



# TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE, 2002

CHARTBOOK MAY 2002



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IN THE CHANGING HEALTH  
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## Introduction

The Kaiser Family Foundation – through its Changing Health Care Marketplace Project – sponsors research and analysis on trends in the marketplace, particularly as they affect vulnerable groups like the poor and the elderly, and on policy proposals that involve the private health care system. There have been striking changes in the health care marketplace in the last few years. Some of these changes build on historic trends; others depart, sometimes dramatically, from prior expectations about how the marketplace would evolve. *Trends and Indicators in the Changing Health Care Marketplace, 2002* (May 2002) presents information on key trends in the health care marketplace of interest to policymakers, public interest groups, the media, and industry analysts and leaders. This chartbook updates many of the exhibits included in an earlier report, *Trends and Indicators in the Changing Health Care Marketplace* (August 1998).

Although managed care remains the dominant form of coverage for those with employment-based insurance, there has been a clear shift in its character. Enrollment has declined in Health Maintenance Organizations (HMOs), which typically use tight care management approaches, while increasing rapidly in Preferred Provider Organizations (PPOs), typically characterized by looser care management and more provider choice.

Two distinct forces likely contributed to this movement to looser forms of managed care. The first was the public backlash against managed care, illustrated by striking increases in the number and scope of state consumer protection laws. The second was the continuation, up until the late 1990s, of an extended phase of relatively modest health care inflation.

However, health care costs are now rising dramatically. Reversing prior trends, U.S. health spending growth has accelerated since 1998. Health insurance premiums have charted a similar course, increasing sharply from 1996 to 2001. The upswing in health inflation, generally, and premium costs, in particular, is expected to continue, fueled in part by increases in prescription drug spending.

Medical errors in health care delivery have been another recent focus for policy debate. Although no comprehensive plan to address the problem has emerged, the issue highlights the ongoing discussion over the appropriate role for government in monitoring and shaping the health care marketplace and health services delivery.

Although the proportion of Americans without health insurance has slightly decreased in the last two years as a result of record economic prosperity, this decline is not likely to continue as the economy slows down and health care costs rise. Despite these recent declines, almost one-fifth of non-elderly Americans lacked health insurance coverage in 2000.

A few key changes and trends, drawn from the chartbook, are highlighted below:

### Health Spending

- The U.S. spent \$1.3 trillion on health care in 2000, representing 13.2% of the Gross Domestic Product. About one-third of this spending was for hospital care (32%), over one-fifth for physician services (22%), and almost ten percent for prescription drugs (9%) (Exhibits 1.1 and 1.5).
- Although not the largest category of health services spending, prescription drug spending is the fastest rising. From 1995 to 2000, drug spending increases were two to five times larger than spending increases for hospital care and physician services. In 2000, drug spending increased by 17%, compared to 5% for hospital care and 6% for physician services (Exhibit 4.7).
- Driven by increases in Medicaid expenditures – due in large part to rising drug costs as well as increases in coverage – the share of personal health spending contributed by public sources increased from 39% to 43% from 1990 to 2000 (Exhibit 1.8).

### Health Insurance Enrollment

- In 2000, about two-thirds of the non-elderly (67%) were covered by employment-based insurance, one-tenth (10%) were enrolled in Medicaid, and almost one-fifth (16%) were uninsured (Exhibit 2.1).
- Of those with employment-based insurance, the share with PPO coverage increased from 28% in 1996 to 48% in 2001, while the proportion enrolled in HMOs declined from 31% to 23% in the same period (Exhibit 2.2).

### Health Insurance Premiums and Costs

- Following years of more modest private sector premium growth (premiums grew 4.8% in 1999 and 8.3% in 2000), premiums for employer-sponsored coverage increased 11.0% in 2001, resulting in an average annual premium of \$2,650 for single coverage and \$7,053 for family coverage (Exhibits 3.1 and 3.3).

### Health Benefits

- More than three-quarters (77%) of the non-elderly population had prescription drug coverage in 1996, mostly provided by employers. Seventy-three percent of Medicare beneficiaries had prescription drug coverage in 1998 (Exhibit 4.5).

### Structure of the Health Care Marketplace

- One of the most striking recent changes in the health care marketplace has been the increase in for-profit managed care. The proportion of HMO enrollees in for-profit plans increased from 12% in 1981 to 64% in 2000, though there has been little change recently as fewer non-profit plans convert to for-profit status (Exhibit 5.10).
- Another important shift has been the decline in the proportion of physicians practicing independently. From 1983 to 1999 the percent of physicians who were self-employed in solo practice declined from 41% to 26% (Exhibit 5.9).

### Health Plan and Provider Relationships

- While hospital and physician participation in managed care has grown significantly in the last 10 years, the use of capitation has grown less as rapidly. About one-third of physicians (35% in 1999) and one-third of hospitals (35% in 2000) have capitated contracts with managed care plans (Exhibits 6.2 and 6.7).

### Consumers and the Safety Net

- The uninsured are much more likely than the insured to have problems accessing health care services. In 2000, 39% of the uninsured reported postponing care, 36% had no regular source of care, and 20% reported not getting medical care for a serious condition (Exhibit 7.3).

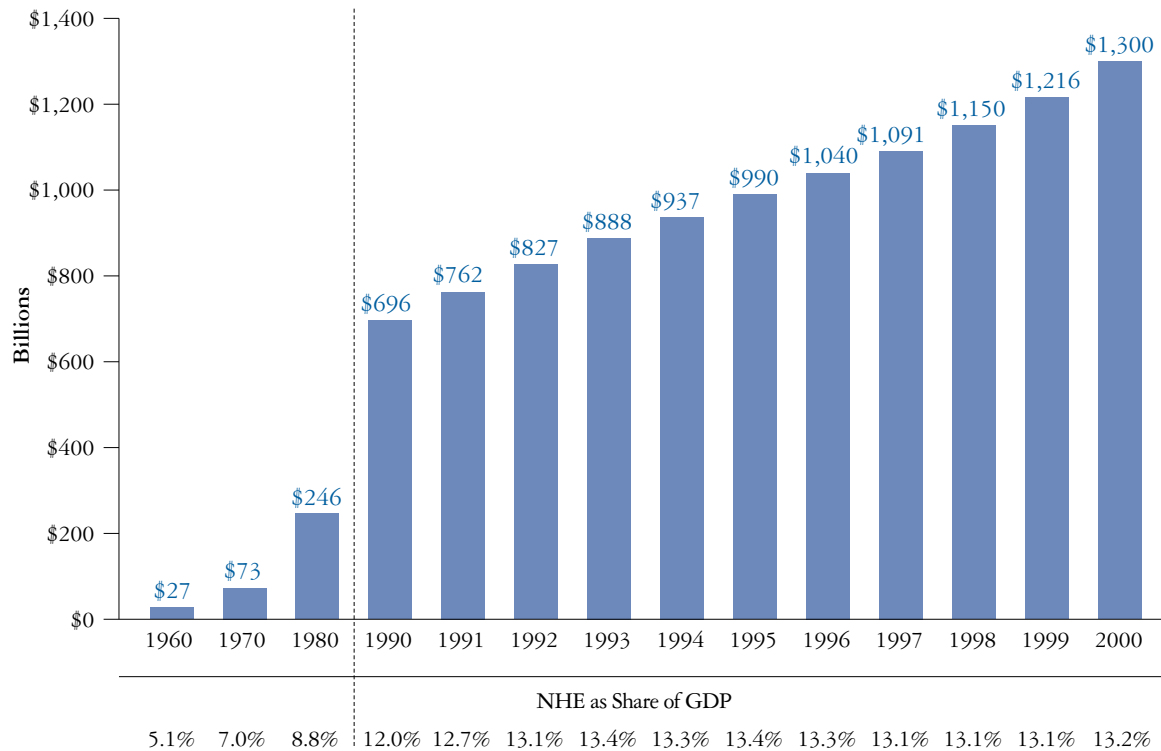
# OVERVIEW OF HEALTH SPENDING



EXHIBIT 1.1

## National Health Expenditures and Their Share of Gross Domestic Product, 1960–2000

Expenditures in the U.S. on health care have increased 87% since 1990, and are more than 5 times the amount spent in 1980. The \$1.3 trillion in national health expenditures (NHE) in 2000 represents 13.2% of the Gross Domestic Product (GDP), more than 8 percentile points higher than the industry's share in 1960. More than half of this increase occurred from 1980 to 1992, when the share rose from just under 9% to 13.1%. Since 1993, the health care share of the GDP has remained remarkably constant with a modest decline in 1997, and a small increase in 2000.

**SOURCE:**

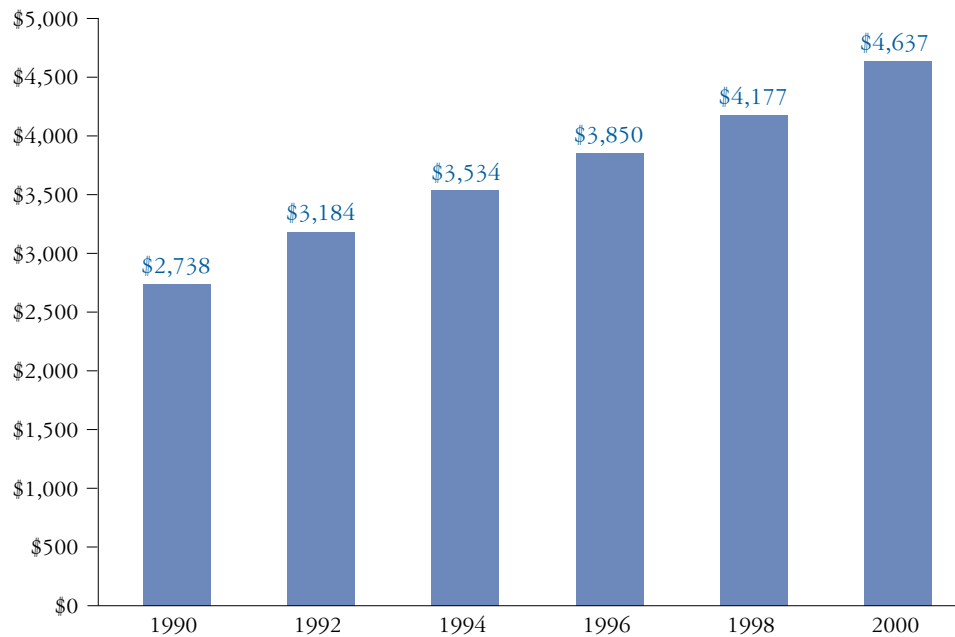
Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. CMS web site, 2000 National Health Care Expenditures Data Files for Downloading, nhegdpo0.csv, at [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/).



## EXHIBIT 1.2

## National Health Expenditures per Capita, 1990–2000

U.S. health expenditures per capita were \$4,637 in 2000, a 69% increase from \$2,738 in 1990.

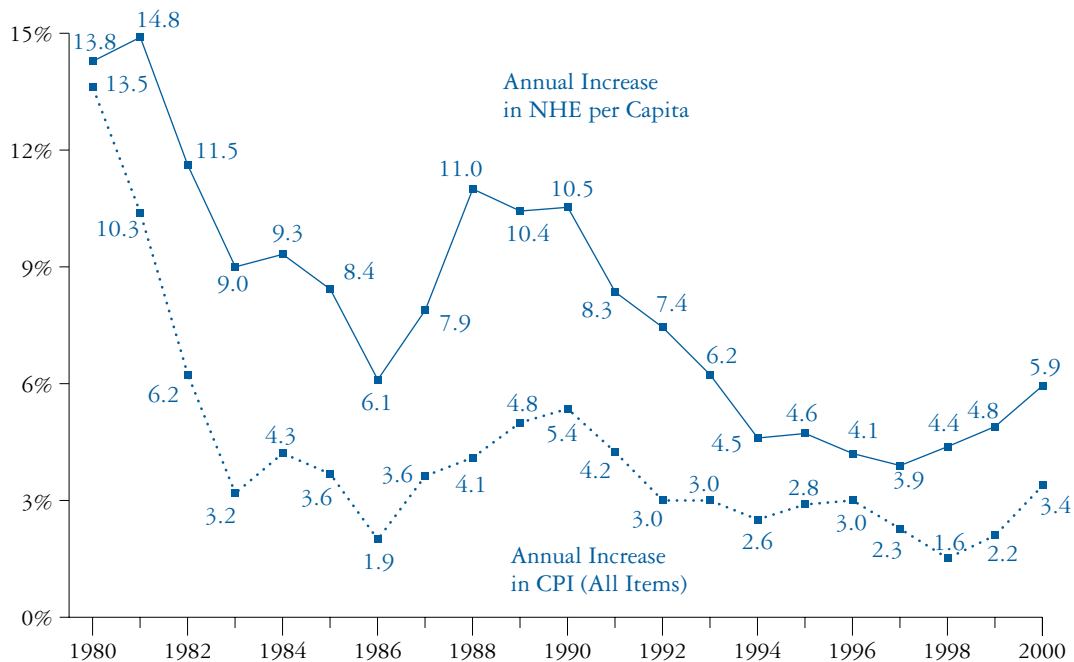
**SOURCE:**

Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. Authors' calculations of data on CMS web site, 2000 National Health Care Expenditures Data Files for Downloading, nhegdpo0.csv, at [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/).

EXHIBIT 1.3

## Percent Annual Increase in National Health Expenditures (NHE) per Capita vs. Increase in Consumer Price Index (CPI), 1980–2000

Growth in U.S. health spending per capita remained under 5% from 1994 through 1999. Although it outpaced overall inflation by one to three percentile points each year during this period, health spending growth tracked more closely to inflation in the late 1990s than it had in the 1980s and early 1990s, periods of rapid growth for health care. Health spending is now accelerating again, increasing almost 6% in 2000.

**NOTES:**

The CPI is for all urban consumers (CPI-U), all items.

**SOURCE:**

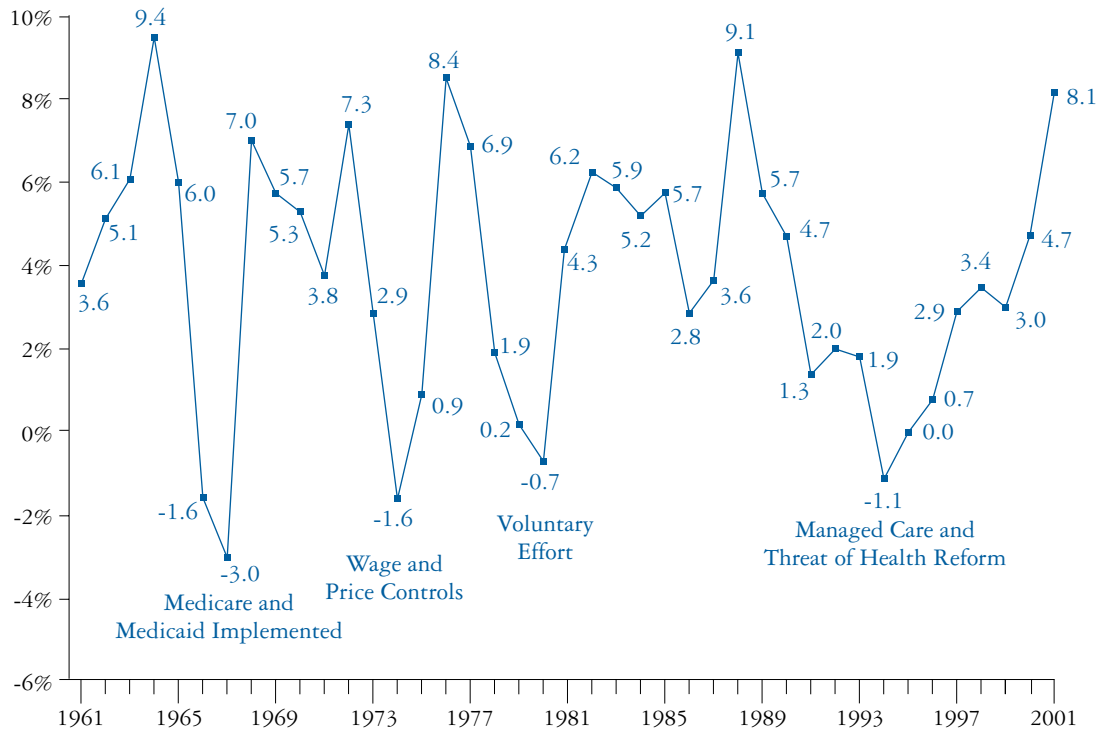
Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. Authors' calculations of data on CMS web site, 2000 National Health Care Expenditures Data Files for Downloading, nhegdpo0.csv, at [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/).

1980–2000 CPI from Bureau of Labor Statistics, Consumer Price Index, All Urban Consumers, (February 2, 2002). BLS web site at [ftp://ftp.bls.gov/pub/special.requests/cpi/cpiat.txt](http://ftp.bls.gov/pub/special.requests/cpi/cpiat.txt).

EXHIBIT 1.4

## Annual Change in Private Health Spending per Capita (Adjusted for Inflation), 1961–2001

There have been repeated upward and downward cycles in the growth rate of private health spending over the last forty years. In this period, public and private efforts to rein in accelerating costs through wage and price controls, voluntary hospital cost containment, and most recently through managed care and the threat of health reform, have triggered sharp declines in private spending growth. But these periods of decline have always proven temporary and have been followed by rapid growth in costs.

**SOURCE:**

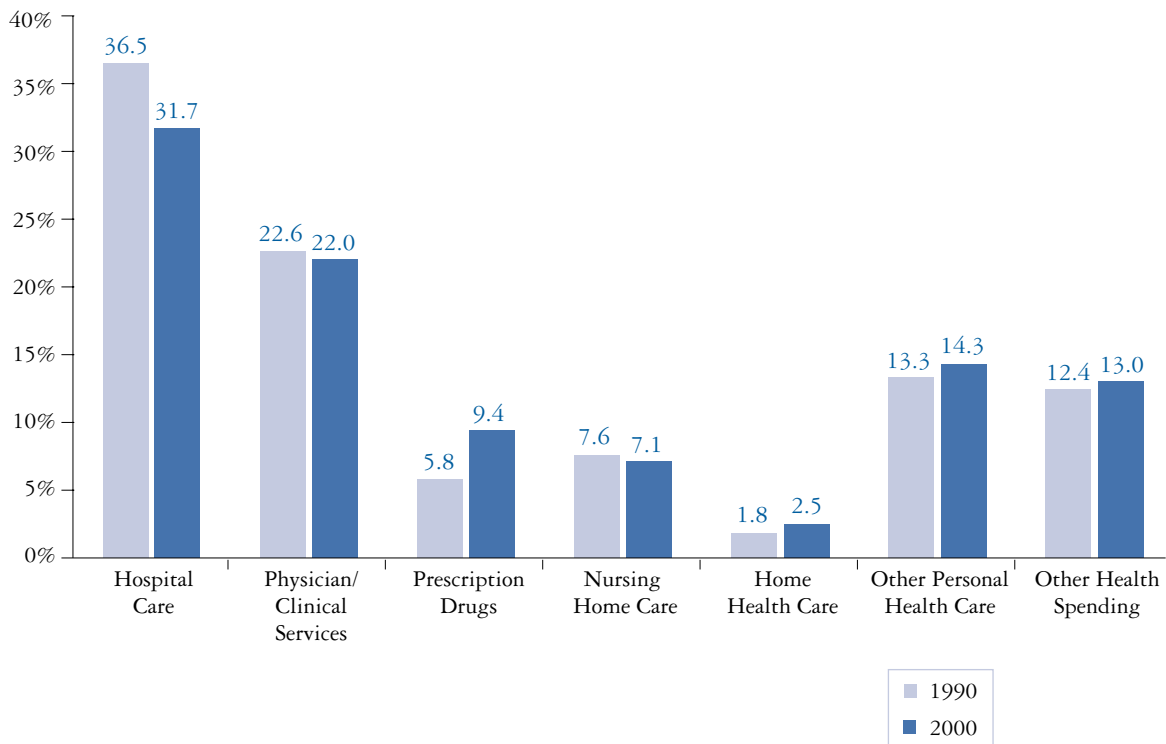
"The Sad History Of Health Care Cost Containment As Told In One Chart" *Health Affairs*, web exclusive at [www.healthaffairs.org](http://www.healthaffairs.org), Jan. 23, 2002.

Private health expenditures per capita 1960–99 from the Centers for Medicaid and Medicare Services (CMS), at [www.hcfa.gov](http://www.hcfa.gov). Change in private spending per capita for 2000 and 2001 is estimated based on average premium increases for employer-sponsored coverage from Kaiser/HRET Survey of Employer-Sponsored Health Benefits at [www.kff.org](http://www.kff.org). Real change in spending is calculated using CPI-U all items, average annual change for 1961–2000 and July to July change for 2001, U.S. Department of Labor, Bureau of Labor Statistics, at [www.bls.gov](http://www.bls.gov).

## EXHIBIT 1.5

## Distribution of National Health Expenditures, by Type of Service, 1990 and 2000

While remaining the largest contributors to spending on health services overall, the proportion of national health expenditures devoted to physician and clinical services and hospital care declined from 1990 to 2000. In the same period, the share spent on prescription drugs increased by over half to 9.4% of U.S. health spending.

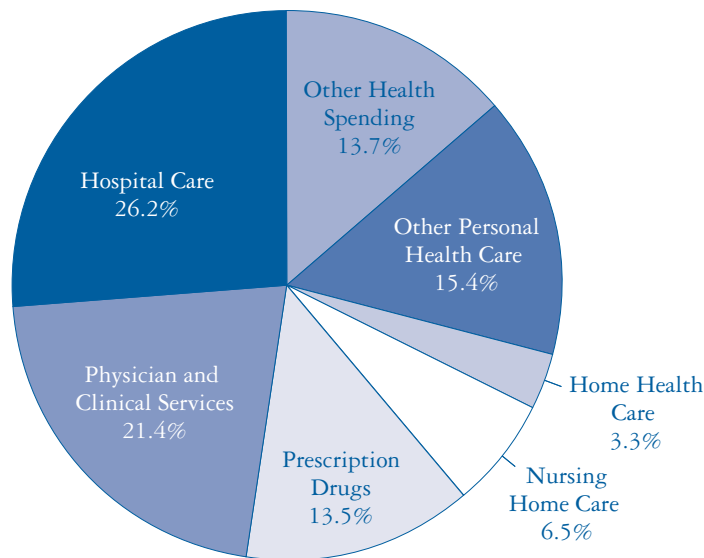
**SOURCE:**

Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. Authors' calculations of data on CMS web site, 2000 National Health Care Expenditures Tables, Table 2, at [www.hcfa.gov/stats/nhe-oact/tables/t2.htm](http://www.hcfa.gov/stats/nhe-oact/tables/t2.htm).

## EXHIBIT 1.6

## Relative Contributions of Different Types of Health Services to Total Growth in Health Expenditures, 1990–2000

Hospital care and physician services each contributed about one-quarter of the total growth in health expenditures between 1990 and 2000. Prescription drugs contributed 13.5% of the total spending growth during this period, although drug expenditures made up only 9.4% of total spending in 2000.

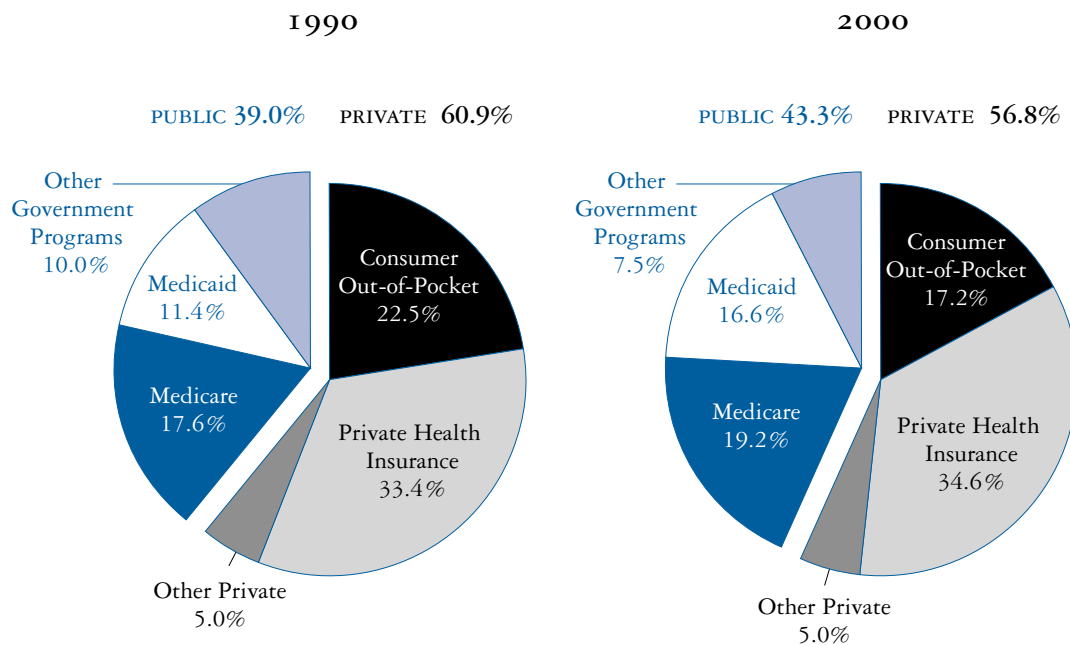
**SOURCE:**

Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. Authors' calculations of data on CMS web site, 2000 National Health Care Expenditures Tables, Table 2, at [www.hcfa.gov/stats/nhe-oact/tables/t2.htm](http://www.hcfa.gov/stats/nhe-oact/tables/t2.htm).

EXHIBIT 1.7

## Distribution of Personal Health Care Expenditures, by Source of Payment, 1990 and 2000

A variety of funding sources contribute to U.S. personal health care expenditures (that is, spending for health services), and their relative shares have shifted noticeably over time. Consumer out-of-pocket costs per capita rose from \$540 in 1990 to \$694 in 2000, but declined over the decade as a percent of overall personal health spending (from 22.5% to 17.2%) and as a percent of personal income (from 3.8% to 3.1%). Private expenditures declined from 61% to 57% of personal health expenditures over the last ten years. Meanwhile, Medicaid's growing role pushed up the overall share of public sources from 39% to 43%. Medicare and private health insurance shares increased slightly.

**NOTES:**

The percentages may not sum to 100% due to rounding. Personal health care expenditures exclude government administration, net cost of insurance, government public health activities, research, and construction.

**SOURCE:**

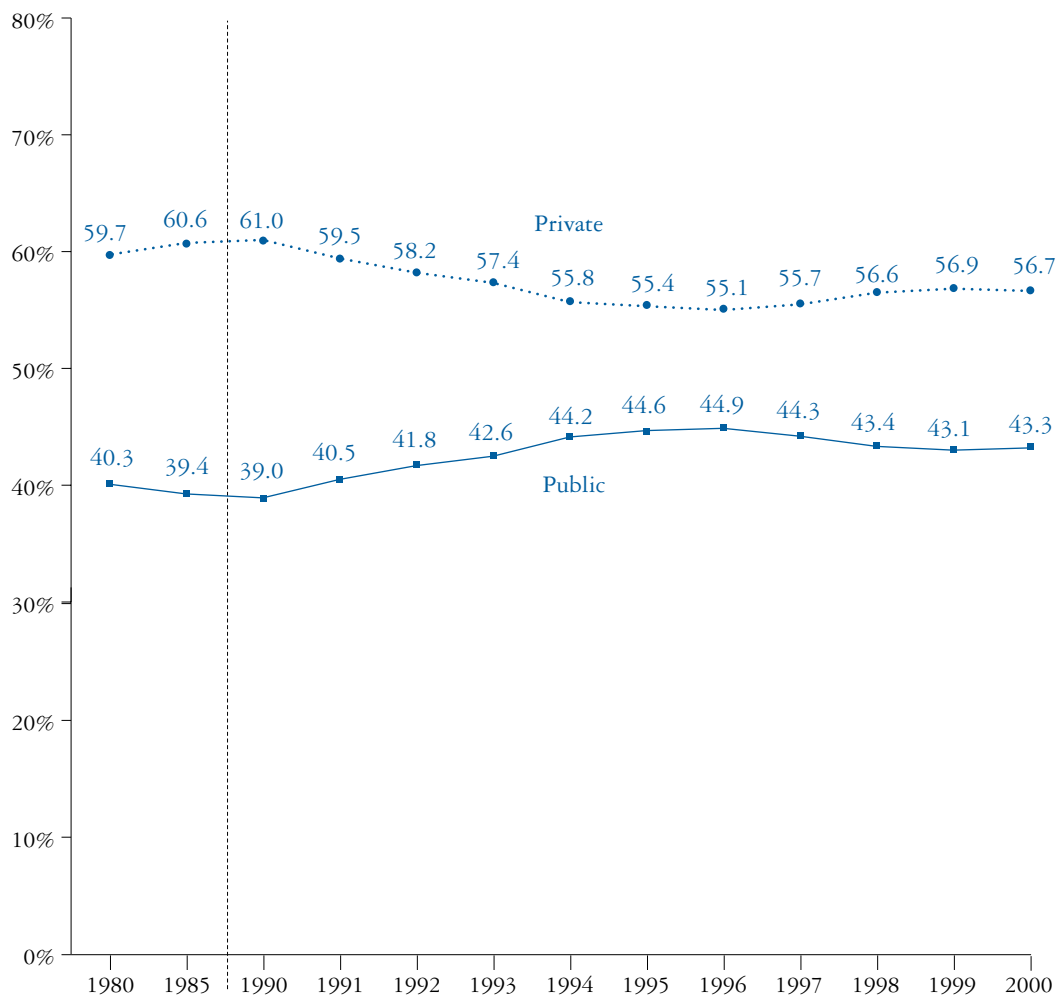
Expenditure data from Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. Authors' calculations of data on CMS web site, 2000 National Health Care Expenditures Tables, Table 4, at [www.hcfa.gov/stats/nhe-oact/tables/t4.htm](http://www.hcfa.gov/stats/nhe-oact/tables/t4.htm).

Income data from the Current Population Survey, Historical Income Tables – People (Table P-1), on the U.S. Census Bureau web site at [www.census.gov/hhes/income/histinc/po1.html](http://www.census.gov/hhes/income/histinc/po1.html).

EXHIBIT 1.8

## Trend in Personal Health Expenditures, by Source of Payment, 1980–2000

After a period of steady but slow decline from 1988 to 1996, the private sector's share of personal health expenditures (including health services, but excluding research, construction, profits, and certain administrative costs) increased somewhat in recent years, reaching 56.7% of health spending in 2000.

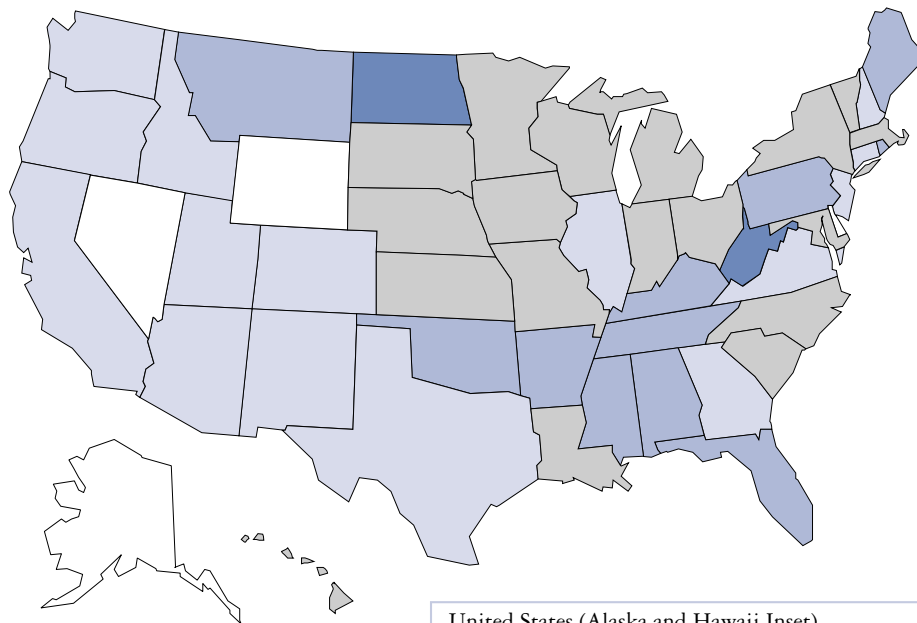
**SOURCE:**

Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. Authors' calculations of data on CMS web site, 2000 National Health Care Expenditures Data Files for Downloading, nhe00.csv, at [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/).

## EXHIBIT 1.9

## Personal Health Care Expenditures as Share of Gross State Product, by State, 1997

Spending on personal health care services averaged 12.2% of the Gross State Product (GSP) across the states in 1997, and ranged from a low of 7.5% in Wyoming to a high of 17.5% in West Virginia, with considerable regional variation. Health spending as a share of GSP in Western and Southwestern states is on the low end of the spectrum, while spending is highest in the South Central area. Factors such as economic output, the demographics of the population, provider supply, practice patterns, and spending on public coverage contribute to differences.



United States (Alaska and Hawaii Inset)  
Personal Health Care Expenditures' Share of GSP

- 15.6% to 17.5% (2 States)
- 13.6% to 15.5% (11 States)
- 11.6% to 13.5% (18 States)
- 9.6% to 11.5% (15 States)
- 7.5% to 9.5% (4 States and DC)

**NOTES:**

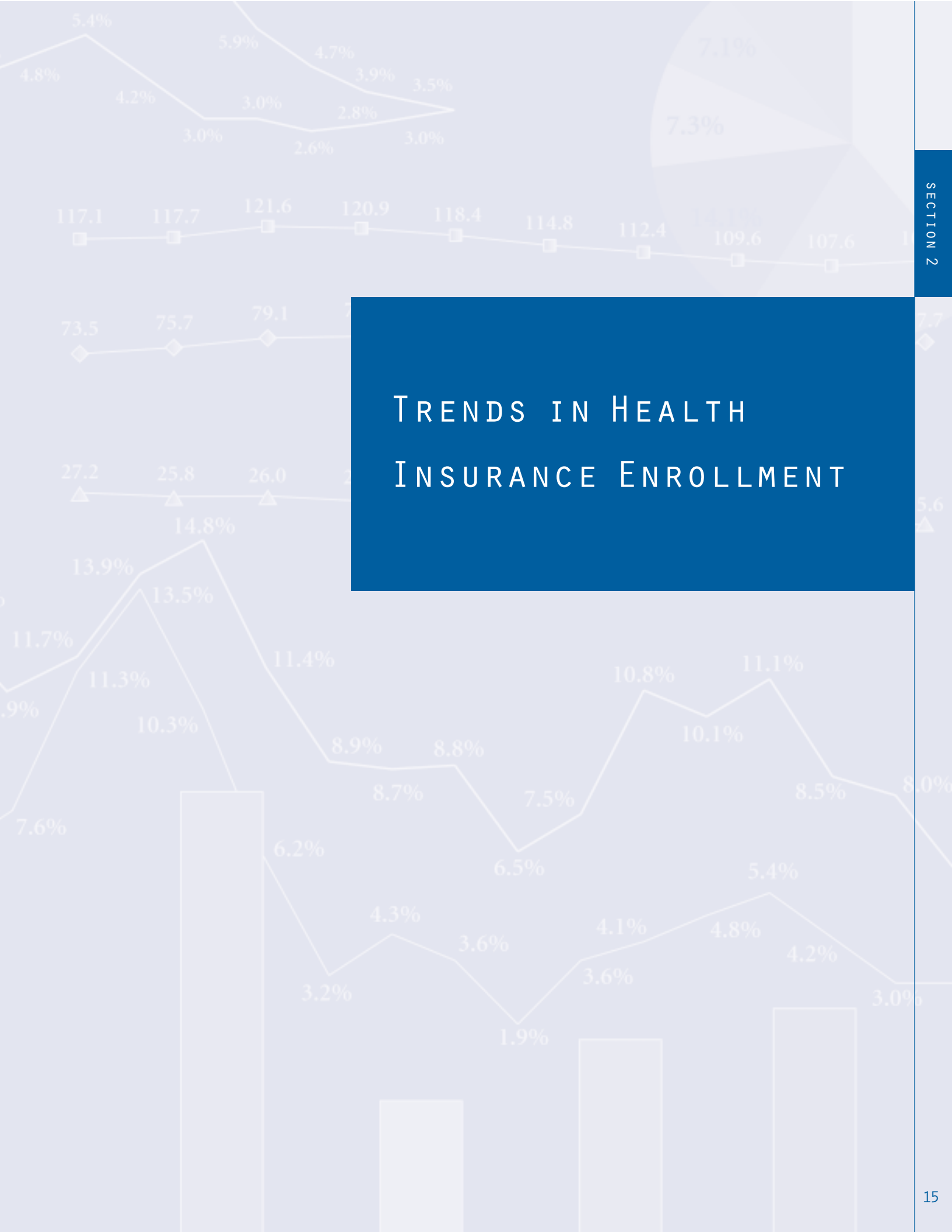
District of Columbia included.

**SOURCE:**

Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group. CMS web site, 1998 State Estimates, Total Personal Health Care as a Percent of Gross State Product, at [www.hcfa.gov/stats/nhe-oact/stateestimates/Tables98/phc\\_gsp.htm](http://www.hcfa.gov/stats/nhe-oact/stateestimates/Tables98/phc_gsp.htm).



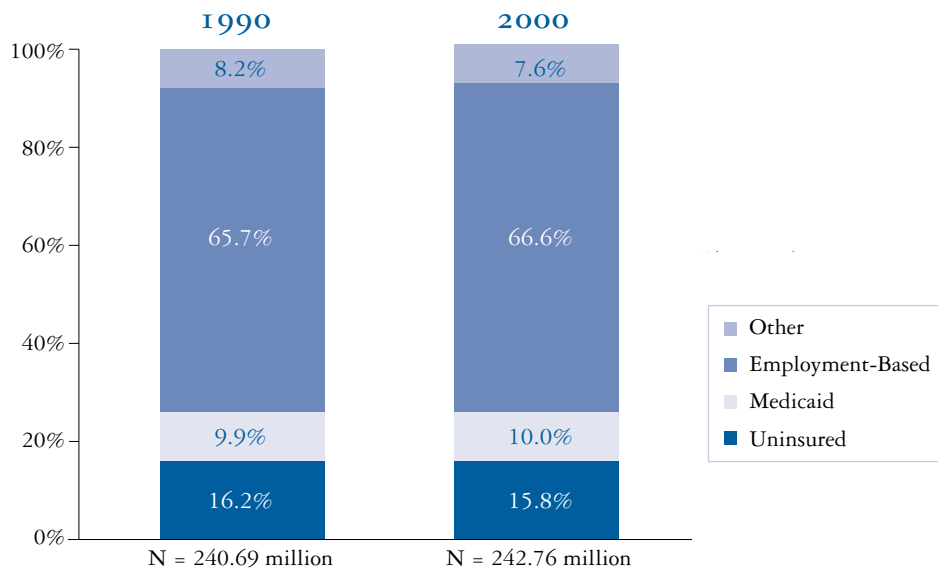
# TRENDS IN HEALTH INSURANCE ENROLLMENT



## EXHIBIT 2.1

## Trends in Health Coverage for the Non-Elderly Population, 1999 and 2000

The uninsured rate has dipped slightly in recent years, declining from 16.2% of the non-elderly population in 1999 to 15.8% in 2000. This modest improvement was due in large part to an upswing in employment-based coverage, which rose from 65.7% to 66.6% of the population, a trend that is not expected to continue as the economy slows down. (For example, analysis prepared by the Kaiser Family Foundation and the Massachusetts Institute of Technology finds that the number of uninsured grows by 1.2 million for every 1 percentage point increase in the unemployment rate, which rose from 4.0% in December 2000 to 5.7% in March 2002.) From 1999 to 2000, the proportion of the population covered by Medicaid held steady at about 10%. These coverage figures are based on “verified” Census Bureau data, using new questions on the 2000 and 2001 Current Population Surveys to attempt to verify whether those who report they do not have health insurance are really uninsured. Unverified trend data for 1994–2000 indicate that the 1999 and 2000 declines in the uninsured rate followed 5 years of increases in the proportion of the population that was uninsured.

**NOTES:**

Excludes persons aged 65 and older and those in institutions or in the Armed Forces.

**SOURCE:**

Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, 2001, based on verified data from March Current Population Surveys, 2000 and 2001. See *Health Insurance Coverage in America, 2000 Data Update*, The Kaiser Commission on Medicaid and the Uninsured (February 2002), and U.S. Census Bureau's Current Population Survey 2001 health insurance data at [www.census.org](http://www.census.org).

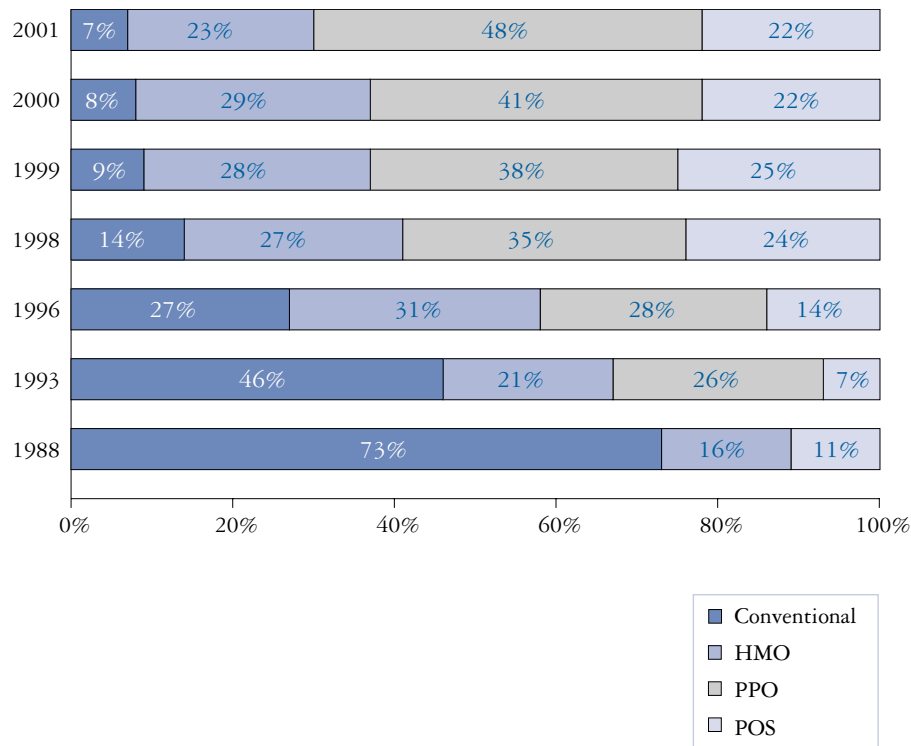
Unemployment data from U.S. Department of Labor, Bureau of Labor Statistics, at [www.bls.gov](http://www.bls.gov).

Unemployment impact on uninsured from *Rising Unemployment and the Uninsured*, Kaiser Family Foundation at [www.kff.org/content/2001/6011/6011.pdf](http://www.kff.org/content/2001/6011/6011.pdf).

## EXHIBIT 2.2

## Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2001

Most Americans with health insurance have coverage through employer health plans. The increase in managed care (including HMOs, PPOs, and POS plans) has been dramatic, rising from 27% in 1988 to 93% in 2001. PPOs' dominance has continued to increase, reaching 48% of covered workers in 2001. HMO enrollment decreased to 23 in 2001, its lowest point since 1993. Conventional Fee-For-Service enrollment has declined from 73% of total enrollment in 1988 to 7% in 2001.

**NOTES:**

See Glossary for definitions of plan types (Conventional, HMO, PPO, and POS).

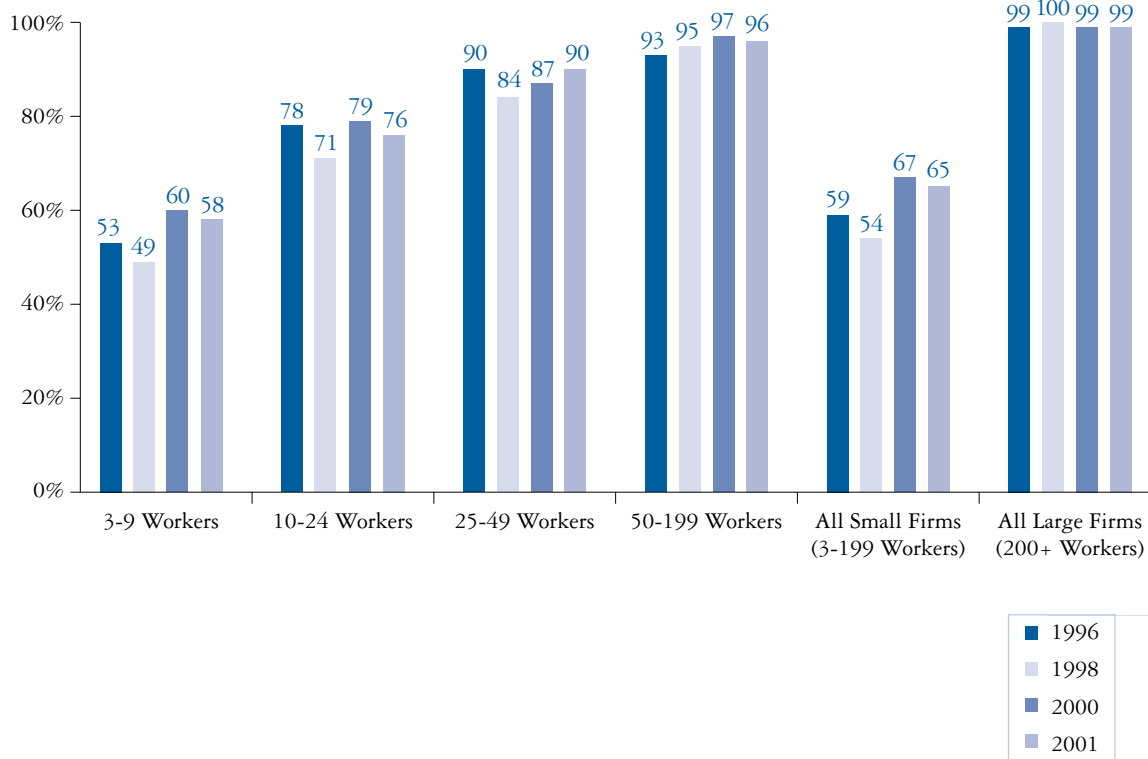
**SOURCE:**

*Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 6.1, p.75. See [www.kff.org](http://www.kff.org).

## EXHIBIT 2.3

## Percentage of Firms Offering Health Benefits, by Firm Size, 1996–2001

While nearly all large employers (99%) offered health benefits in 2001, only about two-thirds (65%) of small firms did so. Even among these small firms – all those under 200 workers – the larger the firm, the more likely it offered coverage in 2001. The share of small firms offering coverage decreased somewhat from 2000 to 2001 but overall has increased from 59% to 65% since 1996. The proportion of large firms providing health benefits has remained close to 100% over this period.

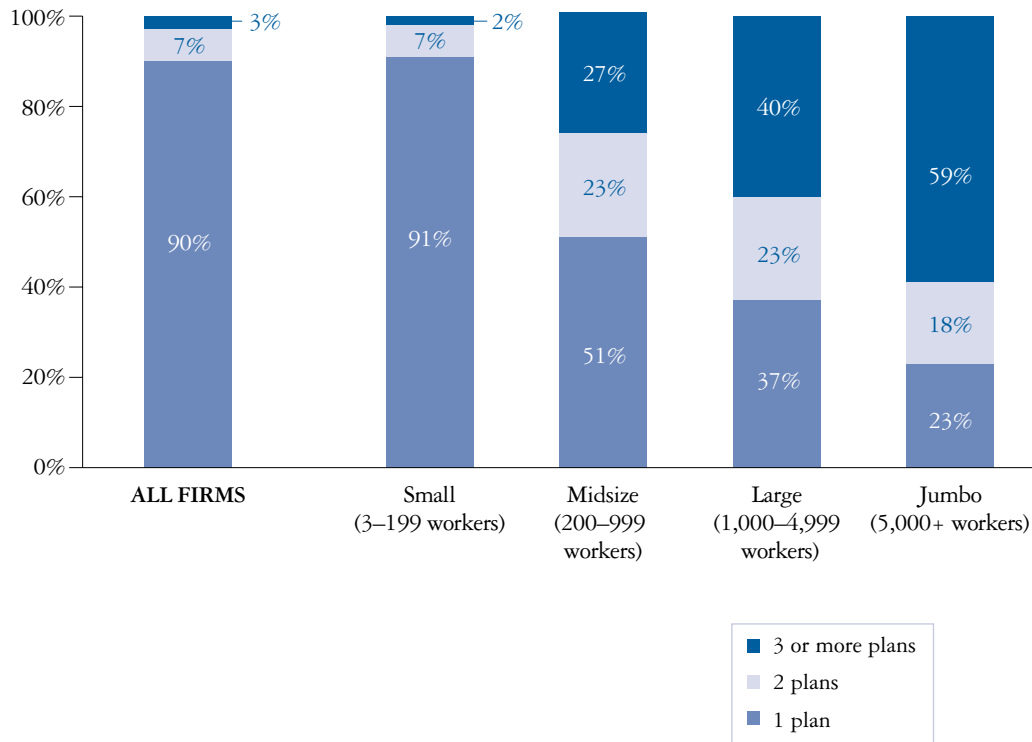
**SOURCE:**

*Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 3.1, p.36. See [www.kff.org](http://www.kff.org).

## EXHIBIT 2.4

## Distribution of Number of Health Plans Offered, by Firm Size, 2001

Larger employers are much more likely to offer employees a choice of health plans than are smaller firms. Only 9% of small employers offer a choice of plans, compared to 63% of large employers and 77% of jumbo firms. However, larger companies employ a larger share of workers than do small firms. Thus, while only 10% of all employers offer a choice of plans, 60% of covered workers (those who have employer coverage) can select among multiple plans.

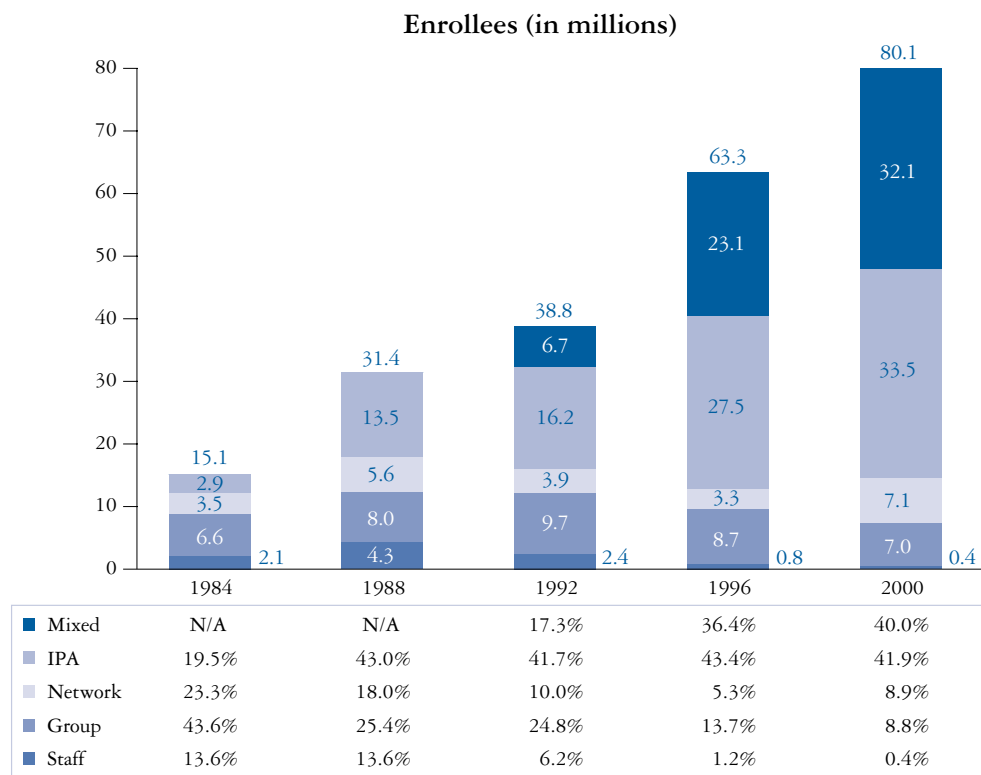
**SOURCE:**

*Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 5.3, p.63. See [www.kff.org](http://www.kff.org).

## EXHIBIT 2.5

## Number and Distribution of HMO Enrollment, by Model Type, 1984–2000

The proportion of HMO enrollment in Mixed model HMO plans has continued its recent upward trend, rising to 40% of HMO enrollment in 2000. IPA model HMOs made up 42% of HMO enrollment the same year, their share remaining relatively unchanged since 1988. Meanwhile, the proportion of enrollment in Group model and Staff model plans has declined substantially since 1984.

**NOTES:**

HMO enrollment includes enrollees in both traditional HMOs and point-of-service (POS) plans through: group/commercial plans, Medicare, Medicaid, the Federal Employees Health Benefits Program, direct pay plans, supplemental Medicare plans, and unidentified HMO products.

Numbers shown in graph may not produce percentages shown because of rounding.

See “Health Maintenance Organization” in Glossary for definitions of model types (Mixed, IPA, Network, Group, and Staff).

**SOURCE:**

2000 data from *The InterStudy Competitive Edge 11.1, Part II: HMO Industry Report*, InterStudy Publications (April 2001), Table 7, p.18.

1984 & 1988 from *Managed Care: A Decade in Review, 1980–1990*, InterStudy Publications (1990).

1992 & 1996 from *The InterStudy Competitive Edge*, InterStudy Publications (1992 & 1997) as shown in *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 2.11, p.23.

All data are as of June 30 or July 1 of respective year.

## EXHIBIT 2.6

## State HMO Penetration, 2000

HMO penetration – the percent of a state’s population enrolled in an HMO – varied strikingly across states in 2000, ranging from a low of less than 2% in Alaska, Mississippi, and Wyoming to a high of 54.1% in California and 45.2% in Massachusetts.

State	State Penetration	State	State Penetration
Alabama	7.0%	Montana	8.1%
Alaska	0.0%	Nebraska	10.8%
Arizona	30.0%	Nevada	21.3%
Arkansas	9.5%	New Hampshire	35.3%
California	54.1%	New Jersey	31.2%
Colorado	36.0%	New Mexico	30.8%
Connecticut	43.5%	New York	34.0%
Delaware	22.2%	North Carolina	16.6%
District of Columbia	33.2%	North Dakota	2.3%
Florida	30.3%	Ohio	24.7%
Georgia	15.4%	Oklahoma	13.9%
Hawaii	31.5%	Oregon	36.9%
Idaho	6.9%	Pennsylvania	33.5%
Illinois	20.2%	Rhode Island	36.7%
Indiana	12.5%	South Carolina	9.6%
Iowa	7.1%	South Dakota	8.7%
Kansas	17.9%	Tennessee	32.1%
Kentucky	32.6%	Texas	16.0%
Louisiana	16.0%	Utah	33.7%
Maine	27.0%	Vermont	5.0%
Maryland	39.0%	Virginia	16.3%
Massachusetts	45.2%	Washington	15.6%
Michigan	27.2%	West Virginia	10.6%
Minnesota	27.8%	Wisconsin	29.8%
Mississippi	1.0%	Wyoming	1.6%
Missouri	32.9%		

**NOTES:**

State penetration was calculated using state population from the Census Bureau as of April 1, 2000.

HMO enrollment includes enrollees in both traditional HMOs and point-of-service (POS) plans through: group/commercial plans, Medicare, Medicaid, the Federal Employees Health Benefits Program, direct pay plans, supplemental Medicare plans, and unidentified HMO products.

**SOURCE:**

*The InterStudy Competitive Edge 11.1, Part II: HMO Industry Report* (using data as of July 1, 2000), InterStudy Publications (April 2001), Table 16, p.34. See also the Kaiser Family Foundation’s State Health Facts Online web site at [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org).

## EXHIBIT 2.7

## HMO Penetration in the 10 Largest Metropolitan Areas, 2000

While higher in urban than in rural markets, HMO penetration in the largest metropolitan areas still varies considerably, from a high of 55.0% in Los Angeles to a low of 17.1% in Dallas.

City	Estimated HMO Penetration	Estimated HMO Enrollment	Estimated Population
Los Angeles-Long Beach, CA	55.0%	5,231,172	9,519,338
Philadelphia, PA-NJ	44.7%	2,280,408	5,100,931
Boston, MA-NH	42.7%	1,450,475	3,398,503
Detroit, MI	31.1%	1,380,896	4,441,551
Washington, DC-MD-VA-WV	31.0%	1,528,129	4,923,153
New York, NY	26.9%	2,503,900	9,314,235
Atlanta, GA	25.5%	1,047,848	4,112,198
Houston, TX	25.4%	1,060,760	4,177,646
Chicago, IL	21.5%	1,777,317	8,272,768
Dallas, TX	17.1%	602,717	3,519,176

**NOTES:**

HMO enrollment includes enrollees in both traditional HMOs and point-of-service (POS) plans through: group/commercial plans, Medicare, Medicaid, the Federal Employees Health Benefits Program, direct pay plans, supplemental Medicare plans, and unidentified HMO products.

**SOURCE:**

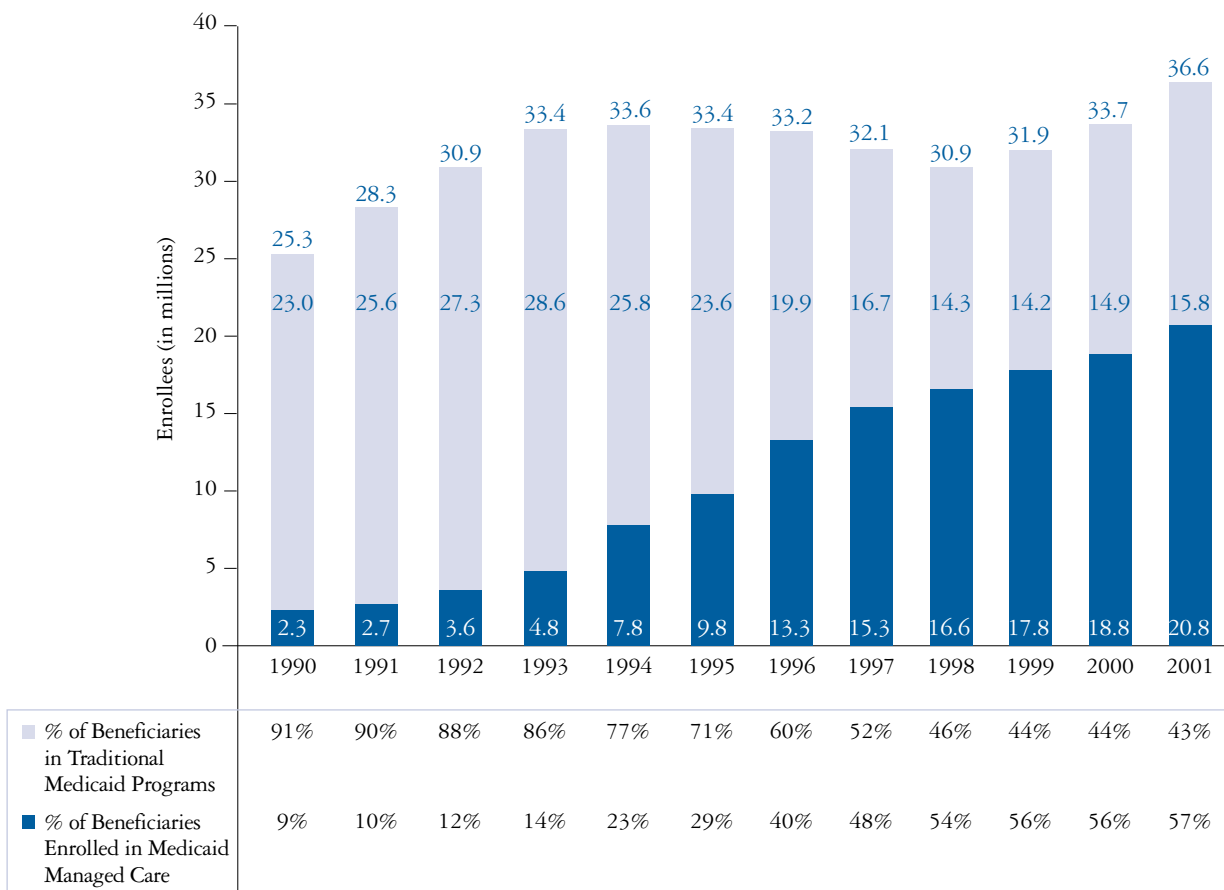
*The InterStudy Competitive Edge 11.1, Part III: Regional Market Analysis* (using data as of July 1, 2000), InterStudy Publications (May 2001), pp.42–99.



## EXHIBIT 2.8

## Medicaid Managed Care and Traditional Enrollment, 1990–2001

Medicaid managed care grew rapidly in the 1990s, with the proportion of enrollees in managed care increasing from 9% in 1990 to 57% in 2001. In 2001, 20.8 million Medicaid beneficiaries were in managed care plans, which included HMOs and Primary Care Case Management (PCCM) programs.

**NOTES:**

Unduplicated managed care enrollment includes individuals receiving comprehensive as well as limited benefits through HMOs or PCCM programs. See Glossary for definition of PCCM.

Numbers shown in graph may not produce totals shown because of rounding.

**SOURCE:**

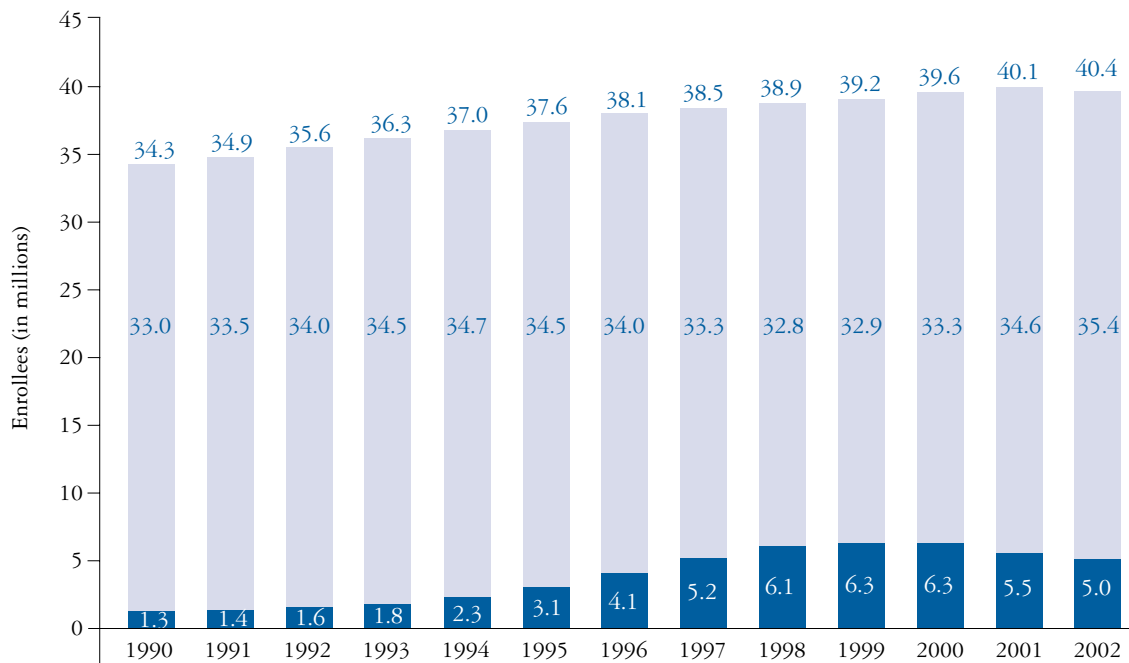
1991–2001 data from Kaiser Commission on Medicaid and the Uninsured, “Medicaid and Managed Care,” Dec. 2001, at [www.kff.org](http://www.kff.org), using and supplemented with data from Medicaid Managed Care Enrollment Reports, Summary Statistics as of June 30 of various years, at [www.hcfa.gov/medicaid/omchmpg.htm](http://www.hcfa.gov/medicaid/omchmpg.htm).

1990 data as shown in *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 2.2, p.17.

## EXHIBIT 2.9

## Enrollment in Medicare Managed Care and Traditional Medicare, 1990–2002

Of the nation's 40 million Medicare enrollees in 2002, 5.0 million were in managed care. Medicare participation in managed care increased slowly over the last 10 years, rising from 4% in 1990 to 16% in 1998–2000, reflecting the voluntary nature of Medicare enrollment and the financial and management challenges of implementing Medicare managed care. However, these challenges have resulted in plan withdrawals from Medicare managed care which have contributed to a recent decline in the number and percentage of Medicare managed care enrollees in 2001 (14%) and 2002 (12%).



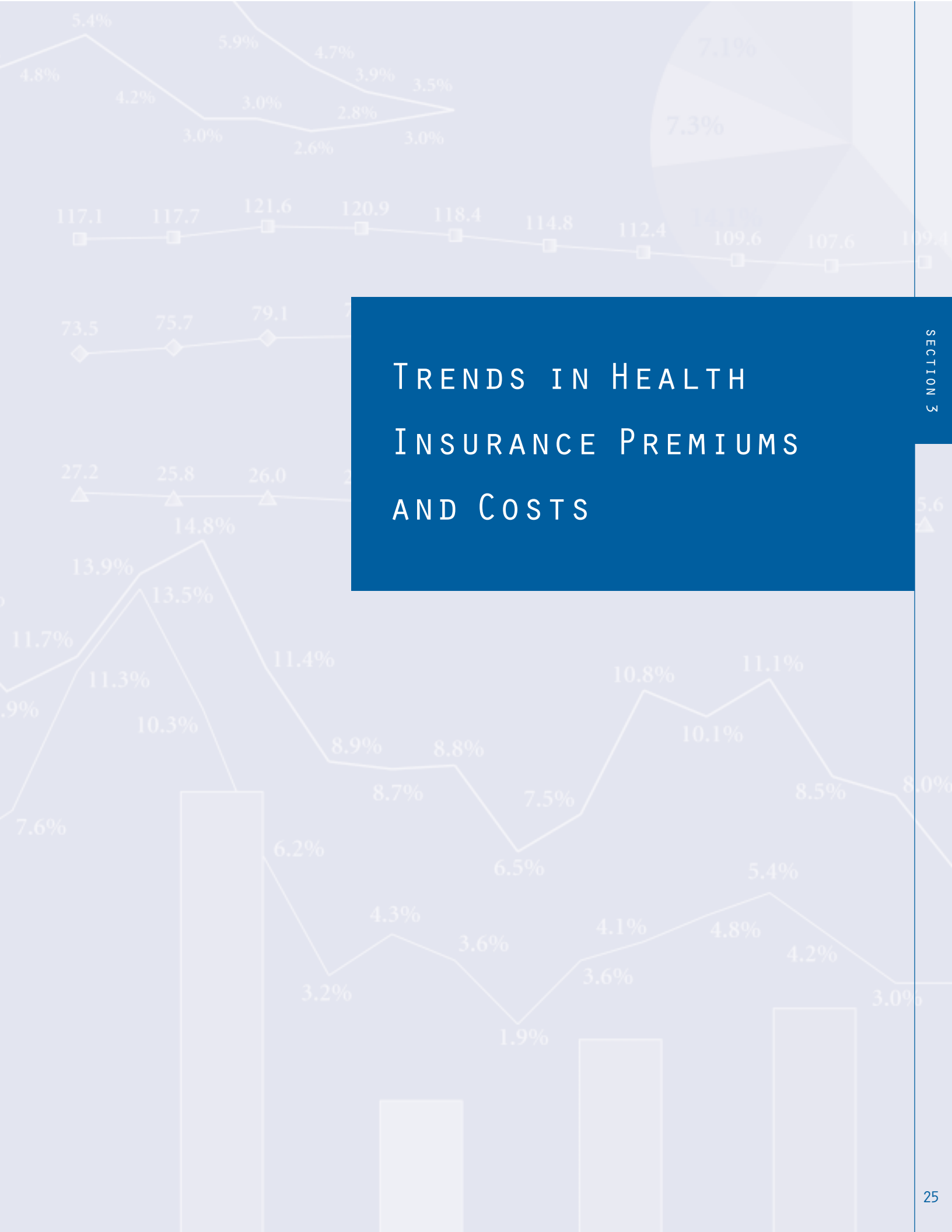
■ % of Beneficiaries in Traditional Medicare Program	96%	96%	96%	95%	94%	92%	89%	86%	84%	84%	84%	86%	88%
■ % of Beneficiaries Enrolled in Medicare Managed Care	4%	4%	4%	5%	6%	8%	11%	14%	16%	16%	16%	14%	12%

**SOURCE:**

Medicare managed care enrollment from Kaiser Family Foundation, *Medicare+Choice Factsheet*, September 2001, and Centers for Medicare and Medicaid Services, Medicare Managed Care Contract Monthly Report at [www.hcfa.gov/stats/mmcc.htm](http://www.hcfa.gov/stats/mmcc.htm). Data is for Dec 1 of each year, except 2002 is from February 1.

Total Medicare enrollment from Centers for Medicare and Medicaid Services, Office of the Actuary, personal communication, April 2002.

# TRENDS IN HEALTH INSURANCE PREMIUMS AND COSTS



## EXHIBIT 3.1

## Average Annual Premiums for Employer Health Plans, by Type of Plan, 2001

On average, annual private employer-sponsored insurance premiums are \$2,650 for single coverage and \$7,053 for family coverage. Conventional Fee-For-Service coverage is the most expensive option, while HMOs remain the least costly choice. The average Conventional family coverage premium exceeds the average HMO family premium by more than one thousand dollars.

	Single Coverage	Family Coverage
Conventional	\$2,851	\$7,685
HMO	\$2,402	\$6,538
PPO	\$2,730	\$7,202
POS	\$2,667	\$7,059
All Plans	\$2,650	\$7,053

**SOURCE:**

*Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 2.16, pp.28–29. See [www.kff.org](http://www.kff.org).

## EXHIBIT 3.2

## Average Annual Premiums for Employer Health Plans, by Type of Plan and Region, 2001

Premiums vary substantially by region. For both single and family coverage, the West has the least expensive and the Northeast has the most expensive average premiums for all plans combined. Interestingly, though, this pattern is not consistent across each type of plan. For example, the West has strikingly lower premiums for HMO coverage compared to other regions, but does not have consistently lower premiums for other plan types.

Single Coverage	Northeast	Midwest	South	West
Conventional	\$2,873	\$2,908	\$2,528	\$2,964
HMO	\$2,586	\$2,392	\$2,412	\$2,228
PPO	\$2,780	\$2,640	\$2,772	\$2,718
POS	\$2,699	\$2,621	\$2,685	\$2,631
All Plans	\$2,715	\$2,633	\$2,676	\$2,520

Family Coverage	Northeast	Midwest	South	West
Conventional	\$7,576	\$8,343	\$6,491	\$6,616
HMO	\$6,983	\$6,682	\$6,705	\$5,832
PPO	\$8,020	\$6,943	\$7,032	\$6,993
POS	\$7,286	\$7,094	\$6,855	\$6,918
All Plans	\$7,529	\$7,127	\$6,914	\$6,484

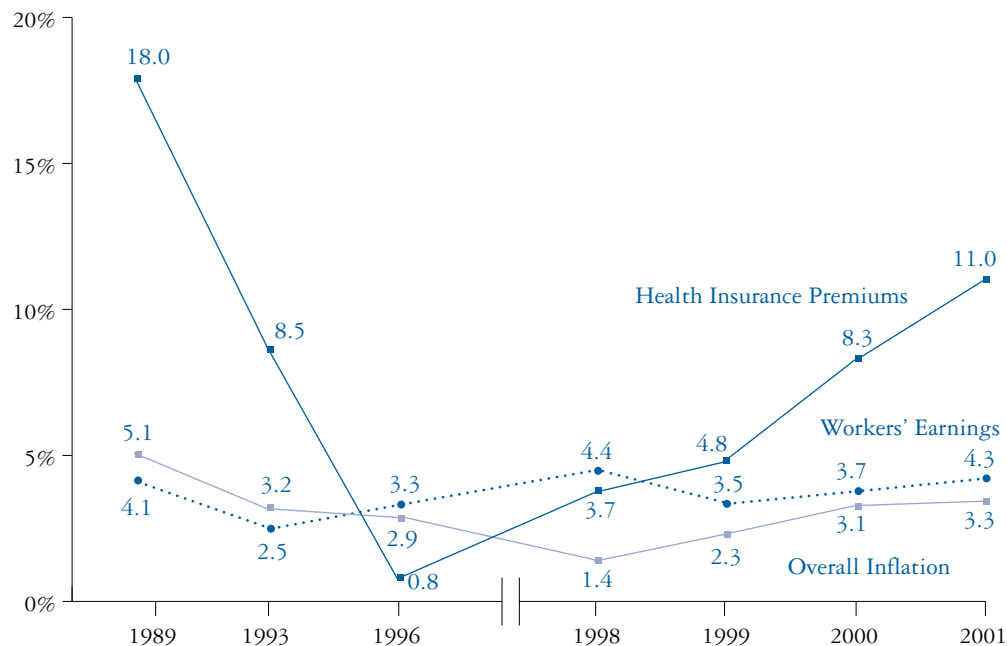
**SOURCE:**

*Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 2.17, p.30. See [www.kff.org](http://www.kff.org) .

## EXHIBIT 3.3

## Increases in Employer Health Insurance Premiums Compared to Increases in Overall Inflation and Workers' Earnings, 1989–2001

While wage growth and inflation have remained relatively constant over the past 13 years, the rate of premium growth has been volatile, ranging from a low of 0.8% in 1996 to highs of 18% in 1989 and 11% in 2001. While premiums rose modestly in the mid-1990s, increases are now returning to the double-digit levels of the late 1980s and early 1990s.

**SOURCE:**

Health Insurance Premiums from personal communication of data from KFF/HRET Employer Health Benefits Surveys from 1999, 2000, 2001; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; HIAA Employer Sponsored Health Insurance Survey: 1989.

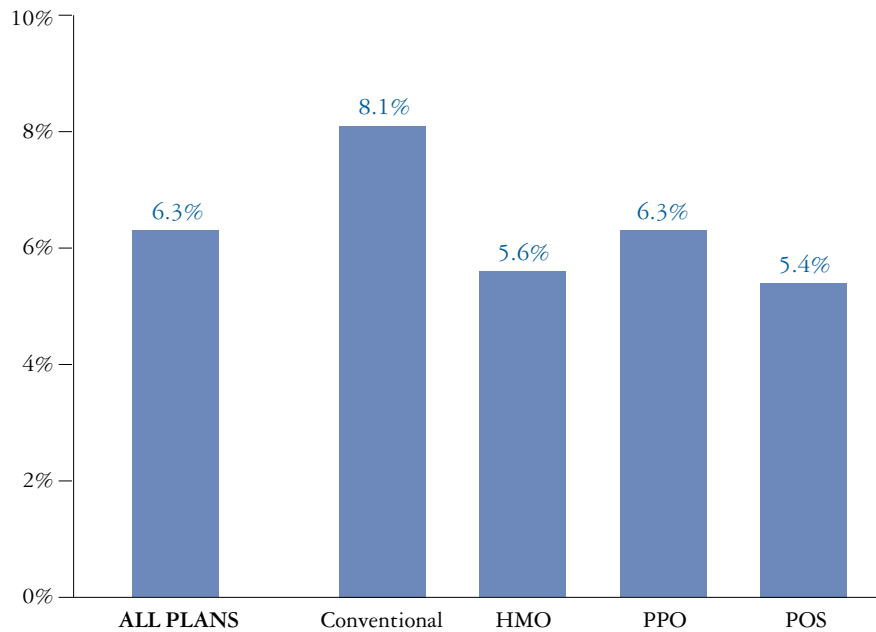
Workers' Earnings from Bureau of Labor Statistics Current Employment Statistics Survey (April-April), 1988–2001.

Overall Inflation from Bureau of Labor Statistics, CPI estimates (April-April), 1988–2001, at [www.bls.gov](http://www.bls.gov).

## EXHIBIT 3.4

## Average Annual Percent Change in Employer Health Insurance Premiums, by Type of Plan, 1996–2001

From 1996 to 2001, employer health insurance premiums grew the fastest for Conventional Fee-For-Service coverage (which experienced an annual average premium increase of 8.1%) and for PPO coverage (average annual increase of 6.3%). HMO and POS coverage both grew somewhat more slowly over this period.

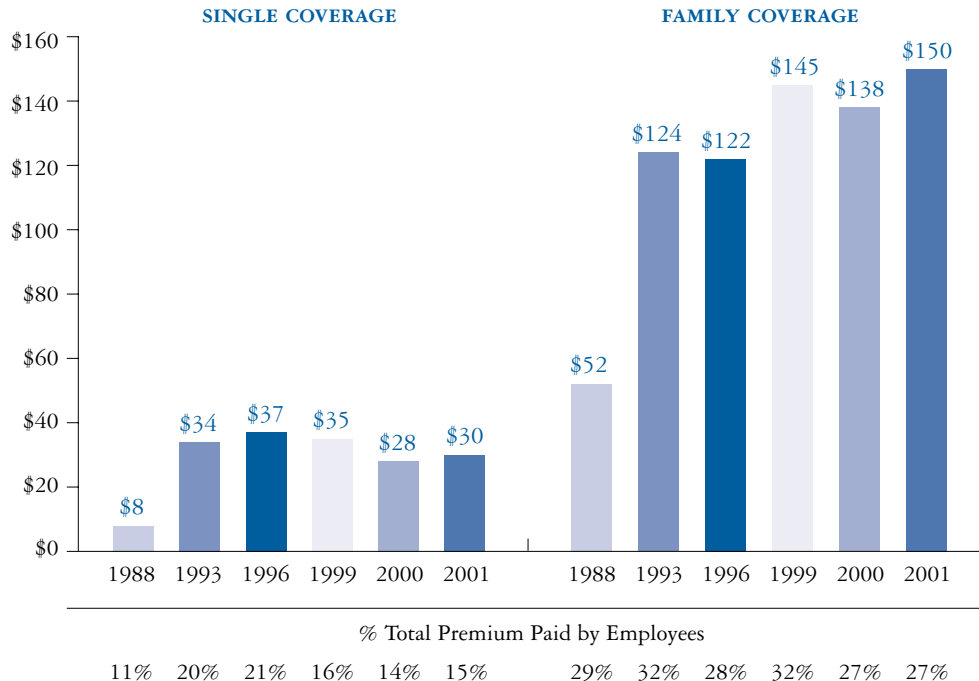
**SOURCE:**

The Kaiser Family Foundation and Health Research and Educational Trust, personal communication of data from the 2001 Employer Health Benefits Survey, August 2001.

## EXHIBIT 3.5

## Average Monthly Employee Premiums and Percent of the Total Premium Paid by Employees, by Coverage Type and Year, 1988–2001

In 2001, employees paid on average 15% of the single coverage premium, or \$30, and 27% of the family coverage premium, or \$150, smaller shares than they paid in 1993. The 2001 Kaiser/HRET Employer Health Benefits Survey found that 75% of large firms and 42% of small firms (44% of all firms) were “very likely” or “somewhat likely” to increase employee premium costs in the next year.

**SOURCE:**

All years except 1999 from *Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibits 7.1 & 7.2, p.87.

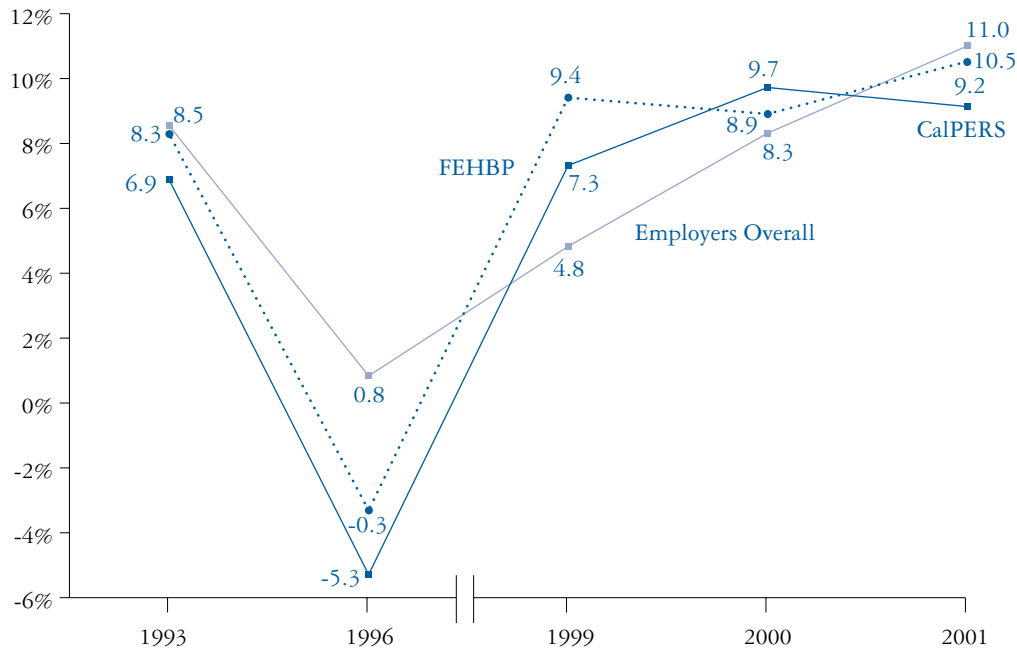
1999 from *Employer Health Benefits, 2000 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibits 7.1 & 7.2, p.74. See [www.kff.org](http://www.kff.org).



## EXHIBIT 3.6

## Annual Change in Health Insurance Premiums for CalPERS, FEHBP, and Employers Overall, 1993–2001

Large purchasing programs like CalPERS and FEHBP are often cited as purchasing models best able to contain costs, but their premium growth has in fact largely mirrored employers overall. Premium trends for all three groups show the same general pattern from 1993 to 2001.

**NOTES:**

For CalPERS data, 1996 figure represents the average across a period longer than 12 months because of a change in the reporting period; premium figures for all years are for Basic Plan HMO Option.

CalPERS: The California Public Employees' Retirement System (CalPERS) provides retirement and health benefit services to more than 1.2 million members and more than 2,400 employers. CalPERS membership consists of active, inactive, and retired members from the State, school districts, and local public agencies.

FEHBP: The Federal Employees Health Benefits Program (FEHBP) provides health insurance benefits to 9 million Federal enrollees, retirees, and their dependents.

**SOURCE:**

Annual change in premiums for Employers Overall from *Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 2.2, p.15.

Annual change in FEHBP Premiums from *Trends in Medical Premiums from the Hay Benefits Report and the Federal Employees Health Benefits Program 1981 through 2001*, The Hay Group (2001).

Annual change in CalPERS Premiums from data provided by CalPERS.

## EXHIBIT 3.7

## Adjusted Medicaid Managed Care Monthly Payment Rates and Comparison to the National Median Payment Rate, 1998

There is substantial geographic variation in the amount states pay plans for public managed care coverage through Medicaid. This likely results from variation in fee-for-service spending levels, differences in eligibility, and demographics. The national median Medicaid managed care (MMC) payment rate is \$124.96 per month, with a low of \$82.75 in California and a high of \$182.52 in Connecticut.

State	Adjusted MMC Rate	Rate to 50th Percentile
Connecticut	\$182.52	46%
Massachusetts	\$173.89	39%
Texas	\$153.75	23%
Kentucky	\$153.15	23%
Hawaii	\$150.22	20%
New Hampshire	\$148.90	19%
District of Columbia	\$145.80	17%
Utah	\$145.44	16%
New Mexico	\$143.80	15%
Rhode Island	\$143.52	15%
Minnesota	\$139.64	12%
New Jersey	\$138.95	11%
Arizona	\$136.55	9%
Washington	\$133.27	7%
North Dakota	\$132.27	6%
Mississippi	\$132.16	6%
Missouri	\$129.93	4%
Iowa	\$128.30	3%
<b>U.S. Median</b>	<b>\$124.96</b>	<b>-</b>
New York	\$121.63	-3%
Maryland	\$121.05	-3%
West Virginia	\$119.80	-4%
Virginia	\$117.12	-6%
Colorado	\$115.29	-8%
Maine	\$111.13	-11%
Ohio	\$110.33	-12%
Oklahoma	\$107.05	-14%
Illinois	\$106.96	-14%
Nevada	\$105.48	-16%
Wisconsin	\$104.31	-17%
South Carolina	\$103.45	-17%
Kansas	\$103.15	-17%
Florida	\$99.61	-20%
Tennessee	\$99.07	-21%
Georgia	\$96.40	-23%
Indiana	\$95.39	-24%
California	\$82.75	-34%

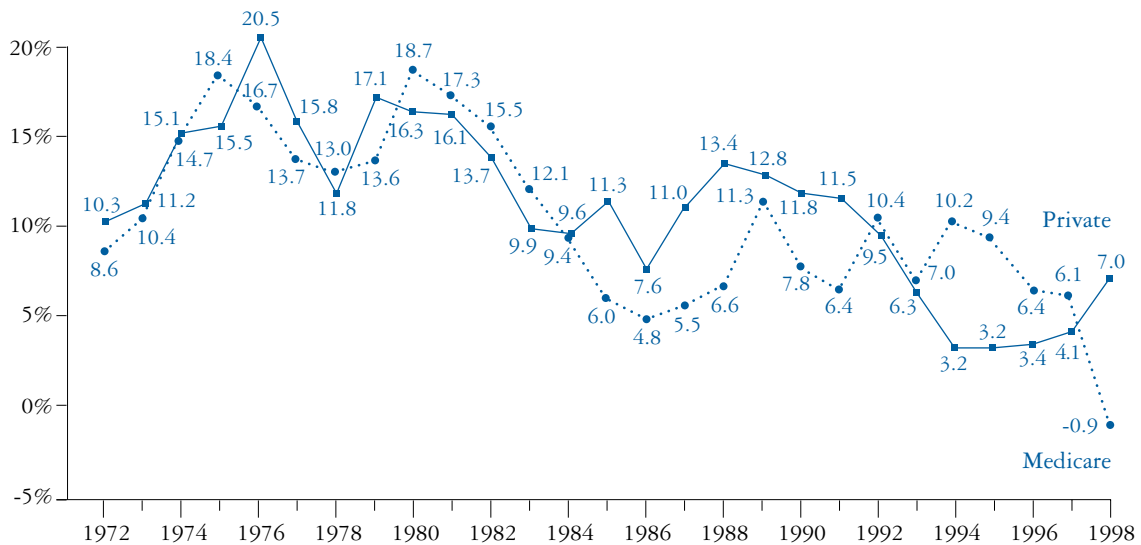
**SOURCE:**

John Holahan, Suresh Rangarajan, and Matthew Schirmer, "Medicaid Managed Care Payment Rates In 1998," *Health Affairs* (May/June 1999), Exhibit 3.

## EXHIBIT 3.8

## Annual per Capita Rates of Growth in Health Care Spending, 1972–1998

Medicare cost growth in the last three decades has largely tracked the growth rate in private insurance costs. Cost growth for both Medicare and private insurance was generally lower from the mid-1980s to 1998 than it had been in the prior period, when costs grew by more than 10% each year. In 1998, Medicare costs went down almost 1% while private insurance costs rose just under 7%. More recent data show that costs have returned to the previous levels, with both private employer-sponsored insurance costs and Medicare costs rising 11% in 2001.

**NOTES:**

The 2001 data are not directly comparable to prior year data since they show total rather than per capita cost increases.

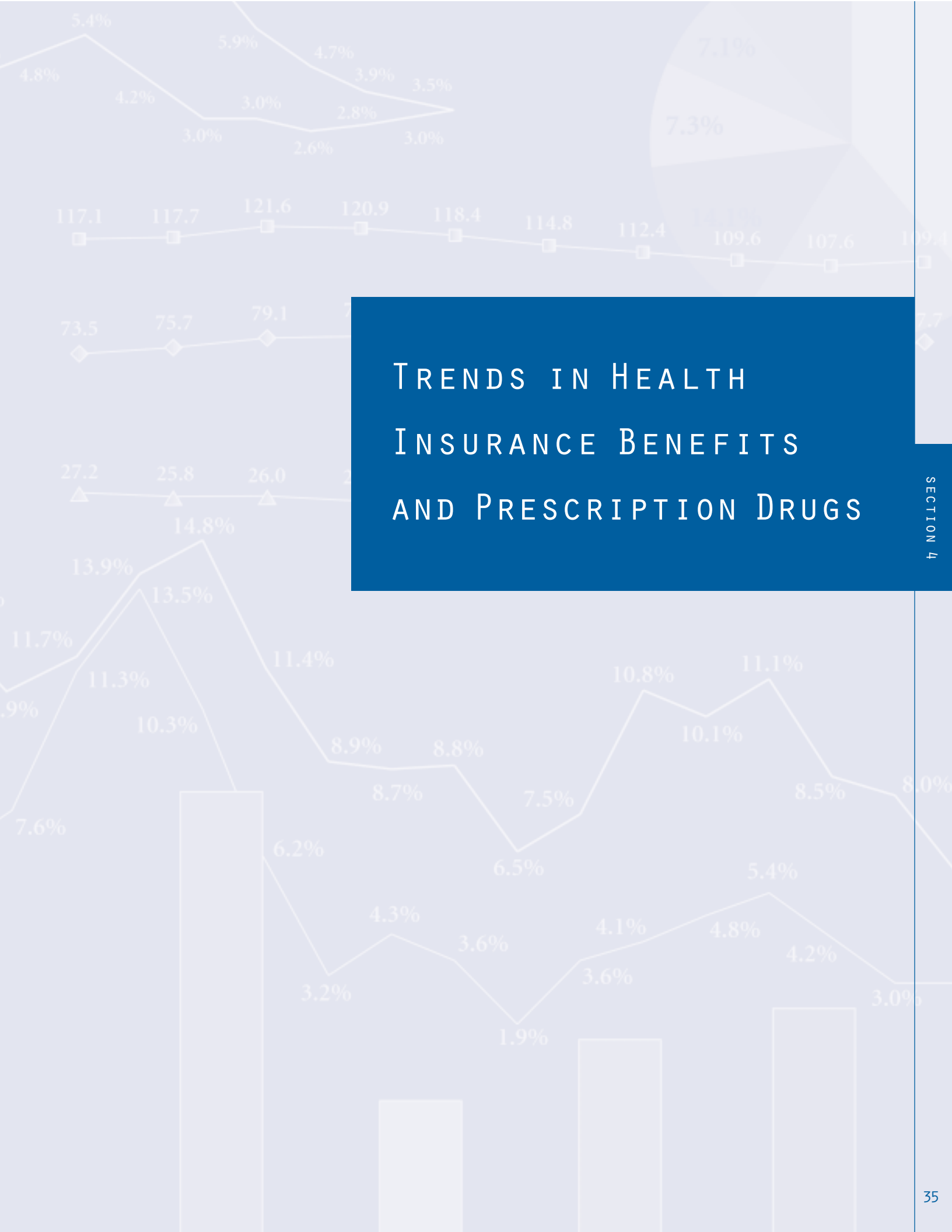
**SOURCE:**

1971–1998 data from *Medicare Chart Book*, Kaiser Family Foundation, Fall 2001, p.30, based on M. Moon, The Urban Institute, May 2001.

2001 private health insurance premium data from *Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 2.2, p.15.

2001 Medicare outlay data from *Monthly Budget Review, Fiscal Year 2001*, Congressional Budget Office, November 2001, at [www.cbo.gov](http://www.cbo.gov).





# TRENDS IN HEALTH INSURANCE BENEFITS AND PRESCRIPTION DRUGS

## EXHIBIT 4.1

## Percent of Covered Workers With Selected Benefits, by Type of Employer Health Plan, 2001

Today, most employer-sponsored health plans cover prevention services such as check-ups and prenatal care. Still, there are differences among different plan types, with Conventional Fee-For-Service plans and PPOs least likely to cover these services and HMOs most likely.

	Conventional	PPO	POS	HMO
Adult Physicals	63%	88%	94%	97%
Annual OB/GYN Visit	81%	93%	97%	97%
Prenatal Care	97%	96%	97%	98%

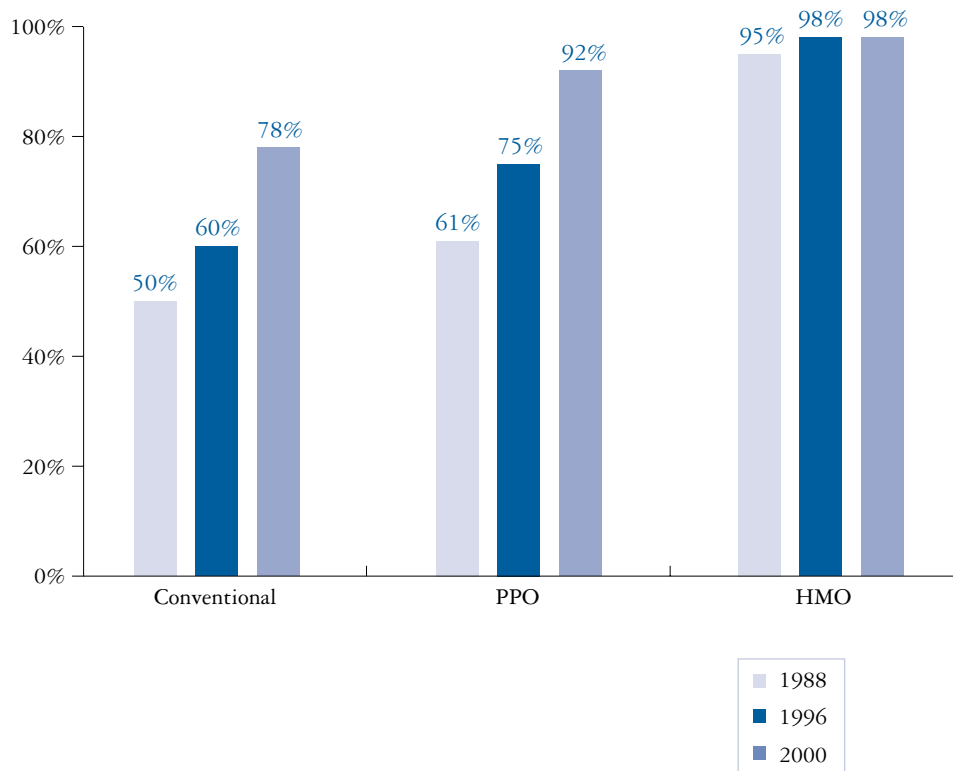
**SOURCE:**

*Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 8.3, p.113. See [www.kff.org](http://www.kff.org) .

## EXHIBIT 4.2

## Percentage of Covered Workers With Coverage of Well-Baby Care, by Type of Plan, 1988, 1996, and 2000

While HMOs have consistently covered prevention services, including well-baby care, Conventional Fee-For-Service and PPO plans have not. However, these plans have dramatically increased their coverage of well-baby care since 1988, when only 50% of employees enrolled in Conventional plans were covered for this service. In 2000, 78% of workers in Conventional plans and 92% of those in PPO plans had coverage of well-baby services; nearly all (98%) workers covered by HMOs had this benefit.

**SOURCE:**

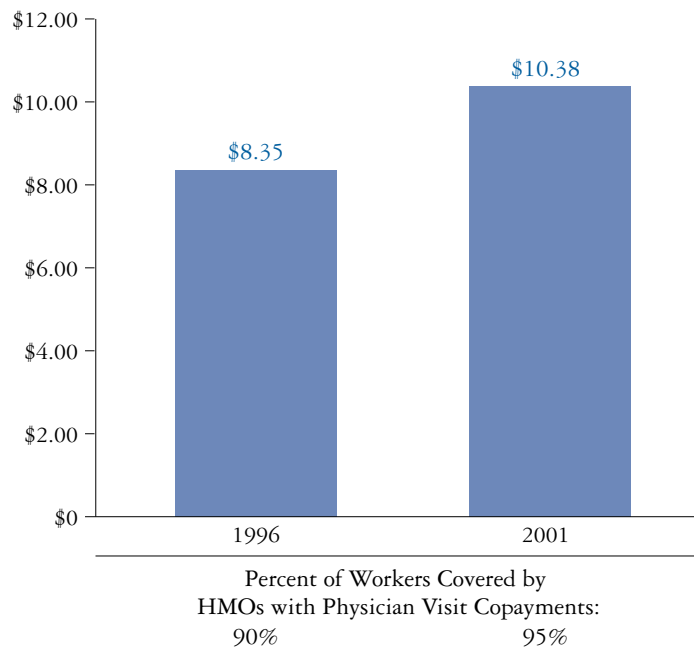
2000 from *Employer Health Benefits, 2000 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 8.2, p.97.

1988 and 1996 from The Kaiser Family Foundation and Health Research and Educational Trust, personal communication, December 2001.

## EXHIBIT 4.3

## Average HMO Copayments for Physician Visits and Percent of Covered Workers in HMOs With Copayment, 1996 and 2001

Both the amount of the average physician visit copayment and the percentage of workers covered by HMOs who face a copayment have increased since 1996. The average copayment rose from \$8.35 in 1996 to \$10.38 in 2001. The percentage of workers covered by HMOs with a copayment requirement rose from 90% in 1996 to 95% in 2001.

**NOTES:**

The average copayment is the average across all HMO enrollees, including those facing no copayment.

**SOURCE:**

Percent of workers for 2001 from *Employer Health Benefits, 2001 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, Exhibit 7.23, p.104.

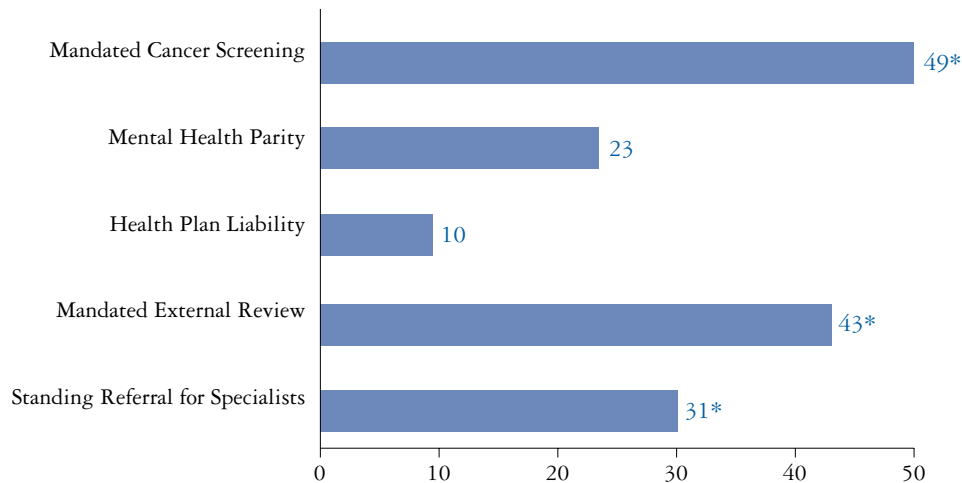
Percent of workers for 1996, and 2001 and 1996 average copayments, from Kaiser Family Foundation and the Health Research and Educational Trust, personal communication, September 2001.



## EXHIBIT 4.4

## Number of States with Consumer Protection and Mandated Benefits Laws, 2001

Over the last few years, an increasing number of states have enacted managed care and consumer protection laws and the scope of these laws has expanded. One of the most significant of these protections is mandated external review of health plan decisions, required by 43 states (including the District of Columbia) in 2001. By contrast, only a handful of states have laws specifying circumstances under which health plans can be sued by patients (health plan liability).

**NOTES:**

\* Includes the District of Columbia.

**SOURCE:**

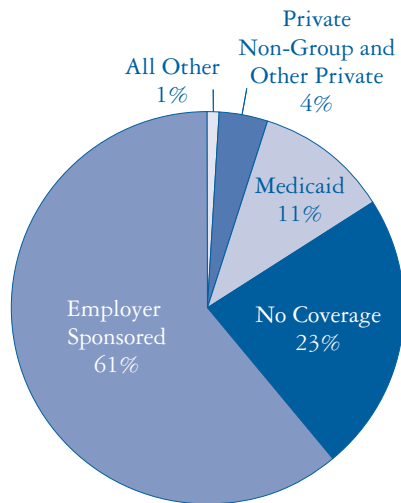
National Conference of State Legislatures, Health Policy Tracking Service, December 31, 2001.

## EXHIBIT 4.5

## Insurance Coverage for Prescription Drugs, 1996 and 1998

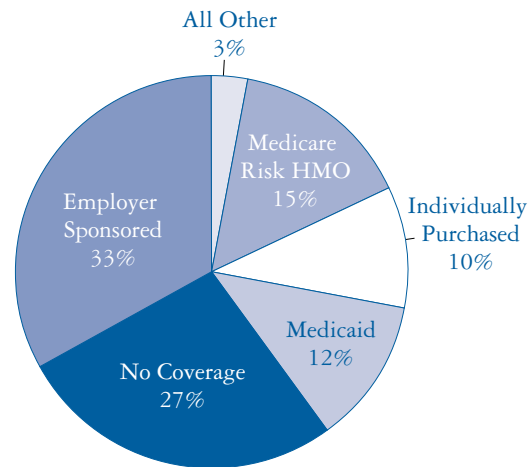
More than three-quarters of the non-elderly population (those under age 65) has prescription drug coverage, mostly provided by employers. Because Medicare does not cover outpatient prescription drugs, people with Medicare – who are primarily over the age of 65 – rely on a variety of supplemental sources for this coverage, most commonly employer-sponsored plans. About one-quarter of both the non-elderly and the Medicare populations have no coverage for prescriptions. More recent data for the Medicare population find that 38% had no prescription drug benefits in the fall of 1999.

NON-ELDERLY POPULATION, 1996



N=231.3 Million

MEDICARE POPULATION, 1998



N=38.1 Million

**SOURCE:**

*Prescription Drug Trends, A Chartbook Update*, The Kaiser Family Foundation and the Sonderegger Research Center (November 2001), Exhibit 1. See [www.kff.org](http://www.kff.org).

Non-Elderly data from Medical Expenditure Panel Survey, Department of Health and Human Services.

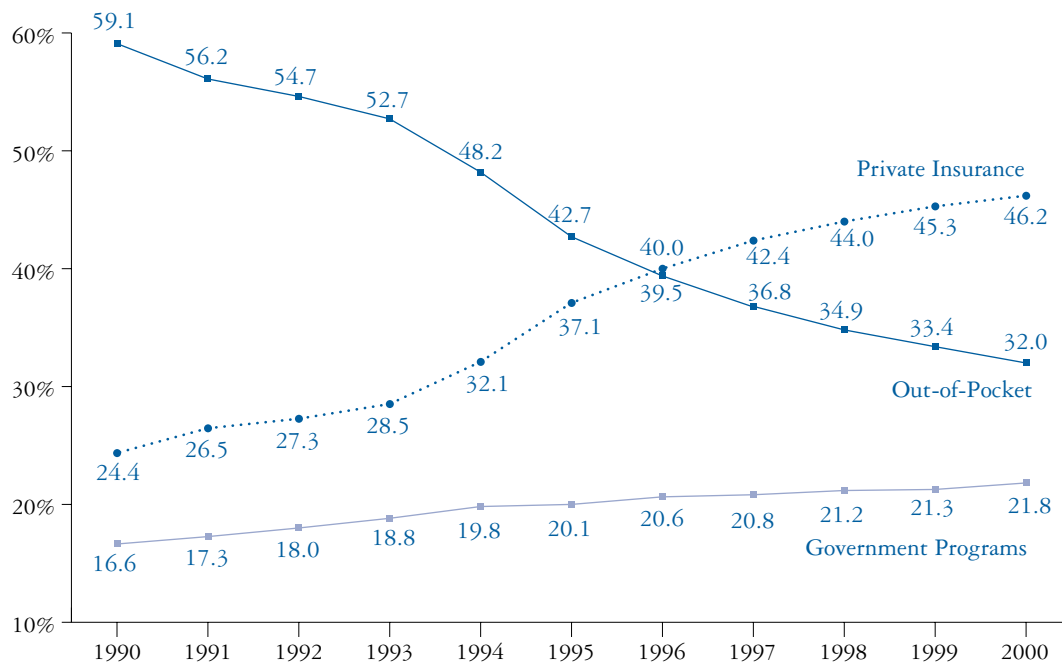
Medicare 1998 data from Poisal, J.A. and Murray, L. "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage," *Health Affairs*, March/April 2001.

Medicare 1999 data from Laschober, M.A et al. "Trends in Medicare Supplemental Insurance And Prescription Drug Coverage, 1996–1999," *Health Affairs*, web exclusive at [www.healthaffairs.org](http://www.healthaffairs.org), February 27, 2002.

## EXHIBIT 4.6

## National Prescription Drug Expenditures, Percent by Type of Payer, 1990–2000

Private insurers have paid an increasingly large share of total drug expenditures over time, their share rising from 24% to 46% between 1990 and 2000. This increase was offset by a decline in the proportion paid out-of-pocket by consumers, which dropped from 59% to 32% in the same period. Meanwhile, the government share, mostly provided by Medicaid, rose modestly from 17% to 22%.

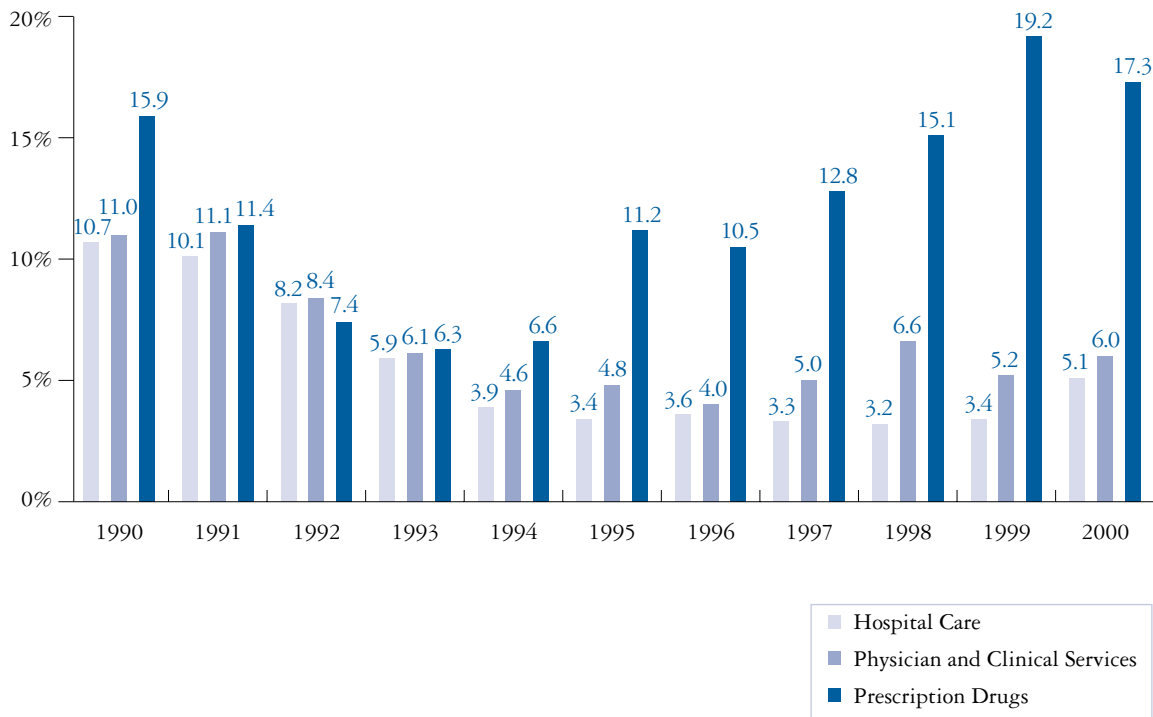
**SOURCE:**

*Prescription Drug Trends, A Chartbook Update*, The Kaiser Family Foundation and the Sonderegger Research Center (November 2001), Exhibit 2, at [www.kff.org](http://www.kff.org), updated with data from Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group at [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/).

## EXHIBIT 4.7

## Annual Percentage Change in National Spending for Selected Health Services, 1990–2000

While increases in drug spending tracked closely to increases in spending on other health services in the early 1990s, this pattern did not continue in the latter half of the decade. From 1995 to 2000, gains in drug spending were two to five times larger than increases in spending on hospital care and physician services. In 2000, for instance, drug spending increased by 17%, while spending on hospital care and physician services rose by 5% and 6%, respectively.

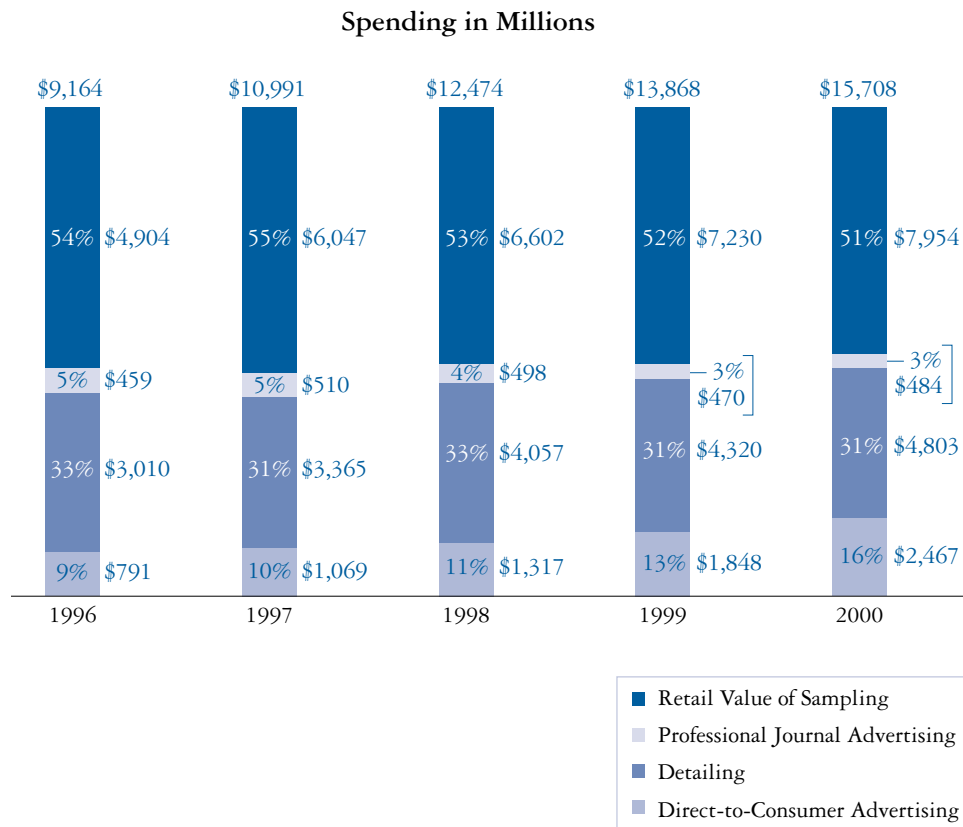
**SOURCE:**

*Prescription Drug Trends, A Chartbook Update*, The Kaiser Family Foundation and the Sonderegger Research Center (November 2001), Exhibit 5, at [www.kff.org](http://www.kff.org), updated with data from Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group at [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/).

## EXHIBIT 4.8

## Promotional Spending by Pharmaceutical Manufacturers, by Promotion Type 1996–2000

Promotional spending by pharmaceutical companies involves a variety of activities whose relative contribution has shifted somewhat over time. Consumers are most aware of direct-to-consumer (DTC) advertising (advertising directly to consumers through television, radio, and popular journals). But while spending in this area has increased markedly (more than tripling) since 1996, DTC represented less than one-fifth (16%) of all promotional spending by pharmaceutical manufacturers in 2000. More than 80% of spending was devoted to promoting drugs directly to physicians in their offices through sampling (51%) and detailing (31%).

**NOTES:**

Percentages may not sum to 100% due to rounding.

Sampling: the value of samples left at sales visits to office-based physicians. The samples are valued at the price they would be sold in retail pharmacies.

Detailing: expenses for sales activity of pharmaceutical representatives directed to office-based and hospital-based physicians. Approximately 83% of detailing is for office-based sales visits.

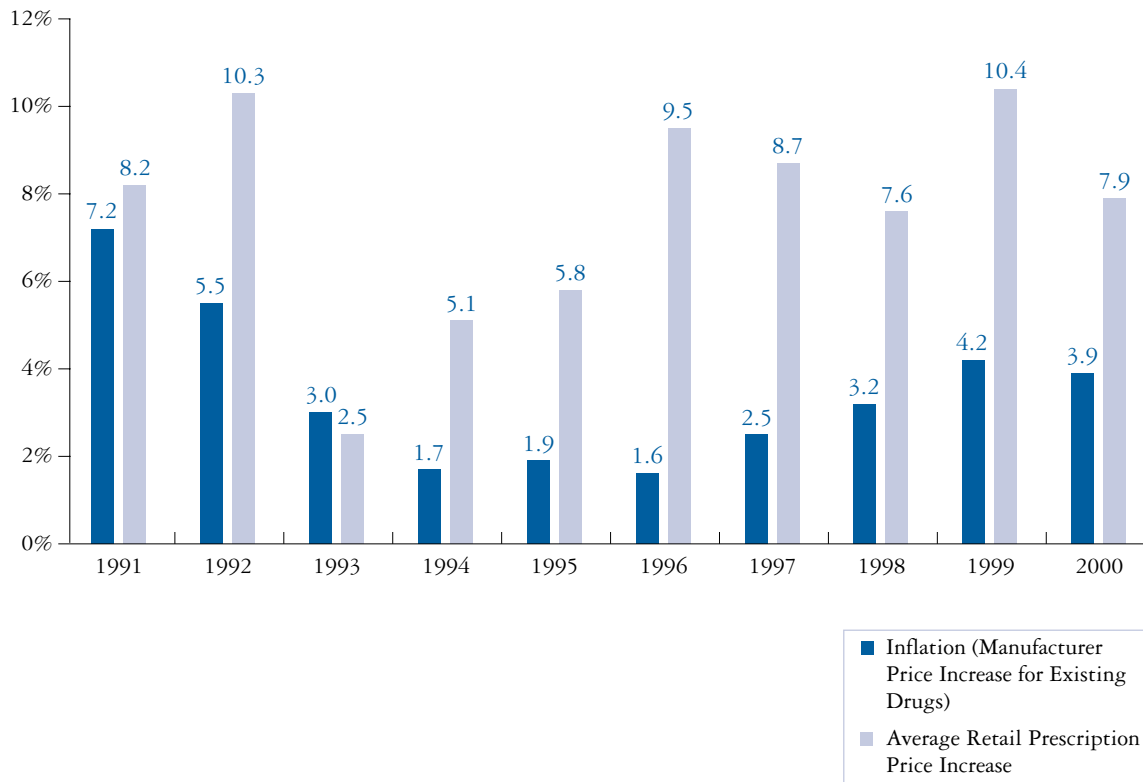
**SOURCE:**

*Prescription Drug Trends, A Chartbook Update*, The Kaiser Family Foundation and the Sonderegger Research Center (November 2001), Exhibit 17. See [www.kff.org](http://www.kff.org).

## EXHIBIT 4.9

## Retail Price Increases Reflecting the Use of Newer Drugs vs. Manufacturer Price Increases for Existing Drugs, 1991–2000

Annual increases in manufacturer prices (a measure of price inflation for existing drugs) have been significantly lower in recent years than increases in average retail prescription prices (which include both inflation and price changes due to newer, more expensive drugs sold). This difference demonstrates the growing contribution of a more expensive drug mix to overall price increases.

**NOTES:**

While increases in prescription drug prices reflect the impact of shifts in use to newer, more expensive drugs, manufacturer price increases represent price increases only for existing drugs. Wholesaler or retail pharmacy pricing contribute little to increased prescription prices over and above manufacturer price increases.

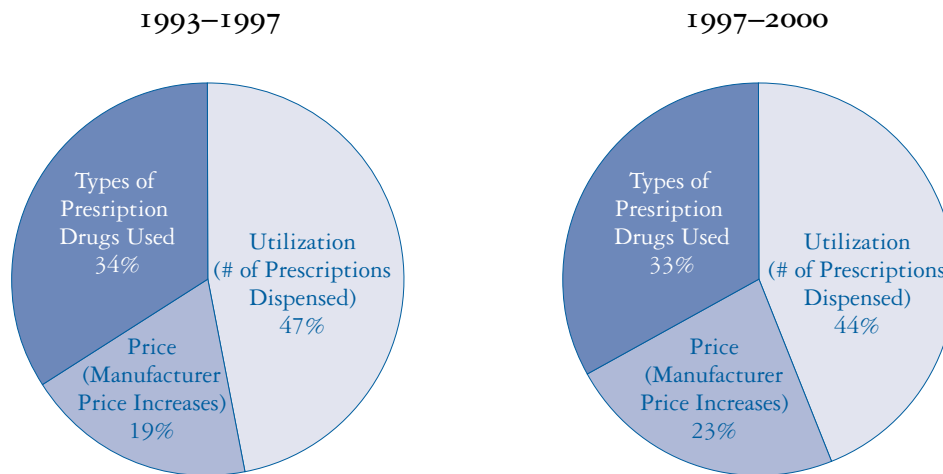
**SOURCE:**

*Prescription Drug Trends, A Chartbook Update*, The Kaiser Family Foundation and the Sonderegger Research Center (November 2001), Exhibit 23. See [www.kff.org](http://www.kff.org).

## EXHIBIT 4.10

## Relative Contributions of Utilization, Types of Prescription Drugs Used, and Price to Rising Prescription Drug Expenditures, 1993–1997 vs. 1997–2000

Increased utilization, changes in the mix of drug types used (from older, less expensive drugs to newer, higher cost drugs), and manufacturer price inflation for existing drugs are the factors driving the dramatic increases in drug spending. Almost half (44%) of the increase experienced from 1997 to 2000 is due to increases in the overall use of drugs (change in the number of prescriptions dispensed), while changes in the mix of drugs used (33%) and price inflation of existing drugs (23%) contribute in lesser proportions. In the period from 1997 to 2000, price inflation was a larger contributor (23%) to drug expenditure increases than in the prior period from 1993 to 1997 (19%).

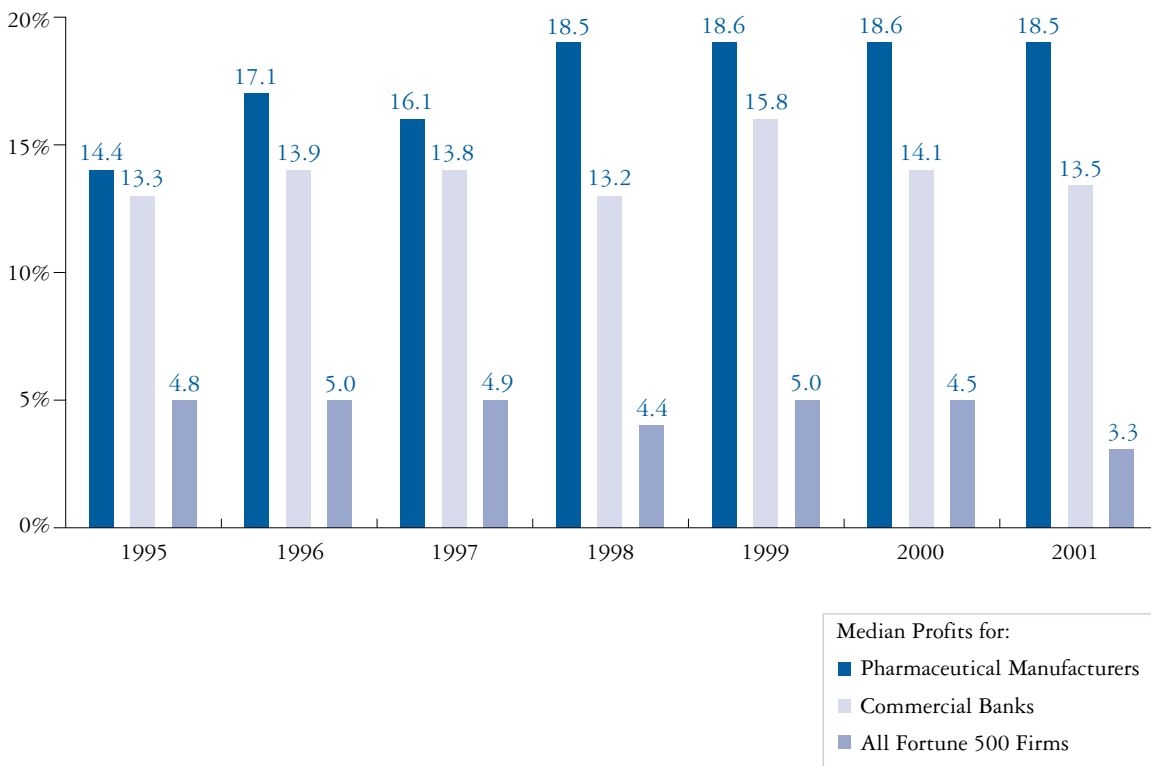
**SOURCE:**

*Prescription Drug Trends, A Chartbook Update*, The Kaiser Family Foundation and the Sonderegger Research Center (November 2001), Exhibit 26, at [www.kff.org](http://www.kff.org), updated with data from Centers for Medicaid and Medicare Services (CMS), Office of the Actuary, National Health Statistics Group at [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/).

## EXHIBIT 4.11

## Profitability Among Pharmaceutical Manufacturers Compared to Other Industries, 1995–2001

For every year from 1995 through 2001, the pharmaceutical industry was the most profitable industry in the U.S. With median profits of 19% in 2001, pharmaceutical manufacturers surpassed the second-ranked industry (commercial banks) by five percentage points. Drug companies were more than five times as profitable as the median for all Fortune 500 companies in 2001.

**NOTES:**

Percent shown is the median percent net profit after taxes as a percent of firm revenues for all firms in the industry. The second ranked industry each year was commercial banks.

**SOURCE:**

*Prescription Drug Trends, A Chartbook Update*, The Kaiser Family Foundation and the Sonderegger Research Center (November 2001), Exhibit 32. See [www.kff.org](http://www.kff.org), updated with 2001 data from Fortune 500 Industry Rankings, *Fortune* (April 15, 2002) p.F-26.

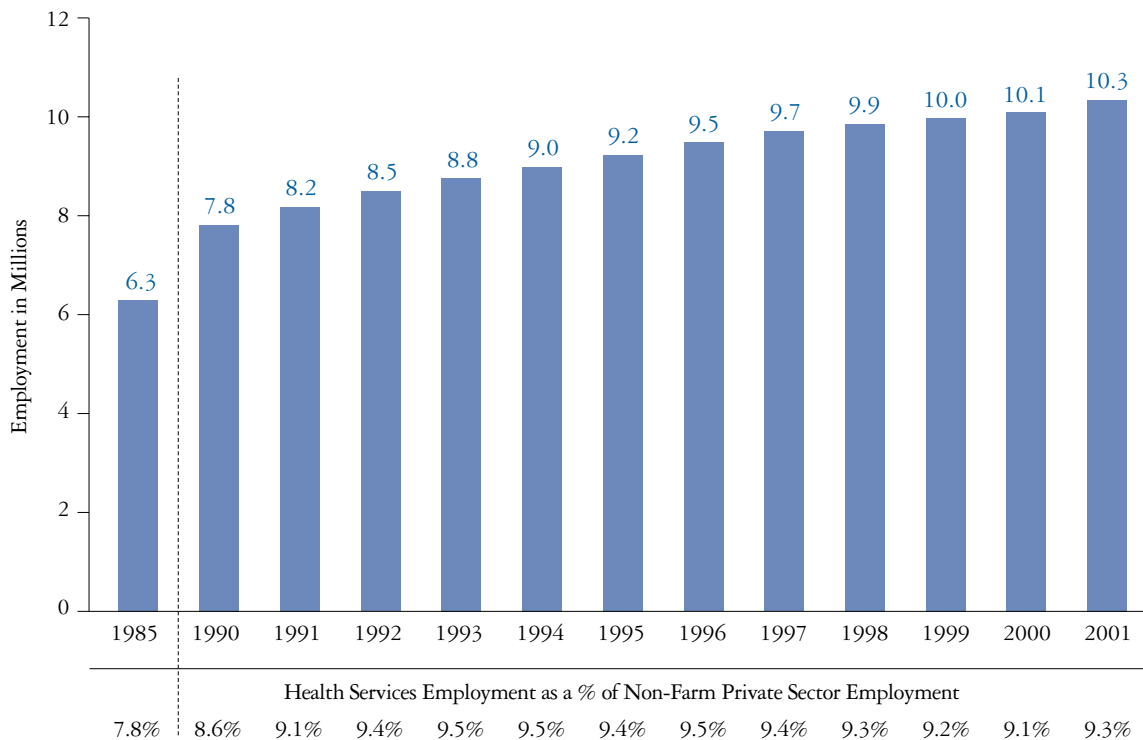


# TRENDS IN THE STRUCTURE OF THE HEALTH CARE MARKETPLACE

## EXHIBIT 5.1

## Total Health Services Employment and Share of Non-Farm Private Sector Employment, 1985–2001

Health services employment as a proportion of all non-farm private sector employment increased from 1985 to 1994, then declined somewhat from 1996 to 2000. In 2001, 9.3% of all workers, or just over 10 million people, held health care jobs. Despite reductions in hospital capacity and an increase in managed care, the number of people employed in the health sector increased each year of the last decade, though the annual increase has declined from 5% in 1991 to 2% in 2001.

**NOTES:**

Not seasonally adjusted.

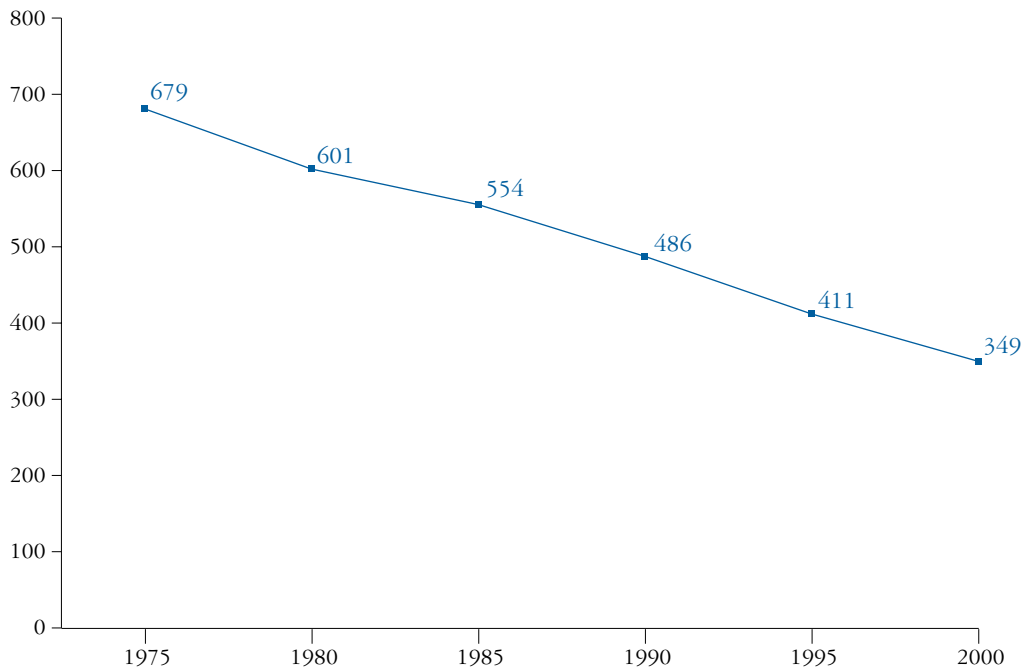
**SOURCE:**

Bureau of Labor Statistics, data extracted from web site at [data.bls.gov/labjava/outside.jsp?survey=ee](http://data.bls.gov/labjava/outside.jsp?survey=ee).

## EXHIBIT 5.2

## Hospital Beds per 100,000 Population, 1975–2000

Hospital capacity has continued to decline as lengths of stay decrease and use of outpatient procedures grows. In 2000, the nation's hospitals housed 349 beds for every 100,000 residents, just over half the capacity that existed in 1975.

**SOURCE:**

Hospital beds from *Hospital Statistics*, Health Forum LLC, an affiliate of the American Hospital Association (2002), Table 1, p.2. 1975–1995

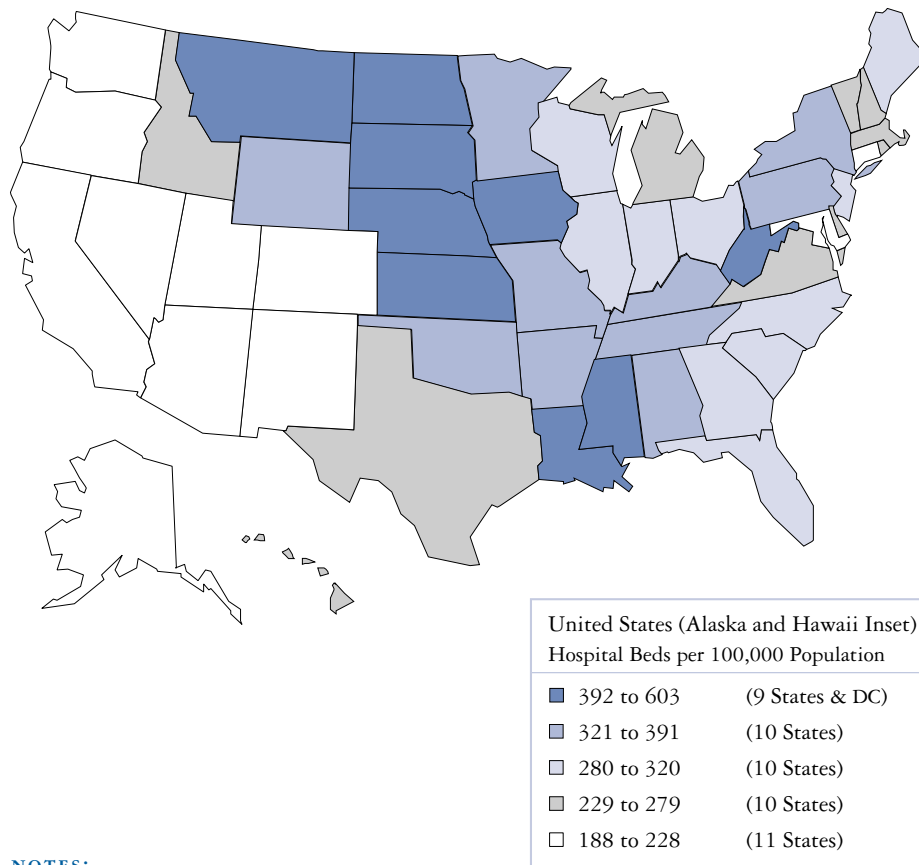
Population from U.S. Census Bureau web site at [www.census.gov/population/estimates/nation/popclockest.txt](http://www.census.gov/population/estimates/nation/popclockest.txt) .

2000 population from U.S. Census Bureau web site at <http://eire.census.gov/popest/data/national/populartables/table01.php> .

## EXHIBIT 5.3

## Hospital Beds per 100,000 Population, by State, 2000

Hospital capacity is not evenly distributed throughout the nation. In 2000, North Dakota had 603 beds per 100,000 residents, while Washington with 188 beds per 100,000 and Nevada with 189 per 100,000 had about a third this capacity. A combination of factors including population density, reimbursement levels, and managed care penetration contribute to the variation. Further, there is clear regional variation: Western and Southwestern states have the lowest levels and Midwestern states the highest levels of hospital capacity.

**NOTES:**

District of Columbia included.

**SOURCE:**

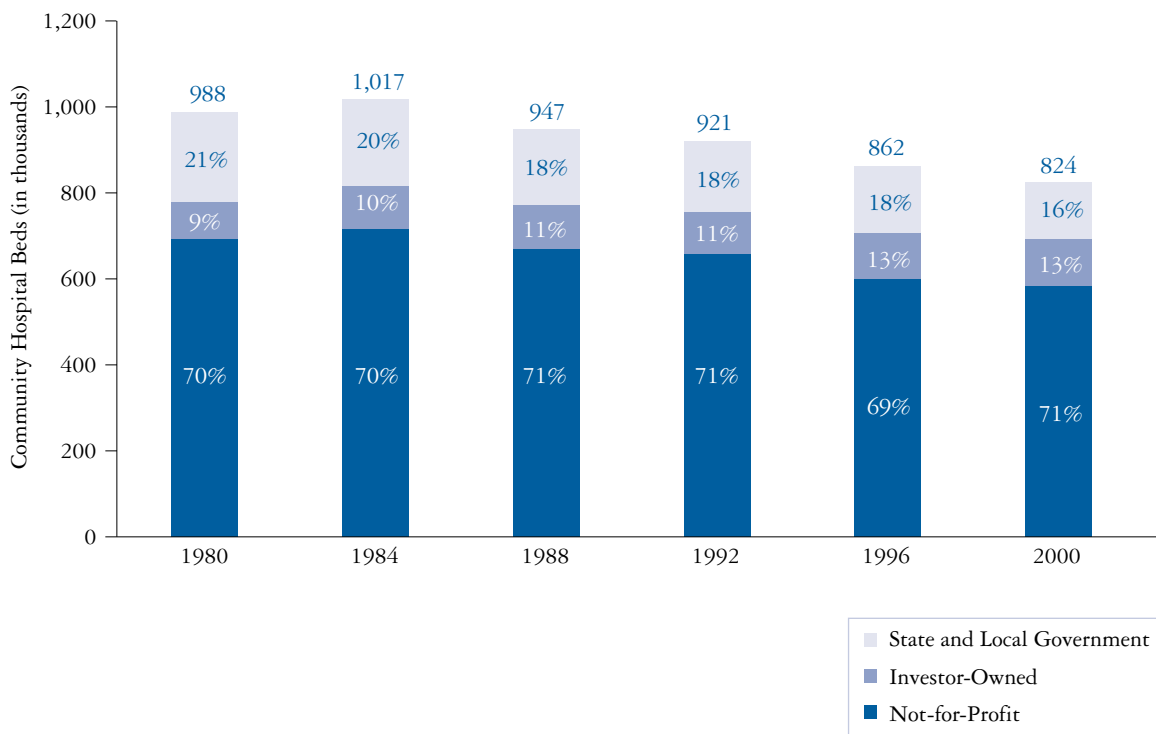
Hospital beds from *Hospital Statistics*, Health Forum LLC, an affiliate of the American Hospital Association (2002), Table 6, p. 49–149. Based on responses to the American Hospital Association's Annual Survey of Hospitals.

Population from U.S. Census Bureau web site at <http://eire.census.gov/popest/data/states/populartables/table01.php>.

## EXHIBIT 5.4

## Number and Distribution of Community Hospital Beds, by Ownership Status, 1980–2000

The ownership status of hospitals has changed little over the last two decades, with the proportion of hospital beds in not-for-profit community hospitals remaining constant at about 70%. Meanwhile, the share of public hospital beds has declined somewhat as the proportion of investor-owned beds increased modestly.

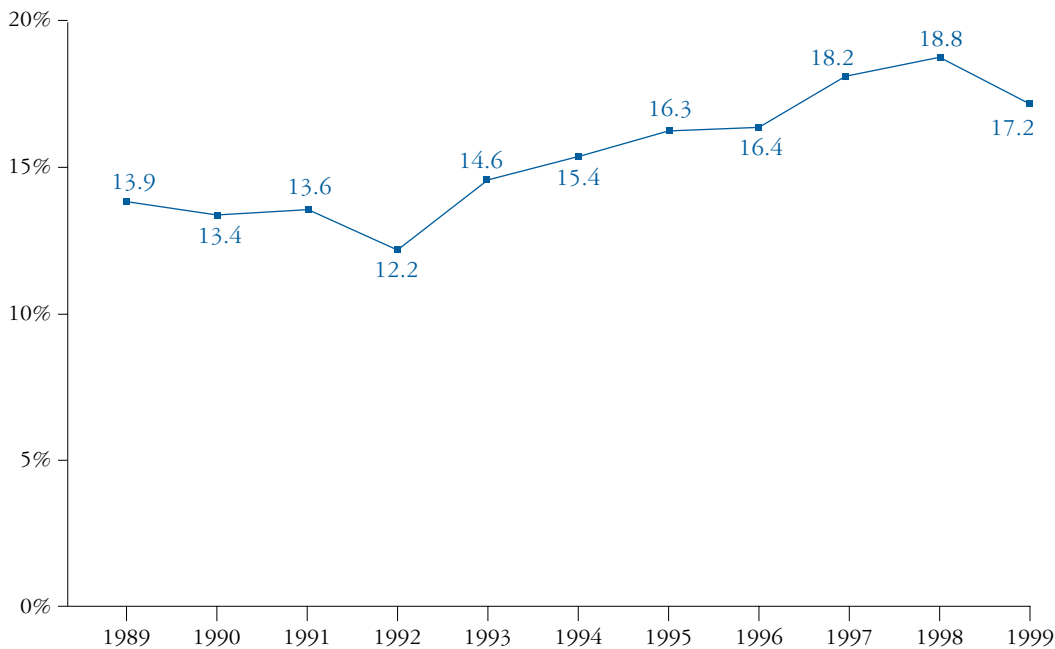
**SOURCE:**

*Hospital Statistics*, Health Forum LLC, an affiliate of the American Hospital Association (2002), Table 1, pp.4–5.

## EXHIBIT 5.5

## Proportion of Hospital Beds in 10 Largest Hospital Systems, 1989–1999

While HMO enrollment is concentrated in a few large firms, the hospital market is still largely local and dispersed. Fewer than 20% of all hospital beds were in the 10 largest community hospital systems in 1999. However, these figures mask an important market transition over the last decade as independent not-for-profit community hospitals have merged together to form large local hospital systems, often dominating certain urban health care markets.

**NOTES:**

The numerator, hospital beds in 10 largest systems, is licensed beds. The denominator, total community hospital beds, is staffed beds. This discrepancy will result in a modest overstatement of the proportion of beds in hospital systems.

**SOURCE:**

1999 hospital system data from *Modern Healthcare* web site at [www.modernhealthcare.com/charts/chart.php3?id=4](http://www.modernhealthcare.com/charts/chart.php3?id=4) and [www.modernhealthcare.com/charts/chart.php3?id=5](http://www.modernhealthcare.com/charts/chart.php3?id=5).

1997 & 1998 hospital system data from *Modern Healthcare*, (May 25, 1998), p.36 and (May 24, 1999), p.24.

1997, 1998 and 1999 total community hospital bed data from *Hospital Statistics*, Health Forum LLC, an affiliate of the American Hospital Association (2000).

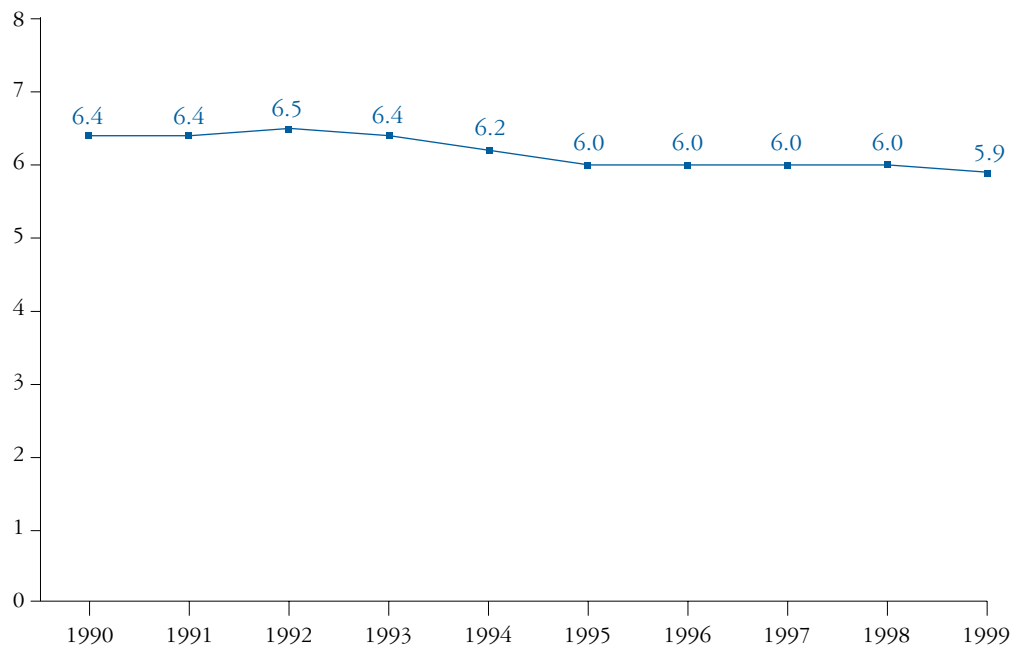
1989–1996 from *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 5.11, p.54.

Information on hospital consolidation trends in local markets from “Back to the future? New costs and access challenges emerge: Initial findings from HSC’s recent site visits.” Issue Brief #35 (February 2001), Cara S. Lesser and Paul B. Ginsburg, The Center for Studying Health System Change.

## EXHIBIT 5.6

## Median Full-Time-Equivalent Employees per 100 Adjusted Discharges, All U.S. Hospitals, 1990–1999

After declines from 1992 to 1995 – a period marked by rapid increases in managed care – hospital staffing levels remained relatively constant for the remainder of the decade, with a slight dip in 1999. In 1999, hospitals had 5.9 full-time-equivalent employees per 100 adjusted discharges, about 8% fewer than in 1990.

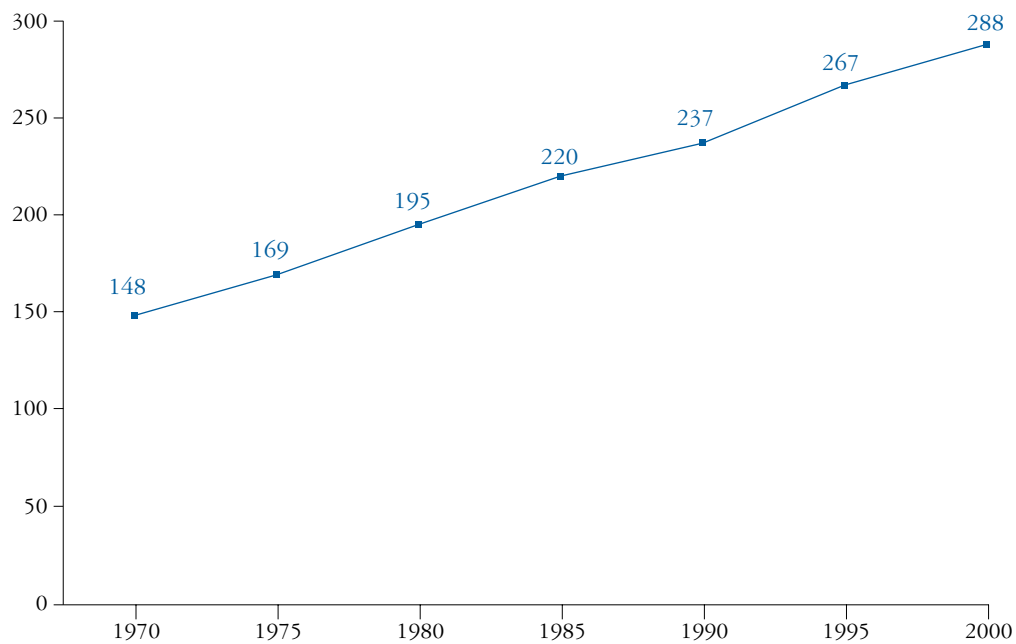
**SOURCE:**

*The Comparative Performance of U.S. Hospitals: The Sourcebook*, Solucient LLC (formerly HCIA-Sachs) and Deloitte & Touche (1995, 1999, 2000, & 2001) pp. 146, 136, 128, & 132.

## EXHIBIT 5.7

## Non-Federal Physicians per 100,000 Civilian Population, 1970–2000

As hospital capacity declines, the supply of physicians has continued to rise. In 2000, there were 288 non-federal physicians for every 100,000 persons, almost twice the physician capacity in 1970.

**NOTES:**

Civilian population includes civilians in the U.S. as of July 1 for corresponding year. Non-federal physicians are active and inactive physicians employed in the private sector in the U.S.

**SOURCE:**

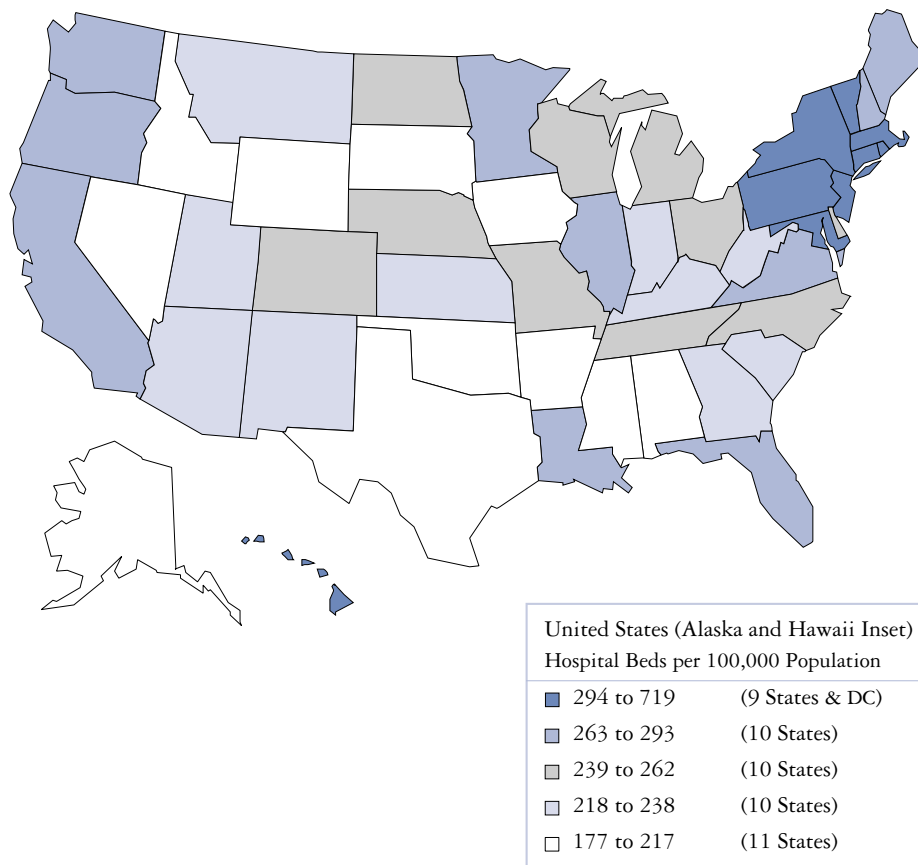
*Physician Characteristics and Distribution in the US, 2002–2003*, American Medical Association (2002), Table 5.17, p. 345.



## EXHIBIT 5.8

## Non-Federal Physicians per 100,000 Population, by State, 2000

There is considerable geographic variation for physician capacity. In 2000, the number of physicians per 100,000 population ranged from a high of 448 in Massachusetts to a low of 177 in Idaho. Sparsely populated and rural states typically have less physician capacity per capita than denser and more urban states.

**NOTES:**

District of Columbia included.

**SOURCE:**

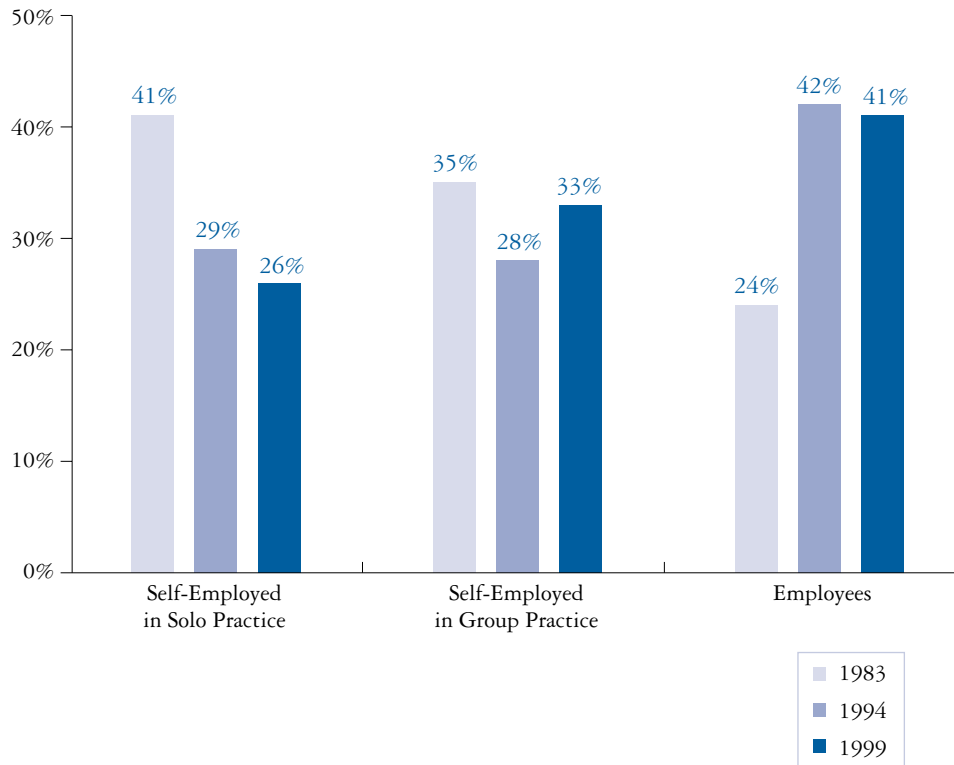
Non-federal physicians from *Physician Characteristics and Distribution in the US, 2002-2003*, American Medical Association (2002), Table 2.7, p. 48.

Population from U.S. Census Bureau web site at [eire.census.gov/popest/data/states/populartables/table01.php](http://eire.census.gov/popest/data/states/populartables/table01.php).

## EXHIBIT 5.9

## Distribution of Physicians, by Type of Practice, 1983, 1994, and 1999

The physician marketplace has changed dramatically since 1983, when 41% of physicians were self-employed in solo practice. In 1999 only 26% of all physicians worked on their own, while 41% of physicians were employees and 33% worked in group practices. An important driver for this trend away from solo practice is physicians' pursuit of market leverage in negotiating payments from managed care plans.

**NOTES:**

Totals for each year may not sum to 100% because of rounding. 1999 employee figure includes independent contractors.

**SOURCE:**

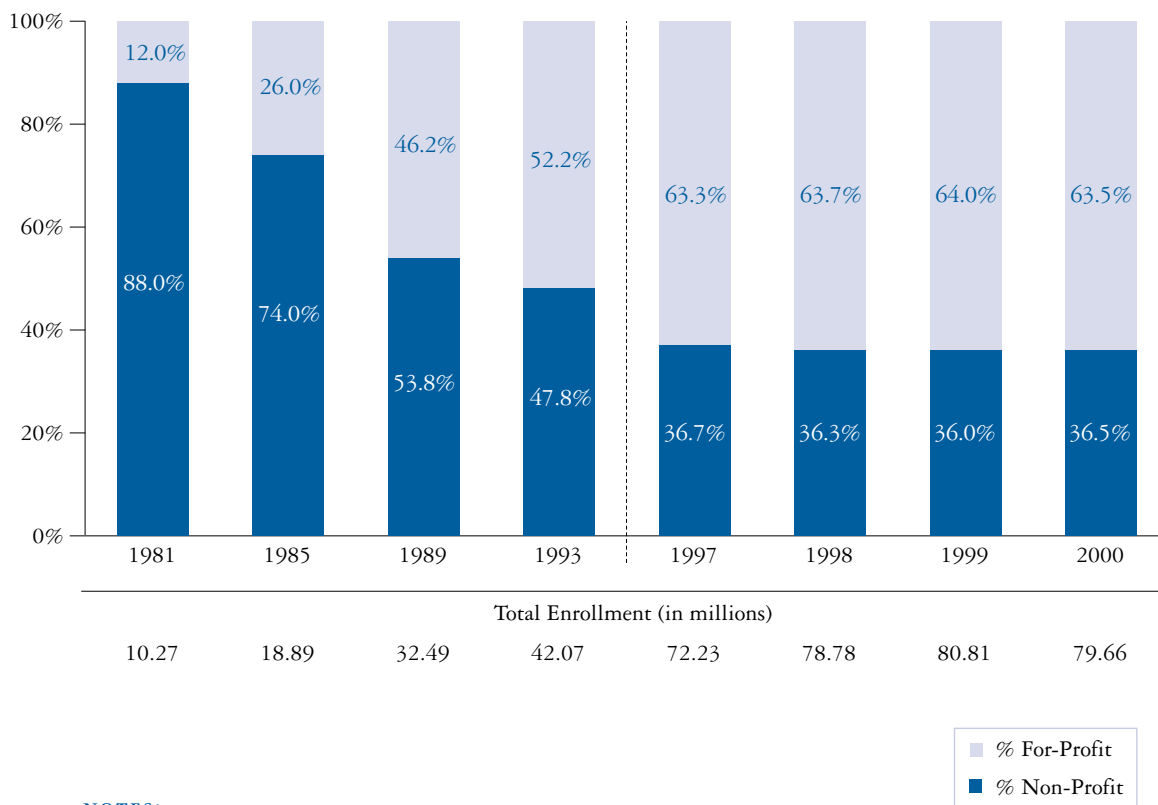
1999 from *Physician Socioeconomic Statistics, 2000–2002*, American Medical Association (2001), Figure 8, p. 30.

1983 and 1994 from *Socioeconomic Characteristics of Medical Practice, 1997*, American Medical Association (1997), p. 35, as shown in *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, The Kaiser Family Foundation (August 1998), Exhibit 5.4, p.49.

## EXHIBIT 5.10

## Distribution of HMO Enrollment, by Ownership Status, 1981–2000

HMO enrollment in for-profit plans increased dramatically from 12% in 1981 to 63% in 1997. The proportion of HMO enrollees in for-profit plans remained steady from 1997 to 2000 as conversions of plans from non-profit to for-profit status became less common.

**NOTES:**

Some plans failed to report profit status and are excluded from the analysis.

HMO enrollment includes enrollees in both traditional HMOs and point-of-service (POS) plans through: group/commercial plans, Medicare, Medicaid, the Federal Employees Health Benefits Program, direct pay plans, supplemental Medicare plans, and unidentified HMO products.

**SOURCE:**

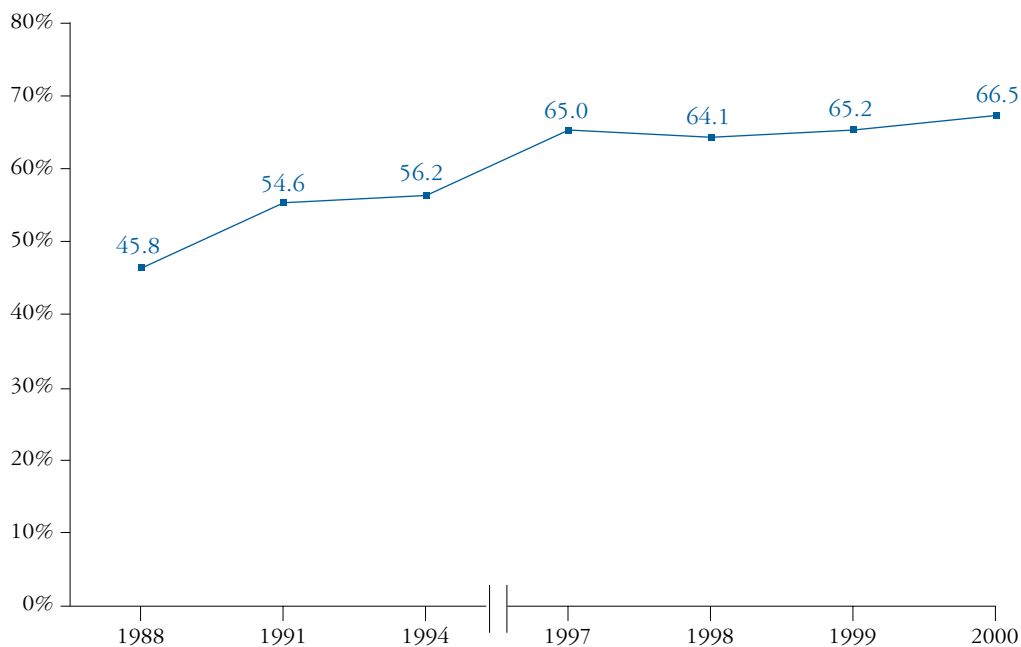
1997–2000 data from *The InterStudy Competitive Edge 8.1–11.1, Part II: HMO Industry Report* (using data as of July 1 of respective year), InterStudy Publications (April 1998–2001), pp. 2, 14, 20, & 18.

1981–1993 data from *The InterStudy HMO Summary* (June 1985); *InterStudy Edge* (1989), Volume 4; *The InterStudy Competitive Edge* (Reporting data as of July 1, 1993), Volume 3, Number 2, as shown in *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 5.7, p. 52.

## EXHIBIT 5.11

## Proportion of Total HMO Enrollment in 10 Largest National Managed Care Firms, 1988–2000

A striking two-thirds (67%) of all HMO enrollees are enrolled in the nation's 10 largest managed care firms, up from 46% in 1988. The largest national managed care firms include Blue Cross and Blue Shield plans, Aetna US Healthcare, Kaiser Permanente, United Health, and PacifiCare.

**NOTES:**

HMO enrollment includes enrollees in both traditional HMOs and point-of-service (POS) plans through: group/commercial plans, Medicare, Medicaid, the Federal Employees Health Benefits Program, direct pay plans, supplemental Medicare plans, and unidentified HMO products.

**SOURCE:**

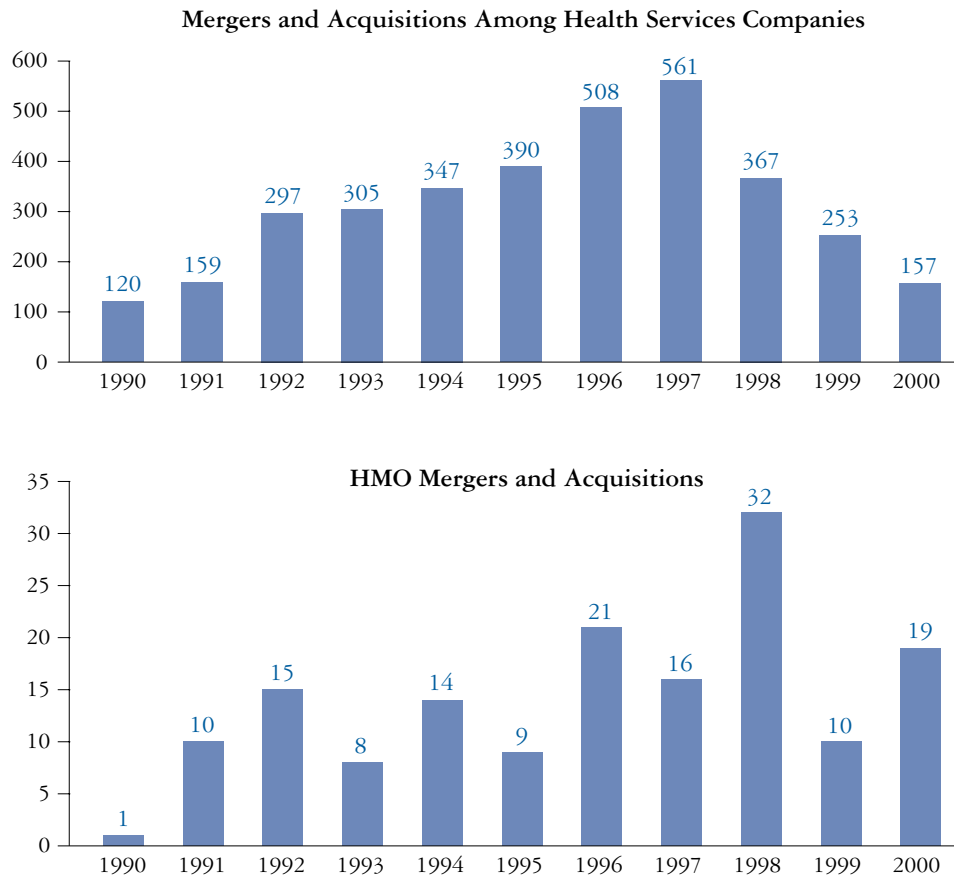
1997–2000 data from *The InterStudy Competitive Edge 8.1–11.1, Part II: HMO Industry Report* (all using data as of July 1 of respective year), InterStudy Publications (April 1998–2001), pp.28, 10, 16, & 42.

1988–1994 data from *InterStudy National HMO Firms 1988* (August 1988); *The InterStudy Competitive Edge* (Reporting data as of January 1, 1991), Vol.1, No.1; *The InterStudy Competitive Edge* (Reporting data as of January 1, 1994), Vol.4, No.1, as shown in *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 5.10, p.54.

## EXHIBIT 5.12

## Number of Mergers and Acquisitions Among Health Services Companies and HMOs, 1990–2000

As stock prices took a downward turn and merged entities confronted management difficulties, the number of health company mergers fell sharply in recent years. In 2000, 157 health services companies completed a transaction, compared to 561 in 1997. The small number of HMO mergers makes identifying a trend difficult, but HMO mergers appear to have increased over the last few years (e.g., there were 61 in 1998–2000, compared to 46 in 1995–1997, and 37 in 1992–1994).

**NOTES:**

Includes completed transactions sorted by date of transaction announcement. Health services companies include those with Standard Industrial Classification (SIC) codes 8000 through 8099: offices and clinics of doctors of medicine or osteopathy, dentists, or other health care providers; nursing and personal care facilities; hospitals; medical and dental laboratories, home health care services; and miscellaneous health and allied services. HMO companies include companies identified as primarily HMO companies (does not include multi-line property/casualty insurance companies that may have an HMO line that represents less than half of its business), as well as other companies classifying themselves as medical services plans (SIC 6324).

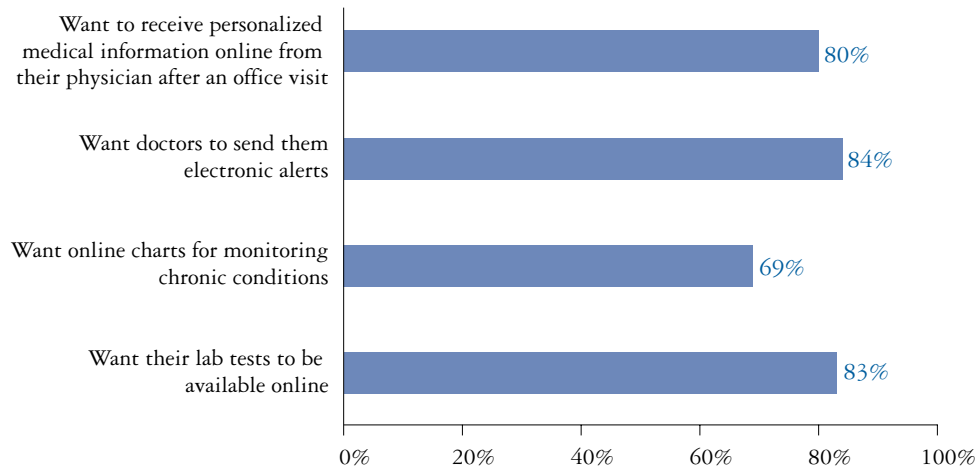
**SOURCE:**

Analysis prepared for the Kaiser Family Foundation by Securities Data Company, June 2001.

## EXHIBIT 5.13

## Consumers' Demand for Electronic Communication With Physicians, 2000

Consumer demand for Internet health information is high, and includes a desire for Internet communication with doctors. Eighty percent or more of consumers say they would like to receive personalized medical information, lab tests, or electronic alerts from their physicians via the Internet. But while the use of and interest in the Internet has grown rapidly, access is still limited. Fewer than half of all U.S. households (42%) and less than one-fifth of lower income households (19% of households with incomes below \$25,000) had access to the Internet in 2000.

**SOURCE:**

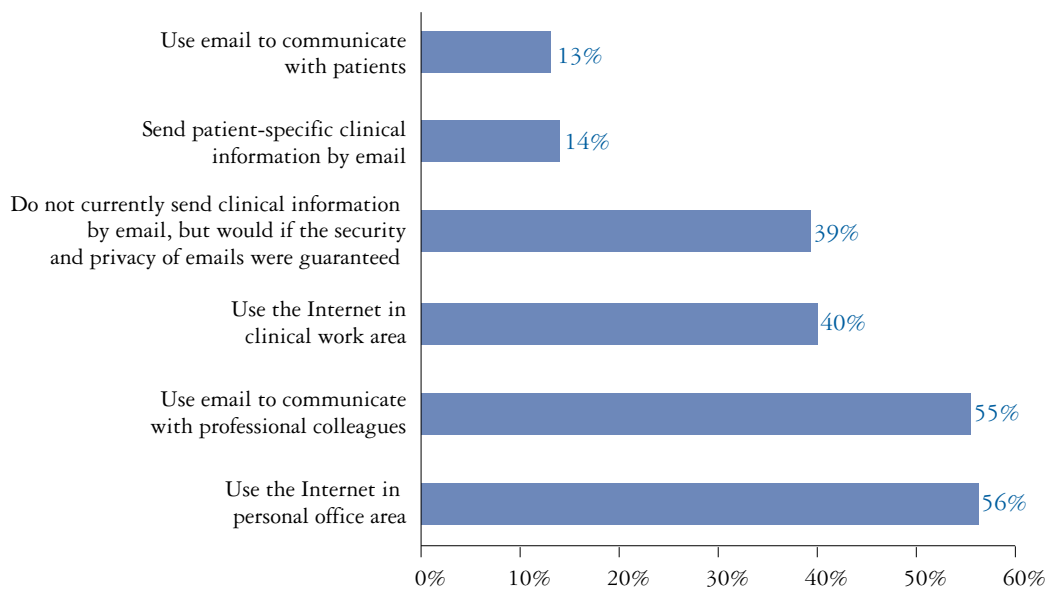
Consumer demand information from Harris Interactive News Release from the Harris Interactive web site at [www.harrisinteractive.com/news/index.asp?NewsID=166&III](http://www.harrisinteractive.com/news/index.asp?NewsID=166&III). Based on responses to the 2000 Healthcare Satisfaction Study conducted by Harris Interactive and ARiA Marketing.

Internet access data from *Home Computers and Internet Use in the United States: August 2000*, by Eric Newburger, Current Population Reports, U.S. Bureau of the Census (September 2001).

## EXHIBIT 5.14

## Physicians' Use of the Internet, 2001

Although consumers would like more communication with their doctors via the Internet, very few physicians have adopted these practices. A sizable group, though, say they would increase their online usage if privacy issues were addressed. Despite their reluctance to use the Internet to relay patient-specific information, the majority of physicians do use email and the Internet in their work.



## SOURCE:

*Health Care News*, Harris Interactive (February 26, 2001), Vol.1, Issue 8, p.2.





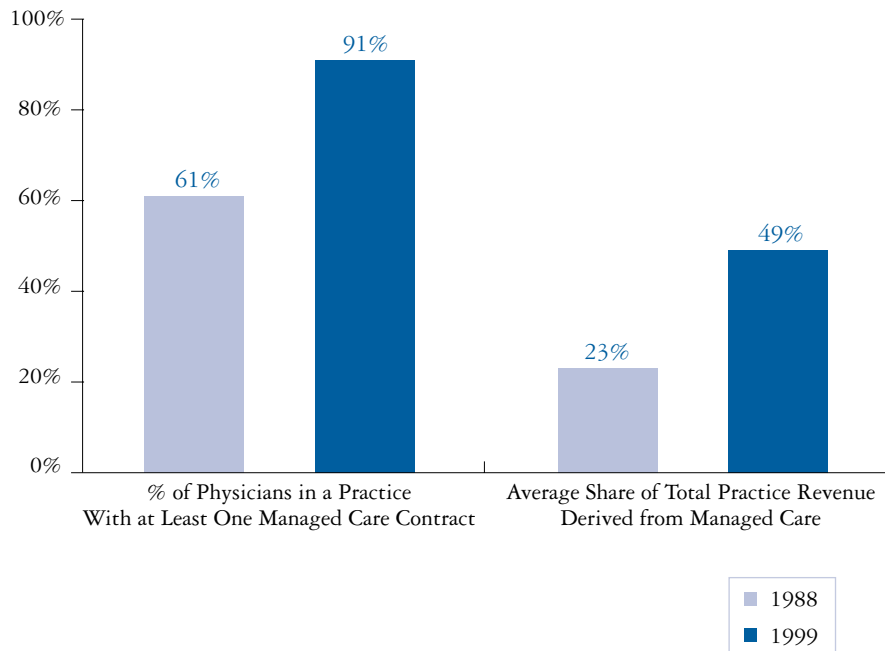
# TRENDS IN HEALTH PLAN AND PROVIDER RELATIONSHIPS



## EXHIBIT 6.1

## Physician Participation in Managed Care, 1988 and 1999

Physician participation in managed care has sharply increased in the last ten years. The proportion of physicians with at least one managed care contract increased from 61% in 1988 to 91% in 1999, while the average contribution of managed care to practice revenue more than doubled (from 23% to 49%) in the same period.

**NOTES:**

Average Share of Total Practice Revenue represents share of revenue among physicians with at least one managed care contract. Managed Care Contracts include contracts with IPAs, HMOs, and PPOs.

**SOURCE:**

1999 practice revenue from managed care from *Physician Socioeconomic Statistics, 2000–2002*, American Medical Association (2001), Table 48, p.96.

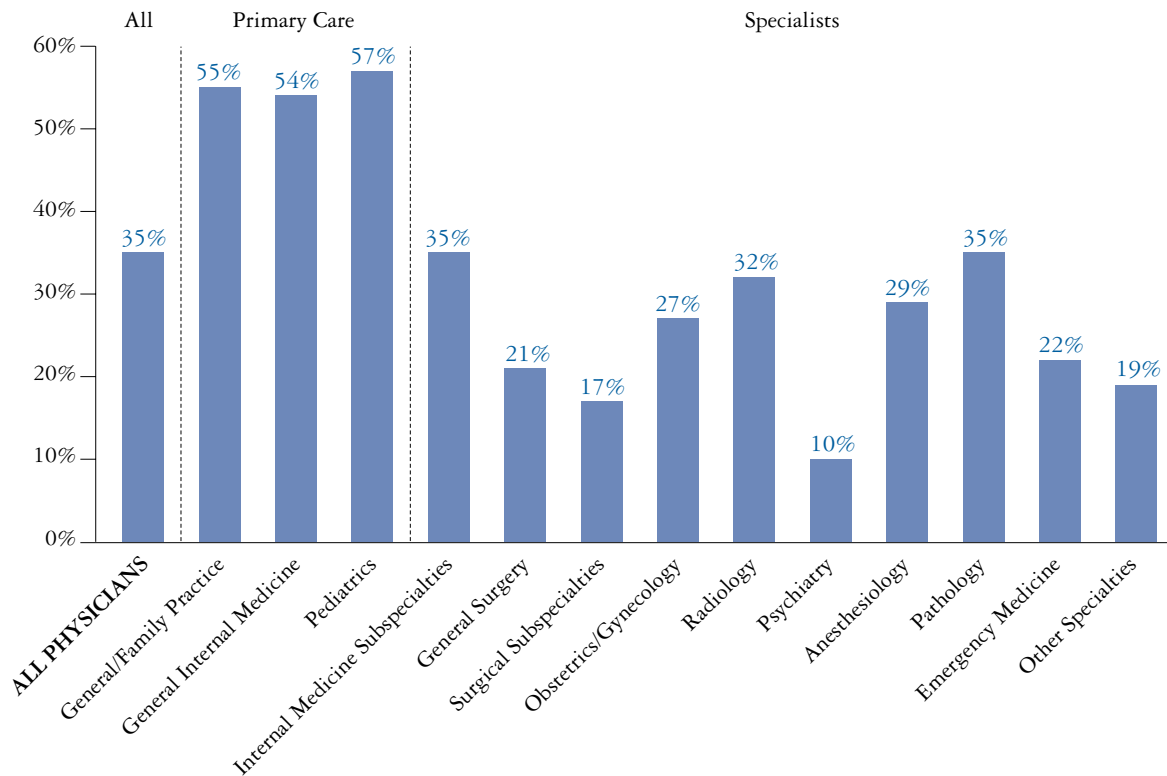
1999 physicians with managed care contracts from *Physician Socioeconomic Statistics, 2000–2002*, American Medical Association (2001), Table 46, p.94.

1988 physician data from *Physician Marketplace Statistics 1997/98*, American Medical Association (1998), pp. 116 and 118, and K.Gillis and D. Emmons, “Physicians’ Involvement with Alternative Delivery Systems,” *Socioeconomic Characteristics of Medical Practice 1993*, American Medical Association (1993), p. 16, as shown in *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, The Kaiser Family Foundation (August 1998), Exhibit 6.1, p.60.

## EXHIBIT 6.2

## Percentage of Physicians With Capitated Contracts, by Specialty, 1999

While nearly all physicians hold managed care contracts (91% do, as shown in Exhibit 6.1), a much smaller proportion, 35%, had capitated contracts in 1999 (contracts where the physician is paid a specific amount per patient). Primary care physicians are more likely than specialists to have capitated contracts: more than half of all primary care physicians had a capitated contract in 1999, compared to between 10% and 35% of specialists.

**SOURCE:**

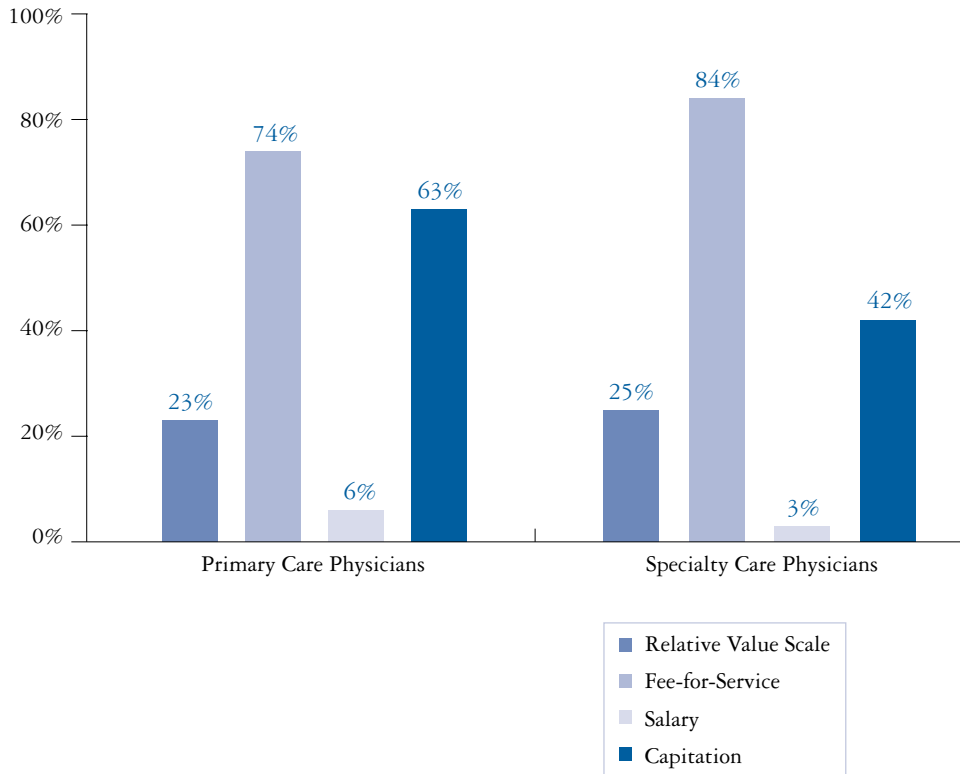
*Physician Socioeconomic Statistics, 2000–2002*, American Medical Association (2001), Table 46, p.94.

## EXHIBIT 6.3

## Method of Physician Reimbursement by HMOs, 2000

HMOs are much more likely to use capitation to pay for physician than for hospital services (See Exhibit 6.6). Sixty-three percent of HMOs pay primary care physicians and 42% pay specialists using capitation. Still, fee-for-service is by far the most common payment method, and its use is increasing. The proportion of HMOs using fee-for-service payment for physicians almost doubled from 1997 to 2000, increasing from 33% to 74% for primary care physicians and from 49% to 84% for specialists.

Percentage of HMOs Using Various Methods

**NOTES:**

Data show percentage of HMOs using various methods for any portion of physician reimbursement.

**SOURCE:**

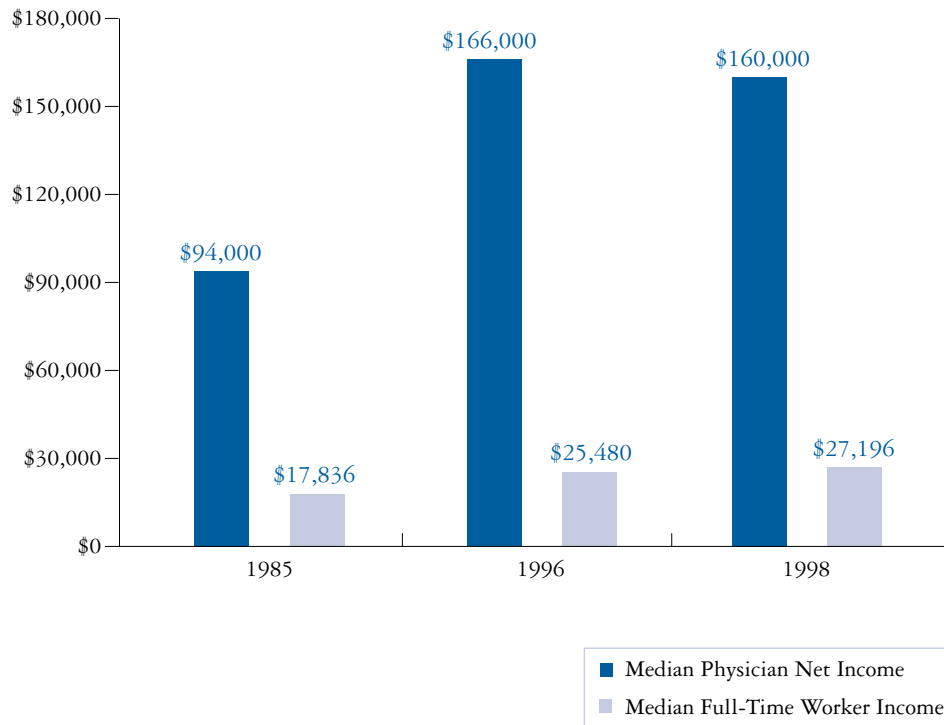
2000 data from *The InterStudy Competitive Edge 11.1, Part II: HMO Industry Report* (using data as of July 1, 2000), InterStudy Publications (April 2001), Table 23, p.52.

1997 data from *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 6.5, p.62.

## EXHIBIT 6.4

## Median Income, Physicians vs. All Full-Time Wage Earners, 1985, 1996, and 1998

While the median wage levels for all workers increased 7% from 1996 to 1998, physician incomes declined 4% over the same period. Still, physician income is about 6 times the median income for all full-time workers.

**NOTES:**

Median Full-Time Worker Income reflects median weekly earnings of full-time workers multiplied by 52.

**SOURCE:**

1998 Median Physician Net Income from *Modern Healthcare*, "Follow the Money, AMA's Long-Delayed Annual Report Offers Unsettling News on Physicians' Incomes" (January 1, 2001), p. 12.

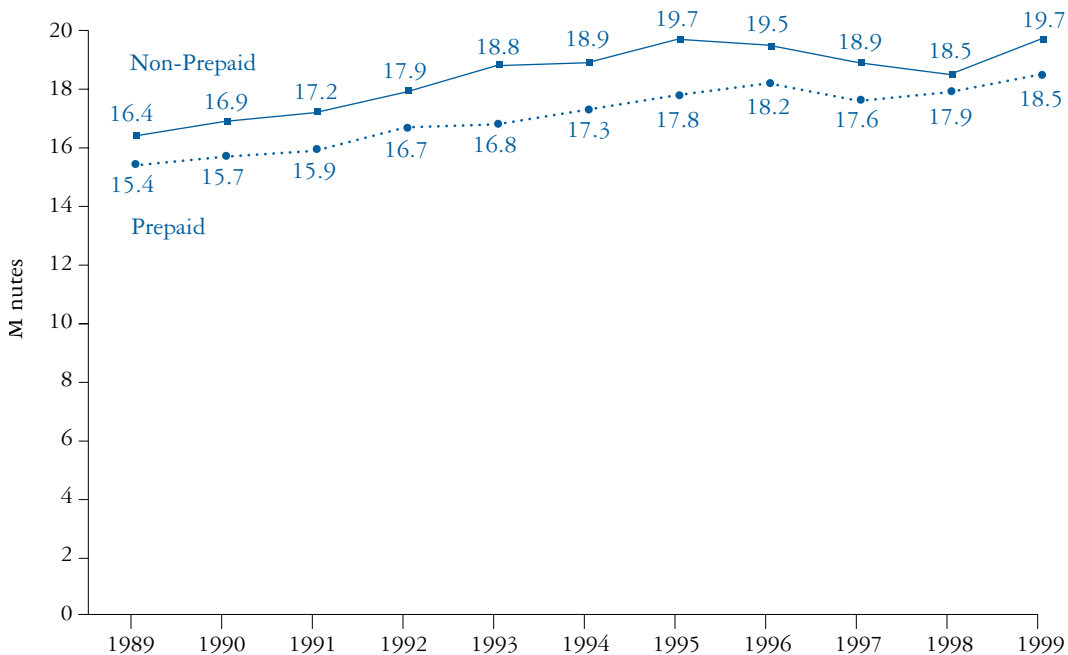
Wage & salary information for full-time workers from U.S. Census Bureau, *Statistical Abstract of the United States, 1995–2000*, Census web site at [www.census.gov/prod/www/statistical-abstract-us.html](http://www.census.gov/prod/www/statistical-abstract-us.html).

1985 and 1996 physician salary data from Kaiser Family Foundation analysis of data published by the American Medical Association, *Physician Marketplace Statistics*, and U.S. Census Bureau, *Statistical Abstract of the United States* as shown in *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 6.10, p.65.

## EXHIBIT 6.5

## Mean Length of Physician Office Visits (in Minutes), by Payment Type, 1989–1999

Perhaps contrary to popular belief, physician visits have gotten longer, not shorter in the last 10 years. Both prepaid and non-prepaid visits were on average over three minutes longer in 1999 than in 1989. The trend has not been continuous: the length of visits increased from 1989 to 1995, decreased in recent years, then rose in 1999. Across the period, non-prepaid visits were slightly longer than prepaid visits.

**NOTES:**

Prepaid visits are visits reimbursed by capitated payments from HMOs.

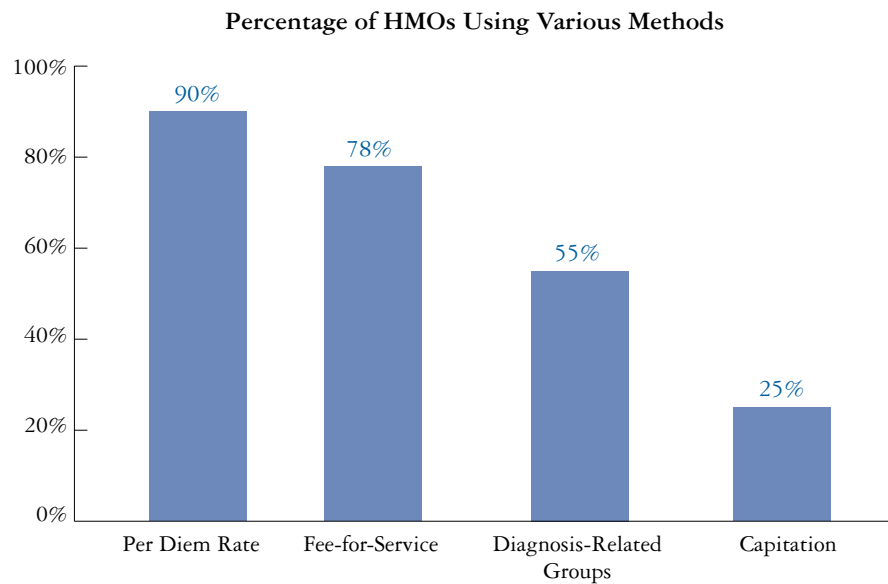
**SOURCE:**

“Are Patients’ Office Visits With Physicians Getting Shorter?” *The New England Journal of Medicine*. David Mechanic, Donna D. McAlpine, and Marsha Rosenthal, (January 18, 2001), Vol. 344, No. 3, p. 200, updated with data from David Mechanic and Donna D. McAlpine, “Fifteen Minutes Of Fame’: Reflections On The Uses Of Health Research, The Media, Pundits, And The Spin,” *Health Affairs* (November/December 2001), Vol. 20, No. 6.

## EXHIBIT 6.6

## Method of Hospital Reimbursement by HMOs, 2000

A small proportion of HMOs (25%) paid for hospital services using capitated contracts in 2000. Per diem rates (used by 90% of plans) and fee-for-service (used by 78% of plans) were the most widely used payment methods. There has been a substantial increase in the use of these latter reimbursement approaches since 1997, when only 53% of HMOs used per diem rates and 16% used fee-for-service payments. Meanwhile, use of capitation has increased modestly, rising from 19% to 25% in the same period.

**NOTES:**

Data show percentage of HMOs using various methods for any portion of hospital reimbursement.

**SOURCE:**

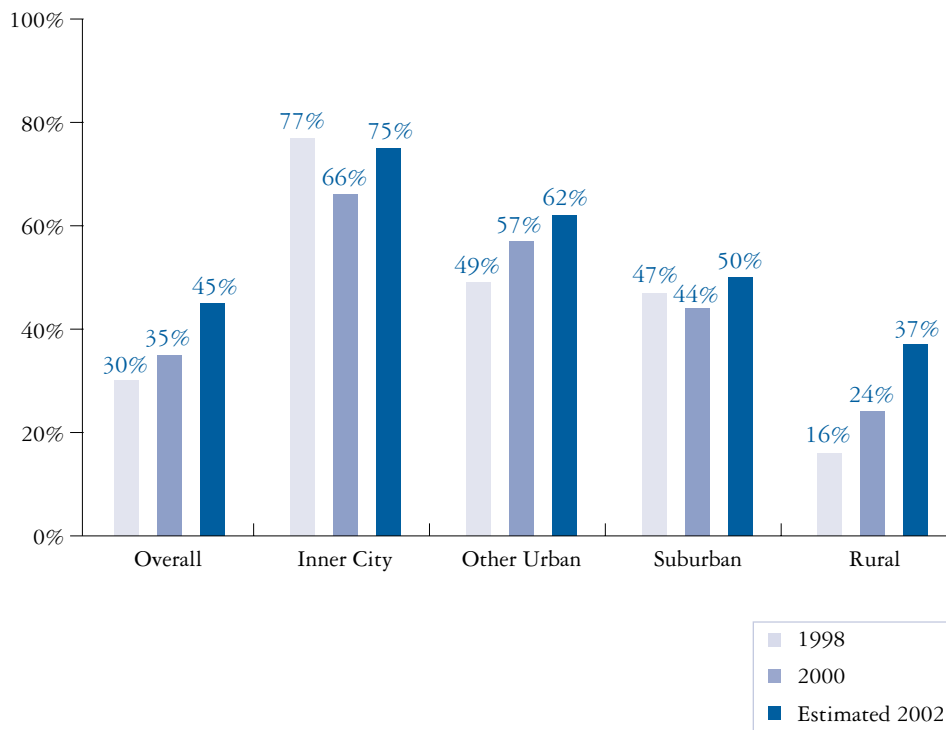
2000 data from *The InterStudy Competitive Edge 11.1, Part II: HMO Industry Report* (using data as of July 1, 2000), InterStudy Publications (April 2001), Table 23, p.52.

1997 data from *Trends and Indicators in the Changing Health Care Marketplace Chartbook*, Kaiser Family Foundation (August 1998), Exhibit 6.4, p.62.

## EXHIBIT 6.7

## Percent of Hospitals Reporting Revenues from Capitated Contracts, by Location, 1998, 2000, and Estimated 2002

Overall, the proportion of hospitals reporting revenue from capitated contracts has increased from 30% to 35% from 1998 to 2000, with projected increases to 45% by 2002. Not surprisingly, hospitals in urban areas, and particularly inner city facilities, are much more likely to report capitation revenues than are rural hospitals.

**SOURCE:**

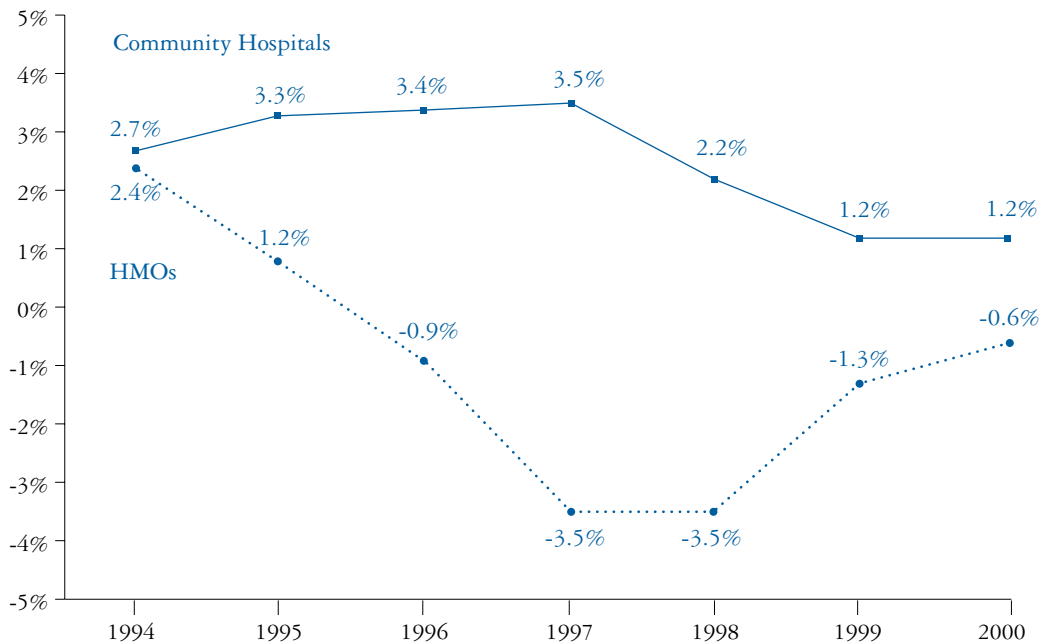
*U.S. Hospitals and the Future of Health Care: A Continuing Opinion Survey, Eighth Edition 2000*, Deloitte & Touche LLP (2000), p. 19.



## EXHIBIT 6.8

## Median Total Profit Margins of Hospitals and HMOs, 1994–1999

Median operating margins for community hospitals dropped from 3.5% in 1997 to 1.2% in 2000. Changes in private payer and Medicare payments (after implementation of the Balanced Budget Act of 1997) likely contributed to this decline. In the same 4-year period, median HMO operating margins improved, although as a group HMOs remained unprofitable in 2000.

**SOURCE:**

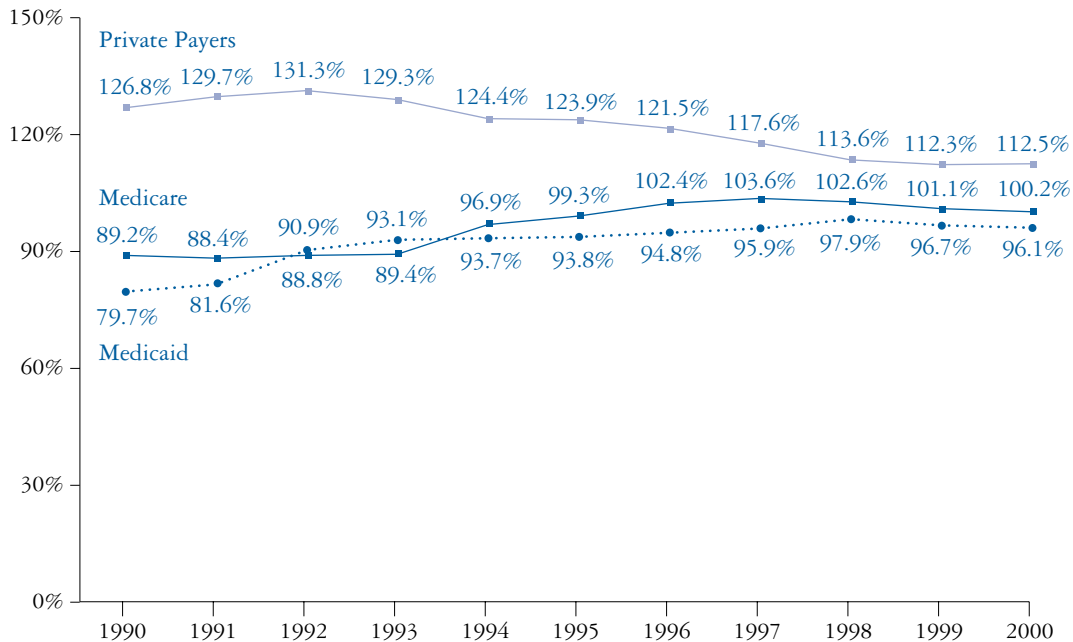
Median operating profit margins of community hospitals from data provided by Health Forum based on the AHA Annual Survey of Hospitals, 1994–2000, personal communication.

Median operating profit margins of HMOs from InterStudy Publications press release, *HMO Enrollment Concentrated in National Firms* (10/31/01), on their web site at [www.interstudypublications.com](http://www.interstudypublications.com).

## EXHIBIT 6.9

## Community Hospital Payment-to-Cost Ratios, by Source of Revenue, 1990–2000

In 2000, Medicare paid about 100% of hospitals' costs, while Medicaid (covering 96% of costs) was nominally unprofitable for hospitals. Medicaid's performance as a payer, like Medicare's, has increased substantially from 1990, when Medicaid payments covered only 80% of the costs. While still the most profitable payer relative to Medicaid and Medicare, the profitability of private payers has steadily declined since 1992, but rose slightly in 2000.

**NOTES:**

Payment-to-cost ratios show the degree to which payments from each payer cover the costs of treating its patients. They cannot be used to compare payment levels across payers, however, because the service mix and intensity vary.

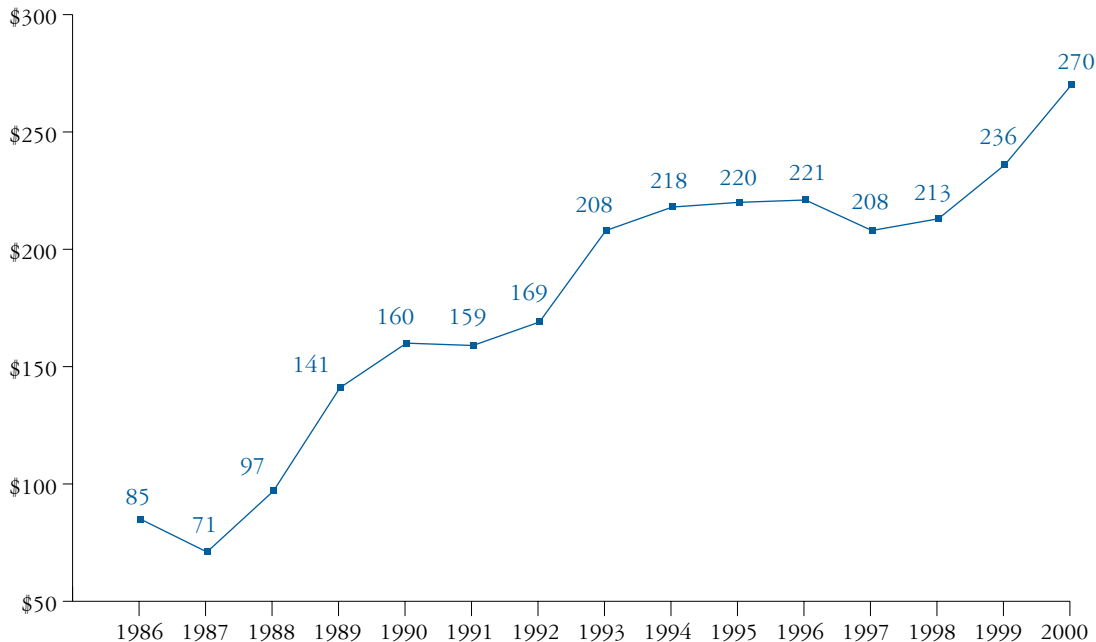
**SOURCE:**

*Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission (March 2002), Table B-11, p.156.

## EXHIBIT 6.10

## Private Health Insurance Administrative Costs per Person Covered, 1986–2000

The cost per enrollee for expenses not related to direct care services (such as administrative costs and profits) continued to rise, from \$85 in 1986 to \$270 in 2000. The most rapid growth occurred in the four-year period from 1987 to 1990, when these costs rose 125%. From 1997 to 2000, the most recent four-year period reported, cost per enrollee rose 30%.

**NOTES:**

These data show the net cost of private health insurance per private enrollee as calculated by CMS. CMS calculates the net cost of private health insurance by summing administrative costs, net additions/subtractions from reserves, and profits. Net cost is calculated as the difference between premiums earned and benefits paid. Net enrollment is constructed using the Health Interview Survey, extrapolating the 1994 HIS to 1990–1996 using the Current Population Survey counts of persons with private health insurance. Net enrollment for earlier years were developed using data on gross and net enrollment and percentage of population privately insured as presented by Carroll and Arnett.

**SOURCE:**

Calculations by authors based on data prepared by Katie Levit, Office of the Actuary, National Health Statistics Group, Centers for Medicaid and Medicare Services (CMS), (March 15, 2002). Private health insurance net enrollment is estimated using net enrollment from the National Health Interview Survey (1978–89) and the Current Population Survey (1980–92), and net and gross enrollment from M. Carroll and R. Arnett in “Private Health Insurance Plans in 1978 and 1979: A Review of Coverage, Enrollment and Financial Experience,” *Health Care Financing Review* (1981), Vol. 3, No. 1, pp. 55–87, and preceding articles (1970–79).

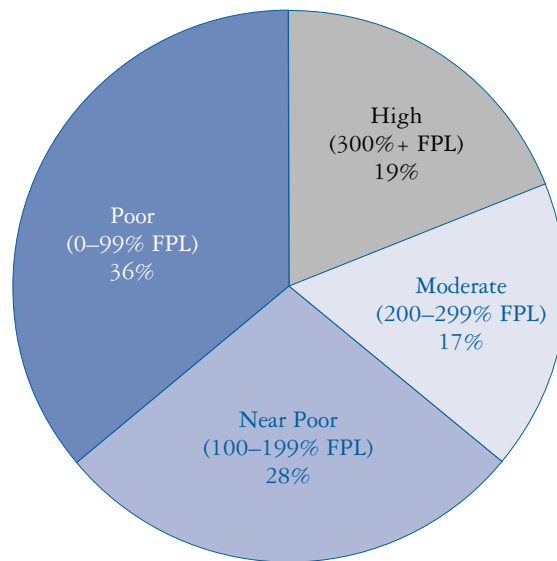


# IMPLICATIONS OF HEALTH MARKET TRENDS FOR CONSUMERS AND THE SAFETY NET

## EXHIBIT 7.1

## Distribution of the Non-Elderly Uninsured, by Poverty Level, 2000

In 2000, almost two-thirds (64%) of the uninsured were from families with low- incomes, defined as those earning less than 200% of the federal poverty level (FPL), or \$27,476 for a family of three. More than one-third (36%) of the uninsured were poor, and 28% were near poor.



N=38.4 Million

**NOTES:**

The poverty threshold (FPL) in 2000 for a family of three was \$13,738.

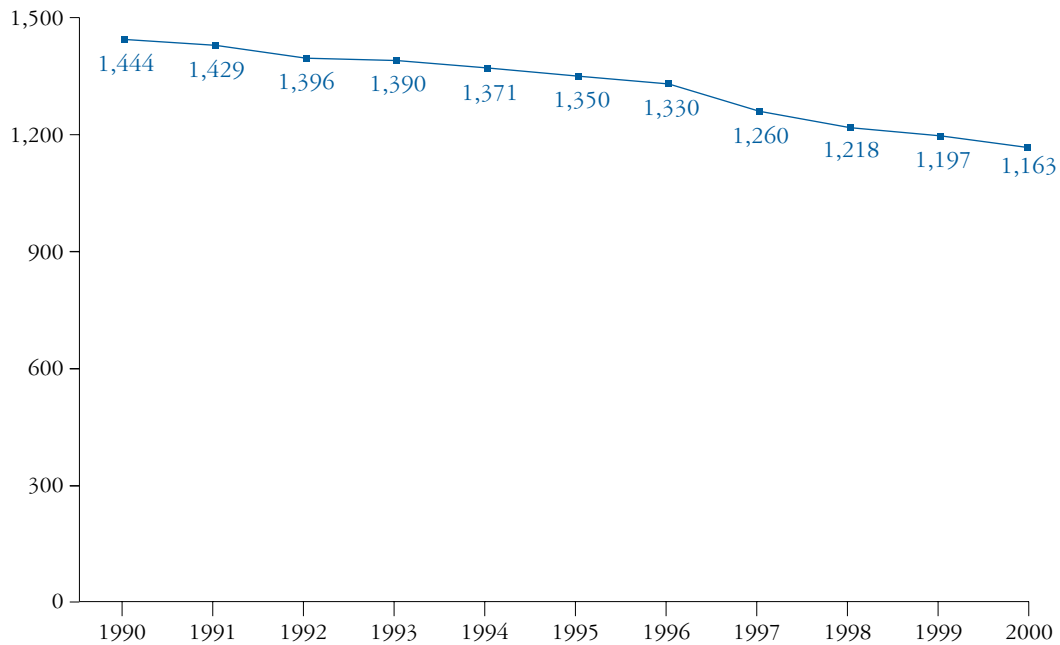
**SOURCE:**

*Health Insurance Coverage in America, 2000 Data Update*, The Kaiser Commission on Medicaid and the Uninsured (February 2002). See [www.kff.org](http://www.kff.org).

## EXHIBIT 7.2

## Number of Public Hospitals, 1990–2000

The number of public hospitals declined by 19.5% from 1,444 in 1990 to 1,163 in 2000. Facility consolidation, mergers, and privatization have all contributed to the decline. Public hospitals typically provide more care to uninsured and low-income patients than do other types of hospitals.

**NOTES:**

Includes all state and local government community hospitals.

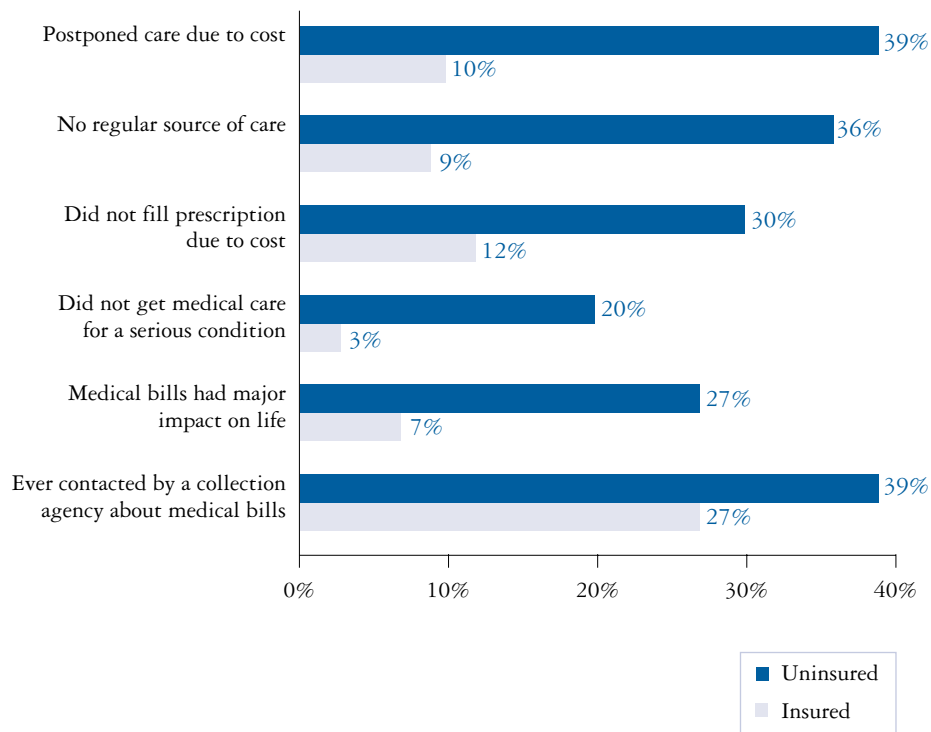
**SOURCE:**

*Hospital Statistics*, Health Forum LLC, an affiliate of the American Hospital Association (2002), Table 1, p. 5.

## EXHIBIT 7.3

## Impact on Non-Elderly Adults of Being Uninsured, 2000

Lacking insurance has serious consequences for the uninsured. The cost of care is often a barrier preventing the uninsured from obtaining recommended health care services and treatment. Nearly forty percent of the uninsured reported postponing needed care due to cost (39%) and lacking a regular source of care (36%). Meanwhile, one-fifth of the uninsured indicated they did not get medical care for a serious condition (20%), and almost one-third did not fill a prescription due to cost (30%).

**NOTES:**

Among adults under age 65.

**SOURCE:**

NewsHour with Jim Lehrer/Kaiser Family Foundation, *National Survey on the Uninsured*, April 2000, on Kaiser Family Foundation web site at [www.kff.org/content/2000/3013/NatlSurveyofUninsured.pdf](http://www.kff.org/content/2000/3013/NatlSurveyofUninsured.pdf).

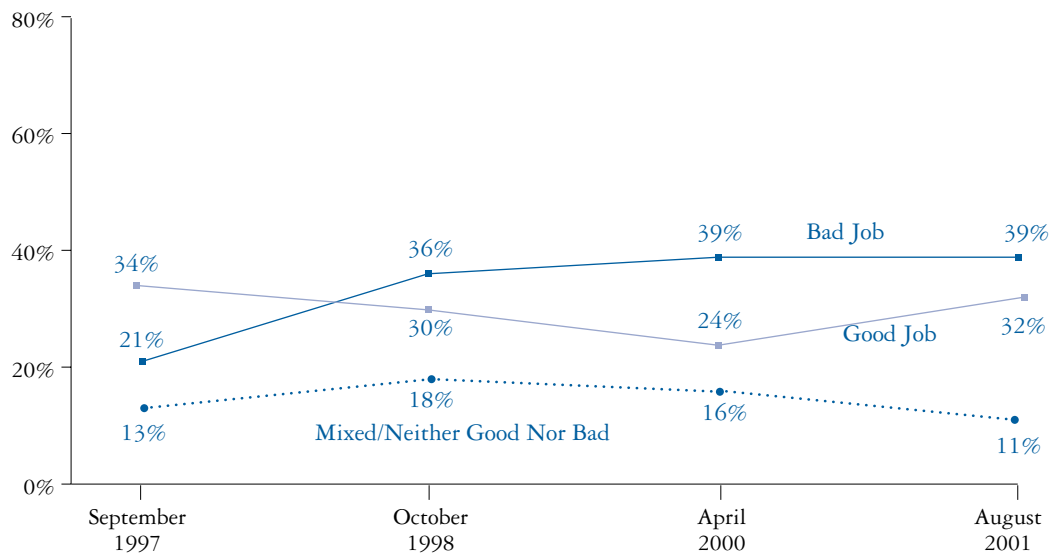


## EXHIBIT 7.4

## Changing Consumer Views of Managed Care Plans, 1997-2001

Americans' views of the managed care industry have grown substantially more negative over the last several years, though there has been little change recently. Thirty-nine percent (39%) say managed care plans do a "Bad Job" serving consumers, almost double the share in 1997 (21%). The percent who say health plans do a "Good Job" serving consumers increased from 2000 to 2001 (from 24% to 32%), but is about the same as in 1997 (34%).

Percent who say that managed care plans are doing a good job or a bad job in serving health care consumers:

**NOTES:**

"Don't Know" not shown.

**SOURCE:**

Kaiser Family Foundation/Harvard School of Public Health *National Survey on Managed Care*, November 1997; Kaiser Family Foundation/Harvard School of Public Health *National Survey on Medicare*, October 1998; Kaiser Family Foundation/Harvard School of Public Health *National Survey Health News Index*, March–April 2000; Kaiser Family Foundation/Harvard School of Public Health *National Survey on Consumer Experiences With and Attitudes Toward Health Plans*, August 2001 (conducted July–August 2001).

## EXHIBIT 7.5

## Consumer Views of the Impact of Managed Care, 1997-2001

An increasing proportion of Americans have negative views of HMOs and other managed care plans, including that these plans have decreased the time doctors spend with patients (from 61% in 1997 to 67% in 2001), decreased the quality of health care for the sick (from 51% to 54%), and not made much difference to health care costs (from 55% to 59%). About the same proportion in both years say that managed care plans have made it harder for the sick to see specialists (59% in both 1997 and 2001). A declining proportion say that managed care has made it easier to get preventive health care services (from 46% in 1997 to 39% in 2001).

Percent who say that, during the past few years,  
HMOs and other managed care plans have:

	September 1997	August 1998	April 1999	August 2001
DECREASED time doctors spend with patients	61%	64%	61%	67%
Made it HARDER for sick to see specialists	59%	62%	63%	59%
NOT made much difference to health care costs	55%	59%	55%	59%
DECREASED quality of health care for sick	51%	50%	50%	54%
Made it EASIER to get preventive services such as immunizations and health screenings	46%	40%	38%	39%

**SOURCE:**

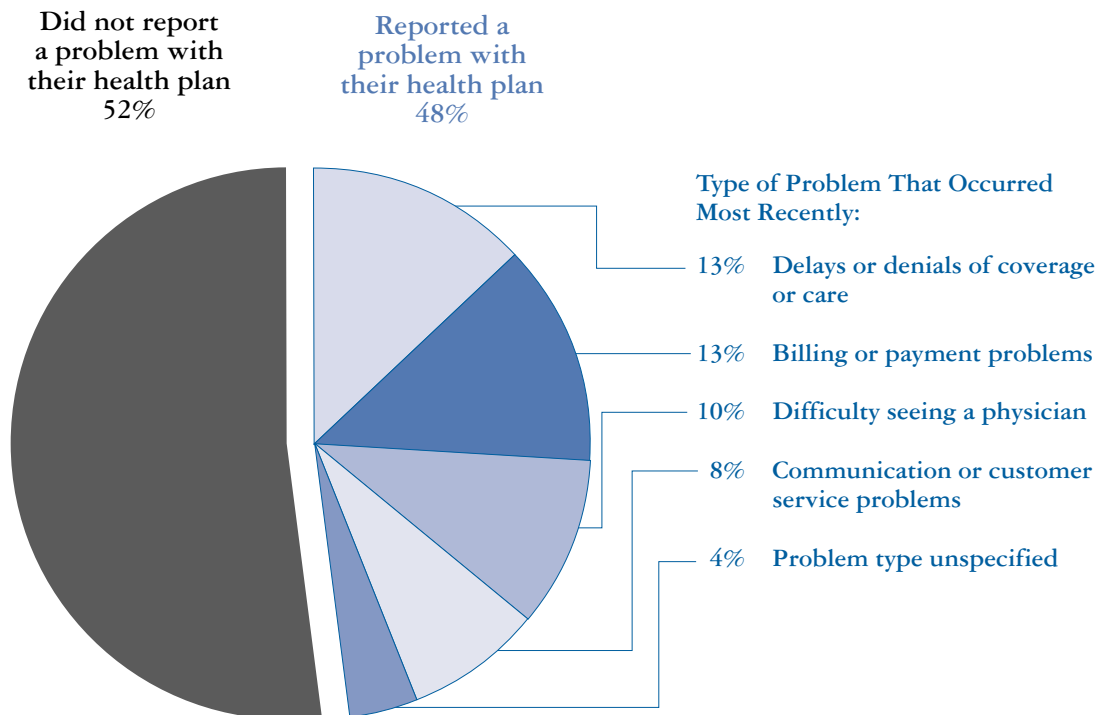
Kaiser Family Foundation/Harvard School of Public Health *National Survey on Managed Care*, November 1997; Kaiser Family Foundation/Harvard School of Public Health *National Survey on Medicare*, October 1998; Kaiser Family Foundation/Harvard School of Public Health *National Survey Health News Index*, March–April 2000; Kaiser Family Foundation/Harvard School of Public Health *National Survey on Consumer Experiences With and Attitudes Toward Health Plans*, August 2001 (conducted July–August 2001).

## EXHIBIT 7.6

## Consumer Experiences With Health Plans, 2001

Although more than six in ten (62%) privately insured American adults under age 65 give their health plans a grade of A or B, about half (48%) say they personally have experienced at least one of fourteen different kinds of problems with their health plan, including denials (12%) or delays (1%) of coverage or care, billing or payment problems (13%), difficulty seeing a physician (10%), and communication or customer service problems (8%).

Percent of privately insured adults under age 65 who:

**SOURCE:**

Kaiser Family Foundation/Harvard School of Public Health *National Survey on Consumer Experiences With and Attitudes Toward Health Plans*, August 2001 (conducted July-August 2001).

## EXHIBIT 7.7

## Consumer Worries About Health Plans, by Type of Plan, 2001

Roughly half (56%) of Americans under age 65 with private health insurance express worry that if they become sick, their health plan will be more concerned about saving money than providing the best treatment. Americans in managed care plans are more likely to say they are worried (59%), while those in the most restrictive managed care plans report greatest concern (67%).

Percent of privately insured adults, by type of health plan, who say they are worried that if they become sick, their health plan would be more concerned about saving money than providing the best treatment:

	“Very” Worried	“Somewhat” Worried	“Not Too” Worried	“Not at All” Worried
Total for ALL Plans	24%	32%	25%	18%
Total for Managed Care	25%	34%	25%	16%
“Strict” Managed Care	31%	36%	21%	11%
“Loose” Managed Care	21%	32%	28%	19%

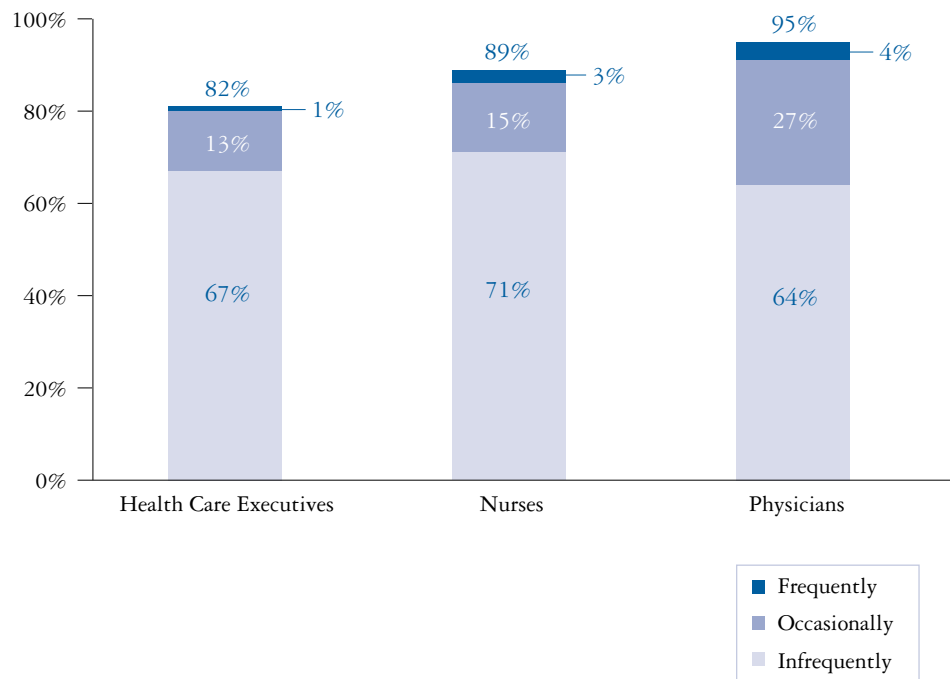
**SOURCE:**

Kaiser Family Foundation/Harvard School of Public Health *National Survey on Consumer Experiences With and Attitudes Toward Health Plans*, August 2001 (conducted July-August 2001).

## EXHIBIT 7.8

## Proportion of Medical Professionals Who Have Witnessed Serious Medical Errors, 2001

A 1999 Institute of Medicine report, *To Err Is Human: Building A Safer Health System*, estimated that between 44,000 and 98,000 die each year in this country from preventable medical errors in hospitals. Although other studies have estimated fewer preventable deaths, the issues of safety and quality in medical care have been a major focus in recent years. Most medical professionals, including almost all doctors (95%), 89% of nurses, and 82% of health care executives, indicate they have witnessed serious medical errors. Among the three groups, physicians are most likely to say they have witnessed serious medical errors occasionally or frequently, rather than infrequently.

**NOTES:**

May not add to total due to rounding.

**SOURCE:**

*Pursuing Perfection*, Results of a Survey Conducted for the Robert Wood Johnson Foundation by Wirthlin Worldwide (March/April 2001), p.3.

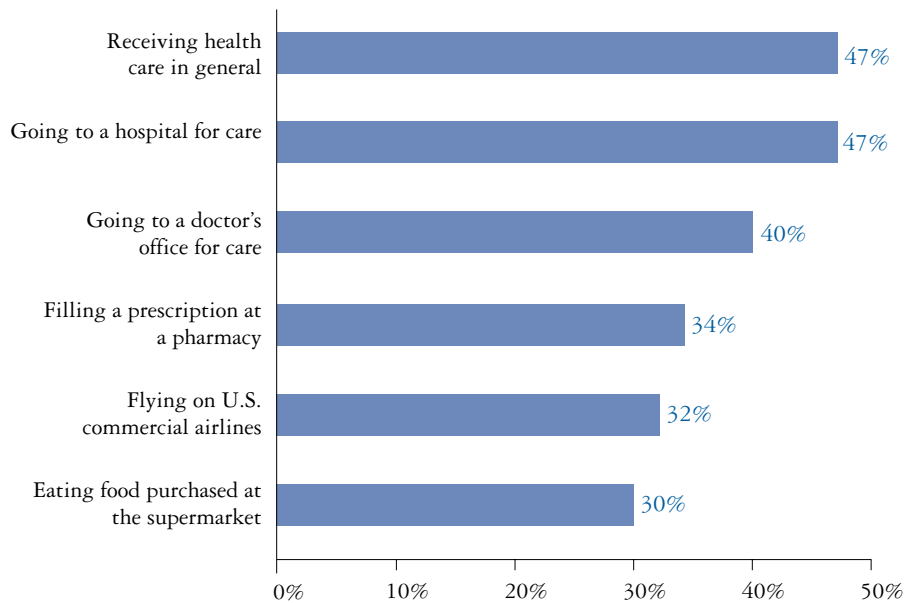
Kohn, LT, Corrigan, JM, Donaldson, M, eds. *To Err Is Human: Building A Safer Health System*, Institute of Medicine (November 1999).

## EXHIBIT 7.9

## Percent of Patients Who Are “Very Concerned” About an Error Resulting in Injury, 2000

While a very small proportion of people (6%) report they have experienced a medical error, almost half of all people say they are very concerned about the possibility of experiencing an error resulting in injury when they receive health care services. More people are concerned about errors in medical care than they are about errors resulting in injury when flying on commercial airplanes.

Percent of Patients Who Are “Very Concerned” About an Error Resulting in Injury When:



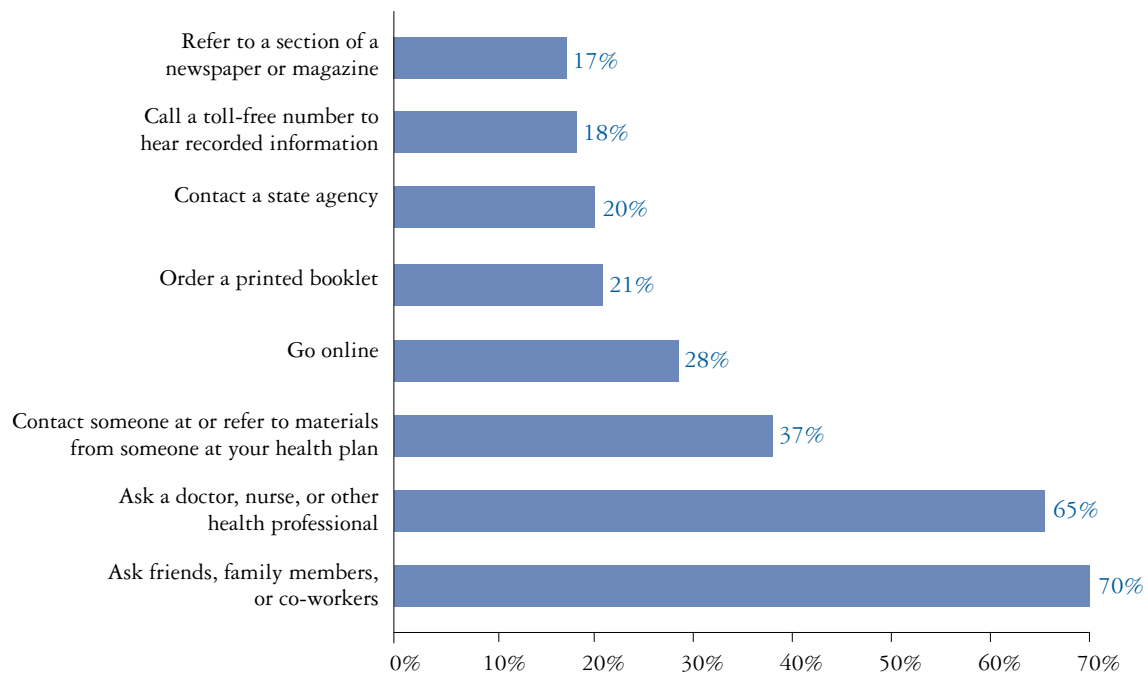
**SOURCE:**

*National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information*, The Kaiser Family Foundation and The Agency for Healthcare Research and Quality (December 2000), Chart 8. See [www.kff.org](http://www.kff.org).

## EXHIBIT 7.10

## Percent Who Say They Would “Very Likely” Try These Methods of Finding Quality of Care Information, 2000

Friends and family (70%), along with health care providers (65%), remain the sources consumers most rely on for quality information. Personal contacts and referrals are preferred to other less personalized sources such as health plans (37%), printed booklets (21%), and state agencies (20%).

**SOURCE:**

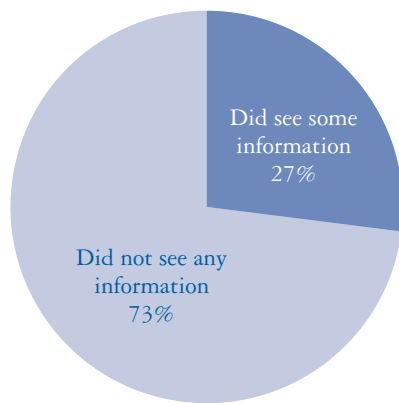
*National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information*, The Kaiser Family Foundation and The Agency for Healthcare Research and Quality (December 2000), Chart 13. See [www.kff.org](http://www.kff.org).

EXHIBIT 7.11

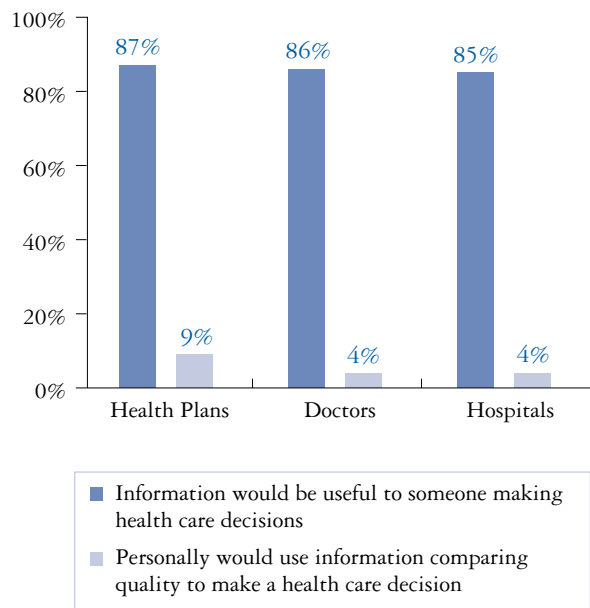
## Consumer Views on the Usefulness of Comparative Health Quality Information, 2000

About a quarter of all consumers (27%) say they have seen information comparing the quality of health providers and plans in the last year. Fewer than 10% say they personally would use the information, although almost 90% think the information would be useful to someone making health care decisions.

Proportion Who Saw Any Information Comparing the Quality of Health Care Plans, Doctors, or Hospitals Within the Last Year, 2000



Usefulness of Information, 2000



- Information would be useful to someone making health care decisions
- Personally would use information comparing quality to make a health care decision

**SOURCE:**

*National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information*, The Kaiser Family Foundation and The Agency for Healthcare Research and Quality (December 2000), Charts 17, 18, & 21. See [www.kff.org](http://www.kff.org).



## Glossary

### **BAD DEBT**

Cost of services for which provider anticipated but did not receive payment.

### **CAPITATION/CAPITATED PAYMENTS**

A dollar amount established to cover the cost of health care services delivered to a person during a specified length of time. The term usually refers to a negotiated per capita rate to be paid to a health care provider by an MCO. The provider is then responsible for delivering or arranging the delivery of all health services required by the covered person under the conditions of the provider contract.

### **CAPITATED CONTRACT**

A contract involving capitated payments. Capitated payments can be for a full or limited range of services.

### **CHARITY CARE**

Cost of services for which the provider neither received, nor expected to receive, payment because it had determined the patient's inability to pay.

### **CONVENTIONAL FEE-FOR-SERVICE (FFS) PLAN**

A payment system by which doctors, hospitals and other providers bill and are reimbursed a specific amount or percentage for each service performed, after the services have been received.

### **COPAYMENT**

A cost-sharing arrangement in which a member pays a specified charge for a specified service (e.g., \$10 for an office visit). The member is usually responsible for payment at the time the service is rendered.

### **DEDUCTIBLE**

A specified amount of money a member must pay before insurance benefits begin. Usually expressed in terms of an annual amount.

### **HEALTH MAINTENANCE ORGANIZATION (HMO)**

A health delivery system that offers comprehensive health coverage for a prepaid, fixed fee. HMOs contract with or directly employ participating health care providers – i.e., hospitals, physicians, and other health professionals – and HMO members choose from among those providers for all health care services.

There are four basic HMO model types:

- Staff Model HMOs employ health care providers directly. The providers are employees of the HMO, and provide care exclusively to HMO members.
- The Group Model HMO contracts with one or more group practices to provide health care services, and each group primarily treats the HMO's members.
- The Network Model HMO contracts with one or more group practices and/or Independent Practice Associations (IPAs) to provide health care services. The network may or may not provide care exclusively for the HMO's members.
- Independent Practice Association (IPA) Model HMOs contract with physicians in solo practice, or with associations of physicians which in turn contract with their member physicians, to provide health care services to members. Solo practice physicians in IPA model HMOs may have a significant number of patients who are not HMO members.

Some HMOs combine two or more of the four basic model types, such that some of their members are in options or components that function as one model type (for example, a Group Model) and others are in plans that function as another model type (for example, a Network Model), although all belong to the same HMO. These are often called “Mixed Model” HMOs.

#### **MANAGED CARE**

A general term for a health care system that manages health care delivery in order to improve quality and control costs.

#### **MANAGED CARE CONTRACT**

A contract between a provider and any managed care organization, including HMOs, PPOs, and POS plans. These contracts do not necessarily involve capitated payments.

#### **MANAGED CARE ORGANIZATION (MCO)**

A health care plan that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers which delivers services and frequently shares financial risk, typically relying on a primary care physician to act as gatekeeper for specialty services.

#### **NON-ELDERLY**

Persons aged 0 through 64.

#### **POINT-OF-SERVICE (POS) PLAN**

An option or product that combines HMO features and out-of-network coverage with economic incentives for using network providers. A POS plan offers members the option to choose to receive a service from participating or non-participating providers. Generally, the level of coverage is decreased (or cost sharing is increased) when services are received from non-participating providers.

#### **PREFERRED PROVIDER ORGANIZATION (PPO)**

A fee-for-service health plan that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care from non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to copayments and deductibles.

#### **PREMIUM**

Money paid in advance for insurance coverage.

#### **PRIMARY CARE CASE MANAGEMENT PROGRAM (PCCM)**

A provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants) that contracts to act as “gate keeper” to locate, coordinate, and monitor covered primary care (and sometimes additional) services to beneficiaries. These gate keepers do not assume financial risk.

#### **PRIMARY CARE PROVIDER (PCP)**

The provider that serves as the initial interface between the plan member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties and who treats and is responsible for coordinating the treatment of members assigned to the plan.

#### **SPECIALTY CARE PHYSICIAN**

A physician who is certified to practice in a specific field, not in general or family practice.



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