UC Berkeley

UC Berkeley Previously Published Works

Title

The Commercial Health Insurance Industry In An Era Of Eroding Employer Coverage

Permalink

<https://escholarship.org/uc/item/5k7393hg>

Journal

Health Affairs, 25(6)

ISSN

0278-2715 1544-5208

Author

Robinson, James C

Publication Date

2006-11-01

DOI

10.1377/hlthaff.25.6.1475

Peer reviewed

The Commercial Health Insurance Industry In An Era Of Eroding Employer Coverage

New types of public-private arrangements are emerging to boost the prospects for private U.S. insurers.

by **James C. Robinson**

ABSTRACT: This paper analyzes the commercial health insurance industry in an era of weakening employer commitment to providing coverage and strengthening interest by public programs to offer coverage through private plans. It documents the willingness of the industry to accept erosion of employment-based enrollment rather than to sacrifice earnings, the movement of Medicaid beneficiaries into managed care, and the distribution of market shares in the employment-based, Medicaid, and Medicare markets. The profitability of the commercial health insurance industry, exceptionally strong over the past five years, will henceforth be linked to the budgetary cycles and political fluctuations of state and federal governments. [*Health Affairs* 25, no. 6 (2006): 1475–1486; 10.1377/hlthaff.25.6.1475]

HEALTH INSURANCE IN THE UNITED STATES is characterized no longer by a basic split between public and private sponsorship but, rather, by the large scale and broad scope of the firms that serve all categories of individuals, groups, and public beneficiaries. Diversification into public programs permits private industry to continue growing despite the erosion of employment-based coverage and, of equal importance, limits its exposure to pressure from any one purchaser. The “single-payer” structure of state Medicaid programs no longer constitutes an insurmountable barrier to investor-owned firms, as they can enter and exit particular states based on changes in payment rates and medical costs. The structure of the new Medicare prescription drug benefit (Part D), which offers coverage only to beneficiaries who enroll in private plans, moves the commercial health insurance industry from Medicare’s margins to its mainstream.

This paper analyzes the commercial health insurance industry in an era of weakening employer commitment to providing coverage and strengthening interest by public programs to offer coverage through private plans. It documents the industry’s willingness to accept erosion of employment-based enrollment rather than to sacrifice earnings; the movement of Medicaid beneficiaries into managed

Jamie Robinson (james.robinson@berkeley.edu) is the Kaiser Permanente Distinguished Professor of Health Economics, School of Public Health, at the University of California, Berkeley.

care; and the distribution of market shares in the employment-based, Medicaid, and Medicare markets. The same cost increases that are driving employers out of the private health insurance market are driving public programs into that market, accelerating the growth and consolidation of the industry. The profitability of the commercial health insurance industry, exceptionally strong over the past five years, will henceforth be linked to the budgetary cycles and political fluctuations of state and federal governments.

Changing Patterns Of Insurance Sponsorship: 1994–2004

Employment-based coverage (excluding the elderly with retiree coverage) peaked in 2000 at 164.4 million—62 percent of the nonelderly population—and fell by almost five million in the subsequent four years (Exhibit 1).¹ Individual purchasing of health benefits declined during the 1990s but has risen by one million since 2001, absorbing some of those leaving employment-based coverage.

Despite the recent erosion of employment-based coverage, the commercial health insurance industry has enjoyed an unprecedented period of financial performance. The major investor-owned firms and the nonprofit Blue Cross and Blue Shield plans have continuously raised premiums ahead of claims costs, reducing medical cost ratios and expanding operating margins and overall earnings.² These price increases have generated sizable shifts in enrollment among the major companies: Aetna and CIGNA have accepted major customer losses to regain profitability, while UnitedHealth Group, WellPoint, and most of the nonprofit Blues have enjoyed growth in both enrollment and premium revenues.

These changes in performance reflect a changed self-understanding of the health insurance industry as a mature sector where earnings growth rather than enrollment growth is the primary metric of success. Wall Street fostered and has celebrated this change in focus. Exhibit 2 presents the stock price index for pub-

EXHIBIT 1

Trends In Employment-Based And Individual Insurance Coverage, Millions Of People, 1994–2004

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
U.S. population											
Total	262.1	264.3	266.8	269.1	271.7	276.8	279.5	282.1	285.9	288.3	291.2
Nonelderly	230.8	232.7	234.9	237.0	239.4	240.7	244.8	247.5	250.8	253.6	255.9
Employment-based											
Total	159.5	161.1	163.0	164.9	168.2	175.1	177.8	176.6	175.3	174.0	174.2
Nonelderly	148.4	150.0	152.0	153.9	157.1	160.3	164.4	162.3	161.0	159.7	159.5
Individually purchased											
Total	31.3	30.2	28.3	27.2	25.9	27.4	26.5	26.1	26.6	26.5	27.0
Nonelderly	17.3	16.8	16.9	16.6	16.3	16.6	16.1	16.4	16.8	17.0	17.4

SOURCES: C. DeNavas-Walt, B.D. Proctor, and C.H. Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Reports no. P60-229 (Washington: U.S. Government Printing Office, 2005); and Employee Benefit Research Institute analyses of data from the Current Population Survey, March 1994–2005 Supplements.

EXHIBIT 2**Monthly Percentage Change In Health Insurance Stock Price Index, 1996–2006**

SOURCE: Lehman Brothers Global Equity Analysis.

licly traded health insurance firms over the past two decades, highlighting the dismal performance of the sector (relative to the broad Standard and Poor's [S&P] 500 index) during the managed care era in the late 1990s and the subsequent run-up in prices from 2000 through 2005. These changes in stock prices were particularly dramatic for firms such as Aetna that proved their willingness to raise prices in the face of enrollment declines and, after passage of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, for firms such as United and Humana that have substantial prospects in the Medicare sector.³ Many firms suffered a reversal of equity pricing trends in the first half of 2006.

■ **Threats to the industry.** The commercial insurance industry's continued financial success is threatened by three related trends in the employment-based sector. First and most obviously, the industry remains reliant on employment-based business for the majority of its overall earnings, and individual firms may fight to retain that business to the point of moderating premium increases relative to underlying cost trends. This price competition, already evident in surveys of 2006 pricing yields, would reestablish the "underwriting cycle" that has characterized the private health insurance industry, both for-profit and nonprofit, for several decades.⁴ The cyclical pattern of pricing and earnings results in part from difficulties insurers experience in predicting medical cost trends, and hence in setting premium prices; however, it also reflects their proclivity to shave prices during periods when earnings per enrollee are exceptionally high and growth is exceptionally profitable.

The second, and related, challenge to the industry comes from the nonprofit structure of the Blues plans, which have accrued financial reserves far in excess of mandated minimums and now face regulatory pressure to offer premium relief.⁵ The slowdown in premium increases by these plans inexorably drives their inves-

tor-owned competitors toward pricing moderation, in turn reducing profit margin per enrollee and overall earnings.

The third, and more slowly evolving, challenge stems from the gradual shift in product mix from insured to self-insured funding and from comprehensive to high-deductible benefit designs. Self-insured business and thin benefit designs reduce insurers' exposure to medical cost growth (shifting risk from insurers back to insureds) and reduce potential profitability per enrollee. Insurers' earnings per enrollee for self-insured (administrative services only, or ASO) business are one-third the level for insured members, while earnings per enrollee in high-deductible plans are 30 percent lower than in comprehensive plans.⁶

■ **Industry response: consolidation.** The erosion in employment-based coverage and the enrollment losses that normally would have resulted from aggressive premium increases have been offset, for the major health insurance firms, by extensive consolidation of the industry.⁷ During the heyday of managed care, from 1980 through 2000, the industry experienced extensive creation of new health plans, sponsored by medical groups, hospital systems, employers, labor unions, consumer cooperatives, and other entities. The traditional Blue Cross and indemnity insurers lost substantial market share to the new entrants. Over time, however, the best-managed firms, some of which were upstart health maintenance organizations (HMOs) and others of which were renovated Blue Cross and commercial indemnity carriers, demonstrated their ability to grow market share and to absorb weaker competitors. Most of the regional HMOs that had converted to for-profit status have been acquired, as have many of the nonprofit health plans sponsored by hospitals and other provider organizations. The industry now comprises four national plans (United, WellPoint, Aetna, and CIGNA); state-specific Blue Cross and Blue Shield plans; a few regional for-profit plans (such as Humana, HealthNet, and Coventry); and, in some markets, regional nonprofit plans (such as Kaiser Permanente, Tufts Health Plan, and HealthPartners).

WellPoint and United each hold 14 percent shares of the national market, with much higher concentrations in specific geographic markets and customer segments (for example, multistate employers), while the nonprofit Blue plans control one-third of the overall market (with local market shares above 65 percent in some states) (Exhibit 3). The other major investor-owned plans retain 17 percent of the overall market but may experience further consolidation. The principal nonregional non-Blue plans, such as Kaiser Permanente, cover 9 percent, while third-party administrators (TPAs) for self-insured firms retain 12 percent.⁸

Shrinking employment-based enrollment, a dwindling supply of acquisition targets, and the specter of renewed price competition are driving the commercial industry toward diversification. Medicaid and Medicare represent the only segments of the health insurance world that are growing. Each is fraught with business and political risks for the industry, which retains uncomfortable memories of earlier incursions into the public sector, but there is no alternative.

EXHIBIT 3**Market Shares For Employment-Based And Individually Purchased Health Insurance, 2005**

SOURCE: M. Borsch, D. Miller, and A. Herman, *U.S. Managed Care Industry Outlook* (New York: Goldman Sachs Global Investment Research, 13 January 2006), Appendix B: "An In-Depth Look at Commercial Enrollment."

NOTES: Includes self-insured (administrative services only, or ASO) as well as insured employment-based coverage. TPA is third-party administrator (for self-insured employers). Excludes people age sixty-five and older. Total enrollment: 178.6 million.

Medicaid Managed Care

Medicaid represents a growth opportunity for private health insurers, as a result of the rise in overall program enrollment and the continuing efforts by many states to outsource management and financial risk. But the basic structure of Medicaid creates strong challenges, with a single purchaser in each state that holds private plans to payment rates below those available for employment-based insurance programs. The history of private plans' involvement in Medicaid has been contentious, leaving bruised feelings on both sides, as states have alternated between increasing payments to attract new entry and cutting payments in response to budgetary deficits.⁹ Many commercial plans entered the Medicaid market in the early 1990s but exited by the end of the decade, leaving the sector in the hands of public fee-for-service (FFS) programs and local provider-sponsored HMOs. By the beginning of the current decade, however, the continued escalation of costs and poor financial performance of many local plans had renewed mutual interest between state Medicaid agencies and the commercial insurance sector.¹⁰

Managed care continues to grow both in absolute size and in percentage terms as overall Medicaid eligibility expands (Exhibit 4).¹¹ Of the forty-five million Americans enrolled in Medicaid in 2004, twenty-seven million (60.7 percent) were in some form of managed care, up from eight million (23.2 percent) a decade ago. Managed care in Medicaid is not purely the domain of comprehensive health plans but includes "primary care case management," where the role of insurers is severely limited. Moreover, much of the enrollment in comprehensive plans remains with small provider-sponsored HMOs, many of which are struggling in the context of low payments, rising medical costs, and difficulties in financing investments in information technology (IT). Approximately nineteen million Medicaid beneficiaries are enrolled in HMOs that transfer to private plans the financial re-

EXHIBIT 4 Managed Care Enrollment In Medicaid, 1991–2004

SOURCE: Centers for Medicare and Medicaid Services, "Medicaid Managed Care Enrollment Reports, 1991–2004," http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp (accessed 11 August 2006).

NOTES: Bars denote Medicaid managed care and total Medicaid enrollees, and they relate to the left-hand y axis. The line denotes Medicaid managed care enrollees as a percentage of all managed care enrollees, and it relates to the right-hand y axis.

sponsibility for managing primary, specialty, and hospital services.

Small HMOs represent acquisition opportunities and have attracted specialized, investor-owned insurers whose principal business model is to acquire, renovate, and expand Medicaid plans across multiple states. Centene, Amerigroup, Molina, and WellCare have been capitalized since 2000 and have grown through acquisitions of provider-sponsored plans, the Medicaid enrollment of Blue plans, and bidding for participation when states open new beneficiary categories to managed care.¹² They now account for 18 percent of Medicaid managed care enrollment nationwide. The financial success of these investor-owned Medicaid plans has stimulated interest among the national insurers, whose core business has been in employment-based benefits. The two largest carriers, United and WellPoint, have created subsidiaries dedicated to Medicaid, developing special networks and programs to accommodate the low payment rates, limited physician participation, diverse languages, and clinical needs of Medicaid and other state-sponsored programs. Some regional insurers, including Humana and HealthNet, are very active in Medicaid managed care, while CIGNA, Aetna, and many Blue plans remain cautious.

Exhibit 5 presents the market shares for Medicaid managed care across the diversified and the specialized commercial insurers, the nonprofit Blue plans, and the local provider-sponsored plans. Attention is restricted to full-service HMOs, to the exclusion of more limited programs that do not transfer financial risk to insurers. The specialized commercial plans have grown from zero in 2000 to 3.5 million enrollees in 2005, constituting 18 percent of the Medicaid HMO market. Blue Cross and Blue Shield plans retain 8 percent of Medicaid HMO enrollment, but few evince enthusiasm for the sector. The largest single share of enrollment remains with the provider-sponsored HMOs, which hold 53 percent but which are

EXHIBIT 5**Health Maintenance Organization (HMO) Plans' Market Shares In Medicaid, 2005**

SOURCES: United, Humana, and other diversified investor-owned health plan enrollment figures were obtained from company documents (primarily SEC 10-K forms). Data for WellPoint were obtained directly from the firm (John Monahan, president, WellPoint State-Sponsored Programs, personal communication, June 2006). Enrollment data for specialized investor-owned plans were obtained from M. Borsch, A. Herman, and D. Miller, *Medicaid Managed Care: Growing Pains and Growth Opportunities* (New York: Goldman Sachs Global Investment Research, 9 June 2006). Nonprofit Blue Cross figures were adopted from S. Agha-Kahn, S. Navovicz-Peat, and I.F. Barnor, *Managed Medicare and Medicaid Factbook 2006* (Washington: Atlantic Information Services, 2006), after subtracting enrollment in Blue and non-Blue (Unicare) plans owned by WellPoint. Total Medicaid HMO enrollment figures were estimated based on the *Managed Medicare and Medicaid Factbook*, after subtracting out primary care case management enrollment.

NOTE: Total enrollment: 18.8 million.

steadily selling out to investor-owned plans. WellPoint, United, and Humana together represent 17 percent of the sector, with other diversified investor-owned carriers (such as HealthNet and Coventry) accounting for 6 percent.

The consolidation of Medicaid managed care plans by multistate carriers will accelerate to the extent that state agencies view them as financially solvent and committed to the sector. Stability among insurers is a virtue for Medicaid regulators with unhappy memories of cleaning up after health plan bankruptcies. Public programs also perceive virtue in having national plans that offer pharmacy benefit management, disease management, and other specialty services. In the short run, the proliferation of investor-financed specialized plans and the heightened interest among the diversified national carriers permit state agencies to put their programs out to bid for those willing to accept low payment rates and detailed performance requirements. However, the continuing consolidation of the Medicaid managed care sector will reduce the number of competitors and may force states to maintain payment rates at levels that retain private plans in their programs. Diversified, multistate plans have proved themselves willing to exit particular markets if they cannot obtain an adequate return on their invested capital. The Medicaid managed care sector may stabilize into an equilibrium where the “single-payer” ability of each state Medicaid program unilaterally to set payment rates is balanced by the ability of private health plans to exit and focus activity elsewhere.

The Medicare Modernization Act

Medicare offers the greatest opportunity for and poses the greatest challenge to the commercial health insurance industry. The aging baby-boom generation is expected to increase enrollment from forty-three million in 2005 to fifty-three million in 2015 and then to seventy-eight million in 2030. With spending per beneficiary almost three times higher than for people with employment-based coverage, Medicare offers revenue gains on a scale that cannot be matched elsewhere in the economy.¹³ The history of private plans' participation in Medicare has been volatile for many of the same reasons afflicting Medicaid plans, with cycles of overpayment, plan entry, and enrollment expansion followed by underpayment, plan exit, and enrollment declines.¹⁴ MMA created a new upswing in the Medicare managed care cycle, legislating additional payments to drug-specific and full-service health plans. Depending on the sustainability of the federal payment levels and the industry's response to the new environment, MMA could either accelerate the privatization of a quintessentially public program or generate a financial debacle for the industry that dwarfs the effects of the Balanced Budget Act (BBA) of 1997.¹⁵

MMA authorized the creation of freestanding prescription drug plans (PDPs) for beneficiaries enrolled in FFS Medicare and expanded funding for the full-service Medicare Advantage with prescription drug (MA-PD) products.¹⁶ It also offered a partial subsidy for employment-based retiree health plans and mandated the transfer of dual eligibles from Medicaid to private PDPs. MMA's implementation has been plagued with administrative difficulties, permitting wildly divergent predictions concerning enrollment patterns. During the first open enrollment period, up through 15 May 2006, thirty-eight million beneficiaries, representing 90 percent of those eligible, gained coverage in either a PDP, MA-PD plan, retiree program, or other governmental program (for example, military).¹⁷

MMA has attracted numerous entrants into the Medicare prescription drug plan market, as pharmacy benefit managers (PBMs, such as Medco and Caremark) and retail pharmacy chains have rushed in.¹⁸ Bidding and price competition for enrollment has been fierce, resulting in a windfall for Medicare beneficiaries, whose premiums are lower than anticipated, but generating speculation about below-cost pricing and an eventual market shakeout. Specialized for-profit plans such as WellCare, HealthSpring, and Universal American have entered the capital markets; nonprofit Blue Cross and provider-sponsored plans have expanded their offerings; and full-service insurers have renewed their involvement in what seemed a moribund business sector. The commercial plans with traditionally large Medicare enrollment, including Humana and HealthNet, have offered new products in new geographic markets, while commercial plans such as United, WellPoint, and Aetna, which had dropped most of their Medicare enrollment after the BBA, now offer HMO products in selected areas and preferred provider organization (PPO) products on regional and national levels.¹⁹

Exhibit 6 presents the distribution of enrollment and market shares in the com-

EXHIBIT 6
Market Shares In Private Medicare Plans, 2006

SOURCE: *Drug Benefit News* 7, no. 9 (2006): 4.

NOTES: Total enrollment: 19.5 million. PBM is pharmacy benefit manager.

combined PDP and MA-PD Medicare market as of April 2006, highlighting the strong role played by the diversified full-service insurers such as United, Humana, and WellPoint but also the continued presence of nonprofit entities in some states and specialized PDP entities nationally.²⁰ Total enrollment was almost twenty million (13.8 million PDP, 5.9 million MA-PD), excluding Medicare beneficiaries covered through retiree programs, those in federal employment and military programs, and those not electing any coverage for prescription drugs. Because of its acquisition of PacifiCare and marketing alliance with AARP, UnitedHealth Group is the dominant player, with almost five million enrollees and a 26 percent market share. Humana has focused on the MA-PD and PDP opportunity, with 3.2 million enrollees and a 17 percent market share; it now derives three-quarters of its earnings from Medicare and has been losing enrollment in the employment-based sector.²¹ WellPoint and the other investor-owned insurers, such as HealthNet and Coventry, account for 22 percent, nonprofit plans (principally Kaiser Permanente and several Blue Cross plans) account for 12 percent, and PBMs and pharmacy chains account for 10 percent.

The consolidation of the Medicare sector is already beginning, evidenced most graphically in United's acquisition of PacifiCare. The short-term potential lies with local provider-sponsored plans, which in 2005 had a combined enrollment of 1.7 million.²² Limits to consolidation will come from nonprofit Blue plans, from Kaiser Permanente, and from selected regional HMOs. In the short term, growth in overall enrollment and entry by new plans will continue to generate competition on the basis of lower premiums and richer benefits. This price competition, more than direct mergers and acquisitions, may serve as the proximate cause for consolidation, by driving out PBMs and pharmacy chains that cannot shift enrollment from low-margin PDPs to high-margin MA-PD products.

The greatest future challenge to commercial participation in Medicare is the same as the greatest past challenge: the fluctuating commitment of the Centers for

Medicare and Medicaid Services (CMS). The contemporary land rush is driven by the Bush administration's dedication to expanding enrollment as part of a larger effort to reduce federal regulatory purview. However, the fat years of generous payments easily could be followed by lean years of payment cuts, as federal budget deficits compete for resources and insurers' robust profits attract attention. Optimists and pessimists with respect to the MMA business opportunity mainly are distinguished by the year in which they predict cutbacks, rather than by any difference in opinion as to whether cutbacks will occur.

Concluding Comments

The contemporary erosion of private employment-based coverage and expansion of public programs could have been expected to reduce the role of the commercial health insurance industry as an intermediary between the purchasers and providers of care. Instead of retrenching, however, the commercial sector is diversifying into Medicaid and Medicare and consolidating into firms that serve the full range of public and private purchasers. The interest among private insurers in serving public programs is reciprocated by the interest among public programs in outsourcing the management of their coverage benefits, provider networks, and enrollee expectations to private health plans. State and federal coverage sponsors increasingly lack the will to navigate the conflicting claims for resources between beneficiaries, taxpayers, and other stakeholders. They seek someone else to perform that inevitably thankless task.

Privatization is well under way in the Medicaid sector, where state budgetary pressures have generated a rapid conversion to managed care and, within managed care, to the multistate commercial insurers. While budgetary pressures will continue to tempt Medicaid programs to cut payment rates, states are reluctant to see the commercial carriers depart and relinquish enrollment back to sometimes-unstable provider-sponsored plans. Over time the sector could reach political and market equilibrium with continuous participation by commercial plans that earn a sustainable, if not exciting, profit margin and with state agencies that interpret their role as purchasers of health insurance rather than of health care itself.

The role of commercial health plans in the Medicare sector is far less developed than in Medicaid, and future trends are necessarily speculative. Medicare does not face severe budgetary pressures for another half-decade, at which point the baby-boom generation will become eligible for coverage. The contemporary efforts at outsourcing program management to the private sector stem from philosophical rather than financial sources. Advocates of private-sector involvement believe that the purchasing of health services, and the inherent trade-offs thereby required, are best performed through market contracting rather than governmental regulation.

The Bush administration has demonstrated its affinity for this vision by generously funding the Medicare Advantage program and, especially, by restricting coverage for prescription drugs to those beneficiaries who enroll in a private PDP or

MA-PD plan. This approach contrasts with the structure of Medicare prior to MMA, where private insurers competed at the margins but most beneficiaries remained with the publicly administered FFS program. Under MMA, there is no publicly administered drug coverage, no fall-back from the private plans. Beneficiaries can remain with the public program for their physician and hospital coverage, but both the industry and the CMS see the enrollment shift from limited PDP plans to comprehensive MA-PD plans as the means by which to greatly reduce the scale of the residual FFS program.

ALTHOUGH IT APPEARS SAFE TO PREDICT continued enrollment growth in the commercial health insurance industry, the earnings prospects for the sector are far from assured. The run-up in industry profits, now in an unprecedented sixth year, has raised the bar of earnings targets high and makes it easier to predict financial compression than expansion for the sector. Stock prices suffered a sharp pullback in the first half of 2006 under fears that the potential revenue and earnings from Medicare, while large on a per enrollee basis, were not sufficient on an aggregate basis to offset the erosion of enrollment and earnings in employment-based enrollment.

For the moment, however, most of the trend lines continue to point upward. Americans are moving from employment-based to public coverage, but public programs are eager to outsource to the private sector the difficult task of managing care. The industry's core strategy has been growth through diversification across purchasers, products, and markets. Health insurance increasingly is bought by public programs but sold by private firms that have grown to a scale and scope unimaginable in the once-fragmented world of health care finance.

.....
This research was supported by the California Healthcare Foundation.

NOTES

1. An additional 8.2 million nonelderly people receive coverage through the military and related federal services.
2. R. Cunningham and D.B. Sherlock, "Bounceback: Blues Thrive as Markets Cool toward HMOs," *Health Affairs* 21, no. 1 (2002): 24–38; J.C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 11–24; and D.B. Sherlock, "A Banner Year for the Blues," *Blues Dashboard for Blue Financial Management* (Gwynedd, Pa.: Sherlock Company, December 2004).
3. J.C. Robinson, "From Managed Care to Consumer Health Insurance: The Fall and Rise of Aetna," *Health Affairs* 23, no. 2 (2004): 43–55; and J.R. Raskin, *Health Care, Managed Care 2006 Outlook: It's Good to Be Big* (New York: Lehman Brothers Global Equity Research, 6 January 2006).
4. The average premium growth rate, measured in six annual surveys (Lehman Brothers, Hewitt, Milliman, Towers Perrin, Sewal, and Kaiser Family Foundation), declined from 14.0 percent to 10.2 percent between 2002 and 2006. Raskin, *Health Care, Managed Care 2006 Outlook*. For insight into the underwriting cycle in insured commercial business, see J.M. Grossman and P.B. Ginsburg, "As the Health Insurance Underwriting Cycle Turns: What Next?" *Health Affairs* 23, no. 6 (2004): 91–102.
5. M. Borsch and A. Herman, *Too Much Profit at the Not-for-Profit Blues* (New York: Goldman Sachs Global Investment Research, 16 December 2005); and M. Borsch, D. Miller, and A. Herman, *Early Signs of a Slowdown in Managed Care* (New York: Goldman Sachs, 24 April 2006).
6. The percentage earnings margin is much higher for self-insured than for insured business, but dollar reve-

- nues per enrollee are much lower. The earnings margin for consumer-directed plans is estimated to be similar to that for comprehensive plans, but annual revenues per enrollee are lower because much of the cost of care is paid directly by enrollees because of the deductible provision. C. Boorady, L.A. Hubbard, and S.C. Morena, *United States Managed Care: The Medicare Industrial Complex* (New York: Citigroup Equity Research, 8 June 2006).
7. Robinson, "Consolidation and the Transformation of Competition"; and American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2005 Update* (Chicago: AMA, 2005).
 8. The "other nonprofit" category is dominated by Kaiser Permanente, Intermountain, Tufts, Harvard-Pilgrim, Group Health Puget Sound, HealthPartners, HIP, GHI, Medica, and Health Alliance.
 9. R.E. Hurley and S.A. Somers, "Medicaid and Managed Care: A Lasting Relationship?" *Health Affairs* 22, no. 1 (2003): 77–88.
 10. G. Nersessian et al., *Medicaid Industry Guidebook* (New York: Lehman Brothers, 1 December 2003).
 11. Centers for Medicare and Medicaid Services, "Medicaid Managed Care Enrollment Reports, 1991–2004," http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp (accessed 11 August 2006). These data include the limited "primary care case management" programs as well as comprehensive managed care plans.
 12. G. Nersessian and J.R. Raskin, *Health Care—Managed Care: Medicaid Outlook 2006* (New York: Lehman Brothers, 13 January 2006); and M. Borsch, A. Herman, and D. Miller, *Managed Care: Medicaid Managed Care* (New York: Goldman Sachs, 9 June 2006).
 13. C. DeNavas-Walt, B.D. Proctor, and C.H. Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Reports no. P60-229 (Washington: U.S. Government Printing Office, 2005). Medicare Advantage revenues per enrollee averaged \$12,000 in 2005, compared with \$4,500 per commercial insurance enrollee. Boorady et al., *United States Managed Care*.
 14. M. Gold, "Private Plans in Medicare: Another Look," *Health Affairs* 24, no. 5 (2005): 1302–1310.
 15. M. Gold, "Can Managed Care and Competition Control Medicare Costs?" *Health Affairs* 22 (2003): w176–w188 (published online 2 April 2003; 10.1377/hlthaff.w3.176).
 16. P.B. Bach and M.B. McClellan, "A Prescription for a Modern Medicare Program," *New England Journal of Medicine* 353, no. 26 (2005): 2733–2735; R.L. Kravitz and S. Chang, "Promise and Perils for Patients and Physicians," *New England Journal of Medicine* 353, no. 26 (2005): 2735–2739; R.A. Elliott et al., "Benefits and Consequences for the Poor and Disabled," *New England Journal of Medicine* 353, no. 26 (2005): 2739–2741; and Henry J. Kaiser Family Foundation, *Medicare Chart Book 2005*, 3d ed., Summer 2005, <http://www.kff.org/medicare/7284.cfm> (accessed 11 August 2006).
 17. C. Boorady and A. Helman, *Managed Care: Final Medicare Part D Enrollment over 38 Million* (New York: Citigroup Equity Research, 8 June 2006).
 18. M. Gold, *The Growth of Private Plans in Medicare*, 2006, Issue Brief, March 2006, <http://www.kff.org/medicare/7473.cfm>; and M. Gold, *The Landscape of Private Firms Offering Medicare Prescription Drug Coverage in 2006*, Issue Brief, March 2006, <http://www.kff.org/medicare/7474.cfm> (both accessed 11 August 2006).
 19. J.R. Raskin, *Health Care, Managed Care Industry Overview: PDP Signed, Scaled, Waiting for Delivery* (New York: Lehman Brothers, 26 September 2005); M. Borsch, D. Miller, and A. Herman, *Managed Care United States: An Update on Medicare Advantage* (New York: Goldman Sachs, 30 March 2006); and Boorady et al., *United States Managed Care*.
 20. *Drug Benefit News* 7, no. 6 (2006): 4. Original data are from CMS, "Part D Enrollment Data," 27 July 2006, http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp (accessed 11 August 2006).
 21. M. Borsch, D. Miller, and A. Herman, *A Tougher Road Ahead for Managed Care Stocks* (New York: Goldman Sachs, 13 January 2006).
 22. This 1.7 million enrollment figure excludes Medicare enrollment in nonprofit Blue Cross plans, Kaiser Permanente, and plans with fewer than 10,000 enrollees. J.R. Raskin, G.K. Nersessian, and S. James, *Medicare Managed Care: Markets and Share* (New York: Lehman Brothers, 26 October 2005).