INSURING HEALTH OR ENSURING PROFIT?

A SNAPSHOT OF THE HEALTH INSURANCE INDUSTRY IN THE UNITED STATES

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Taking Action
Making Change

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INTRODUCTION

Over 170 million people in the United States receive health insurance through the private market.[1] However, as health care costs grow, premiums rise, and benefits shrink, it has become increasingly difficult for individuals and employers to hold onto quality coverage that provides protection from financial risk. Not surprisingly, ensuring access to affordable health care for all people residing in the U.S. has become a top priority for the public.

This report looks at recent financial trends for major national health insurance companies, as well as subsidiaries of national and regional companies and independent insurers[2] in 26 states. As the figures in this report show, the country's major health insurance companies and many of their subsidiaries enjoyed substantial profitability in recent years, while individuals and employers have become increasingly concerned about the availability and affordability of quality health coverage. The data provided in this report suggest that financial gains for insurers do not necessarily translate into improved access to health care or financial protection for individuals.

In the U.S., health coverage continues to be a key gateway to needed health care. Public recognition of this reality is suggested by a recent poll in which over three quarters of respondents expressed "that increasing the number of Americans covered by health insurance is a very important priority for the President and Congress to address."[3] Moreover, the failures of the current health insurance system to secure financial protection and access to needed health care for so many in the U.S. has prompted the public to consider alternatives. One recent poll has revealed that a majority of Americans – spanning political party affiliation – believe the health care system requires change and that government should guarantee access to health care.[4]

This report contributes to public discussions of the future of our health care system and the possibility of guaranteed access to health care for everyone in the United States. Looking at insurers' profitability trends, it raises a number of questions about the role insurers play in our health insurance system and suggests that government assume a central role in securing access to health care.

KEY FINDINGS

This report looks at the 2003-2007 profits for the country's major national health insurance companies (such as UnitedHealth Group and WellPoint), which sell health insurance through their subsidiaries. Over that period, their combined profits increased by 170.2 percent, reaching $12.6 billion at the end of 2007.

This report also looks at profit and surplus figures for 62 insurers (either subsidiaries of larger companies or independent insurers) licensed to sell health insurance in the states. About these insurers, the report finds:

- Thirty-eight of the 62 insurers saw their annual profits increase between 2004 and 2007.
- The greatest increase in annual profits – 721.2 percent – was experienced by UnitedHealthcare Plan of the River Valley. By contrast, during this period its membership grew by 28.2 percent.
- Thirty-seven of the 60 insurers saw their per member per month (PMPM) profits increase between 2004 and 2007.
- The greatest increase in PMPM profits – 609.7 percent – was experienced by BlueCross BlueShield of Montana.
- PacifiCare of Texas had the highest PMPM profit: $81.31, for 2007.
- Fifty-two of the 59 insurers for which surplus figures were available saw their surplus grow from 2004 to 2007.
- The greatest increase in surplus – 166.8 percent – was experienced by New West Health Services.

Growth in wages, 2007[5]	3.7 percent
Overall inflation rate, 2007	2.6 percent
Average increase in premiums for employer-sponsored health coverage, 2007	6.1 percent
Increase in profits for country's seven major health insurance companies from 2006 to 2007	9.7 percent

THE PRIVATE HEALTH INSURANCE MARKET IN THE UNITED STATES

Approximately 68 percent of the U.S. population receives health insurance through the private market. The vast majority (60 percent) has at least some coverage through an employer-sponsored plan, while nine percent of the privately insured purchase their coverage independently. Twenty-seven percent receive government-sponsored insurance, and sixteen percent have no health coverage at all.[6]

Employer-sponsored coverage comes in two forms. In some cases, the employer purchases insurance from an insurer in exchange for a premium, with the insurer bearing the risk for employees' covered health care costs – this is a "fully insured" plan. In other cases, the employer sponsors a "self-funded" or "self-insured" plan in which the employer itself bears the risk for covered health care expenses but may contract with an insurance company to administer that insurance.

The country's major private health insurance companies sell coverage through multiple subsidiaries. The largest among them, WellPoint and UnitedHealth Group (UnitedHealth), together accounted for more than 65 million enrollees as of 2007.[7] WellPoint subsidiaries include numerous insurers (including Anthem Blue Cross and Blue Shield, other Blue Cross and Blue Shield plans, Empire, UniCare, and others), in addition to other health care-related and holding companies. UnitedHealth subsidiaries include Oxford, PacifiCare, Uniprise, UnitedHealthcare, and others. Other large national health insurance companies are Aetna, CIGNA, Humana, Health Net, Coventry Health Care, and Kaiser,[8] which have subsidiaries of their own.

In addition to these large national companies and their subsidiaries, there exist numerous unaffiliated and independently licensed Blue Cross Blue Shield (BCBS) health insurers, such as Blue Cross and Blue Shield of Rhode Island. A number of BCBS-licensed insurers belong to smaller regional or state company groups. For example, Blue Cross Blue Shield of Michigan is affiliated with multiple insurers, including Blue Care Network of Michigan, Michigan Health Insurance Co., and others.[9]

Many BCBS insurers remain non-profit or mutual companies, despite a wave of for-profit conversions and mergers beginning in the 1990's,[10] and in some states BCBS insurers operate under state enabling legislation with particular requirements. At the same time, because non-profit or mutual BCBS plans are not investor-owned and publicly traded, they are not subject to the same scrutiny by investors or the reporting requirements of the Securities and Exchange Commission (SEC).

In many states, the subsidiaries of major national health insurance companies account for the largest portion of that state's accident and health market share (measured by direct written premiums). For example, in Colorado, UnitedHealth Group, Kaiser, and WellPoint claimed nearly 61 percent of market share as of 2006.[11] However, in many other states, the greatest market share is held by an independent BCBS insurer (or a regional group with BCBS licensees).

THE PURPOSE OF HEALTH INSURANCE

The purpose of health insurance is to spread risk among many and make costs more predictable. Risk-spreading is based on the understanding that no individual stays young or healthy forever and also reflects the belief that the cost of health care is a shared responsibility. By spreading risk, everyone in the "pool" protects themselves from the expenses of a health setback.[12]

Despite the importance of spreading risk, in the current private market health insurers have an incentive to avoid it through risk selection (also referred to as "cream skimming" and "cherry picking")[13] – maintaining a healthier pool of enrollees than competitors – and other risk avoidance methods. Insurers fear "adverse selection" (winding up with sicker enrollees as healthier enrollees drop coverage) and can maximize their profits by choosing young, healthy enrollees on whom they will spend relatively little.[14]

Health insurers manage their risk through a number of practices, such as accepting or rejecting applicants based on their health status or other factors, setting premiums based on risk, and excluding coverage for treatment of preexisting conditions.[15] In addition to these well known methods, "health insurers may engage in many subtle forms of risk selection. Examples include selective marketing, location of health facilities in profitable areas, staffing and infrastructure decisions, and distortion of the quality of specific services [for example, by adjusting the convenience of access to those services]."[16] Furthermore, recently insurer "post-claims underwriting" practices have come to light. This occurs after an individual purchases a policy and has a claim submitted for expensive treatment. The insurer then reviews the individual's medical history and "retroactively limit[s] or revoke[es] coverage."[17]

Risk selection may be very profitable for health insurers,[18] but it produces multiple problems. For instance, risk selection makes comprehensive coverage increasingly unaffordable and impedes access to needed care.[19] Strategic design of benefit packages may also drive up costs to providers, who often must contend with scores of different insurers and dedicate staff and resources to manage the billing process. This explains in part why it has been estimated that nearly one-third of U.S. health care spending goes to administrative overhead.[20]

REGULATION OF HEALTH INSURANCE

Health insurance regulation generally is the responsibility of state governments. Nonetheless, in many states – if not most – the oversight powers of regulators are very limited. For example, many state insurance regulators have no or very restricted authority to limit rate increases for a particular insurance product. Additionally, all but a handful of states allow insurers to reject individual applicants due to their health conditions or charge vastly different premiums for the same coverage based on an enrollees' health status, age, gender, or other factors.[21] In some cases, states set no limits on the amount an insurer can vary its premiums for the same product.[22]

Moreover, post-claims underwriting largely escapes oversight: "[f]orty-four states and the District of Columbia allow insurers to limit or revoke coverage of individual policyholders without the state's review."[23] In 19 states, individual policyholders "do not have appeal rights if their policy is revoked."[24] Finally, "self-funded" or "self-insured" plans are not subject to state regulation at all, but to more limited federal oversight.[25]

In addition, many state regulators do not have the power to enforce rules that do exist, or they do not apply the oversight that has been granted to them. A 2002 study found that regulators in only 27 states actively reviewed rates for both small-group and individual insurance products. Thirteen reviewed rates in only one market, while ten states had no active rate review for either market. Many states do not limit the amount an insurer can vary rates based on health status. However, a number of states that do have such constraints do not monitor compliance with them. According to the authors, "[i]n the small group market, 21 states have rate constraints in statute but do not review rates."[26]

As a result, individuals and employers face the private health insurance market with little protection in the form of government oversight. In a relatively unregulated market, insurers compete by selecting for risk and reducing their spending on health care, whether by rejecting less healthy applicants, shifting costs onto enrollees, limiting coverage, or through other practices that, ultimately, impede access to health care and leave enrollees financially vulnerable.[27]

THE PUBLIC'S EXPERIENCES IN THE PRIVATE HEALTH INSURANCE MARKET

Although the majority of people in the United States use private health coverage, in recent years it has become increasingly difficult for individuals to meet their needs through the health insurance market. Under current conditions, people face the overlapping challenges of retaining any coverage at all (regardless of adequacy) and maintaining coverage that protects against financial risk and provides access to necessary services. These challenges are particularly acute for those who have or develop complex and costly conditions and, consequently, face a high likelihood of being forced to forego care or falling into medical debt or even bankruptcy.

Costs of coverage. According to the Kaiser Family Foundation and the Health Research and Educational Trust, premiums have been rising faster than both worker earnings and inflation. For example, in 2007, premiums increased by 6.1 percent, compared to 3.7 percent for worker earnings and 2.6 percent inflation.[28] Since 1999, the portion of small and medium-sized businesses offering health benefits to their employees has declined considerably. In 1999, 56 percent of firms with three to nine employees offered health coverage to their employees, compared to only 45 percent in 2007. The rate at which firms with three to 199 employees offered health coverage dropped from 65 percent in 1999 to 59 percent in 2007.[29] Nationwide, both the number and percentage of uninsured people has increased, reaching 15.8 percent, for a total of 47 million people.[30]

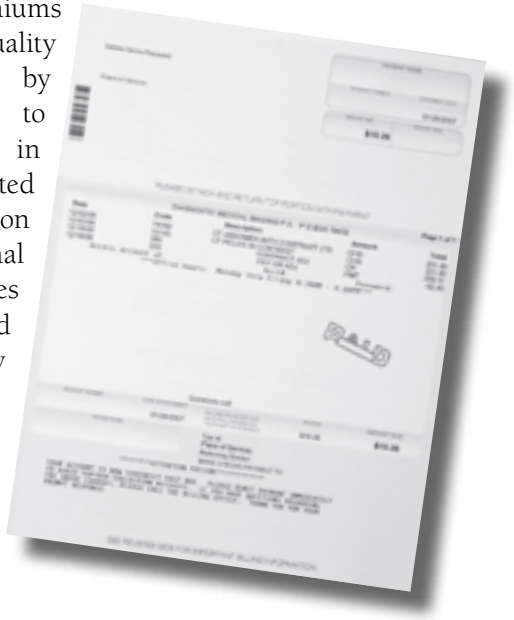
Premium increases – and the variability of these increases – particularly affect people who obtain their coverage in the individual market. Between 1997 and 2002, for instance, premiums increased by 40 percent in the individual insurance market in California.[31] Additionally, "becoming uninsured is most likely for those [in very good health] with individual insurance."[32] Moreover, according to the Commonwealth Fund, "most adults who seek to purchase insurance coverage through the individual market never end up buying a plan, finding it either very difficult or impossible to find one that met their needs or is affordable."[33]

Quality of coverage. In a national survey of working-age adults, Consumer Reports recently estimated that 29 percent of those with health insurance were underinsured, "with coverage so meager they often postponed medical care because of costs."[34] This underinsured rate may reflect a movement toward health insurance products that place a greater portion of cost burdens on enrollees. For example, increasingly, firms that offer their employees coverage offer high deductible insurance that entail very high out-of-pocket costs for enrollees. (One of these insurers includes a deductible exceeding $3,800.)[35] To the extent that such insurance products involve increased cost-sharing, they shift costs from insurers onto enrollees, who too often cannot afford them.

The range of services covered in a health insurance plan represents an additional quality concern. In 2005, researchers from Georgetown University and the American Diabetes Association released a study that examined, among other issues, insurance adequacy for diabetes patients. The study found that "[m]ost often problems of the insured related to the fact that their insurance did not adequately cover diabetes care [such as physician office visits, prescription drugs, and diabetes care], hindering access to treatment and driving some into medical debt."[36]

Impact on family budgets. Exorbitant out-of-pocket costs affect a considerable portion of families in the United States. According to a study conducted by Families USA, "nearly one out of four Americans under the age of 65…is in a family that will spend more than 10 percent of its pre-tax income on health care costs in 2008"— and most of them (82.4 percent) have health coverage.[37] Moreover, the study found, the burden of out-of-pocket costs has grown over the course of the decade. The portion of non-seniors in families spending more than 10 percent of pre-tax income on health care was 17 percent in 2000. By 2008, this segment of the population had grown to 23.2 percent.[38]

When it comes to both maintaining coverage and paying for care, an increasing number of people living in the U.S. face uncertainty. This rising insecurity – and the need to address it – raises a number of questions. How have the country's health insurers been faring? And, to what extent are increases in premiums and changes in the quality of coverage driven by the aim of insurers to increase profitability in a relatively unregulated market? By reporting on recent profits of national insurance companies and state-based insurers, this study opens conversation of these crucial questions.



DATA AND METHODS

This study reports on the profits (net income) for two types of companies participating in the health insurance market:

- *Major national health insurance companies,* like UnitedHealth Group, that essentially are holding companies for subsidiary healthinsurers that sell health coverage products.

- *Health insurers licensed to sell health coverage to the residents of a particular state.* Some of these insurers are subsidiaries of the national companies included in this report. Others are subsidiaries or parents of regional groups, while others are independent.

Selection of health insurers in the states

Some insurers are licensed to offer coverage in many states, while others focus on a particular state or region. In addition, a parent company may have multiple insurer subsidiaries licensed in a single state. (We refer to these as belonging to a group.) Generally, each insurer must file its own annual statement. The insurers discussed in this report were identified through the following process:[39]

- We identified the insurer groups that, in combination, account for 55 percent of market share for the state (or, in less concentrated markets, the top three groups)[40]

- For each insurer group, we selected one subsidiary, considering the following factors:

- Whether the insurer is domiciled in the particular state
- Market share relative to other subsidiaries in the insurer group
- Whether the insurer files a health statement
- Whether the insurer had been selected for another state

For example, the Maine snapshot features Anthem Health Plans of Maine, Inc. In addition to this insurer, other Anthem-affiliated insurers licensed in Maine include Anthem Insurance Companies, Inc. and Anthem Life Insurance Co.[41] Neither of these insurers, however, is based in Maine, and Anthem Life Insurance Co. does not file a health statement. For Tennessee, however, we selected UnitedHealthcare Plan of the River Valley (based in Illinois) over United HealthCare of Tennessee because information obtained from Tennessee indicated that the former has greater market share in the state. In some cases, the insurer profiled will not have the greatest market share or be the largest subsidiary of its parent company selling insurance in the respective state.

Finally, the insurer may do business under a name different from the one under which it files its annual statements. We use the name that appears on the insurer's annual statement.

States selected include those that fall within the author organization's health care access project, with additional states included for geographic diversity.

Data sources

National health insurance companies. As large investor-owned firms, the major health insurance companies must file specified reports with the federal Securities and Exchange Commission (SEC). Unless otherwise noted, data cited in this report have been gathered from companies' SEC filings for 2007, which include figures for 2003 through 2007; these figures may have been changed or restated from previous year filings.[42]

Health insurers in the states. States require health insurers to file financial statements with their respective regulatory authorities. Generally, insurers file standardized forms developed by the National Association of Insurance Commissioners (NAIC). Unless otherwise indicated, data from the state snapshots have been gathered from these forms, which were obtained through the state regulatory agency or the NAIC.

Although most insurers included here file health statements, some file life/health/accident statements. Not all figures are available from life/health/accident statements. Additionally, a number of carriers began the period filing life/accident/health statements and switched to health statements in a later year. In such cases, we used the health statement for that year's and the preceding year's figures.

All figures are for the insurer as a whole, and not only the portion of its business that can be attributed to a particular state. Similarly, only those amounts reported in the individual insurer's statement are included; no figures for affiliated insurers filing separately are included.

For some items, health statements include current and prior year figures, as well as five-year historical data. Occasionally,

prior year figures differ from those reported in the prior year statements and/or the five-year historical data. In the case of such discrepancies or restatements, we used the figures reported in the five-year historical data included in 2007 annual statements. In almost all cases, however, the differences were minor and did not affect the calculations included in this report. One exception is Aetna Health Inc. (of Pennsylvania), with which three other Aetna insurers merged in 2007; Aetna Health Inc. survived and reported a restatement in the five-year historical data page in its 2007 annual statement.

The country's current health care troubles require vigorous action on the part of federal lawmakers – action that addresses the difficulties so many in the United States encounter in the private health insurance market.

Figures included in this report

Annual profit figures in this report refer to annual net income, and the terms "net income" and "profit" are used interchangeably throughout.[43] It includes net income associated with the company or insurer as a whole, and not only that net income attributed to health coverage products, commercial health insurance, or comprehensive health insurance.

For state insurers, in addition to reporting annual net income, we have calculated per member per month (PMPM) profit based on net income.[44] For state insurers, member months reported by the insurer are for individuals enrolled in fully insured plans – those enrollees for whom the insurer bears insurance risk – and do not include individuals enrolled in self-funded plans administered by the insurer. (Insurers do not report self-funded enrollment in their NAIC annual statements.) By accounting for differences in membership, the PMPM allows for cross-insurer comparison. We have also calculated change in membership. For this calculation, we look at member months for each year.

Additionally, for state insurers, we include figures for surplus and capital. Surplus represents an insurer's retained earnings not associated with a particular liability,[45] or the accumulation of net income that insurers keep on hand for investment, to compete for market share, to maintain solvency, or for other purposes.

Again, all figures are for the insurer as a whole, and not only the portion of its business that can be attributed to a particular state.

DISCUSSION OF HEALTH INSURANCE COMPANY PROFITS

In the following sections, we discuss profits of the national health insurance companies and address some of the findings for the state insurers. Complete state snapshots follow as appendices.

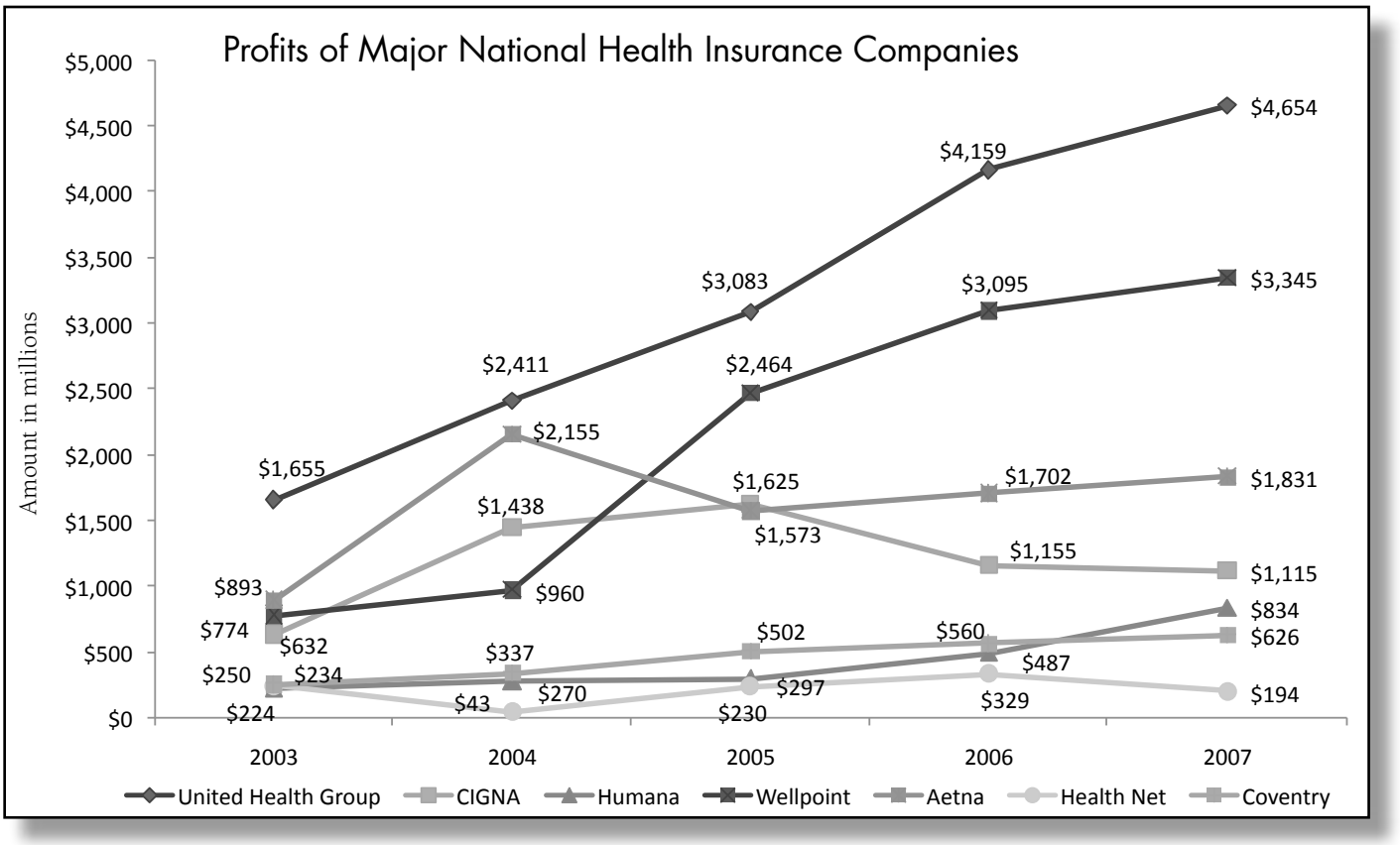
Profits of Major National Health Insurance Companies

In 2007, UnitedHealth Group was the most profitable of the country's major health insurance companies, with net income of nearly $4.65 billion. This represented a 181.2 percent increase from 2003, when the company made profits of $1.66 billion.[46] (These represent lower profit figures than those originally posted by UnitedHealth, which revised its 1994 to 2006 earnings.[47]) WellPoint came in second, with 2007 profits of $3.35 billion, followed by Aetna ($1.83 billion) and CIGNA ($1.12 billion).

All of the country's major health insurance companies, except Health Net, saw their profits rise from 2003 to 2007. CIGNA's most profitable year in that period was 2005, when its net income reached $1.63 billion. With the exception of CIGNA and Health Net, all the companies saw their profits at least double. In fact, WellPoint's profits grew by 332.1 percent.[48] Humana saw an increase in excess of 270 percent from 2003 to 2007. By the end of 2007, the companies had combined profits of $12.6 billion, an increase of 170.2 percent from 2003.

In some cases, the growth in profits – again, profits for the company overall and not just their health insurance business – may be associated with a growth in health care membership (including both insured and self-funded enrollees, and commercial and government products).[49] For example, from 2006 to 2007, Coventry's membership grew by 13.8 percent and its profits by 11.8 percent. However, during this period, UnitedHealth saw an 11.9 percent increase in profits and a 0.4 percent increase in its health care services membership.[50] WellPoint's profits also grew more than its medical membership – a rate of 8.1 percent for profits, compared to 2.1 percent for membership. (Only 2006 and 2007 membership figures are reported in the 2007 filings, and we did not gather them from prior years to avoid possible inconsistencies.) Therefore, increases in enrollment alone cannot account for increases in net income.

More recent experience may shed some light on this question. After years of generally steadily increasing profitability, 2008 came with dampened growth. In April, WellPoint announced that its first quarter profits were down 25 percent from the previous year's.[51] UnitedHealth reported that its first quarter profits had grown, but by only seven percent,[52] and CIGNA also reported lower-than-expected profits.[53] These announcements received considerable attention in the business press.



A number of factors were cited in relation to the 2008 profit figures, including slower growth in enrollment (and decline in some membership). This has been attributed to the general economic downturn,[54] high premiums,[55] and, in the case of UnitedHealth, poor customer service.[56] However, in addition, observers noted that insurers may be realizing lower return on their investments[57] and, perhaps more importantly, spending a greater portion of premiums on health care.[58]

This measure, called the "medical loss ratio," quantifies the portion of revenue "lost" to health care expenses. Even small shifts in medical loss ratio can prompt concern on the part of investors and observers. WellPoint, for example, dedicated almost 15 percent of premiums to administrative expenses and profit in the first quarter of 2008, compared to approximately 17 percent in the first quarter of 2007 – a two percentage point drop – but even such differences have figured in the discussion of health insurance companies' financial prospects.[59]

Even with a slowing or reversal in the companies' profitability spike, they remain profitable[60] and it is not yet known what their financial results in 2008 will be. Yet the news of lower-than-expected profits was greeted with declines in stock value,[61] a development that raises the question of how the companies will respond – including whether they will step up risk selection, limit benefits, or restrict access to services in order to meet expectations created over years of steady profit growth.

Discussion of state snapshots

The state snapshots follow as appendices to this report. A number of observations can be drawn from the data on state insurers:

- Of the 62 insurers included in this report, 38 saw their profits increase from 2004 to 2007. The rates of increase ranged from 3.3 percent (Blue Cross Blue Shield of Arizona) to 721.2 percent (United Healthcare Plan of the River Valley). For those insurers that had a decrease in profits, the rates of decrease ranged from 0.2 percent (UnitedHealthcare of the Mid-Atlantic) to 93.2 percent (Blue Cross Blue Shield of Michigan).[62] In addition to this growth or decline, for some insurers, profits fluctuated between the years of 2004 and 2007.

- Of the 60 insurers for which 2004-2007 per member per month (PMPM) net income could becalculated,[63] 37 experienced an increase in PMPM profits. The rates of increase ranged from 0.2 percent (Providence Health Plan) to 609.7 percent (BlueCross BlueShield of Montana). For those insurers that had a decrease in PMPM profits, the rates of decrease ranged from 1.4 percent (Independence Blue Cross) to 93.1 percent (Blue Cross Blue Shield of Michigan).

- Increases in profitability often partly reflect increases in membership, but in many cases insurer profits increased at a significantly higher rate than did membership. For example, Anthem Health Plans of Maine saw its profits grow by 89.2 percent, while its membership grew by only 2.4 percent. And, PacifiCare of Colorado saw profits increase by 74.6 percent, while the number of member months *fell* by 42.2 percent.

- Often, the insurers with the highest annual net income in their respective states were not the ones with the highest per member per month profit. For example, UnitedHealthcare of North Carolina had a 2007 PMPM profit of $32.73, compared to $11.82 for Blue Cross Blue Shield of North Carolina (BCBS of NC). However, BCBS of NC had 2007 annual net income of $198.1 million, whereas UnitedHealthcare's annual profits were $55.4 million. (The highest PMPM profit was $81.31, for PacifiCare of Texas in 2007.) Similarly, the companies with the greatest increase in profits did not always have the highest profits, whether annual or PMPM.

- Of the 59 insurers for which 2004-2007 surplus figures were available,[64] 52 saw their surpluses grow. The rates of increase ranged from 5.2 percent (Hawaii Medical Service Health Plan) to 166.8 percent (New West Health Services). For those insurers that had a decrease in surplus, the rates of decrease ranged from 7.3 percent (UnitedHealthcare of Illinois) to 33.2 percent (CIGNA of Arizona).

IMPLICATIONS FOR POLICY

The shortfalls in the current health insurance and health care systems have prompted concern on the part of not only the public but policymakers and researchers as well.

Noting that "the nation is losing ground on coverage," researchers from the Commonwealth Fund recently proposed a framework for coverage expansion "that uses the building blocks of both private markets and publicly sponsored insurance with broad risk pooling."[65] Among other features, the plan allows people to keep their employer-sponsored coverage, includes a public option as an alternative to private insurance, expands current public health insurance programs, and establishes public oversight and rules in private health insurance markets.

In support of their framework, the authors note the efficiency gains of broad risk pooling, the impacts of churning and volatility in private insurance markets, and the "substantial transaction and overhead costs" created by a multiplicity of health insurance plans. Furthermore, the authors point out, "the U.S. insurance industry is characterized by high overhead costs for marketing, underwriting, and administration, as well as often high profit margins that lower the share of premiums paid for medical care."[66] At the same time, the authors note, employer-sponsored coverage receives considerable public support and continues to play an important role in health care financing.

One recent poll has revealed that a majority of Americans – spanning political party affiliation – believe the health care system requires change and that government should guarantee access to health care.

Numerous others have developed or explored proposals with similar elements,[67] and researchers have presented considerable evidence in support of these elements. Looking at the example of Medicare, they have shown that relative to private insurance public health plans offer cost containment advantages, administrative efficiency, and higher enrollee satisfaction.[68] For instance, a 2001 survey showed "[a]fter differences in income, health status, and drug coverage were accounted for, respondents insured through the two main public insurance programs – elderly Medicare and Medicaid beneficiaries – were found to be more satisfied with their insurance than were those with employer coverage."[69] Furthermore, public plans do not engage in the risk selection practices so prevalent in private insurance.

To address these practices and limit incentives to compete around risk, researchers have proposed a number of approaches. Examining the individual market in particular, researchers from the Harvard School of Public Health made a number of recommendations, such as: requiring insurers to offer coverage to all applicants; prohibiting insurers from factoring health status, gender, and some other demographic factors into rates; requiring products with standardized scope of benefits; and, creating clear rules for market conduct to deal with techniques insurers use to avoid selling coverage to higher risk people.[70]

Given the risk-pooling available in group coverage (as opposed to individual coverage), the authors also point out that policymakers should "support approaches that make group coverage available to as many people as possible."[71] Finally, they discuss potential federal regulatory standards to "ensure a base of protection in every state while permitting states to adopt more stringent approaches based on their own market conditions and philosophies."[72] The authors' observations and recommendations, though focusing particularly on the individual market, speak to issues affecting private health insurance markets more broadly.

The above explorations pose serious alternatives to the current health insurance system, which is undermining health care access and economic stability to an increasing number of people in the United States.

CONCLUSION

Growing health care insecurity raises questions about the role the health insurance industry currently plays and should continue to play in the country's health care system. From 2003 through 2007, the country's major insurance companies saw their profits grow from $4.7 billion to $12.6 billion. Moreover, many insurers in the states saw their profits grow without a corresponding increase in the number of members covered. Meanwhile, the country's uninsured rate grew, as did the number of people both insured and uninsured spending a significant portion of income on health care costs. These trends suggest that financial gains for insurers do not translate into improved access to care or financial protection for individuals. The country's current health care troubles require vigorous action on the part of federal lawmakers – action that addresses the difficulties so many in the United States encounter in the private health insurance market.

REMAINING QUESTIONS

This report provides a snapshot of key financial trends for select insurers, pointing to additional issues that merit exploration, such as the following:

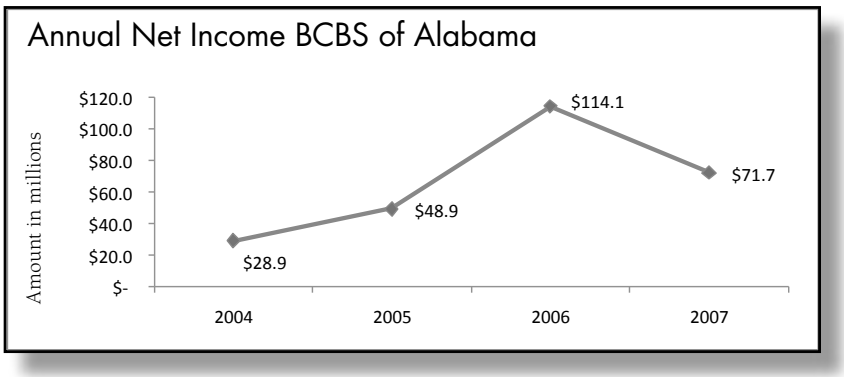
- The flow of dollars between parent companies and their subsidiaries and among subsidiaries of a parent company, such as through dividend payments and administrative contracts.
- The extent to which drops in membership and/or profit represent a strategy on the part of insurers to shed higher- cost enrollees or win market share.
- The negative effects of competing for market share, such as health insurers lowering (or maintaining) premiums and then drastically raising them, creating what one regulator has called a "whipsaw" effect.[73]
- The extent to which surpluses may exceed insurers' needs.
- Insurers' use of dollars spent on non-health-care-related expenses, such as marketing, product design, claims processing, and underwriting expenses.
- Whether insurer administrative expenses have decreased along with the decline in managed care and, if they have not decreased, the reasons they have not.
- The extent to which, during this period, insurers have developed new products that attempt to reach the previously uninsured and how much enrollment these products have attracted.

RECOMMENDATIONS

Establish strong federal oversight of health insurers. Current state regulatory standards are inadequate for protecting the public from practices, such as risk selection methods, in which insurers engage to maintain profitability. Federal lawmakers should increase oversight of the industry, with particular attention to the methods insurers use to avoid risk.

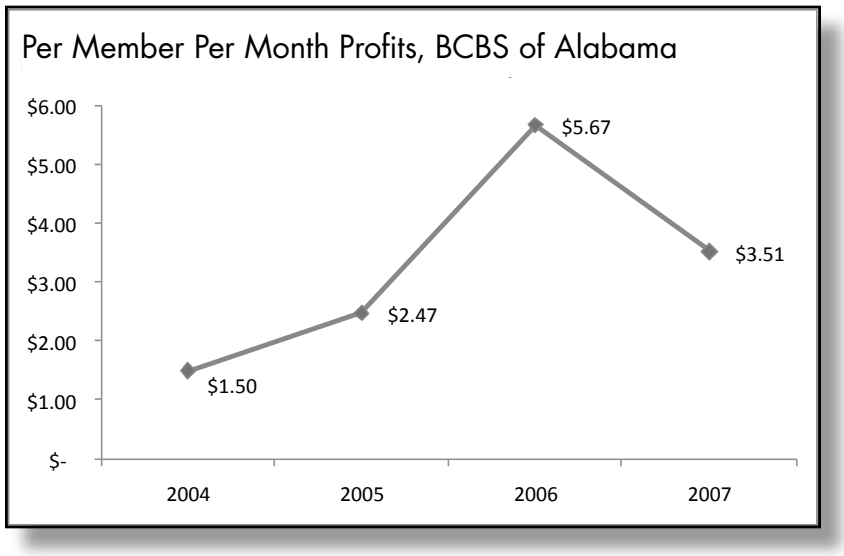
Create a public health insurance option. Given the strong incentives of insurers to engage in practices that undermine access to health care – and the fact that public plans fare favorably compared to private health insurance – lawmakers should establish a public alternative to private coverage.

Promote greater transparency of the financial performance of insurers. Despite regulatory requirements for periodic filings of financial information, few states actively disseminate this information. Doing so with more vigor would enable individuals to assess the value being achieved for their premium dollars. It would also enable the public to judge whether its needs are being served by insurers selling health coverage in their states.



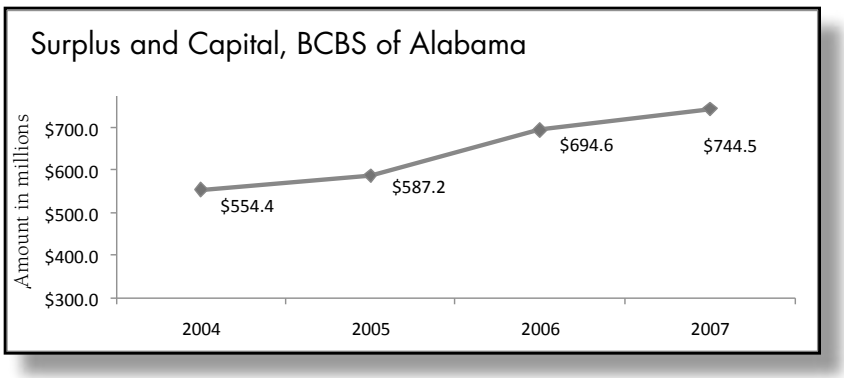
BlueCross Blueshield of Alabama (BSBC of AL) is the state's major insurer.

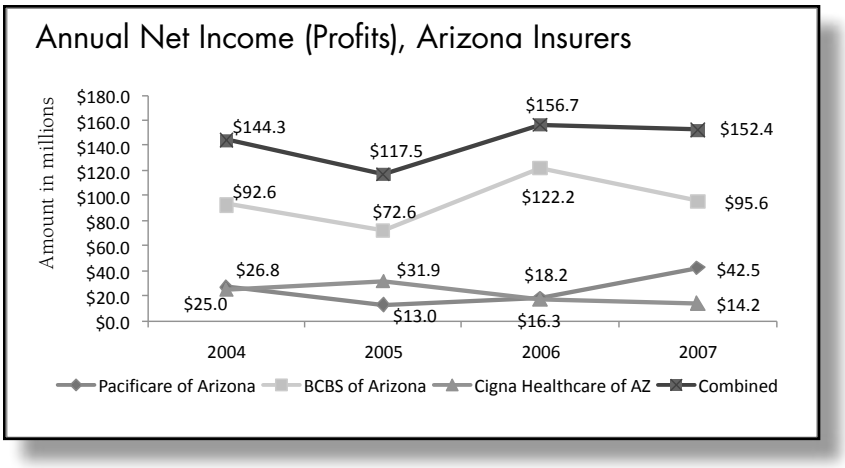
PROFITS. BlueCross BlueShield of Alabama posted $71.7 million in profits for 2007, up 148.1 percent from its 2004 profits of $28.9 million. During this period, its membership grew by 5.5 percent. However, 2007 does not represent the insurer's most profitable year during this period: in 2006, it reported profits in excess of $114 million.

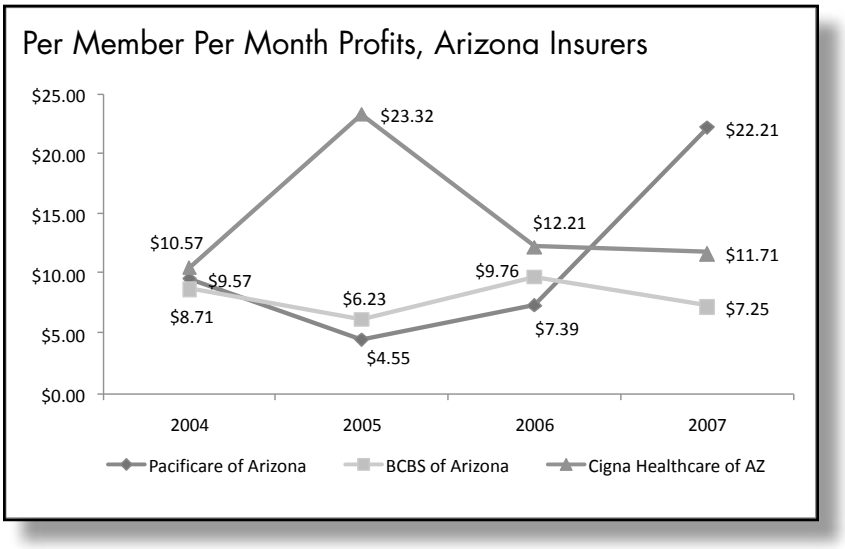


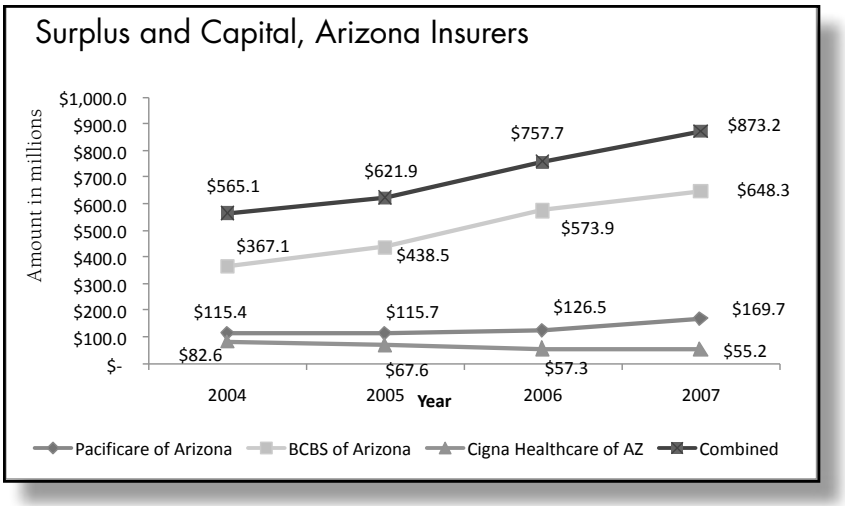
PER MEMBER PER MONTH PROFITS. As of 2007, BCBS of AL earned a monthly profit of $3.51 for each member covered, an increase from its 2004 per member per month (PMPM) profits of $1.50. In 2006 it had its highest PMPM profit, coming in at $5.67.

SURPLUS AND CAPITAL. In 2004, the insurer reported just over half a billion dollars in surplus ($554.4 million). By 2007, its surplus had reached $744.5 million, increasing steadily by 34.3 percent.







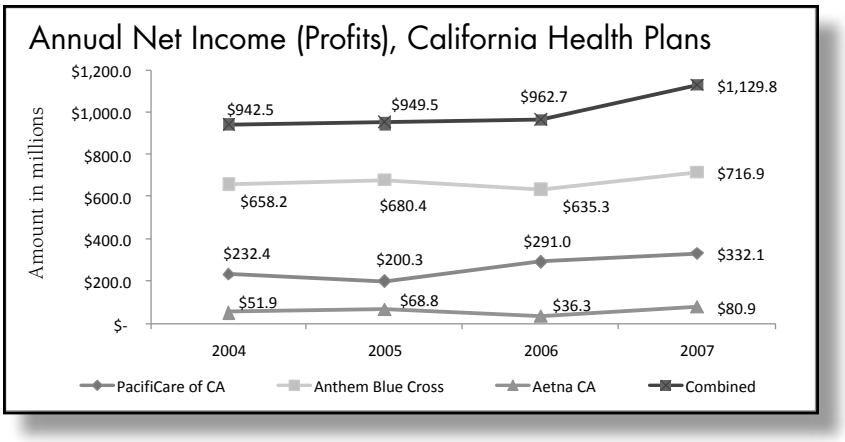


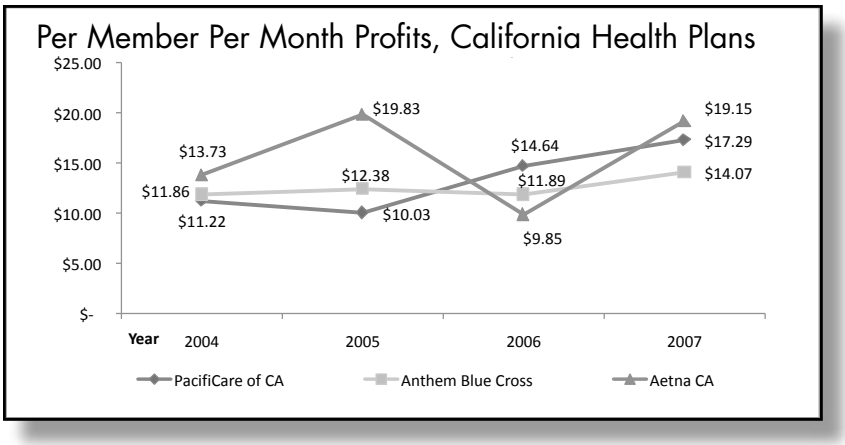
The insurers profiled include: BlueCross BlueShield of Arizona (BCBS of AZ), CIGNA HealthCare of Arizona, and PacifiCare of Arizona (now a subsidiary of UnitedHealth).

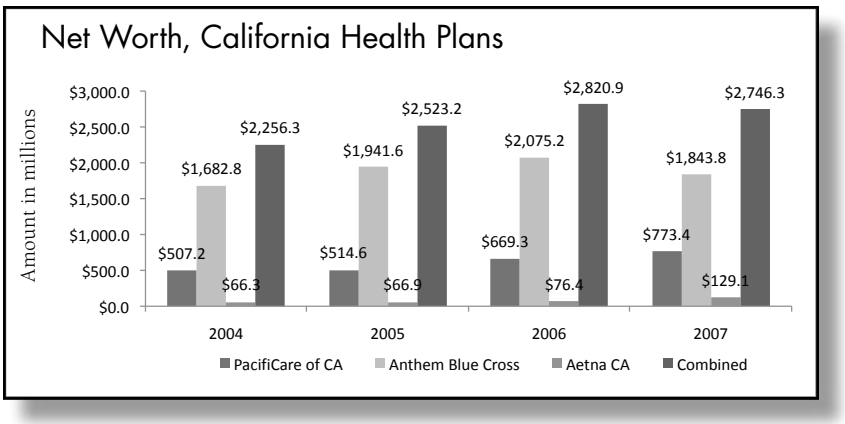
ANNUAL PROFITS. In combination, the three insurers posted profits of $152.4 million in 2007, with BCBS of AZ claiming the largest share: $95.6 million. Between 2004 and 2007, this insurer's most profitable year was 2006, when it reported profits of $122.2 million. Its profits grew by 3.3 percent and its membership by 24.1 percent. PacifiCare saw the greatest growth in profit, with a 58.7 percent increase between 2004 and 2007, while its membership dropped by 31.6 percent. CIGNA's overall profits went down by 43.1 percent and its membership by 48.7 percent during the same period.

PER MEMBER PER MONTH PROFITS. During the 2004-2007 period, PacifiCare's growth in per member per month (PMPM) profits – 132 percent – was greater than the increase it saw in overall annual profits. By 2007, the insurer netted an average $22.21 each month for each member covered. CIGNA, though experiencing a drop in overall annual profits, saw 10.8 percent growth in its PMPM profits, which hit $11.71 in 2007. That year, BCBS of AZ had per member per month profit of $7.25, down 16.8 percent from 2004.

SURPLUS AND CAPITAL. Together, the three insurers had over $873.2 million in surplus as of 2007. BCBS of AZ's surplus grew by 76.6 percent between 2004 and 2007, reaching $648.3 million. PacifiCare's surplus also underwent growth – 47.1 percent – and hit nearly $170 million. CIGNA's surplus, on the other hand, dropped to $55.2 million from $82.6 million.







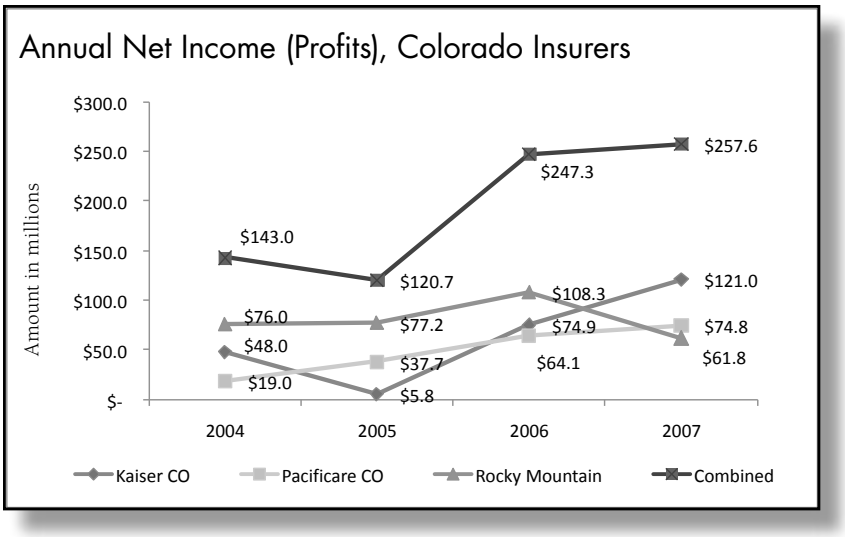
The selected insurers include PacifiCare of California (a subsidiary of UnitedHealth), Anthem Blue Cross (a subsidiary of WellPoint, and until recently named Blue Cross of California),[74] and Aetna Health of California.

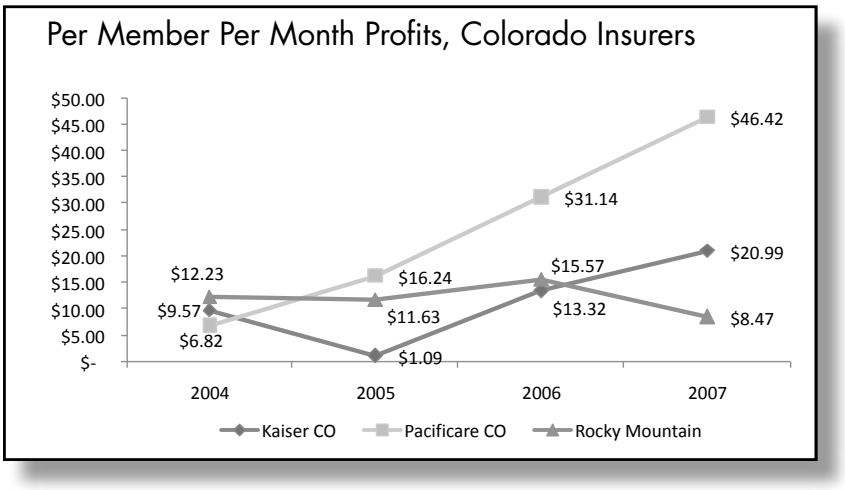
California divides regulation of insurers between the Department of Managed Health Care (DMHC) and the Department of Insurance.[75] We chose to focus on insurers filing statements with the DMHC. These statements differ somewhat from the NAIC annual statement forms used in other states.

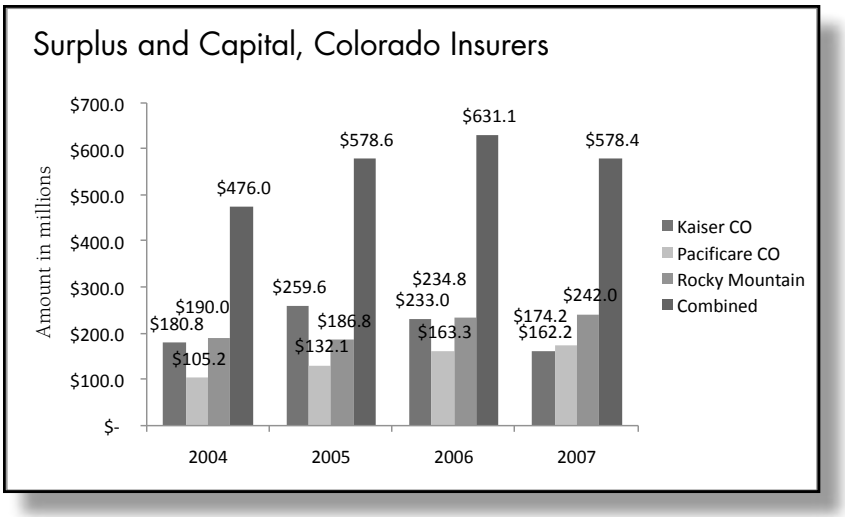
ANNUAL PROFITS. The insurers had combined profits of $1.1 billion in 2007, with Anthem claiming the bulk: $716.9 million. Its profits grew by 8.9 percent from 2004 to 2007, and its membership dropped by 8.2 percent. PacifiCare, too, saw its profits grow (by 42.9 percent) and its membership fall (by 7.3 percent). It closed 2007 with net income of $332.1 million. Aetna saw growth in both profits and membership, but profit growth (55.8 percent) outpaced membership growth (11.7 percent). In 2007, it made profits of $80.9 million.

PER MEMBER PER MONTH PROFITS. During the four-year period, none of the insurers saw its profits dip below $10.00 per enrollee per month, except for Aetna in 2006 ($9.85). Aetna also had the highest PMPM profits: $19.83 in 2005. All three insurers saw their PMPM increase from 2004 to 2007: by 54.1 percent for PacifiCare, 39.4 percent for Aetna, and 18.7 percent for Anthem.

NET WORTH. On DMHC forms, insurers report their net worth rather than surplus. The net worth of all three insurers increased. The growth was greatest for Aetna (94.6 percent), followed by 52.5 percent for PacifiCare and 9.6 percent for Anthem. In combination, the three ended 2007 with net worth of $2.75 billion, of which Anthem claimed the largest share ($1.84 billion).







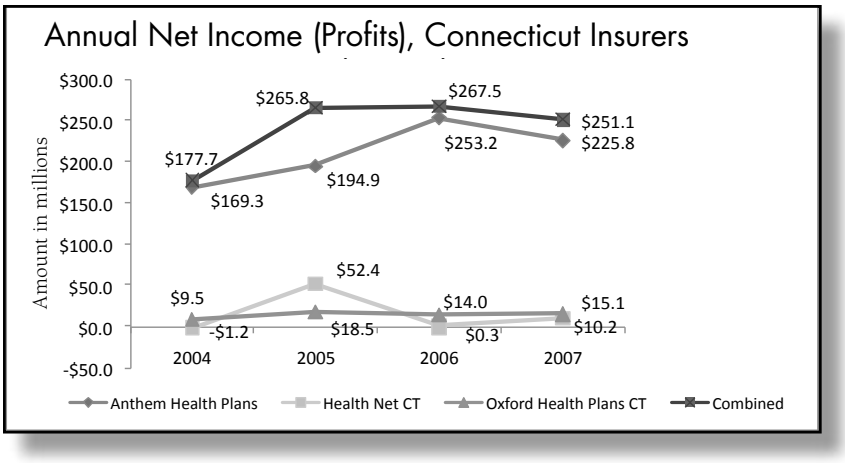
The insurers featured include: Kaiser Foundation Health Plan of Colorado, PacifiCare of Colorado (now a subsidiary of UnitedHealth), Rocky Mountain Hospital and Medical (a WellPoint subsidiary doing business as Anthem Blue Cross Blue Shield).[76]

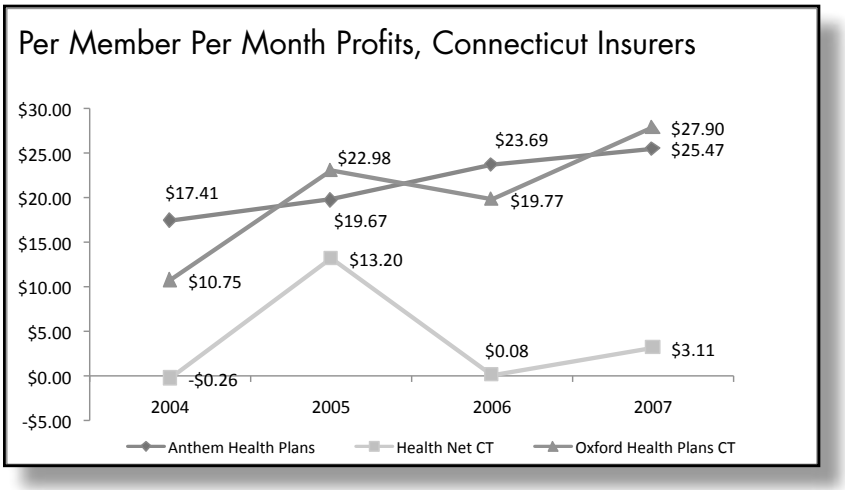
ANNUAL PROFITS. Together, the three insurers posted profits of $257.6 million in 2007. Among the three, Kaiser led with profits of $121 million, followed by PacifiCare ($74.8 million), then Rocky Mountain ($61.8 million). Rocky Mountain experienced its most profitable year in 2006 ($108.3 million).

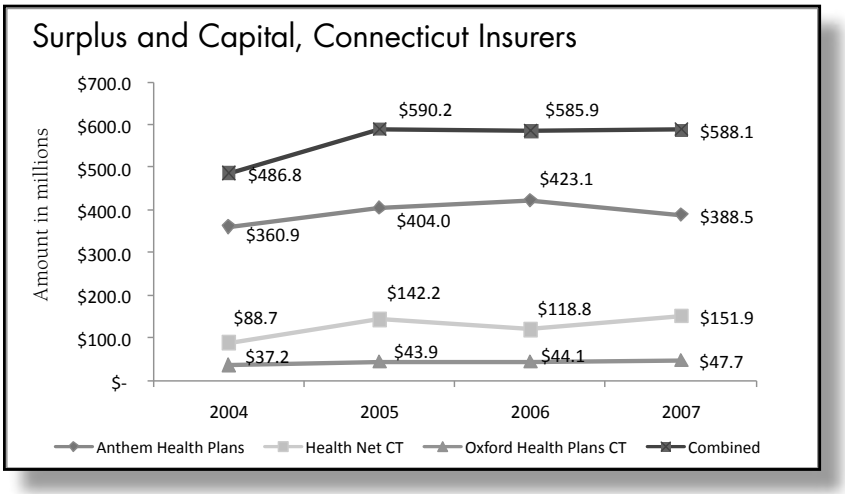
Rocky Mountain's profits declined by 18.6 percent from 2004 to 2007, while its membership increased by 17.4 percent. By contrast, Kaiser's net income went up by 151.9 percent, along with a smaller membership increase of 14.8 percent. Meanwhile, PacifiCare's profits more than tripled, spiking by 293.4 percent, although its membership fell by 42.2 percent.

PER MEMBER PER MONTH PROFITS. Kaiser saw its PMPM profits more than double from 2004 to 2007 (reaching $20.99), while PacifiCare's increased by 580.6 percent and hit $46.42. Rocky Mountain's PMPM profits declined by 30.7 percent.

SURPLUS AND CAPITAL. Together, by 2007 the three insurers had over $578 million in surplus, of which Rocky Mountain claimed $242 million. PacifiCare's surplus increased by 65.6 percent and Rocky Mountain's by 27.4 percent, while Kaiser's dipped by 10.3 percent.





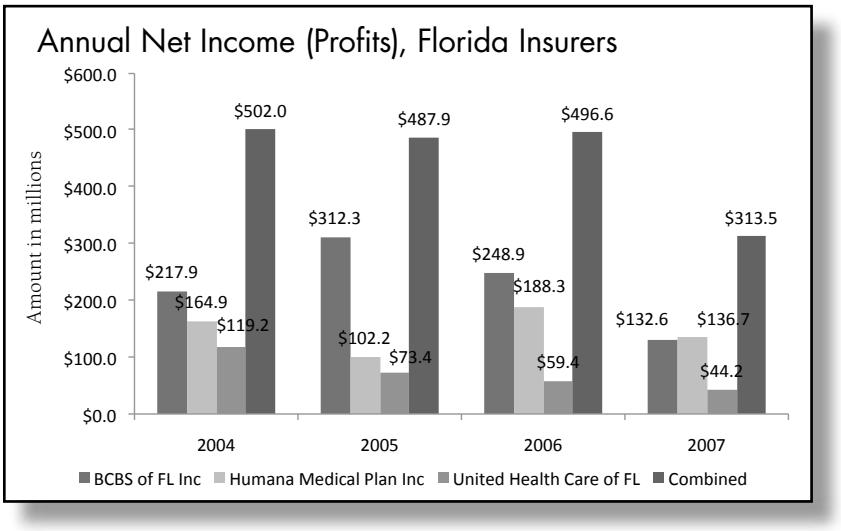


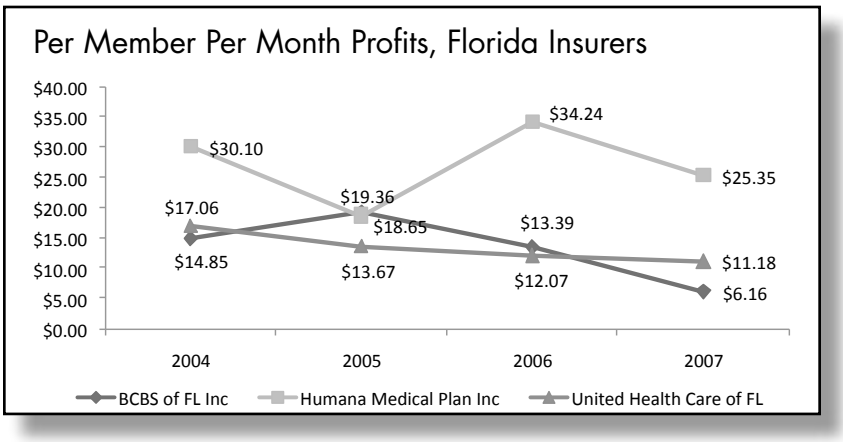
The profiled insurers include: Anthem Health Plans (the state's Blue Cross Blue Shield licensee and a WellPoint subsidiary), Health Net of Connecticut, and Oxford Health Plans of Connecticut (a member of UnitedHealth Group).

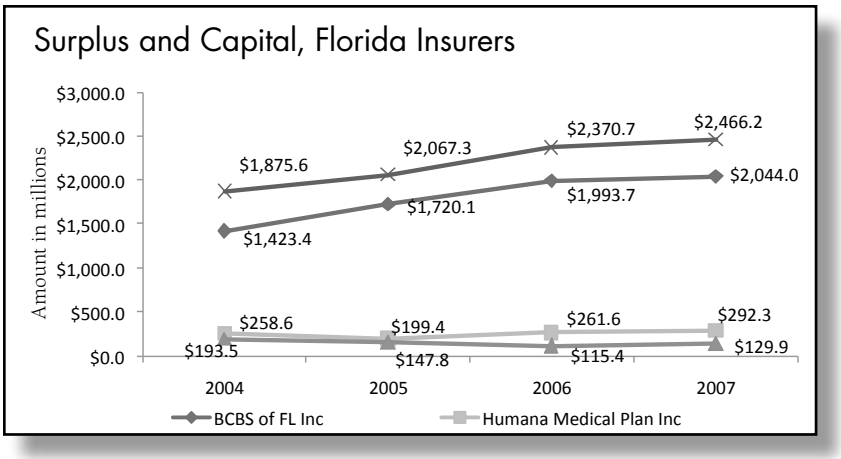
ANNUAL PROFITS. The annual profits of all three insurers rose between 2004 and 2007, with the most dramatic increase and fluctuation for Health Net. In 2004, that insurer lost $1.15 million, but it brought in profits of over $52.4 million in 2005, approximately $293,000 in 2006, and $10.2 million in 2007. Meanwhile, its membership fell steadily, with a 24.6 percent decline from 2004 to 2007. Anthem's profits increased by 33.3 percent, and its membership dropped by 8.9 percent. More dramatically, Oxford's profits grew by 59.4 percent, while its membership declined by 38.6 percent. With net income of $225.8 million (and the highest membership), Anthem led the three in profits in 2007. That year, the three insurers posted combined profits of $251.1 million.

PER MEMBER PER MONTH PROFITS. Although Anthem ranked first in annual profits in 2007, Oxford led in PMPM profits, at $27.90. From 2004 to 2007, its PMPM profits grew by 159.6 percent. Anthem came in second, with PMPM profits increasing by 46.3 percent and reaching $25.47 at the end of 2007. Health Net experienced considerable fluctuation and ended 2007 with $3.11 in PMPM profits.

SURPLUS AND CAPITAL. All three insurers saw an increase in their surplus. Anthem's increased by 7.7 percent, coming in at $388.5 million in 2007, and Health Net's increased by 71.2 percent, reaching $151.9 million. Oxford's surplus grew by 28.2 percent, ending 2007 at $47.7 million.







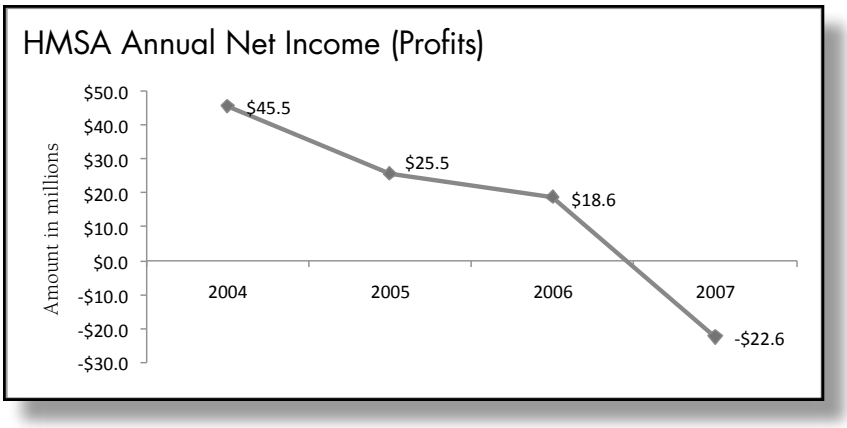
The insurers profiled include: Blue Cross and Blue Shield of Florida (BCBS of FL), Humana Medical Plan, and UnitedHealthcare of Florida (United).

ANNUAL PROFITS. 2004 was the top year for combined profits, with the three insurers posting a total of $502 million in net income. However, 2004 was not the top-earning year for each of the insurers individually. BCBS of FL posted its highest profits ($312.3 million) in 2005 and its lowest profits in 2007 ($132.6 million), while Humana's top year among the four was 2006 ($188.3 million) and its lowest was 2005 ($102.2). In 2007, they reported combined profits of $313.5 million.

From 2004 to 2007, all three saw their profits drop: by 39.1 percent for BCBS of FL,[77] 17.1 percent for Humana, and 63 percent for United. United also saw a 43.5 percent drop in membership, but membership grew for BCBS by 46.8 percent. For Humana, membership dipped by 1.5 percent.

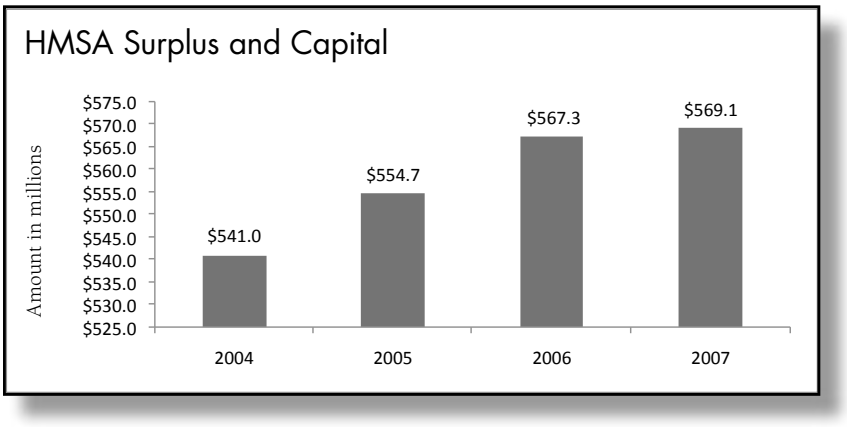
PER MEMBER PER MONTH PROFITS. Among the three insurers, Humana had the highest PMPM profits in three of the four featured years, with a high of $34.24 in 2006 and a low of $18.65 in 2005. United's PMPM profits ranged from $11.18 in 2007 to $17.06 in 2004. BCBS of FL ended 2007 with PMPM profits of $6.16, compared to its high of $19.36 in 2005.

SURPLUS AND CAPITAL. Both BCBS of FL and Humana experienced an increase in their surpluses, while United's declined by 32.9 percent. BCBS of FL's increased by 43.6 percent, reaching $2.04 billion in 2007. Humana's increased by 13 percent and reached $292.3 million. United posted a 2007 surplus of $129.9 million. Between 2004 and 2007, the combined surplus of the three insurers increased by 31.5 percent.

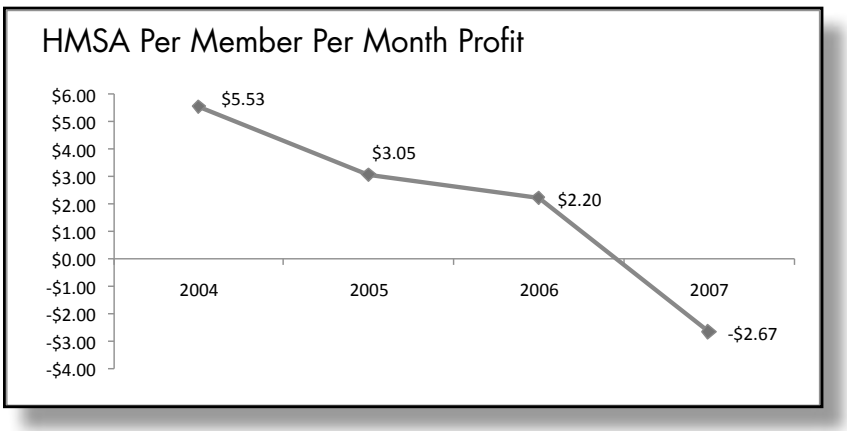


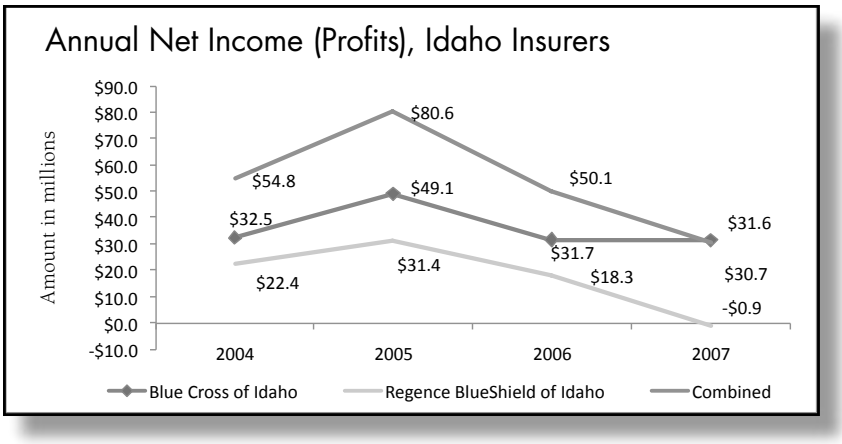
The dominant health insurer in Hawaii is the Hawaii Medical Service Association (HMSA), a Blue Cross Blue Shield licensee.

PROFITS. For the 2004 to 2007 period, HMSA's most profitable year was 2004, when it reported income of $45.5 million. In 2007, however, HMSA posted a loss of $22.6 million. Its membership from 2004 to 2007 remained steady, with a 2.8 percent increase. Similarly, in 2007 HMSA lost $2.67 per member per month, compared to PMPM profits of $5.53 in 2004.



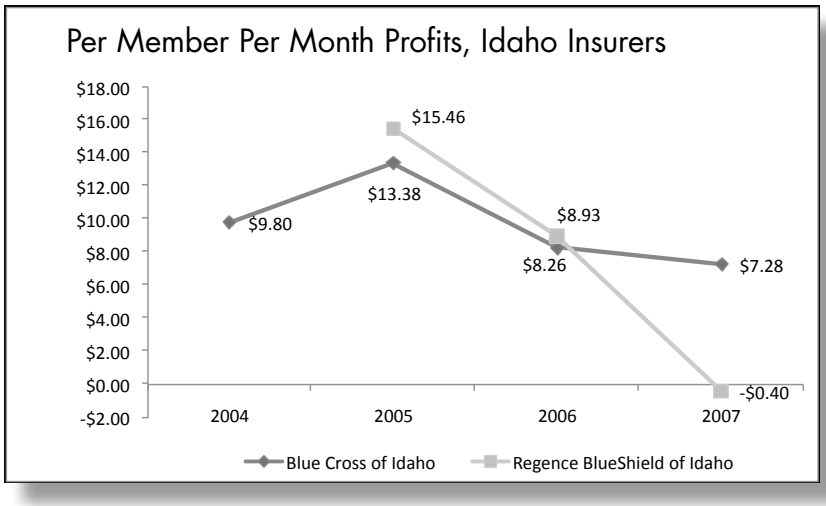
SURPLUS AND CAPITAL. Despite the decline in profits, HMSA's surplus grew by 5.2 percent between 2004 and 2007, when it reached $569.1 million.





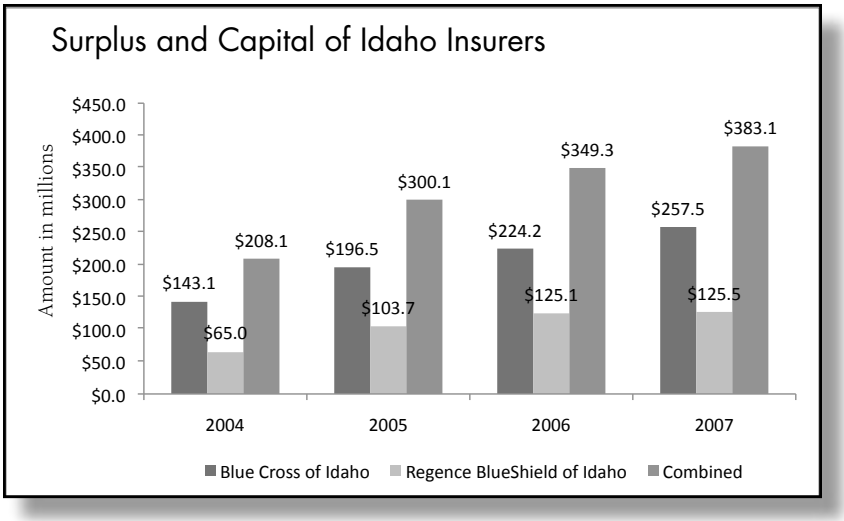
The featured insurers are: Blue Cross of Idaho and Regence BlueShield of Idaho.

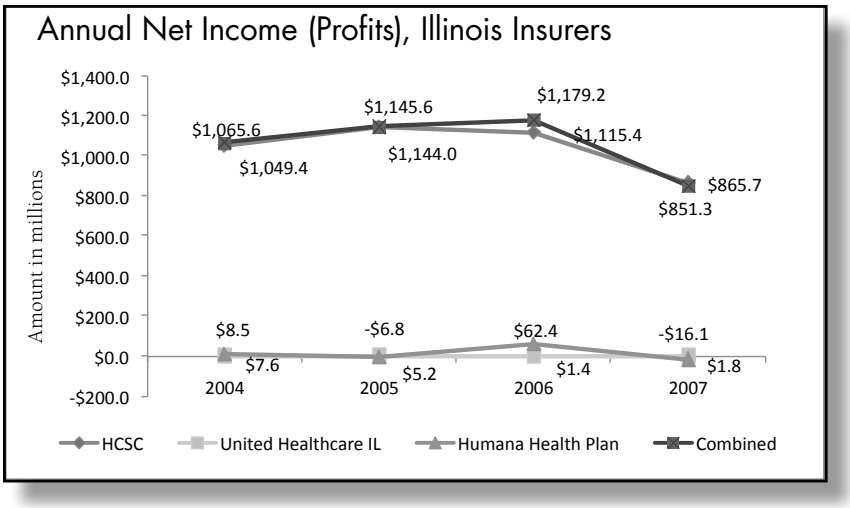
ANNUAL PROFITS. The most profitable year for both Blue Cross and Regence[78] was 2005, when they posted combined profits of $80.6 million. Aside from the 2005 spike, Blue Cross' profits remained fairly steady during the four-year period, dipping by 2.7 percent. Regence, on the other hand, reported a loss of about $900,000 in 2007. Between 2004 and 2007, Blue Cross' membership increased by 31.1 percent and Regence's by 12 percent.

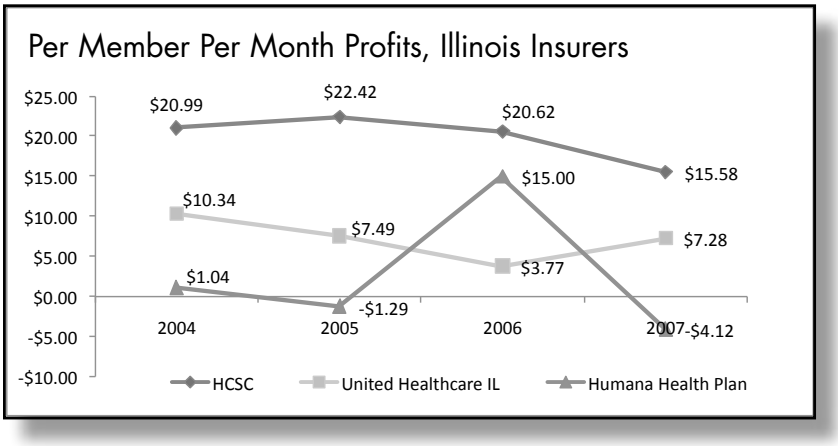


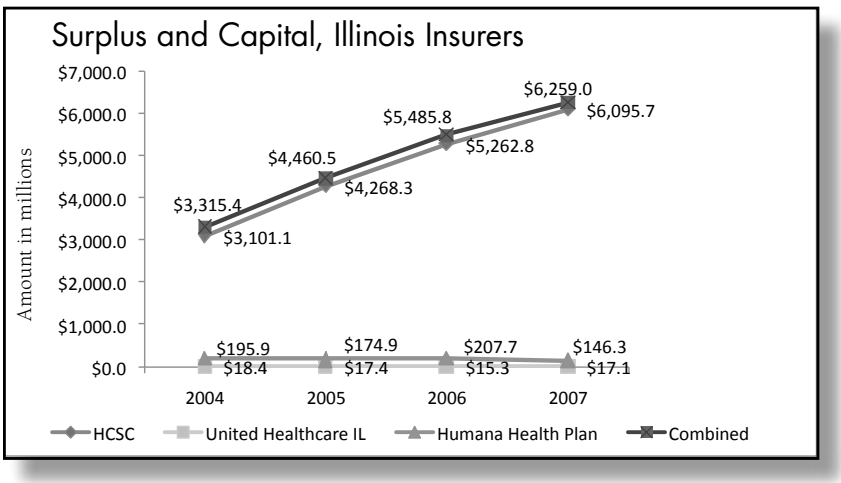
PER MEMBER PER MONTH PROFITS. Again, 2005 represented the most profitable year for both carriers: Blue Cross had per member per month (PMPM) profits of $13.38 and Regence had PMPM profits of $15.46. (2004 PMPM profits could not be calculated for Regence, since it filed a life/health/accident statement in 2004 and 2005.) Blue Cross saw its PMPM profits fall by 25.8 percent from 2004 to 2007.

SURPLUS AND CAPITAL. Both carriers saw surplus grow steadily between 2004 and 2007 – by 80 percent for Blue Cross and 93.1 percent for Regence – reaching a combined 2007 surplus of $383.1 million. Of this amount, Blue Cross, which covered more members, claimed $257.5 million.









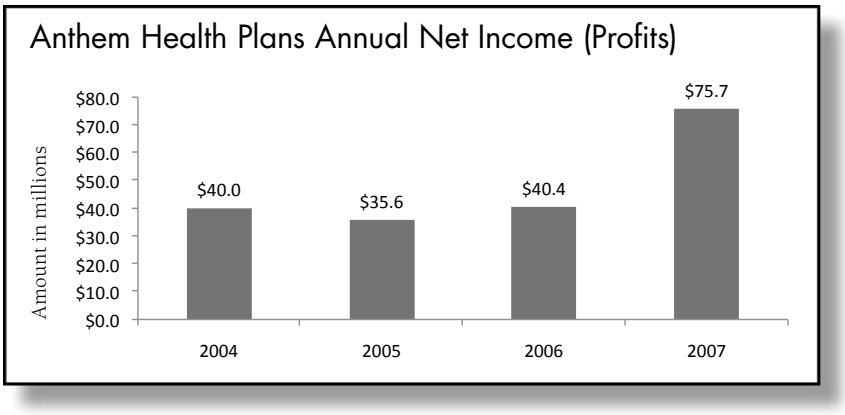
The featured insurers include: Health Care Service Corporation (of which BlueCross BlueShield of Illinois is a division), UnitedHealthcare of Illinois (United), and Humana Health Plan.

ANNUAL PROFITS. In 2007, the three insurers reported combined profits of $851.3 million, down from their 2004-2007 high of $1.18 billion the previous year. HCSC is the largest insurer among the three, claiming the vast majority of profits and covering most members.[79] The insurer posted its highest profits for the four-year period in 2005, coming in at $1.15 billion. Between 2004 and 2007, its profits dropped by 17.5 percent, while its membership grew by 11.1 percent. United's profits dropped by 79.5 percent and its membership by 70.8 percent. Humana underwent the greatest fluctuation in profits, posting $62.4 million in profits in 2006 and a loss of $16.1 million in 2007.

PER MEMBER PER MONTH PROFITS. In addition to reporting the highest overall profits, HCSC also claimed the largest per member per month profits among the three insurers, ranging from $22.42 in 2004 to $15.58 in 2007. Both United and Humana experienced fluctuation in their PMPM profits, with United's decreasing by 29.6 percent between 2004 and 2007 and Humana losing $4.12 PMPM in 2007.

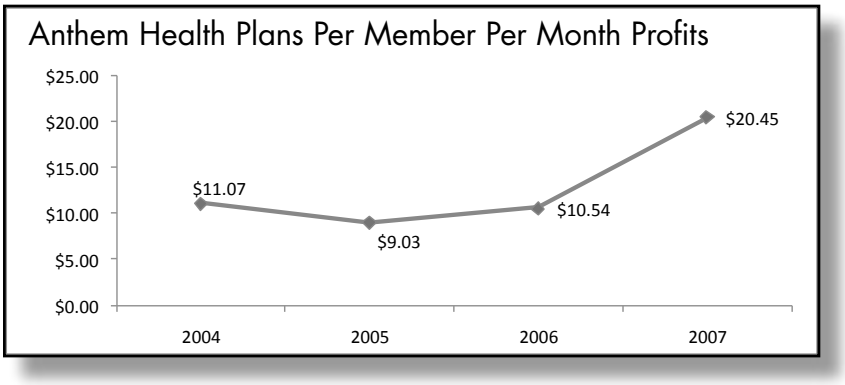
SURPLUS AND CAPITAL. Despite a drop in profits, HCSC saw its surplus nearly double from 2004 to 2007, reaching $6.1 billion. United closed 2007 with a surplus of $17.1 million and Humana with a surplus of $146.3 million – both decreases from 2004. Humana's peak surplus year was 2006, when it held $207.7 million in surplus.

MAINE

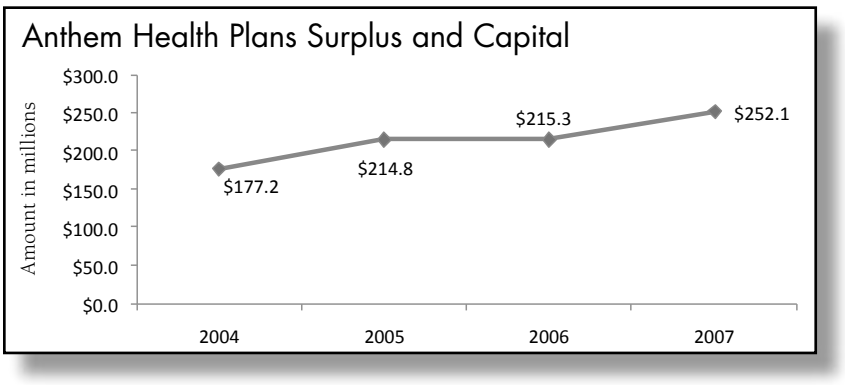


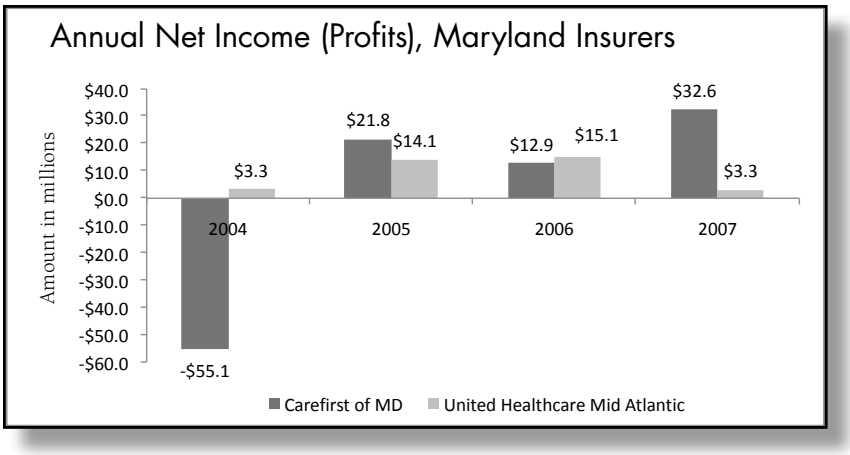
Anthem Health Plans of Maine, a Blue Cross Blue Shield licensee and subsidiary of WellPoint, is Maine's major health insurer.

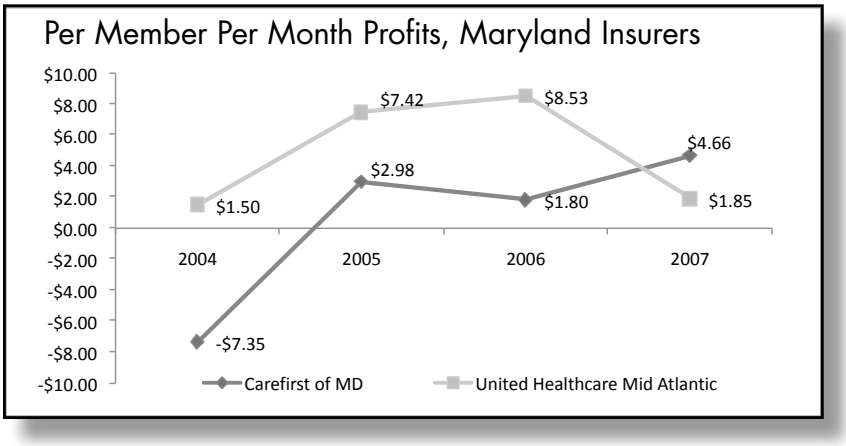
PROFITS. Between 2004 and 2007, Anthem's annual profits grew by 89.2 percent, increasing from $40 million to $75.7 million, while its membership increased by only 2.4 percent. The insurer's per member per month profits increased at a rate similar to the rate of growth in overall profits – by 84.8 percent – spiking from $11.07 in 2004 to $20.45 in 2007.

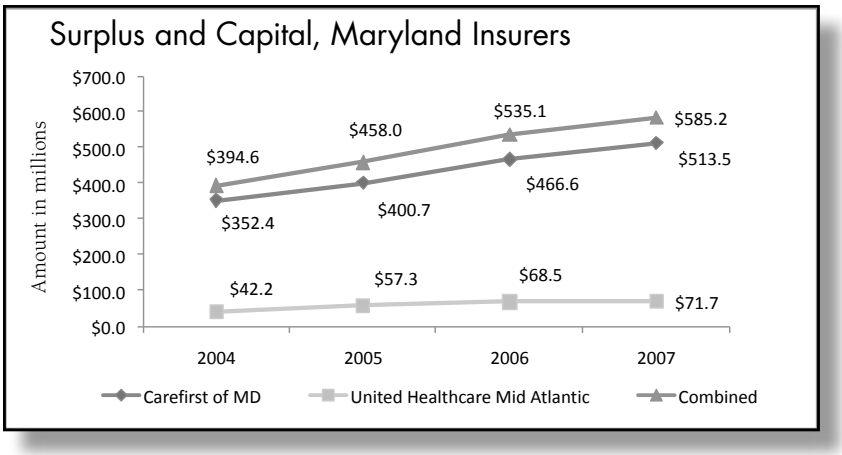


SURPLUS AND CAPITAL. During the 2004-2007 period, Anthem's surplus grew from $177.2 million to $252.1 million, without decreases in the intervening years.







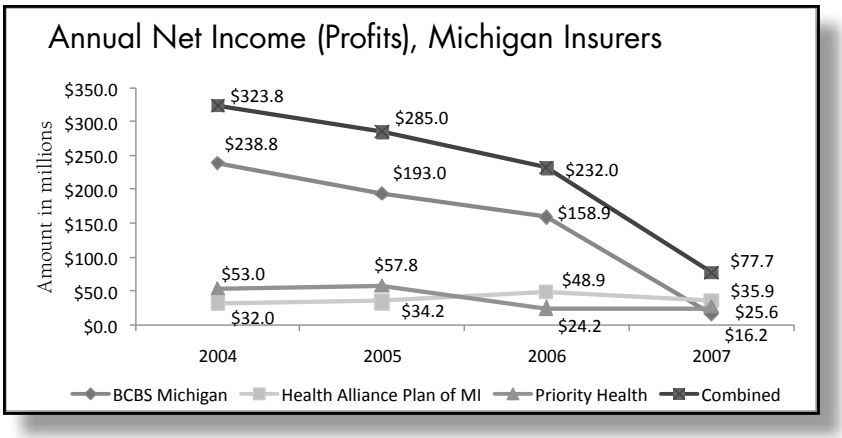


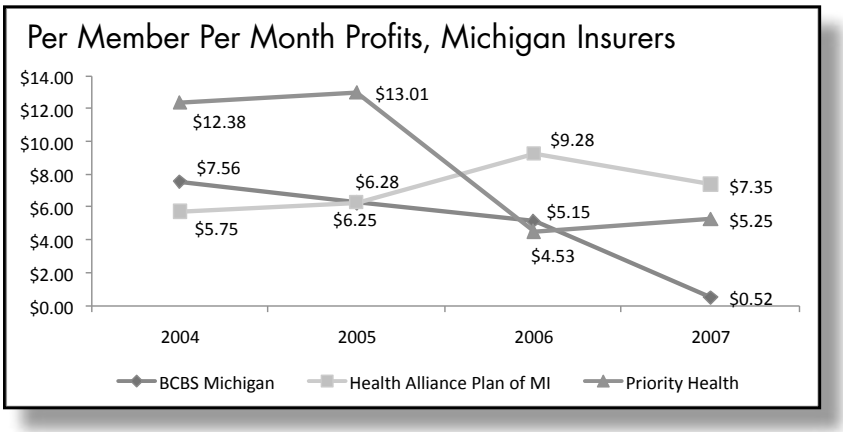
The featured insurers include: CareFirst of Maryland, a Blue Cross Blue Shield licensee, and UnitedHealthcare of the Mid-Atlantic (United).

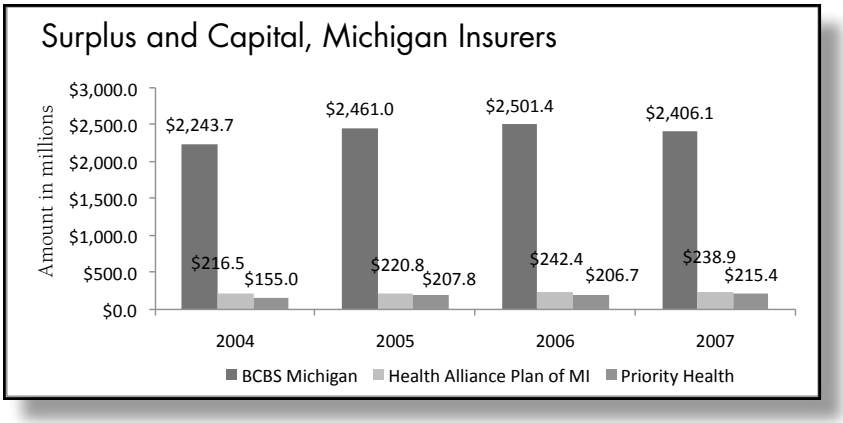
ANNUAL PROFITS. CareFirst went from reporting a $55.1 million loss in 2004 to posting profits of $32.6 million in 2007. During that period, its membership declined by 6.7 percent. United posted its highest profits, of $15.1 million, in 2006, ending 2007 with $3.3 million in profits. Between 2004 and 2007, its profits dipped by 0.2 percent – but this was following a spike to $14.1 million in 2005 and $15.1 million in 2006 (both years in which it covered fewer members than in 2004). Between 2004 and 2007, its membership fell by 18.8 percent.

PER MEMBER PER MONTH PROFITS. For three of the four years, United's PMPM profits exceeded CareFirst's. In 2004, United had PMPM profits of $1.50 while CareFirst had a PMPM loss of $7.35. Then, in 2005 and 2006, United's PMPM profits grew to $7.42 and $8.53, respectively, before dropping to $1.85. CareFirst ended 2007 with PMPM profits of $4.66.

SURPLUS AND CAPITAL. CareFirst posted a surplus of $352.4 million in 2004, and this sum increased steadily to $513.5 million through 2007 (for a 45.7 percent increase). United's surplus also grew, at a rate of 70.1 percent, from $42.2 million to $71.7 million. As with CareFirst, its surplus did not dip during this period.





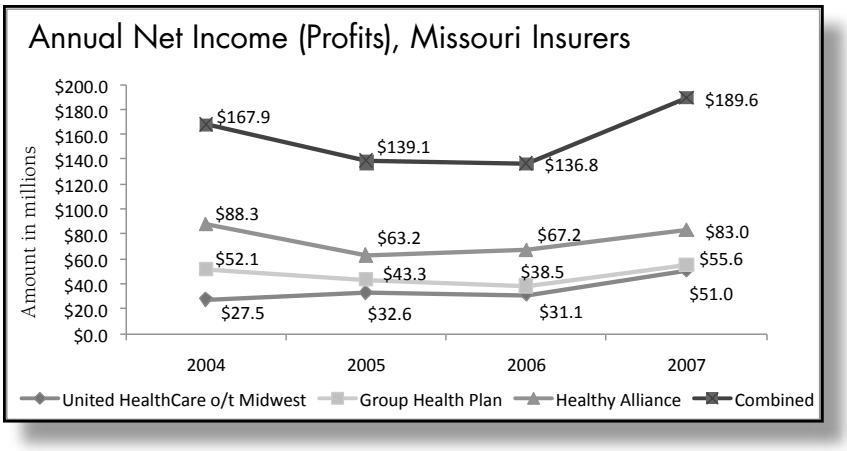


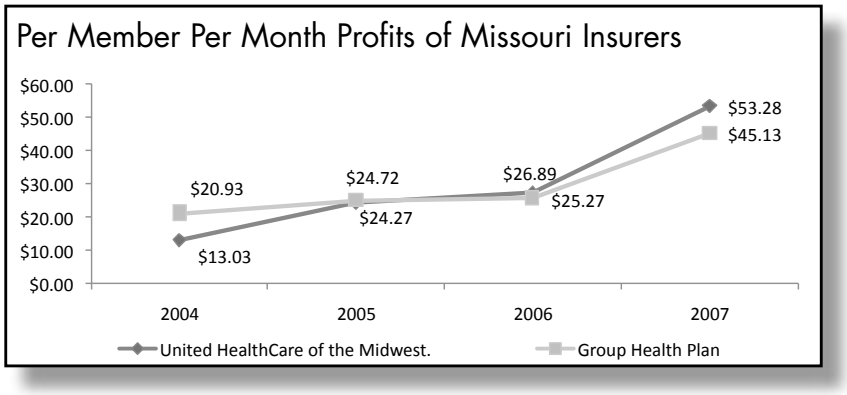
The selected carriers include: Blue Cross Blue Shield of Michigan (BCBS of MI), Health Alliance Plan of Michigan (HAP), and Priority Health.

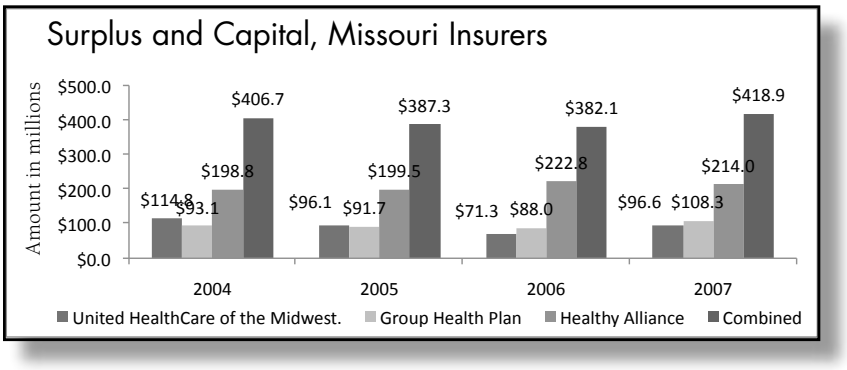
ANNUAL PROFITS. The most profitable year for the insurers, in combination, was 2004, when they reported total profits of $323.8 million. In 2007, their combined profits reached $77.7 million. HAP's profits grew by 12.3 percent between 2004 and 2007, and its membership fell by 12.2 percent, while BCBS of MI's profits fell by 93.2 percent and Priority Health's by 51.7 percent. BCBS's membership remained steady (dipping by 1.9 percent) and Priority Health's grew by 13.7 percent.

PER MEMBER PER MONTH PROFITS. Change in per member per month (PMPM) profits reflected changes in the insurers' annual profits, with HAP seeing a 2004-2007 increase of 27.9 percent, and BCBS of MI and Priority seeing a decrease of 93.1 percent and 57.6 percent, respectively. Priority Health, however, accounted for the highest PMPM profits during the period: $13.01 in 2005.

SURPLUS AND CAPITAL. Despite its decrease in profits, BCBS of MI saw its surplus grow by 7.2 percent from 2004 to 2007, reaching $2.4 billion – although its highest year was 2006, when it had accumulated $2.5 billion in surplus. HAP's surplus grew by 10.4 percent and Priority Health's by 39 percent. By the end of 2007, the insurers had a combined surplus of $2.86 billion.







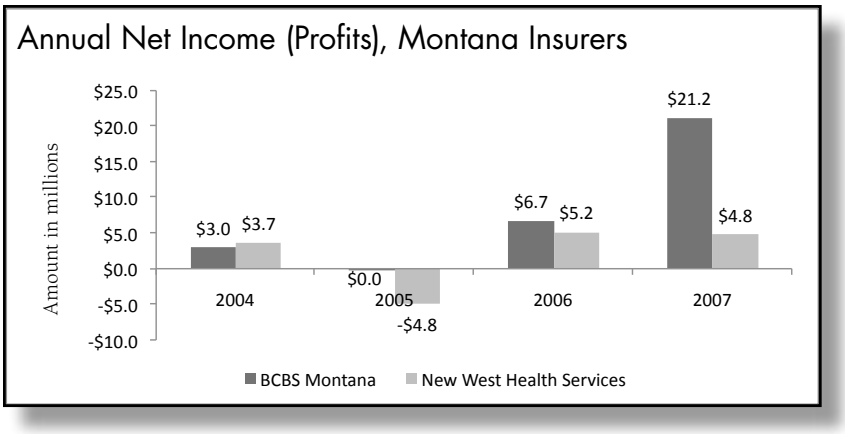
The insurers selected include: United HealthCare of the Midwest (United), Group Health Plan (GHP, an affiliate of Coventry), and Healthy Alliance Life Insurance Co. (which does business as Anthem Blue Cross Blue Shield and is a subsidiary of WellPoint).

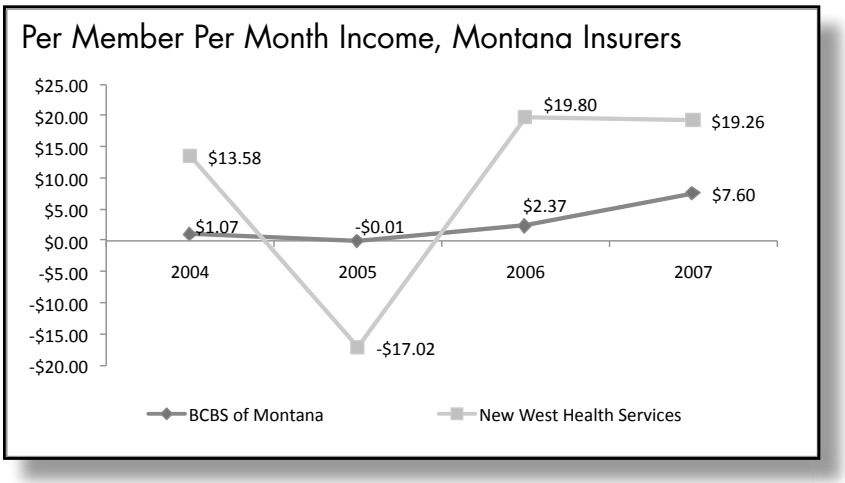
ANNUAL PROFITS. Although United did not post the highest profit levels among the three insurers, over the four-year period it experienced the greatest increase in profits: 85.3 percent, with profits growing from $27.5 million in 2004 to $51 million in 2007. Meanwhile, its membership fell by 54.7 percent.

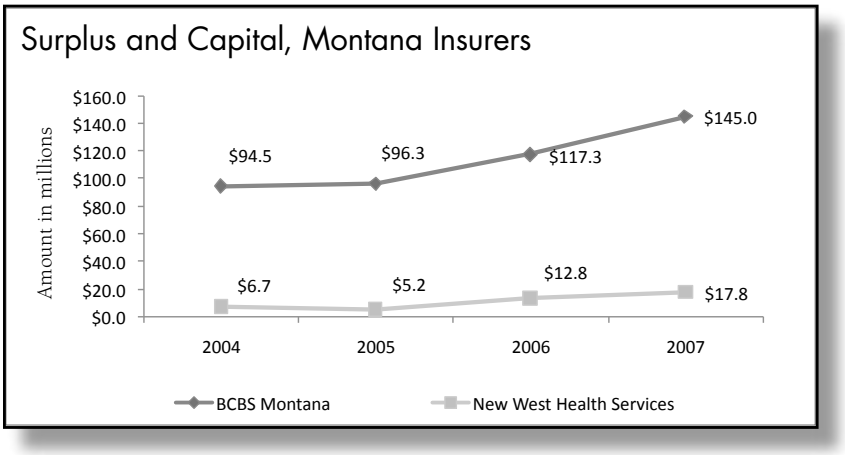
Healthy Alliance posted the highest profit figure, reporting $88.3 million in 2004 (compared to $83 million in 2007). (Membership information was not available for Healthy Alliance because it files a life/accident/health statement.) GHP began the four-year span with profits of $52.1 million and ended it with $55.6 million – a 6.7 percent increase – experiencing a dip in 2005 ($43.3 million) and 2006 ($38.5 million). Its membership fell steadily by 50.5 percent.

PER MEMBER PER MONTH PROFITS. United's PMPM profits more than tripled over the four-year period, increasing by 309 percent. In 2004, United posted monthly profits of $13.03 for each member covered. By 2007, that figure had grown to $53.28. GHP, however, did not fall far behind – it had 2007 PMPM profits of $45.13, an increase of 115.6 percent from its 2004 PMPM profits of $20.93.

SURPLUS AND CAPITAL. Both GHP and Healthy Alliance saw their surpluses grow from 2004 through 2007, while United's surplus dipped by 15.9 percent. GHP's surplus increased by 16.3 percent, from $93.1 million to $108.3 million. Healthy Alliance's surplus grew by 7.6 percent, from $198.8 million to $214 million.





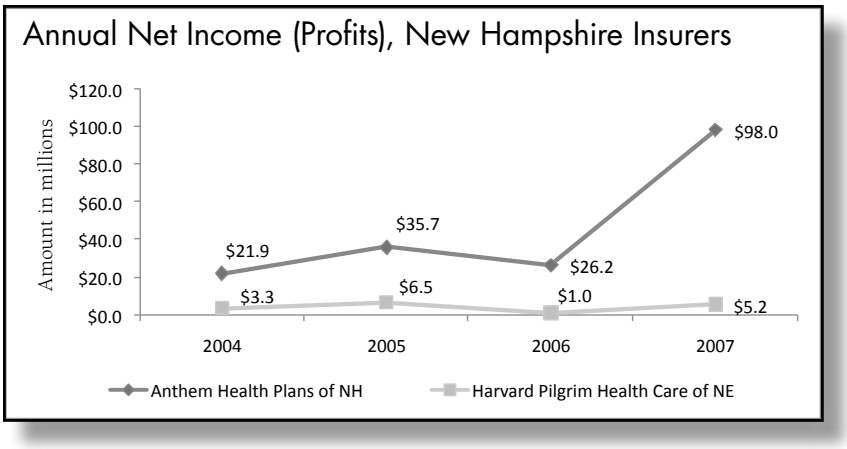


The selected insurers include: BlueCross BlueShield of Montana (BCBS of MT) and New West Health Services.

ANNUAL PROFITS. Net income for both BCBS of MT and New West grew during the four-year period, although growth in BCBS of MT's profits – 609.7 percent – far outpaced the 30.2 percent increase in New West's profits. BCBS of MT went from reporting $3.0 million in profits in 2004, and a $22,092 loss in 2005, to posting $21.2 million in profits in 2007. New West, too, had a loss in 2005, but it closed 2007 with net income of $4.8 million. During this period, BCBS of MT's membership stayed flat, while New West's dropped by 8.2 percent.

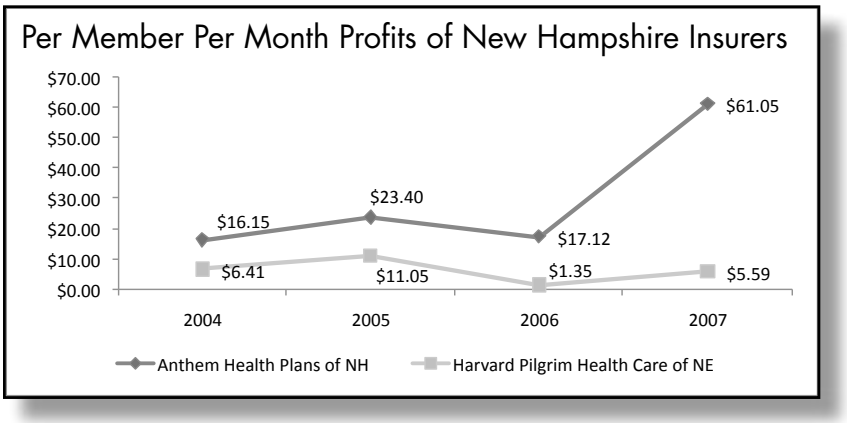
PER MEMBER PER MONTH PROFITS. For BCBS of MT, the increase in PMPM profits mirrored growth in annual profits, increasing at a rate of 609.7 percent, from $1.07 to $7.60. Except for 2005, when New West experienced a loss, its PMPM profits were considerably higher than those of BCBS of MT, ranging from $13.58 in 2004 to $19.80 in 2006 and $19.26 in 2007.

SURPLUS AND CAPITAL. Both BCBS of MT and New West saw their surpluses rise between 2004 and 2007. BCBS of MT started the period with $94.5 million in surplus and ended it with $145 million (a 53.4 percent increase). New West started with $6.7 million and ended with $17.8 million. Over the four years, BCBS did not have a decline in surplus, while New West's dipped in 2005 and then more than doubled in 2006. By 2007, its surplus had grown by 166.8 percent from 2004.



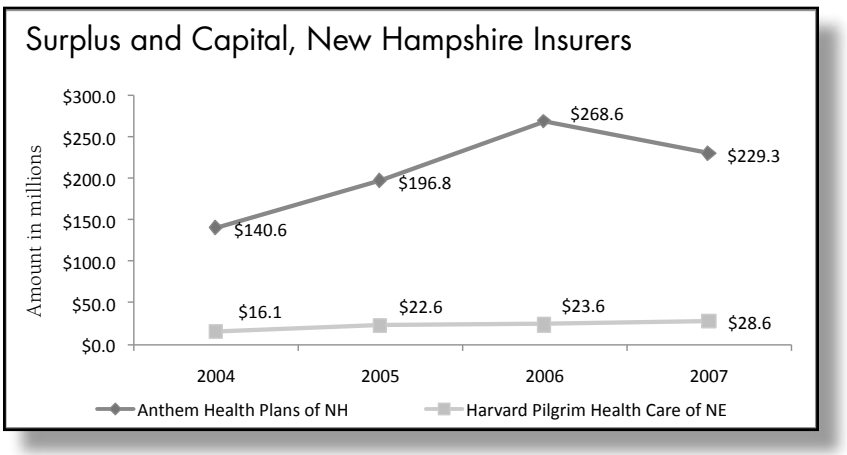
The insurers featured include: Anthem Health Plans of New Hampshire (a Blue Cross Blue Shield licensee and WellPoint subsidiary) and Harvard Pilgrim Health Care of New England.

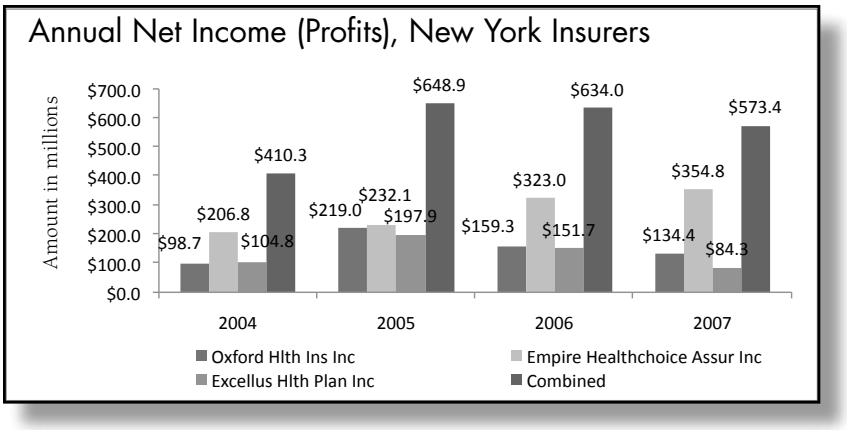
ANNUAL PROFITS. With a 348.5 percent increase, 2004-2007 net income growth for Anthem far outpaced that for Harvard Pilgrim, which saw its profits rise by 60.1 percent. During this period, Anthem's membership grew by 18.6 percent, while Harvard Pilgrim's grew by 83.8 percent. In 2007, Anthem posted profits of $98 million, while Harvard Pilgrim posted $5.2 million in net income that year.

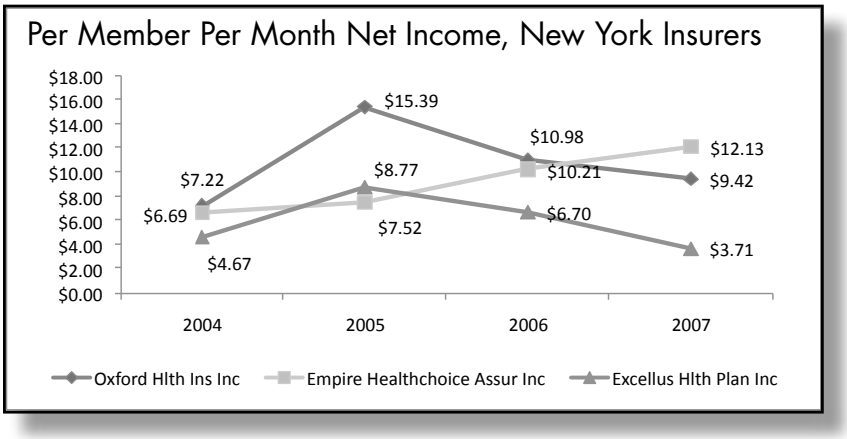


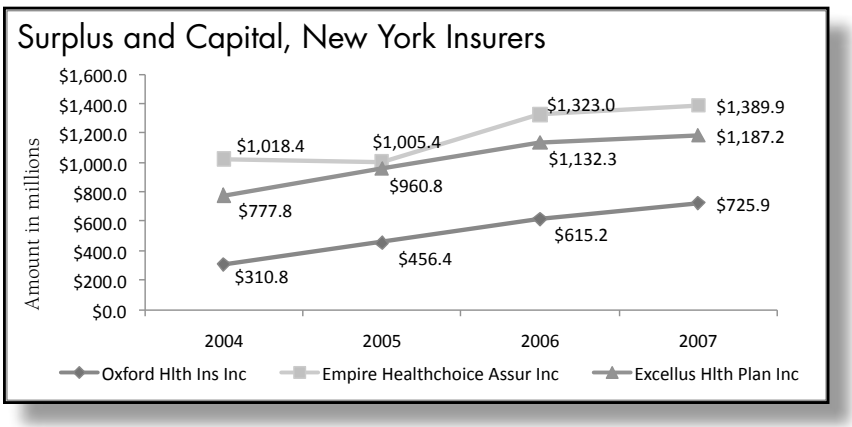
PER MEMBER PER MONTH PROFITS. On top of posting higher annual profits and covering more members, Anthem also consistently had PMPM profits exceeding those of Harvard Pilgrim. In 2007, Anthem had PMPM profits of $61.05. During the four-year period, its PMPM profits more than tripled. Harvard Pilgrim, though experiencing increased overall profits, saw its PMPM profits decrease by 12.9 percent, from $6.41 in 2004 to $5.59 in 2007.

SURPLUS AND CAPITAL. Both insurers underwent an increase in surplus – 63.1 percent for Anthem and 77.9 percent for Harvard Pilgrim. By the end of 2007, the two insurers had a combined surplus of $258 million, with Anthem accounting for $229.3 million and Harvard Pilgrim $28.6 million.









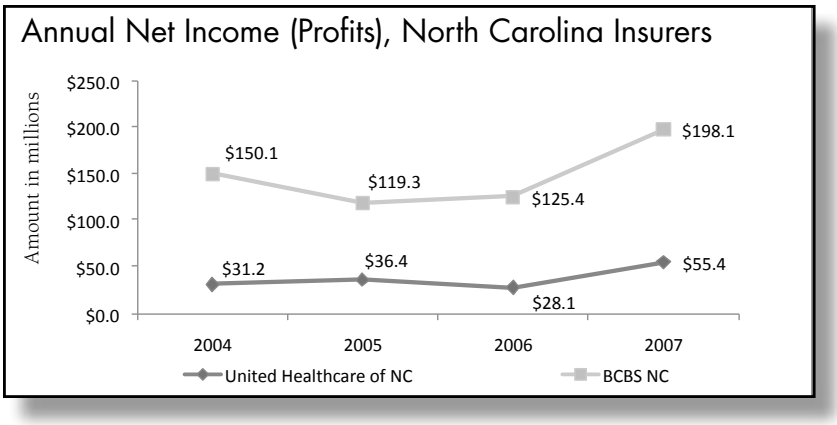
The featured insurers include: Oxford Health Insurance (a UnitedHealth Group subsidiary), Empire Healthchoice Assurance (a Blue Cross Blue Shield licensee and WellPoint subsidiary), and Excellus Health Plan (also a Blue Cross Blue Shield licensee).

ANNUAL PROFITS. From 2004-2007, annual profits for both Oxford and Empire increased – by 36.2 percent and 71.6 percent, respectively – while those for Excellus decreased by 19.6 percent. Oxford went from reporting $98.7 million in 2004 profits to reporting $134.4 million in 2007. During this period, its membership increased by 4.4 percent. Its most profitable year was 2005, when it reported net income of $219 million.

Empire's profits rose steadily from $206.8 million in 2004, reaching $354.8 million in 2007. Meanwhile, its membership fell by 5.3 percent. Excellus, on the other hand, ended the period with profits of $84.3 million, down from $104.8 million in 2004. Its most profitable year was 2005, when it reported net income of $197.9. Its membership remained steady, increasing by 1.3 percent.

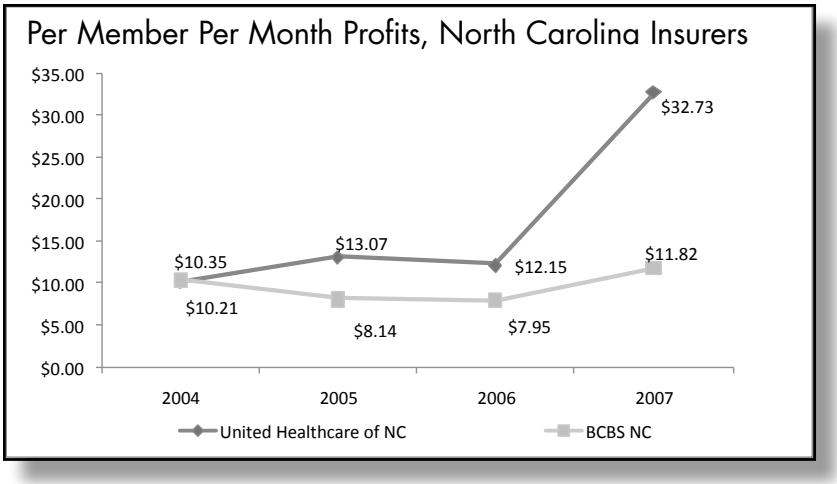
PER MEMBER PER MONTH PROFITS. The highest PMPM profits during the four-year period were for Oxford, in 2005; they came in at $15.39 that year. Oxford's PMPM profits increased by 30.5 percent and Empire's by 81.2 percent over the four years, while Excellus saw a decrease of 20.6 percent.

SURPLUS AND CAPITAL. All three insurers saw an increase in their surplus between 2004 and 2007. Oxford had the most marked increase, at 133.5 percent; its surplus rose from $310.8 million to $725.9 million. Empire started and ended with the largest surplus: from $1 billion to $1.39 billion, at a 36.5 percent increase. (It also consistently covered more member months than the other two insurers.) Excellus' surplus grew by 52.6 percent to $1.19 billion.



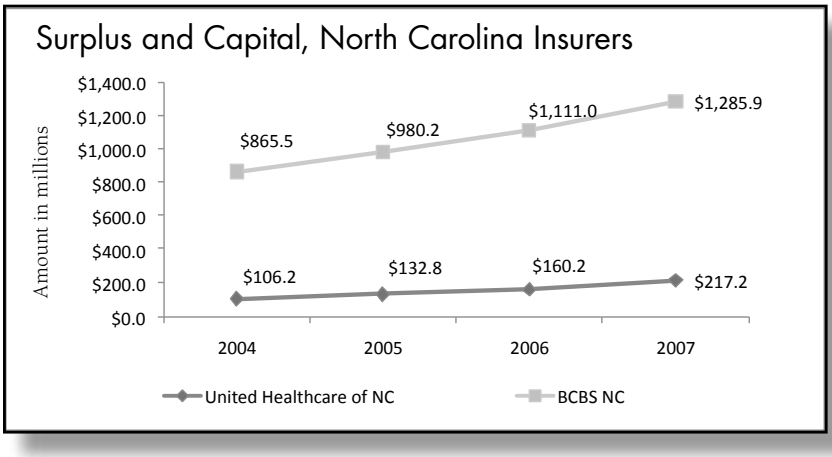
The featured insurers are: United Healthcare of North Carolina and Blue Cross Blue Shield of North Carolina (BCBS of NC).

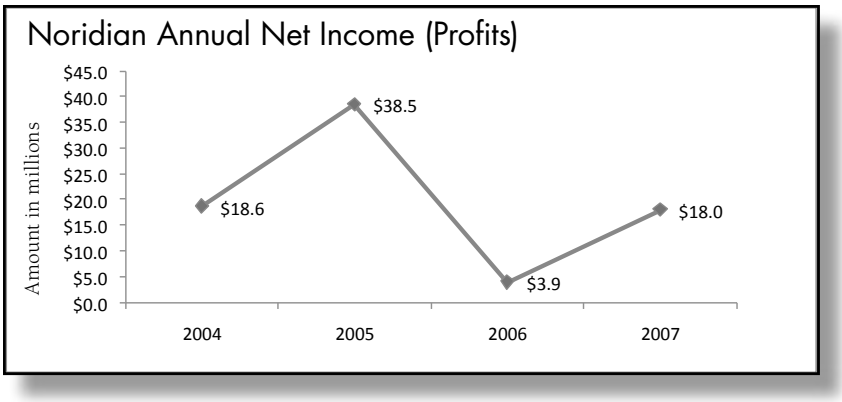
ANNUAL PROFITS. United Healthcare's profits increased at a rate of 77.4 percent from 2004 to 2007, while the members it covered dropped by 44.6 percent. BCBS of NC's profits also rose, at a rate of 31.9 percent, increasing from $150.1 million in 2004 to $198.1 million in 2007. Its membership increased by 15.5 percent. The insurers' combined profits in 2007 were $253.5 million.



PER MEMBER PER MONTH PROFITS. For three of the four years, United Healthcare's PMPM profits exceeded those of BCBS of NC, although both insurers saw their PMPM profits rise. United Healthcare's more than tripled and BCBS of NC's grew by 14.2 percent, although they dipped in 2005 and 2006. United Healthcare started with $10.21 in PMPM profits and wound up 2007 with profits of $32.73 each month for each member covered.

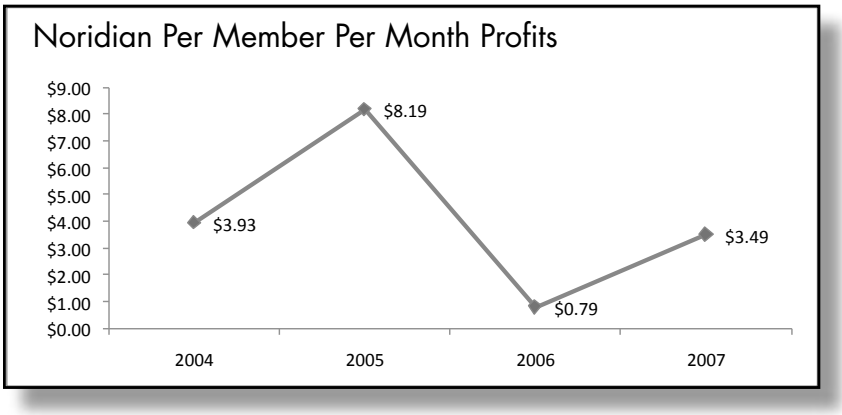
SURPLUS AND CAPITAL. United Healthcare's surplus doubled from $106.2 million in 2004 to $217.2 million in 2007, increasing each year during the period. BCBS of NC's surplus grew from $865.5 million to $1.29 billion in 2007.



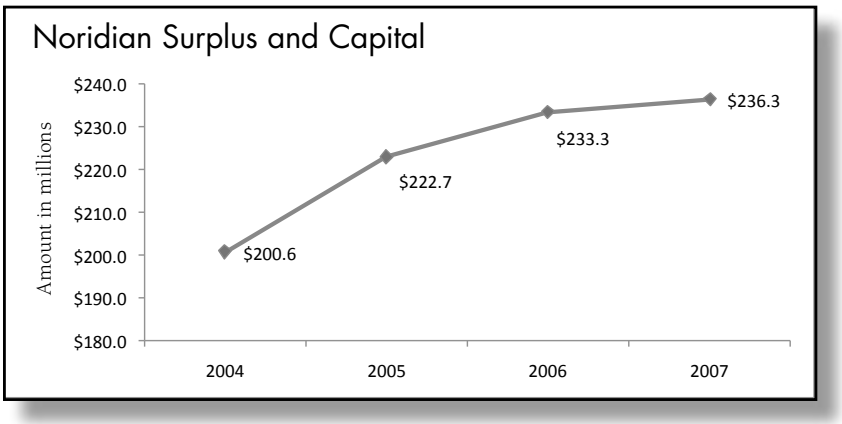


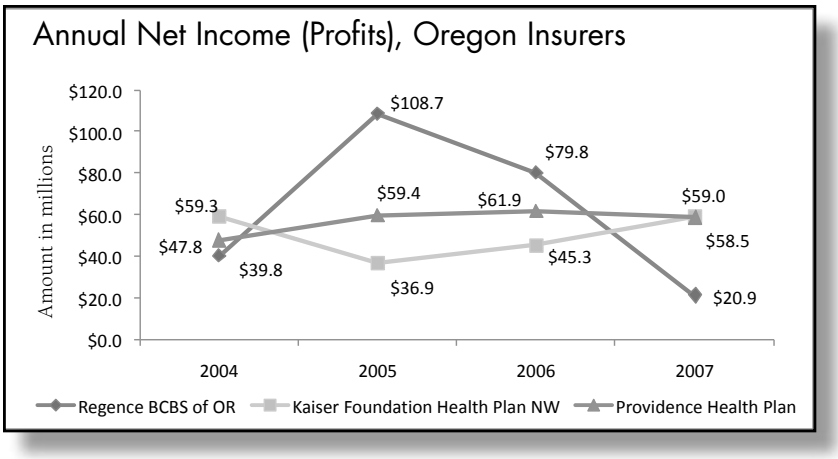
Noridian Mutual Insurance Company (which sells BlueCross BlueShield of North Dakota coverage) is the state's major health insurer.

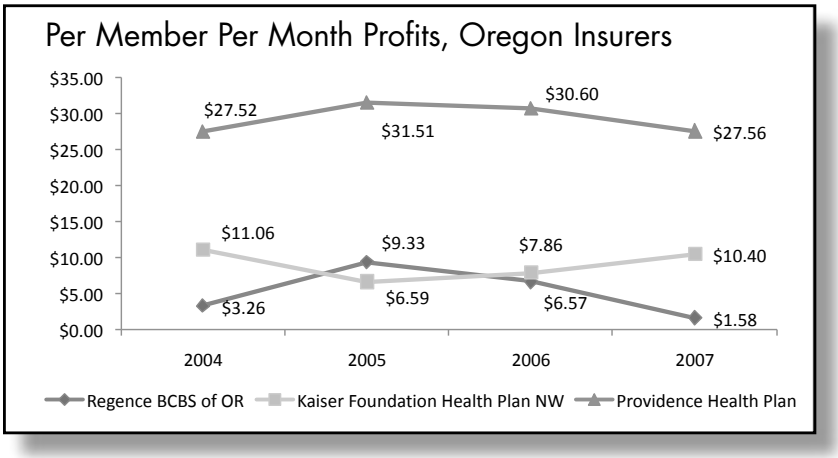
PROFITS. The insurer posted annual profits of $18.6 million in 2004 and $18.0 million in 2007, amounting to a decrease of 3.2 percent. However, in 2005, the insurer's profits hit $38.5 million and then dropped to $3.9 million in 2006. Its membership increased by 9.2 percent. There also was fluctuation in its per member per month profits, which moved from $3.93 in 2004, $8.19 in 2005, $0.79 in 2006, to $3.49 in 2007.

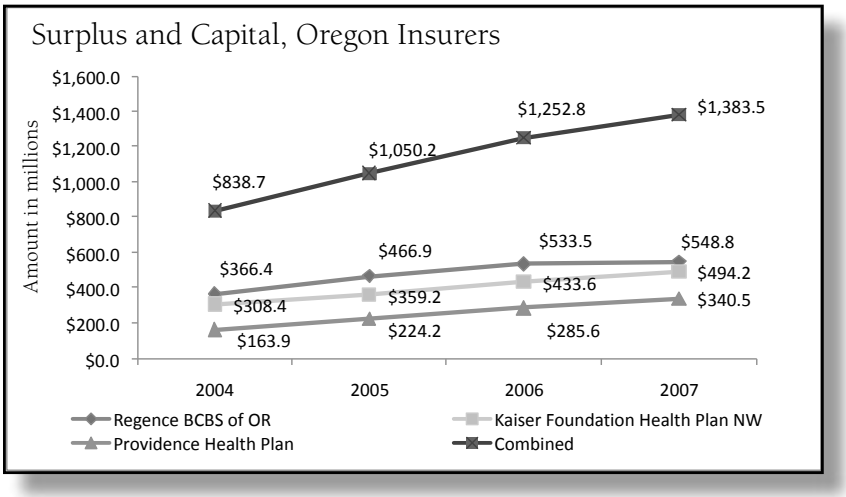


SURPLUS AND CAPITAL. Noridian/BCBS of ND saw its surplus grow from $200.6 million in 2004 to $236.3 million in 2007. This represented an increase of 17.8 percent.









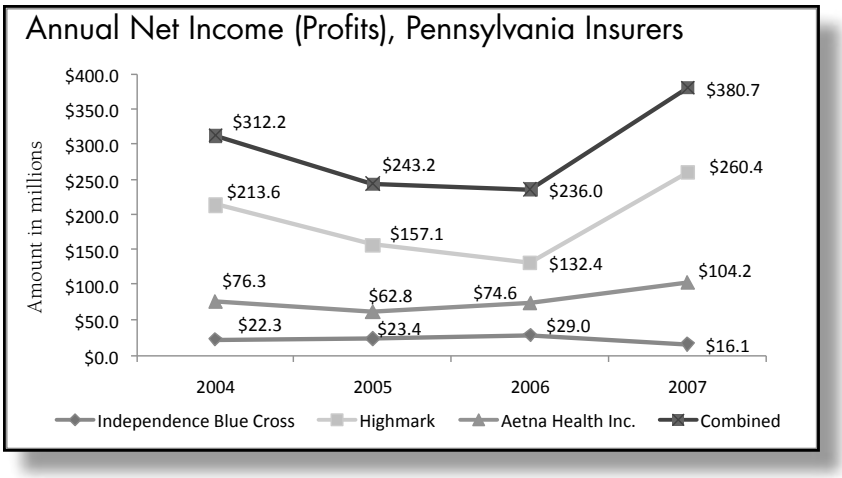
The featured insurers include: Regence BlueCross BlueShield of Oregon, Kaiser Foundation Health Plan, and Providence Health Plan.

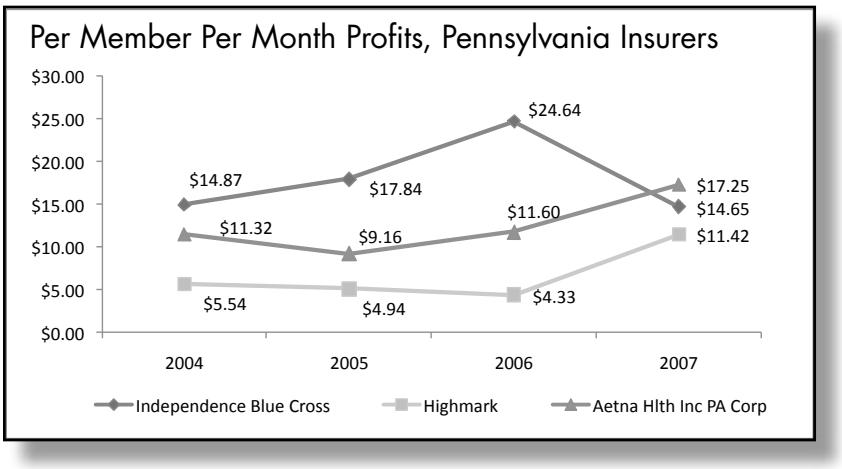
ANNUAL PROFITS. The insurers' most profitable year was 2005, when together they reported $205 million in net earnings. In 2007, their profits hit $138.4 million, a 5.8 percent decrease from the 2004 figure of $146.9 million.

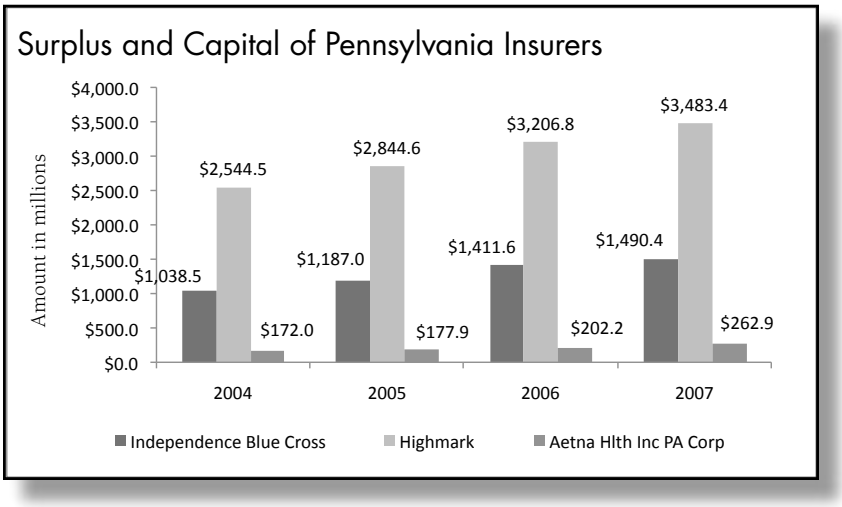
Among the three insurers, Regence experienced the greatest variability in profits. From $39.8 million in 2004, its net income spiked to $108.7 million in 2005, then decreased to $79.8 million in 2006 and $20.9 million in 2007. Overall, it experienced a 47.6 percent decrease in profits, while its membership rose by 8.4 percent. Kaiser reported profits of $59.3 million in 2004 and $59 million in 2007 (a decrease of 0.4 percent), with dips in 2005 and 2006. Its membership grew by 6.0 percent. Providence, by contrast, saw its profits go up by 22.2 percent from 2004 to 2007 – from $47.8 million to $58.5 million, with a peak of $61.9 million in 2006. Meanwhile, its membership grew by 22 percent.

PER MEMBER PER MONTH PROFITS. Providence's PMPM profits consistently outstripped those of the other insurers, ranging between $27.52 and $31.51 during the four-year period. With the exception of 2005, Kaiser's PMPM profits came in second: $11.06 in 2004, $7.86 in 2006, and $10.40 in 2007. Regence's PMPM profits ranged from $1.58 (in 2007) to $9.33 in 2005.

SURPLUS AND CAPITAL. All three insurers experienced steady surplus growth in the four-year period. Providence's surplus doubled, going from $163.9 million to $340.5 million. Kaiser's surplus, which went from $308.4 million to $494.2 million, increased by 60.2 percent. Regence saw its surplus move from $366.4 million to $548.8 million.







The selected insurers include: Independence Blue Cross, Highmark (a Blue Cross licensee), and Aetna Health Inc. Independence and Highmark have proposed a merger. In 2007, Aetna Health Inc.(of Pennsylvania) completed a merger with three Aetna subsidiaries in other states and restated net income, member months, and surplus for the years covered here.[80]

ANNUAL PROFITS. In 2007, the three insurers posted combined profits of $380.7 million, with Highmark accounting for the greatest portion: $260.4 million. Between 2004 and 2005, Highmark's profits dropped from $213.6 million to $157.1 million, then to $132.4 million in 2006. Yet by the end of 2007 its profits had increased by 21.9 percent from its 2004 figure. Meanwhile, the number of members Highmark covered dropped by the end of each of the four years, ultimately by 40.8 percent from its 2004 figure.

Aetna experienced the greatest 2004-2007 increase in profits – 36.6 percent – while its membership dropped by 10.3 percent. Independence, meanwhile, saw its profits decline from $22.3 million in 2004 to $16.1 million in 2007, along with a 26.9 percent decline in its membership.

PER MEMBER PER MONTH PROFITS. Despite having the lowest overall profits, of the three insurers Independence reaped the greatest profits per member per month for all years except 2007. The insurer's PMPM profits rose from $14.87 in 2004 to $24.64 in 2006, dipping back down to $14.65 in 2007. That year, Aetna took the lead, with PMPM profits of $17.25, up from $11.60 in 2006. Highmark's PMPM profits doubled, from $5.54 in 2004 to $11.42 in 2007.

SURPLUS AND CAPITAL. The three insurers ended 2007 with combined surplus exceeding $5.2 billion, representing a 39.5 percent increase from their 2004 combined surplus of $3.8 billion. Over this period, Aetna underwent the most rapid increase in its surplus – 52.9 percent – and ended with $262.9 million in surplus. The increase in

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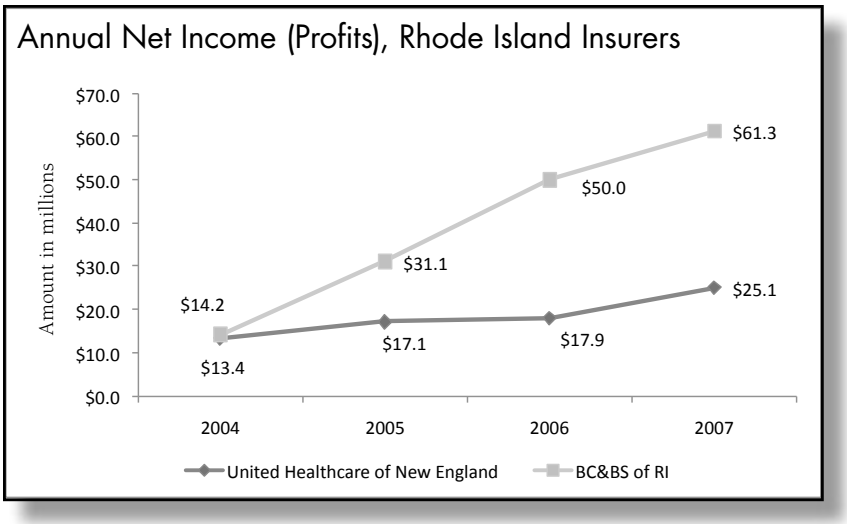
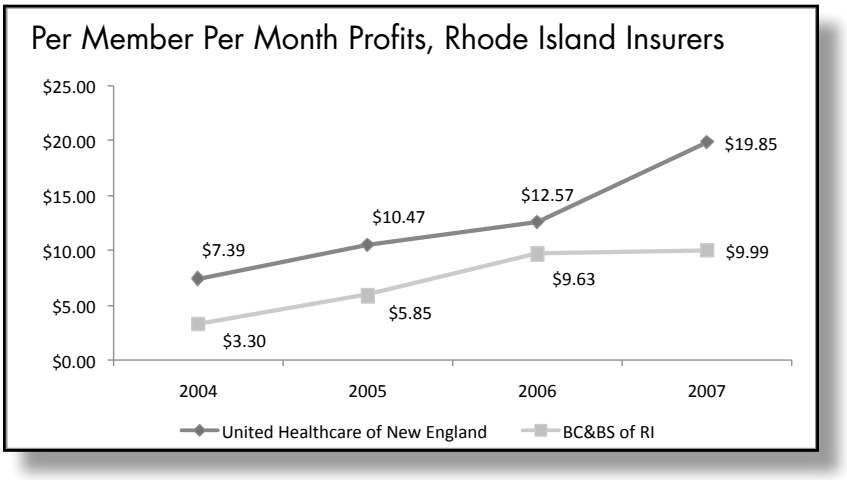
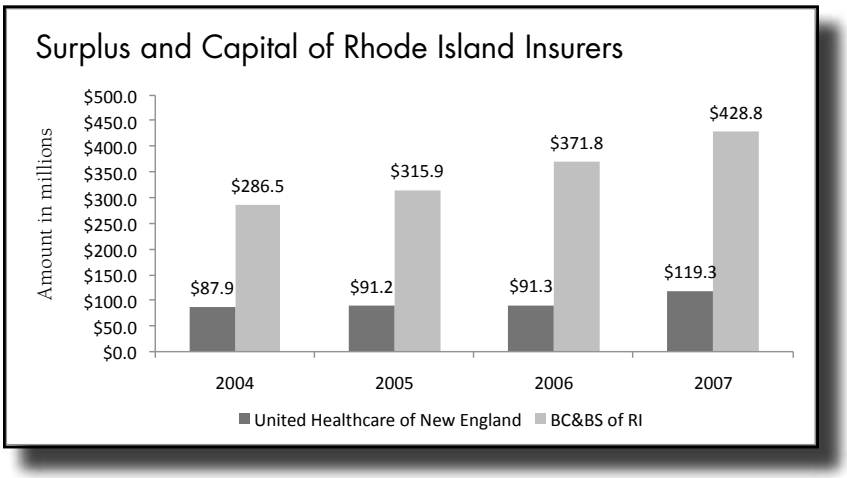
36.9 percent for Highmark. Both of these insurers started the period with surpluses exceeding $1 billion – $1.04 billion for Independence and $2.5 billion for Highmark.





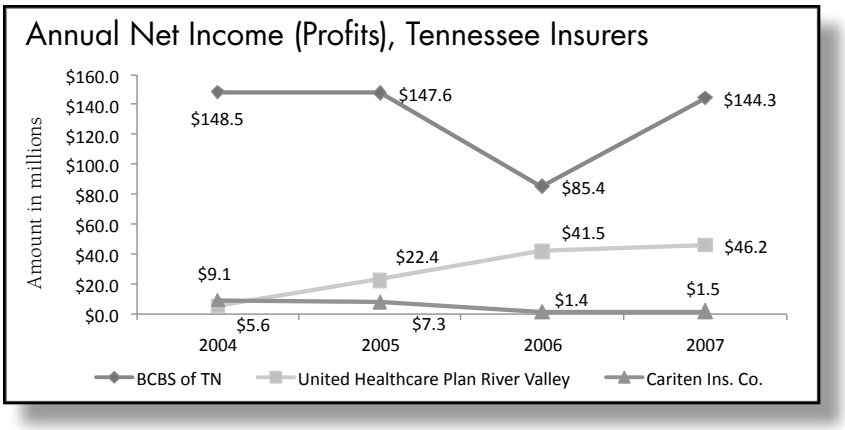


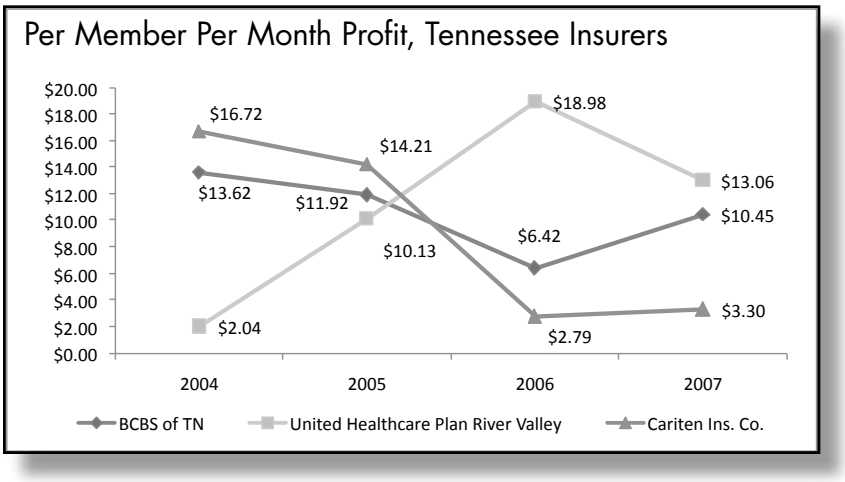
The featured insurers include: United Healthcare of New England and Blue Cross and Blue Shield of Rhode Island (BCBS of RI).

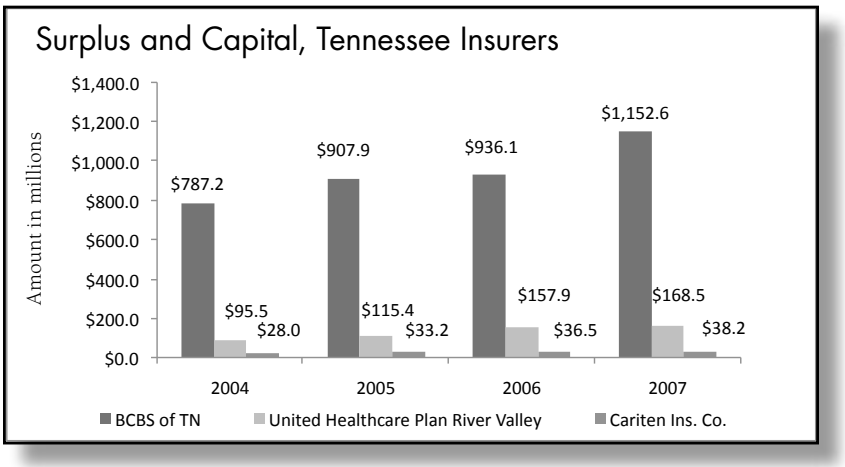
ANNUAL PROFITS. Both insurers saw their profits increase between 2004 and 2007. United Healthcare's profits grew by 86.7 percent – from $13.4 million to $25.1 million – although its membership dropped by 30.5 percent. BCBS of RI's profits grew by 330.7 percent, rising from $14.2 million to $61.3 million, while its membership grew by only 42.3 percent.

PER MEMBER PER MONTH PROFITS. In addition to increases in overall profits, BCBS of RI and United Healthcare alike experienced growth in PMPM profits. BCBS of RI saw a rise from $3.30 PMPM profit in 2004 to $9.99 in 2007, for a 202.8 percent increase. United Healthcare's PMPM profits increased steadily by 168.4 percent from $7.39 in 2004 to $19.85 in 2007.

SURPLUS AND CAPITAL. Surplus for both insurers increased over the four-year period – United Healthcare's from $87.9 million to $119.3 million and BCBS of RI's from $286.5 million to $428.8 million.







The selected insurers include: BlueCross BlueShield of Tennessee (BCBS of TN), United Healthcare Plan of the River Valley (which purchased John Deere Health Plan), and Cariten Insurance Company.

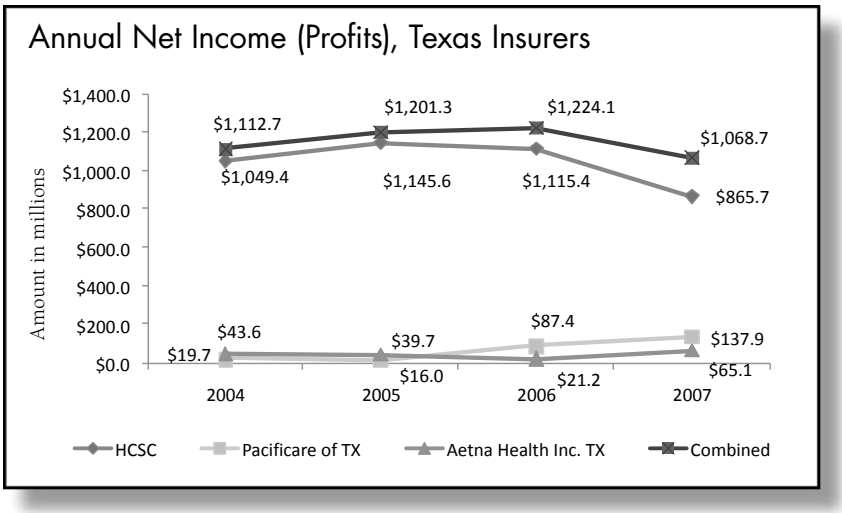
ANNUAL PROFITS. For all years, BCBS of TN claimed the largest portion of the three insurers' combined profits. In 2004, it reported profits of $148.5 million, followed by $147.6 million in 2005 and $85.4 million in 2006. In 2007, its profits rose again to $144.3 million. From 2004 to 2007, its annual net income fell by 2.8 percent, while its membership grew by 26.6 percent.

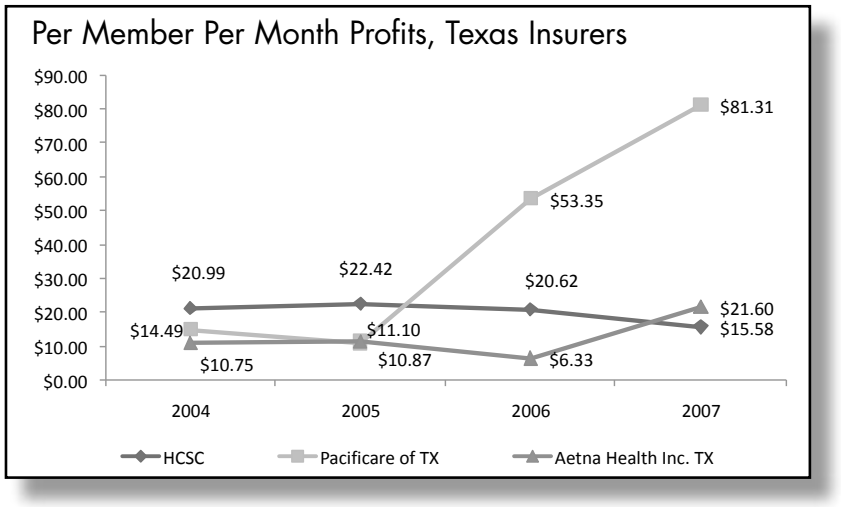
United Healthcare's profits jumped from $5.6 million in 2004 to $22.4 million in 2005 and then nearly doubled to $41.5 million in 2006, although the number of members it covered decreased each year during that period. In 2007, the insurer reported profits of $46.2 million and its membership also increased. Between 2004 and 2007, its annual profits rose by 721.2 percent although its membership grew by 28.2 percent. Cariten, by contrast, saw its profits drop by 83.7 percent, from $9.1 million to $1.5 million in 2007, while its membership fell by 17.5 percent.

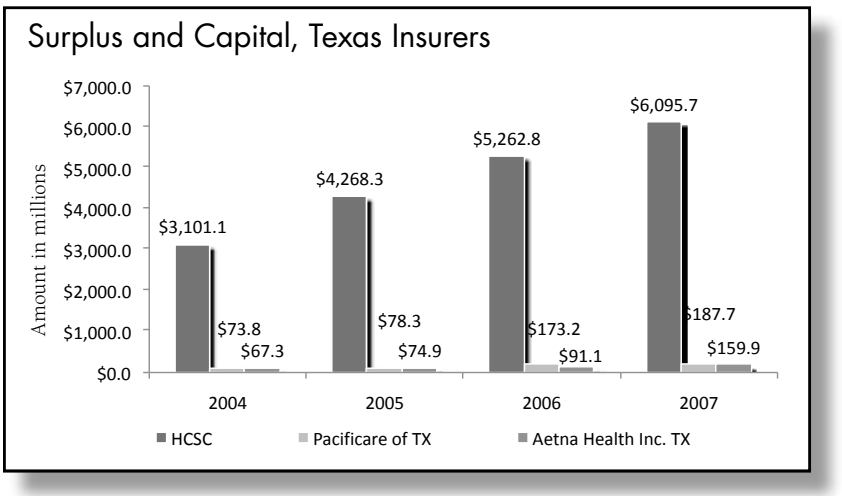
PER MEMBER PER MONTH PROFITS. Cariten began the four-year period with the highest PMPM profits – $16.72 in 2004 – and then again in 2005, with monthly profits of $14.21 for each member covered. However, in 2006, United Healthcare reaped profits of $18.98 each month for each covered member, compared to $6.42 for BCBS of TN and $2.79 for Cariten. In 2007, BCBS of TN's PMPM profits rose again to $10.45 and Cariten's to $3.30. United Healthcare ended the year with monthly profits of $13.06 for each member covered. From 2004 to 2007, its PMPM profits rose by 540.5 percent.

SURPLUS AND CAPITAL. All three insurers had consistent growth in their surpluses over the four-year period. In combination, they reported surplus of $910.7 million in 2004 and then $1.36 billion by 2007. BCBS of TN led in surplus, with $787.2 million in 2004 and $1.15 billion by 2007

(a 46.4 percent increase). United Healthcare's surplus grew by 76.5 percent, from $95.5 million (2004) to $168.5 million (2007). Cariten's surplus was $28 million in 2004, then rose by 36.6 percent in 2007, hitting $38.2 million.





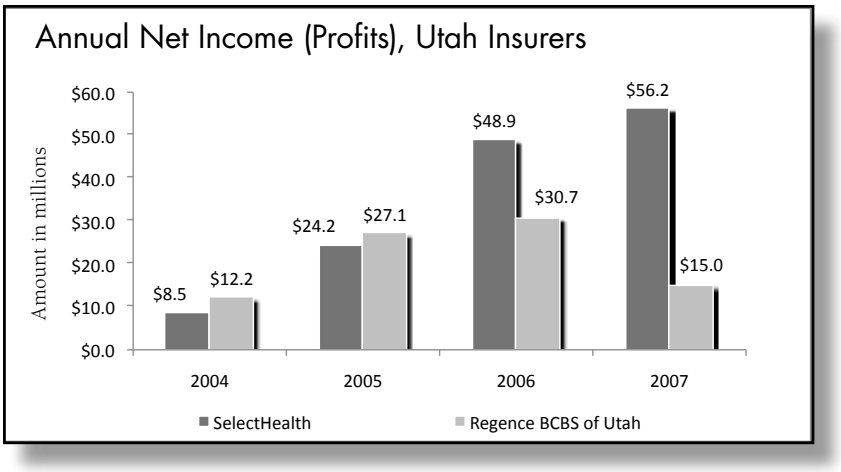


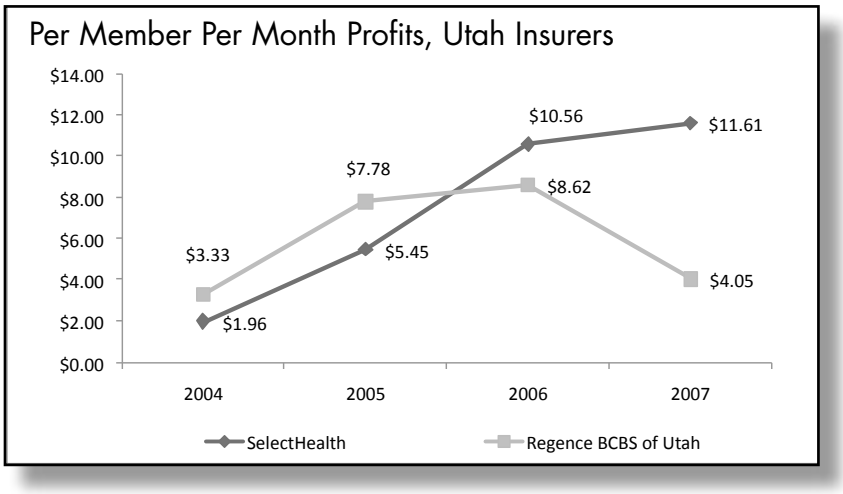
The selected insurers include: Health Care Service Corporation (HCSC, an Illinois-based mutual insurance company of which Blue Cross and Blue Shield of Texas is a division), PacifiCare of Texas (now a UnitedHealth Group subsidiary), and Aetna Health Inc. (Texas).

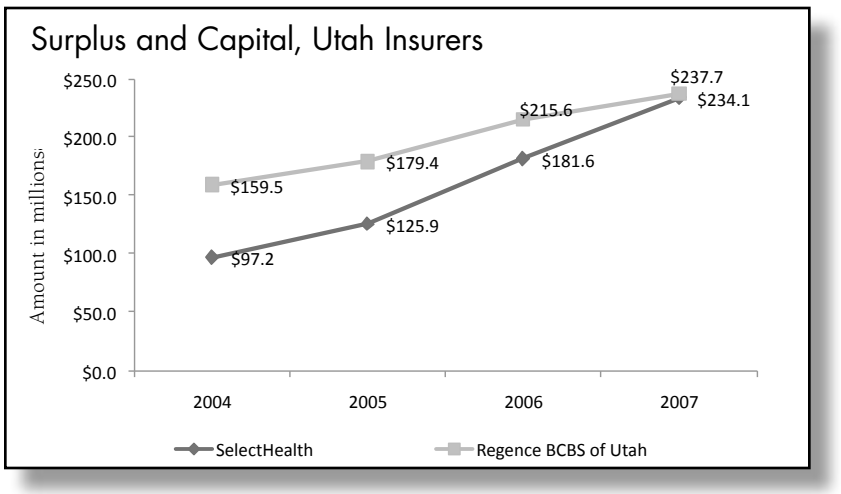
ANNUAL PROFITS. Although HCSC consistently brought in the highest profits – ranging from $865.7 million in 2007 to $1.15 billion in 2005 – PacifiCare enjoyed greater growth in its profits: 600.9 percent, compared to HCSC's negative 17.5 percent change. PacifiCare reported profits of $19.7 million in 2004 and $137.9 million in 2007. Meanwhile, HCSC's membership grew by 11.1 percent, while PacifiCare's grew by 24.9 percent. Aetna's profits also grew, at a rate of 49.3 percent, from $43.6 million in 2004 to $65.1 million in 2007; its membership dropped by 25.7 percent.

PER MEMBER PER MONTH PROFITS. Of all insurers examined in this report, none had higher PMPM profits than did PacifiCare of Texas in 2007. That year, it netted an average of $81.31 each month for each covered member. (Its PMPM profits grew by 461.1 percent between 2004 and 2007). In 2004 and 2005, however, the PMPM profit for HCSC exceeded that for PacifiCare: HCSC's $20.99 and $22.42, respectively, compared to PacifiCare's $14.49 and $10.87. In 2007, HCSC had its lowest monthly, per member profit – $15.58 – while Aetna had its highest, at $21.60. HCSC's PMPM profits dropped by 25.8 percent from 2004 to 2007, while Aetna's grew by 101 percent.

SURPLUS AND CAPITAL. Surplus for all three insurers increased steadily from 2004 to 2007, by 96.6 percent for HCSC, 137.8 percent for Aetna, and 154.4 percent for PacifiCare. At the end of 2007, the sum of their surplus was $6.4 billion.





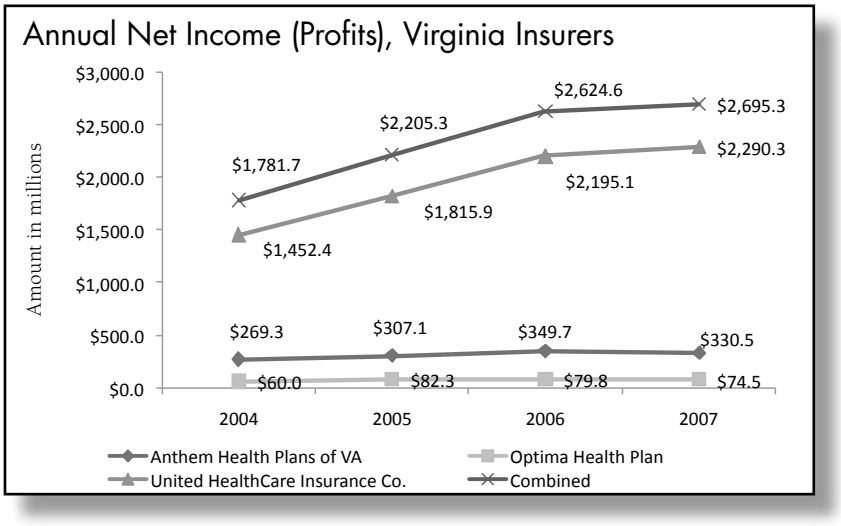


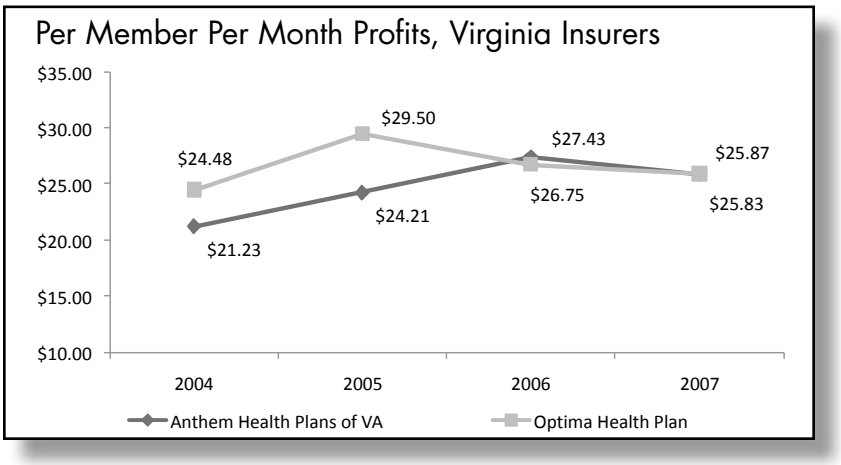
The insurers featured are SelectHealth, formerly known as IHC Health Plans and a subsidiary of Intermountain Healthcare, and Regence BlueCross BlueShield of Utah.

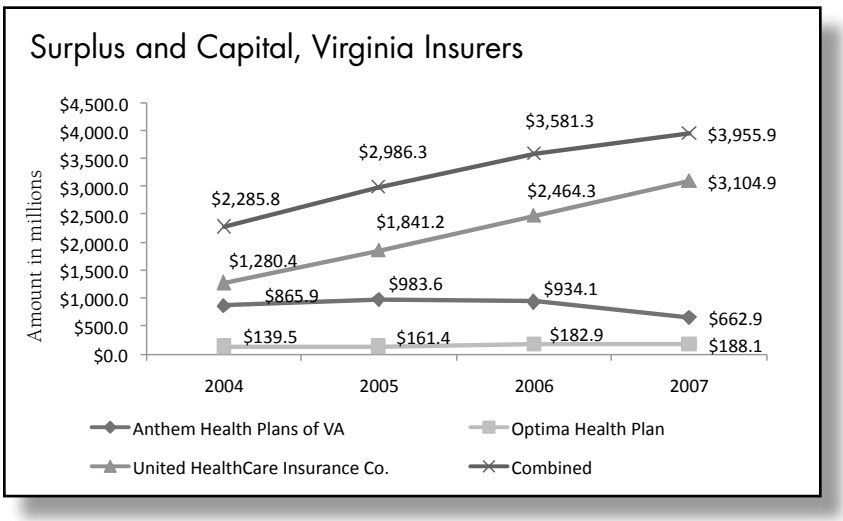
ANNUAL PROFITS. SelectHealth's profits increased steadily by 559.6 percent between 2004 and 2007, while its membership rose by 11.3 percent. Regence's profits, too, increased, but at a rate of 23.1 percent. (Its membership increased by 1.1 percent.) Moreover, Regence's most profitable year was not 2007, but 2006, when it netted $30.7 million.

PER MEMBER PER MONTH PROFITS. As with its annual profits, Regence experienced its most profitable year in 2006, when it netted $8.62 per member per month. That year, however, SelectHealth made a profit of $10.56 for each member month, followed by another increase to $11.61 PMPM in 2007. Its PMPM profits rose by 492.8 percent from 2004, while Regence's rose by 21.7 percent.

SURPLUS AND CAPITAL. Surplus rose steadily for both insurers from 2004 to 2007, without decreases in the intervening years. For SelectHealth, surplus grew by 140.8 percent, from $97.2 million to $234.1 million. Regence's surplus increased from $159.5 million to $237.7 million, rising by 49.1 percent.





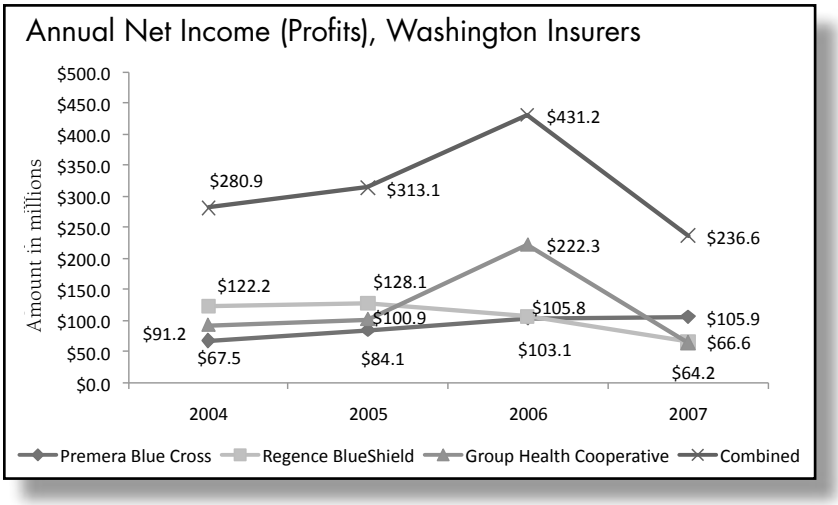


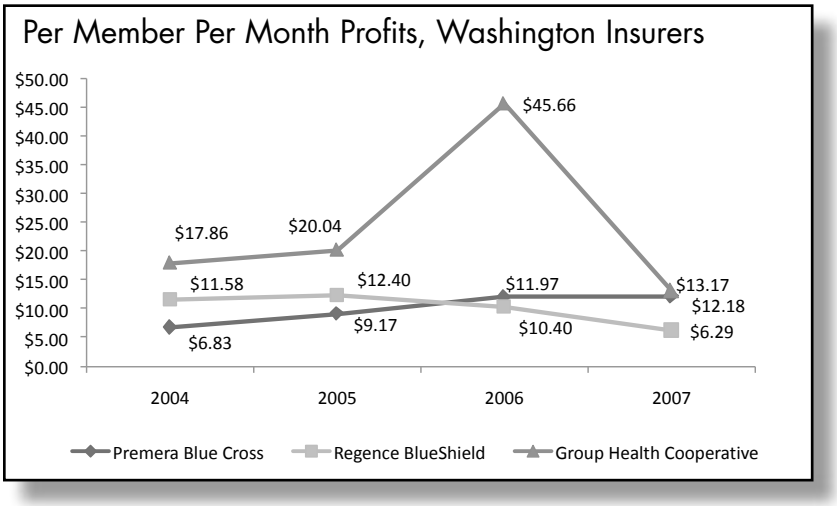
The selected insurers are: Anthem Health Plans of Virginia (a Blue Cross Blue Shield licensee and WellPoint subsidiary), Optima Health Plan (which belongs to Sentara Health Management Group), and United HealthCare Insurance Company (a subsidiary of UnitedHealth Group licensed across the country).[81]

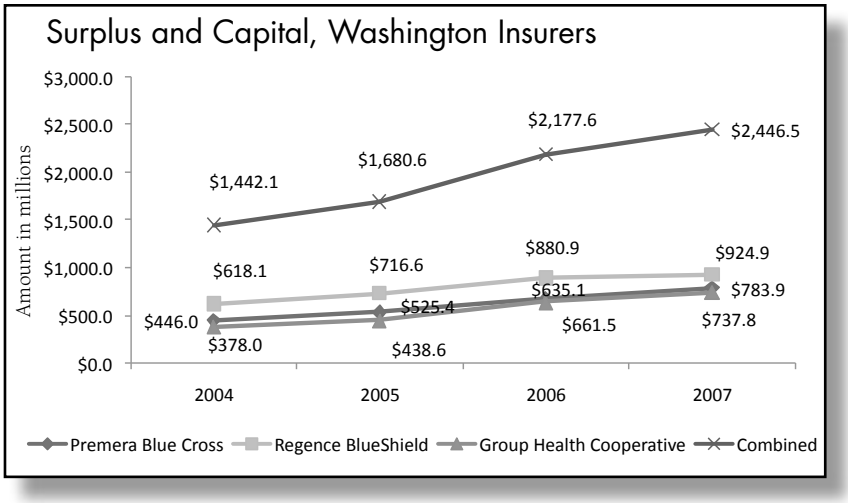
ANNUAL PROFITS. From 2004 to 2007, United saw its profits rise steadily by 57.7 percent, reaching $2.3 billion. (Membership information was not available for United, which files a life/accident/health statement.) Anthem's profits grew by 22.7 percent and hit $330.5 million, while its membership held at 0.9 percent growth. Optima's most profitable year was 2005 ($82.3 million), but its profits grew by 24.1 percent between 2004 and 2007, while its membership rose by 17.4 percent.

PER MEMBER PER MONTH PROFITS. Optima's PMPM profits remained steady over the four years, growing by 5.7 percent, with a high point of $29.50 PMPM profits in 2005. Anthem's PMPM profits grew by 21.7 percent, hitting $27.43 in 2006, followed by $25.83 in 2007. PMPM profits could not be calculated for United.

SURPLUS AND CAPITAL. Both Optima and United saw their surpluses rise steadily between 2004 and 2007, without dips in intervening years. Optima's grew by 34.9 percent, from $139.5 million to $188.1 million. United's rose by 142.5 percent, from $1.28 billion to $3.1 billion. Anthem, on the other hand, experienced a 23.4 percent decrease in its surplus. At the end of 2004, the insurer had $865.9 million in surplus, an amount that rose to $983.6 million in 2005, and then decreased to $934.1 million in 2006 and, ultimately, to $662.9 million in 2007.







The selected insurers include: Premera Blue Cross, Regence BlueShield, and Group Health Cooperative.

ANNUAL PROFITS. In 2007, the three insurers reported combined profits of $236.6 million. (Together, the insurers' most profitable year was 2006, when they brought in $431.2 million in profits.) In 2007, Premera posted the highest profits among the insurers, $105.9 million, although it did not cover the most members. Its profits rose by 56.9 percent from 2004 to 2007, while its membership dropped by 12 percent. Group Health, after seeing its profits more than double from 2004's $91.2 million to 2006's $222.3 million, netted $64.2 million in 2007. From 2004 to 2007, its profits fells by 29.6 percent, while its membership dropped by 4.5 percent. Regence had its most profitable year in 2005, when it had net income of $128.1 million. Between 2004 and 2007, it saw profits decline by 45.5 percent, while its membership stayed steady (at 0.3 percent growth).

PER MEMBER PER MONTH PROFITS. Premera, which saw an increase in its annual profits, experienced a 78.4 percent increase in its PMPM profits. As of 2007, it was netting $12.18 monthly for each covered member. During the four-year period, Group Health had the highest PMPM among the insurers – $45.66 in 2006 – and again closed 2007 with the highest PMPM profits for that year: $13.17. Regence's PMPM profits ranged from $6.29 (2007) to $11.58 (2004).

SURPLUS AND CAPITAL. The insurers' surpluses grew consistently from 2004 through 2007, without a decline in the intervening years. At the end of 2004, the sum of the three insurers' surplus was $1.44 billion. This surpassed the $2 billion mark in 2006, reaching $2.18 billion, and by the end of 2007 it had hit $2.45 billion. Regence claimed the greatest share of the 2007 surplus: $924.9 million, followed by Premera with $783.9 million and Group Health with $737.8 million.[82]

NOTES

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4 CBS News/New York Times, "U.S. Health Care Politics," March 1, 2007, viewed at: http://www.cbsnews.com/htdocs/CBSNews_polls/health_care.pdf.
5 Kaiser Family Foundation, "Health Insurance Premiums Rise 6.1 Percent in 2007, Less Rapidly than in Recent Years, But Still Faster than Wages and Inflation," News Release, September 11, 2007.
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15 Katherine Swartz, "Government As Reinsurer for Very-High-Cost Persons in Nongroup Health Insurance Markets," Health Affairs, Oct. 23, 2002 [hereinafter Swartz, "Government As Reinsurer"]; Mark A. Hall, "The Structure and Enforcement of Health Insurance Rating Reforms," prepublication copy, n.d.
16 Eggleston & Bir, "Measuring Selection Incentives in Managed Care," p. 2, citations omitted.
17 Ella Hushagen & Cheryl Fish-Parcham, "Failing Grades: State Consumer Protections in the Individual Health Insurance Market," Families USA, prepublication copy on file with the author, June 2008, p. 14 [hereinafter Hushagen & Fish-Parcham, "Failing Grades"].
18 Shen and Ellis write that:

> *insurers can gain significant profit as long as they are able to costlessly obtain additional information to identify and select individuals with non-negative expected profit. The potential profit that the insurer can gain is still considerable even if it enrolls individuals with small expected profits or losses.*

Shen & Ellis, "How Profitable Is Risk Selection?," p. 173.
19 Eggleston & Bir, "Measuring Selection Incentives in Managed Care"; Swartz, "Government As Reinsurer"; Elliot K. Wicks, "Coping with Risk Segmentation: Challenges and Policy Options," Economic and Social Research Institute, n. 2, February 2003 [hereinafter Wicks, "Coping with Risk Segmentation"].
20 Steffie Woolhandler, Terry Campbell, & David Himmelstein, "Costs of Health Care Administration in the United States and Canada," New England Journal of Medicine, August 21 2003, p. 768 [hereinafter Woolhandler, Campbell & Himmelstein].
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22 See, Sudha Xirasagar, et al., "A Comprehensive Snapshot of States' Small Group Market Reforms on Access and Enhancing Valued Insurer Features, 1999," Journal of Health & Social Policy, Vol. 19, n. 3. 2004.
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24 Ibid.
25 Hinda Ripps Chaikind, "ERISA Regulation of Health insurers: Fact Sheet," CRS Report for Congress, Updated March 6, 2003.

26 Adele M. Kirk & Deborah J. Chollet, "State Review of Major Medical Health Insurance Rates," Journal of Insurance Regulation, Summer 2002.
27 See, Nancy C. Turnbull & Nancy M. Kane, "Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Findings from a Study of Seven States," The Commonwealth Fund, February 2005 [hereinafter Turnbull & Kane, "Insuring the Healthy or Insuring the Sick?"]; Wicks, "Coping with Risk Segmentation."
28 Kaiser Family Foundation & Health Research and Educational Trust, "Employer Health Benefits: 2007 Summary of Findings," 2007. [Hereinafter KFF Employer Health Benefits.]
29 Ibid, p. 3.
30 U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," August 2007, p. 18.
31 Melinda Beeuwkes Buntin, et al, "Trends and Variability in Individual Insurance Products in California," Health Affairs, web exclusive, September 24, 2003.
32 Mark V. Pauly & Robert Lieberthal, "How Risky Is Individual Health Insurance?," Health Affairs, web exclusive, May 6, 2008.
33 Sara R. Collins et al., "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," Commonwealth Fund, September 2006, p. viii.
34 "Are You Really Covered?: Why 4 in 10 Americans Can't Depend on Their Health Coverage," Consumerreports.org
35 KFF Employer Health Benefits, p. 5.
36 Pollitz, et al., Falling through the Cracks, pp. x & 10.
37 Families USA, "Too Great a Burden: America's Families at Risk," December 2007.
38 Ibid, p. 6.
39 For California, we identified the top three carrier groups and selected subsidiaries/affiliates filing annual statements with the Department of Managed Health Care.
40 Market share figures are from the NAIC Market Share Report (which uses 2006 figures). Figures are included for the insurer as a whole, and not only the portion of its business in a particular state.
41 See Maine Bureau of Insurance website at: http://maine.gov/pfr/insurance/.
42 Net income is reported as net income or net earnings.
43 Figures are rounded unless otherwise indicated. For definitions of the items included in health insurer annual statements, see Oregon Department of Consumer and Business Services, Insurance Division, "Appendix A: Guide to Insurance Company Financial Information," viewed May 1, 2008 at: http://www.cbs.state.or.us/external/ins/health_report/appendix_a.pdf.
44 Per member per month profit figures represent the insurer's net income for the year divided by the number of member months reported in its annual statement.
45 See, for example, Tim Barclay, Milliman Consultants and Actuaries, "Information Gathering Hearing Related to Insurer Surplus, Office of the Insurance Commissioner," December 8, 2005.
46 Figures are rounded.
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48 WellPoint was formed by a merger of Anthem and WellPoint Health Network in 2004. All net income and membership figures are taken from WellPoint's 2007 10-K filing.
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57 Freed, "Membership, Lower Investment Income."
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59 Krauskopf, "WellPoint Profits Slump."
60 Ibid.
61 Carl Gutierrez, "Humana Drops Another Shoe," Forbes.com, March 12, 2008.

62 Five insurers had negative net income in either 2004 or 2007: Health Net of Connecticut, Humana Health Plan (Illinois), Hawaii Medical Service Association, CareFirst, and Regence BlueShield of Idaho. Percent changes could not be calculated for them.
63 Membership figures were not available for two insurers filing life/accident/health statements.
64 California HMOs not included.
65 Cathy Shoen, Karen Davis, & Sara R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Insurance," Health Affairs, May/June 2008, p. 646.
66 Ibid, p. 647.
67 See, e.g., John Sheils & Randall Haught, "Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage," Robert Wood Johnson Foundation/Economic and Social Research, October 2003; Ezekiel J. Emanuel & Victor R. Fuchs, "Health Care Vouchers – A Proposal for Universal Coverage," New England Journal of Medicine, March 24, 2005.
68 See, Cristina Boccutti & Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," Health Affairs, March/April 2003; Woolhandler, Campbell & Himmelstein; "Ask the Experts: A Public Plan Option under Health Reform," Transcript, Kaiser Family Foundation, May 1, 2008.
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70 Turnbull & Kane, "Insuring the Healthy or Insuring the Sick?"
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74 See www.anthem.com/ca/welcome/home.html, viewed June 3, 2008.
75 See, Debra L. Roth & Deborah Reidy Kelch, "Making Sense of Managed Care Regulation in California," California HealthCare Foundation, November 2001.
76 See www.anthem.com.
77 BCBS of Florida's 2004 new income appears as $217,897,219 in its 2004 and 2005 annual statements and as $217,987,219 in the five-year historical data in its 2006 and 2007 statements. Because this appears to be a transposing error, in consultation with the Florida Department, we chose to use the former figure.
78 Regence BlueShield's 2005 net income figure is taken from the 2006 amended annual statement. (It appears as $31.9 million in its 2005 annual statement.) The year 2005 is not included in Regence BlueShield's 2007 five-year historical data, therefore the figure could not be checked against this sheet. However, the $31.4 million figure appears again in notes to the 2006 annual statement.
79 Based on change in member months.
80 Eric Bunty, CPA, Pennsylvania Insurance Department, conversation with author, June 2, 2008.
81 United HealthCare Insurance Co. has subsidiaries that file their own annual statements; none of these subsidiaries are included in this report.
82 Figures are rounded.

The Northwest Federation of Community Organizations (NWFCO) convenes community groups nationwide on critical public policy issues. To foster public conversation of these issues, NWFCO provides research and policy analysis. Recent reports include:

- The Race for Wages: Living Wage Jobs in the Current Economy (Northwest Job Gap Study)
- The Small Business Health Care Crisis in Washington: A Survey of Pike Place Market Businesses
- Bar to a Healthy Future: Stories of the Immigrant Children Left Behind

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