense Ratio	14.6%	15.2%	15.3%
Return on Equity	17.3%	18.7%	18.9%
Debt/ Capital Ratio	32.1%	30.1%	29.1%
Common Stock Dividends/Share	0.0300	0.4050	0.6125

Table B shows a decrease in the medical care ratio. Lower medical care ratios mean that UNH is using money earned to finance non-health insurance specific projects. The operating expense ratio has risen slightly over the past three years, so UNH could look to try to lower this number and increase profits further by cutting expenses, as discussed in the Strategic Recommendations section. Further, UNH has done a good job of strengthening its balance sheet for the past few years. Strong positive cash flow has funded growth while also reducing its debt/capital ratio to below 30% (29.1% in 2011). Also, a successful share repurchase program has fueled EPS growth and raised the share price, and return on equity increased 20 basis points over 2010. This stronger balance sheet, combined with strong short-term cash holdings (\$28 billion), enables UNH to move quickly in the acquisition or joint venture market. For an example of how UNH might leverage these funds, see Case Study: An Acquisition Candidate under Strategic Recommendations.





While a financial snapshot of UNH shows excellent financial health, the aforementioned federal legislation is causing its primary market to undergo a potential paradigm shift that makes its growth prospects and future health uncertain. Specifically, the PPACA adds another layer of uncertainty about the future prospects for UNH. The potential financial consequences of the PPACA are discussed in the SWOT and Strategic Recommendation sections of this report.

While Tables A and B provide a short illustration of UNH's financial performance, to better understand UNH's financial situation, it is helpful to segment UnitedHealth Group into its component businesses.

## UNITEDHEALTHCARE

UnitedHealthcare is the largest business sector in UnitedHealth Group. This operation offers health insurance, health plan administration and specialized insurance and health services to employer groups, government agencies and consumers. It offers programs whereby UnitedHealthcare has risk (for utilization and costs of care) and whereby UnitedHealthcare provides administrative services only (referred to as ASO programs).

The exhibit below shows select figures from a research report by CreditSuisse, an investment banking firm, on UNH.

TABLE C<sup>xi</sup>

<b>UNITED HEALTHCARE</b>								
- in millions-								
	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>5-Yr CAGR</u>
<b>Commercial Risk</b>								
Enrollment	9,405	9,550	9,400	9,541	11,996	13,170	14,346	8.5%
Growth	-0.1%	1.5%	-1.6%	2%	26%	10%	9%	
Revenue	\$36,933	\$40,896	\$41,443	\$44,936	\$54,071	\$59,880	\$66,141	10.1%
Growth	0.8%	10.7%	1.3%	8%	20%	11%	11%	
EBITDA	\$2,959	\$3,568	\$3,601	\$3,610	\$2,937	\$3,202	\$3,446	-0.7%
% of Revenue	8.00%	8.70%	8.70%	8.00%	5.40%	5.30%	5.20%	
<b>Commercial ASO</b>								
Enrollment	15,405	16,320	16,870	17,376	15,339	14,321	13,302	-4.0%
Growth	1.3%	5.9%	3.4%	3.0%	-11.7%	-6.6%	-7.1%	
Revenue	\$4,015	\$4,285	\$4,409	\$4,640	\$4,137	\$3,901	\$3,660	-3.1%
Growth	2%	7%	3%	5%	-11%	-6%	-6%	
EBITDA	\$612	\$643	\$661	\$696	\$621	\$585	\$549	-3.1%
% of Revenue	15.2%	15.0%	15.0%	15%	15%	15%	15%	



<b>Medicare Advantage</b>								
Enrollment	2,070	2,240	2,514	2,766	3,042	3,194	3,258	7.8%
Growth	15.6%	8.2%	12.2%	10%	10%	5%	2%	
Revenue	\$22,967	\$22,731	\$25,054	\$27,819	\$32,131	\$35,424	\$37,939	10.8%
Growth	18.80%	-1.00%	10.20%	11.00%	15.50%	10.30%	7.10%	
EBITDA	\$2,231	\$2,057	\$1,994	\$2,200	\$2,220	\$2,133	\$2,284	2.1%
% of Revenue	9.7%	9.1%	8.0%	7.9%	6.9%	6.0%	6.0%	
<b>Medicare Part D</b>								
Enrollment	6,505	7,100	6,700	6,868	6,936	7,006	7,076	-0.1%
Growth	9.6%	9.1%	-5.6%	2.5%	1.0%	1.0%	1.0%	
Revenue	\$6,494	\$6,822	\$6,603	\$6,804	\$6,940	\$7,080	\$7,222	1.1%
Growth	-3.5%	5.0%	-3.2%	3.0%	2.0%	2.0%	2.0%	
EBITDA	\$404	\$339	\$332	\$343	\$350	\$357	\$364	1.4%
% of Revenue	6.2%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	
<b>Medicaid</b>								
Enrollment	3,320	3,525	3,870	4,258	5,739	6,313	6,439	12.8%
Growth	14.5%	6.2%	9.8%	10.0%	34.8%	10.0%	2.0%	
Revenue	\$10,299	\$13,727	\$15,526	\$17,406	\$26,983	\$30,275	\$31,498	18.1%
Growth	23.9%	33.3%	13.1%	12.1%	55.0%	12.2%	4.0%	
EBITDA	\$420	\$619	\$641	\$709	\$1,089	\$1,070	\$1,114	12.5%
% of Revenue	4.1%	4.5%	4.1%	4.1%	4.0%	3.5%	3.5%	
<b>Total United Healthcare</b>								
Enrollment	36,705	38,735	39,354	40,809	43,052	44,004	44,421	2.8%
Growth	4.4%	5.5%	1.6%	3.7%	5.5%	2.2%	0.9%	
Revenue	\$80,708	\$88,461	\$93,035	\$101,605	\$124,262	\$136,560	\$146,460	10.6%
Growth	8.6%	9.6%	5.2%	9.2%	22.3%	9.9%	7.2%	
EBITDA	\$6,626	\$7,226	\$7,229	\$7,558	\$7,217	\$7,347	\$7,757	1.4%
% of Revenue	8.2%	8.2%	7.8%	7.4%	5.8%	5.4%	5.3%	

Table C indicates that there is significant change on the horizon for UnitedHealthcare's business segments. Revenues increased 7% over 2010, indicating solid performance. The Commercial Risk segment, the largest of UnitedHealthcare's divisions, should continue to see good growth, especially in 2014 when employers of a certain size must offer health coverage to their employees or face fines. However, the profitability of the business will fall dramatically as the pending legislation forces economies of scale and cost reductions to be shared with policyholders. While remaining a healthy business, UnitedHealthcare will not see this segment contribute to growth in income.

UnitedHealthcare's Medicare Advantage programs are projected to suffer a similar future, with increasing enrollment and revenue but little growth in income to show for



this top-line growth. This estimated slow growth is a consequence of the PPACA, which will change the Medicare industry. As almost one-fourth of UnitedHealthcare earnings come from Medicare, this development will have a large impact on UNH. The commercial services (Commercial ASO) and Medicare Part D businesses (UnitedHealthcare offers Medicare Part D programs that are marketed by AARP to its members) are forecast to suffer generally flat enrollment, revenues and earnings over the next five years. The bright spot for UnitedHealthcare is its Medicaid business (operated by the individual States). Here, UnitedHealthcare is expected to see strong double-digit annual growth in enrollment, revenue and earnings due largely to the expansion of Medicaid under the PPACA.

Another bright spot is the increase in enrollment for UnitedHealthcare. As Table D below illustrates, membership has risen by 1.8 million in 2011.

TABLE D

<b>UnitedHealthcare Covered Lives</b>		
- in millions-		
	<u>2010</u>	<u>2011</u>
Employer & Individual	25.0	26.0
Medicare & Retirement	10.3	10.9
Community & State	<u>3.3</u>	<u>3.5</u>
Total	38.6	40.4

## **OPTUM**

UnitedHealth Group's Optum businesses are not consumer facing. They operate to improve outcomes and manage care (and cost) for governments, program administrators and health providers such as hospitals. Whereas the UnitedHealthcare businesses are predominately USA-based, some Optum businesses have international clients. These businesses are more medical knowledge and outcome oriented than the UnitedHealthcare segments. As such, the Optum side of UnitedHealthcare has very different operating parameters and significantly different profitability and growth prospects.



TABLE E<sup>xii</sup>

<b>OPTUM</b>								
- in millions-								
	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>5-Yr CAGR</u> (2011-16)
<b>Optum Health</b>								
Revenue	\$5,782	\$6,613	\$7,811	\$8,202	\$8,612	\$9,042	\$9,494	7.5%
Growth	5.8%	14.4%	18.1%	5%	5%	5%	5%	
EBITDA	\$667	\$464	\$559	\$655	\$688	\$722	\$758	10.3%
% of Revenue	11.5%	7.0%	7.2%	8%	8%	8%	8%	
<b>Optum Insight</b>								
Revenue	\$2,341	\$2,669	\$2,846	\$3,416	\$4,099	\$4,509	\$4,960	13.2%
Growth	28.4%	14.0%	6.6%	20%	20%	10%	10%	
EBITDA	\$422	\$526	\$618	\$773	\$968	\$1,110	\$1,271	19.3%
% of Revenue	18%	20%	22%	23%	24%	25%	26%	
<b>Optum Rx</b>								
Revenue	\$16,771	\$19,278	\$19,700	\$27,580	\$29,786	\$32,169	\$34,743	12.5%
Growth	16.1%	14.9%	2.2%	40%	8%	8%	8%	
EBITDA	\$613	\$545	\$511	\$833	\$900	\$972	\$1,050	14.0%
% of Revenue	3.7%	2.8%	2.6%	3%	3%	3%	3%	
<b>Total Optum</b>								
Revenue	\$24,894	\$28,560	\$30,357	\$39,198	\$42,497	\$45,720	\$49,197	11.5%
Growth	14.9%	14.7%	6.3%	29.1%	8.4%	7.6%	7.6%	
EBITDA	\$1,702	\$1,535	\$1,688	\$2,261	\$2,556	\$2,804	\$3,079	14.9%
% of Revenue	6.8%	5.4%	5.6%	5.8%	6.0%	6.1%	6.3%	

Table E outlines a 5-year forecast for the Optum businesses. As is shown, the Optum businesses offer different relative profitability, from the high margin Optum Insight segment to the low margin Optum Rx business, with Optum Health in between. However, it is also important to see the constant factor in these Optum businesses – high growth.

## FREE CASH FLOW FORECAST

UNH has accumulated a substantial cash and short-term investment position. As of December 31, 2011, its cash, cash equivalent and available-for-sale investments totaled \$28 billion. With just over one billion shares of common stock outstanding (and no preferred shares), UnitedHealth Group has short-term investments of over \$27 per share. While insurance companies need to keep some short-term assets to float against



liabilities presented by their insurance pool, UNH does not need to keep such a significant amount of cash. Instead, some of these short-term securities could be better suited to fund acquisitions, repurchase shares, increase dividends or invest in transformative technologies.

UNH was able to generate such a strong cash position through its substantial cash-generating business operations. CreditSuisse estimates future free cash flow (after taxes, dividends, and capital expenditures) as shown below:

TABLE F

<b>UnitedHealth Group</b>							
-\$ in millions-							
	<u>2010A</u>	<u>2011A</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>
Capital	\$-878	\$-1,018	\$-1,007	\$-1,153	\$-1,233	\$-1,344	\$-1,440
Free Cash Flow	4,788	4,801	5,260	5,254	2,993	4,804	5,581

As the above forecast indicates, with the exception of the potentially disruptive implementation of the new health care acts in 2014, free cash flows should be between \$4.5 billion and \$5.5 billion annually, with the potential to increase further after 2016. With relatively minimal accounts receivable but substantial accounts payable (premiums are paid prior to the use of covered medical services), UnitedHealth Group has relatively low working capital requirements. Therefore, UnitedHealth Group can grow with substantial new investment in property, plant and equipment (compared to a manufacturing operation). These conditions enable UnitedHealth to generate strong cash flows while keeping strategic options open to enhance shareholder value.

## LIQUIDITY

Liquidity, which assesses UNH's ease in converting assets to cash, is also an important component to examine. The table below highlights UNH's liquidity over the past five years.

TABLE G<sup>xiii</sup>

<b>Liquidity</b>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
Current Ratio	0.84	0.76	0.82	0.78	0.85
Quick Ratio	0.68	0.6	0.67	0.63	0.69
Cash Ratio	0.52	0.42	0.5	0.47	0.5
Debt to Equity Ratio	0.55	0.62	0.47	0.43	0.41



Usually, a current ratio under one suggests that the company would have problems paying off its debt, but the healthcare industry as a whole tends to have low liquidity (low current ratio). UNH's current ratio, therefore, does not suggest that the company is facing financial challenges. Especially since the company is sitting on \$28 billion in cash, it is safe to say UNH does not have a liquidity problem. The same is true for the quick ratio, which again would indicate areas to improve if not for the large cash flow UNH experiences. Finally, the debt to equity ratio for UNH indicates a strong financial position, as it has no problem paying the money it owes, thereby allowing the company to engage in acquisitions. In 2011, for every \$41 in long-term liability, UNH had \$100 in equity fund balance. This low number suggests UNH uses little leverage to finance its operations and has a strong equity position.

Further, UNH's strong balance sheet and growth suggest that despite somewhat low ratios, UNH maintains a strong financial standing. Comparing UNH to its competitors below further illustrates this fact.

## COMPETITION

UNH operates in a highly competitive market, as discussed further in Competitive Analysis. UNH identifies its main competitors as managed health care companies, insurance companies, HMOs and third-party administrators (TPAs).<sup>xiv</sup> These include Aetna Inc., Cigna Corporation, Humana Inc., Kaiser Permanente and WellPoint, Inc.<sup>xv</sup> Kaiser is not included in Tables H, I and J because it is not a publicly traded company. Though it should be noted if Kaiser were, it would rank third in revenue.<sup>xvi</sup>

TABLE H

<b>Revenues</b>						
-\$ in billions-						
	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>CAGR</u>
UnitedHealth	\$75.4	\$81.3	\$87.1	\$94.2	\$101.9	7.8%
Wellpoint	61.4	62.5	61.7	58.8	60.8	-0.2
Humana	25.3	29.0	31.0	33.9	36.8	9.9
Aetna	27.7	31.6	34.9	34.3	33.8	5.1
Cigna	17.7	19.1	18.5	21.3	22.0	5.6



TABLE I

<b>Pretax Income</b>						
-\$ in billions-						
	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>CAGR</u>
UnitedHealth	\$7.3	\$4.6	\$5.8	\$7.4	\$8.0	2.2%
Wellpoint	5.3	3.1	7.4	4.4	4.0	-6.9
Humana	1.3	1.0	1.6	1.7	2.2	14.7
Aetna	2.8	2.2	1.9	2.6	3.1	2.4
Cigna	1.6	0.4	1.9	1.9	2.0	4.8

TABLE J

<b>Pretax Margin</b>						
(Revenues / Pretax Income)						
	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>Chg</u>
UnitedHealth	9.7%	5.7%	6.7%	7.8%	7.8%	-1.9%
Wellpoint	8.6	5.0	12.0	7.4	6.5	-2.1
Humana	5.1	3.4	5.2	5.2	6.1	1.0
Aetna	10.1	7.0	5.5	7.7	9.1	-1.0
Cigna	9.2	2.0	10.3	8.8	9.0	-0.3

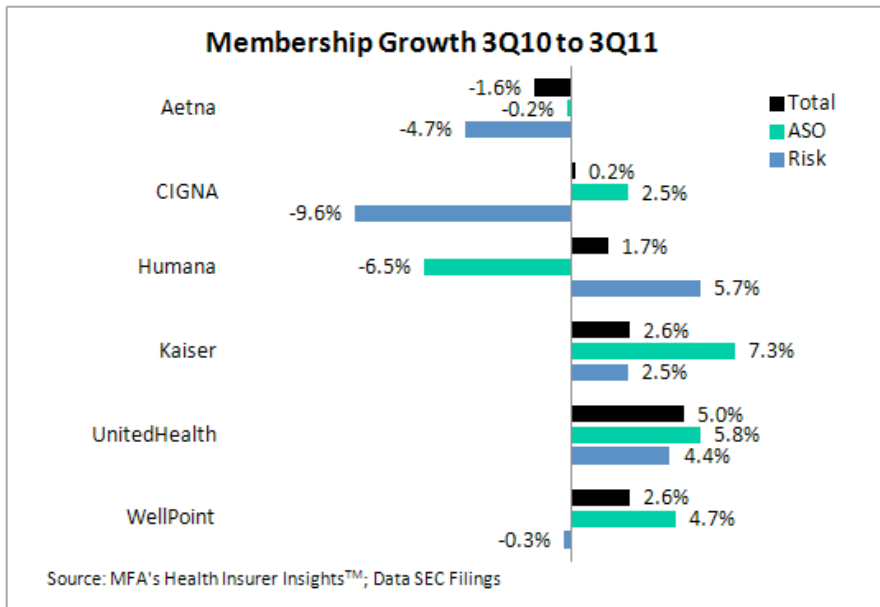
Tables H, I and J illustrate that UnitedHealth Group is in a very strong competitive position as it covers one in seven Americans with health benefits. It is 1.5 times as large as Wellpoint, its largest competitor, and is the size of #2 (Wellpoint) and #3 (Humana) combined. UNH is in a very strong market position as the market (measured by revenues) for health services continues to increase.

Additionally, UNH has a large international operation with offices in 19 countries, and especially sizeable operations in India and the United Kingdom. By contrast, Wellpoint, Cigna, and Humana have a much more limited international profile, offering international insurance for American citizens and some small European offerings. These international operations represent both current diversification and possible sources of future growth.

In contrast to key competitors, UNH has grown both risk-based plans (where UnitedHealth or a subsidiary pays for health care costs) and ASO (administrative services only) plans, as shown in Figure 1.

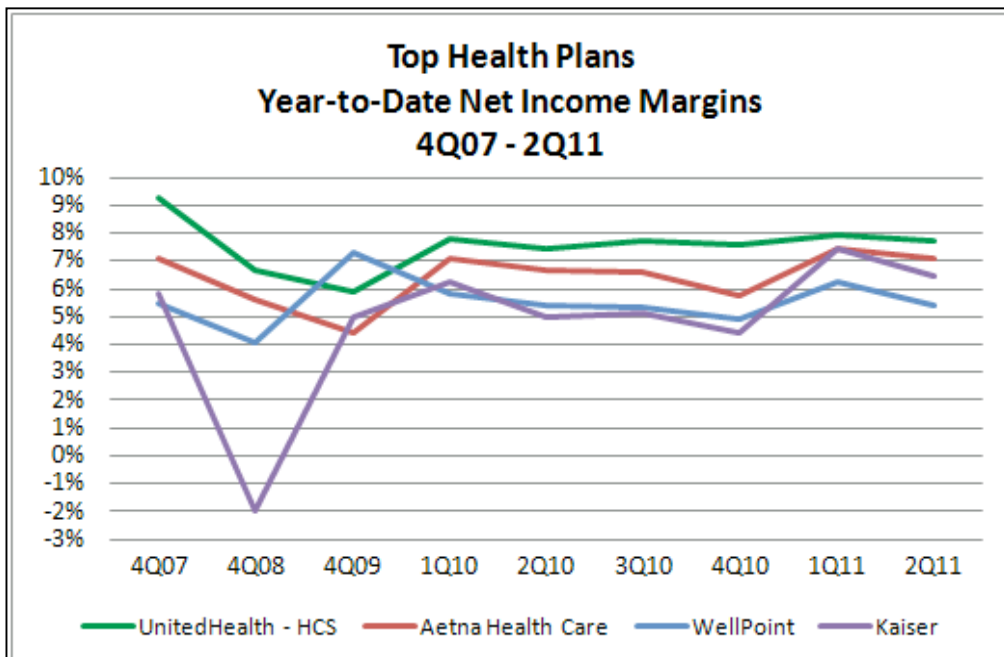


FIGURE 1<sup>xvii</sup>



In sum, compared to its competitors, UNH has been in a much stronger financial position, as shown in Tables H, I and J. Its margins are consistently ahead of competitors, and its revenue growth has been much more significant. A further depiction of this strength is in Figure 2, which illustrates superior income margin.

FIGURE 2<sup>xviii</sup>







## STOCK MARKET ANALYSIS

Publicly traded companies compete not only for customers but also for capital. As such, having compared UNH's financial performance over time with its competitors, it is also important to consider the capital market performance.

The figure below is a snap shot of UNH's stock performance compared to the Standard & Poor's 500 stock index (S&P 500) from March 2010 to end of March 2012.

FIGURE 3<sup>xix</sup>



UNH's share price has performed well. From January 2011 to July 2011, UNH significantly outperformed the Standard & Poor's 500 stock index (S&P 500). Since that time, UNH's stock price has generally followed market index performance.

Note also that UNH's stock price, in 2010, underperformed the general market index during this period. President Obama signed the PPACA on March 23, 2010 and its companion, the Health Care and Education Reconciliation Act of 2010, on March 30, 2010. Initially, investors apparently took a dim view of the Act's future impact on the growth and profitability on UNH. This original reaction, however, did not hold. The graph above shows the PPACA does not continue to affect investor decisions, as UNH has maintained a steady share price. Perhaps investors perceive this act as a source of growth, as more people will enroll with UNH. More on the potential consequences of the PPACA are discussed further in the Strategic Recommendations section.



## COMPETITIVE ANALYSIS

### PORTER'S FIVE FORCES<sup>xx</sup>

Degree Of Internal Rivalry	High
Threat of New Entrants	Low
Threat of Substitutes/ Complements	Low
Supplier Power	Moderate
Buyer Power	High

### DEGREE OF INTERNAL RIVALRY

A large number of firms compete in the health and well-being industry, creating a high degree of internal rivalry. UnitedHealth Group competes mainly against for-profit managed care organizations (MCOs). These MCOs may be provided in a variety of settings, which include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and local plans. Health insurance is not a national market, as different state mandates on the extent of health care coverage create local markets, and many of these are far more concentrated. For example, a company may have significant market share in one state but not nationally due to the high level of competition. An example is the difference between UNH and Wellpoint. In 2009, Wellpoint had 71% of the market in Maine but was second behind UNH in national revenues. UNH, on the other hand, led the nation in revenues but only managed to command 35% of the market in its most dominate state, Colorado.<sup>2</sup>

Internal rivalry in this market has likely intensified in recent years for several reasons. First, the number of firms, both non-profit and for-profit, competing and offering distinguishable, affordable and preferable products has grown. Second, industry-wide growth has slowed, causing existing firms to fight for market share. However, this second point is likely to change in coming years as the PPACA brings previously uninsured individuals into the market for health insurance.

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<sup>2</sup> See Table H



The PPACA will also change the landscape for competition. With the implementation of health insurance exchanges, policy shoppers will be able to compare rates and coverage, resulting in an increase in competition for the consumer.

In the face of the challenges of competing with other managed care organizations, UNH has experienced higher profitability than competitors since the start of the decade. UNH succeeds largely due to its vast network and well-known reputation. Its size is especially important given that the health care services industry is very fragmented but concentrated. Of the 1,354 managed care companies operating within the United States, the 50 largest generate approximately 75% of the total revenue in the industry. UNH's extensive network of 754,000 health care professionals, 5,400 hospitals, and 61,000 pharmacies makes it a formidable competitor as options and availability remain at the forefront of consumer decision-making for health care services. The combination of economies of scale, willingness to innovate and strong financials makes UNH a formidable player in the health care services industry. Although it faces competition from over 1,000 firms, UNH has solid positioning and can be considered a powerhouse despite the high degree of competition. For more information on competitors, see Financial Analysis: Competition.

### **THREAT OF NEW ENTRANTS**

Due to the nature of the industry, threat of new entrants is low. Despite the enticing potential influx of customers who must now buy health insurance from private insurers, market concentration is likely to remain high because of the presence of significant economies of scale, which is to the advantage of firms like UNH. Sizable companies in the managed care industry not only have the advantage of streamlined operations but also have a critical advantage in negotiating favorable contracts with a large number of healthcare providers. This breadth of coverage is a key selling point to potential buyers. Therefore, because of the advantages of size, it is most likely that existing firms will compete for any remaining population soon to join the health insurance universe, and that larger companies will be the most competitive in attracting these new potential customers.

The best way for small companies to compete successfully in the managed care industry is by providing special coverage plans as part of government programs such as Medicaid or offering unique plans for specialized populations. It seems the current trend does not suggest that new, small companies are able to compete in the industry, as the managed care industry has experienced rapid consolidation driven by larger players taking share and acquiring smaller firms.



## **THREAT OF SUBSTITUTES/COMPLEMENTS**

The threat of substitutes is low, largely due to the individual mandate in the PPACA. Before this reform, a substitute for UNH might be no health insurance at all. If the Supreme Court upholds the PPACA, however, opting not to have health insurance is no longer possible. Further, companies of 50 or more employees will face penalties if they do not provide insurance to their workers.

Substitutes might include looking abroad for cheaper drugs that do not require insurance. Yet regardless of where consumers receive their prescriptions, there is no replacement for healthcare coverage. Further, it is unlikely that suddenly a new alternative will arise or affect the risk of substitutes. Anything but the most revolutionary and dramatic of ideas – such as the extreme scenario of a complete government buyout of the health insurance industry - still leaves behind a sizable functional role for UNH.

## **SUPPLIER POWER**

As previously mentioned, managed care companies become more attractive to customers as they gain the ability to offer extensive networks of hospitals and doctors with their plans. Understandably, large hospital chains gain significant bargaining power with which they can force higher payments with managed care companies. However, UNH's large customer base can partially offset this bargaining power, as large hospitals want to bring in as many customers as possible and could suffer as a result of a loss of UNH's patient base. In this case, large hospitals are more likely to be willing to negotiate favorable terms with UNH compared to smaller companies. Since size represents an advantage in combating supplier power, UNH is unlikely to experience greater bargaining challenges than other firms in the managed care market; in fact, UNH is in better standing due to its impressive size.

## **BUYER POWER**

Buyer power, already high, will increase with the PPACA. Given the large number of competitors in the industry, UnitedHealth Group's primary customer base – employers – have a wide selection of options from which to choose. Even more so now, employers, as well as individuals and the government will also gain buyer power with the PPACA. Health insurance exchanges give consumers more power, as they have complete information on policy costs and coverage details. Further, the government's bargaining power (in the form of legislation) is extremely high, which could leave UNH vulnerable to unexpected changes that increase costs and affect operations. For example, the PPACA requires health plans offered in the individual and small group markets, both inside and outside of the new health insurance exchanges, to offer a



comprehensive package of specific mandated items and services. Additionally, the government mandated that, as of 2014, insurers cannot refuse individuals based on previously existing conditions. The American Association of Retired Persons (AARP) also has some buyer power because it is a very large customer of UNH. Consequently, the loss of this contract could damage UNH’s expected future profitability and growth. Thus, despite UNH’s advantageous size and network, buyer power is still high.

## SWOT ANALYSIS

<b>Strengths:</b>	<b>Weaknesses:</b>
1. Network/Size	1. Competition
2. Predicting Costs	2. Medicare Changes
3. Acquisitions	3. Uncertainty
4. Modernization	
<b>Opportunities:</b>	<b>Threats:</b>
1. Acquisitions	1. Regulation Uncertainty
2. Medicare/AARP	2. AARP Changes Providers
3. The PPACA	3. Inflation

### STRENGTHS

- Network/Size
  - Serving over 75 million individuals through 754,000 health care professionals, 5,400 hospitals and 61,000 pharmacies, UNH leads the industry through its extensive network. With this network, UNH establishes brand reputation and recognition.
  - With its immense size, UNH can take advantage of both economies of scale and scope. UNH can keep medical and operating costs low due to its size (economies of scale, bargaining power).
  - UNH has diversified (through the Optum businesses, representing economies of scope) into non-insurance, high growth health services. It has also applied these services internationally.
- Predicting costs
  - UNH has a history of correctly predicting and controlling costs, as indicated by their low medical cost ratio, which allows for less volatile cash flows and low capital costs.<sup>xxi</sup>
  - Although there is risk in estimating incorrectly because of inflation, regulation or other factors, UNH finds little difference between predicted



and actual medical costs. Specifically, Medicare policies generate revenue based on estimates of future medical costs over the fixed contract time frame; UNH has been successful in accurately forecasting medical costs.

- Acquisitions
  - As seen in the Company History section above, UNH has taken advantage of acquisition opportunities to expand its network.
  - Recently, UNH has continued along this path, with the acquisition of XL Health, which sells Medicare Advantage plans. In February, the XLHealth acquisition added 117,000 Medicare Advantage members.<sup>xxii</sup>
- Modernization<sup>xxiii</sup>
  - UNH has a history of modernizing and improving health care using mobile technology. NowClinic is one of the newest health care models from OptumHealth that allows patients and physicians to chat in real-time or video conference each other. This smart-phone program is the first mobile device application that allows patients to find UnitedHealthcare doctors and care providers to facilitate a higher quality, cost effective search for urgent care centers.
  - OptumRx launched a new mobile application that reminds people to take their medications, refill prescriptions or transfer prescriptions to mail service.<sup>xxiv</sup>
  - UNH implements IT practices to make it easier for physicians to shift away from paper-based systems. The Physician Model Office saves physicians and staff time by helping them access clinical knowledge about a patient's medical information immediately. At the same time, this model helps UNH by assuring medical records are easily available, reducing prescriptions for unneeded medical tests.

## **WEAKNESSES**

- Industry competition
  - Even though UNH is a leader in the healthcare industry, the sheer competitiveness of the industry can be viewed as a weakness in gaining more market share. As the largest US provider of health care, UNH commands only a 16.5% market share. Compared to other industries, this share is remarkably low.
  - Adding to this fragmentation is the fact that health insurance is not necessarily a national market; different state mandates on the extent of health care coverage create local markets, and many of these are far more concentrated. While UNH is the largest player nationally, in reality it operates based on state mandates. Each state has its own regulations, meaning that some competitors represent threats only within a particular region. With this large fragmentation, it is hard to gain a dominating market share.
- Medicare
  - The PPACA changes the landscape of Medicare. Profits are likely to drop due to the new legislature. As Medicare makes up a quarter of UnitedHealthcare's revenues, as discussed in the Financial Analysis section, this policy change will hurt UNH revenues.



- The Center for Medicare and Medicaid Services (CMS) reassigned approximately 470,000 auto-assigned, low-income beneficiaries from UNH's Medicare Part D program to others.<sup>xxv</sup>
- Uncertainty
  - The health care industry suffers from great uncertainty. Uncertainty of:
    - Operating costs depending on effectively estimating the price for and management of medical costs.<sup>xxvi</sup>
    - New regulations that come along with Health Reform, specifically the PPACA. While the legality of this legislation is still before the Supreme Court, if deemed legal in June, the law has the potential to affect UNH in myriad ways. The possible consequences of this legislation are discussed below in Opportunities and Threats.

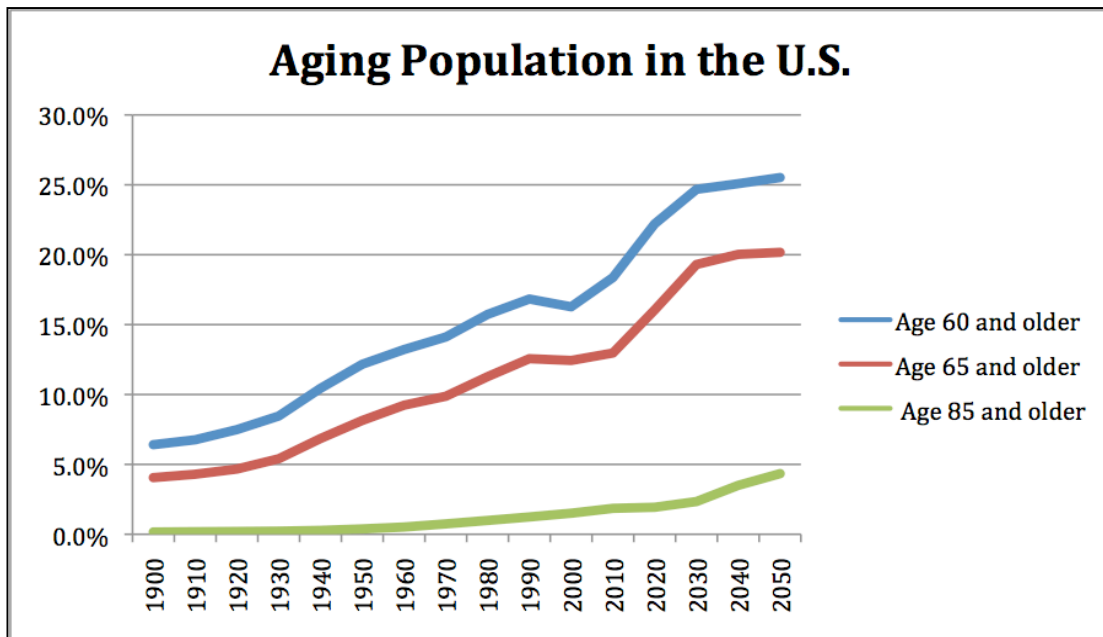
## OPPORTUNITIES

- Acquisitions
  - UNH has a historically positive record of acquisitions, and continuing down this path could better position UNH.
  - With good financial standing, UNH can acquire more companies to expand its market share and network. A potential acquisition target is discussed below in Strategic Recommendations.
- Medicare, AARP<sup>xxvii</sup>
  - UNH provides the most services of any health company to AARP, giving them an edge in providing services to the elderly. UnitedHealthcare Medicare & Retirement, working with AARP, offers health and well-being benefits to 3.8 million seniors in the U.S. With the baby-boomers growing older, this segment continues to enlarge.
  - An aging population shifts those covered under employer plans to Medicare plans. If UNH can capitalize on its Medicare platform, it will generate more revenue. Figure 4 illustrates the aging population, which is the market for Medicare and AARP coverage.





FIGURE 4<sup>xxviii</sup>



- Opportunities through the PPACA
  - Adding New Members
    - According to the U.S. Census Bureau, 83.3% (253.6 million) of Americans had health insurance in 2009 (most current record). If the PPACA passes, UNH has the potential to gain more customers.
    - The addition of 30 million new people into the health insurance market will assuredly increase demand for health services. One major source of UNH profitability is in claims administration, as someone has to handle paying the health provider. So, more people covered equates to more health transactions, and UNH's share of these increased transactions should mean profitable growth for UNH.
    - Part of the PPACA stipulates that businesses with more than 50 employees must provide insurance. As such, the commercial payment method is likely to increase, potentially allowing UNH to gain more customers.
    - Health insurance exchanges have the potential to add more members; these exchanges are designed to bring more people into the health insurance market. Congressional estimates are that 22 million people will be shopping at these health exchanges for coverage.<sup>xxix</sup> A good portion of these people will be new customers to the health insurance industry and, therefore, provide a new avenue for growth for UNH.
  - The Federal government's interest in containing health costs
    - One of the greatest risks facing pre- PPACA UNH was how to reduce the length of hospital stays, the frequency of expensive tests





and the high costs of patented pharmaceuticals for chronic conditions in order to cut overall medical costs. With the PPACA, the Federal government is now a partner with UNH in seeking cost controls.

## THREATS

- Uncertainty from the PPACA
  - One outcome health insurers are hoping to avoid is adverse selection. While UNH does not believe this will occur, if the uninsured are indeed less healthy, UNH will face rising costs.
    - If adverse selection occurs, cost per covered life will rise. Part of the PPACA includes regulation of premiums, meaning UNH would not be able to raise premiums as high as it would need to cover costs in case adverse selection takes place.
  - The PPACA also changes medical loss ratios for all commercial health plans in the large employer group, small employer group and individual markets. UNH must not drop below this 80% threshold. Companies who do not reach these targets will have to return portions of their premiums to their customers each year.
    - As a result, UNH will have to monitor its spending closely.<sup>xxx</sup> Possible consequences will be changes in compensations to employees or departments.
    - UNH borders the 80% threshold currently and must be aware of this number when doing its balance sheet and financials. Otherwise, the company will incur financial penalties.
  - While the aging population opens doors for increase in enrollment in UnitedHealthcare Medicare & Retirement, the PPACA will affect how Medicare and Medicaid function.
    - Since UNH has business segments in several areas (Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP), the company will likely experience a drop in revenue and/or a hike in costs.
    - The PPACA will restructure payments to Medicare Advantage plans by changing Medicare fee-for-service (FFS) rates.<sup>xxxi</sup> Whereas now FFS is about 95%, under the new plan, UNH will receive less revenue.
  - Threats arise from the implementation of health insurance exchanges due to decreased sources of differentiation, increased competition and increased role of public policymakers:
    - Decreased sources of differentiation – these health insurance exchanges will require minimum standards of coverage and will limit the types of policies offered to four tiers (offering enhanced benefits). The opportunity for UNH to design and market



- insurance programs to specific segments of the marketplace may be reduced.<sup>3</sup>
- Increased competition – having private insurers offer a limited number of insurance programs through an exchange allows all insurers to compete for business on a level playing field. This certainly is sub-optimal for those, like UNH, that have developed effective marketing programs and expertise in customer acquisition.
  - Increased role of public policymakers in the healthcare marketplace – the move toward “healthcare as a right, not a privilege” may ultimately lead to hostile feelings towards UNH.
  - Several of the provisions in PPACA will also likely increase costs for UNH.
    - New taxes on medical devices, annual fees on prescription drug manufacturers and amplified coverage requirements will occur.
    - There will be an annual insurance industry tax, \$8 billion for the entire industry in 2014 with rising annual amounts every year, which will clearly increase operating costs. Premium increases could offset these increased operating costs if they are approved.<sup>xxxii</sup>
    - A tax on employer-sponsored plans will also go into effect. This tax will try to dissuade over insuring on company health plans, but it will also increase costs for UNH.
  - AARP changes providers
    - If AARP were to no longer seek UNH’s services, a huge portion of its Medicare business would be lost.
    - With the aging population, Medicare and AARP represent both an opportunity and a threat.
  - Inflation
    - With the economic uncertainty, inflation has potential to increase medical costs above predicted levels.
    - Increasing inflation, and thus increasing costs, hurt profitability.

## STRATEGIC RECOMMENDATIONS

Griffon Consulting Group has identified key areas in which UnitedHealth Group can improve its performance and continue to succeed. First, we address the strategies UNH should employ if the Supreme Court passes the PPACA in June. Next, we look at other strategies for UNH, outside of Health Reform legislation. Finally, we present an acquisition candidate.

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<sup>3</sup> For example, there may be a segment of the market that only wants “catastrophic” coverage (emergency, hospitalization and recovery medical services) and does not require any primary care coverage (will pay for that themselves out-of-pocket). Such a policy is not allowed under the exchange rules.



## ADDRESSING THE PPACA IMPACT

UNH currently employs business practices that make it a leader in the health and wellness industry. With the evolving industry after the PPACA, however, UNH needs to focus on a few key potential consequences. The PPACA could affect UNH's business practices with its provisions about medical loss ratios, Medicare/Medicaid changes, health insurance exchanges and tax implementations. We have examined strategies to counteract some of the negative effects from the PPACA. These include focusing on the operating expense ratio and implementing more cost-reducing procedures.

UNH has made it a focus in the past to decrease the medical care number. The company has done so successfully, as Table B in the Financial Analysis section (reinserted below) shows. With the implementation of the PPACA, however, UNH will be punished if this percent drops below 80%, as discussed above in the Threats segment of SWOT Analysis. Therefore, with the PPACA, UNH needs to change its focus to the operating expense ratio, instead.

TABLE B

<b>Key Performance Indicators</b>	<b><u>2009</u></b>	<b><u>2010</u></b>	<b><u>2011</u></b>
Medical Care Ratio	82.6%	80.6%	80.8%
Operating Expense Ratio	14.6%	15.2%	15.3%
Return on Equity	17.3%	18.7%	18.9%
Debt/ Capital Ratio	32.1%	30.1%	29.1%
Common Stock Dividends/Share	0.0300	0.4050	0.6125

Table B shows this expense ratio is on the rise. Since UNH cannot lower the medical care number much further, it should focus on the expense ratio to keep costs low and profits high. UNH needs to strive to get people out of the hospital faster and healthier than before, for less money. Cutting costs is even more crucial with the implementation of health insurance exchanges because consumers can pick private insurers based on policy pricing. UNH needs to offer competitively priced packages in order to gain more market share.

Another way to cut expenses and keep the medical care number where it needs to be is through changes to Optum. If UNH sells 20% of Optum in the public market, the value of this managed care subsidiary will be recognized in the public market, allowing full consolidated reporting of Optum's financial results with minority interest. Further, UNH needs to reduce operating costs through technology and economies of scale. If Optum can implement technologies to streamline hospital services and manage employee hours and machine usage, operating costs will decrease and the industry will experience more efficient operating behavior.



Unfortunately, UNH cannot reverse the Medicare or tax provisions in the PPACA. It will have to weather these changes along with competitors. UNH should, however, weather this new legislation better than rivals due to its size and reputation. With an extensive national network, UNH is a leader in the health care industry. With more individuals buying health insurance, UNH could benefit from the increase in number of premiums received. While adverse selection is presented as a threat in the Threats segment of SWOT Analysis, the likelihood of it occurring is small and the consequences of it occurring can be reduced due to the individual mandate. In fact, health insurance companies actually supported the individual mandate section of the PPACA but not the rest of the legislation.<sup>xxxiii</sup> While health insurance companies will not be able to refuse coverage due to pre-existing conditions, the hope is that the overall increase in premiums will cover any costs associated with insuring those with these pre-existing conditions. To weather any risk of new, unhealthy customers, UNH needs to maintain its relationships with physicians, hospitals and other care providers.<sup>xxxiv</sup> One such example is maintaining a relationship with AARP, which is currently a crucial customer for Medicare.

## **OTHER STRATEGIES**

In addition to the PPACA, UNH faces other risks that must be addressed. As discussed in the Competitive Analysis, competition is high in this industry. Thus, we recommend UNH implement strategies of innovation, modernization and acquisition to distinguish itself from competitors.

UNH needs to continue its tradition of innovation through the use of technology. We foresee telemedicine as the way of the future, as it can streamline patient-physician interaction and cut costs. High-resolution teleconferencing technology and digitalized diagnostic equipment allow physicians to diagnose patients face-to-face when in-person appointments are not possible.<sup>xxxv</sup> UNH benefits from this innovative technique because costs decrease, as people do not undergo unnecessary tests that might occur if they had not spoken with their physician. UNH needs to market this technology and implement it further nationally and internationally.

Further, modernizing Medicare can improve the quality of care for beneficiaries and cut costs at the same time. Reforming Medicare is no easy task, but UNH could incorporate data-driven approaches to improve quality of care.<sup>xxxvi</sup> These technological implementations need to continue to be feasible strategies. If UNH can eliminate costs across the healthcare spectrum (for physicians, hospitals, providers, etc), UNH will be the most prominent health services provider. With this reputation, UNH will continue to expand its network and gather more customers.

With the evolving health care industry, UNH needs to distinguish itself from competition by working with the government to modernize health care. For three



decades, UNH has strived to make high quality health care accessible and affordable by making it easier for people to get necessary care, strengthening the relationships between patients and doctors, improving consistency and connectivity among all involved in health care, and discovering new ways to keep quality high and costs low.<sup>xxxvii</sup> UNH also works with the Center for Health Reform and Modernization to address serious health challenges.<sup>xxxviii</sup> This type of behavior needs to not only be continued but be amplified. UNH should work with federally funded organizations to teach children about health and fitness. Implementing Type 2 Diabetes programs in urban areas or through the YMCA is another way UNH can become a trusted and open advisor to the government. Doing so will enable UNH to gain enough good will to affect reform regulation that will benefit UNH and make the company even more of a powerhouse in the industry.

UNH needs to continue expanding through acquisitions and mergers. Throughout its history, UNH has merged with and acquired important businesses (see Company History). Aggressive acquisitions are especially enticing due to the changing market environment. With UNH in a strong position, especially compared to competitors that lack UNH's vast network, the company should take advantage of its cash flow and seek to expand further to gain more market share and market dominance.

### **CASE STUDY: AN ACQUISITION CANDIDATE<sup>xxxix</sup>**

While UnitedHealth Group has historically grown and profited by acquisitions, some analysts have raised concerns that this model may have become invalid since healthcare reform and consolidation have changed the health insurance industry dramatically. We believe that this is not the case, and profitable opportunities for acquisition still exist. Especially as UNH has potential to weather the PPACA better than rivals, it should use this good standing to seek more opportunities to distance itself from competition.

As an example of a potential UnitedHealth acquisition target, we present a case study sketching out the viability, feasibility, and profitability of further acquisitions. The following is not meant to substitute for UnitedHealth's analysis of this acquisition target; rather, it illustrates that UnitedHealth still has room to expand.

#### *Acquisition of American National Insurance Co. Health Insurance Segment*

American National Insurance Company (ANAT) is a publicly traded comprehensive insurance provider. The company is structured into five segments: Life, Annuity, Health, Property & Casualty, and Corporate & Other. The Health segment is focused on Medicare supplemental, medical expense, and group insurance plans. We suggest that UnitedHealth is in a position to acquire ANAT's health insurance business cheaply and improve its operations significantly.

#### *Acquisition Feasibility*



ANAT Health generates only \$258 million in revenue, or slightly less than 10% of ANAT's total revenues; its net income has fluctuated in recent years from a \$21 million loss to a \$17 million profit, even as ANAT as a whole has remained profitable. This relatively small share of revenues and uncertain future profitability, suggest that health insurance is not a core ANAT business and the company might be willing to divest it.

ANAT health also has a serious regulatory problem. Despite low margins, the segment pays out only 68% of premiums in claims. As discussed earlier, the PPACA imposes a minimum ratio of 80%, with the remainder to be rebated to consumers effective January 1 2014. We further investigate the consequences of this in the "Pricing for UNH Takeover" section.

Additionally, ANAT Health has been hit hard by recent regulation. In 2010, ANAT discontinued its sales of individual expense insurance plans due to increased regulation. In its 2011 annual report, the company wrote, "In 2012, we intend to establish new distribution channels and sales strategies through which we expect to see results." Any new distribution channels will be expensive, and ANAT will be competing against much larger, established players. In conclusion, it is hard to conclude that the ANAT board can look at its Health segment with much enthusiasm.

#### *Pricing for UNH Takeover*

In order to simplify pricing, we use a P/E valuation model to determine ANAT's health insurance business. Most health insurers trade at approximately 10x earnings. Since acquisitions generally involve paying a significant premium, we present a number of different potential valuations. Additionally, we consider the effect of several different adjustments to the PPACA disbursement requirements: a no-impact scenario where ANAT Health maintains current profitability, a partial-adjustment scenario where ANAT reallocates expenses to cover 10% of existing premiums, and a full-adjustment scenario where ANAT Health is forced to pay out or reimburse 80% of premiums. These scenarios are represented below in Figure 5.





FIGURE 5

**Potential Valuations for ANAT Health Segment (-\$ in millions-)**

PPACA Adjustment Scenario	Earnings Multiple Paid in Acquisition	Earnings Multiple Paid in Acquisition			
		7x	10x	15x	20x
No Impact	68% premiums paid \$17 million net income	119	170	255	340
Partial Adjustment	75% premiums paid \$3 million net income	21	30	45	60
Full Adjustment	80% premiums paid -\$9 million income	N/A	N/A	N/A	N/A

Essentially, this (admittedly oversimplified) model shows that ANAT might demand anything from a nominal amount to \$340 million for its health insurance business. However, we believe that the most likely scenario is the “partial adjustment” after 2014, and that \$60 million is a reasonable back-of-the-envelope selling point.

*Income Drivers in UNH Acquisition*

There are two main reasons to believe that UNH could run ANAT Health more profitably. First, in an acquisition, ANAT Health’s premiums and claims would be folded into the UNH overall proportions. Since UNH has the ability to investigate every possible re-classification of a non-claim expense into a health-improving expense, we are confident that in 2014 and beyond UNH will avoid having to rebate customers.

Second, we believe that with a UNH acquisition, UNH could cut ANAT Health costs significantly, leading to a more profitable business. Due to its relatively small size, ANAT Health spent \$72.9 million on operating expenses in 2011, or 31% of revenues. UNH spends an average of 14.6% of revenues. Reducing ANAT Health operating expense to 20% would save \$27 million annually.

*Total Potential Gain*

If these moves are achieved, ANAT would move from \$17 million of net income per year to \$34 million. Given an 11x earnings valuation, this would make the restructured, integrated ANAT Health business worth a total of \$374 million to UNH. If ANAT and UNH were to split this surplus, then UNH would gain \$187 million through this strategic acquisition.



## **CONCLUDING REMARKS**

If UNH can continue to expand and innovate, it will become too large to fail. UNH has been a successful company throughout its history and must endeavor to be an expert in all aspects of the industry. It is already working to connect different medical players together through technology, and this type of innovation will serve UNH well in the future.





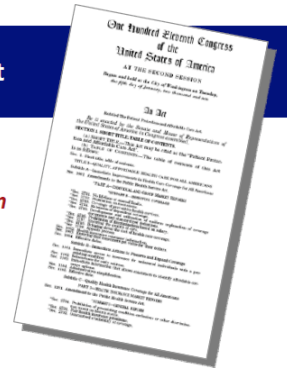
# APPENDIX

## HEALTH REFORM LEGISLATION

Below highlights a PowerPoint from UNH outlining the PPACA impact on the health industry.<sup>x1</sup>

### An Overview: The Patient Protection and Affordable Care Act

*The Patient Protection and Affordable Care Act commits \$940 billion over 10 years to expand coverage to nearly 32 million of the 54 million uninsured Americans. This would be offset by \$438 billion in new taxes and more than \$500 billion in spending reductions, largely in the Medicare program.*



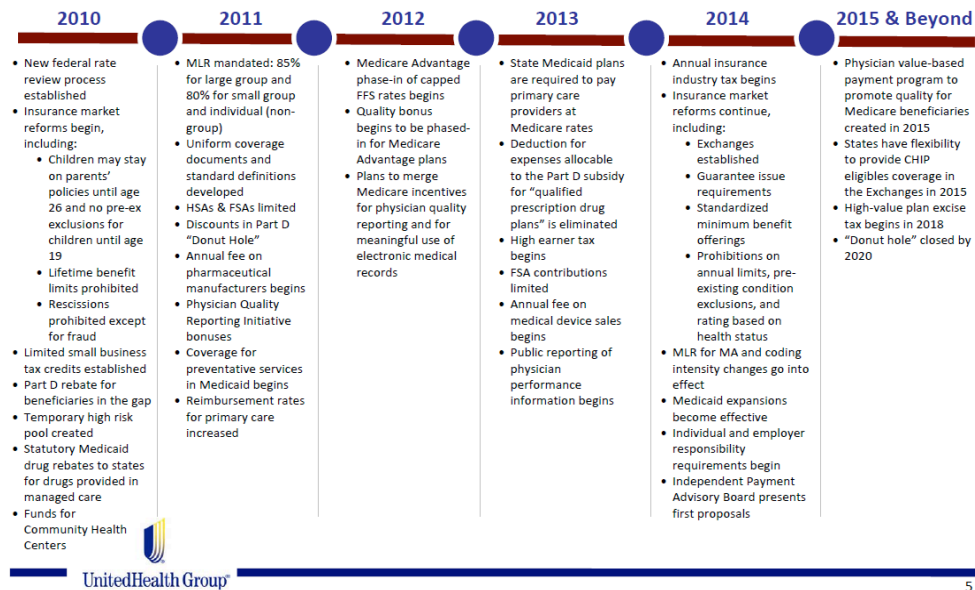
The Patient Protection and Affordable Care Act includes:

- 1) Creation of a new insurance marketplace, resulting in expanding access to coverage and the formation of state-based Exchanges
- 2) Sweeping insurance market reforms
- 3) Fundamental changes to Medicare, expansion of the Medicaid Program, and reforms to Part D, closing the “Donut Hole” by 2020
- 4) Fraud and abuse, health IT, and prevention and wellness initiatives, including the promotion of prevention programs across the health care system





## Timeline of Key Elements: The Patient Protection and Affordable Care Act



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## The New Insurance Marketplace & Other Insurance Market Reforms

*The Patient Protection and Affordable Care Act fundamentally reforms the insurance market, both in providing access to coverage for those previously uninsured and in changing the system for those who already have coverage*

### The New Insurance Marketplace...

- ✓ State health insurance Exchanges (for individuals and small employers up to 100 employees) estimated to provide coverage to 24 million
- ✓ New coverage alternatives, such as CO-OPs and benefit plan levels
- ✓ Individual responsibility requirement and employer requirements/penalties for not offering coverage
- ✓ Subsidies and tax credits to offset insurance premiums
- ✓ Temporary high-risk pool established until 2014 to provide coverage to those who can't obtain insurance due to health status or a pre-existing condition
- ✓ New voluntary long-term care insurance program for individuals with functional limitations

### ...and Other Insurance Market Reforms

#### *Effective 2010:*

- ✓ Children up to age 26 covered on their parents policies and up to age 19 obtain coverage with no pre-ex condition exclusions
- ✓ Lifetime caps ended
- ✓ Prohibition on rescissions except in the case of fraud or intentional misrepresentation
- ✓ New rate review authority process established

#### *Effective 2011:*

- ✓ Establishment of standard MLRs for all plans
- ✓ Uniform health plan documents created

#### *Effective 2014:*

- ✓ Guarantee issue coverage for all
- ✓ No exclusions for pre-existing conditions
- ✓ Minimum, essential benefits and standard benefit offerings
- ✓ Insurance industry annual tax begins

#### *Effective 2018:*

- ✓ High-value plan excise tax begins

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## Medicare Reforms

### Medicare Advantage (MA) Reforms

- ✓ Starting in 2012, MA payment benchmarks will be phased-in relative to local Medicare fee-for-service costs, and quality bonuses will be phased-in based on a five-star rating system
- ✓ Starting in 2014, MA plans are subject to a new minimum medical loss ratio (MLR) requirement of 85%
- ✓ MA and Prescription Drug Plan (PDP) enrollment period changes
  - ✓ In 2011, the January - March MA open enrollment period (OEP) for beneficiaries is eliminated and replaced with an opportunity to move to a fee-for-service plan from January 1 - February 15
  - ✓ In 2012, the MA and PDP annual election period (AEP) is moved up to October 15 - December 7
- ✓ Medicare beneficiaries are entitled to an annual wellness visit with no copayment or deductible. Cost-sharing is also removed for immunizations, screening tests and preventative services
- ✓ A new Independent Payment Advisory Board is established to present proposals to the President and Congress to reduce excess cost growth, improve quality of care for Medicare beneficiaries, and slow the growth in national health expenditures

### Part D Coverage Gap ("Donut Hole" Coverage)

- ✓ A \$250 rebate will be given to beneficiaries who enter the coverage gap in 2010
- ✓ The donut hole will be closed by 2020 by reducing coinsurance to 25% for all spending between the deductible and the catastrophic limit for both generic and brand name drugs
- ✓ In 2011, pharmaceutical manufacturers whose drugs are covered in Part D must provide a 50% discount for brand-name drugs
- ✓ A generic drug discount in the form of a federal subsidy is also provided to eligible beneficiaries in the donut hole beginning in 2011

### Retiree Drug Plans

- ✓ Starting in 2013, the deduction for expenses allocable to the Medicare Part D subsidy for "qualified prescription drug plans" is eliminated



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## Fraud and Abuse, Health IT, and Prevention & Wellness Initiatives

### Fraud and Abuse

- ✓ Increases funding for fraud and abuse prevention, enforcement and control
- ✓ Expands fraud and abuse rules to ERISA plans, Medicaid, and Medicare Parts C and D
- ✓ Increases penalties for violations
- ✓ Streamlines procedures for Medicare administrative contractors to conduct Medicare prepayment reviews

### Comparative Effectiveness Research

- ✓ In 2010, the Patient Centered Outcomes Research Institute is established
- ✓ Evaluates and compares health outcomes and the clinical effectiveness, risks, and benefits of two or more medical treatments, services, and items. Does not allow comparisons based on cost

### Administrative Simplification

- ✓ HHS to promote uniform adoption of electronic transactions standards, including standards for patient insurance eligibility and patient financial requirements. Electronic funds transfer rules are required by July, 2012, effective July, 2014
- ✓ Beginning in 2015, all payments made by Medicare must use EFT

### Prevention & Wellness

- ✓ Promotion of healthier eating habits and increased physical activity through increased funding for Community Transformation Grants
- ✓ All health plans to provide coverage for preventive benefits with no co-insurance or cost sharing
- ✓ Grants to states or local health departments to conduct pilot programs in the 55-to-64 year-old population for prevention and wellness programs designed to reduce Medicare costs
- ✓ New food labeling requirements for chain restaurants and vending machines



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## Medicaid Expansion and Medicaid, CHIP, & SNPs Reforms

### Medicaid Expansion

- ✓ Expands the Medicaid program in 2014 to individuals and families with incomes up to 133% of the federal poverty level
- ✓ Entitles childless adults and parents to coverage in the program. States will receive an enhanced federal match for this expansion (100% federal match in 2014 - 2016, phasing down in 2017 and beyond)
- ✓ Newly-created Exchanges will act as national enrollment vehicle starting in 2014

### Federal Statutory Prescription Drug Rebates & Medicaid Managed Care

- ✓ As of January 2010, drug manufacturers are required to provide statutory Medicaid drug rebates to states for drugs provided in managed care
- ✓ Provides an immediate savings opportunity for states that currently deliver their drug benefit through managed care

### Primary Care Payments in Medicaid

- ✓ In 2013 and 2014, states are required to pay primary care providers equivalent to Medicare rates

### Children's Health Insurance Program (CHIP)

- ✓ Extends the CHIP Program through 2015
- ✓ Beginning in 2014, states receive a 23% increase in their federal CHIP match rate
- ✓ States have flexibility to provide CHIP eligibles coverage in the Exchanges in 2015

### Special Needs Plans (SNPs)

- ✓ Extends the authorization for Medicare SNPs through 2013
- ✓ Extends the current state contracting requirement for dual SNPs through December, 2012



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## BACKGROUND OF HEALTH INSURANCE EXCHANGES

The federal government has expressed concerns about the natural conflict that is inherent in the for-profit insurance business. That is, that for-profit insurers could financially benefit by denying care to covered customers or denying paying for care. As such, Congress has developed a significant distrust of the for-profit health insurance business. As evidence that such distrust is well-founded, industry critics point to the House Committee on Energy and Commerce finding that in 2007-2009, the four largest private health insurers refused to issue health insurance policies to over 650,000 potential customers due to their previous medical history.<sup>xli</sup> In addition, the Committee identified another 212,000 claims of valid policyholders had been denied due to a "pre-existing condition".<sup>xlii</sup> Under the PPACA, both denial of policy and denial of coverage for pre-existing medical condition will be illegal.

Each state may set up an exchange or support a multi-state exchange. Failure to certify and operate their exchanges by January 1, 2014 could result in the federal government establishing a health insurance exchange.<sup>xliii</sup> Health Insurance Exchanges are essentially like a farmer's market. Consumers can peruse insurance plans and pick the best combination of health coverage and price that suites their needs. An objective of these



exchanges is to provide some consumer protections (thus the “Patient Protection” phrase in the name of the Act) in the health insurance business. Further, these exchanges may enable health insurance policy shoppers to more easily compare rates and coverage, resulting in not only more consumer choice (always seen as desirable), but also to increase competition for the consumer and to lead to reduced consumer cost.

## SOURCES

- 
- <sup>i</sup> UnitedHealth Group Annual Report
- <sup>ii</sup> UnitedHealth Group 2011 10K
- <sup>iii</sup> UnitedHealth Group About Us: History and Innovation.  
<<http://www.unitedhealthgroup.com/AboutUs/HistoryAndInnovation.aspx>>
- <sup>iv</sup> All financial figures are from the 2011 10K unless otherwise stated
- <sup>v</sup> UnitedHealth Group 2011 10K page 6
- <sup>vi</sup> *Ibid*
- <sup>vii</sup> Annual Report pages 3-4
- <sup>viii</sup> UnitedHealth Group 2011 10K page 32
- <sup>ix</sup> UnitedHealth Group 2011 10K page 3
- <sup>x</sup> UnitedHealth Group 2011 10K
- <sup>xi</sup> Credit Suisse report 1/22/12
- <sup>xii</sup> *Ibid*
- <sup>xiii</sup> Data from UnitedHealth Group Inc. Annual Reports
- <sup>xiv</sup> Annual Report page 10
- <sup>xv</sup> Comparative figures used in Tables H, I and J are from the respective companies’ 10K reports
- <sup>xvi</sup> Kaiser Permanente: About Us.  
<<https://businessnet.kp.org/health/plans/ca/home/aboutus>>.
- <sup>xvii</sup> MFA Health Insurer Insights; Data from SEC and Kaiser Press Releases
- <sup>xviii</sup> *Ibid*
- <sup>xix</sup> Yahoo! Finance
- <sup>xx</sup> Hoovers.com and Annual Report
- <sup>xxi</sup> UnitedHealth Group Online Report
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- <sup>xxiii</sup> Annual Report page 9
- <sup>xxiv</sup> *Ibid*
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- <sup>xxvii</sup> UnitedHealth Group 2011 10K page 5
- <sup>xxviii</sup> The Department on Health and Human Services Administration on Aging
- <sup>xxix</sup> Roby DH. “Private Health Insurance Under Health Care Reform and Health Benefit Exchanges.” [Lecture]



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- <sup>xxx</sup> UnitedHealth Group 2011 10K
- <sup>xxx</sup><sub>i</sub> Kaiser's Summary of New Health Reform Law page 8
- <sup>xxx</sup><sub>ii</sub> UnitedHealth Group 2011 10K
- <sup>xxx</sup><sub>iii</sub> UnitedHealth Group's Roadmap for Transforming America's Health Care System UNH PDF 1-7.
- <sup>xxx</sup><sub>iv</sub> UnitedHealth Group 2011 10K
- <sup>xxx</sup><sub>v</sub> Annual Report page 7
- <sup>xxx</sup><sub>vi</sub> Roadmap for Transforming America's Health Care System UNH PDF 1-7.
- <sup>xxx</sup><sub>vii</sub> Annual Report page 3
- <sup>xxx</sup><sub>viii</sub> Annual Report page 22
- <sup>xxx</sup><sub>ix</sub> Much interpretation and speculation is used in this case study. Financial figures are from ANAT's 10K.
- <sup>xi</sup> Roadmap for Transforming America's Health Care System  
<[www.unitedhealthgroup.com/hrm/Health-Care-Law.pdf](http://www.unitedhealthgroup.com/hrm/Health-Care-Law.pdf)>.
- <sup>xii</sup> Pauly MV, Herring B. "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market." "Health Affairs". 2007; 26 (3): 770-779.
- <sup>xiii</sup> Waxman HA, Stupak, B. "Re: Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market" [Memorandum]
- <sup>xliii</sup> InformationWeek Healthcare, July 12 2011.  
<<http://www.informationweek.com/news/healthcare/policy/231001432>>.