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LABORATORY INDUSTRY REPORT®

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HIGHLIGHTS

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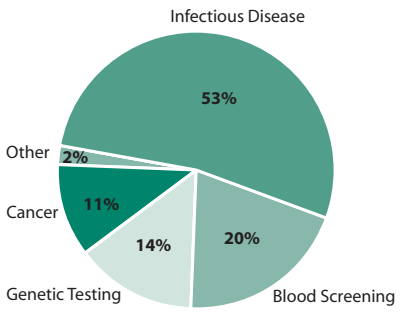
Molecular Diagnostics Market Growing at 15% Per Year

The molecular diagnostics market is growing at about 15 percent a year and is expected to reach $7 billion in 2011, estimates G2 Intelligence. This compares to a growth rate of about 5 percent to 6 percent for the lab industry as a whole, according to Stephanie Murg, managing director of G2 Intelligence, who gave an overview of the MDx market during G2's annual molecular diagnostics conference, held in Boston April 13-15.

Global MDx Testing by Segment



Source: G2 Intelligence

Although molecular diagnostics tests are rapidly becoming the standard of care in diagnosing many illnesses and conditions, they still are offered by only a fraction of clinical laboratories, Murg noted. In part, this is because of numerous

Continued on page 2

LabCorp to Expand Forensics Testing With Purchase of Orchid Cellmark

LabCorp's (Burlington, N.C.) planned purchase of Orchid Cellmark for $85.4 million will expand the company's DNA testing capabilities and allow it to establish a presence in identity testing in the United Kingdom.

LabCorp said April 6 that it would purchase 30.5 million outstanding shares of Orchild Cellmark, including options, at $2.80 per share, which represents a 39 percent premium to the closing price April 5. Orchid Cellmark provides DNA testing services for forensic, family relationships, and security applications, with its business split between the United Kingdom (63 percent) and the United States (37 percent).

Orchid's revenue growth has fluctuated over the last several years but grew 7.9 percent in 2010. In that year, the U.K. government represented 25 percent of the company's total revenues. With 2010 revenues of $63.7 million, the purchase price is about 1.3x revenues.

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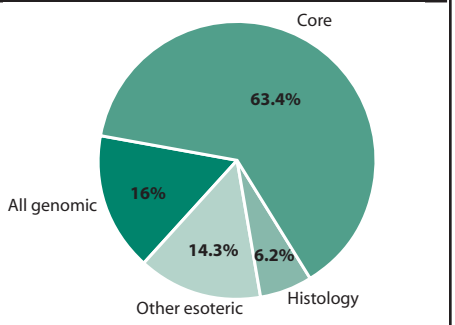
■ MDx Market Growing at 15% Per Year, *from page 1*

challenges facing the MDx market, including reimbursement issues, lack of standardization across platforms, quality-control concerns, high expectations for accuracy, the inability to fully interpret test data, clinical utility, increasing cost-management pressures, lack of personnel and expertise, the need for technologies that make MDx easier to automate and less expensive, smaller markets, and more complex targets.

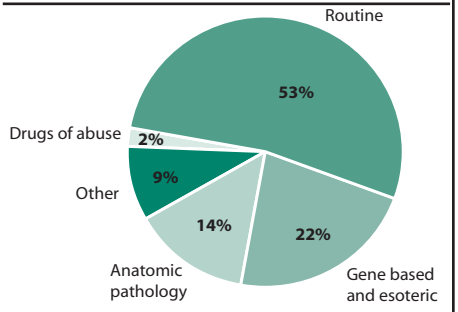
According to G2 Intelligence, infectious disease testing comprises about 53 percent of the molecular diagnostics market, followed by blood screening (20 percent), genetic testing (14 percent), cancer (11 percent), and other (2 percent).

LabCorp U.S. Test Mix, 2010



Source: G2 Intelligence and company reports

Quest U.S. Test Mix, 2010



Source: G2 Intelligence and company reports

In a survey conducted by G2 Intelligence in 2009, clinical laboratories said the key factors influencing their decision to offer molecular diagnostic testing were send-out data, potential clinical impact, cost data, Medicare and insurance reimbursement rate, time and resources required to develop the test, Food and Drug Administration status of the test, whether competitors offer the test, prospective payer mix, and turnaround time.

Going Mainstream

Although molecular tests have been used for some time for clinical diagnosis, neonatal screening, prenatal diagnosis, carrier testing, and HLA typing, MDx is now going mainstream, with more clinical laboratories adopting new tests. MDx in this new world means broader commercialization of extant assays (which will decrease costs), faster turnaround time, high sensitivity at small concentrations, broader menus on a single platform, and a move to develop technologies that can be easily adapted to low-complexity settings, such as doctors' offices.

While molecular diagnostic tests often are more expensive than routine tests, Murg notes that they actually lead to health care cost savings through decreased hospital stays, an established duration of therapy, discontinuation of ineffective therapy, and the ability to identify high-risk patients.

In order to be financially viable, a molecular diagnostics lab must contribute to overall hospital savings, save send-out test costs, and generate revenues. Examples of financially viable MDx labs are those that offer high-volume infectious disease testing or prenatal screening tests, those that offer disease or therapy monitoring (such as repeat testing of leukemia or BMT patients), and those that have carved out a niche as being the only lab in the country offering clinical testing for a specific genetic disorder.

"Molecular diagnostics can transform the spectrum of disease management from ensuring the early detection of disease to defining the prognosis of disease evolution and predicting a patient's response to specific therapies," notes Murg.

Large clinical laboratories clearly see the benefits of offering molecular diagnostic testing. Both Quest (Madison, N.J.) and LabCorp (Burlington, N.C.) have

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acquired a number of MDx companies in recent years. Esoteric testing now accounts for about 40 percent of LabCorp's test mix, while it makes up about 22 percent of Quest's mix.

A recent wave of partnership and deals between molecular diagnostic and pharmaceutical companies also signals that pharma has seen the value of MDx as well, notes Murg, although these types of collaborations are not without their challenges—among them, coordination and alignment of parallel development paths for a drug and a diagnostic assay, assay verification that requires substantial volume of patient samples, and difficulties in information sharing. What's more, insurers are still reluctant to cover many MDx tests, and clinicians are not fully prepared to integrate genetic information into routine clinical practice.

Despite these challenges to MDx, the rate of adoption is increasing rapidly, notes Murg, who predicts that next-generation genome sequencing will be the next major breakthrough in this area. Personal genomic mapping is becoming less expensive and more scalable than other sequencing technologies, and Jonathan Rothberg, inventor of a desktop device that performs sequencing, vows that by 2012 he will have invented a machine that will decode in two hours all 20,000 human genes that code for proteins (roughly 3 percent of all DNA).

"Next-generation sequencing is making inroads into the clinical laboratory at an incredibly rapid pace," says Murg. "As the costs associated with sequencing continue to plummet, it will be critical for early adopters to demonstrate the clinical utility of this technology and how it can affect clinical decisionmaking." G2

Proposal Provides Framework for Accountable Care Organizations

Health care providers, including laboratories and pathologists, now have some guidance on how to participate in accountable care organizations (ACOs), part of a new program that allows providers to coordinate services, cut Medicare costs, and share in the savings.

In proposed rules issued March 31, the Centers for Medicare and Medicaid Services (CMS), along with other federal agencies, provided a road map on how ACOs are to be set up and operated, including guidance on such issues as eligibility, governance, legal structure, quality, and privacy.

Under the proposed rule, an ACO refers to a group of providers and suppliers of services that will work together to coordinate care for the patients they serve. The Patient Protection and Affordable Care Act (PPACA) specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ❏ ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements;
- ❏ Networks of individual practices of ACO professionals;
- ❏ Partnerships or joint venture arrangements between hospitals and ACO professionals; and

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- ❏ Other Medicare providers and suppliers as determined by the secretary of Health and Human Services.

The law requires that each ACO include health care providers, suppliers, and Medicare beneficiaries on its governing board. The ACO must take responsibility for at least 5,000 beneficiaries for a period of three years.

Though the Medicare Shared Savings Program does not actually take effect until Jan. 1, 2012, many hospital and provider networks have already begun forming ACOs. According to G2 Intelligence, there were at least 123 ACOs being implemented in the United States as of February 2011. We estimate that there will be a total of about 375 ACOs in early 2012, with an additional 75, or 450 total, by 2013.

Among the physician quality reporting initiative measures used to assess performance, at least 21, or 12 percent, can be identified as relating to laboratory testing.

Sharing Savings

Under the proposed rule, Medicare would continue to pay individual health care providers and suppliers for specific items and services as it currently does under the original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings or to be held accountable for losses. CMS also is proposing to establish a minimum sharing rate that would account for normal variations on health care spending so that the ACO would be entitled to shared savings only when savings exceeded the minimum sharing rate. The amount of shared savings depends on whether an ACO meets or exceeds quality performance standards.

CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing savings and losses in the third year) and a two-sided risk model (sharing savings and losses for all three years), allowing the ACO to opt for one or the other model. This will help organizations with less experience with risk models to gain experience with population management before transitioning to a risk-based model, said CMS Administrator Donald Berwick.

ACOs that participate in the two-sided model would be able to obtain greater savings. However, the rule also proposes to establish a minimum sharing rate. ACOs in the one-sided risk program that have smaller populations would have a larger sharing rate, and ACOs with larger populations (and have less variation in expenditures) have a smaller rate. Under the two-sided approach, CMS proposed a flat 2 percent minimum sharing rate.

Measuring Quality Improvement

CMS said the proposed rule would establish quality performance measures and a methodology for linking quality and financial performance "that will set a high bar on delivering coordinated and patient-centered care by ACOs, and emphasize continuous improvement around the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures."

The proposed rule would require the ACO to have in place procedures and processes to promote evidence-based medicine and beneficiary engagement in their

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care. It would also require ACOs to report quality measures to CMS and give timely feedback to providers. The rule proposed 65 quality measures across five key areas: patient/caregiver care experiences, care coordination, patient safety, preventive health, and at-risk population/frail elderly health.

Under the proposed rule, an ACO that meets the program's quality performance standards would be eligible to receive a share of the savings it generates below a specific expenditure benchmark that would be set by CMS for each ACO. The proposed rule would also hold ACOs accountable for downside risk by requiring ACOs to repay Medicare for a portion of losses (expenditures above its benchmark).

The proposed rule would require the ACO to have in place procedures and processes to promote evidence-based medicine and beneficiary engagement in their care.

The quality measures are aligned with the measures in other CMS programs such as for electronic health records (EHR) and the Physician Quality Reporting Initiative (PQRI). An ACO that successfully reports the quality measures required under the shared savings program would be deemed eligible for a PQRI bonus. However, the rule specifies that ACOs may not participate in any other shared savings program or demonstration under the Center for Medicare and Medicaid Innovation or Independence At Home Medical Practice pilot program to ensure that savings are not counted twice.

Among the physician quality reporting initiative measures used to assess performance, at least 21, or 12 percent, can be identified as relating to laboratory testing. The proposed rule is available at *www.ofr.gov.* Comments are due by June 6.

Fraud and Abuse, Antitrust

At the same time that CMS released the proposed ACO rules, the HHS Office of Inspector General (OIG), the Department of Justice (DOJ), the Federal Trade Commission (FTC), and the Internal Revenue Service (IRS) issued notices related to fraud and abuse, antitrust, and tax guidance.

In its notice, the OIG sets forth proposals for waivers of fraud and abuse laws that it believes will be necessary to carry out the Medicare Shared Savings Program. The agency says it is soliciting comments on these proposals and expects to issue waivers applicable to ACOs participating in the savings program concurrently with CMS's publication of final regulations for the program.

The DOJ and FTC, meantime, issued a proposed statement of enforcement policy that would establish different levels of antitrust scrutiny depending on the specific ACO arrangement. The IRS also issued a notice inviting comments on how ACOs and the shared savings program would apply to hospitals and other health care organizations that enjoy tax-exempt status.

The joint CMS-OIG notice is available at *www.ofr.gov*. The proposed antitrust policy statement is available at *www.ftc.gov/opp/aco*. The IRS guidance is available at *www.irs.gov/pub/irs-drop/n-11-20.pdf.*

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Inside The Lab Industry

Pharmacogenomics on Verge of Explosion
Accelerating Technologies Creating the Perfect Storm

Randy Scott

While pharmacogenomics is already influencing the way many illnesses are treated, accelerating technology is about to change the game altogether, predicts Randy Scott, co-founder and executive chairman of Genomic Health (Redwood City, Calif.), developer of the Oncotype Dx tests for breast and colon cancer.

"A perfect storm of accelerating factors is about to hit health care," says Scott, who spoke at G2 Intelligence's Molecular Diagnostics Conference, held April 13-15 in Boston. Rapid advances in technology, information, and biology will significantly improve the treatment of diseases by allowing pharmaceutical companies—with the help of molecular diagnostics—to more accurately target drug therapies.

"We spend billions of dollars every year treating diseases we don't understand—poorly," says Scott. "Maybe it's time we begin to focus on the underlying biology of disease and fit the drug to the patient rather than fitting the patient to the drug."

Scott predicts the convergence of three trends that will revolutionize medicine:

- **Moore's Law:** With costs dropping rapidly, whole genome analysis will become routine in all state-of-the-art clinical trials within five years, linking genomics to real clinical outcomes;
- **Metcalfe's Law:** Network effects will emerge in health care analgous to the network effects that transformed personal computing. New business models will emerge to manage disease with large network effects.
- **The Law of Finite Genomes:** There will be a finite set of molecular targets and biomarkers for virtually all major diseases within the next 20 years. The probability of pharmaceutical success will begin to increase and the cost of health care will begin to decline as solutions accelerate.

Genomics will also help drive growth in the pharmaceutical industry, says Scott, who notes that pharmaceutical innovation is losing steam. Although money spent on pharmaceutical research and development continues to increase, the number of new drug approvals has actually dropped in recent years, from a high of 53 in 1996 to 24 in 2008.

Part of the reason drug development has slowed, notes Scott, is that while molecular dissection of cancer has led to a revolution in therapy, diagnosis is still based on standard pathology, largely uninformed by molecular biology. New tools that allow researchers to analyze multigene expression in fixed paraffin-embedded tissue now can help them determine the molecular fingerprint or "oncotype" of a specific cancer.

Chemotherapy tends to be the first line of treatment for patients diagnosed with cancer, but this treatment is successful in only a small percentage of patients treated. The use of oncotype diagnostics gives cli-

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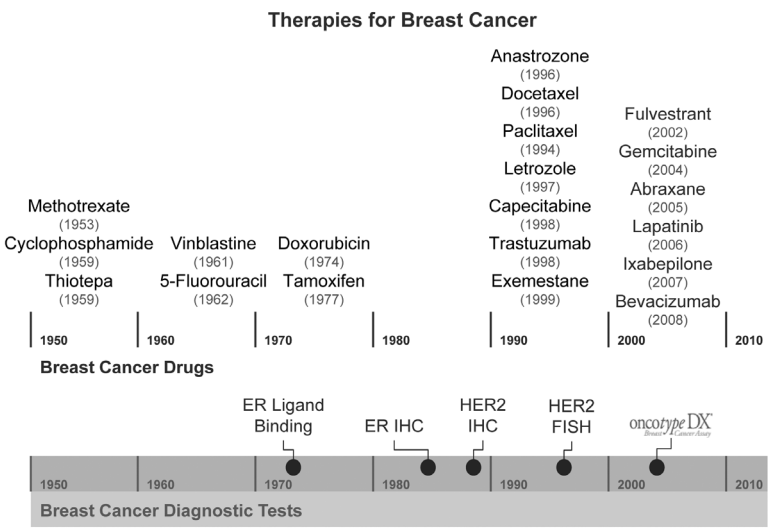
Society is Underinvested in Diagnostics Relative to Therapeutics



Source: Randy Scott, Genomic Health

nicians the ability to identify patients who are likely to benefit from chemotherapy.

Scott cited a meta-analysis of seven studies of 912 patients with breast cancer. Based on clinical parameters alone, chemotherapy was recommended for 62 percent of the patients. When Oncoype Dx was used to determine a patient's likelihood of responding to chemotherapy, there was a 37 percent change in treatment decisions.

"The treatment paradigm has changed," says Scott, who argues that society is underinvested in diagnostics relative to therapeutics. Development of a new drug to treat cancer can take 10 to 15 years, cost more than $500 million, and have only about a 20 percent success rate, he says. In comparison, Genomic Health was able to develop its Oncotype Dx test in three to four years at a cost of less than $100 million and improve the success rate for oncology treatment to about 75 percent.

The rate at which companion diagnostic products are developed is set for an explosion, says Scott, quoting Clayton Christensen, author of *The Innovator's Prescription*: "In contrast to the past, when diagnostic products were regarded as unattractive stepchildren, in the future diagnostics will become quite profitable relative to therapeutics. . . . The modest profitability of diagnostic products and services has been an artifact of today's reimbursement system."

More rapid development of companion diagnostics will be driven, in part, by the declining cost of whole genome analysis, predicts Scott. Next-generation sequencing is now cost-effective for large-scale clinical research, and Genomic Health is building the infrastructure to bring whole genome analysis to clinical practice, he says. Soon, the company will be able to deliver next-generation sequencing diagnostics to physicians, payers, and patients.

"Genomics and computing are converging into a technology wave that will dramatically increase the power and value of genomic diagnostics," he says. "We are the beginning of a historic and disruptive shift from a drug/therapy-centric economy to a patient/diagnostic-centric economy. Innovative new business models will be required to accelerate the science and change clinical practice."

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■ **LabCorp to Expand Forensics Testing**, *from page 1*

The company's U.K. business grew by more than 31 percent in the fourth quarter of 2010 while the forensics component grew by about 40 percent. "While our total U.S. business was down approximately 11 percent in the fourth quarter, our paternity business has stabilized, and we completed the consolidation of our U.S. testing facilities, which we expect will continue to favorably impact our U.S. results," said Thomas Bologna, president and CEO of Orchid, in announcing financial results March 10.

"The proposed acquisition of Orchid Cellmark significantly diversifies and strengthens our specialized forensic and family relationship testing," said Dave King, chairman and CEO of LabCorp, in a statement.

The purchase is the second by LabCorp since last fall when it announced the acquisition of Genzyme Genetics for $925 million. G2

Empire Adopts Recommendations on H. Pylori Testing

Empire BlueCross BlueShield is implementing guidelines set forth by the American Gastroenterological Association (AGA) and the American College of Gastroenterology (ACG) on testing for helicobacter pylori, an infection that is a precursor to serious stomach ailments.

As estimated 30 percent to 40 percent of the U.S. population is infected with H. pylori, a causative agent linked to the development of adverse health conditions such as peptic ulcer disease (PUD), gastric malignancy, and dyspeptic symptoms. Guidelines from the AGA and the ACG recommend an approach to H. pylori that includes testing, treating, and retesting and confirming eradication. Moreover, the guidelines promote awareness of inappropriate serology use and the long-held practice of using empirical proton-pump inhibitor (PPI) therapy as a first line of treatment.

Empire BlueCross BlueShield is implementing the guidelines set forth by the AGA and ACG for the evaluation and management of dyspepsia and PUD, as they promote improved effectiveness in patient care and quality for those who suffer from H. pylori infection.

"Prior to implementation of the guidelines, many patients who had dyspepsia without reflux symptoms were not being tested for H. pylori. Instead, they were given a PPI, which masks patients's symptoms," said Michael Jaeger, M.D., a medical director with Empire's parent company and project leader for the H. pylori initiative. "Patients may feel better, but they are not being appropriately tested and treated, and as a result, the H. pylori is not eradicated."

The AGA and ACG guidelines indicate that long-term use of a PPI is not beneficial for patients with H. pylori, yet all too often, a PPI is utilized and patients stay on it for years. In addition, the guidelines recommend that patients under age 55, with no known major health issues, can be tested in a primary care setting with a noninvasive active infection test, such as the stool antigen test, HpSA, developed by Meridian Bioscience Inc.

The new recommendations emphasize the need to discontinue serology testing

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and to test and retest symptomatic patients as well as confirm eradication utilizing active H. pylori infection testing. In addition, the guidelines call for testing for active infection prior to having a PPI prescribed for many patients. According to the guidelines, it is important to test for active H. pylori infection because studies indicate that about 50 percent of patients with a positive H. pylori serology do not have active infection.

Fight Over Patent Eligibility of Diagnostic Methods Continues

The fight over the patent eligibility of medical diagnostic methods may yet have another day, as Mayo Collaborative Services once again sought U.S. Supreme Court review after the U.S. Court of Appeals for the Federal Circuit made almost no changes to an earlier opinion despite the high court's *Bilski* decision.

Mayo filed a petition for writ of certiorari March 17 (*Mayo Collaborative Services, dba Mayo Medical Laboratories, v. Prometheus Laboratories, Inc.*). At issue is the Federal Circuit's Dec. 17 holding that claimed methods for calibrating the proper dosage of a drug for treating autoimmune diseases are patentable subject matter under 35 U.S.C. §101.

Prometheus vs. Mayo

Prometheus Laboratories Inc. is the exclusive licensee of two patents (6,355,623 and 6,680,302) that involve measuring the level of certain metabolites in the blood of patients taking thiopurine drugs, including the anti-Crohn's disease drug azathioprine, for treatment of autoimmune diseases.

The patented test is claimed as a method providing a means to measure the level of two metabolites, whereby metabolite levels greater than certain threshold levels of either one provide a "warning" of toxicity or inefficacy and indicate to the treating physician that an adjustment in drug dosage may be required. The claims at issue do not include a step for further action by the physician.

Prometheus brought a patent infringement suit against Mayo, alleging that Mayo's tests measuring the same metabolites infringe the patents. The Federal Circuit in a 2009 ruling overturned a lower court's finding of patent ineligibility. The court applied its then-definitive "machine-or-transformation" test, determining that the claims met the transformation prong of the test. The high court's *Bilski v. Kappos* decision in June, however, declared the machine-or-transformation test to be a valuable tool but not determinative.

A day after the *Bilski* decision, the Supreme Court granted certiorari in *Prometheus*, vacated the appellate court's panel decision, and remanded the case to the Federal Circuit for reconsideration in light of the *Bilski* decision.

On remand, a reconstituted Federal Circuit panel used the test as an investigative tool, as the high court had allowed, and again held that the claims asserted passed the transformation prong of the test. The court did not end its analysis there, though, as it further concluded that the asserted claims did not preempt all uses of the correlations between the results of the diagnostic tests and the toxicity and efficacy of the drug dosage, that the testing steps were not mere data gathering, and that a final "warning" step requiring no physical action by a physician did not negate patent eligibility.

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Effect on Innovation?

The question presented in Mayo's March 17 petition is "Whether 35 U.S.C. §101 is satisfied by a patent claim that covers observed correlations between blood test results and patient health, so that the claim effectively preempts all uses of the naturally occurring correlations, simply because well-known methods used to administer prescription drugs and test blood may involve 'transformations' of body chemistry."

However, the scope of the petition was significantly broader. "This case concerns whether a patentee can monopolize basic, natural biological relationships," Mayo asserted prior to presenting its question. The petition's introduction particularized that concern:

"The issue presented in this case is one of exceptional importance in the healthcare and life science fields that affects patients across the nation. Simply put, Prometheus's patents monopolize every useful implementation of a correlation between particular types of drug treatment and the natural bodily metabolism resulting from that drug treatment. This correlation is unquestionably a natural phenomenon. From it, doctors may determine if a dose of a drug is too high, too low, or needs no adjustment at all. But if Prometheus's patents are allowed to stand, doctors will no longer be free to consider this biological phenomenon in treating patients or in attempting to develop new treatments for disease. And numerous similar, overly-broad patents that restrict doctors' ability to treat patients will stand as well. This will stifle innovation, as well as raise the cost and degrade the quality of medical care throughout the United States."

The petitioner claimed that the Supreme Court effectively has unfinished business, as it not only rejected the opportunity to comment on the instant case the first time around, but it also left issues unresolved in *Laboratory Corporation of America Holdings d/b/a LabCorp v. Metabolite Laboratories Inc.*, in which the court first granted certiorari and then determined—with a vigorous three-justice dissent—that it was improvidently granted.

Mayo Sees No Change in Remand Decision

Mayo gave little weight to the Federal Circuit's changes in the second decision. "On remand, the Federal Circuit refused to alter its decision, stating that this Court in *Bilski* 'did not undermine' the Federal Circuit's prior analysis—an analysis that equated this Court's ultimate preemption standard with the Federal Circuit's 'machine or transformation' test," the petition stated.

As to the second panel's preemption analysis, the petitioner simply disagreed with the Federal Circuit's characterization of the initial method steps. "[B]ecause the steps that lead up to the correlations are not uses of the correlations, they do nothing to narrow the scope of the patent and do not leave others free to use the correlations in different ways, including to develop new ways of treating patients," Mayo argued.

"Instead, those data-gathering steps are simply the commonplace and well-understood steps of administering a drug and measuring its metabolites—the only way to assess the correlations," the petitioner explained. "The result of the Federal Circuit's analysis is to uphold claims that in fact preempt anything that a physician might do with these naturally-existing correlations."

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Lab Index Climbs 16% on Orchid Cellmark Deal

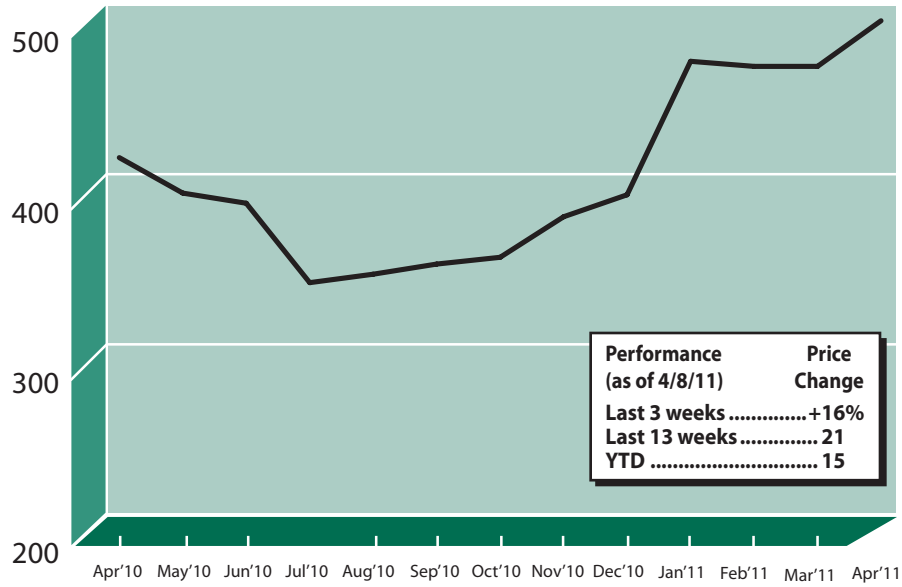
The G2 Intelligence Laboratory Stock Index rose 16 percent in the three weeks ended April 8, largely as a result of a 35 percent jump in the share price of Orchid Cellmark following LabCorp's announcement that it planned to buy the company. Of the 11 stocks tracked by the index, 10 gained in price, and one remained virtually unchanged. Since the beginning of the year, the index is up 15 percent. In comparison, the Nasdaq composite is up 5 percent, and the S&P 500 is up 6 percent.

Shares of **Orchid Cellmark** (Princeton, N.J.) surged 33 percent to $2.76 after news broke that LabCorp (Burlington, N.C.) planned to buy the company for more than $85 million. Though the deal is a relatively small one, it expands LabCorp's reach into the DNA testing market and is expected to be accretive to cash earnings per share in 2011.

Genomic Health (Redwood City, Calif.) shares rose 14 percent to $26.32. The company recently reported that new European studies found use of its Oncotype Dx test to identify which breast cancer patients would benefit from chemotherapy changed treatment choices 33 percent of the time. Chemotherapy was used 17 percent less often in Germany and 14 percent less often in the United Kingdom.

Shares of **Bio-Reference Laboratories** (Elmwood Park, N.J.) climbed 4 percent to $22.88. The company in March reported that net revenues for the first quarter of fiscal 2011 were $121.7 million, an increase of 23 percent over revenues for the same period in 2010. Revenue per patient rose 2 percent from $79.21 to $80.99 while operating income increased 17 percent to $8.7 million.

G2 Laboratory Stock Index



Source: The G2 Laboratory Stock Index is tabulated weekly by Laboratory Industry Report *from the average percentage change of 11 laboratory testing service stocks.*

Percent Price Change, Three weeks ended 4/8/2011

	Price	Percent Change
UP		
Bio-Reference	$22.88	+4
Enzo Biochem	3.77	+9
Genomic Health	26.32	+14
LabCorp	92.82	+6
Myriad Genetics	20.29	+8
Quest	57.99	+7
Psychemedics	10.20	+12
Orchid Cellmark	2.76	+35
Genzyme	76.25	+1
Neogenomics	1.45	+7
NO CHANGE		
Medtox	16.10	0

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INDUSTRY BUZZ

2011 Is Shaping Up to Be a Big Year for M&A Activity

LabCorp's (Burlington, N.C.) decision to purchase DNA testing business Orchid Cellmark (Dayton, Ohio) for $85.4 million is yet another sign that 2011 could top 2010 in terms of total mergers and acquisitions in the laboratory industry.

Already in 2011 there have been several significant acquisitions involving labs. Quest Diagnostics (Madison, N.J.) recently completed the acquisition of Athena Diagnostics (Worcester, Mass.) for $740 million and is in the process of acquiring Celera Corp. (Alameda, Calif.) for $671 million. In addition, Swiss pharmaceutical giant Novartis announced in January that it is acquiring pathology testing company Genoptix (Carlsbad, Calif.) for $470 million.

Based on M&A activity in the first fourth months of this year, G2 Intelligence predicts that total acquisitions in 2011 will far surpass the $2.3 billion in acquisitions in 2010 and could even top 2007's total acquisitions of $3.1 billion (*LIR, February 2011, p. 5*). This is a far cry from 2008 and 2009 when total lab acquisitions didn't even reach the $500 million mark.

LabCorp said April 6 that it has signed an agreement to acquire Orchid Cellmark for $2.80 per share, which represents a 39 percent premium over the closing price April 5.

New G2 Intelligence research

Lab Industry Strategic Outlook 2011: Market Trends & Analysis

Key industry developments
Market data
In-depth analysis
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References

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Bio-Reference 201-791-3600
Celera Corp. 510-749-4200
Empire BlueCross BlueShield 212-476-1000
Genomic Health 650-556-9300
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