Enrollment in the HIP and Preliminary Expanded HIP

Revised for clarification: September 25, 2008

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Preliminary Study by Dec 1, 2008 To Governor and Legislature

- The Board report shall include an implementation plan and incorporate the individual and small group markets into HIP by applying small group regulations and examine the impact upon:
  - Utilization of services and the cost of health plans offered in HIP.
  - Access to health services and the cost of coverage for these markets in HIP.
  - The membership of the Board to reflect incorporating the individual and small group markets.
- The Board can make recommendations, although not specifically directed to by the legislature.

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Final Study by Sep 1, 2009 To Governor and Legislature

- The Board shall report and make recommendations on the risks and benefits of additional markets participating in HIP under small group regulations:
  - Washington State Health Insurance Pool (WSHIP).
  - Basic Health Plan.
  - Public Employees' Benefit Board (PEBB).
  - Public school employees.
  - Provide final recommendations about incorporating the individual and small group markets in HIP.

Final Study by Sep 1, 2009 To Governor and Legislature

- Examine:
  - Use of services and the cost of health plans offered in HIP.
  - Access to services and the cost of coverage for markets in HIP.
  - Board membership to reflect incorporating additional markets.
  - Distinct participation of active and retired PEBB employees. Currently, nonMedicare retirees are pooled with active employees; Medicare retirees would not be affected.
  - The risks and benefits of establishing a requirement that residents age 18 or over obtain and maintain affordable creditable coverage, as defined in HIPAA, and how to enforce a requirement in Washington.

Overview of HIP and PHIP Projections

- Microsimulation methods
- Rules for the HIP and Preliminary Expanded HIP (PHIP)
- Targeting low-wage, non-offering small firms for coverage
- Projected enrollment in the HIP
- Projected enrollment in the PHIP
- State cost of subsidies
- Impact on the uninsured

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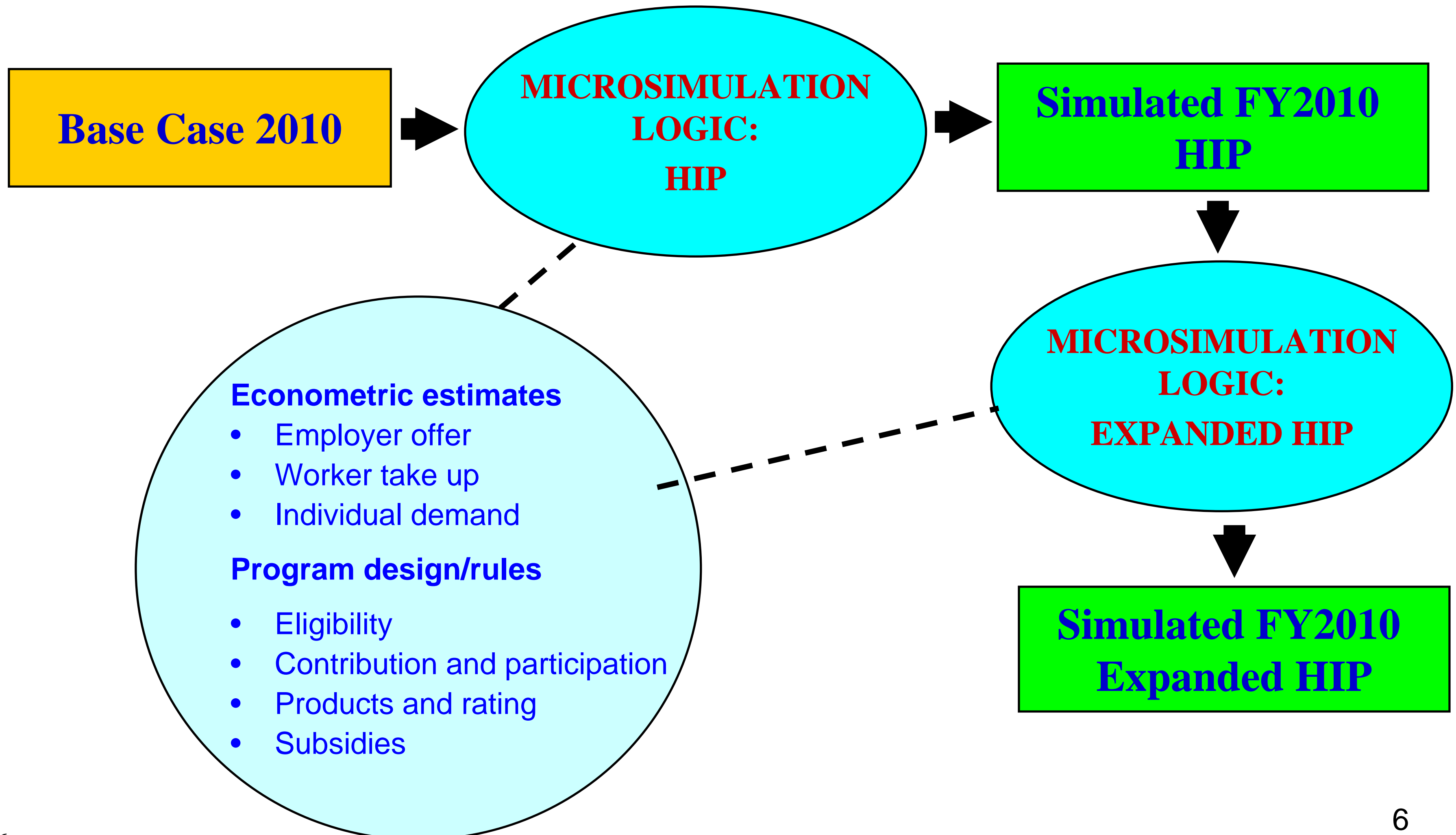
Methods: Microsimulation Model



Rules for the HIP and PHIP

HIP	Preliminary Expanded HIP (PHIP)
Groups 2-50 with no offer	Merged small group and individual markets
At least ½ of workers are low-wage	Current products convert
Employer choice	Individuals not guaranteed issue
Composite rating	Worker/individual choice
Employer pays at least 40% of single premium	List/individual rating
12 HIP products	Defined employer contribution
HIP enrollees have Section 125	All workers have Section 125
Low-income workers are subsidized	Low-income workers and individuals are subsidized
	Employers in association plans consider HIP coverage

To complete the FY2010 Base Case, Mathematica...

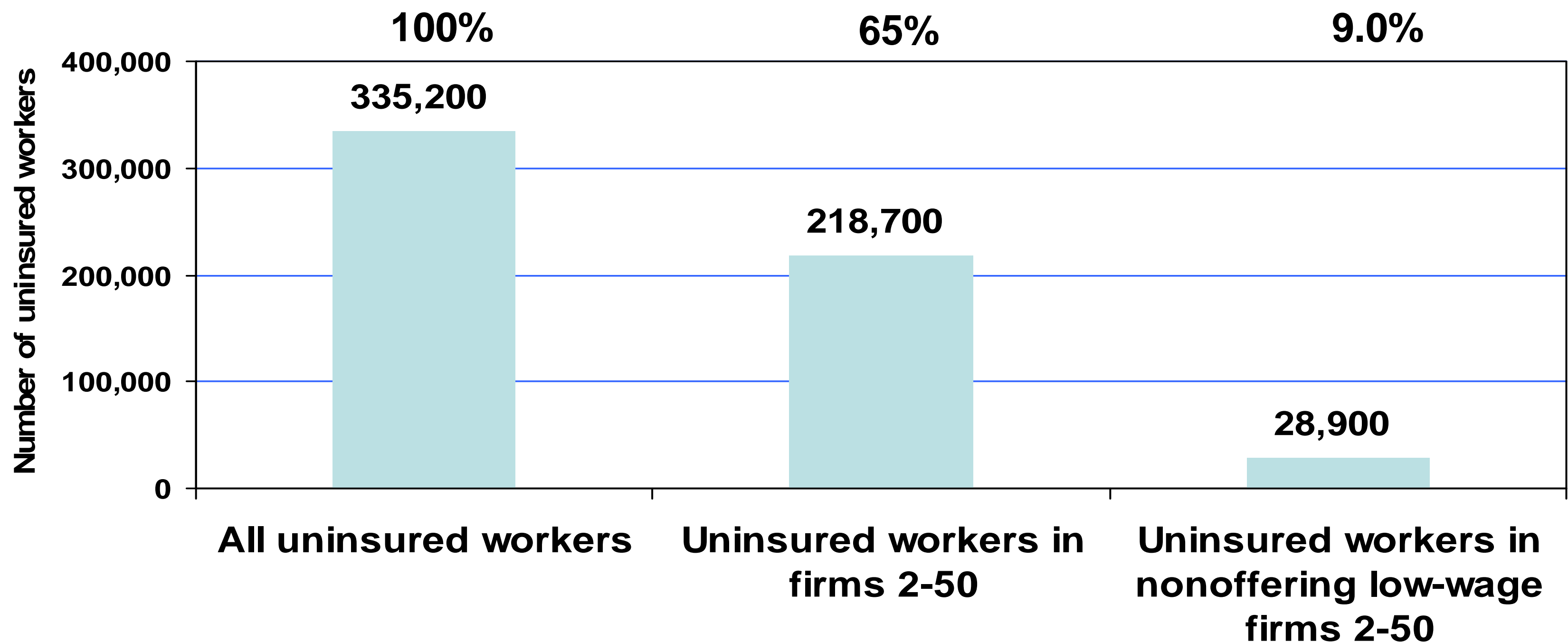
- Developed an estimate of the FY2010 Washington State population and coverage without HIP

- Estimated maximum HIP enrollment in the FY2010 population under current HIP rules

- All figures are FY2010 estimates

Of All Uninsured Workers in Washington, HIP Targets Just 9 Percent

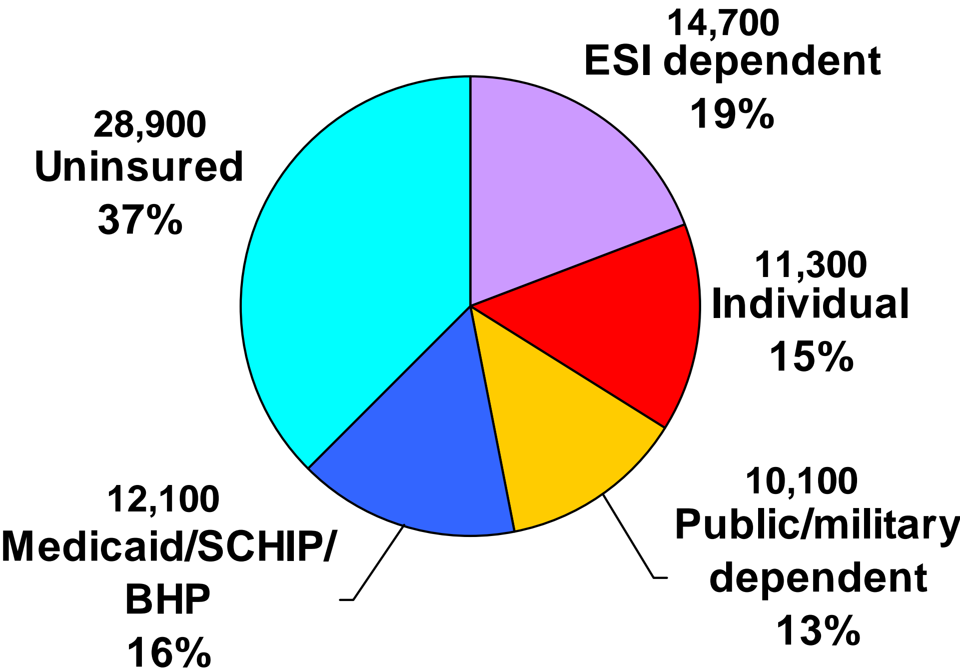
This slide compares all uninsured workers in Washington to uninsured workers eligible for HIP.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

HIP-Eligible Workers: Most are Insured

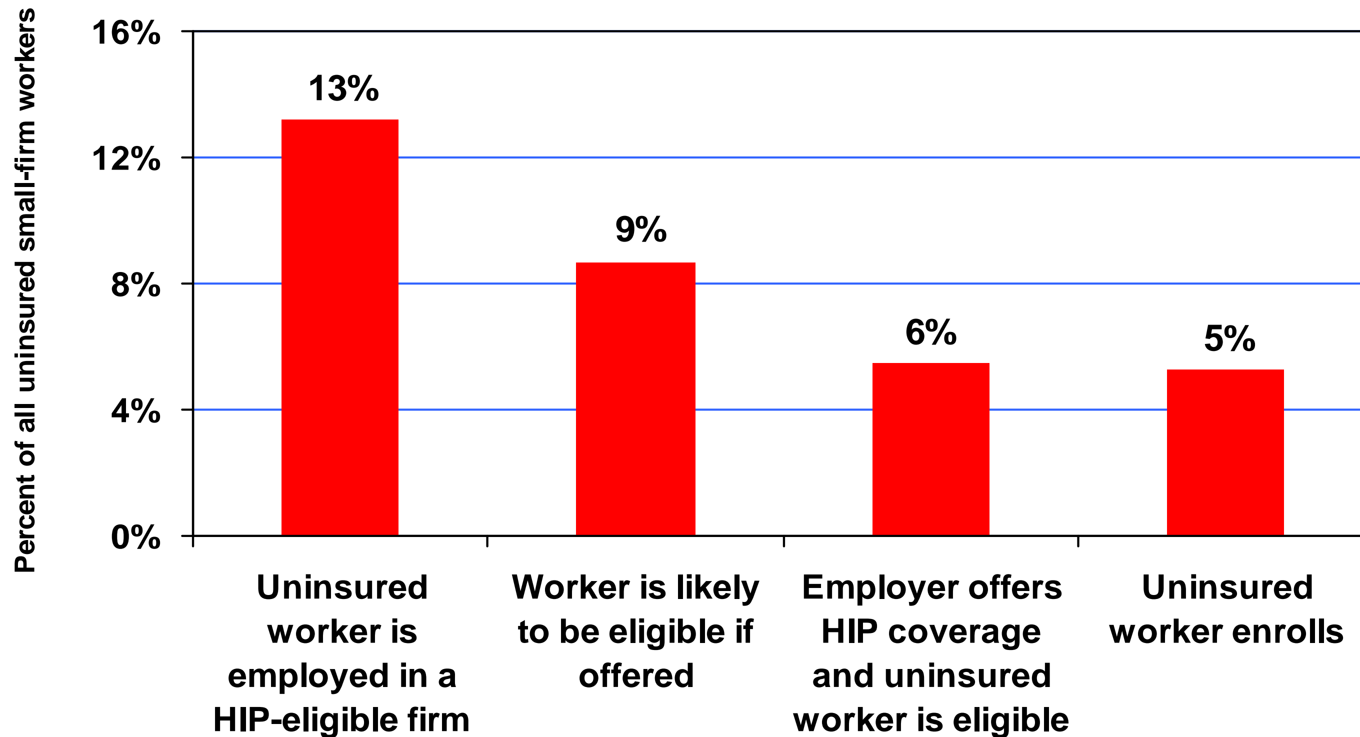
HIP-Eligible workers can be insured or uninsured. This slide sorts all HIP-eligible workers by their current insurance status and source of coverage.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

Uninsured Small-Firm Workers: 13 Percent are HIP-Eligible and 6 Percent are Offered HIP Coverage

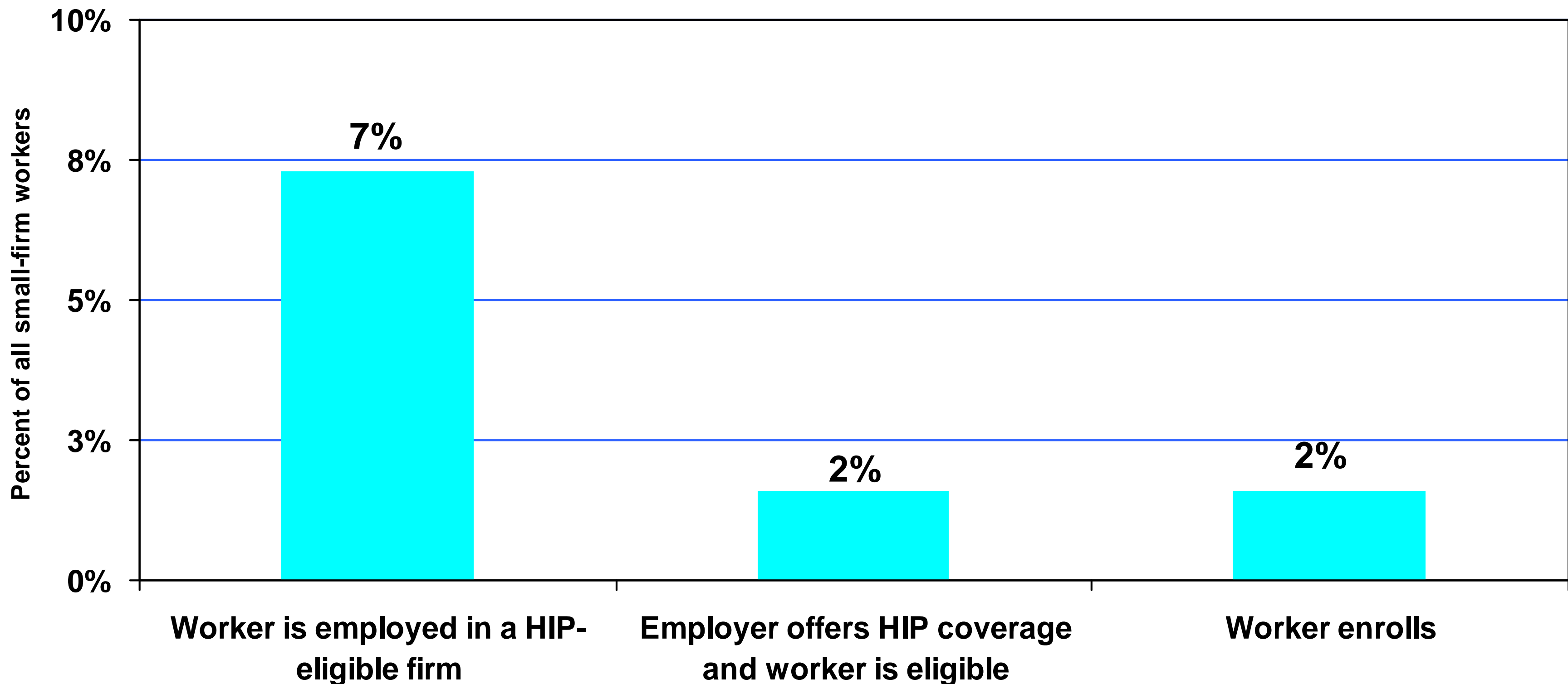
This slide shows that HIP would cover 5 percent of uninsured workers in small firms overall. In HIP-eligible firms, many uninsured workers would themselves be ineligible (e.g., part time workers), and others would not be offered coverage. Once an offer is made, most uninsured eligible workers would enroll because of the subsidies.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

<u>All Small-Firm Workers</u>: 7 Percent are HIP-Eligible and 2 Percent are Offered HIP Coverage

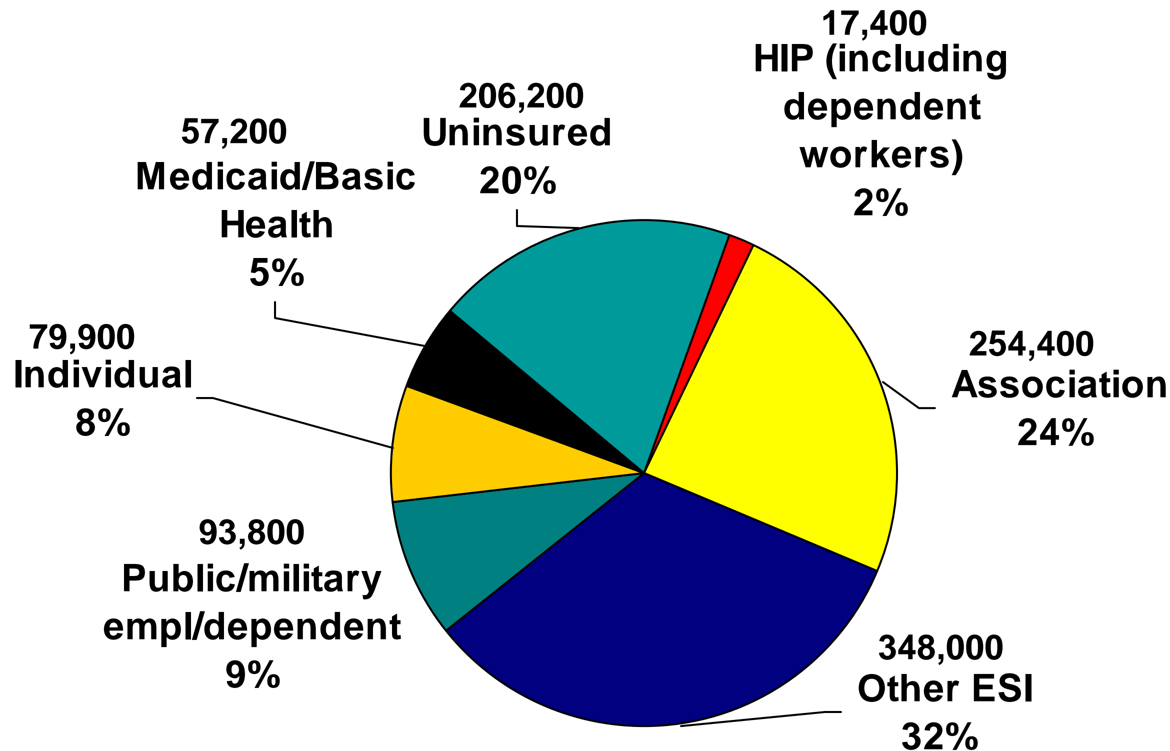
This slide shows a similar story as for uninsured HIP-eligible workers on the previous slide: low eligibility and offer, but nearly all HIP-eligible workers take-up an employer's offer of coverage because of the subsidies.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

At Maximum Enrollment, HIP Could Cover 1 to 2 Percent of Small-Firm Workers

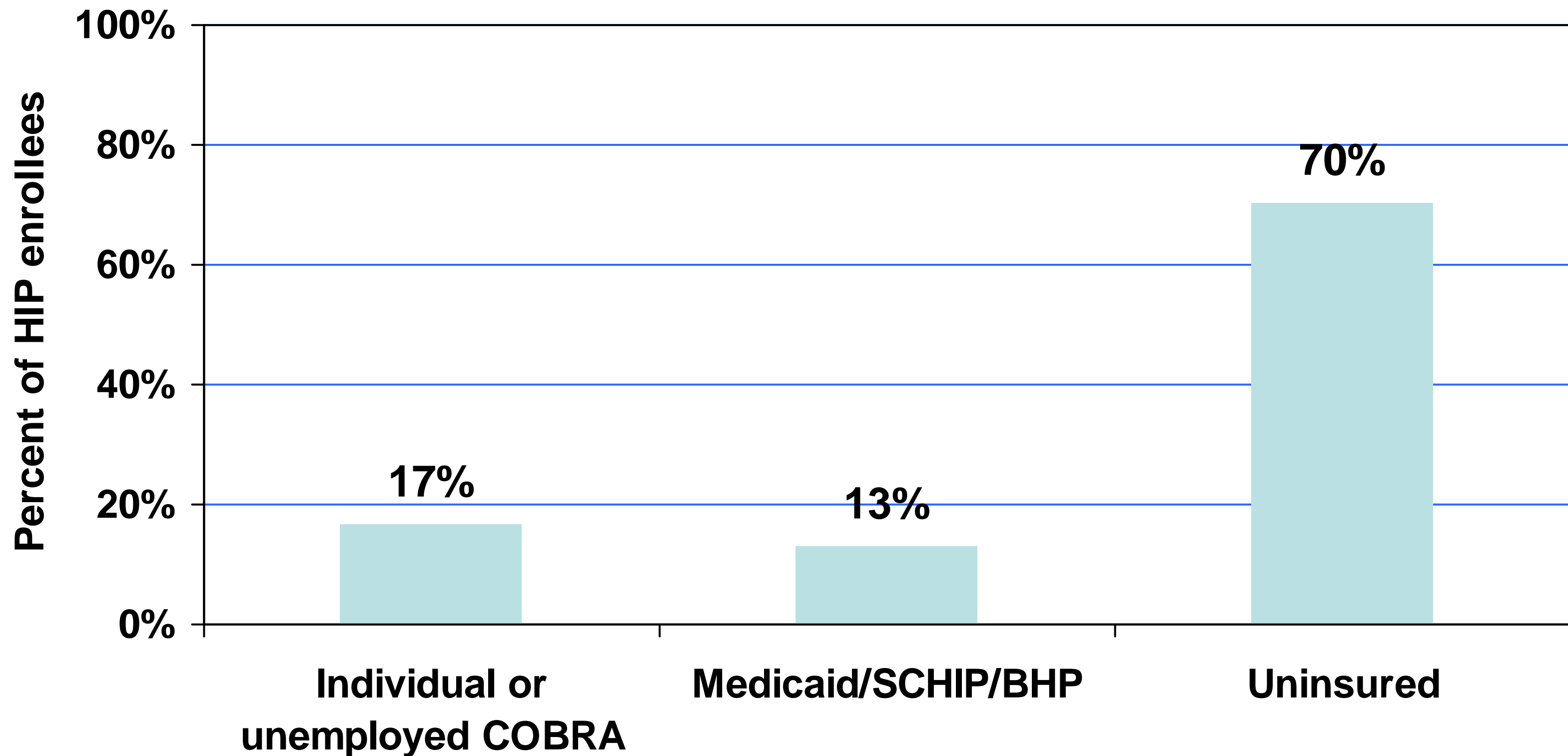
This slide shows where small-firm workers in Washington would be covered under full HIP implementation.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

Most HIP Enrollees Were Uninsured

This slide shows the prior source of coverage for workers and dependents projected to enroll in HIP.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

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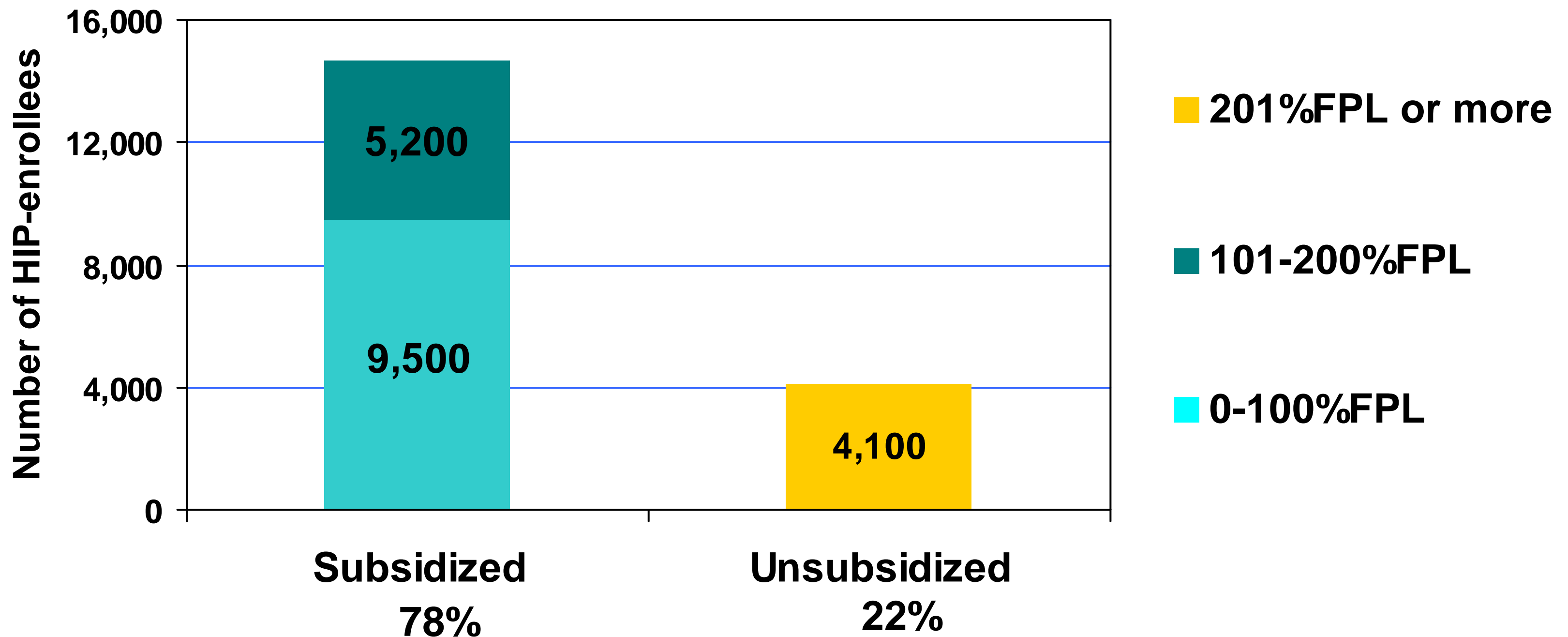
78 Percent of HIP Enrollees Are Subsidized

This slide shows the maximum number of subsidized and unsubsidized workers and dependents projected to enroll in HIP by family income.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

Note: Estimates exclude workers covered only as dependents of HIP-enrolled workers.

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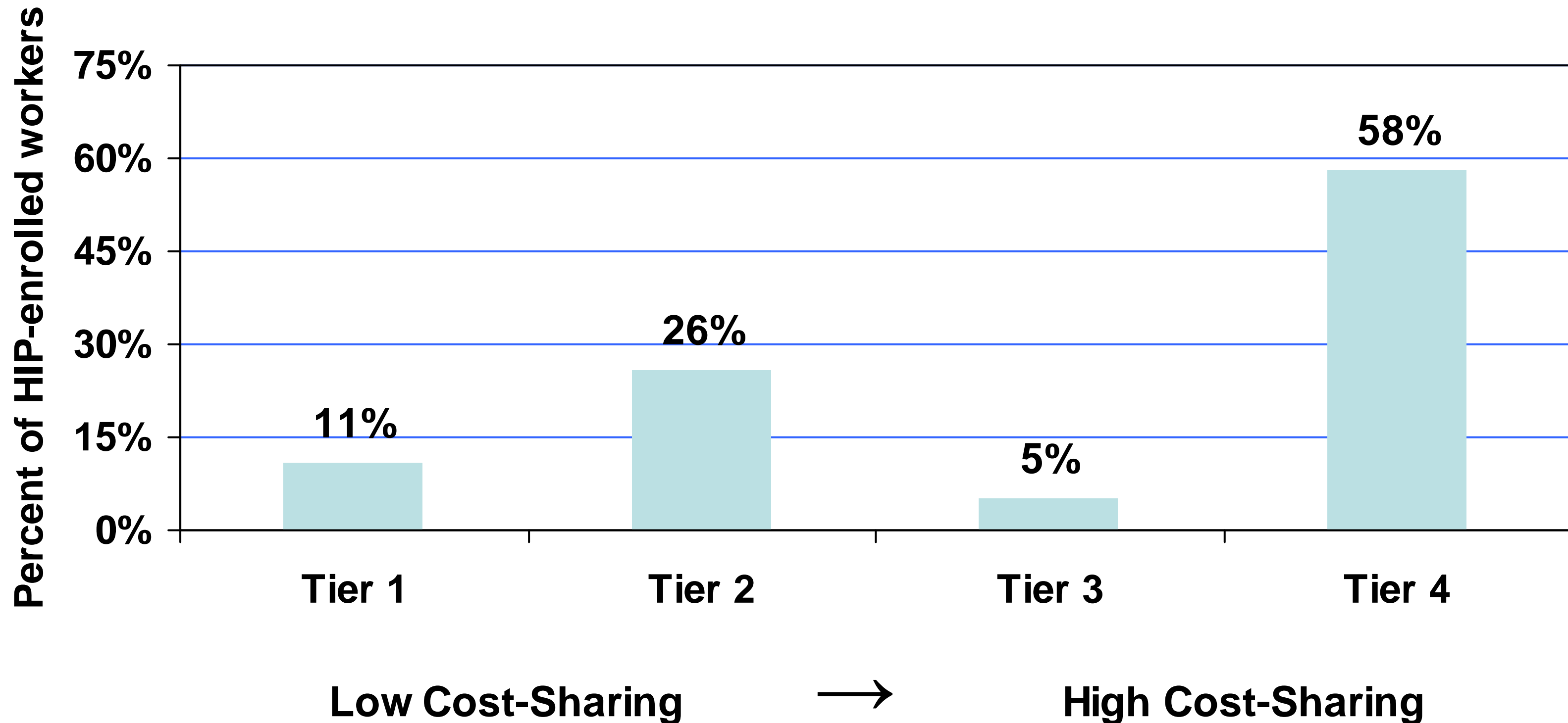
Distribution of HIP Enrollees and Subsidies

Family Income	Enrollees	Subsidy Dollars
0-100% FPL	50%	62%
101-200% FPL	28%	38%
201% FPL+	22%	-
TOTAL	18,900	$1.1 million/month
AVERAGE, per subsidized enrollee per month	-	$76

Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

Most Workers in HIP Enroll in the Highest Cost-Sharing Plans

This slide shows the percent of workers enrolled in each of HIP's four plan tiers. Carriers offer similar plans within each tier.



Low Cost-Sharing → High Cost-Sharing

Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

Preliminary Expanded Health Insurance Partnership (PHIP)

PHIP Simulation Results

- Number of uninsured declines by almost half
- Many newly insured persons, but some insured enrollees drop coverage
- Potential entry into PHIP from association plan enrollees
- Average subsidies are much lower for enrollees in group coverage than for those in individual coverage

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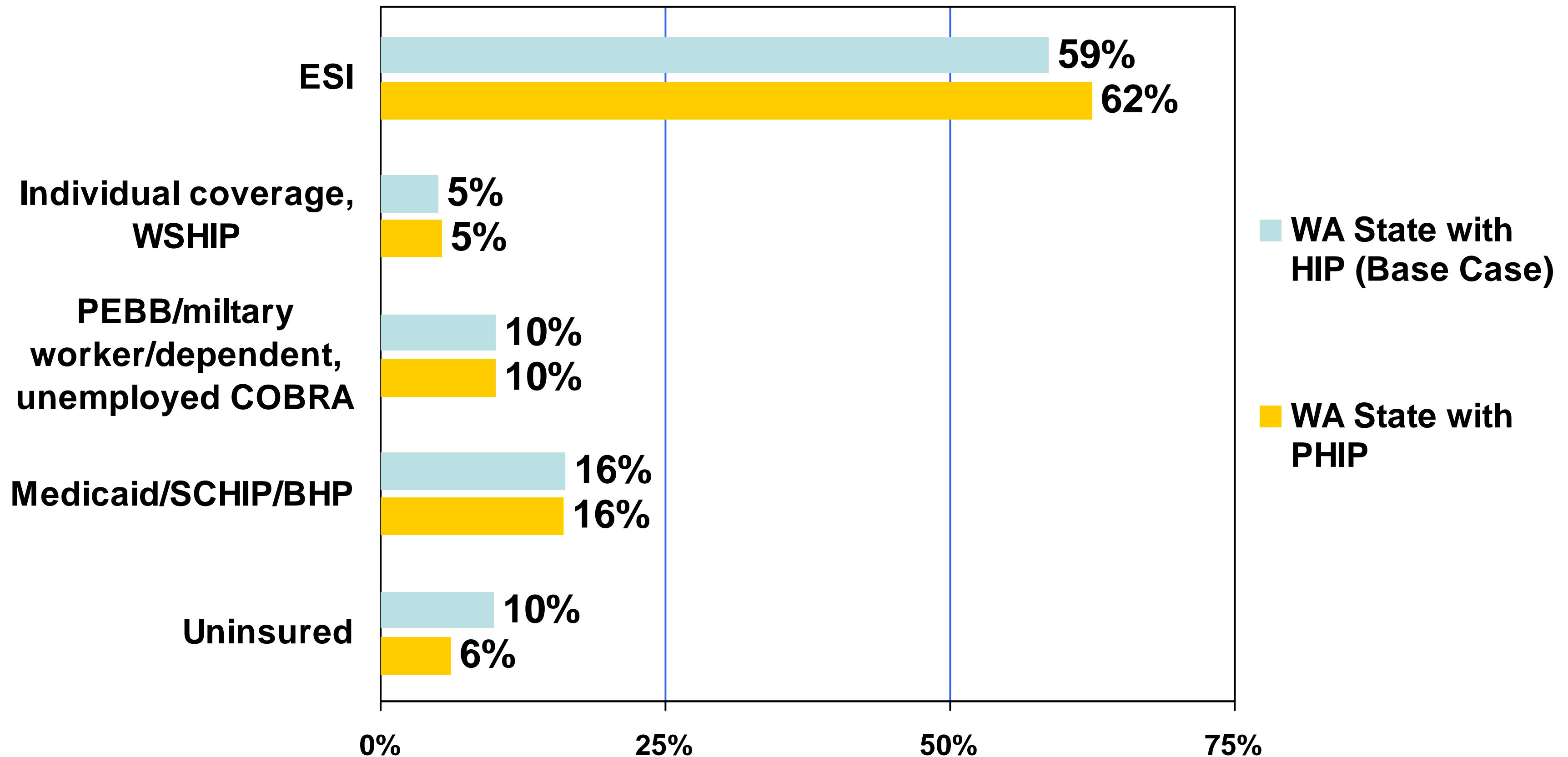
More PHIP Simulation Results

- Movement toward higher cost sharing
  - To retain coverage when the individual and small group markets are merged, some individual enrollees “buy down” to a plan with higher cost sharing
  - To retain employer-sponsored coverage under list rating, some older workers “buy down” to a plan with higher cost sharing
  - Previously uninsured enrollees take-up plans with higher cost-sharing at a lower premium compared to current enrollees

PHIP Cuts the Rate of Uninsured People in Washington State

This slide shows the percent of Washingtonians under age 65 by source of coverage if PHIP were implemented.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

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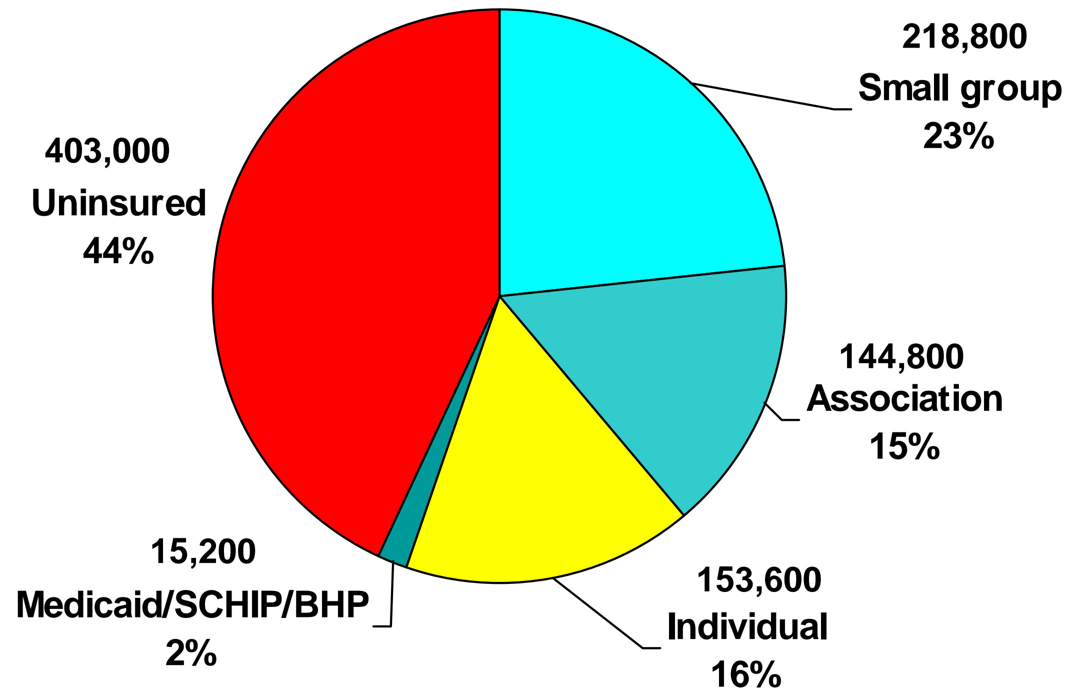
4 in 10 PHIP Enrollees Were Uninsured

This slide sorts projected PHIP enrollees by their prior source of coverage.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

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Distribution of PHIP Enrollees and Subsidies

	TOTAL	Group enrolled workers and dependents	Individual enrollees
Total enrollees	935,200	634,100	301,200
Percent subsidized	54%	38%	89%
TOTAL subsidies per month	$83.8m	$12.8m	$71.0m
AVERAGE, per subsidized enrollee per month	$165	$53	$265

Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

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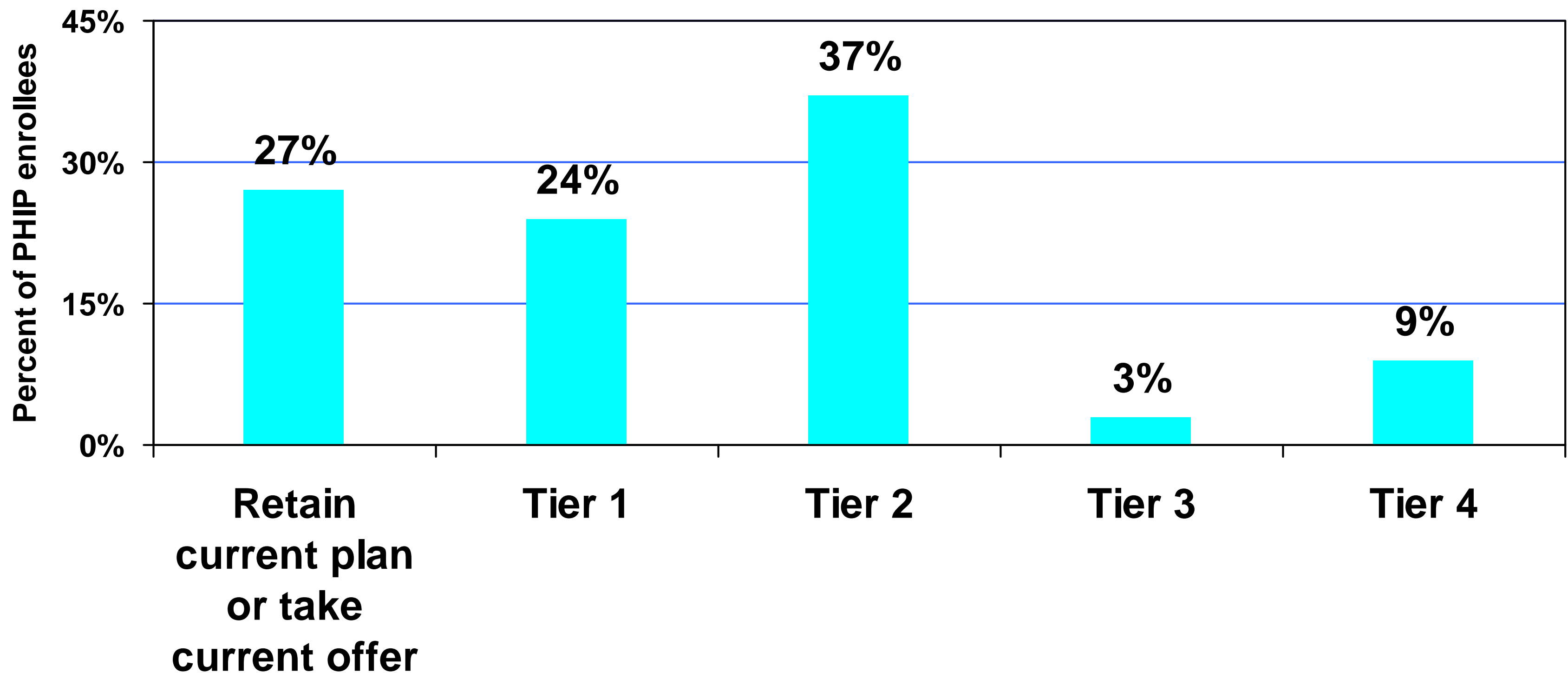
7 in 10 PHIP Enrollees Would Select a Plan From the Current HIP Tiers

This slide shows the percent of PHIP enrollees that retained their current plan or accepted a current offer, versus those who selected a plan in one of HIP's four plan tiers. Carriers offer similar plans within each tier.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

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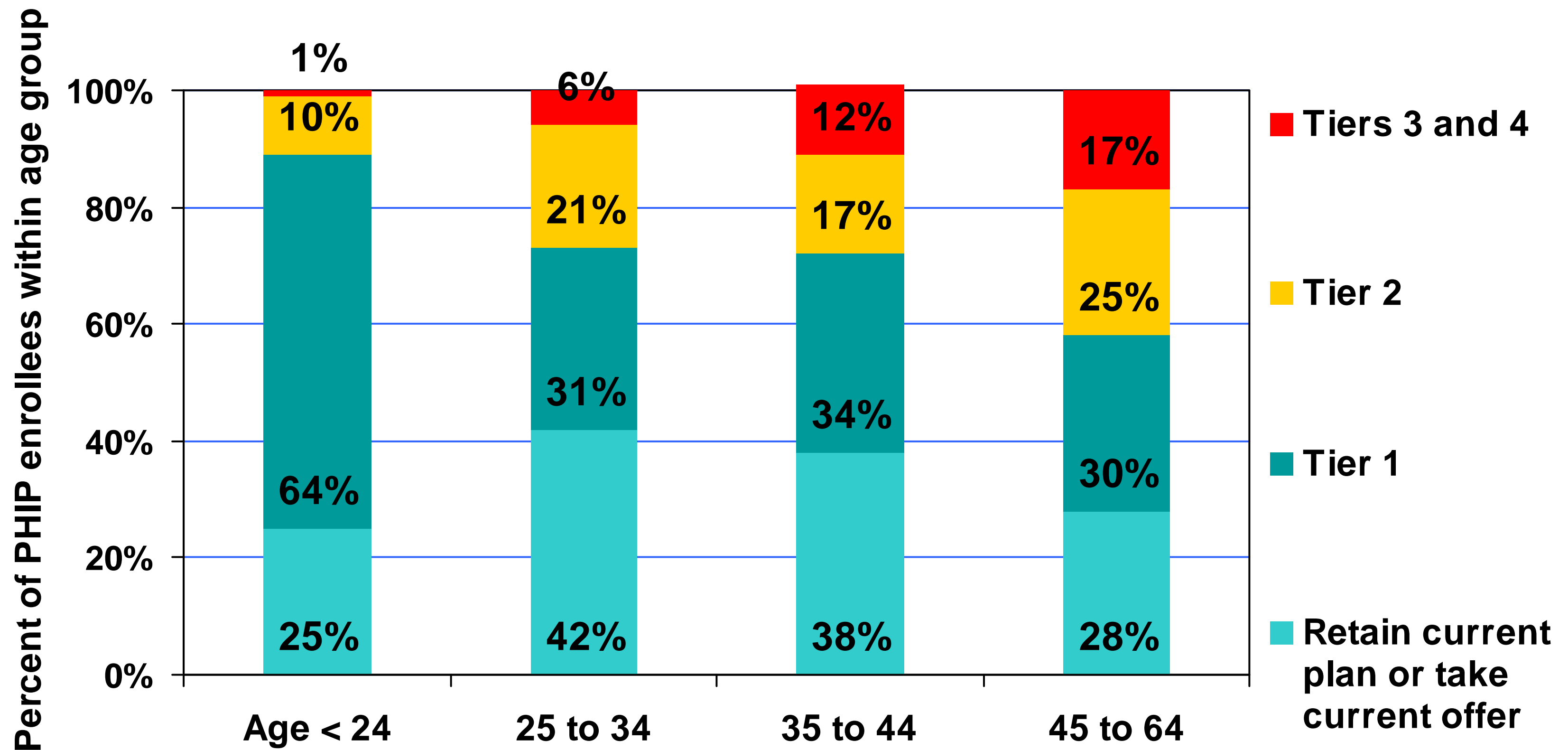
Older Workers in PHIP Group Coverage Move Toward Plans with Greater Cost Sharing

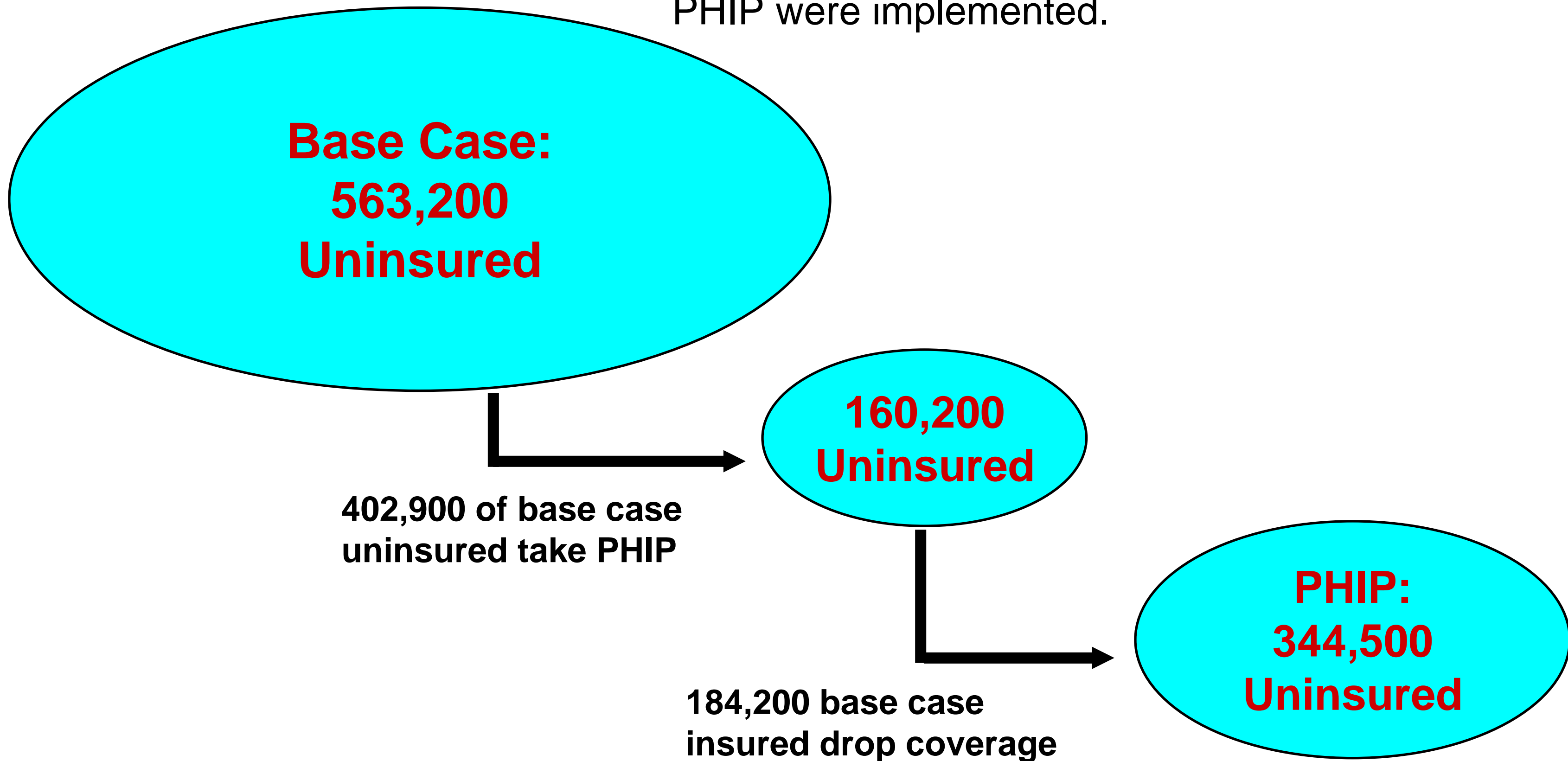
This slide shows the plans selected by younger and older workers with group coverage in PHIP, where employee contributions increase with age.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

PHIP Gains and Losses in Uninsured People

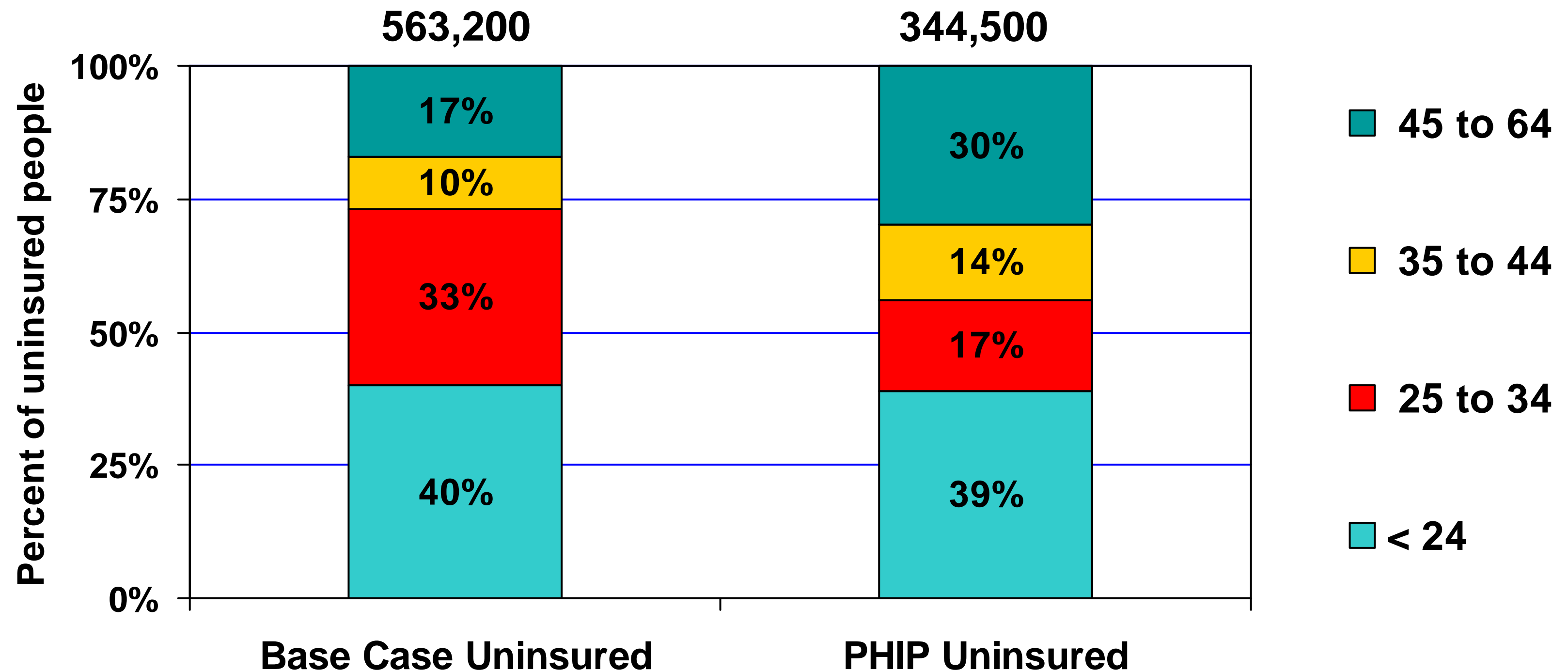
This slide shows a net reduction in uninsured persons and disruption to current coverage: 402,900 uninsured people obtain insurance, and another 184,200 would drop insurance if PHIP were implemented.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

With PHIP, There Are Fewer Uninsured People, but They are Older

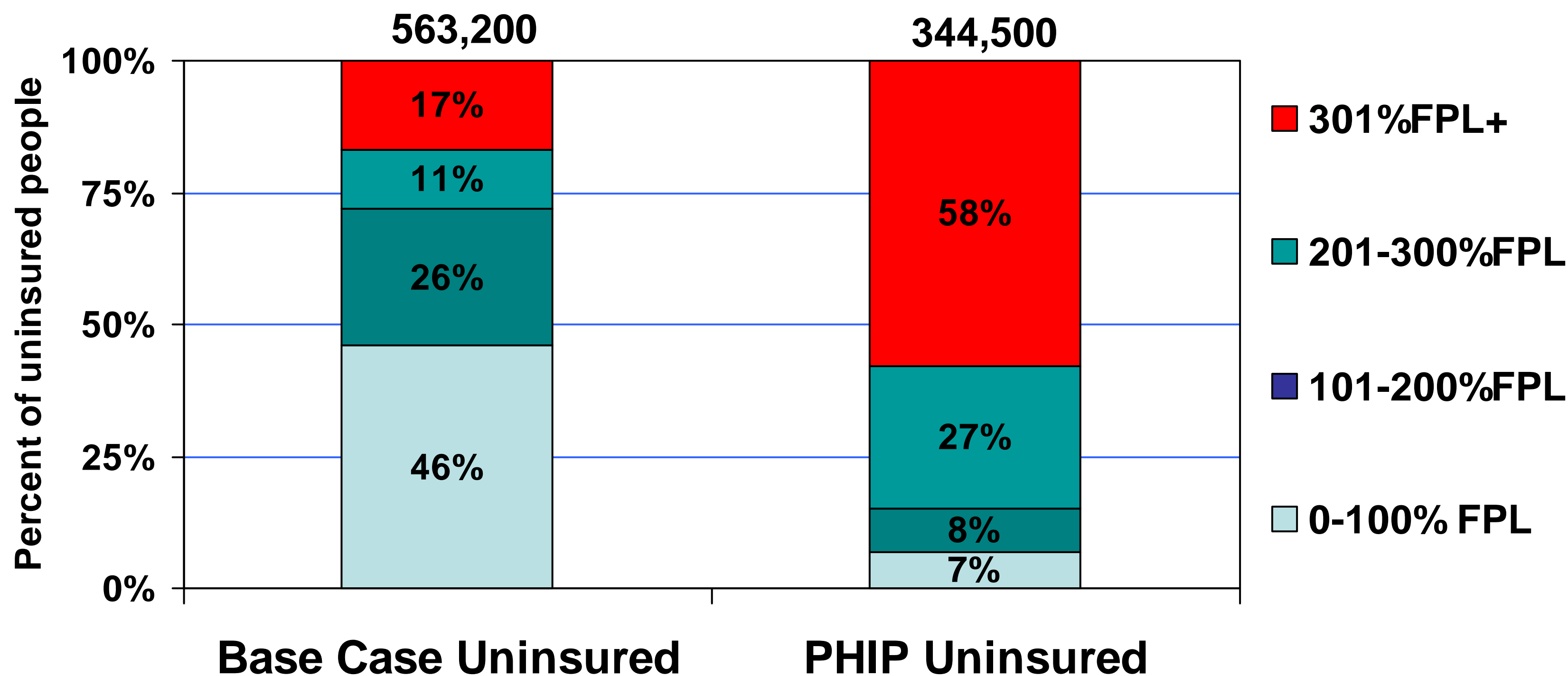
This slide shows that the share of uninsured people under 24 would be about the same under PHIP, but persons 45-64 would make-up a larger share of the uninsured.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

Under PHIP, Fewer Uninsured People Would Be Low-Income

This slide shows that a small percentage of low-income people (0-200% FPL) would remain uninsured.



Source: Mathematica Policy Research. These FY2010 estimates exclude persons over age 65, Medicare beneficiaries, and active military.

Schedule: Upcoming Board Meetings

- Early October
  - Discuss stakeholder comments to draft Preliminary Report
  - Identify a package of policy recommendations
- Late October (teleconference)
  - Identify final revisions to draft Preliminary Report
  - Revise policy recommendations
- Mid November (teleconference)
  - Request approval of Board recommendations and Preliminary Report

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Consolidation And The Transformation Of Competition In Health Insurance

Health insurance will be either revitalized by the private sector or disciplined by the public sector, because current trends cannot be sustained.

by James C. Robinson

PROLOGUE: Competition drives innovation and efficiency in the larger economy, and for decades the United States has sought to use competition to motivate improvements in the health care system's performance. But competition requires competitors. The emergence of managed care in the 1980s was accompanied by the creation of hundreds of health insurance plans—mostly health maintenance organizations (HMOs)—which forced the incumbent indemnity insurers to reduce their costs or lose their customers. The subsequent senescence of managed care has been accompanied by an equally remarkable shrinkage in the number of competing health plans, as small firms sold out to their larger rivals and as even some of the industry's biggest names disappeared in a wave of mergers and acquisitions. In the past year, for example, UnitedHealthcare has acquired Oxford Health Plans, and Anthem has announced the acquisition of WellPoint, creating megaplans with twenty-two million and twenty-eight million enrollees, respectively.

In this paper James Robinson presents new data on the consolidation of the insurance industry in fifty states and jurisdictions, highlighting the dominance of a few firms in each market. Robinson documents the dramatic increases in premiums and profits enjoyed by the leading firms during the past four years but notes the change in pricing dynamics that may dampen Wall Street's enthusiasm. Competition without competitors will not deliver the desired incentives for health care improvement, and Robinson argues that the industry must undergo rejuvenation through new firms and products or face increased regulatory oversight from a disenchanted public sector.

Robinson (jamie@berkeley.edu), a frequent contributor to *Health Affairs*, is a professor of health economics in the University of California, Berkeley, School of Public Health.

Robinson's paper is accompanied by Perspectives by David Hyman and William Kovacic (representing the U.S. Federal Trade Commission); William Kopit (Epstein, Becker, and Green); and Arnold Milstein (Pacific Business Group on Health).

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ABSTRACT: This paper presents data on fifty state and substate insurance markets, in terms of the 2003 relative shares of the largest health plans and the antitrust index of concentration. It presents 2000–03 data on rates of growth in premiums, costs, operating earnings, returns on equity, and share prices for the nation's largest health plans (WellPoint, Anthem, United, Aetna, and CIGNA). Private insurers face renewed price and profit pressures in the short term, but long-term prospects depend on the emergence of new products and new competitors in an increasingly consolidated industry.

The contemporary imagery of health care consumerism evokes a transfer of decision-making rights and responsibilities from the insurer to the individual and the consequent withering away of the managed care organization. Yet health plans are growing larger, not smaller, consolidating local markets and reaching into new geographic regions, products, and customer segments. The commercial health insurance market in many states is dominated by two to three carriers. The same set of corporate logos now extends across once-distinct niches, from insured small-group coverage to self-insured corporate accounts and from Medicaid managed care to pharmaceutical, behavioral, and other specialty health benefits. Prices and profits have been at historic highs, as insurers have refused to sacrifice margins for enrollment volume. Premiums are moderating in the short term, as investor-owned insurers pursue growth in an already consolidated industry and state regulators demand pricing rollbacks from nonprofit Blue Cross and Blue Shield (BCBS) plans.

This paper analyzes the consolidation of the commercial insurance industry, taking into consideration rivalry among incumbent firms, barriers to entry by firms from other sectors, paucity of substitute products, ability to pass through cost increases from suppliers, and ineffective pushback from purchasers. Data are presented on the concentration of market shares across both health maintenance organizations (HMOs) and preferred provider organizations (PPOs) and across both insured and self-insured employer funding arrangements. The economic success of the industry is highlighted through data on premiums, costs, earnings, and share prices for the sector's leading firms. The industry faces one of two futures: rejuvenation by the private sector or domestication by the public sector.

Quantifying Consolidation

Available data on health insurance market shares are distorted because of the differences among products and customer segments in the manner by which insurance is regulated and enrollment is counted. Most HMOs are insured at the state level, and data on firms and enrollment are available from consultants, vendors, and researchers willing to collect the data from state insurance departments. But the majority of Americans covered by commercial health insurance are not enrolled in insured HMOs but in PPOs and in self-insured products not covered or counted by state regulatory agencies.[1] The focus on HMO market shares, to the exclusion of insured PPO and self-insured products, sometimes reflects a mistaken

view that HMO and PPO product designs, and insured and self-insured funding arrangements, do not compete with one another.

■ **Data sources.** To assess the extent of concentration in the commercial health insurance industry, it is necessary to amalgamate data from multiple sources. Firm-specific data are available for the Blue Cross and Blue Shield plans, both nonprofit and for-profit, and for the investor-owned commercial plans, and state-specific enrollment data are available for insured products (which includes most nonprofit HMOs). Commercial health plan enrollment (employment-based and individually purchased) must be separated from noncommercial lines of insurance offered by the same carriers, including Medicare, Medicaid, and the military TRICARE managed care programs. Commercial coverage does include public employee health benefits, both insured and self-insured, such as the Federal Employees Health Benefits Program (FEHBP) and state public employee programs. The following discussion relies on data compiled by Goldman Sachs Global Equity Research, based on state regulatory filings; investor reports from publicly traded firms; information from nonprofit BCBS plans; the InterStudy *HMO Directory* (based on state regulatory filings); the InterStudy *PPO Performance Report* (based on surveys by InterStudy); and direct contacts with individual firms. The figures for the investor-owned plans were last updated as of December 2003; some nonprofit plan data are from 2002.[2]

Data are available at the state level only, even though some states include multiple geographic markets and some geographic markets overlap state lines. Several states have multiple Blue Cross plans that operate in nonoverlapping parts of the state and do not compete directly with one another (except in border regions). Pennsylvania has four region-specific Blues plans; New York has three. Data are available separately for upstate and downstate New York, because of the radically different markets in New York City and the western part of the state (two Blues plans operate in upstate New York). The data for the District of Columbia include northern Virginia (suburban Washington, D.C.).[3] No data are available for Hawaii and Alaska; North Dakota data are not available for health plans other than BCBS. The ensuing discussion refers to fifty "states" but in fact includes forty-seven states, two parts of one state (New York), and one jurisdiction (District of Columbia, including northern Virginia).[4]

■ **Commercial insurance enrollment.** Exhibit 1 presents total commercial insurance enrollment (including insured and self-insured funding arrangements) for each state market, plus the percentage held by the largest firm in the market, the percentage held by the three largest firms, the Herfindahl-Hirschman Index (HHI) of market consolidation used by the Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ), and the extent of antitrust concern derived from FTC/DOJ guidelines (based on the HHI).[5]

The striking feature of the numbers in Exhibit 1 is the large market shares controlled by the leading firm in each state. In thirty-eight states the largest firm controls one-third or more of the market; in sixteen states the largest firm controls

EXHIBIT 1
Commercial Insurance Enrollment, Consolidation, And Antitrust Concern Levels In State Health Insurance Markets, 2002–03

State	Commercial insurance enrollment (thousands)	Share of largest health plan (%)	Share of three largest plans (%)	Market concentration index (HHI)	Antitrust concern (merger guidelines)
AL	2,836	71	81	5,054	High
AZ	3,020	30	84	2,461	High
AR	1,343	56	74	3,283	High
CA	19,677	27	67	1,842	Moderate
CO	3,651	19	41	883	Low
CT	2,507	57	78	3,629	High
DE	543	59	84	3,931	High
DC/No. VA	1,837	69	98	5,495	High
FL	8,583	30	65	1,758	Moderate
GA	4,916	43	65	2,184	High
ID	836	32	75	2,041	High
IL	7,905	47	64	2,471	High
IN	3,951	46	57	2,258	High
IA	1,983	66	78	4,405	High
KS	1,738	37	56	1,587	Moderate
KY	2,562	46	75	2,685	High
LA	2,217	41	66	2,058	High
ME	766	70	97	5,312	High
MD	3,833	34	92	2,921	High
MA	4,350	47	81	2,883	High
MI	6,563	47	61	2,393	High
MN	3,745	53	89	3,535	High
MS	1,584	47	59	2,356	High
MO	3,812	36	71	2,111	High
MT	476	59	67	3,490	High
NE	1,112	54	72	3,160	High
NV	1,203	17	40	664	Low
NH	860	66	100	5,275	High
NJ	6,113	39	60	2,260	High
NM	884	25	65	1,541	Moderate
NY downstate	8,191	26	51	1,497	Moderate
NY upstate	3,659	26	69	1,786	Moderate
NC	4,799	50	91	3,353	High
ND	395	51	–[a]	–[a]	–[a]
OH	7,859	33	62	1,677	Moderate
OK	1,957	36	48	1,441	Moderate
OR	2,195	43	66	2,282	High
PA	8,797	33	63	1,718	Moderate
RI	894	56	100	5,071	High
SC	2,266	44	74	2,444	High

more than half the market. In all states except California and Nevada the largest insurer is a Blue Cross or Blue Shield plan, or both. The role of leading firms is un-

EXHIBIT 1
Commercial Insurance Enrollment, Consolidation, And Antitrust Concern Levels In State Health Insurance Markets, 2002–03 (cont.)

State	Commercial insurance enrollment (thousands)	Share of largest health plan (%)	Share of three largest plans (%)	Market concentration index (HHI)	Antitrust concern (merger guidelines)
SD	462	56	69	3,305	High
TN	3,451	43	62	2,217	High
TX	11,116	32	55	1,428	Moderate
UT	1,571	32	70	1,767	Moderate
VT	342	44	71	2,316	High
VA	4,642	57	80	3,519	High
WA	3,764	27	66	1,796	Moderate
WV	819	43	58	1,972	High
WI	3,405	17	39	689	Low
WY	275	44	64	2,105	High

SOURCES: Goldman Sachs Global Equity Research; *InterStudy HMO Directory; InterStudy PPO Performance Report;* and company data.
NOTE: HHI is Herfindahl-Hirschman Index.
[a] Not available.

derestimated in these figures, as some states have distinct geographic markets, with a dominant firm in each. For example, if the four regional Blue Cross plans in Pennsylvania were added together, the resulting firm would control 63 percent of the statewide "market" rather than the 33 percent shown in Exhibit 1.

■ **Dominant firms.** The top three firms typically dominate each market, as indicated in the third column of Exhibit 1. In only three state markets do the largest three plans control less than 50 percent of the total enrollment, and in only fourteen do the largest three plans control less than 65 percent. The fourth column of Exhibit 1 presents the HHI, which is calculated by squaring the market share of each firm in the market and summing across all competitors; the HHI is commonly used to analyze markets and sometimes to block mergers and acquisitions. As evident in Exhibit 1, the HHI for commercial health insurance at the state level is very high, with only three of the state indexes falling below 1,000 (the FTC/DOJ threshold for low level of antitrust concern), twelve falling between 1,000 and 1,800 (moderate level of antitrust concern), and thirty-four exceeding 1,800 (high level of antitrust concern).

Exhibit 2 provides an alternative perspective on the consolidation of the commercial health insurance industry by highlighting the relative shares of each state market held by the four largest U.S. firms (WellPoint, United, Aetna, and CIGNA) and by the BCBS plans that are not part of WellPoint. The Blues, including WellPoint, hold the largest market share in every state except Nevada (where they tied with Sierra Health Services for first) and California, where Blue Cross of California (WellPoint) is tied for first (with Kaiser Permanente) and Blue Shield of California comes in third. While the state-specific BCBS plans formally are owned by

EXHIBIT 2
Percentage Of Commercially Insured Population Enrolled In The Largest U.S. Health Plans, 2002–03

State	WellPoint (including Anthem)	Other Blue Cross and Blue Shield	UnitedHealth Group	Aetna	CIGNA	Total in largest U.S. plans
AL	0%	71%	4%	2%	2%	79%
AZ	0	30	26	7	28	91
AR	0	56	9	2	9	76
CA	27	13	2	6	3	51
CO	19	0	11	6	11	58
CT	57	0	4	4	10	75
DE	0	59	6	9	3	77
DC/No. VA	0	69	2	0	0	71
FL	0	30	24	11	9	74
GA	43	0	11	6	11	71
ID	0	58	17	0	0	75
IL	9	47	8	6	4	74
IN	46	0	4	6	4	60
IA	0	66	7	3	1	77
KS	0	37	8	2	2	49
KY	46	0	15	10	3	74
LA	0	41	18	4	4	67
ME	70	0	3	9	18	100
MD	0	34	30	28	8	100
MA	1	47	3	5	4	60
MI	0	47	4	4	2	57
MN	0	53	2	2	3	60
MS	8	47	4	2	3	64
MO	36	18	17	6	6	83
MT	0	59	5	0	2	66
NE	0	54	14	3	3	74
NV	17	0	3	4	4	28
NH	66	0	4	0	31	100
NJ	0	39	15	16	12	82
NM	0	25	3	0	3	31
NY downstate	0	26	13	11	11	61
NY upstate	0	26	25	0	0	51
NC	0	50	18	3	23	94
ND	0	51	0	0	0	51
OH	33	0	16	13	4	66
OK	2	36	4	7	4	53
OR	0	43	2	4	4	53
PA	0	63	3	14	2	82
RI	0	56	44	0	0	100
SC	0	44	12	1	18	75
SD	0	56	0	0	1	57
TN	0	43	11	8	8	70
TX	4	32	12	11	7	66
UT	0	32	17	3	4	56
VT	0	44	0	0	17	61

EXHIBIT 2
Percentage Of Commercially Insured Population Enrolled In The Largest U.S. Health Plans, 2002–03 (cont.)

State	WellPoint (including Anthem)	Other Blue Cross and Blue Shield	UnitedHealth Group	Aetna	CIGNA	Total in largest U.S. plans
VA	57	0	14	1	9	81
WA	0	51	2	11	3	67
WV	0	43	0	7	5	55
WI	17	0	13	4	3	37
WY	0	44	9	0	0	53

SOURCES: Goldman Sachs Global Equity Research; *InterStudy HMO Directory; InterStudy PPO Performance Report;* and company data.

forty independent companies, some covering multiple states and others just one, they cooperate with one another in the market for multistate corporate accounts and in building the Blue brand nationally. If all Blues plans were considered part of one firm, they would control 44 percent of the national market. In comparison, if all nonprofit Blues were considered one firm (thereby excluding for-profit WellPoint and WellChoice), the nonprofit plan would control 31 percent of the national market.[6]

The consolidation of the industry at the hands of the largest health plans is evident in the far right column of Exhibit 2. The market shares of United, Aetna, and CIGNA are quite modest in most states, with exceptions where they have acquired regional HMOs, but the overall scale of the firms is large because of their wide geographic scope. Together the Blues plans and the three national non-Blues carriers control more than 60 percent of the market in thirty-four states and more than 70 percent of the market in twenty-three states. Regional nonprofit HMOs today remain strongest in the states where they launched three decades ago (California, Minnesota, Massachusetts, and Oregon). Regional for-profit plans such as PacifiCare, HealthNet, Humana, and Coventry have dispersed enrollment and do not dominate any single market.

The figures presented in Exhibits 1 and 2 should be interpreted with caution, because of the partially distinct customer segments that make up the commercial insurance industry. Large, multistate employers typically purchase self-insured benefits administration from one or more of the national carriers listed in Exhibit 2 or from a state-specific Blues plan linked to the national BlueCard network. The number and relative size of local health plans may be largely irrelevant.[7] The market for multistate employers in 2003 was served by Aetna (14 percent), CIGNA (9 percent), United (15 percent), WellPoint (12 percent), Anthem (5 percent), other Blue Cross plans (12 percent), First Health (8 percent), and other (25 percent).[8]

Prices And Profits

Exhibit 3 presents indicators of the financial performance of the largest U.S. health insurers during 2000–2003. This includes year-over-year rates of growth in medical costs, premium rates, operating profit margins, and share prices, plus the average yearly ratio of medical costs to premium revenues for insured products (medical cost ratio). Data are presented for WellPoint and Anthem separately, as their merger was announced only in 2004, as well as for United, Aetna, and

EXHIBIT 3
Premiums, Medical Costs, Earnings, Return On Equity, And Stock Prices In The Largest U.S. Health Plans, 2000–2003

	WellPoint (excluding Anthem)	Anthem	UnitedHealth Group	Aetna	CIGNA
Medical cost growth					
2000	7.5%	–[a]	8.5%	11.0%	8.0%
2001	9.0	13.5%	12.0	17.5	12.5
2002	11.0	12.0	12.0	14.5	14.0
2003	11.0	9.5	10.0	8.0	15.0
Premium growth					
2000	7.5	–[a]	8.5	11.0	8.0
2001	9.0	14.0	12.0	17.0	12.0
2002	11.0	14.5	13.0	19.0	15.0
2003	13.0	10.0	12.0	14.0	14.5
Medical cost ratio					
2000	80.8	84.8	84.9	87.0	87.1
2001	81.5	84.6	84.2	89.8	87.3
2002	81.5	82.4	81.5	82.8	88.6
2003	80.5	80.8	80.0	78.3	86.9
Operating earnings margin					
2000	4.9	8.5	5.7	2.3	3.6
2001	6.6	5.1	6.7	−0.8	8.0
2002	7.1	6.6	8.7	3.2	5.9
2003	8.1	7.8	10.2	7.7	8.9
Return on equity					
2000	23.2	12.6	19.0	1.3	18.7
2001	22.0	18.5	24.1	−2.7	21.3
2002	21.9	13.5	32.5	4.1	21.1
2003	19.9	13.2	38.2	11.1	31.8
Stock price growth					
2000	74.8	–[a]	131.1	46.9	64.2
2001	1.4	34.7	15.3	−19.7	−30.0
2002	21.8	29.7	18.0	24.6	−55.6
2003	36.3	19.2	39.4	64.4	39.8

SOURCE: Lehman Brothers Equity Analysis.

NOTES: Medical cost ratio is payments to physicians, hospitals, pharmaceutical firms, and other providers and suppliers of medical care services, as a percentage of insurance premium revenue. Operating earnings = EBIT (earnings before interest and taxes).

[a] Not available.

CIGNA.

The first four rows of Exhibit 3 report the rate of inflation in medical claims payments made by each of the insurers, documenting on a plan-specific basis the resurgence of growth in unit prices and use of services after the hiatus of the 1990s.[9] Growth in claims costs adversely affects health plans only to the extent that insurers cannot raise premiums at an equivalent or faster rate. As indicated in the next four rows of Exhibit 3, however, health plans during these years were able to raise prices consistently above the rate of growth in costs, with premium yields 1.5 to 2.0 percentage points above cost trends since 2000. The ability of premiums to outpace claims is further illustrated in the subsequent rows, which present the ratio of medical costs to premium revenues for insured products.[10] Between 2000 and 2003 the medical cost ratios declined by more than four percentage points for Anthem and United and by nine percentage points for Aetna, while holding constant for WellPoint (with the lowest baseline ratio) and CIGNA.

Exhibit 3 next presents the operating earnings margin (earnings before interest and taxes) over the four-year period.[11] Given its position as an intermediary between purchasers and providers, the insurance industry traditionally reports thin profits as a percentage of revenues. It was remarkable that during this period of high medical cost inflation, large health plans were able to increase their operating margins. With the exception of Anthem, large plans grew their margins by at least 50 percent (WellPoint and United) and in two cases by more than 100 percent (Aetna and CIGNA, starting from lower baselines).

The numbers of particular interest to investors are the returns on equity, the percentage rate of return for each dollar invested in health insurance firms. As indicated in the next section of Exhibit 3, returns on equity were excellent over the recent four-year period for the leading firms in the sector with the exception of Aetna, which crashed and almost burned as a result of excessive acquisition-driven growth.[12] Returns on invested capital were approximately 20 percent each year for WellPoint, CIGNA, and United, with United spiking to almost 40 percent in 2003, and were comfortably in the teens for Anthem. Even Aetna recovered after its debacle, with return on equity rising into the double digits in 2003 after negative returns two years earlier. Returns for mid-size health plans (not shown in Exhibit 3) were equally attractive, with the 2003 sector high for Oxford (58.7 percent) and an average of 19.9 percent for all publicly traded health plans.[13] While return-on-equity measures are not available for nonprofit health plans, the nonprofit BCBS plans enjoyed financial results equal to or better than those of their for-profit counterparts. Between 2002 and 2003 the non-profit Blues increased operating earnings by 111 percent and net income by 87 percent, compared with the increase of 42 percent in operating earnings and 36 percent in net income on the part of their for-profit Blues counterparts.[14]

The final rows of Exhibit 3 highlight the investor perspective on the health insurance industry.[15] Aetna and CIGNA endured setbacks and loss of market share

(mostly to Blue Cross plans) and a consequent volatility in share prices during these four years. WellPoint, Anthem, and United, however, consistently received double-digit rates of appreciation in share prices. By way of comparison, the Standard and Poor's (S&P) 500 index of equity prices for the broader stock market declined by 10.1 percent in 2000, 13.0 percent in 2001, and 23.4 percent in 2002, followed by a rise of 26.4 percent in 2003.

Pressures On Profitability

The correlation between the structure of an industry, measured in terms of the share distribution of competing firms, and its long-term profitability, is patchy at best, because of the important role of other determinants of revenues and costs. It would not be appropriate, for example, to infer that the high levels of consolidation documented in Exhibit 2 caused the high levels of profitability documented in Exhibit 3 without considering the role of other determinants. The consolidation among firms already in the industry is only one of five factors typically highlighted in discussions of corporate strategy. The others include barriers that prevent entry by competing firms from other markets, substitute products from other industries, bargaining power among suppliers, and bargaining power among purchasers. Generally, the profit potential is lower in industries with low barriers to entry by firms from adjacent markets, easy replacement by substitute products, and pressure from consolidated suppliers and consolidated purchasers.[16]

■ **Barriers to entry.** For two decades the most important source of competitive pressure in health insurance has been the availability of new entrants, including start-up HMOs and carriers from adjacent geographic regions willing to fight for enrollment through lower prices. Today, start-ups are rare because there have been no major innovations in technology, product design, or organizational structure that new firms could use to offset the scale advantages enjoyed by incumbents. Even large and successful firms are cautious as to the ease of extending into new markets. Today a national plan will make a serious entry into a new regional market only through the purchase of a large local firm. If the national plan already has a presence in the local market where it makes the acquisition (as it almost invariably the case), market expansion increases rather than decreases consolidation at the local level.

■ **Substitute products.** The most radical form of competition comes from substitute products rather than from new purveyors of existing products, as when the personal computer replaced the typewriter. Health insurance had seen no meaningfully different substitute products since the HMO was introduced thirty years ago. However, the recent experimentation with "consumer-directed" health plans combining a tax-sheltered health savings account with a high-deductible PPO, represents a potential substitute, replacing much of third-party (insurer) payment by consumer out-of-pocket payment.[17] The advent of these plans stimulated the formation of several new firms (for example, Definity and Lumenos) and the entry by firms from adjacent product niches (for example, Great West, Fortis, and Mutual of

Omaha). For the moment, however, the consumer-directed plan seems more an incremental change to the PPO than an actual substitute and can be offered by large incumbent firms such as Aetna and Humana.

■ **Supplier consolidation.** The consolidation of the health insurance industry has been accompanied in many markets by the consolidation of the hospital sector, which has permitted hospital systems to raise the rates charged to insurers.[18] Rising costs for clinical products and services are not incompatible with insurance industry profitability, however, if plans retain the discipline to raise their premiums at a rate commensurate with expected increases in underlying medical costs. Over the past several years, as hospital and other provider costs have surged, the major health plans (including those in Exhibit 3) have not only maintained but reduced their medical cost ratios, from an average of 85.1 percent in 2000 to 82.1 percent in 2003.[19]

■ **Purchaser pressure.** Despite the prominent role of the corporate purchaser of health benefits in the theory of managed care and managed competition, purchasers have proved ineffective in restraining premiums and profits in markets where consolidation has reduced the number of competing health plans. In the short term, health plans are moderating the rate at which they are increasing premiums relative to costs, but this is primarily attributable to an interest in growing (profitable) enrollment rather than to any consolidated purchasing power among employers. The longer-term risk to insurance industry profitability could be an abandonment by employers of health insurance as a fringe benefit and any resulting growth in publicly provided insurance (especially Medicaid expansions).

Short-Term Prospects

Consolidation of local markets, substantial barriers to new entry, few substitute products, ability to pass on increased provider costs, and a paucity of purchaser pressure are transforming competition in the health insurance industry. Further consolidation, and a further increase in entry barriers, is to be expected, as small local plans continue to sell out to the dominant carriers. The regional investor-owned health plans could be acquisition targets, offering national carriers increased enrollment and further reducing the potential for price competition. UnitedHealthcare's acquisitions of MAMSI and Oxford eliminate the most dynamic local plans in the mid-Atlantic and New York markets, respectively, perhaps foreshadowing acquisition efforts targeted at mid-size plans elsewhere. Investment bankers have developed scenarios and price estimates for the acquisition of the remaining regional plans, including HealthNet, PacifiCare, Coventry, WellChoice, Humana, and Sierra.[20]

Unrealistic enrollment growth targets among the for-profit firms and regulatory pressures on the nonprofit plans are driving premium moderation in the short term. The investor-owned firms announced aggregate commercial enrollment targets for 2004 of 1.8 million, exceeding realistic possibilities. The commercial health insurance industry shrank by one million covered individuals in 2002 and

regained only 300,000 in 2003, as the economy edged out of recession. There are fewer and fewer local health plans from which the major carriers can seize enrollment. Some observers believe that the investor-owned firms will feel forced to sustain enrollment growth even at the cost of lower premiums and profit growth, while others foresee continued pricing discipline and strong profit margins.[21]

The other potential source of premium moderation lies with the nonprofit BCBS plans, which have accumulated capital reserves far in excess of statutory requirements. In 2003 the nonprofit Blues expanded their excess capital reserves by more than 50 percent.[22] To the extent that regulators are successful in jawboning Blue Cross to lower premiums, however, the consolidation of enrollment and market share will only accelerate. The cycle of consolidation, "excess reserves," jawboning, premium moderation, and increased Blue Cross market share has already been witnessed in states as diverse as Tennessee, Pennsylvania, and Rhode Island.[23]

Alternative Futures

Outside health care, consolidation often signals a period of prosperity and decline, as the industry is spared both the rigors and the stimulus of competition.[24] A sustained period of high prices and profits in health insurance would result in continuing shrinkage in the number of firms purchasing coverage for employees, which eventually would engender a political backlash. Conversely, the entry of new products and new competing firms could deconsolidate and revitalize the industry. Two alternative futures for commercial health insurance can be envisaged, each representing a different mix of political initiatives and market responses.

■ **Private-sector rejuvenation.** If the U.S. experiment with market-oriented health insurance is to be sustained, the industry must be subjected to renewed rivalry from new product designs and competing firms. One product design that can claim to be innovative and hence disruptive of the industry status quo is the consumer-driven health plan. If the numerous network, tax, regulatory, and customer-acceptance problems facing this product can be resolved, it has the potential to attract new competitors into an otherwise consolidated industry.[25] The creation of start-ups such as Definity and the reentry of erstwhile indemnity carriers such as Great West might presage entry by banks and mutual funds with expertise in financial products and the ability to rent provider networks and disease management programs.

An alternative and equally radical product innovation, compared with the dominant insurance designs of today, would renew close contractual ties between particular insurers and physician organizations, as was attempted during the era of managed competition.[26] Coordination between the financing and delivery of care has the potential to improve quality and efficiency, but it requires creative solutions to the problems of medical group structure, capitation payment, and regulatory barriers that have plagued prepaid group practices in past years.[27]

■ **Public-sector domestication.** Despite its pricing power and recent profit-

ability, the private health insurance industry may be at the threshold of creeping control or replacement by a publicly financed and administered system. Continued growth in premiums and the number of uninsured citizens could impel an expansion of public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP). The broadening of criteria for public programs could accelerate the "crowding out" of private insurance, as employers trim their benefits with the understanding that employees can obtain publicly subsidized coverage.

A continuing shift from employers to government as the primary sponsor of coverage need not imply the demise of the private health insurance industry, however, as evident in the role of the commercial industry in servicing TRICARE, the FEHBP, and Medicaid managed care programs. In this scenario, governmental entities will specify some product components while outsourcing to the health plans organizational specifics such as provider reimbursement, disease management, supplemental benefits, and electronic connectivity. The once-competitive insurance industry would evolve into a framework of franchise contracting between consolidated public purchasers and consolidated private insurers.

One of the great theorems of economics, and of life generally, is that unsustainable trends will not be sustained. Double-digit growth in premiums, earnings, and equity share prices are examples of unsustainable trends. In the long term, health insurance will be either revitalized by the private sector, through product innovation and competitive entry, or disciplined by the public sector, through purchasing power and regulatory requirements.

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NOTES

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3. The market share data for Virginia do not include the suburban areas of metropolitan Washington, D.C., which are combined with the data for the District of Columbia. Enrollment data for the Maryland suburbs of Washington are included in the Maryland state numbers, not with those for the District of Columbia.
4. The use of state-level data probably understates the true degree of consolidation in the insurance market for individuals, small firms, and mid-size accounts and perhaps overstates consolidation in the market for multistate corporate accounts. To the extent that particular plans focus their efforts and concentrate their enrollment in particular cities within a state, leaving the other parts of the state to other firms, firms and individuals shopping for coverage in any one local will enjoy fewer choices than would appear to be the case from these data. On the other hand, the insurance market for large, multistate employers is not bounded by the plans incumbent in any one state but is served by the three national commercial carriers (Aetna, CIGNA, and United), each with 18–19 percent; by the network of BCBS plans through the

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