



# HEALTH CARE INDUSTRY MARKET UPDATE

Managed Care

November 28, 2001

Dear Friends of CMS:

As the regulators of over \$500 billion per year of Medicare, Medicaid, and S-CHIP funds, we believe it is incumbent on us to better understand the finances of our contractors, health providers, and other related businesses that provide services to the more than 70 million beneficiaries these programs serve. Health plans, hospitals, nursing homes, home health agencies, DME suppliers, medical device manufacturers, and pharmaceutical companies are just some of those whose finances are heavily reliant on these public programs.

As a lawyer and former trade association CEO, I represented many of these companies, both shareholder owned and non-profit. I was always surprised at how little Wall Street and Washington interacted—and how these companies often provided different financial information to each. I am a strong believer in adequate funding for our major partners in these programs, but I do not think they should be saying one thing to investors and another to regulators (as it is occasionally in their interest to do). If health plans or providers need help, we should have a thorough understanding of their real financial status to assess the true level of need.

With that in mind, when I joined CMS, I decided the agency should review the vast array of data available from Wall Street analysts that is not widely reviewed in Washington. Many investment banking firms conduct detailed analyses of major health providers, both for the equity investors in for-profit companies, and for the debt holders of for-profit and non-profit entities. Health systems typically provide these investors with clear financial data. These data can be used by regulators and legislators to assess funding adequacy, or the need for regulatory reforms.

I asked CMS' Office of Strategic Planning (OSP) to get research reports from the major investment firms, summarize their analyses, and condense them into a short, and hopefully, understandable format. Our goal is to provide objective summary information that can be quickly used by CMS, HHS, Congress, and their staffs that oversee these programs. The primary person at CMS assigned to this task is Lambert van der Walde, an OSP analyst who previously worked for Salomon Smith Barney in New York and is experienced with corporate financial analysis and reviewing corporate research.

Our first report focuses on publicly traded managed care organizations. In coming months, we will review the financial and market performance of nursing homes, home health agencies, and virtually every other major provider sector. Though I am proud of this initial effort, and believe it will add to understanding of the programs, we welcome comments on the content and format of this report. This is a first try, and we want to make this as consumer friendly as possible for everyone who reads it. Please provide comments to Lambert at [lvanderwalde@cms.hhs.gov](mailto:lvanderwalde@cms.hhs.gov) or Rob Sweezy at [dsweezy@cms.hhs.gov](mailto:dsweezy@cms.hhs.gov).

Sincerely,

Tom Scully

November 28, 2001

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Administrator

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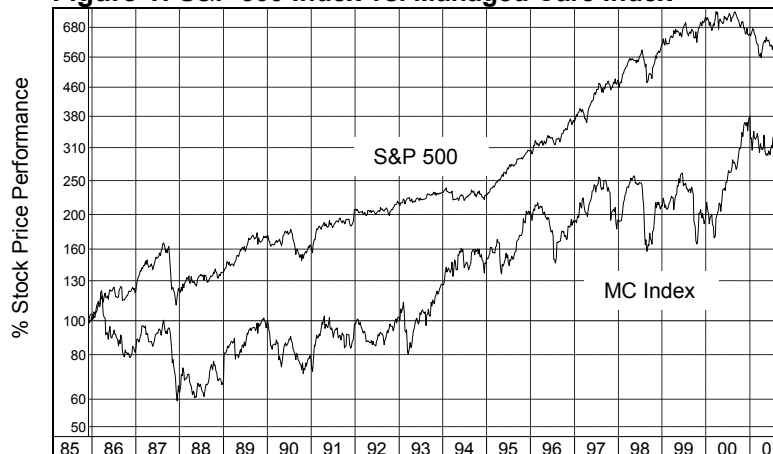
## Wall Street's View of Managed Care

Publicly held sector performance improves. Withdrawals from Medicare + Choice contribute to the recovery.

- ◆ **The Managed Care Sector is benefiting from an upswing in the underwriting cycle due to better pricing and less focus on enrollment growth**
- ◆ **The publicly held companies with high participation in Medicare + Choice have had the worst performance**
- ◆ **Companies that continue to participate in Medicare + Choice are experiencing accelerating gross margin deterioration**
- ◆ **Consumer behavior is driving the commercial managed care market from the closed-panel HMO to the more open POS and PPO models**

Historically, the managed care industry has underperformed the market and has experienced more volatility.

Figure 1: S&P 500 Index vs. Managed Care Index



	Annual	Cumulative
S&P 500	+11.1%	+428.6%
MC Index	+ 7.5%	+216.6%

Source: Salomon Smith Barney, 11/30/1985-10/31/2001.

Note: Managed Care index includes: CIGNA, Coventry, Health Net, Humana, Mid Atlantic Medical Services, Oxford Health Plans, RiteCHOICE Managed Care, Trigon Healthcare, UnitedHealth Group, and WellPoint Health Networks.

**The Managed Care Sector is benefiting from an upswing in the underwriting cycle due to better pricing and less focus on enrollment growth**

Wall Street believes the managed care industry will benefit from an attractive underwriting environment for the next few years.

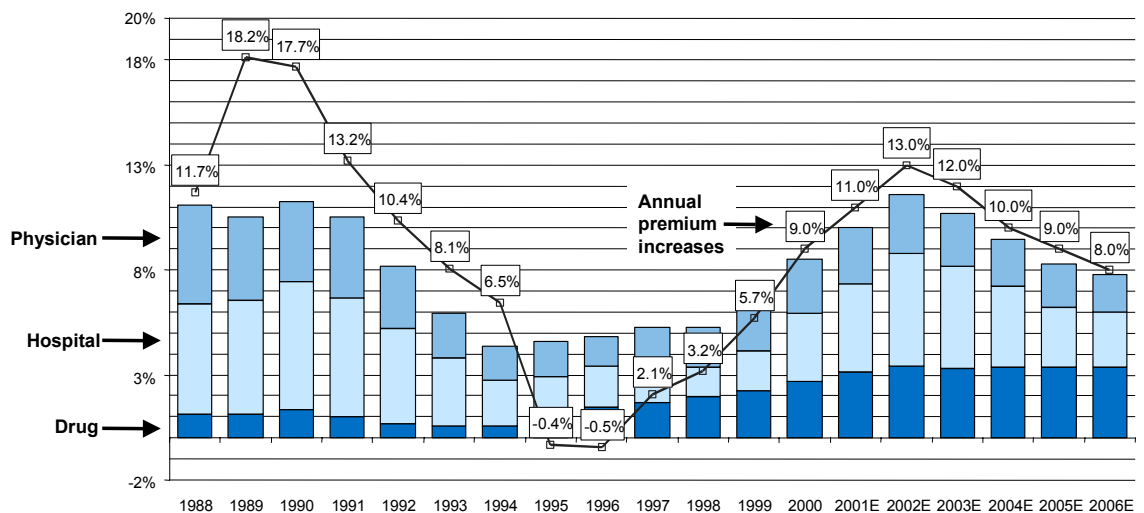
Wall Street analysts believe that the commercial pricing cycle is very strong—which is to say that price competition for the sake of attracting new members is not occurring as it was in the mid-to-late 1990s. According to James Lane of Salomon Smith Barney, plans are recognizing upward trends in medical costs and increasing prices accordingly. Meanwhile, however, the total growth in demand for employee benefits is declining as unemployment rises.

Managed care outperformed the S&P 500 in 2000-2001.

Despite the concern that employers will reduce employee health benefits given the uncertain state of the economy, Wall Street sees managed care as a good defensive sector in which to invest. Charles Boorady of Goldman Sachs recommends that investors hold large positions in the managed care sector. After six years of underperformance, **managed care outperformed the S&P 500 in 2000-2001: a net gain of 42% for managed care vs. a net loss of 28% for the S&P** (see Figure 1 for the last sixteen years). Goldman expects the profit cycle will improve through at least 2003 as it too believes that the industry is on the positive side of the underwriting cycle. Well-run companies have been disciplined in their approach to pricing and the result is profit margin expansion. Goldman believes this discipline is due to the reduced market competition and new discipline from the managed care organizations (MCOs) planning to become public companies. Also, Boorady of Goldman expects, "...lower administrative costs in 2003 and beyond as Internet and other technology infrastructure investments in 2000-2002 and HIPAA compliance spending begins to pay off."

Boorady notes, "After a negative underwriting cycle for 1994 to 1999, we believe the positive spread between premiums and cost will continue through 2004." (Figure 2)

**Figure 2: Commercial Health Care Premium vs. Cost Increase Components 1988-2006**



Commercial health care premium increases are keeping ahead of cost increases.

Medicare reimbursement, however, is falling behind cost increases.

Source: Goldman Sachs Research estimates based on data from CMS, Milliman & Robertson, AAHP, KPMG. Note: Cost increases show rate of cost increase and do not include Health Service & Supplies, Personal Health Care, Dental, Other Professional Care, Home Health Care, Other Non-Durable Medical Products, Durable Medical Equipment, Nursing Home Care, Other Personal Healthcare, Administration & Net Cost of Private Health Insurance, or Public Health. The cost increases reflect the share of increase accounted for by the three major sectors.

## The publicly held companies with high participation in Medicare + Choice (M+C) have had the worst performance

Wall Street analysts view M+C instability as a negative.

The market recognizes that companies that participate in the M+C program face an uncertain revenue stream from the government. This unpredictability is a risk to earnings. James Lane of Salomon Smith Barney states:

“For the past four years, we have been negatively disposed toward [managed care] companies that had significant exposure to the Medicare+Choice program, due to the highly erratic nature of the government’s management of reimbursement and administrative requirements for private sector health insurers that are vendors to the Medicare+Choice program.”

Wall Street analysts typically are less likely to recommend companies with high M+C participation.

Stock price performance for managed care companies is generally better for those that choose not to participate in the M+C program, or that participate only to a limited extent. In the chart below (Figure 3) managed care companies are ranked by the percent of their premium revenue which is generated from their Medicare business segments. Wall Street analysts typically are less optimistic about companies with high M+C participation and are less likely to recommend their stocks as buys. The companies at the top of the list are the most dependent on Medicare and have suffered the most in the stock market over the last three years.

**Figure 3: Medicare Exposure by Percent of Premium Revenue**

Managed Care Medicare Exposure	M+C as % of Premium Revenue <sup>(1)</sup>	M+C Beneficiaries <sup>(2)</sup>	Stock Price Performance 1/1/99 - 11/27/01	Average Wall Street Recommendation <sup>(3)</sup>
PacifiCare Health Systems	59 %	1,002,100	-77.7 %	3.17
Sierra Health Services	39 %	57,800	-60.5 %	3.00
Humana	31 %	418,000	-34.6 %	2.71
Health Net	16 %	224,000	+78.8 %	2.29
Oxford Health Plans	16 %	85,200	+79.1 %	2.17
UnitedHealth Group	15 %	365,000	+214.0 %	1.57
Coventry	14 %	52,522	+30.1 %	2.40
Aetna	10 %	279,000	-21.7 %	2.83
Cobalt <sup>(4)</sup>	8 %	10,978	-20.9 %	3.00
WellPoint Health Networks	4 %	63,000	+38.6 %	1.29
CIGNA	2 %	45,000	+17.9 %	2.29
American Medical Security	0 %	0	-27.4 %	3.00
First Health Group	0 %	0	+181.8 %	1.60
Mid Atlantic Medical Services	0 %	0	+107.9 %	2.25
RightCHOICE Managed Care <sup>(5)</sup>	0 %	0	+490.4 %	2.00
Trigon Healthcare	0 %	0	+73.2 %	1.71

Source: Estimates calculated from Wall Street research and company data.

(1) For the six months ending 6/30/01, except Sierra and WellPoint which are for the year ending 12/31/00.

(2) As of 6/30/01, except WellPoint which is as of 12/31/00.

(3) Wall Street Recommendations: 1 = Strong Buy, 2 = Buy, 3 = Hold, 4 = Sell

(4) Cobalt (formerly Blue Cross & Blue Shield United of Wisconsin) has announced that it will no longer participate in M+C in 2002.

(5) WellPoint has announced that it intends to acquire RightChoice

The MCOs with the three highest proportions of revenue generated from M+C lost over \$3.5 billion in market value over the last three years.

UnitedHealth has strategically exited out of markets it targeted as potential loss generators.

The anomaly in Figure 3 is giant UnitedHealth Group (NYSE: UNH), which has had tremendous stock market performance and is acclaimed by most Wall Street analysts. The success comes despite depending on M+C members for 15% of its premium revenue. The explanation is that UnitedHealth has carefully managed its M+C exposure and has strategically exited out of markets it targeted as potential loss generators. At the beginning

of the 214% run-up of its share price, UnitedHealth had 483,000 M+C members. By gradually paring down its M+C membership by 25% and reducing benefits for 1999-2001, United succeeded in improving its margins while slowly exiting M+C. United has withdrawn from markets that served 57,000 members for 2002 and has significantly restructured its benefits in other markets.

At least one analyst still hopes that legislative and regulatory changes may benefit M+C HMOs. Salomon's Lane believes:

“...in light of weakening U.S. economic conditions, meaningful exposure to the Medicare + Choice program in 2002 and beyond may be a positive for earnings predictability as likely increased reimbursement and less onerous regulation probably will enable larger vendors to offset tougher operating conditions in their commercial health benefits product lines.”

### **Companies that continue to participate in Medicare + Choice are experiencing accelerating gross margin deterioration**

MCOs, like other insurance or financing companies, generate relatively narrow income margins and are very sensitive to small changes in revenue and cost structures. M+C margins are even more modest and, based on current trends, most Wall Street analysts hold little hope for improvement. In the case of *commercial* managed care, cost increases get largely passed through to customers. In the M+C program, however, it is difficult for the MCO to pass cost increases along while keeping attractive pricing and benefits in the program.

**MCOs are withdrawing because they are either losing money or anticipate losses soon.**

In counties where government reimbursement does not cover costs, companies will not continue to offer M+C benefits, at least not in the long term. In a report analyzing the market withdrawals from the M+C program by managed care organizations, an analyst at Credit Suisse First Boston commented that, “This story [of M+C exits] is not new, or unique to any one company. Government reimbursement is rising at only 2-3% a year, well behind medical cost inflation, which is running 9-10% a year, or higher.” Goldman Sachs projects the Medicare HMO medical cost trend for 2002 at 10.3% (see Figure 6). Goldman's Boorady explains that, “The market exits reflect anemic profit margins that continue to suffer from the premium rate caps mandated by the 1997 Balanced Budget Act.”

**For 2002, 536,000 M+C beneficiaries nationwide will be affected by market exits.**

National trends in health care costs and the payment methodology used to determine M+C payment increases have contributed to MCOs leaving the program. From 1998 to 2002, the cumulative increase in fee-for-service spending is estimated to be 21%. Over the same period, M+C payment rates for counties where over two-thirds of M+C enrollees live increased only 14.5%. In addition, M+C payment rates for all counties increased about 4% in 2002, while premium increases for private sector plans are in the double digits.

As discussed earlier, Wall Street is optimistic about the managed care sector as a whole, but its research analysts remain concerned about the low or negative margins generated by managed care plans in their M+C business segments. In October, Goldman Sachs performed an analysis of the 2002 Medicare market exits and benefits changes. It calculated the forecasted Medical Loss Ratios (MLR) and the operating margins of several plans (Figure 4). The MLR is the MCO's total cost for the medical service

provided divided by the total revenue from monthly premiums. In addition to the medical costs, an MCO also incurs other business and administrative expenses. These costs are generally calculated as the Administrative Loss Ratio (ALR). A well-run plan generally has an ALR of 8-12%. These expenses (ALRs) are subtracted from gross profit to calculate operating profit. The operating margin is defined as the amount left over to pay interest, taxes, any dividends, etc. divided by the total premium revenue. (100% – MLR – ALR = Operating Margin)

**Figure 4: M+C Managed Care Organizations: Medicare Operating Margins**

		Aetna AET	Coventry CVH	Health Net HNT	Humana HUM	Oxford Health Plans OHP	PacifiCare Health Systems PHSY	United Health Group UNH	Weighted Average <sup>(1)</sup>
2001E	Weighted Average Premium, PMPM	\$ 600	\$ 562	\$ 581	\$ 578	\$ 663	\$ 568	\$ 579	\$ 580
	MLR	95.5 %	84.6 %	93.6 %	84.5 %	87.7 %	90.5 %	90.1 %	90.1 %
	Operating Margin	(4.0)%	0.0 %	1.0 %	4.5 %	(1.0)%	(1.0)%	3.0 %	0.3 %
2002E	Weighted Average Premium, PMPM	\$ 632	\$ 575	\$ 634	\$ 612	\$ 697	\$ 602	\$ 596	\$ 613
	MLR	92.7 %	84.9 %	90.5 %	84.6 %	87.4 %	89.6 %	90.1 %	89.2 %
	Operating Margin	(1.2)%	0.1 %	4.1 %	4.4 %	(0.8)%	(0.2)%	3.0 %	1.3 %
	Margin Increase (Decrease)	2.8 %	0.1 %	3.1 %	(0.1)%	0.2 %	0.8 %	0.0 %	1.0 %

Source: Goldman Sachs research estimates and company data.

(1) Weighting based upon relative annual revenue.

**Forecasted 2001-2002 operating income increase for M+C HMO business segment averages 1.0%.**

Despite the addition of new premiums or the increase of existing premiums, the MCOs in Goldman's study are generating an average 1.5% increase in revenues. The projected average premium increase is 5.6%, comprised of the premium increases, legislated increases in premiums paid by Medicare (a 3.4% increase), and the benefit derived from exiting markets (a 0.7% increase), (Figure 5).

**Figure 5: M+C Managed Care Organizations: Annual Premium Increase, All Markets**

All Markets	AET	CVH	HNT	HUM	OHP	PHSY	UNH	Weighted Average <sup>(1)</sup>
2002/	Premium Increase: Government	3.2 %	3.0 %	2.8 %	3.2 %	3.2 %	4.5 %	3.4 %
2001E	Premium Increase: Member Paid	1.0 %	0.0 %	4.5 %	1.0 %	1.0 %	1.8 %	1.5 %
	Mix Change: Market Exits	1.1 %	0.0 %	1.7 %	1.7 %	1.0 %	(1.5)%	0.7 %
	Total Premium Increase	5.3 %	3.0 %	9.0 %	5.9 %	5.9 %	3.0 %	5.6 %

Source: Goldman Sachs research estimates and company data.

(1) Weighting based upon relative annual revenue.

In the Goldman analysis, the premium increase realized when calculating only the continuing markets, which includes the value of benefit cuts in addition to premium increases, will yield an average of 11.3%. This exceeds the expected cost trend of 10.3%—resulting in what Goldman forecasts as a 1.0% premium increase (Figure 6). This increase, however, comes at the expense of benefit decreases, and increasing member premiums and co-payments by an average of 6.5%.

**Figure 6: M+C Managed Care Organizations: Annual Premium Increase, Continuing Markets**

Continuing Markets <sup>(1)</sup>	AET	CVH	HNT	HUM	OHP	PHSY	UNH	Weighted Average <sup>(2)</sup>
2002/ Premium Increase: Government	3.2 %	3.0 %	2.8 %	3.2 %	3.2 %	3.2 %	4.5 %	3.4 %
2001E Premium Increase: Member Paid	1.0 %	0.0 %	4.5 %	1.0 %	1.0 %	1.8 %	0.0 %	1.5 %
Total Premium Increase	4.2 %	3.0 %	7.3 %	4.2 %	4.2 %	5.0 %	4.5 %	4.8 %
% Benefits Reductions <sup>(3)</sup>	9.0 %	6.0 %	3.7 %	5.0 %	5.5 %	7.6 %	5.0 %	6.5 %
Ttl. Premium Increase (Prem+Benefits)	13.2 %	9.0 %	11.0 %	9.2 %	9.7 %	12.6 %	9.5 %	11.3 %
Combined Cost Trend <sup>(4)</sup>	10.1 %	8.9 %	7.6 %	9.3 %	9.5 %	11.7 %	9.5 %	10.3 %
year/year change (basis points) <sup>(5)</sup>	2.84 %	0.12 %	3.05 %	(0.06)%	0.16 %	0.79 %	0.00 %	1.00 %

Source: Goldman Sachs research estimates and company data.

(1) Continuing market increases exclude the premium increase impact of market exits (mix change) in Figure 5.

(2) Weighting based upon relative annual revenue.

(3) Value of benefit changes as a percent of total benefit expenses.

(4) Combined medical & administrative cost trend.

(5) Change in margin may not be exactly equal to total yield less cost trend.

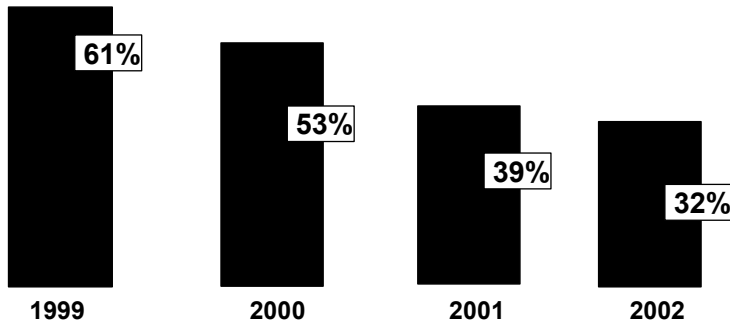
Despite premium increases of 4.8% and benefit reductions valued at 6.5%, plans are increasing M+C operating margins by a narrow 1.0%.

MCOs are using a number of different tactics to reduce costs and reallocate revenue streams in their M+C plans.

In order to maintain or achieve profitability in Medicare + Choice, MCOs are adjusting their M+C offerings in several ways. As recently as 1999, 61% of Medicare beneficiaries could enroll in a zero premium plan (Figure 7). For 2002, that number has been nearly halved to 32%. Between the inception of premiums for some plans, and increases to existing premiums for others, M+C members, on average, will potentially see an increase in their premium of 45% if they remain in their current plan (Figure 8). In addition to premium increases, MCOs are instituting much higher-cost sharing amounts. Figure 9 illustrates that the average increase in out-of-pocket cost sharing has increased 79%. MCOs are also reducing the additional benefits that traditional Medicare does not cover, such as prescription drug coverage. Figure 10 shows the decline in plans with any drug coverage. Figure 11 shows that some M+C MCOs (25% of them), while maintaining drug coverage, are covering only generic drugs beginning in 2002.

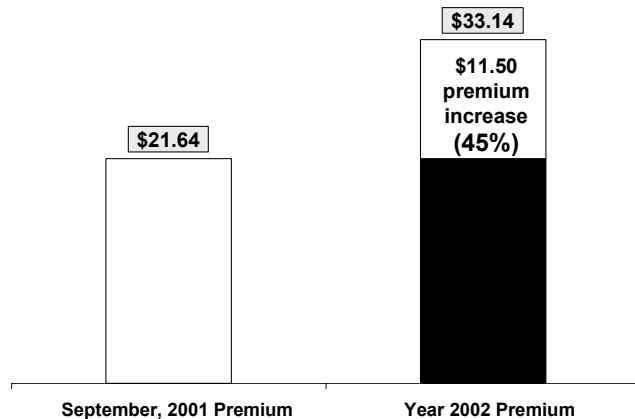
For those MCOs with few or no measures left to save or reallocate costs, the next alternative is to completely withdraw M+C coverage from a market. Figure 12 tracks the decline in Medicare beneficiaries who have access to M+C plans.

**Figure 7: Population with Access to Zero Premium M+C Plans**



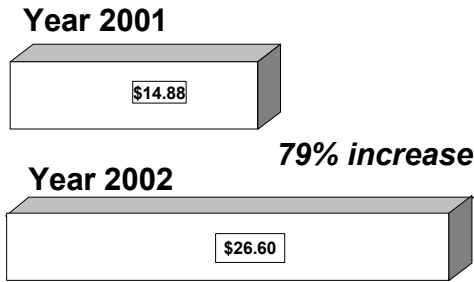
Source: CMS

**Figure 8: Premium Change**



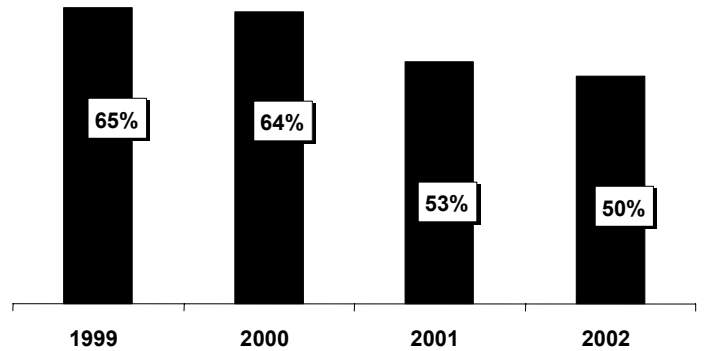
Source: CMS

**Figure 9: Out-of-Pocket Cost Sharing for Medicare-Covered Services, Per Enrollee Per Month**



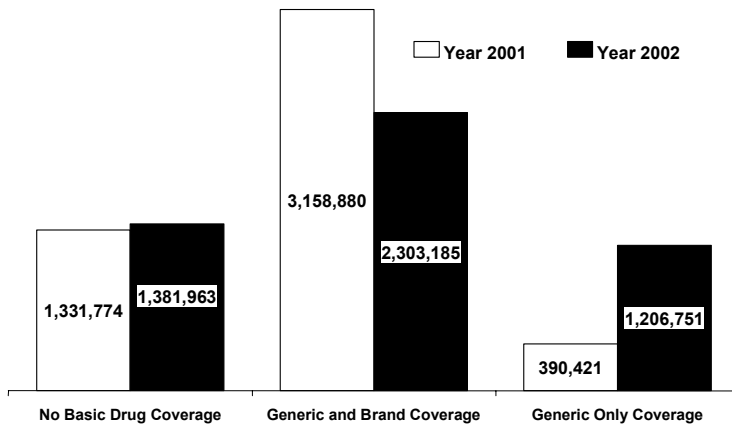
Source: CMS

**Figure 10: Access to Any M+C Plan with Drug Coverage**



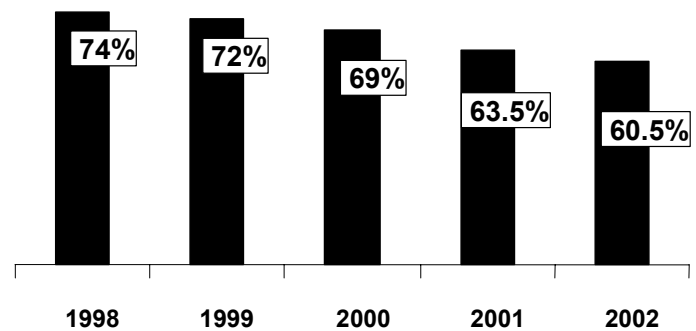
Source: MedPAC analysis of Medicare Compare data for 1999 through 2001; CMS analysis of ACR data for 2002. Includes any type of plan (basic or high option) covering drugs.

**Figure 11: Enrollment by Type of Drug Coverage**



Source: CMS estimates

**Figure 12: Population with Access to at Least One M+C Plan**



Source: CMS

**Three of the seven MCOs in the Goldman Sachs study, Aetna, Oxford, and PacifiCare, are expected to lose money in M+C for 2001 and 2002.**

As the Goldman analysis shows (Figure 4), managed care plans, on average, are forecasted to have operating incomes of 0.3% in 2001 and 1.3% in 2002. Three of the seven MCOs are expected to lose money in M+C for 2001 and 2002 (Aetna, Oxford, and PacifiCare). The 1.0% improvement from 2001 to 2002 is attributed to future market exits and reductions in benefits to the Medicare beneficiary. Goldman’s Boorady notes:

“Margin improvement in 2002 is a positive, but not enough to give us confidence in the viability of the Medicare HMO business as it is currently structured and funded. We remain negative unless we see evidence that major pro-business reforms can pass congress, which we think is an unlikely prospect in the near term.”

Roberta Goodman of Merrill Lynch concurs. She believes that M+C, “...will remain financially problematic until and unless the payment formula is adjusted to match underlying medical cost trends.” Goodman does not anticipate near-term relief to M+C, due to the events of September 11<sup>th</sup> and the weakening economy, and believes that margins will remain pressured.



**Consumer behavior is driving the commercial managed care market from the “closed-panel” HMO to the more open POS and PPO models, M+C Plans are usually “closed panel”**

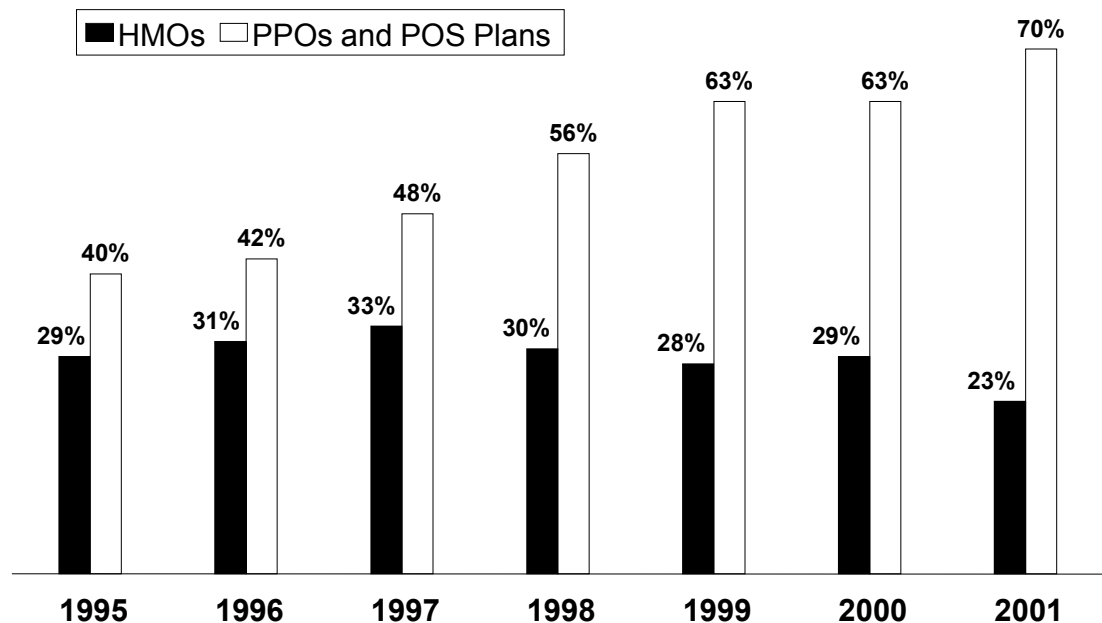
In the non-Medicare, under-65 commercial market, consumers are moving to plans with open and flexible networks in a backlash against restrictive closed panel HMOs. Point of service (POS) and preferred provider organization (PPO) plans offer the choices and access to health care that consumers desire. This trend can be thought of as a move away from the HMO model and toward a “managed indemnity” model. The POS and PPO versions of managed indemnity are looser and more costly than HMOs—contributing to increasing medical inflation.

Medicare beneficiaries increasingly want hybrid plans like they had with their employers—PPO or POS plans that combine benefit “freedom” with some of the cost containment of managed care. Most M+C plans are closed panel in calendar year 2001, less than 15% of M+C counties had POS plans offered and only two MCOs offered PPOs. Independence Blue Cross in Pennsylvania offered a PPO plan, and it lost money.

Medicare beneficiaries want more choice, but these hybrid plans generally cost 10% more than “closed panel” HMOs in the commercial market, or have significantly higher-cost sharing. These two trends, (i) a desire for more flexibility among consumers and (ii) double digit cost growth among the existing M+C “closed panel” HMOs, are irreconcilable under the current program structure.

Figure 13 illustrates the trend into higher-cost PPO and POS plans in the commercial market. These higher-cost plans have helped to drive the increases in medical costs in the market.

**Figure 13: Shares of Employer Group Market in HMOs Versus PPOs and POS Plans, 1995-2001**



Sources: KPMG Peat Marwick for 1995-1999, and successor survey, Kaiser/HRET for 2000 and 2001 (as reported in Kaiser/HRET "Health Benefits in 2001")

## Summary

The managed care business is currently *very* healthy in commercial markets, and has significantly improved in recent years, though it is largely due to large price increases. The current Medicare market, however, is anemic for MCOs, and the plans that were heavily engaged in Medicare have fared the worst with investors. Wall Street pressure is driving M+C MCOs to exit selected markets, and almost every major plan has done so.

If the trend for M+C—large scale disenrollment—is to be reversed, it will require a combination of more consistent funding and more flexible program design.