THE HENRY J. KAISER FAMILY FOUNDATION

Market*Facts*

THE KAISER CHANGING HEALTH CARE MARKETPLACE PROJECT

March 1999

A Financial Overview of the Managed Care Industry

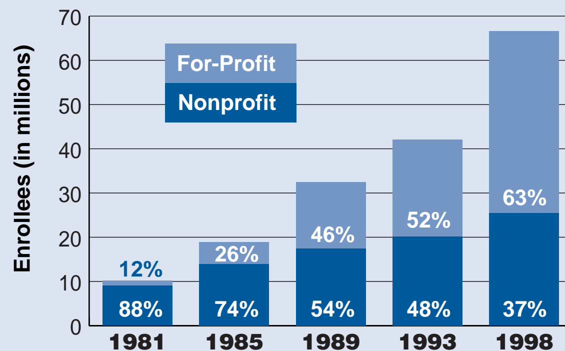
The rapid growth of managed care has brought with it a growing connection between the stock market and health care organizations. Health care services have evolved from being delivered by physicians and tax-exempt institutions to a market-driven industry attracting investment capital from numerous sources. The market capitalization, or total stock value, of the relatively young HMO industry grew from a little over $3 billion in 1987 to almost $39 billion in 1997—an almost twelve-fold increase—while the stock market as a whole grew about four-fold to a total of $10.5 trillion. However, recent health plan earnings and premium announcements indicating companies' difficulties in managing medical costs have led some equity analysts and investors to question whether these health sector stocks will offer growth potential in the future. And, financial difficulties in the HMO industry may have important implications for health policy debates that are increasingly connected to the practices and potential of private health plans.

The Growing Influence of For-Profit Organizations

The increased corporate influence in health care is especially evident in the growing prevalence of for-profit companies within the HMO sector. Between 1981 and January 1998, for-profit HMOs grew from representing 12% to 63% of total HMO enrollees, and from 18% to 74% of plans (InterStudy). Among hospitals, on the other hand, for-profit companies have increased their role, but nonprofit organizations continue to dominate the industry. Between 1980 and 1996, for-profit companies grew from representing 9% to 13% of community hospital beds (American Hospital Association).

The growing role of for-profit companies in the HMO and hospital sectors has resulted from a combination of the emergence and growth of for-profit companies, as well as conversion of not-for-profit companies to for-profit status. One outcome of these conversions is the establishment of charitable foundations designed to preserve the charitable missions and assets of the formerly not-for-profit organizations. As of February 1999, there were at least 109 conversion foundations in the U.S., with assets totaling about $13 billion. Health plan conversions represented the source of only 11 of the foundations, but these foundations hold almost half of the total assets (Grantmakers in Health).

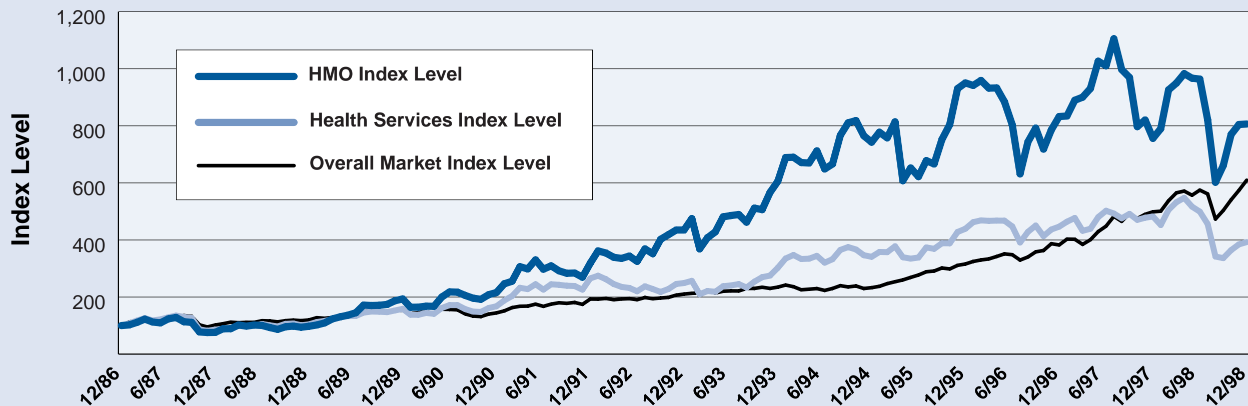
Distribution of HMO Enrollment by Ownership Status, 1981-Jan.1998



Source: InterStudy

KAISER FAMILY FOUNDATION 2400 Sand Hill Road • Menlo Park, CA 94025
(650) 854-9400 • fax (650) 854-4800 • www.kff.org

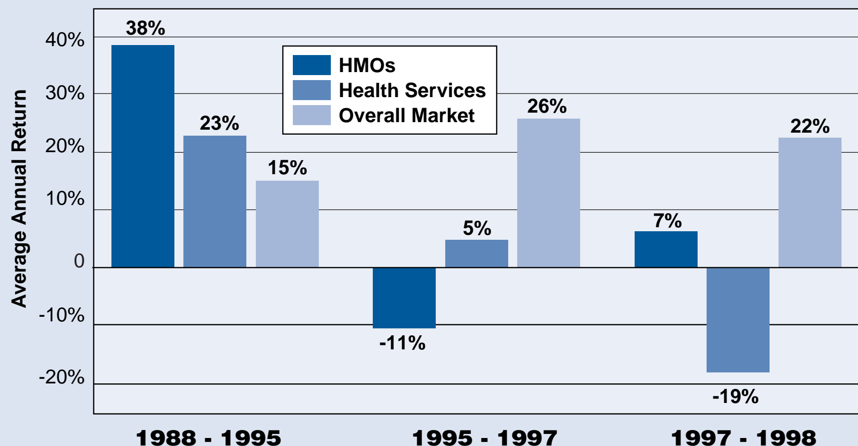
Stock Price Performance of HMOs, Health Services, and Overall Stock Market, 1987-1998



Source: Prepared for the Kaiser Family Foundation by CRSP, University of Chicago. Used with permission. All rights reserved.

Stock Trends

Average Annual Returns of HMO, Health Services, and Overall Market Stocks



Source: Prepared for the Kaiser Family Foundation by CRSP, University of Chicago. Used with permission. All rights reserved.

Many for-profit health care companies have tapped the stock market for financing. According to an analysis prepared for the Kaiser Family Foundation by Securities Data Company, there were 233 initial public offerings (IPOs) of stock of health companies between 1987 and 1997.

The total stock value (or market capitalization) of publicly traded health services and HMO companies has increased dramatically over the past decade. Total market capitalization of HMOs grew from $3.3 billion in January 1987 to $38.9 billion as of the end of November 1997, an almost twelve-fold increase. For companies classifying themselves as health services (including hospitals and nursing homes), capitalization grew from $16.3 billion to $112.7 billion over the same time frame. In comparison, the overall stock market grew a little over four-fold during this time period. Wall Street's growing interest and role in health care companies is also evidenced by the increased number of investment analysts following health care stocks—from 152 in 1987 to 559 in 1997, according to Nelson's Directory of Investment Research.

Over the last decade, HMO stocks generally out-performed the market as a whole, although they experienced periods of significant price declines, most recently between July and September 1998. In contrast, health services companies tracked just somewhat above the market through much of the decade until 1998, when health services fell below the market. Recently, average annual returns for health services and HMO companies have suffered relative to the overall market. Using a University of Chicago index developed for the Kaiser Family Foundation that measures the market-weighted return of stocks, a 1987 investment of $100 in the market as a whole would

have grown to $610 by the end of 1998. In comparison, an investment of $100 in HMOs would have grown to $807, while a similar investment in helath services companies would have increased to only $393. In 1998, HMOs performed a bit better than in the previous couple of years – with average stock prices rising 7% over the course of the year compared to a drop of 11% from 1995 to 1997 – but health services companies did quite a bit worse in 1998 and saw stock values fall by 19%. Many anticipate that slow recovery will continue for HMOs in 1999, but not to historic levels of stock price growth.

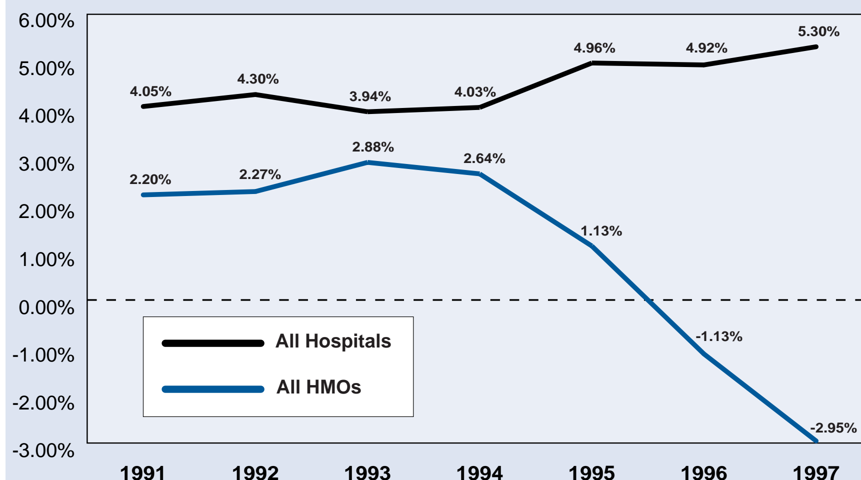
Recent HMO Activity

After 6 years of steady growth, HMO profits declined in 1994, 1995, and 1996; in 1997, nearly 60 percent of HMOs lost money (Weiss Ratings). Although HMO net income plunged from 1994 through 1997, HMO enrollments were up 72% and total revenues rose 77% over that period (Best's Aggregates & Averages — HMO, 1998). At the same time, health services companies have grown increasingly profitable throughout the 1990s.

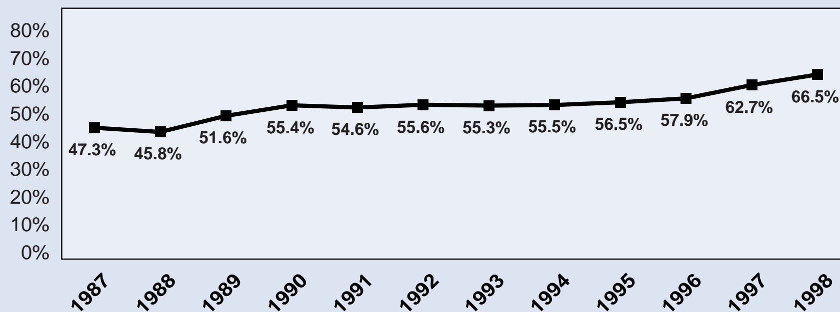
While underlying health care costs have continued to grow – especially for prescription drugs – plans competing for market share have until recently sought to hold premium levels down. HMO premium increases moderated throughout the early 1990s, and the rates charged to large employers actually declined by 0.4% in 1996. Since then, premiums charged to large firms have increased 2.0% in 1997 and 2.9% in 1998 (KPMG Peat Marwick). Most analysts now expect premiums to escalate, with one study predicting increases of 6-9% in 1999 (Hewitt Associates).

In part due to recent premium increases, some plans — including PacifiCare, Wellpoint, and United HealthCare — are now reporting positive balance sheets. However, other plans are continuing to report significant losses. For example, Kaiser Permanente, one of the nation's largest and most visible HMOs, lost $288 million in 1998 (or 2.8 percent of operating revenues), on top of a loss of $266 million in 1997 (3.2 percent of operating revenues). Kaiser attributes 1998 losses to increases in the cost of care from pharmacy and hospital services, and the use of non-Kaiser Permanente health facilities.

Responding in large part to financial pressures and to payment reforms in the Balanced Budget Act of 1997, plans have pulled back from some markets, especially in the Medicare program. For 1999, nearly 100 HMOs either reduced their service areas or terminated their contracts with Medicare, affecting more than 400,000 beneficiaries (nearly 7% of Medicare HMO enrollees). The reasons cited by HMOs for the withdrawals were the inadequacy of Medicare's payment rates and the regulatory burden of participating in Medicare, including increased requirements for consumer protections.



Mergers and acquisitions have been another feature of HMO activity in recent years. The proportion of HMO enrollees in the 10 largest national managed care firms — one indicator of market concentration — has grown rapidly recently after remaining steady at about 55% for a number of years, rising to 67% in January 1998 (InterStudy). Major mergers in the industry include Aetna's purchase of U.S. Healthcare in 1996 and CIGNA's acquisition of Healthsource in 1997. More recently, Aetna announced that it will buy Prudential for $1 billion. This deal has been criticized by such organizations as the



American Medical Association and is under review by federal and state regulatory agencies. Mergers may put a strain on an HMO's financial results, in part because of the difficulties of integrating the businesses acquired. Concerns have also been raised about the resulting domination of a small number of HMOs in certain geographic markets, the impact on providers' ability to negotiate payment rates and resulting impact on treatment time and options, and patient fears that provider networks will be disrupted. At the same time, mergers can lower costs through economies of scale and increased purchasing leverage by plans.

Issues

Do recent stock price declines signal a shift in prospects for the managed care industry? Many investors were drawn to managed care companies as growth stocks that would achieve success by meeting the rapidly growing demand for lower-cost managed care products, as well as the potential to increase efficiency. Now, over three-quarters of those with employment-based health insurance are enrolled in some type of managed care plan, so potential further growth in that segment of the market is limited. Overall, enrollment growth has been especially visible in open-access products, but there are uncertainties regarding the ability of these plans to control costs.

How will rising premiums affect insurance coverage? While premium increases may help to restore the financial health of HMOs, such increases also impact the cost of health care for employers and enrollees. Small businesses (who are least likely to offer coverage) and lower income individuals (who are most likely to be uninsured) are particularly vulnerable to cost increases. The number of uninsured has continued in recent years to rise by more than one million a year, even in a period of unprecedented economic prosperity and moderate growth in health insurance premiums. Rising premiums can only increase the already large number of people uninsured.

Would the passage of consumer protection legislation affect the financial viability of HMOs? Consumer protection legislation has been introduced in Congress and in many states. What would be the impact of provisions such as mandating external review programs, "prudent layperson" payment requirements for emergency care, and health plan liability? Some estimates suggest that the cost of these and other provisions could be large, but independent analyses by the Congressional Budget Office and Coopers & Lybrand (prepared for the Kaiser Family Foundation) point to a more modest cost impact.

For more information, visit the Foundation's web site at www.kff.org or call the publication request line at (800) 656-4533.

What is the future of HMOs in Medicare? Despite plan withdrawals for 1999, HMOs are expected to cover an increasing proportion of beneficiaries. With future pressure to lower federal payments to plans, will HMOs continue to find this market attractive and provide expanded benefits such as prescription drugs?

How do market pressures affect quality of care? It is not clear whether profit status matters in the quality of care that is delivered, or whether, in the near future, we will have reliable measures to judge quality across not-for-profit and for-profit organizations. Market incentives have been both credited for eliminating unnecessary care and blamed for forcing providers to skimp on quality and quantity of care.

The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.