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Opportunities and Capacity for Community Benefit: GHMSI's Potential Role in the National Capital Area

Final Report

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EXECUTIVE SUMMARY

This study was developed in the wake of an attempt by CareFirst, Inc. to be sold to a for-profit health plan, WellPoint, in 2001. The sale did not occur, but discussion continues about the appropriate role of CareFirst's nonprofit affiliates in providing community benefit consistent with their status in the community and respective charters. This study focuses on just one of CareFirst's nonprofit member companies—General Health and Medical Services, Inc. (GHMSI). GHMSI is the largest insurer in the District of Columbia, and a major insurer in suburban Maryland and Northern Virginia as well. It is also the largest of the CareFirst affiliated companies.

This study approaches the question of GHMSI's potential role in providing community benefit from three perspectives. We first consider the viewpoints of community health leaders who responded in writing and in interviews to questioning about how a large health insurer might contribute to improving community health and health care in the national capital area.

We then consider the roles of four nonprofit health plans located in various areas of the country (including one in the national capital area). Each of these plans holds roughly the same share of the market, or less, than GHMSI holds in the District of Columbia, and each generally is viewed as providing significant benefit to their community. We conducted document review and a series of interviews with the senior officials in each plan responsible for planning and implementing community benefits activities to learn how they identified and prioritized community needs, set and met community benefit funding goals, and viewed the effect of competition on their community benefit mission.

Finally, we present an economic and financial analysis of GHMSI's capacity to provide community benefit beyond its current efforts. We consider GHMISI's relative market position, measure its use of market power in setting economic prices (that is, premiums net of medical benefits paid), and market power in the national capital area, and confirm the practice of shadow pricing by the smallest insurers in the market. Based on this evidence, we consider GHMSI's level and accumulation of surplus (premiums net of both medical benefits and administrative cost) since 1998 and develop a simple simulation model to project GHMSI's premiums and surplus to 2008, assuming the same relative level of administrative costs and a downward underwriting cycle of the same magnitude as the upward cycle since 1998. We find that GHMSI's surplus levels are approximately twice those of significant competitors, higher than other CareFirst companies that write business in the national capital area, and two to four times as high, respectively, as the BCBS and NAIC standards that would trigger possible concern about the company's financial strength.

We conclude that GHMSI is indeed capable of significantly greater community benefit than it now provides. At least through 2008, a community benefit goal of 2 to 3 percent of direct premiums appears to be a feasible goal for GHMSI, consistent with both its market power and extraordinary accumulated surplus. This level of commitment annually would provide an estimated $41 to $61 million for community benefit in 2004, and potentially $67 to $100 million by 2008.

Addressing Community Need

The prevalent concerns of community health leaders in the national capital area mirror those of health leaders across the country. Population health status and behaviors related to obesity, mental health, substance abuse, teenage pregnancy, and HIV/AIDS are of great concern. Targeted health

education, action to stem the erosion of private health insurance, and greater access to culturally competent providers and services could address many of the most debilitating and costly health problems that affect area residents.

Local health leaders believe that the area's health insurers could be key players in several roles that few have developed broadly or at all. Insurers can engage residents in healthier lifestyles and facilitate greater access to health care services by supporting public clinics and subsidizing enrollment in own plans. They can develop and disseminate best practices for ongoing quality improvement, and diagnostic and care protocols for management of public health emergencies. The area's largest insurers have developed educational materials for their members that would be equally valuable to the broader community if distributed through the area's safety net clinics or in the "community wellness centers" that some local health leaders envision.

The need for greater capacity to deliver care to uninsured and underserved populations throughout the region is apparent. Local health leaders cite the need for more clinics, greater incentives for providers to serve low-income and uninsured adults and children, more language interpreters, and more training in cultural competency. The inability of patients—insured or uninsured—to "use the system" effectively (sometimes due to the plans' own administrative practices) diminishes health outcomes and adds to cost in the region. Failure to coordinate primary care and failures of access to prescription drugs are obvious sources of low-quality care and unnecessary cost. Some health leaders suggest that insurers are uniquely positioned to improve the efficiency and quality of care and therefore reduce cost, but few have made a real effort to do so.

Affordable health insurance is a critical issue, especially in the area's suburbs where general affluence masks a significant and apparently rising number of uninsured residents. The low-cost private insurance programs that one nonprofit insurer offers in the national capital region and in other communities are limited and have not developed widely. However, a substantial and growing need for "dues subsidy" programs that adjust health insurance premiums to family income is apparent.

Local health leaders view the area's prominent health insurers as potential partners and leaders in other areas, as well. For example, insurers could take a lead role in educating their members, health care providers, and the general public in how to respond to public health emergencies. Providers might be instructed how to coordinate with public health departments in such an emergency. Financial incentives to adhere to clinical guidelines for testing and treatment could reduce health care costs in general and help to avoid system "overload" during a public health emergency.

Examples of Community Benefit

Some nonprofit health plans have extensive histories of community benefit. These plans offer a window on how GHMSI might proceed to develop and implement its community benefit mission. We investigated four such plans. Each defines its community benefit role in consultation with the community in some way—although the processes typically are informal. Coincidentally, all but one originated as a clinic- or hospital-based integrated health care plan. These plans continue to rely on their provider networks to implement some part of their community benefit mission, but all pursue significant community benefit activities in addition to those that they undertake to meet their nonprofit hospital community benefit obligations. All four plans see access to care as an essential part of their community benefit mission, and all attempt to improve access in important ways—by

serving public programs, funding and supporting health clinics, and/or substantially subsidizing plan enrollment for low-income children and adults.

Resources and Competition

The annual level of resources these plans devote to community benefit typically ranges from 1 to 2 percent of earned premium. Each balances the priorities of managing a sound financial operation and pursuing its community benefit mission somewhat differently, but all have a commitment to protecting and developing funding for community benefit. None regard competition as a compelling constraint on community benefit, although of course all recognize the fundamental importance of maintaining the health plan's financial integrity. In general, each regards competition as "baked into the business" and community benefit as an essential part of the health plan's mission.

GHMSI's Market Position

GHMSI is the largest insurer in the national capital area. It held an estimated 29 percent of the risk market in 2003, including its FEHBP business, other group coverage, and individual coverage (but excluding its business as an administrator for self-insured employer plans). Kaiser is GHMSI's nearest competitor, although it is about half GHMSI's size.

Over the last five years, GHMSI's total premium revenue has grown at an average rate of 15 percent per year, and much faster in suburban Maryland and Northern Virginia— respectively averaging 40 percent and 21 percent per year. For non-FEHBP coverage especially, average premiums have grown very fast: from 2002 to 2003, average (per enrollee) premiums increased more than 25 percent. At the same time, enrollment dropped 3 percent in the District, 6 percent in suburban Maryland, and nearly 14 percent in Northern Virginia. It is likely that at least some of those leaving GHMSI enrollment in response to steep premium increases became uninsured.

Market Power

GHMSI's very large market share offers simple evidence of a noncompetitive health insurance market. In recent years GHMSI has accumulated surplus (net of medical and administrative costs) at an average rate of 27 percent per year. GHMSI's accumulated surplus equaled 21 percent of premiums in 2003, nearly four times Kaiser's level of surplus relative to premiums. In 2003, GHMSI's surplus build-up accounted for about 6 percent of premiums, while Kaiser "gave back" to enrollees about 1 percent of premiums in the form of surplus reduction.

Much of GHMSI's surplus and surplus build-up may relate to BCBS plans' general practice of holding very high surplus relative to risk-based capital (a measure of an insurer's financial condition). However, between 1998 and 2003, GHMSI's average surplus relative to risk-based capital was more than four times the level that would trigger regulatory concern, and more than twice that of either its largest competitors or BCBS minimum standards. In general, this means that GHMSI's competitors were able to offer lower consumer prices for coverage, provide more health care per premium dollar, or both. However, it means also that GHMSI's pricing has sheltered smaller competitors that shadow-price GHMSI's products, and probably has raised area prices for health insurance overall.

Statistical analysis of insurer behavior in the District, Maryland, and Virginia, offers strong evidence that GHMSI exercises significant market power in the national capital area. Specifically, we

estimate that GHMSI built nearly $14 billion into its economic prices between 1998 and 2003 related to its market power, averaging 2.1 percent of earned premium.

Financial Capacity for Greater Community Benefit

A simulation of the impact of greater expenditure for community benefit on GHMSI's financial position indicates that it is financially capable of providing substantial community benefit. At the likely low point of the underwriting cycle (in 2008), we estimate that GHMSI could allocate annually an additional 2 to 3 percent of premium to community benefit while maintaining its current level of surplus relative to premium (and therefore not raising the observed price (that consumers pay for coverage) net of increases in medical benefits paid). At that level of expenditure for community benefit, GHSMI's projected surplus also seems likely to remain at approximately twice the NAIC standard and also greater than the BCBS standard for minimum risk-based capital.

A commitment of 2 to 3 percent of GHMSI's direct premiums would equate to community benefit of $41 to $56 million in 2004, and as much as $100 million in 2008. However, if total premiums were to rise very fast—by 15 percent per year through 2008—it might put upward pressure on observed prices, as GHMSI may attempt to spread accumulated surplus over its fast-rising premium base. Thus, our simulations lend support to a more obvious point: any rule for allocating a percentage of premiums must be managed with flexibility. Nevertheless, it seems clear that GHMSI could allocate substantially more than it does now to community benefit, and a range of 2 to 3 percent of direct premiums appears to be a feasible goal for this expenditure.

I. COMMUNITY HEALTH NEEDS

The problems of health status and health care in the Washington, DC metropolitan area are significant and complex. As in other metropolitan areas of the United States, the socioeconomic and ethnic diversity of the national capital area's population complicates the challenge of addressing problems of health care access and quality that all parts of the region have in common. But the Washington, DC area also faces unique challenges, including the relatively high likelihood of a region-wide public health emergency and the need to coordinate responses across multiple city, county, and state jurisdictions.

This report describes the major problems of health status among area residents and then reviews a series of issues that were raised by area health leaders as priorities for concern and targets of current local, often isolated, initiatives. These include the development of healthy behaviors to prevent illness, mental and behavioral health problems, children's access to care, more general access to care, language and cultural competency, health care quality, and emergency preparedness. The purpose of our investigation of local health problems and initiatives was to identify and understand in some detail the initiatives that area insurers—and GHMSI in particular—might pursue in the context of a focused community health program.

The information in this report comes from several published sources as well as an extensive process of obtaining commentary from local area health leaders—including health agency directors, leaders of community service organizations, and others engaged in advocating for improved health access and services in the national capital region. Their commentary was provided in response to an e-mail survey, semi-structured interviews conducted by telephone and in person, and a group discussion. The data collection process is described in Appendix A.

A. HEALTH CONDITIONS AND BEHAVIORS

1. Clinical Indicators of Health Status

On many measures of health status, residents of the Washington, DC metropolitan area rank at or above the national average. One recent report prepared by the Metropolitan Washington Public Health Assessment Center concluded that the region scored better than the national average for 19 of 27 health indicators.[1] Improvements in some indicators of health status—death from coronary heart disease and screening for breast cancer—have surpassed 2010 national targets, and the change in adult obesity is approaching the 2010 target (Metropolitan Washington Public Health Assessment Center 2001). Nevertheless, all three—coronary heart disease, breast cancer, and obesity—continue to be important health problems in the national capital area, as they are nationally, as well as major

[1] A recent study conducted by the Metropolitan Washington Public Health Assessment Center provides information on health conditions for people living in the larger metropolitan area, including the District of Columbia, northern Virginia, and suburban Maryland. Data for the study were obtained from the Centers for Disease Control and Prevention (CDC)—including the National Center for Health Statistics (NCHS), the Behavioral Risk Factor Surveillance System (BRFSS), and CDC's disease surveillance systems—as well as from the health departments of the District of Columbia, Maryland, and Virginia and from the Metropolitan Washington Council of Governments.

sources of health care costs. In the District of Columbia, the rate of death due to heart disease (296 per 100,000 population in 1999) is higher than deaths due to any other cause and exceeds the national average (270 per 100,000 population) (CDC 1999).

Rates of HIV/AIDS and other sexually transmitted diseases (STDs), binge drinking, and firearm-related deaths also are relatively high among residents of the Washington, DC metropolitan area. And the area-wide rates of infant mortality and low birth weight exceed the national average. These problems largely reflect health conditions in the District of Columbia. In 2001, the District reported 152.1 AIDS cases per 100,000 population—10 times the national average (14.9 per 100,000 population) (CDC 2001). The rate of infant deaths in the District was nearly twice the national average—12.0 per 1,000 live births compared with 6.9 nationally (CDC 2002).

The prevalence of specific health conditions varies among the jurisdictions that comprise the Washington, DC metropolitan area. Residents of higher-income jurisdictions generally have better average health status. Consistent with this pattern, residents of the District of Columbia on average have much worse health status than residents of suburban Maryland and Virginia.

However, there are some notable exceptions to this. For example: Prince George's County residents have higher rates of coronary heart disease, obesity, diabetes, and motor vehicle crashes than residents of the District. In Alexandria, the number of people reporting poor mental health on 8 or more days of the past 30 days is higher than in either the District or the region as a whole. In Arlington County, the suicide rate is higher than in the District, the region, or the nation as a whole (Metropolitan Washington Public Health Assessment Center 2001).

2. Prioritizing Health Conditions

While various indicators of area residents' health status suggest cause for concern, we attempted to identify which may be of greatest concern in terms of the social cost or burden of illness. A disability-adjusted life-year, or DALY, is one measure developed for this purpose. Computed as the sum of (1) years of life lost due to premature mortality in the population and (2) years of disability, DALYs measure fatal and nonfatal health outcomes for diseases, injuries, and risk factors in terms of lost productive years of life. International studies of public health needs often use DALYs to help target research and interventions on areas of improvement likely to have the greatest benefit for the community (Michaud 2001).

Table 1

Estimated Disability-Adjusted Life Years (DALYs) for Major Conditions - Washington, DC Metropolitan Area

MEN					WOMEN				
Rank	**Condition**	**Total DALYs[a] (in thousands)**	**DALYs per 100,000 population**	**% of Total DALYs**	**Rank**	**Condition**	**Total DALYs[a] (in thousands)**	**DALYs per 100,000 population**	**% of Total DALYs**
	All conditions	318.7	63.4	100%		All conditions	276.4	55.0	100%
1	HIV/AIDS	104.7	20.8	33-46%	1	Ischemic heart disease	18.4-19.0	3.7-3.8	7%
2	Homicide/violence	47.7	9.5	15%	2	Unipolar major depression	18.4	3.7	7%
3	Ischemic heart disease	29.6-30.5	5.9-6.1	9-10%	3	Cerebrovascular disease	12.2	2.4	4%
4	Alcohol abuse/dependence	14.9	3.0	5%	4	Lung, trachea, and bronchus cancers	10.5-12.4	2.1-2.5	4%
5	Lung, trachea, and bronchus cancers	11.4-12.2	2.3-2.4	4%	5	Breast cancer	8.8	1.8	3%
6	Road traffic conditions	11.1	2.2	3%	6	Alcohol abuse/dependence	8.4	1.7	3%
7	Cerebrovascular disease	10.9	2.2	3%	7	Osteoarthritis	8.3	1.7	3%
8	Drug use	9.9	2.0	3%	8	Dementia	8.1	1.6	3%
9	Unipolar major depression	7.8	1.6	2%	9	Diabetes Mellitus	8.0	1.6	3%
10	Congenital abnormalities	7.6	1.5	2%	10	Congenital Abnormalities	7.1	1.4	3%
11	Diabetes mellitus	7.0	1.4	2%	11	Road traffic conditions	5.5	1.1	2%
12	Osteoarthritis	6.3	1.3	2%	12	Chronic obstructive pulmonary disease	5.3	1.1	2%
13	Dementia	6.1	1.2	2%	13	Asthma	4.7	0.9	2%
14	Chronic obstructive pulmonary disease	5.8	1.1	2%	14	Colon or rectum cancer	3.6	0.7	1%

Source: Mathematica Policy Research, Inc. Washington, DC.

[a]Calculated from the U.S. figures (Michaud, CM, CJL Murray and BR Bloom, "Burden of Disease: Implications for Future Research," JAMA (285:5), February 7, 2001), adapted to the Washington DC MSA based on information reported for Washington, DC (Behavioral Risk Factor Surveillance System, National Vital Statistics System, CDC HIV/AIDS Surveillance Report, SAMHSA National Household Survey on Drug Abuse) or all MSAs (National Health Interview Survey).

We calculated DALYs separately for men and women for 14 health conditions that rank as major sources of lost disability-adjusted life-years.[2] Notably, the ranking of health problems in the Washington, DC metropolitan area differs for men and women, potentially contributing to a diversity of perspectives about priority health needs in the metropolitan area (Table 1).[3]

Among men in the national capital area, HIV/AIDS and homicide/violence are the greatest sources of disability-adjusted life-years lost (whereas they rank fourth and seventh, respectively, in the United States as a whole). Drug use and congenital abnormalities also are greater sources of disability and lost life-years among men in the national capital area than nationally.[4]

Among women, the conditions that contribute most to disability or lost life-years are much different than for men. Heart disease, depression, cerebrovascular disease (stroke), and lung and related cancers are leading sources of disability-adjusted lost life-years among women in the region. However, like men, women in the national capital area suffer more often from the burden of alcohol dependence and congenital abnormalities than the average nationwide.[5]

As a guide for health policy in the Washington, DC metropolitan area, these estimates warrant at least two important caveats. First, the incidence and burden of children's illnesses in the region may be underrepresented. Because DALY calculations discount future years of productivity relative to current productivity, they systematically give less weight to disease burden among children.[6]

Second, while obesity is a major public health concern in the United States, published DALY calculations (from 1996) omit obesity as leading source of lost disability-adjusted life-years. This omission may reflect how obesity was measured and classified—as one of a number of risk factors that contribute to health problems, but not itself a principal diagnosis. Nevertheless it is likely that

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2 Data sources are described in Appendix B. Using published sources, we considered only health conditions that correspond to high DALY estimates nationally. However, we were unable to identify any conditions that were significantly more prevalent in the District of Columbia (or in Metropolitan Statistical Areas generally) than in the United States as a whole.

3 Comparing various health status indicators for the District, Delaware, Maryland, and Northern Virginia, Lewin (2004) identified a similar (though less detailed) list of conditions. Their report identified (1) reducing chronic disease through improved health behaviors; (2) improving access to primary and preventive services, (4) improving the quality of services related to chronic disease/prevention, and (4) eliminating racial disparities as themes for potential action to improve health status and health systems.

4 In contrast, other risk factors such as road traffic incidents and chronic obstructive pulmonary disease are more prominent as national issues. Some potentially important sources of disability and lost life-s, such as self-inflicted injuries (which ranked n for men in the United States) are omitted from this list, as we had no data for the District of Columbia or metropolitan areas separate from other geographic areas for calculating a local ranking.

5 In contrast, osteoarthritis and chronic obstructive pulmonary disease are more prominent sources of disability-adjusted lost life-years among women nationally.

6 Even so, in 1999, 5 of the top 10 causes of disease burden worldwide primarily affected children. These included lower respiratory tract infections, diarrheal diseases and nutritional deficiencies (Michaud 2001).

many risk factors—physical activity, diet, and cholesterol and blood pressure levels, as well as obesity—contribute to the burden of disease and should be considered (Michaud 2001).

When asked about their perceptions of significant health problems in the region, local residents and stakeholders identified priorities that vary according to the part of the region and type of organization they represent. For example, in a recent survey conducted by the Kaiser Family Foundation, a sample of adults in the District identified HIV/AIDS and other STDs as the most pressing health issue.[7] Our questioning of local health leaders also identified HIV/AIDS as a major problem, but they also identified mental health and substance abuse, chronic disease (including asthma, diabetes, cardiovascular disease), and lifestyle/obesity as important health problems.

Health leaders in the Maryland and Virginia suburbs identified a different range of issues. In Maryland, health leaders pointed to infant mortality and rising rates of HIV infection—specifically among women in Prince George's County—as important problems. Other health leaders identified cancer, violence and abuse, trauma and related disorders, problems that the growing population of elderly face, and unintended pregnancies and poor birth outcomes as critical health issues regionally. In Alexandria, early findings from an area health assessment suggest that priorities for that community are obesity, tobacco use, and mental health/substance abuse; HIV/AIDS is of less concern.

B. COMMUNITY ISSUES AND INITIATIVES

Personal health and health behaviors, improvements in access to care, cultural competence, and quality improvement are problems in the Washington, DC metropolitan area, as they are nationally. Local health leaders identified several problems where greater attention and resources would make important differences—including effective education to promote healthy behaviors; greater access to mental health, adult and child health services; language and cultural competency; quality of care; and emergency preparedness. While funding is available for a number of local activities that have made progress in addressing these problems, most initiatives have operated on a scale that is too small to achieve significant impacts. When asked what needs to be done to make important improvements with respect to any of the problems that local health leaders identified as priorities, respondents listed ideas that ranged from building on current programs to "thinking big" and creating systemic change.

The following sections summarize responses to a formal survey of health leaders in the Washington, DC Metropolitan area as well as discussions that occurred in a series of in-person and telephone interviews. Specifically, we asked what might be done to address the major concerns that area health leaders identified and, in particular, what health insurers in the region might do.

1. Healthy Behavior

Local health leaders contend that many of the region's most debilitating and costly health conditions—HIV/AIDS, substance abuse, chronic diseases, and obesity—could be addressed by

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[7] Responding to an open-ended question about serious health concerns in the District of Columbia, 24 percent identified HIV/AIDS as a major concern (Lillie-Blanton 2003).

improving nutrition, encouraging exercise, and reducing unsafe sex, use of illegal drugs, and smoking. Area residents appear to be receptive to such activities. Responding to a survey conducted by the DC Primary Care Association (DCPCA), residents' most frequent request was for more fitness and wellness programs (DCPCA 2003).

Local health leaders suggested various interventions as likely to be helpful in improving healthy behaviors, including the following examples:

- A regional campaign of preventive efforts focused on diet, exercise, and smoking might be mounted. Washington, DC's current campaign urging residents to "Eat Smart, Move More" was offered as one model.[8] Health leaders also pointed to Philadelphia's seemingly effective campaign to control obesity as a possible model for expanding efforts to promote healthy behavior.

- Health education programs for children and adults might be developed regionally. Local health leaders generally agreed that current health education strategies are inadequate and often ineffective. Because many children adopt behaviors from their peers, formal peer education programs might reach children more successfully than instruction by adults, along with better enforcement of health education requirements and activities in schools.[9] Montgomery County is exploring such school-based strategies to address childhood obesity.

- "Lifestyle change centers" for adults could provide access to dieticians, counselors, nurses, and other health professionals via existing community organizations. In addition, programs such as the area food bank's Super Pantry Program might be expanded to increase the number of practical classes that teach parents how to prepare nutritious meals. Medicaid and other insurers do not routinely cover such nutritional classes or obesity interventions. Private insurers might also share more broadly with the community the materials they develop to educate their own members on management of specific conditions (such as hypertension).

- Financial incentives might encourage health providers to engage in health promotion activities and for plan members to participate in such activities. For example, providers might be reimbursed for health education and promotion activities and insured employees

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[8] The Washington, DC *Eat Smart/Move More* Food Stamp Nutrition Education Program (FSNEP) offers community-based nutrition education programs for families with young children, youth, the elderly, and individuals with special needs who receive or are eligible to receive Food Stamps. *Eat Smart/Move More* is funded by the U.S. Department of Agriculture's Food and Nutrition Service (FNS), with matching state and local support from the District of Columbia Department of Health, Nutrition Programs Administration and the Department of Human Services, Income Maintenance Administration [http://dchealth.dc.gov/services/wic/index_fsnep.shtm] accessed August 26, 2004.

[9] One respondent suggested the National Commission for Health Education Credentialing, which certifies health educators, as a potential partner in the enforcement of schools' health education and activities requirements.

and public program beneficiaries rewarded for obtaining regular preventive screenings and improving their health status.

- Public policy changes could create effective incentives to improve health. For example, measures to prevent or address childhood obesity could be adopted and coordinated throughout area schools, tobacco taxes might be increased, and region-wide policies to discourage smoking might be developed.

2. Mental and Behavioral Health

Mental health problems are reported to be a leading diagnosis in hospital admissions in the District of Columbia and a crucial issue throughout the region. In the suburban counties mental health issues are even more prevalent than in the District of Columbia.

Local health leaders identified several factors that contribute to the problem:

- The number of behavioral health practitioners willing to treat low-income patients for mental health and substance abuse problems is inadequate. The U.S. Health Resources and Services Administration (HRSA) has classified the Anacostia area of the District of Columbia as well as several safety net providers as having shortages of mental health professionals (HRSA 2004).

- The reduced supply of public hospital beds in the District of Columbia has prevented some residents from obtaining proper care for mental illness and co-occurring disorders.

- The District of Columbia's adoption of the Medicaid Rehabilitation Option reportedly has ended reimbursement for preventive services and limited the roles of some mental health professionals.

- Issues with Medicaid recertification sometimes interfere with the continuity of patients' compliance with drug regimens for behavioral health problems. Concern is growing as the number of mental health providers who prescribe such medications continues to increase.

Health leaders were unable to point to any current, comprehensive effort to address the region's mental health needs.

3. Children's Health

Despite significant activity to improve children's health in the national capital area, local health leaders cited the need to expand current programs and services. Implementation of the State Children's Health Insurance Program (SCHIP) in 1998 has produced no significant improvement in District children's health indicators or outcomes. However, local health leaders identified several initiatives that might achieve such improvements:

- In the District of Columbia, the primary care clinics operated by Children's National Medical Center are overloaded. Demand for the District's medical van program (which provides dental and preventive services for children) is estimated to be approximately twice the

program's current capacity. Additional resources for these and similar programs would be of value.

- Parental awareness and access to pediatric vaccinations could be greatly improved—with efforts made to provide vaccinations free of charge to parents well before the beginning of the school year.

- New programs for obesity intervention at an early age might be valuable, as would an expansion of school-based mental health programs that apparently are effective. Programs to promote healthy behavior among pregnant women and mothers also could be of value in improving children's health.

- The school nurse program administered by Children's National Medical Center for the District of Columbia Health Department is straining to accommodate the rising number of medically fragile children (e.g., those with tracheotomy tubes or on oxygen) who are mainstreamed into the public schools.

- A program that provides home visits for prenatal care and infant and preschool immunizations to at-risk children, the Freddie Mac Foundation's Healthy Families DC, might be expanded. Area health leaders view the program as effective in reducing infant mortality.

Low-income children in suburban areas also face important gaps in access to care. In Arlington County, a shortage of pediatricians for all children severely limits access to care for children in low-income families. Unmet demand for pediatric care is estimated at about twice the county's current capacity.[10] Children's access to dental care is a problem throughout the region.

Specific efforts identified as effective potential targets for greater resources or replication included the following examples:

- For a number of years, Arlington County staffed the Women, Infants and Children (WIC) program office with a nurse practitioner who provided standard vaccinations to children when their mothers applied to WIC for food and baby formula. County budget cuts forced an end to this practice.

- Acting on the findings of the county's Fetal Infant Mortality Review Commission, Prince George's County created a women's wellness center, developed outreach activities, and established a toll-free health line. Such an effort might be expanded and replicated across the region.

- With help from Catholic Charities and Kaiser Permanente, Prince George's County created the Medical Care for Children Program to provide free health insurance for 700 low-income

[10] The State Health Access Data Assistance Center (SHADAC) reports that the number of physicians per 100,000 population in Virginia is below the state average nationwide (SHADAC 2003).

children. With the elimination of county funds the program started charging a premium of $60 per child, resulting in a significant drop in participation. Kaiser Permanente also partners with other jurisdictions in the area to provide reduced-premium insurance coverage.

- Montgomery County operates several small dental clinics that serve children (as well as pregnant woman and seniors) who are uninsured and ineligible for Medicaid. Nevertheless, the county estimates the unfunded need for dental care at $16 million per year. That amount would support a higher level of Medicaid reimbursement among dentists and implementation of a strategic plan to target second graders for oral health screening and preventive dental care.

- Lead poisoning among children is a concern in suburban areas as homeowners renovate old housing. Screening of two-year-olds for blood lead levels is critical, but insurers have been reluctant to make lead screening a member or community priority.

4. General Access Issues

Although the national capital area's rate of insurance coverage exceeds the national average, gaps in access to primary care, specialty services, dental care, and prescription drugs are still major problems (SHADAC 2004). Including participation in the DC Healthcare Alliance, an estimated 9 percent of District adults were uninsured in 2003. Alexandria's rate of uninsured is informally estimated at about 11 percent.

The DC Healthcare Alliance has made progress in providing services to the uninsured, but the Kaiser Family Foundation survey of adults in the District of Columbia found that only 23 percent of residents familiar with the alliance thought that the organization had improved residents' access to care (Lillie-Blanton 2003). Residents face difficulty in finding affordable individual or small group insurance coverage, particularly if they have prior or ongoing health problems.

Among residents of the Washington, DC metropolitan area, 19.1 percent have no usual source of care (AHRQ 2004). Such gaps may cause residents to delay necessary care and turn to hospital emergency rooms for problems that might have been prevented and care that might be provided in a less costly setting.

In the District of Columbia, more than half of the population (approximately 300,000 residents) live in official primary-care shortage areas (HRSA 2004). Although the District has many more federally sponsored safety net clinics for its population size than the national average (SHADAC 2004), the demand for safety net care exceeds the capacity of the existing clinics, even when supplemented by additional free clinics and mobile health care vans. In 2003, 45 percent of uninsured District adults responding to the Kaiser Family Foundation survey had not made a medical visit in the past 12 months, compared with 11 percent of those with private coverage (Lillie-Blanton 2003).

In the national capital area's suburbs, there is a serious shortage of federally qualified health centers (FQHCs) to serve low-income residents. The deficiency is attributed not to low need but rather to the proximity of low-income neighborhoods to middle- and high-income areas, making it difficult for suburban counties to qualify as medically underserved areas. Suburban Virginia has just one FQHC, which is located in Alexandria; it opened in 2004 after Alexandria received special

designation as a medically underserved area. Likewise, Prince George's County has just one FQHC, and Montgomery County has none (the county's Primary Care Coalition advocates for funding to support safety net clinics).

The Washington, DC, area has a relatively large number of physicians, but relatively few are willing to treat low-income, uninsured residents.[11] In the District, the shortage of physicians in general and of specialists in particular is acute in the poorest parts of the city, Anacostia and other parts of Southeast Washington. Local health leaders throughout the region view low reimbursement and administrative complexity as the chief reasons for declining physician participation in Medicaid and inadequate access to health and dental care for the uninsured. In Montgomery County, the high and rising cost of medical malpractice insurance is viewed as a major problem affecting the supply of obstetric services especially.

Several initiatives are underway to address shortages of basic health care services in the region. In general, any of these efforts would welcome the participation of private insurers as collaborators and partners:

- In an effort to expand basic health care services to District residents, the DCPCA is conducting a Medical Home initiative in collaboration with the Office of the City Administrator, the District of Columbia Department of Health, the Brookings Institution, the RAND Corporation, and others. The initiative will develop a citywide assessment of gaps in the primary care safety net, help clinics improve their quality of care and financial and management systems, assist clinics in business and capital planning, and identify debt and equity sources to finance clinic construction and rehabilitation.

- Strategies and incentives are needed to encourage dentists to treat low-income adults and children—both Medicaid beneficiaries and the uninsured. While the District of Columbia and some counties operate free or low-cost dental clinics for uninsured children, adults, and seniors, area health leaders point to a critical need for additional capacity.

- Expansion of pharmaceutical assistance programs for low-income residents also is another critical need. Although the DC Healthcare Alliance covers prescription drugs, a restricted formulary prevents some enrollees' from obtaining needed medications. The District of Columbia has a pharmaceutical assistance program, called AccessRx, which enables low-income, elderly and uninsured residents to obtain prescription drugs at reduced cost. This program is supported through manufacturer rebates, pharmacy discounts and negotiated discounts (Washington DC Resident Resource Center 2004). However, cost is not the only barrier to prescription drugs: in some areas of the District, pharmacies do not to stock certain drugs for fear of burglary.

- Arlington County operates a prescription medication program for low-income elderly or disabled residents, but not for most low-income adults and children. Because the application

[11] The District of Columbia has approximately four times the national average of physicians per 100,000 population while Maryland has approximately the national average. The number of physicians per 100,000 population in Virginia is below the national average (SHADAC 2003).

process for the assistance programs offered by pharmaceutical companies is complex and varies by company, a staff person dedicated to this task can facilitate access and save practitioners' time. The Arlington County Health Department employs a staff member to perform this function. Such a program could be extended to other low-income adults and children and also replicated throughout the region.

- Local health leaders report the lack of affordable health insurance as a basic problem throughout the region, especially in suburban areas where programs like the DC Healthcare Alliance are unavailable to low-income residents. Some advocated deeply discounting premiums for low-income individuals and families to enroll them in private coverage (such as the "dues subsidy" programs that Kaiser Foundation Health Plan operates for low-income adults and children, described in Chapter II), as well as deeper premium discounts for coverage available to "uninsurable" individuals.[12] Others suggested that a small-group subsidy program could be of value in encouraging employers to offer and contribute to coverage.

- Some services (such as dental care and prescription drugs) may be difficult to obtain even for those enrolled in insurance programs. Local health leaders suggested targeted outreach and discounted insurance to address these problems, as well as creation of an health care ombudsman to help residents navigate the complex system of coverage and available services.[13]

5. Language and Cultural Competency

The Washington, DC region's considerable and growing racial and ethnic diversity presents an increasing challenge for the effective delivery of health care services. Immigrants to the Washington, DC metropolitan area speak a vast array of languages and originate from numerous countries with varied cultural traditions. Across the national capital area, 18 percent of residents are foreign-born, and 22 percent speak a language other than English at home (AHRQ 2004). To be effective, the delivery of care—as well as public health campaigns and public health education—must be culturally appropriate, delivered in several languages, and targeted to relatively low reading levels. Area health leaders cited problems with health care providers who are not respectful of low-income patients from diverse cultural backgrounds or are unable to communicate effectively with such patients. Probably related in part to these problems, 37 percent of the lowest-income respondents to the Kaiser Family Foundation survey of District adults rated the services they received as fair or poor compared with 13 percent of residents with higher incomes (Lillie-Blanton 2003).

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[12] At present, GHMSI is the insurer of last resort for District and Northern Virginia residents who otherwise are denied private individual coverage. In the District, GHMSI is charged with allocating as much as 1 percent of its total premium income to "rate stabilization" for these individuals. In Maryland, uninsurable individuals may enroll in the state high-risk pool, which is subsidized by an assessment on all insurers in the state.

[13] Advocates of creating a position of health care ombudsman in the District estimate that it would cost $500,000 per year. The current proposal would rely on a tobacco tax for funding.

In the Maryland and Virginia suburbs, an even higher percentage of the population is foreign-born or speaks a language other than English at home (AHRQ 2004). In Arlington County, approximately one-third of residents—and the majority of low-income residents—speak English as a second language. Developing adequate interpretation for care is a significant challenge: approximately 80 percent of services provided by the Arlington County Health Department are in languages other than English.

Differences in access to coverage and cultural adaptation to the concept of health insurance drive differences in health insurance coverage among the area's racial and ethnic groups at the same income levels. Latinos in the District of Columbia are less likely to be insured than either the District's African American or white population (Lillie-Blanton 2003).

A number of efforts have been mounted to address the significant and growing need for care appropriate to a multicultural population. For example:

- Some District organizations attempt to meet the needs of Latinos by operating safety net clinics in their neighborhoods. For example, the Children's National Medical Center added a health center in the Adams Morgan/Columbia Heights neighborhood of the District to better serve the Hispanic population.

- Montgomery County operates Project Delivery, a prenatal care program for the county's undocumented immigrants, but sees a growing need for public health surveillance for tuberculosis and other infectious diseases among the county's large refugee population.

However, by all accounts, the demand for culturally competent care greatly exceeds the area's capacity to provide it.

6. Quality of Care

Perceptions of health care quality in the Washington, DC metropolitan area are mixed. Except in the case of care provided by physicians and health professionals whose mission is to serve the low-income population, low-income residents generally view quality as poor and sporadic. In fact, area providers generally have not focused on quality improvement. One health department director observed that efforts to improve health care quality must be "practical and supportive to be fair." Local health leaders view hospitals as generally unable to influence the behavior of community doctors and possibly not sufficiently aggressive in their efforts to reduce inpatient medical errors. Employers in the Washington, DC area have not yet joined forces to address health care quality, though the Washington Board of Trade has recently established a Health Care Taskforce to consider health care quality improvement.

Failure to coordinate primary care compromises the quality of care and care outcomes for insured and uninsured residents alike. Some insurers do not cover preventive care (such as vaccinations) when delivered by internists, although enrollees may select an internist as their primary care physician. Low-income residents often delay care or do not adhere to care plans, particularly with respect to filling prescriptions. Several health leaders estimated that many of the quality issues for low-income residents are fundamentally access issues.

Poor communication between providers and public health agencies also compromises the quality of response to health problems, if not the quality of care. One health leader indicated that many physicians in Virginia do not communicate reportable diseases (for example, food-borne illnesses) to their local health department, frustrating the department's ability to intervene and prevent further illness. Failure to report suspicion of other and less common illnesses (such as SARS or anthrax infection) can lead to serious public health problems if a health department is unable to inform physicians of elevated risk and provide guidelines for treatment.

Area health leaders generally believe that insurers could be highly effective—and more effective than others in the health care system—in improving the quality of care, including coordination of primary care. For example:

- The insurance industry reportedly supports a statewide effort in Virginia to reduce medical errors, though there is little apparent activity at the local level, which is where quality improvements need to occur.

- The Institute of Medicine report, the Delmarva Foundation reports and other literature offer several recommendations for quality improvement. Area health leaders view insurers as ideally situated to develop systems and incentives that will encourage providers to heed these recommendations, including coordinated collection of data and sharing of best practices among providers.

- Area health leaders viewed health insurers as uniquely situated to improve communication between emergency departments and outpatient providers, especially about drug errors and interactions. Efforts to develop more effective screening tools and incentives for pharmacies to identify medication errors were identified as areas in which insurers should be more involved.

7. Emergency Preparedness

Despite extensive efforts to improve emergency preparedness across the Washington, DC metropolitan area, local health leaders voiced concerns about the likely adequacy of health providers' response to an area-wide emergency. For example, some leaders questioned the advisability of an emergency response that relies on volunteer physicians and other health professionals without obtaining in advance their commitment to serve during a crisis. Others observed that attention to hospital preparedness generally has superseded attention to preparedness among individual practitioners. As a result, many practitioners may lack the information needed to recognize an illness and to provide appropriate initial and follow-up care. For example, a breakdown in communication to private practice clinicians resulted in the widespread ordering of tests for anthrax in 2001 following contamination of the District's main post office and other sites. With local laboratories overwhelmed with anthrax tests, many of which were clinically inappropriate, results were delayed for cases in which anthrax infection was a probable diagnosis.

Many local health leaders see the potential for insurers to play an important role in developing an area-wide capacity for effective emergency response:

- Insurers have a unique line of access to residents and health care providers to offer information about the appropriate response to the release of biological agents and other

emergency events. For example, they could arm plan members with information and distribute clinical guidelines and testing protocols to providers. They could make the same information available more broadly to residents and providers in the community, thereby reducing crowding in emergency departments when people do not know where else to turn for diagnosis or care during an incident. Finally, they could adopt and enforce a policy of not reimbursing for tests that clearly do not meet clinical guidelines.

- Insurers could coordinate with—and help replicate—existing systems to communicate with providers about suspected public health emergencies or emergencies in progress. For example, Arlington County has developed a "blast fax" system that automatically faxes information to all physicians, hospitals, and pharmacies in the county. (In meetings with providers, the county determined that all health providers routinely use faxes to communicate with insurers and pharmacies but that relatively few use Internet communication.)

Area health leaders viewed all of these activities as consistent with the interests of insurers' members, as well as the interests of the larger community.

C. INFRASTRUCTURE FOR ENGAGING THE COMMUNITY

There is a general consensus that the District dominates the national capital area's concerns, although the District accounts for less than 20 percent of the area's population. The District government has not been viewed as effective in providing leadership to address the health care problems of District residents, much less those that residents of the metropolitan area have in common.[14] Without a strong leader, the region lacks both the focus and structure needed to make significant progress in health care promotion, to meet public health goals, and to champion needed service expansion.

Area health leaders expressed considerable interest in the role that dominant insurers such as Group Health and Medical Services, Inc. (GHMSI) might play in helping the region improve communication and coordination of health goals and strategies. Many area health leaders believe that larger-scale, regional initiatives are needed as well as stronger regional leadership and accountability. But they emphasize that specific approaches to common problems must recognize the circumstances of individual communities, including cultural and political differences and differences in the availability of services.

Given local governments' recent and deep budget cuts, several health leaders expressed concern that, if additional private resources were available for community health needs, local governments would pull back on their existing initiatives or spending. One suggested that a maintenance-of-effort agreement should be part of any significant change in leadership or strategy, thus ensuring net increases in funding and initiatives for the community. Many suggested greater participation by both employers and insurers as essential to improving health care across the region.

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[14] For example, the Kaiser Family Foundation Survey of District of Columbia adults found that a higher percentage of District residents rated the District of Columbia government as "fair or poor" in addressing health care problems, rather than "excellent or good" (Lillie-Blanton 2003).

At least two organizations are now attempting to coordinate approaches and responses to various regional concerns across jurisdictions within the metropolitan area: the Washington Council of Governments (which coordinates across local governments) and the Washington Board of Trade (a regional "chamber of commerce" organization).[15] To date, neither has taken on improvements in health status or health care provision as strategic areas. Each organization and its efforts related to health are described briefly below.

1. Washington Council of Governments

The Washington Council of Governments (COG) brings together elected officials and agency heads from across the several jurisdictions comprising the Washington, DC, area. COG is primarily financed through federal funds for transportation and air quality issues, but member dues and outside grants allow the COG board to convene a Human Services Policy Committee. COG focuses on issues that are clearly cross-jurisdictional, such general HIV/AIDS education (posting educational messages on the Metro rail and bus system), developing regional emergency preparedness, and developing strategies to address West Nile virus and drunk driving. COG is less likely to take on issues viewed as local, such as health care access, cost, or quality.

2. Washington Board of Trade

The Washington Board of Trade includes 1,200 member organizations in the District of Columbia, Virginia, and Maryland. Many of its members are small businesses. Comprised of CEO-level leaders from member organizations, the board's Potomac Conference is charged with fostering collaboration among private, government, and not-for-profit employers across the region. In June 2004, the Potomac Conference established a Health Care Taskforce, responding to employers' concerns about escalating health care costs. The Health Care Taskforce is primarily funded by foundation grants but expects that member organizations will fund specific activities to achieve employer cost savings. The task force includes several area health care insurers and providers as members.

The Health Care Taskforce has established four interconnected work groups—employer coalition, regional workforce, regional wellness, and health policy—to address issues of access, cost, and quality. The employer coalition work group will partner with Leapfrog and other employer groups, determine whether to create a regional employer coalition, and evaluate strategies to create value-based purchasing. The regional workforce work group will address the supply of qualified health care workers in the region and the coordination and expansion of training efforts and job placement programs. The wellness work group will study and develop workplace health education and promotion activities and incentives. A primary goal of the health policy work group will be the

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[15] Other organizations engaged in working across jurisdictions in the metropolitan area include the Business Group on Health (which has linked local health departments and major corporations to address various health promotion issues), the National Commission for Health Education Credentialing, and the Delmarva Foundation (which has interest and experience in quality oversight). Area health leaders also pointed to perhaps less likely partners in improving community health, including parks and recreation departments, which have jurisdiction over a wide range of community spaces and facilities.

development of a regional medical record system as well as advocacy for medical liability tort reform (specifically, caps on jury awards).

D. SUMMARY AND DISCUSSION

Information from surveys, analyses of available public health data, and discussions with community health leaders all indicate that health status, access, and quality issues warrant substantial and coordinated attention and investment across the region. Many of residents' most debilitating and costly health problems—HIV/AIDS, chronic diseases, obesity, and behavioral health problems—might be addressed with targeted health education to change behaviors and improve access to culturally competent providers and services.

Local health leaders believe that the area's health insurers could be key players in several roles that few have yet developed broadly or at all. GHMSI might meet its obligation to promote and safeguard the community health by providing leadership, dedicating significant resources, and achieving measurable outcomes in any or several of these areas. For example:

- Insurers can engage residents in healthier lifestyles and facilitate access to health care services. They can develop and disseminate best practices for ongoing quality improvement, and diagnostic and care protocols for management of public health emergencies. The area's largest insurers have developed educational materials for their own members that would be equally valuable to the broader community if distributed through the area's safety net clinics or in the "community wellness centers" that some local health leaders envision. Such materials include information about patient management of specific chronic illnesses (such as hypertension and diabetes) and guidance about behavioral health (such as smoking cessation, safe sex, nutrition, and physical activity).

- The need for greater capacity to deliver care to uninsured and underserved populations throughout the region is apparent. Local health leaders cited the need for more clinics, greater incentives for providers to serve low-income and uninsured adults and children, more language interpreters, and more training in cultural competency.

- Many local health leaders identified the inability of patients—insured or uninsured—to "use the system" effectively as a serious problem of wasted resources and opportunities to support and improve health status. In some instances, insurers themselves have erected administrative barriers that frustrate the appropriate use of primary care—such as disallowing reimbursement for vaccinations when provided by a specialist—including internists who are designated primary care providers. Failure to coordinate primary care and failures of access to prescription drugs are obvious sources of low-quality care and unnecessary cost in the region.

- Affordable health insurance is a critical issue, especially in the area's suburbs where general affluence masks a significant and apparently rising number of uninsured residents. Some health leaders suggest that insurers are well-positioned to improve the efficiency and quality of care and therefore reduce cost. But few have made a real effort to do so. To date, GHMSI has not attempted to develop a subsidized insurance product such as Kaiser offers in the national capital region.

- Area health leaders saw important roles for health insurers in educating both the public and health care providers in how to respond to public health emergencies and how to coordinate with public health departments. They viewed the area's prominent health insurers as potential partners and leaders in emergency response—roles that area health insurers generally, and GHMSI in particular, have not developed.

Finally, several topics raised in our discussions with area health leaders may offer growing opportunities for partnering with area health insurers. Prominent among these topics are problems related to the health and health care of the region's elderly population. One area health leader emphasized the importance of increasing the availability of in-community care and setting standards for that care; another focused on the importance and implications of clinical and practical efforts to prevent falls at home as well as in hospitals and nursing facilities. As the new Medicare Advantage program develops and larger numbers of Medicare beneficiaries enroll in private health insurance plans, insurers will become essential community partners also in meeting the health needs of the national capital area's growing elderly population.

II. LEARNING FROM OTHERS: EXAMPLES OF COMMUNITY BENEFIT

A. BACKGROUND AND METHODS

While many nonprofit health plans may pursue community benefit mission, there is no common source of information about how many plans do so, or how they implement, fund, and maintain community benefit mission in a highly competitive market. In this chapter, we describe the context and implementation of community benefit mission by four nonprofit health plans. These include Kaiser Permanente—GHMSI's major competitor in Washington, DC and a significant competitor throughout the national capital area—and three nonprofit plans located in other states: Harvard Pilgrim Health Care (with business primarily in Massachusetts, but also in Maine and New Hampshire), InterMountain Health Care, or IHC (with business primarily in Salt Lake City, Utah), and Highmark Blue Cross and/or Blue Shield Companies (with business in Western and Central Pennsylvania).

While we selected Kaiser Permanente as a major local competitor, Harvard Pilgrim, IHC and Highmark were of interest for a number of reasons. First, each enjoys a generally positive reputation as strong corporate citizens in their communities. Our goal was to understand better the specific activities that supported their reputations: how they identified and prioritized among community needs, and developed an effective response to community need. Second, each holds roughly the same share of their market or less than GHMSI holds in Washington, DC—although unlike GHMSI, none is the largest insurer in the state. By selecting nonprofit insurers of approximately equal or smaller size, we hoped to identify plans that had comparable or even fewer resources to pursue community benefit than GHMSI might have. Such plans may offer feasible models of community benefit for GHMSI, illustrating the kinds of processes and programs that GHMSI could pursue to improve community health.

B. MARKET POSITIONS OF SELECTED PLANS

While each of the selected plans holds a significant share of its primary market (defined at the state level), none is as dominant in that market as GHMSI is in Washington, DC (Table 1). Their statewide markets are similar, however, to GHMSI's position in the national capital area—including the District, as well as Montgomery and Prince Georges counties in Maryland, and Alexandria, Arlington, Fairfax, and Prince Williams counties in Virginia. Each holds about one- third of its primary market. Both Kaiser and Harvard Pilgrim hold much lower shares of the market outside their primary service areas (respectively, California and Massachusetts).

TABLE 1

PREMIUM VOLUME AND MARKET SHARE OF SELECTED NONPROFIT HEALTH INSURANCE PLANS, 2001

Plan name	State	Reported major medical premiums earned (millions)	Group market share	Non-FEHBP group market share	Individual (nongroup) market share
Group Hospitalization & Med Services	DC	$1,095.2	47.0%	31.7%	47.5%
Kaiser Foundation Health Plan, Inc.	CA	$10,295.6	31.0%	31.0%	22.4%
Kaiser Foundation Health Plan, Inc.	DC	$467.6	19.7%	26.2%	41.8%
Highmark, Inc.	PA	$3,539.0	33.0%	33.0%	47.4%
IHC Health Plans Inc	UT	$547.0	30.3%	30.3%	55.0%
Harvard Pilgrim Health Care Inc	MA	$1,354.4	27.6%	27.6%	19.4%

Source: Mathematica Policy Research, Inc. Estimates from NAIC data.

Several dimensions of these plans' business are relevant to understanding their comparability to GHMSI. First, GHMSI's total premium volume—including its FEHBP, non-FEHBP group, and nongroup business—is about in the middle of the range of the plans that we studied. In 2001, GHMSI wrote more than twice as much business in the District as Kaiser and twice as much as IHC wrote in Utah. In terms of total premium volume, GHMSI was most like Harvard Pilgrim in Massachusetts.

Second, in comparison to GHMSI, none of the comparison plans write even nearly as much Federal Employee Health Benefit Plan (FEHBP) business as GHMSI. In fact, it is GHMSI's FEHBP business that most distinguishes its group market business. Absent that business, GHMSI also held about one-third of the group health insurance market in 2001, as did Highmark, IHC, Harvard Pilgrim, and Kaiser in California. In the District, GHMSI's non-FEHBP group market share was about 20 percent more than Kaiser's.

Third, in the District, GHMSI's 47-percent share of the nongroup health insurance market is comparable to most of the plans we studied—including Kaiser in both California and the District and Highmark. IHC wrote more than half of the nongroup market in Utah in 2001. Nongroup insurance is widely viewed as a difficult business, likely to attract high-cost enrollees and entail high administrative cost. GHMSI is a designated insurer of last resort in the District and in Northern Virginia, as Highmark is in Western Pennsylvania. As Blues plans, both also enjoy a name recognition that attracts individual membership.

In contrast, Harvard Pilgrim, IHC, and Kaiser are diversified health plans; each offers PPO and POS products, as well as HMO coverage. Harvard Pilgrim's principal market is in Boston, but it also serves urban and small-town communities in Maine and New Hampshire. In Massachusetts and Maine, all insurers are required to offer coverage to individual applicants (a requirement called guaranteed issue). The wide spreading of individual risk in these states probably explains Harvard Pilgrim's relatively low enrollment in individual coverage.

IHC is an integrated health system that operates a network of hospitals, as well as staff-model ambulatory care centers and clinics. IHC facilities are located in the most populous area of the state—Salt Lake City, which includes nearly 45 percent of Utah's total population—contributing to

higher individual enrollment. Likewise, Kaiser operates several facilities within the District, as well as in suburban Maryland and Northern Virginia. However, neither IHC nor Kaiser are insurers of last resort: both can deny coverage to individual applicants, but they nevertheless accept as much or more of the nongroup market as GHMSI or Highmark.

Finally, it is striking that Kaiser, Harvard Pilgrim, and IHC all originated as clinic- or hospital-based integrated health care plans. Each continues to rely on its provider network to implement some part of its community benefit mission. However, the community benefit activities we probed in this report are *in addition* to those that these insurers pursue to meet the community benefit obligations of their nonprofit hospitals and therefore are analogous to the activities that GHMSI might pursue in developing its community benefit mission.

C. DEVELOPMENT OF COMMUNITY BENEFIT MISSION

Each of the plans we investigated emphasized the role of corporate mission in developing their community benefit activities. Remaining rigorously true to mission—and redirecting activities to update mission—was important to each. Similarly, working with the community to ground and leverage the plans' community benefit was seen as essential to each of the plans. The activities that constitute the health plans' community benefit programs, and their processes for identifying and prioritizing community benefit needs, are described below.

1. Commitment to Community benefit

All of the plans have a strong, stated commitment to community benefit and undertake a variety of community benefit activities.

- **Harvard-Pilgrim Health Plan** organizes its community benefit mission and activities through a nonprofit foundation, the Harvard Pilgrim Health Care Foundation. Established in 1980,[16] the Foundation's articulated mission is to prevent illness and promote better health through medical education, research, and community benefit. Harvard Pilgrim Foundation has been in operation since 1980; in 1992, it created the nation's first joint academic department between a health plan and a medical school—the Department of Ambulatory Care and Prevention at Harvard Medical School. The Department operates research and education programs that include teaching at community-based sites, research in Medicaid medical management (especially for children with asthma or diabetes), and work with community clinics. In January 2004, the Foundation launched The Institute for Linguistic and Cultural Skills to reduce health disparities via cross-cultural and interpreter training programs for health clinicians, nurses, and others.

  The Foundation also operates grant programs in Massachusetts, Maine, and New Hampshire to fund community-based activities in four areas: (1) reduction of health disparities, (2)

[16] The Harvard Pilgrim Health Care Foundation originated as a foundation of the Harvard Community Health Plan (a staff model HMO), before it combined with Pilgrim Health Care (an independent practice association, or IPA). The Foundation developed from the closing of a community clinic that had been the basis for Harvard Community Health Plan.

obesity, (3) HIV/AIDS, and (4) youth and families. These include funding a national conference on health disparities, hosting a statewide coalition of agencies and residents to reduce disparities related to cancer diagnosis and treatment, and supporting a local Boys and Girls Club that focuses on healthy lifestyles and nutrition.

- **Highmark** operates the Caring Foundation, which gained national prominence in the 1980s for operating a low-cost health insurance program for children; this program ultimately became the model for the State Children's Health Insurance Program (SCHIP, in Pennsylvania called simply CHIP).[17] In 1992, Highmark created Special Care to provide an affordable health care option to low-income adults. Special Care served as the model for the Commonwealth's adultBasic program, which was launched in 2003 with funds from the state's tobacco settlement.[18] The Caring Foundation donates funds to administer and conduct outreach for Pennsylvania's CHIP and adultBasic programs. In 2003, Highmark made available a $100 voucher to anyone on the waiting list for enrollment in adultBasic (an estimated 90,000 adults) good at community health centers, which scale charges to family income; 6,000 people accepted.

  In addition, the Caring Foundation operates the Caring Place, a grieving center for children and adolescents in two locations (in Pittsburgh, Erie, and the Harrisburg area). It also operates a small Health Education Center (organized as a 501(c)(3)) focusing on underserved, vulnerable populations and health disparities.

- **IHC** operates two community-oriented foundations, the IHC Foundation and the Intermountain Community Care Foundation (ICCF).[19] The IHC Foundation provides grants to fund primary health care for the underserved and/or uninsured population; maternal and fetal health and children's health care are a primary focus of IHC Foundation grants. ICCF sponsors "community health partnerships," funding four IHC community and school clinics and nine community clinics and federally qualified health centers (FQHCs). ICCF provides approximately half of the operating budgets of the two FQHCs in Salt Lake

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[17] This program included an evaluation component, conducted in cooperation with the University Of Pittsburgh School of Public Health that developed information influential to the passage of SCHIP. Such information included the results of reducing delayed care and unmet needs, and having a primary care provider; as well as impacts on enrolled children's environment for general development (such as parental restrictions on playground activities) associated with having health insurance.

[18] AdultBasic is administered by the Pennsylvania Insurance Department with funds from Pennsylvania's tobacco settlement. Individuals eligible for adultBasic must be uninsured, ineligible for Medicaid or Medicare, and have family income below 200 percent of poverty. Highmark estimates that one-third of enrolled adults have income below 100 percent of poverty. The program covers preventive care, physician services, diagnostics, inpatient and outpatient hospital care, and emergency care. The premium is $30 per adult per month; care for preexisting conditions is covered. Highmark Blue Shield is the adultBasic contractor in two of four regions in Pennsylvania. Approximately 25,000 people are in Special Care, and another 22,200 people are enrolled in adultBasic in Western Pennsylvania.

[19] Several of the IHC hospitals also operate separate fund-raising foundations specifically to benefit those hospitals.

City, and IHC hospitals do "virtually all" of the FQHCs' lab tests at reduced cost. IHC hospitals also provide significant charity care, some associated with the activities of the Foundation Programs.

- **Kaiser Foundation Health Plan – MidAtlantic (Kaiser)** operates a number of programs directly, similar to its parent corporation, Kaiser Permanente. Kaiser Permanente has a corporate philosophy and long history of community benefit integrated into the company's day-to-day operations; it does not operate a separate foundation. Kaiser's community benefit activities include subsidized Kaiser membership for uninsured children below 250 percent of poverty in five counties in Maryland and Virginia (Montgomery, Prince Georges, Fairfax, Loudon, and Prince Williams) and in the District of Columbia. Kaiser also operates heavily subsidized "bridge" programs for adults and families below 250 percent of poverty in Baltimore City and several Maryland counties with proximity to Kaiser medical centers, as well as a subsidized program for adults below 250 percent of poverty in Baltimore County.[20] [21] In total, these programs enroll approximately 3200 adults and children in the District, Maryland, and Northern Virginia.

  Kaiser operates two additional programs with a community focus: a Community Health and Impact Grants program and an educational theatre program for children and adolescents. Kaiser community grants program provides funding for initiatives that address access to care, preventive care, health education, and health literacy—this year with a special emphasis on childhood obesity. Applicants compete for funding. The educational theatre program employs professional actors who provide free performances to schools and community organizations on topics ranging from basic health education (for young school children), peer pressure and violence (for middle-school students), and HIV/AIDS (for high-school students).[22] In addition, Kaiser has provided funding to various safety net clinics, as well as Northern Virginia (NOVA) Community College to give allied health professionals "hands on" training in a new clinic for uninsured Northern Virginia residents.[23]

2. Identifying and Prioritizing Community Needs

Each of the health plans relies on its board and relationships with the community to identify and prioritize its community benefit activities. In Massachusetts—Harvard Pilgrim's principal market—

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[20] For qualified adults and families with income below 175 percent of poverty, Kaiser subsidizes 95 percent of the premium; for others below 250 percent of poverty, Kaiser subsidizes 90 percent of the premium. The program offers Kaiser's standard comprehensive benefit. The program operates in all Maryland counties except Ann Arundel county, where Kaiser does not have a medical facility.

[21] Kaiser's program in Baltimore City provides all primary care in Kaiser's medical centers; the Baltimore County Health Department arranges separately for hospitalization and specialty care.

[22] Actors are trained in facilitation skills, and conduct conversational sessions with even very young children following the performances. Fairfax County has selected Kaiser's educational theatre series as the only non-county program allowed in its school system.

[23] The Kaiser Permanente Medical Mall is a "state of the art" clinic that operates near Springfield Mall in Northern Virginia.

the state (in cooperation with health plans and community leaders) has developed guidelines that formalize this process.[24] [25] IHC and Kaiser Permanente operate community benefit programs without specific state guidelines or requirements that affect their processes for defining or implementing specific programs. Highmark operates with a court order to provide community benefit as a condition of a corporate merger; that order identifies a series of activities—all or most ongoing activities of Highmark and/or its Caring Foundation—by which Highmark might (or must) meet its community benefit obligation.[26]

- **Harvard Pilgrim** draws information from a number of sources to assess health care needs in its market area, including an automated health status indicator system (called MassCHIP) developed by the Massachusetts Department of Health[27] and current health services and health policy research that the Foundation itself may fund.[28] Senior Foundation and health

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[24] In Massachusetts, the guidelines offered by the Attorney General call upon HMOs to formalize their approach to community benefits planning and to collaborate with the communities they serve to identify and create programs to address unmet needs. These include: (1) adopting and making public a Community Benefits Policy Statement; (2) making senior management of the HMO responsible for developing the Community Benefits Program, including resource allocation and regular evaluation; (3) seeking assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program and in defining the targeted population and health care needs to be addressed; and (4) assessing the health care needs and resources of target populations, particularly lower- and moderate-income communities, and considering the health care needs of a broad spectrum of age groups and health conditions (http://www.cbsys.ago.state.ma.us/pubs/ hccbhmoguide.pdf, accessed October 1, 2004).

[25] The Attorney General makes a wide range of material available electronically, including the current version of the guidelines; HMO community benefits annual reports, corporate annual reports, and contact information; a searchable database of access information about each HMO's community benefits programs and extractable HMO benefits program data; a "links library" to support HMOs and community organizations in planning and implementing community benefits initiatives; information about of the AG's Community Benefits Advisory Task Force; and summary descriptions and contact information related to other states' community benefits initiatives (http://www.cbsys.ago.state.ma.us/ healthcare/hccbindex.asp, accessed October 1, 2004).

[26] A court order related to the 1996 consolidation of Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania requires Highmark to "annually dedicate to social or charitable health care endeavors 1.25% of its direct written premium" and to provide a summary report to the Department of Insurance of "its charitable and benevolent endeavors" refers to the merger of those companies. The order identifies a number of activities that would represent fulfillment of Highmark's obligation—including the Special Care program, the Caring Program for Children, 65 Plus and Security Blue (Medicare risk programs), participation in SCHIP, and annual open enrollment, and activities of the Caring Foundation.

[27] Specifically, the Behavioral Risk Factor Surveillance System (BRFSS) conducted by the Centers for Disease Control and Prevention (CDC) (http://masschip.state.ma.us/, accessed October 1, 2004).

[28] For example, in its 2004 annual community benefits report, the Foundation mentioned its reliance recently on the *Common Health for the Commonwealth: Massachusetts Trends in the Determinants of Health* study issued by the Massachusetts Health Council and funded in part by a Foundation grant. The study examined Massachusetts' performance on a number of Healthy People 2010 leading indicators and identified possible policy solutions that could be implemented.

plan staff participate in a number of health-related advisory committees, and also host a number of community forums. The latter include the AIDS Action Committee and the Massachusetts Department of Education's AIDS Advisory Panel; the Massachusetts Health Council; and the Massachusetts Violence Prevention Task Force, Workgroup on Suicide Prevention. Harvard Pilgrim also participates in the Massachusetts Health Funders' Network.

"From any one of those seats we have a birds-eye view of what is going on among stakeholders in health care and a basis for conversation with the community about what is important to people in Massachusetts" (Fuccillo 2004). In addition, in 2000, the Foundation tapped a number of "key informants" (including local, state, and regional public health officials, community leaders, medical educators, and executives from other philanthropic organizations (such as the United Way) to understand their sense of the Foundation's contributions to the community and to advise the Foundation board on a set of strategies going forward. The Foundation board also takes an active role in the needs assessment process.

- A significant share of the **Highmark** Caring Foundation's community benefit activities relates to Highmark's statutory obligation to bid for Pennyslvania's CHIP and adultBasic programs. However, the Caring Foundation also relies on informal networking with social service agencies and others to identify community needs.

  Highmark's Caring Foundation sees itself as "an incubator for ideas, …building partnerships with the community" (LaValee 2004). Relying on a very small staff, the Foundation director generates ideas that the Foundation board (including Highmark's chief operating officer and its senior vice president of corporate affairs) prioritizes.

- **IHC**'s two community-oriented Foundations also develop their community benefits using an informal process of networking. In 2003, the IHC Foundation changed its perspective on its activities to emphasize interaction and partnership with the communities that IHC serves. Foundation staff members communicate regularly with various local agencies, and twice per year the IHC Foundation solicits grant applications. The IHC Foundation Board establishes priorities for Foundation activities and grants. Because the IHC Foundation's endowment funds were generated through health care (the closure of a nonprofit hospital), the Board has focused both Foundations' activities exclusively on the provision of health care. However, there is growing interest in an "upstream vision of health" (Thompson 2004) that includes health education, potentially implemented in cooperation with local school systems and existing state and local agency programs.

- In California, **Kaiser Permanente** has begun to integrate into its community benefits planning with the needs assessment that the state requires of Kaiser Permanente's nonprofit hospitals. But in Kaiser's Mid-Atlantic region, the environment is very different: there are no statutory guidelines for nonprofit health plans' community benefit and Kaiser's operations are not hospital-based. Consequently, the process is more strategically focused around subsidized coverage for low-income adults and children and grant making. It relies heavily on networking—working formally and informally with various organizations and agencies—to identify needs and to understand what other organizations may be attempting to address them. Kaiser's network "partners" include Mary's Center for Maternal and Child

Care, Catholic Charities, the Baltimore County Health Department, the Fairfax County Office of Partnerships, Northern Virginia Family Services in Loudon County, and the health working group of regional grant makers.

Kaiser's general priorities for community benefit are established at the corporate level. They include coverage for low-income people, partnership with the safety net, community health initiatives,[29] and development and dissemination of knowledge—including educational programs to train technicians and nurses (like that at NOVA Community College), many placed in underserved communities to address both the health care and economic needs of the community.

3. The Cost and Funding of Community Benefit

Each of the health plans we investigated determines its own level of funding for community benefit, and these levels varied substantially across plans. The sources of funding also varied; they included endowment funds and corporate funds allocated on a matching basis or as an annual decision by the corporate board.

- **Harvard Pilgrim** Health Care has the ultimate authority and responsibility for approving the Harvard Pilgrim Foundation's budget. When the Foundation was formed in 1980, it established a community-benefit funding goal of 1.5 percent of revenue, but it was never implemented. Since 1995, Harvard Pilgrim has allocated to the Foundation a baseline amount of $4.5 million per year. Including other funds available to the Foundation, its 2003 direct expenses totaled $5.9 million.[30] The Foundation allocates 60 percent of its budget to community teaching and research, and 30 percent to community benefit; 10 percent is allocated to administration of the Foundation. The Foundation's direct expense budget for community benefits programs in 2004 is $6.0 million. Harvard Pilgrim also contributes substantially (as do other insurers in Massachusetts) to the state's uncompensated care pool

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[29] For example, Kaiser Permanente encouraged all regions to support local health departments to apply for CDC's *Steps to a Healthier US* grants. It participated in 13 applications, one of which was funded. Kaiser Permanente funded another eight programs for one year to support re-application for CDC funding. A centerpiece of the *Steps* initiative is the 5-year cooperative agreement to fund states, cities, and tribal entities to implement chronic disease prevention efforts. These efforts focus on reducing the burden of diabetes, overweight, obesity, and asthma and addresses three related risk factors—physical inactivity, poor nutrition, and tobacco use. The FY 2003 initiative distributed $13.6 million to 12 applicants. Funds went to four states representing 15 small cities or rural communities (average award: $1.5 million), one tribal consortium (award: $250,000), and seven large cities (average award: $1.04 million). These 23 communities will implement community action plans to reduce health disparities and promote quality health care and prevention services (http://www.cdc.gov/nccdphp/steps/index.htm, accessed October 1, 2004).

[30] In 2003, Harvard Pilgrim also provided funding for the Community Health Center Enhancement Fund, a grant program created in 1998 (when Harvard Pilgrim entered into an affiliation agreement with the Neighborhood Health Plan) to enable community health centers to improve their ability to provide care for their communities in an increasingly competitive environment. In 2003, Harvard Pilgrim provided approximately $400,000 in grants to community health centers, completing its 5-year, $15 million commitment to the Fund.

(in 2003, $12.3 million)—together with its baseline allocation, totaling approximately 1percent of earned premium.

- **Highmark**'s expenditures for community benefit are defined by its 1996 consolidation agreement following the merger of Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania. That agreement requires the company to expend 1.25 percent of it direct written premium for community benefit, an estimate that the company claims to exceed substantially and consistently. In 2003, Highmark estimates that it expended $96.1 million for health care and health coverage associated with its role as insurer of last resort and enrollment in Highmark's Special Care program for low-income adults against $7.1 billion in total revenues—approximately 1.3 percent.

  Other direct expenditures for community benefit—including the Caring Foundation budget—are much smaller. The Caring Foundation raises half of its budget through grants, contracts, and donations; Highmark matches these dollar for dollar and donates the services of the Foundation director and staff.

- **IHC** estimates its annual community benefits at $180 million (in 2002), including payments for charity care and a lower operating margin than is usual among for-profit health plans. IHC's budgeted operating margin for 2002 and 2003 was 2 percent, maximizing the value "returned to the community in the form of improved facilities, better services, and lower patient charges" (Intermountain Health Care 2003). IHC was the only plan we investigated that included reduced margin in its calculation of community benefit. In 2002, IHC's estimated community benefit net of the uncompensated care provided by its hospitals was an estimated 7.9 percent of its gross funds available from all "nonpatient activities"—including health insurance premiums, investment income, donations, and other resources.

- **Kaiser Permanente**'s national organization has a target level of community benefit of 3 percent of revenues, not to exceed 50 percent of net income. However, regions may consider their own circumstances in meeting this target.

  In the Mid-Atlantic region, Kaiser's community benefit activities will exceed an estimated $8.4 million in 2004. Three-quarters of this amount is associated with Kaiser's county-partnership programs of reduced-premium enrollment for uninsured adults and children ineligible for Medicaid or SCHIP. In 2004, Kaiser made additional grants totaling $800,000 to community organizations to provide health care, pharmacy, food assistance, and health screening and education to low-income residents in the District, Maryland, and Northern Virginia. Finally, Kaiser's educational theatre program operates on a budget of $1.0 to $1.2 million per year. A rough sum of these expenditures indicates that Kaiser will spend 1.5 to 2 percent of 2004 premium revenues in the Mid-Atlantic region on community benefit activities.

D. COMPETITION AND COMMUNITY BENEFIT

In very competitive markets, it may be difficult for one plan to initiate significant community benefit without losing its financial edge. This perspective on markets assumes that prices are set at minimum levels for corporate survival. However, none of the plans that we investigated believed that competition precluded significant attention and dedication of corporate resources to

community benefit. Instead all recognized that the costs of community benefit were absorbed into the companies' general cost structures and, arguably, in their prices over the long term—although all recognize that it takes some level of client education in an era of fast-rising health care costs to have them appreciate the long-term wisdom of community benefit.

In only one location—Massachusetts—were nonprofit insurers required to report community benefit activities and expenditure in a standardized and comparable format. Massachusetts' guidelines for community benefit do not require a minimum level of expenditure, but do require a level of transparency (with comparable reporting formats) that helps the public to understand the plans' relative investment in community benefit.

- In recent years, **Harvard Pilgrim** has weathered serious financial problems.[31] Nevertheless, the Foundation focused on continuing community benefit and minimizing disruption in its activities. "One of the benefits of having direct guidance from the AG [is that] it does provide us a good, safe place to do our best work" in a competitive market (Fuccillo 2004). Harvard Pilgrim recognizes that its Foundation's efforts are "overshadowed" by the new Foundation budget of its much larger competitor, Massachusetts Blue Cross and Blue Shield. However, it will "continue to put [its] best foot forward to address health needs and provide resources…though [it] cannot match [BCBS's] scale."

- **Highmark**'s consolidation agreement to expend a fixed percentage of revenues for community benefit has built this expenditure into its operations. "[Highmark] needs to succeed" to have capacity to provide community benefit, but "it's possible to succeed at business and [also] serve mission" (LaValee 2004).

- **IHC** "leads the way in giving dollars and services to the state of Utah" in part in an attempt to balance its roles as a hospital system and a health plan. As a major provider of charity care in the state, IHC is concerned that the burden of increases in unmet need and deferred care ultimately would fall largely on its shoulders. "It's a balance between money and mission" (Thompson 2004). Necessarily, IHC is "careful" about adverse selection. To reduce the unnecessary use of emergency services in IHC's and other hospitals, IHC funds culturally appropriate community clinics and "teaches them to use their resources wisely as a primary medical home." Service to the community, "whether it's money or [people] assets, we think it improves our competitive position."

- **Kaiser Permanente**'s national organization has "worked hard to distinguish [its] mission-driven activities from [its] business purposes" (Baxter 2004). Still, it is becoming "much

[31] Harvard Pilgrim (then Harvard Community Health Plan) was in receivership from January through June of 2000, and currently is under "administrative supervision," a status in which the Attorney General would review any major expenditure, merger, or acquisition on behalf of the receivership. The company attributes its financial problems to difficulties with systems integration during rapid growth following the 1995 merger of Harvard Community Health Plan and Pilgrim Health Care, as well as having acquired the Rhode Island Group Health Association in 1991, with its financial problems. It attributes its turnaround to withdrawing from Rhode Island, outsourcing claims and information technology, recontracting with providers and vendors, and various other operational and systems improvements.

more proactive about saying you can't have healthy members in a toxic community. We have a responsibility to be broader."

With respect to Kaiser's activities in its mid-Atlantic region, that perspective continues. "If you are a nonprofit plan, you have an obligation to community. Competition is baked into your business. But you get a lot of benefit [from being nonprofit]; it would cost you not to be nonprofit. So you have obligations" (Mathews 2004).

E. SUMMARY AND DISCUSSION

Each of the plans that we investigated has an extensive history of community benefit, and each offers a window on how a significant community benefit mission might be developed and implemented. Each of the plans defines its community benefit role in consultation with the community in some way—although the processes typically are informal. It is striking that all but one originated as a clinic- or hospital-based integrated health care plan, and they continue to rely on their provider networks to implement some part of their community benefit mission. However, the community benefit activities we probed in this report are in addition to those that they pursue to meet their nonprofit hospital community benefit obligations. In these organizations especially, the culture of community benefit resonates with a sense of commitment to community health improvement as well as improved access to care. All of the plans see access to care as an essential issue, and all attempt to improve access in important ways—by serving public programs, funding and supporting health clinics, and/or substantially subsidizing plan enrollment for low-income children and adults.

The annual level of resources these plans devote to community benefit typically ranges from 1 to 2 percent of earned premium. Each balances the priorities of managing a sound financial operation and pursuing their community benefit mission somewhat differently, but all have a commitment to protecting and developing funding for community benefit.

None regards competition as a compelling constraint on community benefit, although of course all recognize the fundamental importance of maintaining the health plan's financial integrity. In general, each regards competition as "baked into the business" and community benefit as an essential part of the health plan's mission.

Whether the plan is disadvantaged by pursuing such a mission depends fundamentally on the nature of competition—which in all health insurance markets is monopolistic: consumers can distinguish among products, and one or two large insurers are price leaders (we document this market behavior in the next chapter). In such markets, competing insurers may vary their margins in a variety of ways—for example, by adjusting product design, improving the efficiency of case and disease management, restructuring provider contracts, reducing administrative cost, or altering the level and timing of internal financing decisions. As a result, plans that pursue community benefit mission typically have many avenues for financing it that neither disadvantage policyholders nor jeopardize their competitive standing, and they are accustomed to financing community benefit as a component of their business. In Massachusetts, one plan mentioned the value of the "level playing field" in Massachusetts that results from the state having developed clear guidelines for nonprofit health plan community benefit and standard public reporting.

In summary, possibly the clearest themes that emerged from our investigation of these insurers is the fundamental importance of developing both a clear and uncompromising commitment to community benefit, and an open and cooperative relationship with the community to identify needs and opportunities. An ongoing dialog with the community is itself an essential element of success. In each health plan, key informants emphasized that it is essential to cultivate an active relationship with the community in order to understand where additional resources might have real impact—and equally important to communicate clearly how the plan has chosen to target its resources, the amount of resources it will expend, and the results that it expects to achieve.

III. GHMSI'S FINANCIAL CAPACITY FOR COMMUNITY BENEFIT

A. INTRODUCTION AND METHODS

In a highly competitive market, the ability of insurers to undertake significant community benefit and remain financially sound is an important concern. As GHMSI is the dominant insurer in the national capital area, maintaining its solid financial position is perhaps of greater concern than it might be were it one of many very small insurers in the market. But GHMSI's size also raises legitimate public expectations about its role in the community and GHMSI's capacity to pursue significant community benefit may also be greater.

In this chapter, we attempt to balance these perspectives: we investigate GHMSI's financial performance in the national capital area, and estimate its financial capacity to undertake substantial community benefit, well beyond the magnitude of its current investment. The analysis is presented in three sections. First, we describe GHMSI's position in its market area in substantial detail—both in the national capital area overall and separately in each jurisdiction that GHMSI serves (the District of Columbia, suburban Maryland, and Northern Virginia). We also consider the distribution of GHMSI's total business by major line: participation in the Federal Employees Health Benefit Program (FEHBP)—nearly all of which is attributed to the District as the source of federal employment—and its non-FEHBP business, including private group and individual coverage, and various other types of coverage with lower enrollment (for example, Medicare supplement).

In the second section, we assess the extent of competition in the national capital area from an economic perspective. In perfectly competitive markets, all sellers are price takers—that is, none have the capacity to price differently from the other. But in more concentrated markets, sellers are able to differentiate both products and pricing. We investigate the extent to which GHMSI demonstrates the price-setting behavior that is indicative of market power. We conclude that GHMSI does have such power, and that GHMSI's pricing behavior indicates an ability to initiate community benefit unilaterally, even in a market that GHMSI itself may perceive to be very competitive.

In the final section, we develop a simple simulation of GHMSI's financial situation, were it to undertake significant expenditure to support community benefit over the next several years. Any simulation of this type requires recognition of the underwriting cycle—a cyclical pattern of gains and losses that insurers experience locally and nationally. Based on a general industry consensus about the duration and amplitude of underwriting cycles, we project the current cycle to 2008, its likely lowest point. We then use alternative scenarios of community benefit expenditures to simulate the impact on GHMSI's projected financial condition.

Our analysis is based on financial reports from the major insurance carriers writing coverage in the District of Columbia, Maryland, and Virginia. We analyzed 2001 National Association of Insurance Commissioners (NAIC) data to select the largest insurers in each jurisdiction. We then contacted the District of Columbia Department of Insurance, Securities and Banking; the Virginia Bureau of Insurance; and the Maryland Insurance Administration to confirm that these carriers accounted for the largest part of the market in each area. Each jurisdiction provided to us the

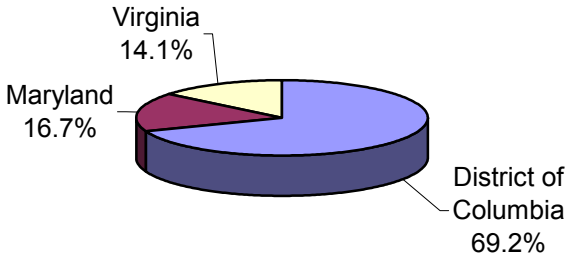
financial information that every carrier filed annually, as was available from 1998 through 2003.[32] Because GHMSI serves only Montgomery and Prince George's counties in Maryland and Alexandria, Arlington, Fairfax, and Prince William counties in Virginia, we allocated other carriers' state-level data to counties as needed to support comparison with GHMSI in those counties.[33]

B. GHMSI'S BUSINESS AND MARKET

1. Market Position

In 2003, GHMSI earned $1.89 billion in health insurance premiums. In 2003, nearly 70 percent of its premiums—$1.3 billion—were earned in the District of Columbia (Figure 1). GHMSI's business in Maryland ($316 million) exceeded that in Virginia ($267 million) in 2003. GHMSI's business in Maryland and Virginia respectively accounted for 17 percent and 14 percent of the company's total earned premiums in the national capital area.

Figure 1. Distribution of GHMSI's Earned Premiums by State, 2003



2. Lines of Business

GHMSI is the largest FEHBP insurer in the national capital area, and FEHBP represents the largest share of GHMSI's business. In 2003, FEHBP accounted for 57 percent of GHMSI's earned premiums (Figure 2). All of this business was associated with FEHBP nominally written in the

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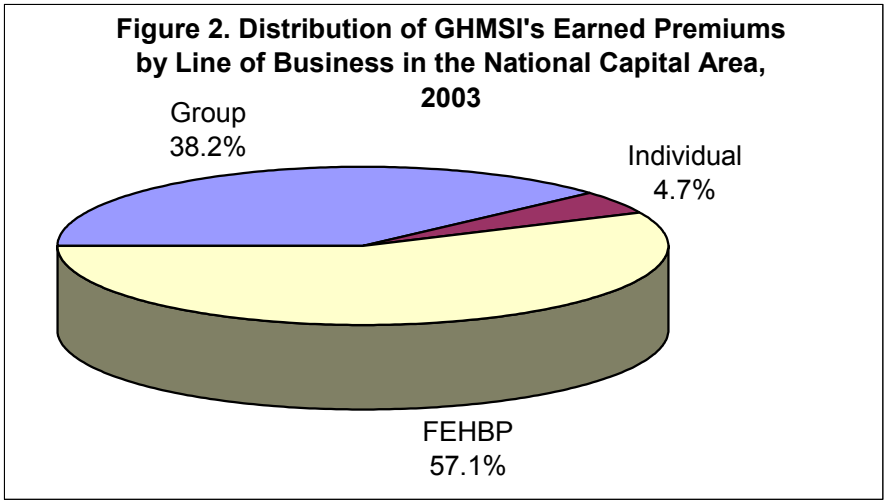
[32] The NAIC filing format differs by type of insurer and among years for each type of insurer. We attempted to use reported items that were defined consistently among years and companies, and calculated values as necessary to maintain consistent definitions. The District, Maryland, and Virginia have very different capacity for housing reported information; the number of years and companies that we obtained from each state varied. The analysis was designed to accommodate these complexities.

[33] For HMOs, state-level reported data were allocated to counties by enrollment (as reported in *InterStudy Competitive Edge—HMO Directory 2003*). State-level data for all other carriers were allocated to counties in proportion to the total population in the state. The final database included 1998-2003 observations of 41 insurers writing coverage in the District, and 2000-2003 observations of 18 insurers each in Maryland and Virginia. The insurers included in each jurisdiction are listed in Appendix C.

District of Columbia, although many of GHMSI's FEHBP policyholders reside in Maryland or Virginia.

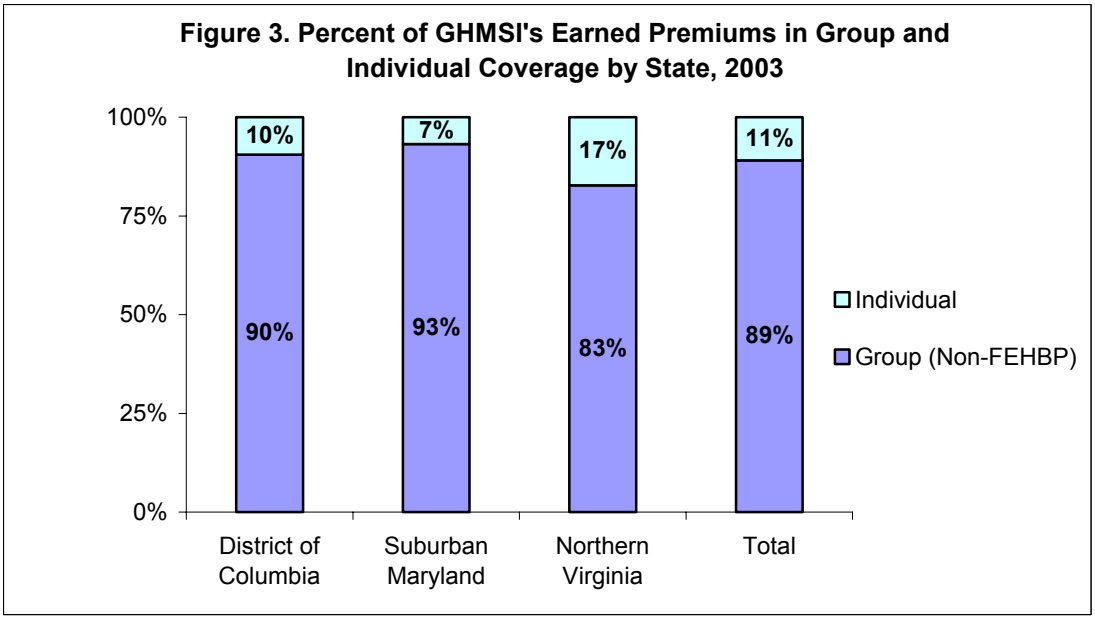
About 38 percent of GHMSI's earned premiums in 2003 were associated with group coverage other than FEHBP. Much, although not all, of this business is probably associated with small- and moderate-sized employer groups. Less than 5 percent of GHMSI's total business is associated with individual enrollment.



In the District and in Northern Virginia, GHMSI (or CareFirst) is the carrier of last resort in the individual market. In this capacity, GHMSI must periodically offer open enrollment without underwriting.[34] In 2003, individual coverage accounted for about 10 percent of GHMSI's non-FEHBP earned premiums in the District and 17 percent of non-FEHBP premiums in Northern Virginia (Figure 3). In Maryland, where a state-operated high-risk pool accepts uninsurable individuals, GHMSI's individual business accounted for just 7 percent of earned premiums.

GHMSI also writes various smaller products, including Medicare supplement, dental coverage, and others. The premium volume for these products is relatively small; it is included in totals for GHMSI and the other carriers described here, but not presented separately.

[34] Other carriers may deny coverage to new applicants at any time (although all must renew coverage once it is first issued) or offer coverage that is priced according to health status and may permanently exclude coverage for specific conditions or body systems. When not in an open enrollment period GHMSI and CareFirst also may deny coverage, offer substandard coverage, or rate up for health status. Open enrollment policies cannot permanently exclude coverage for specific conditions or body systems, but they are much more expensive than underwritten coverage.

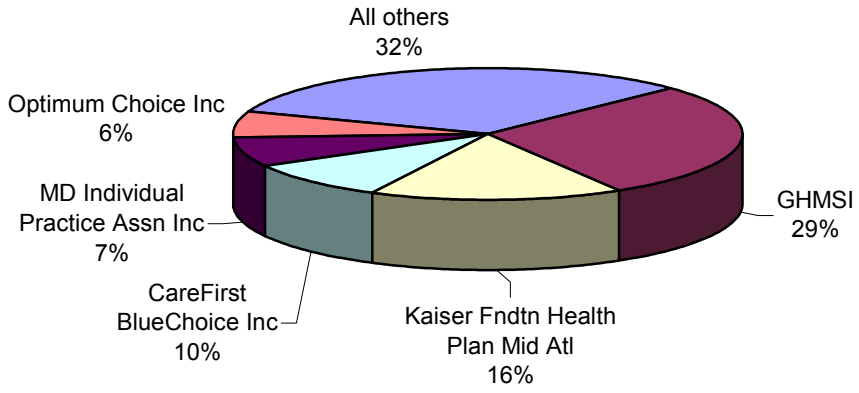


3. Major Competitors

Because insurers are fundamentally financial intermediaries, earned premium is in general considered a good measure of their size and also their market share. With $1.9 billion in earned premiums, GHMSI is the largest insurer in the national capital area, holding 29 percent of the combined FEHBP, other group, and individual markets in 2003 (Figure 4). With its for-profit affiliate—CareFirst Blue Choice—CareFirst accounted for nearly 40 percent of the combined market in the national capital area. The mid-Atlantic region of the Kaiser Foundation Health Plan (Kaiser) is GHMSI's largest competitor in the national capital area, but it is only about half GHMSI's size in the combined market. In 2003, Kaiser earned less than $1.1 billion in premiums and held about 16 percent of the area health insurance market.

In the District, GHMSI is the largest FEHBP insurer as well as the largest non-FEHBP insurer. With $1.3 billion earned premiums, GHMSI held approximately 42 percent of the District's combined health insurance market in 2003. The District's non-FEHBP market (including other group coverage and individual coverage) is less concentrated, with smaller insurers taking somewhat larger market share. Nevertheless, GHMSI also holds nearly a quarter of this market (23 percent) (Figure 5).

Figure 4. Distribution of Earned Premiums Among Major Insurers in the National Capital Area, 2003



Kaiser is GHMSI's largest competitor in the District, as it is regionally. But Kaiser is about half the size of GHMSI, accounting for 19 percent of the District's health insurance market in 2003 (Figure 5). Kaiser is a somewhat closer competitor in the non-FEHBP group and individual markets in the District (holding 18 percent, compared to GHMSI's 23 percent). The District's largest for-profit carrier, Optimum Choice, holds 15 percent of the nonFEHBP market in the District, but does not participate in FEHBP. [35]

In suburban Maryland, GHMSI holds a much smaller share of the market (15 percent) than in the District (Figure 6). Again, Kaiser is the closest competitor to any of the CareFirst companies in Maryland—but it is smaller than each of them. Kaiser held an estimated 10 percent of suburban Maryland's total health insurance market and 11 percent of the non-FEHBP market in 2003.

GHMSI also is the largest insurer in Northern Virginia, although it competes more closely with the second largest insurer—Kaiser—than in either the District or suburban Maryland (Figure 7). In Northern Virginia, GHMSI and Kaiser each hold an estimated 19 percent of the total health insurance market and 20 percent of the non-FEHBP market. HealthKeepers is the closest competitor to GHMSI and Kaiser in Northern Virginia, but it is about half their size, holding an estimated 11 percent of the market in 2003.

[35] All other insurers—including Aetna, MAMSI, and United Healthcare—each held less than 5 percent of the market in GHMSI's market area in 2003. In Maryland, including territory outside of GHMSI's market area, these competitors held slightly greater market share—together, about 18 percent of the market in 2003.

Figure 5. Health Insurer Market Shares in the District of Columbia, 2003: Total and Non-FEHBP (Percent of Premiums)

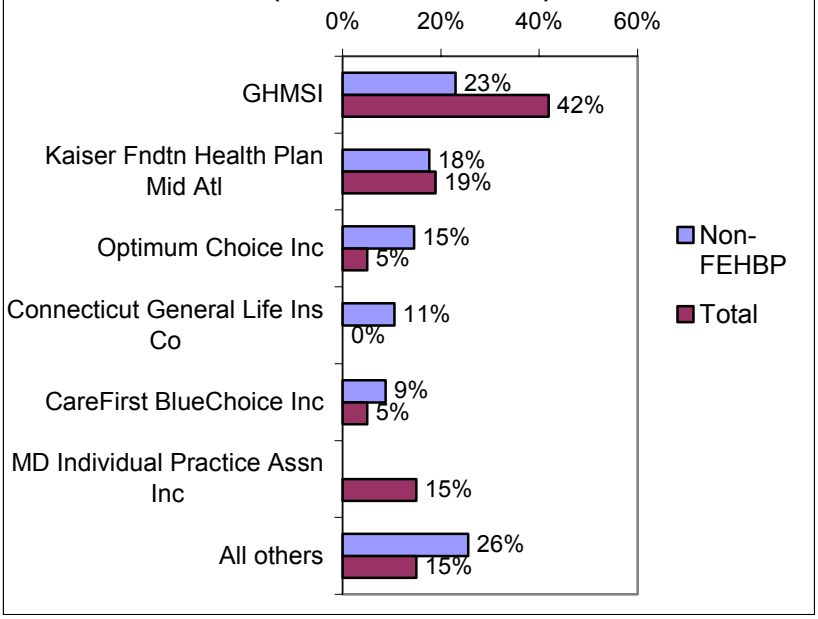
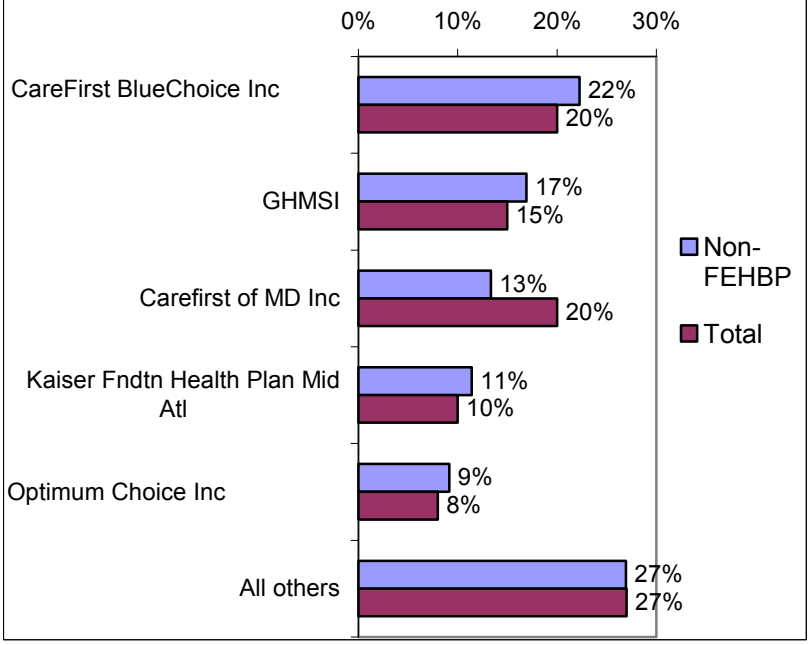
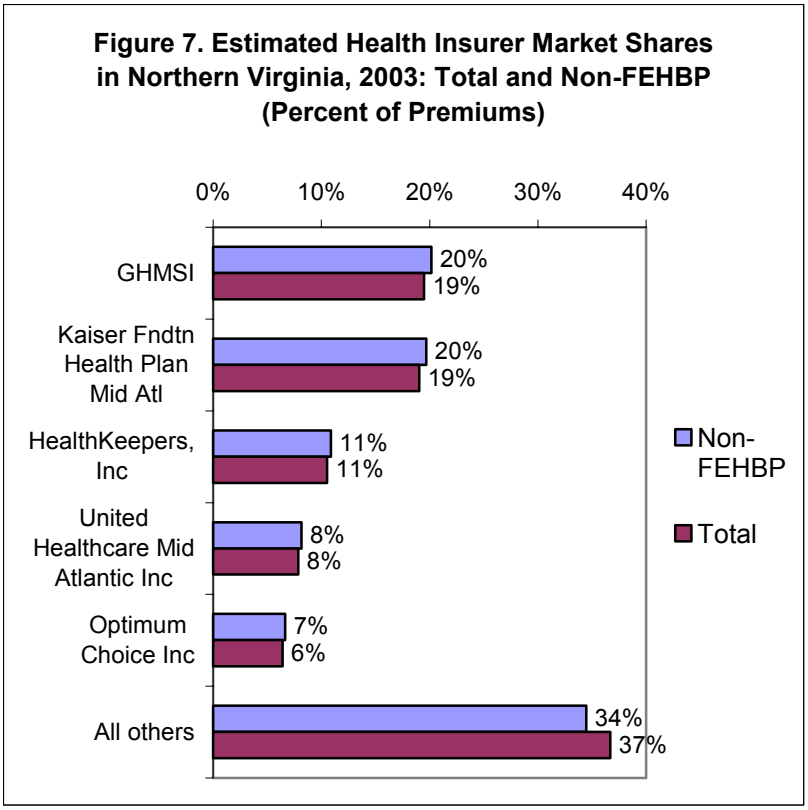


Figure 6. Estimated Health Insurer Market Shares in Suburban Maryland, 2003: Total and Non-FEHBP (Percent of Premiums)





4. Changes in GHMSI's Earned Premiums and Market Position

Since 1999, GHMSI's earned premium revenue has grown steadily, at an average rate of 15 percent per year. The rate of growth in GHMSI's earned premium has ranged from 20 percent in 2000 to 10 percent in 2003—but it has been significant in each year.

GHMSI's earned premium revenue has grown much faster in suburban Maryland and Northern Virginia than in the District. From 1999 to 2003, GHMSI more than doubled its premium revenue in suburban Maryland—growing at an average rate of 40 percent per year, compared to 27 percent in Northern Virginia and 10 percent in the District (Table 1).

TABLE 1

GHMSI'S EARNED PREMIUMS: TOTAL AND DISTRIBUTION BY STATE, 1999-2003

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Total earned premiums, 2003 ($millions)	$1,891.2	$1,308.7	$315.7	$266.8
Average annual rate of growth, 1999-2003	14.6%	9.6%	40.0%	27.0%
Percent of GHMSI's market:				
1999	100.0%	82.8%	7.6%	9.5%
2001	100.0%	73.9%	12.8%	13.3%
2003	100.0%	69.2%	16.7%	14.1%
Non-FEHBP earned premiums, 2003 ($millions)	$788.6	$239.9	$297.9	$250.7
Average annual rate of growth, 2001-2003	21.0%	17.2%	29.1%	16.4%
Percent of GHMSI's market:				
2001	100.0%	32.5%	33.1%	34.4%
2003	100.0%	30.4%	37.8%	31.8%

Source: MPR analysis of data provided by the District of Columbia, Maryland, and Virginia.

Note: Premiums earned in suburban Maryland and Northern Virginia are estimated from state-level data. FEHBP premiums were reported separately in 2001-2003, but not in earlier years.

The very fast growth of GHMSI's business in Maryland is consistent with a significant increase in its non-FEHBP business in Maryland, at least in the later years for which GHMSI reported FEHBP premiums separately (2001-2003). During this time, GHMSI's non-FEHBP premium revenue increased at an average rate of 29 percent per year in Maryland. In the District and Virginia, non-FEHBP premium growth was slower, averaging 17 percent and 16 percent per year, respectively. Following five years of much slower growth of premium revenue, the District accounted for a smaller share of GHMSI's total earned premiums in 2003 than in 1999—dropping from 83 percent in 1999 to 69 percent in 2003.

The distribution of enrollment in GHMSI across the District, suburban Maryland, and Northern Virginia is similar to the distribution of earned premiums. In 2003, enrollment in the District accounted for 69 percent of GHMSI's total enrollment—reflecting the high proportion of FEHBP enrollment allocated to the District (Table 2). Non-FEHBP enrollment is more evenly distributed among jurisdictions: 37 percent is in suburban Maryland, 32 percent in Northern Virginia, and 30 percent in the District.

TABLE 2

GHMSI'S NUMBER OF MEMBERS: TOTAL AND DISTRIBUTION BY STATE, 2001-2003

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Total members, 2003 (thousands)	710.9	68.8%	17.7%	13.5%
Non-FEHBP members, 2003 (thousands)	256.8	30.1%	37.3%	32.6%

Source: MPR analysis of data provided by the District of Columbia, Maryland, and Virginia.

The overall distribution of GHMSI's business may continue to change. Although the numbers of enrollees in the District and Virginia are likely to remain significant, suburban Maryland's faster average rate of growth in enrollment from 2001 to 2003—with very little loss of non-FEHBP enrollees in 2003—suggests that suburban Maryland may account for a growing percentage of GHMSI's total business and members in future years.

Across GHMSI's market area, its business—in terms of both total premium revenue and total membership—has continued to grow, though its recent loss of non-FEHBP enrollment in the District and in Northern Virginia is striking. It seems apparent that much if not all of this loss has related to steep increases in average premiums in this segment of its business. Between 2002 and 2003, GHMSI increased its average premiums by 25 percent across the national capital area, from 23 percent in the District to more than 28 percent in suburban Maryland (Table 3). At the same time, non-FEHBP enrollment declined 11 percent in the District and nearly 12 percent in Northern Virginia (Table 4). In Maryland, GHMSI's non-FEHBP enrollment remained flat.

In markets that are as concentrated as those in the national capital area, fast premium growth creates a problem of affordability, with employers and individuals increasingly unable or unwilling to maintain coverage—resulting in growing numbers of uninsured. Fast premium growth may indicate a failure of competition to constrain prices. The following section addresses this issue.

TABLE 3

GHMSI'S EARNED PREMIUMS PER MEMBER
AND ANNUAL RATES OF GROWTH: 2001-2003[A]

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Total earned premiums per member, 2003	$2,660.2	$2,675.6	$2,509.9	$2,778.7
Annual rate of growth:				
2001-2002	8.5%	7.0%	10.0%	18.9%
2002-2003	15.7%	9.9%	34.2%	26.5%
Non-FEHBP earned premiums per member, 2003	$3,071.3	$3,105.1	$3,108.5	$2,997.4
Annual rate of growth:				
2001-2002	na[b]	na[b]	6.8%	20.7%
2002-2003	25.4%	22.9%	28.4%	24.4%

Source: MPR analysis of data provided by the District of Columbia, Maryland and Virginia.

[a] Information on the number of members is available only for 2001 and subsequent years.

[b] The number of members in the DC group market was misreported in 2001.

C. MARKET POWER

The concentration of a health insurance market among just a few insurers offers simple evidence that it is not perfectly competitive. However, this observation alone does not indicate the extent of market power that the largest insurers enjoy. In a perfectly competitive market, each firm would be a price taker; a seller would not survive if it set prices above those of its competitors. As a seller gains market power, it is able to set prices that are different—and higher—than other sellers in the market. In markets that are concentrated among a few sellers (a situation called oligopoly), the largest sellers will tend to move prices together; smaller sellers may "shadow price," or set rates near or just below that of the largest insurers and underwrite (deny or limit coverage) to achieve that price.

TABLE 4

ANNUAL RATES OF GROWTH IN GHMSI ENROLLMENT: 2001-2003[A]

	Total	District of Columbia	Suburban Maryland	Northern Virginia
Rate of growth in total enrollment:				
2001-2002	5.0%	2.8%	17.4%	2.1%
2002-2003	-5.0%	-2.9%	-5.7%	-13.6%
2001-2003 average	0.0%	-0.1%	5.8%	-5.8%
Rate of growth in non-FEHBP enrollment:				
2001-2002	na[b]	na[b]	22.3%	2.1%
2002-2003	-7.7%	-10.9%	-0.6%	-11.9%
2001-2003 average	na[b]	na[b]	10.8%	-4.9%

Source: MPR analysis of data provided by the District of Columbia, Maryland, and Virginia.

[a] Information on the number of members is available only for 2001 and subsequent years.

[b] The number of members in the DC group market was misreported in 2001.

Health insurance markets typically do not fit the conventional model of competition. They typically are concentrated. In addition, insurers vary their products in complex ways—with different cost sharing provisions, benefit coverage, drug formularies, and provider networks. These practices make comparison of prices very difficult for consumers. Given the complexity of the product, consumers often lean heavily on the insurer's reputation and perceived experience, reinforcing the market power of larger and established insurers.

From an economist's perspective, the price of insurance is measured not as the observed price that consumers pay, but the difference between the average premium paid and the average medical benefit received. Risk aversion determines the economic price that consumers are willing to pay. Groups or individuals who are risk-neutral would remain uninsured if the premium exceeded the expected benefit—that is, if the economic price were non-zero. Risk-averse consumers are willing to pay a higher economic price, which covers the insurer's administrative cost and contributes to surplus (or unobligated funds). All else being equal, we expect that insurers with market power are able to charge higher economic prices to risk-averse consumers, and systematically do so.

1. Understanding Insurer Pricing

Rising economic prices may indicate two characteristics of the market. For an individual insurer, increases in the economic price of insurance suggest growing market power. However, when all insurers increase (or decrease) economic prices, it more likely indicates the progress of an underwriting cycle.

Since the 1960s, when data to measure insurers' financial status became available, the health insurance industry has exhibited a repeating pattern of underwriting gains (positive premium revenues net of claims cost and administrative expense) in several years followed by several years of

underwriting losses (negative net premium revenues). Called an underwriting cycle, this phenomenon is driven by both forecasting error—especially in anticipating medical costs—and imperfect competition.[36]

For decades, the underwriting cycle followed a very consistent pattern: three years of gains followed by three years of losses. During the 1990s, however, the cycle apparently lengthened and its amplitude declined, reducing differences between the cycle's top and bottom. This change generally has been attributed to the introduction of managed care, but it may also relate to the growing concentration of health insurance markets and, therefore, greater market power exerted by the largest insurers. In either case, industry experts expect underwriting cycles to be still more muted in the current decade.

Since 1998, GHMSI's aggregate economic price (total premiums earned minus medical claims incurred) has risen as a percent of premiums—from 8.6 percent to 11.4 percent, reaching as high as 15.5 percent in 2000 (Table 5).[37] [38] Moreover, GHMSI's economic price is three to five times as high as that of its nearest competitor, Kaiser. Optimum Choice—a for-profit company that has been gaining market share quickly—shows an economic price that is steadily approaching GHMSI's, suggesting that it may be shadow pricing GHMSI as it gains market share.

It is notable that GHMSI's economic price for its non-FEHBP business is much higher than that for its total business, and it is growing much faster. This pattern suggests that GHMSI may be pricing more competitively in the FEHBP program than the general market—behavior that is unsurprising given FEHBP's efforts to structure a price-competitive market for federal employees. Indeed, there is no reason to expect that FEHBP carriers would *not* set prices higher in the general market, where there is less consumer information available to support true competition. In contrast, Kaiser—a smaller but significant FEHBP carrier—sets economic prices for FEHBP and non-FEHBP enrollees at about the same level in the national capital area.

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[36] The dynamic of an underwriting cycle is as follows: In periods of underwriting gain, some insurers may seek to gain market share by reducing prices. In a competitive market, other insurers will follow suit to protect their market share, causing a general reduction in economic prices that for many may generate underwriting losses. Economic prices will continue to decline until a lead insurer (with market power) increases economic prices to restore at least "break even" revenues. As other insurers follow suit, economic prices will rise—and will continue to rise as insurers take underwriting gains as compensation for the "bad years." At some point, the cycle will repeat, as one or more insurers attempts to gain market share at the top of the cycle. Because health care costs may be rising throughout the cycle, consumers typically experience these cycles as accelerations or reductions in the rate of increase in the observed price of health insurance.

[37] This measure is equal to one minus the insurer's medical loss ratio. A loss ratio is defined as the insurer's total medical losses divided by its premium revenues.

[38] In order to capture companies' pricing behavior with more precision, state-level premium and claims data are used for this analysis, not the county-level estimates reported earlier.

TABLE 5

ECONOMIC PRICE AS PERCENT OF PREMIUMS EARNED IN THE DISTRICT, MARYLAND, AND VIRGINIA: TOTAL AND NON-FEHBP PREMIUMS OF SELECTED MAJOR INSURERS, 1998-2003

	GHMSI		Kaiser		Optimum Choice	
	Total	Non-FEHBP	Total	Non-FEHBP	Total	Non-FEHBP[a]
1998	8.6%	na	Na	na	na	na
1999	11.1%	na	Na	na	na	na
2000	15.5%	na	3. 9%	3.9%	8.4%	8.4%
2001	10.0%	17.7%	0.2%	-0.8%	9.1%	9.1%
2002	10.3%	16.4%	2.6%	1.8%	9.6%	9.6%
2003	11.4%	18.9%	3.0%	3.0%	13.4%	13.4%

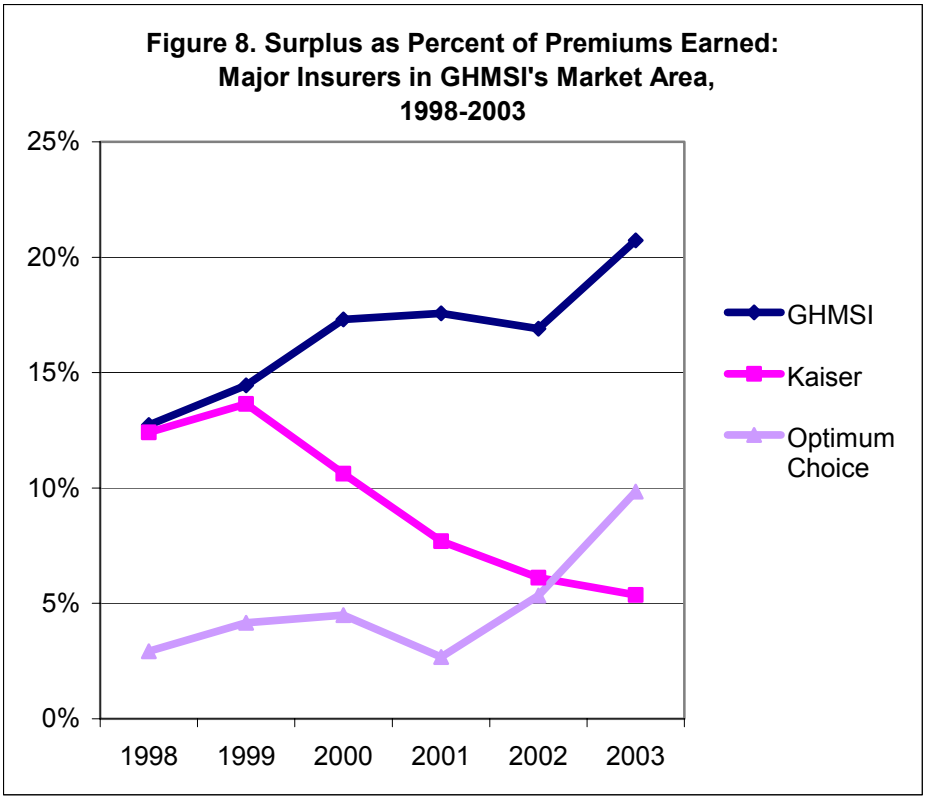
Source: MPR analysis of data obtained from DC, Maryland, and Virginia.

[a]Because Optimum Choice has very little FEHBP business, estimates of total and non-FEHBP prices are the same.

2. Insurer Surplus

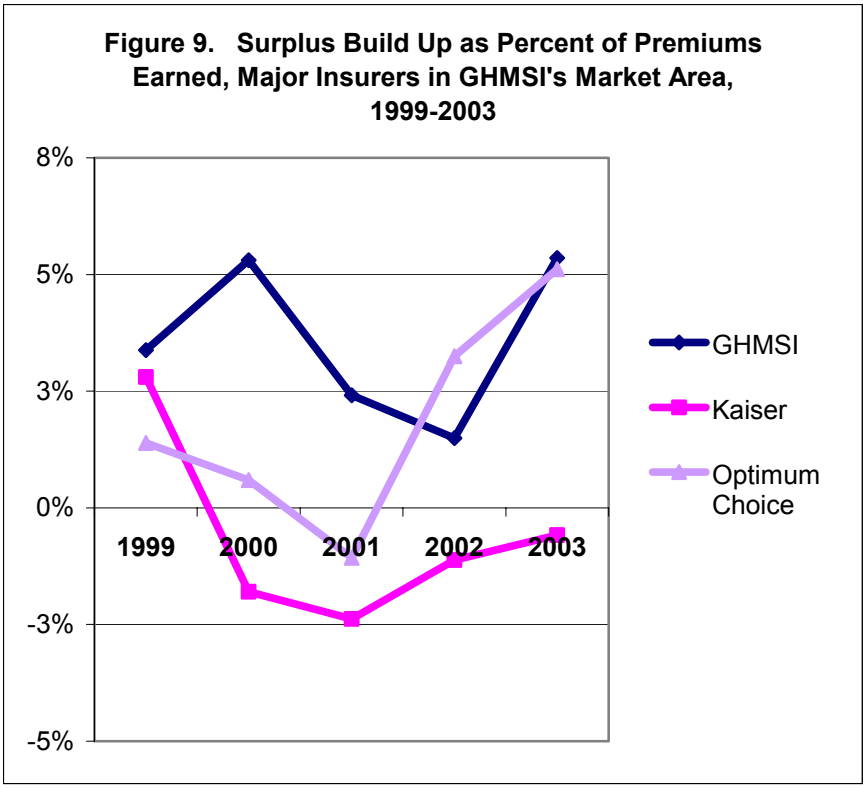
To understand GHMSI's higher economic pricing, it is instructive to look at a major component of its price: unassigned funds, or surplus. An insurer's surplus is its "capital on hand" after all liabilities have been deducted from assets. Insurers create surplus over time, as accumulated annual underwriting gains and losses. In 2003, GHSMI held $392 million in surplus, equal to 21 percent of premiums (Figure 8).

GHMSI's high levels of surplus suggests that its pricing is consistent with market power—that is, GHMSI is not setting the lowest possible price as would occur in a competitive market. Indeed, its level of surplus relative to premium far exceeds that of both Kaiser and Optimum Choice. While Kaiser's surplus as a percent of premium was also about 13 percent in 1998, it has declined continuously since then. In 2003, Kaiser held a surplus of approximate $70 million—just 5 percent of earned premiums. Optimum Choice's surplus as a share of premiums is higher than Kaiser's but it has been consistently lower than GHMSI's.



The change in surplus from the prior year is a measure of the addition to current-year economic prices associated with the current-year build-up of surplus. From 1998 to 2003, GHMSI increased the level of its surplus continuously (not shown), at an average rate of 27 percent each year. GHMSI's surplus build-up raised its premiums by an average of 3.6 percent each year during this period—accounting for 26 percent of the total increase in premiums between 1998 and 2003 (Figure 9). In 2000—when GHMSI priced very high relative to medical cost—the addition to surplus accounted for more than 5 percent of earned premiums and fully half of the increase in premiums from 1999.

In contrast, Kaiser's addition to surplus has been negative and decreasing since 1999, although it has attempted to regain surplus since 2001. In effect, Kaiser "gave back" to enrollees about 1 percent of premiums in the form of surplus reduction in 2003. Optimum Choice also has built substantial surplus since 2001, generally increasing surplus in tandem with GHMSI. Like GHMSI, its addition to surplus accounted for about 5 percent of earned premiums in 2003.



3. Surplus Relative to Regulatory Standards

Insurers measure the capital they hold in terms of the risk associated with its investment. Each insurer reports two risk-based capital measures: total adjusted risk-based capital (TAC) and authorized control level (ACL) risk-based capital. Developed by the National Association of Insurance Commissioners (NAIC), the risk-based capital formula establishes a measure of surplus for every insurer that adjusts for the risk inherent in its contractual obligations and asset portfolio; the calculation of risk-based capital is the same for nonprofit and for-profit companies.[39]

Insurance commissioners use risk-based capital measures to gauge an insurer's financial condition and risk of insolvency. When an insurer's TAC falls to 200 percent of ACL risk-based capital (called the "company action level"), the insurance department typically intervenes to place the insurer under regulatory control as a precaution against insolvency. Most companies maintain their TAC above this level.

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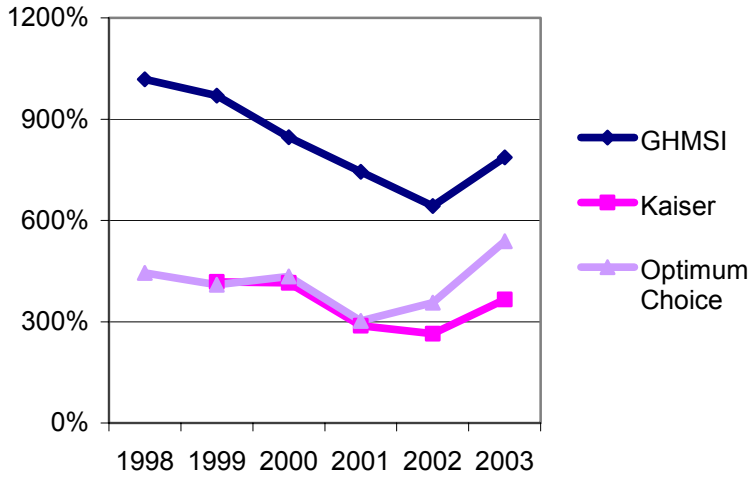
[39] For health companies, TAC is usually equal to reported surplus plus other types of capital held. This typically includes capital stock if the insurer is a stock company, as well as surplus notes (that is, capital contributed by a parent corporation that may be repaid upon notification of the regulatory authority). Commercial (life) companies use a more complicated formula to calculate risk-based capital, but their TAC is usually also greater than reported surplus.

The Blue Cross Blue Shield Association (BCBSA) has its own risk-based capital requirements for Blue Cross plans. BCBSA requires companies using its name to maintain risk-based capital equal to at least 375 percent of the ACL level, compared to NAIC's 200-percent "action" level (Serota 2004).

Whatever the reason, GHMSI's TAC is significantly higher than its non-Blues competitors, but it is also much higher than 375 percent of ACL risk-based capital. Between 1998 and 2003, GHMSI's TAC ranged from 1,018 percent to 643 percent of ACL risk-based capital, averaging 835 percent over the six-year period (Figure 10). This is twice the average that either Kaiser or Optimum Choice maintained over the same period. Both Kaiser and Optimum Choice averaged a TAC level at about 400 percent of ACL, although Optimum Choice's TAC accelerated to 538 percent of ACL in 2003.[40]

[40] CareFirst has suggested that an appropriate measure of surplus would be surplus per enrollee, and that by this measure, GHMSI's total reserves average out to $405 per member—"less than the cost of one visit to a hospital emergency room." While evocative, this approach to measuring the adequacy of insurer surplus is unique: the literature never assesses surplus adequacy by this kind of measure. Moreover, no regulatory authority proposed such a standard, nor does recent correspondence from the Blue Cross and Blue Shied Association (BCBSA) to the Insurance Commissioner of Pennsylvania on this topic (Serota 2004).. Such a standard would imply that GHMSI's current high surplus–and also that of all other insurers–should be maintained or even increased as a precaution against all subscribers using a hospital emergency room visit in the same year or events that GHMSI officials also have mentioned to explain need for high surplus—an extraordinarily severe flu season or major terrorist attack. . It further would imply that GHMSI could not responsibly use its surplus for any reason other than for medical expense, although it apparently does intend to use substantial surplus for other purposes such as capital investments, new product development, and information technology improvements.

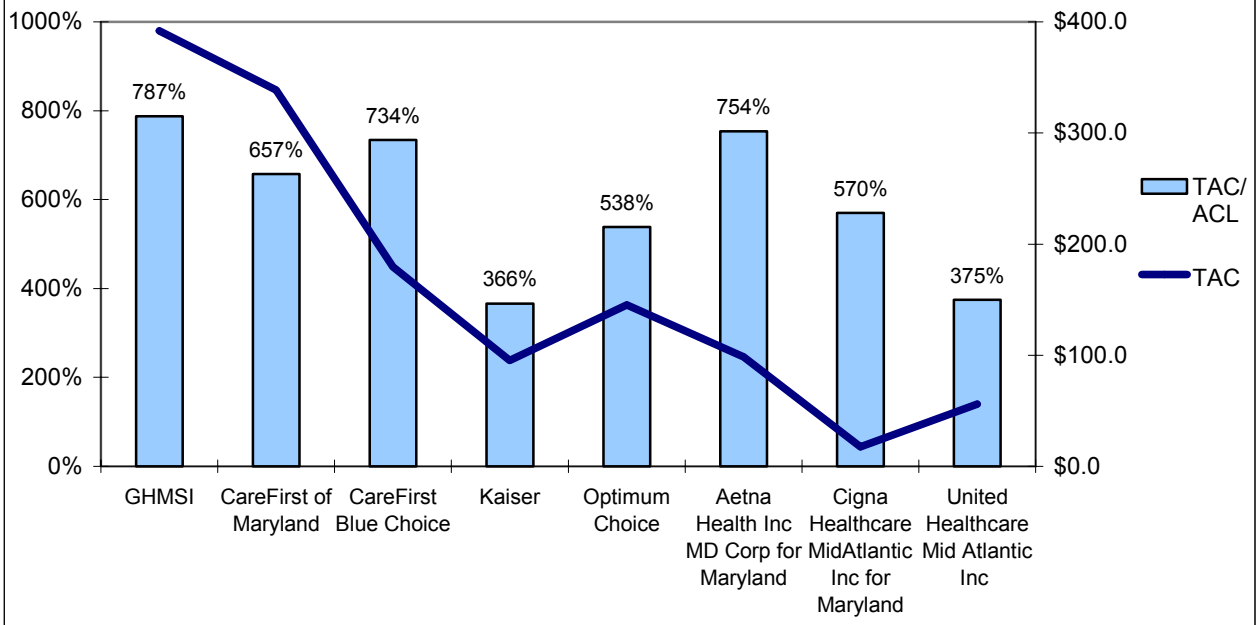
Figure 10. Total Adjusted Capital as Percent of Authorized Control Level Risk-Based Capital: Selected Major Insurers 1998-2003



In 2003, GHMSI's TAC relative to ACL also exceeded that of the other large CareFirst companies and CareFirst's primary commercial competitors in Maryland (Figure 11). Only Aetna—with a much smaller share of the market than GHMSI—held about the same TAC relative to ACL as GHMSI or other CareFirst companies.[41]

[41] Like the CareFirst affiliated companies, companies with a national affiliation or parent company—such as Aetna and United Healthcare—may move capital between the company and its affiliate or parent in the form of either donated capital or a "surplus note." While either is unusual, surplus notes are more customary among companies with national affiliation. A surplus note represents an obligation to repay, but is repayable only upon notification of the regulatory authority.

Figure 11. Total Adjusted Risk-Based Capital (TAC in $millions) and TAC per Authorized Control Level (ACL) Risk Based Capital: GHMSI, Other CareFirst Companies, and Selected Insurers in CareFirst's Market Area, 2003



In summary, compared to normal regulatory measures and the practices of its competitors, GHMSI has substantially higher surplus that it might draw down for community benefit. The difference between GHMSI's level of TAC and 400 percent of ACL—approximately the average among GHMSI's major competitors—was $193 million in 2003.

4. Statistical Analysis of Market Power

To measure the effect of market power on economic prices in the national capital area, we modeled insurers' economic prices as a function of a series of company-level explanatory variables. The model controlled for the time period of the observation (a proxy for the underwriting cycle) and other factors that may affect economic prices, including TAC levels relative to ACL. Insurer size was included to gauge market power. We estimated a simple clustered linear regression model using company-level data, pooling all major insurers in the national capital area from 1999 to 2003. The specification of the model and statistical results are summarized in Appendix D.

To the extent that the market is competitive (and insurers are price takers), we hypothesized that differences in company operations would not influence economic prices significantly. However, the results of this analysis offer strong statistical evidence that large insurers in the District, Maryland, and Virginia charge higher economic prices than mid-sized insurers. But the smallest insurers also charge higher economic prices (even controlling for differences in administrative cost), shadow-pricing the area's largest insurers.

As the largest insurer in the national capital area, GHMSI exerts substantial market power, and its economic prices are higher. Specifically, we estimate that market power accounted for $13.8 billion of GHMSI's economic prices between 1998 and 2003 (relative to Kaiser)—averaging 2.1 percent of earned premium per year. GHMSI's use of market power probably also raised the level of prices that smaller insurers charged as they shadow-priced GHMSI's products.[42]

D. FEASIBILITY OF GHMSI'S PROVIDING GREATER COMMUNITY BENEFIT

In this section, we offer a simple simulation to measure the financial impact on GHMSI of undertaking substantially greater expenditures for community benefit. In order to make reasonable projections of any insurer's financial performance, it is necessary first to project the underwriting cycle in order to understand how the market environment—and the insurer's surplus from which additional expenditure would be financed—is likely to change. Since at least 2000, the insurance industry has been on the rising side of the underwriting cycle, but it seems likely that 2003 will be the last year of expansion; in 2004 and at least through 2007, the premiums are likely to increase at a rate much closer to the rate of increase in medical costs as the industry moves into the down-side of the underwriting cycle.[43]

Figure 12. GHMSI's Economic Price and Surplus Build Up as a Percent of Earned Premiums: 1998-2008 (projected)

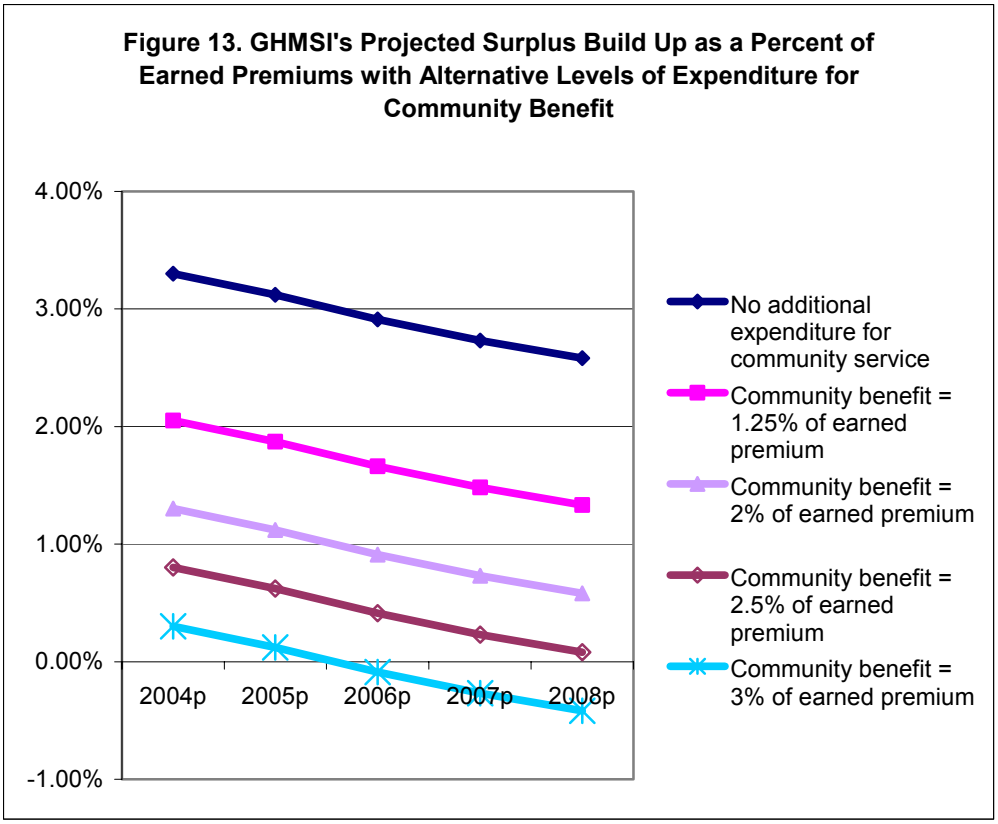
[42] In addition, we find that insurers with greater FEHBP business appear to charge lower economic prices in that segment of their market, consistent with significantly greater competition in the FEHBP market—and therefore charge lower economic prices overall. However, both for-profit insurers and insurers in Virginia charge significantly higher economic prices (relative to Maryland insurers), all else being equal. Insurers in the District appear to price similarly to those in Maryland.

[43] General industry trends are reported in CMS 2003).

We used the trajectory of the last underwriting cycle to project the probable length and depth of current underwriting cycle. This method is consistent with all available economic and industry literature about the current stage of the underwriting cycle, but may project a lower position in 2008 than will occur, as the literature also suggests that future underwriting cycles may be shallower than those in the past. Specifically, we assumed that the low point of the current cycle will be 2008, and that GHMSI's economic price in 2008 will equal its economic price in 1998—about 8.6 percent of earned premium (Figure 12). This compares to a projected economic price of 12 percent of earned premium in 2004 and about 9.7 percent of earned premium in 2006. GHMSI's surplus build-up from 2004 to 2008 also is likely to slow.

To simulate the potential impact of GHMSI undertaking additional annual expenditures to support community benefit mission, we considered the range of other nonprofit plans' actual expenditures for community benefit (1.25 percent to 3 percent of premiums) as well as the margin on GHMSI's premiums associated with their market power (about 2 percent of premiums). We then calculated the potential impact of these levels of annual expenditure on GHMSI's financial position in terms of its impact on surplus build-up—in effect, assuming GHMSI's annual expenditure for community benefit would not be financed by raising observed prices, but by reducing their economic price and annual surplus build-up.

Figure 13. GHMSI's Projected Surplus Build Up as a Percent of Earned Premiums with Alternative Levels of Expenditure for Community Benefit

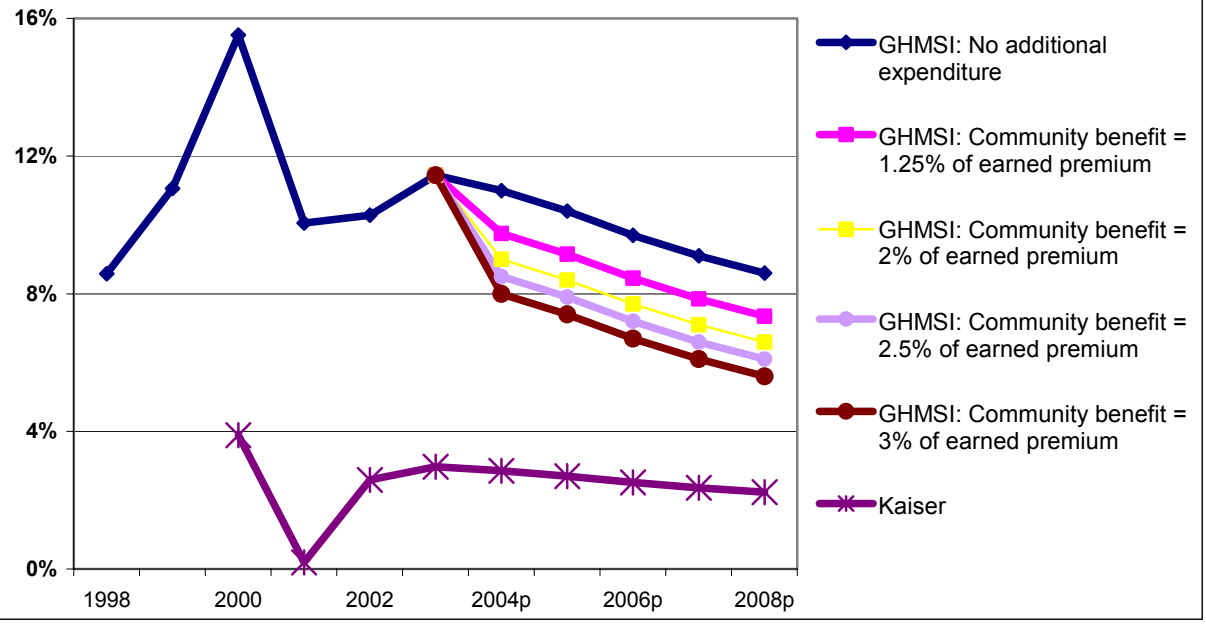


We estimate that, despite a downturn in the underwriting cycle, GHMSI is likely to have sufficient latitude within its current pricing structure to continue to accumulate surplus—even with higher levels of expenditure for community benefit. Projected surplus build-up in 2008 with no additional expenditure for community benefit exceeds 2.6 percent of earned premium (Figure 13). With additional community benefit expenditure equal to 2 percent of earned premiums, GHMSI's

projected surplus build-up in 2008 still would equal 0.6 percent of earned premiums. With an additional annual expenditure for community benefit of approximately 2.5 percent of earned premium, GHMSI would continue to build surplus until 2008 at a declining rate, and the ratio of surplus to current premiums would decline. Nevertheless, we estimate that in 2008—the likely low point in the underwriting cycle—GHMSI would maintain a level that far exceeds that of its competitors.

Our calculations indicate that GHMSI could finance additional community benefit within its current economic price, so that observed prices might rise due only to increases in medical benefits paid. In addition, because GHMSI's past and current expenditure for community benefit is reflected in its current and projected levels of surplus, all estimates are in effect measures of *additional* expenditure that GHMSI would make for community benefit.

Figure 14. GHMSI's Recent and Projected Economic Price as a Percent of Earned Premiums with Alternative Community Benefit Expenditures, and Comparison to Kaiser



GHMSI's projected economic price net of new expenditure for community benefit under alternative assumptions about expenditure for community benefit is reported in Figure 14. For purposes of comparison, we also project Kaiser's economic price using the same extrapolation methods described above.

Even with higher levels of expenditure for community benefit, GHMSI is projected to maintain much higher economic prices than Kaiser, net of the new expenditure. Assuming alternative levels of expenditure for community benefit, GHMSI's 2008 net economic price is projected to range from 5.6 percent to 7.4 percent of earned premium—compared with 2.2 percent for Kaiser. We conclude that devoting additional funding to community benefit in the range illustrated here would not affect GHMSI's competitive viability or financial soundness.

Finally, we extended our simulation analysis to project both the level of TAC as a percent of ACL risk-based capital that GHMSI might experience if it were to reduce its surplus build-up by spending greater amounts for community benefit, and the amount of community benefit that allocation of alternative percentages of earned premium might yield. We assume a baseline trajectory of surplus reduction on the downside of the underwriting cycle that mirrors GHMSI's surplus buildup from 1999 to 2003, as well as accelerated growth of ACL relative to premium. Our projection of ACL relative to premium proxies the arithmetic formula by which ACL is actually calculated and, we expect, overstates future ACL. As a result, our projected ratios of TAC to ACL probably are conservative.

Table 6 summarizes the results of the simulations with respect to projected TAC as a percent of ACL risk-based capital. The purpose of this exercise is not to project these relationships with precision, but rather to understand the general magnitudes and sensitivity of TAC relative to ACL that might occur, were GHMSI to retrace the same general financial path that it took from 1998 through 2003, with the underwriting cycle depressing total premium growth from 2004 through 2008.

TABLE 6

GHMSI'S PROJECTED TOTAL ADJUSTED RISK-BASED CAPITAL (TAC) AS A PERCENT OF PROJECTED AUTHORIZED CONTROL LEVEL (ACL) RISK-BASED CAPITAL WITH ALTERNATIVE ASSUMPTIONS ABOUT TOTAL PREMIUM GROWTH AND COMMUNITY BENEFIT EXPENDITURE: PROJECTED 2004 AND 2008

Additional annual community benefit expenditure as a percent of earned premium	Average Annual Growth in Total Premium:					
	8 percent		10 percent		15 percent	
	2004p	2008p	2004p	2008p	2004p	2008p
0 percent	823%	974%	836%	942%	794%	940%
2 percent	775%	681%	748%	580%	728%	516%
2.5 percent	756%	599%	729%	503%	710%	443%
3 percent	738%	518%	710%	427%	691%	371%

Note: Supporting detail is provided in Appendix E.

The results of this exercise indicate that GHMSI would continue to accumulate surplus, but at a declining rate (as shown earlier in Figure 14), if it did not make additional expenditures for community benefit. Within the premium growth rates that we modeled (averaging 8 to 15 percent per year), GHMSI would continue to have substantially higher levels of TAC relative to ACL compared to either the BCBS or NAIC "early warning" standard: from 794 percent to 823 percent in 2004, rising to 940 percent to 974 percent in 2008. Everything else being equal, GHMSI's TAC/ACL ratio is likely to be lower if its total premiums grew faster—in part because the simulation assumes that ACL will accelerate with faster premium growth, but also because GHMSI may be called upon to spread its accumulated surplus over a larger premium base.

If GHMSI makes additional expenditures for community benefit, it is likely still to achieve significant levels of surplus—without increasing observed prices net of increases in medical benefits paid. With an expenditure of 2 percent of premiums for community benefit, GHMSI might still hold surplus equal to 516 percent to 681 percent of ACL, depending on total premium growth.

Only with additional expenditures for community benefit equal to 3 percent of premium with 15 percent average annual premium growth through 2008 does it seem likely that GHMSI might need to raise its premiums to consumers to maintain the BCBS standard. However, even that relatively unlikely scenario produces a ratio of 371 percent—still substantially greater than the NAIC minimum for all insurers and approximately equal to the BCBS minimum.[44]

The degree to which GHMSI should approach these minimum amounts is, of course, a matter of GHMSI's legitimate needs for greater levels of surplus. However, it is notable that GHMSI now holds capital at a level that substantially exceeds that of its largest competitors (as well as its Maryland CareFirst affiliates), while its potentially most significant needs for capital on hand—to cope with unforeseen health expenditures or a fall in return to investments—are common to all insurers in the market.

Projected levels of GHMSI's annual expenditure for community benefit associated with the assumptions explored above are reported in Table 7. If it used a 2-percent of premium rule, GHMSI would spend $41 million for community benefit in 2004 (assuming low growth in total premiums) and as much as $44 million (assuming high premium growth from 2003 to 2004). Our projections indicate that expenditures in 2008 would likely be in the range of $56 million to $76 million, depending on average premium growth. With an additional annual commitment of 3 percent of premium, assuming moderate average annual growth of total premiums (10 percent), GHMSI might allocate an additional $100 million to community benefit by 2008 without increasing consumer premiums relative to baseline projections.

TABLE 7

GHMSI'S PROJECTED ADDITIONAL EXPENDITURE FOR COMMUNITY BENEFIT WITH ALTERNATIVE ASSUMPTIONS ABOUT TOTAL PREMIUM GROWTH AND COMMUNITY BENEFIT EXPENDITURE AS A PERCENT OF EARNED PREMIUM: PROJECTED 2004 AND 2008
($ millions)

Additional annual community benefit expenditure as a percent of earned premium	Average Annual Growth in Total Premium:					
	8 percent		10 percent		15 percent	
	2004p	2008p	2004p	2008p	2004p	2008p
2 percent	$40.8	$55.6	$42.4	$66.7	$43.5	$76.1
2.5 percent	$51.1	$69.5	$53.0	$83.3	$54.4	$95.1
3 percent	$61.3	$83.4	$63.5	$100.0	$65.2	$114.1

Note: Supporting detail is provided in Appendix E.

[44] In addition, we simulated the impacts on GHMSI's projected TAC relative to ACL, if it were to make substantial expenditure over the next several years for capital investment, new product development, and information technology improvements. CareFirst has suggested that the magnitude of its expected commitment of surplus for these purposes is $300 million over three years. Presuming that GHMSI's share of this commitment would be as much as half of the CareFirst total ($150 million), we projected GHMSI's TAC in 2008 to be approximately 410 percent of ACL, assuming 10 percent annual premium growth and an annual commitment of 2 percent of premium to community benefit. This is 9 percent higher than the 375 percent minimum that BCBSA requires.

E. SUMMARY AND DISCUSSION

Like many health insurance markets across the country, the national capital area's market is concentrated. In 2003, GHMSI accounted for 29 percent of the market, including its very large business as an FEHBP carrier in the region. Kaiser is GHMSI's nearest competitor, though only about half GHMSI's size. Taken together, Kaiser, MD IPA, and Optimum Choice hold about the same market share as GHMSI.

GHMSI is the largest insurer in the District, and a major insurer in Maryland and Virginia as well. Even excluding it substantial FEHBP business, GHMSI held nearly one-third of the market in the District and more than half of the market in suburban Maryland. GHMSI controls about 20 percent of the market in Northern Virginia.

Over the last five years (for which data were available), GHMSI's premium revenue has grown at an average rate of 15 percent per year. In both suburban Maryland and Northern Virginia, its premium growth has been much faster— respectively averaging 40 percent and 21 percent per year.

For non-FEHBP enrollees, average premiums have grown very fast, and enrollment has dropped. For non-FEHBP enrollees, average (per enrollee) premiums increased more than 25 percent from 2002 to 2003. Average premium increases ranged from 23 percent in the District to 28 percent in Maryland. At the same time, enrollment dropped 3 percent in the District, 6 percent in suburban Maryland, and nearly 14 percent in Northern Virginia. It is likely that at least some of those leaving GHMSI enrollment in response to steep premium increases became uninsured.

Both the concentration of the market among a few large insurers and GHMSI's very large market share offer simple evidence of a noncompetitive health insurance market, although size alone does not predict that an insurer will use its market power. GHMSI accumulated surplus at an average rate of 27 percent each year from 1998 to 2003. In 2003, GHMSI's accumulated surplus equaled 21 percent of premiums, nearly four times Kaiser's level of surplus relative to premiums. In 2003, GHMSI's surplus build-up accounted for about 6 percent of premiums, while Kaiser "gave back" to enrollees about 1 percent of premiums in the form of surplus reduction.

Much of GHMSI's surplus and surplus build-up may relate to BCBS plans' general practice of holding very high surplus relative to risk-based capital (a measure of an insurer's financial condition). However, between 1998 and 2003, GHMSI's average surplus relative to risk-based capital was more than four times the level that would indicate financial distress, more than twice that of its largest competitors, and twice the level that BCBSA requires of Blues licensees. While none of these measures is necessarily an adequate gauge of GHMSI's specific business and competitive needs for capital, GHMSI's relatively high surplus implies that that its competitors were able to offer lower consumer prices for coverage, provide more health care per premium dollar, or both.

Statistical analysis of insurer behavior in the District, Maryland, and Virginia, offers strong evidence that GHMSI does exercise market power in the national capital area. We estimate that GHMSI built nearly $14 billion into its economic prices between 1998 and 2003 due solely to its market power, equal to 2.1 percent of earned premium.

A simulation of the impact of greater expenditure for community benefit on GHMSI's financial position suggests that it is financially capable of providing greater community benefit. Even at the

likely low point of the underwriting cycle (in 2008), we estimate that GHMSI could allocate as much as 3 percent of premium to community benefit without adjusting observed prices net of medical benefits paid, and still maintain a ratio of total adjusted capital (TAC) relative to authorized control level (ACL) risk-based capital equal to 400 percent or more—approximately the 2003 industry average in GHMSI's market area (at the high point of the underwriting cycle), and above the BCBS minimum standard of 375 percent. An allocation of 3 percent of premium would yield an estimated $61 million for community benefit in 2004 assuming low premium growth (8 percent), and as much as $100 million in 2008, assuming intermediate annual growth in total premiums (10 percent).

However, given our very rough approximation of ACL risk-based capital (which accelerates with faster premium growth), allocating 3 percent of premiums to community benefit might cause observed prices to rise, if medical benefits and, therefore, total premiums rise very fast—in our simulation, 15 percent per year throughout the simulation period. While this high systematic rate of growth is unlikely, observation of its mechanical impact on GHMSI's need for surplus merely lends support to a more obvious point: any rule for allocating a percentage of premiums must be managed with flexibility. Nevertheless, it seems clear that GHMSI could allocate substantially more than it now does to community benefit, and a range of 2 to 3 percent of total premiums per year appears to be a feasible goal for this expenditure.

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APPENDIX A

QUALITATIVE METHODOLOGY

To learn more about the health care needs of the Washington, DC metropolitan area, we solicited input from directors and other leaders of local agencies, organizations, providers, and advocacy groups in the District of Columbia, northern Virginia (Alexandria and Arlingtonand Fairfax counties) and Maryland (Montgomery and Prince George's counties). We sought to collect information on current health conditions, access issues and health care quality, and related current initiatives and to obtain insights into priorities and potential new strategies.

We collected the information in three ways: a written survey e-mailed to selected area health leaders, a group meeting, and telephone and in-person interviews. The survey consisted of a letter to describe the project, followed by approximately 33 open-ended questions. The questions were organized into four categories: (1) health conditions and behaviors, (2) health care services, (3) quality of care and health insurance coverage, and (4) health care planning.

We distributed the survey twice, first in May 2004 and then in a follow-up in June 2004 to nonrespondents. We received five written responses from 43 individuals to whom we sent the survey, typically via email. We then invited the original sample of health leaders to a breakfast meeting to obtain responses in a semi-structured format. Eight attended that meeting, some of whom had previously completed the survey. To ensure sufficient representation from the District of Columbia, Virginia, and Maryland, we completed nine additional telephone and in-person interviews with area leaders who had not yet responded to the survey or attended the breakfast meeting. In all, we received survey responses or directly interviewed fourteen community leaders. We organized and analyzed the written survey responses, combined with extensive notes from the group meeting and individual interviews, for this summary report.

APPENDIX B

CALCULATION OF DISABILITY-ADJUSTED LIFE-YEARS

Washington, DC area estimates of disability-adjusted life-years (DALYs) were derived from national estimates, adapted to the District of Columbia Metropolitan Statistical Area (MSA) based on information from several sources. Metropolitan-area prevalence estimates for various conditions were obtained from the web sites and publications of Centers for Disease Control (the Behavioral Risk Factor Surveillance System, National Vital Statistics System, Centers for Disease Control HIV/AIDS Surveillance Report) and the Substance Abuse and Mental Health Services Administration (the National Household Survey on Drug Abuse). For some conditions, prevalence estimates for the national capital area were unavailable, and we tabulated the 2002 National Health Interview Survey to obtain national MSA estimates.

National DALY estimates were derived from a collaborative study of the Centers for Disease Control and the Harvard School of Public Health (see Table B-1). We adjusted U.S. average prevalence rates to DC metropolitan area rates to calculate Washington, DC MSA DALYs.

TABLE B.1

ESTIMATED DISABILITY ADJUSTED LIFE YEARS FOR U.S. POPULATION

	Men			Women		
Rank	Condition	DALYs	Percent of Total	Condition	DALYs	Percent of Total
	All conditions	18,314,401	100	All conditions	15,886,327	100
1	Ischemic heart disease	1,969,256	10.8	Ischemic heart disease	1,181,298	6.5
2	Road traffic conditions	933,953	5.1	Unipolar major depression	1,073,911	5.9
3	Lung, trachea, and bronchus cancers	812,675	4.4	Cerebrovascular disease	836,345	4.6
4	HIV/AIDS	773,640	4.2	Lung, trachea, and bronchus cancers	549,963	3.0
5	Alcohol abuse and dependence	736,572	4.0	Osteoarthritis	521,443	2.8
6	Cerebrovascular disease	673,877	3.7	Breast cancer	514,729	2.8
7	Homicide and violence	567,322	3.1	Chronic obstructive pulmonary disease	510,084	2.8
8	Chronic obstructive pulmonary disease	545,350	3.0	Dementia	506,858	2.8
9	Self-inflicted	541,640	3.0	Diabetes mellitus	500,932	2.7
10	Unipolar major depression	477,040	2.6	Road traffic conditions	459,489	2.5
11	Drug use	467,127	2.6	Alcohol abuse and dependence	414,792	2.3
12	Diabetes mellitus	459,247	2.5	Congenital abnormalities	351,553	1.9
13	Osteoarthritis	413,818	2.3	Asthma	270,559	1.5
14	Congenital abnormalities	410,390	2.2	Colon or rectum cancer	234,460	1.3

Source: Michaud, CM, CJL Murray, and CR Bloom, "Burden of Disease—Implications for Future Research," JAMA (285:5), February 7, 2001.

APPENDIX C

INSURERS INCLUDED IN ANALYSIS OF MARKET POWER

District of Columbia	Suburban Maryland	Northern Virginia
Aetna Health Inc MD Corp	Aetna Health Inc MD Corp for Maryland	Aetna Health Inc MD Corp
Aetna Life Ins Co for DC	Aetna Life Ins Co for Maryland	Aetna Life Insurance Co
American Natl Ins Co	CareFirst BlueChoice Inc for Maryland	CareFirst BlueChoice Inc
CareFirst BlueChoice Inc	Carefirst of MD Inc	Cigna Healthcare MidAtlantic Inc
Cigna Healthcare MidAtlantic Inc	Cigna Healthcare MidAtlantic Inc for Maryland	Group Hospitalization & Med Srvcs
Connecticut General Life Ins Co	Connecticut General Life Ins Co for Maryland	Guardian Life Insurance Co of America
Corporate Health Ins Co	Coventry Health Care Of DE Inc	HealthKeepers, Inc.
Coventry Health & Life Ins Co	Fidelity Ins Co	Kaiser Fndtn Health Plan Mid Atl
Delaware American Life Ins Co	FreeState Health Plan Inc	Mutual of Omaha Insurance Co
Fortis Benefits Ins Co	Group Hospitalization & Med Srvcs for Maryland	OneNation Insurance Company
Fortis Ins Co	Guardian Life Ins Co Of Amer for Maryland	Optimum Choice Inc
GE Grp Life Assur Co	Kaiser Fndtn Health Plan Mid Atl for Maryland	Peninsula Health Care, Inc.
George Washington Univ Health Plan	Mamsi Life And Health Ins Co for Maryland	Priority Health Care, Inc.
Golden Rule Ins Co	MD Individual Practice Assn Inc	Southern Health Services, Inc.
Graphic Arts Benefit Corp	Optimum Choice Inc for Maryland	Unicare Health Plan of Virginia
Great West Life & Annuity Ins Co	PHN Hmo Inc	UNICARE Life & Health Insurance Co
Group Hospitalization & Med Srvcs	Unicare Life & Health Ins Co for Maryland	United Healthcare Ins Co
Guardian Life Ins Co Of Amer	United Healthcare Ins Co for Maryland	United Healthcare Mid Atlantic Inc
Healthy Alliance Life Ins Co		
Humana Ins Co		
John Alden Life Ins Co		
Kaiser Fndtn Health Plan Mid Atl		
Mamsi Life And Health Ins Co		
MD Individual Practice Assn Inc		
Mega Life & Health Ins Co The		
Mid West Natl Life Ins Co Of TN		
Mutual Of Omaha Ins Co		
New York Life Ins Co		
Nippon Life Ins Co Of Amer		
Optimum Choice Inc		
Pacific Life & Annuity Co		
Pacificare Life & Health Ins Co		
Pan American Life Ins Co		
Principal Life Ins Co		
Prudential Ins Co Of Amer		
Transamerica Life Ins Co		
Trustmark Ins Co		
Unicare Life & Health Ins Co		
United Healthcare Ins Co		
United Healthcare Mid Atlantic Inc		
United States Life Ins Co In NYC		

APPENDIX D

THE EFFECTS OF SELECTED INSURER CHARACTERISTICS ON ECONOMIC PRICES: MODEL SPECIFICATION

The model was estimated using the following general linear specification:

$$P_{its} = a_{it} + b_1 SIZE_{its} + b_2 SHARE_{its} + b_3 FEHBP_{its} + b_4 IND_{its} + b_5 RBC_{its} + b_6 ADM_{it} + b_7 PROFIT_{its} + b_7 STATE_{it} + b_8 YEAR_{it} + e_{its},$$

with observations specific to the insurer (i), year (t) and state (s) (n=233). The model was estimated using ordinary least squares with year fixed effects and with a "cluster" adjustment to the standard error to account for the observation of the same insurers in more than one year.

The variables were defined as follows (with the sign of the coefficient and levels of significance after cluster adjustment):

P = the insurer's economic price, defined as total earned premium minus medical losses incurred (dependent)

SIZE = Insurer size, measured as total premiums earned in the District, Maryland, and Virginia, respectively (positive, significant at 0.99)

SHARE = Market share, a categorical variable equal to one for insurers estimated to hold less than 10 percent of the market, and zero otherwise. This measure is an indicator of very small insurer's propensity to shadow price larger insurers in the market (positive, significant at 0.98)

FEHBP = The insurer's earned premiums for FEHBP as percent of the sum of FEHBP, non-FEHBP group, and nongroup earned premiums statewide (negative, significant at 0.99)

INDIV = The insurer's earned premiums for individual coverage as a percent of its total earned premiums in the state (not significant)

RBC = The insurer's lagged RBC ratio, calculated as the previous year's TAC as a percent of ACL risk-based capital. This measure, representing the insurer's financial condition in the prior year, varies by company and year, but is the same across states (not significant)

ADMIN = Administrative cost, calculated as the insurer's company-wide administrative expenses as a percent of total premiums earned. This measure also varies by company and year, but is the same across states (positive, significant at 0.99)

PROFIT = A categorical variable that equals one if the insurer is for-profit and zero otherwise, and represents the company's tax status (positive, significant at 0.99)

STATE = A categorical variable controlling for state-specific effects (Maryland= control; VA=positive, significant at 0.99; DC=not significant).

YEAR = A categorical variable controlling for year-specific effects (1998 and 1999 = control).

This specification explained 78.6% of variation (adjusted r^2). Further detail about these results is available upon request.

APPENDIX E

SIMULATED GHMSI SURPLUS AND EXPENDITURE FOR COMMUNITY BENEFIT

TABLE E.1. SIMULATED GHMSI SURPLUS WITH 2 PERCENT OF PREMIUM FOR COMMUNITY BENEFIT: ALTERNATIVE PREMIUM GROWTH ASSUMPTIONS, 2004-2008
($millions)

	Premiums earned	Surplus build-up	Surplus buildup minus % of premium for community benefit	Net total adjusted capital (TAC)	Authorized control level (ACL) risk-based capital	TAC/ACL	Expenditure for community benefit
Low total premium growth (8 percent)							
2004p	$2,042.5	$67.4	$26.6	$418.6	$54.0	775%	$40.8
2005p	$2,205.9	$68.9	$24.7	$443.3	$58.3	760%	$44.1
2006p	$2,382.4	$69.4	$21.7	$465.1	$63.0	739%	$47.6
2007p	$2,572.9	$70.3	$18.8	$483.9	$68.0	711%	$51.5
2008p	$2,778.8	$71.7	$16.2	$500.0	$73.4	681%	$55.6
Intermediate total premium growth (10 percent)							
2004p	$2,118.1	$69.9	$27.6	$419.6	$56.1	748%	$42.4
2005p	$2,372.3	$74.1	$26.6	$446.2	$62.8	710%	$47.4
2006p	$2,657.0	$77.4	$24.2	$470.4	$70.4	669%	$53.1
2007p	$2,975.8	$81.3	$21.8	$492.2	$78.8	625%	$59.5
2008p	$3,332.9	$86.0	$19.4	$511.5	$88.3	580%	$66.7
High total premium growth (15 percent)							
2004p	$2,174.9	$71.8	$28.3	$420.3	$57.7	728%	$43.5
2005p	$2,501.1	$78.1	$28.1	$448.4	$66.4	676%	$50.0
2006p	$2,876.3	$83.7	$26.2	$474.6	$76.3	622%	$57.5
2007p	$3,307.7	$90.3	$24.2	$498.8	$87.8	568%	$66.2
2008p	$3,803.9	$98.2	$22.1	$520.9	$100.9	516%	$76.1

Note: ACL is projected based on the 2003 ratio of ACL to total earned premium. Projections based on low, intermediate, and high premium growth assume that the 2003 ACL/premium ratio is incremented per year by 0.1 percent, 0.15 percent, and 0.2percent respectively.

TABLE E.2. SIMULATED GHMSI SURPLUS WITH 2.5 PERCENT OF PREMIUM FOR COMMUNITY BENEFIT: ALTERNATIVE PREMIUM GROWTH ASSUMPTIONS, 2004-2008
($millions)

	Premiums earned	Surplus build-up	Surplus buildup minus % of premium for community benefit	Net total adjusted capital (TAC)	Authorized control level (ACL) risk-based capital	TAC/ACL	Expenditure for community benefit
Low total premium growth (8 percent)							
2004p	$2,042.5	$67.4	$16.4	$408.4	$54.0	756%	$51.1
2005p	$2,205.9	$68.9	$13.7	$422.1	$58.3	724%	$55.1
2006p	$2,382.4	$69.4	$9.8	$431.9	$63.0	686%	$59.6
2007p	$2,572.9	$70.3	$6.0	$437.9	$68.0	644%	$64.3
2008p	$2,778.8	$71.7	$2.3	$440.1	$73.4	599%	$69.5
Intermediate total premium growth (10 percent)							
2004p	$2,118.1	$69.9	$17.0	$409.0	$56.1	729%	$53.0
2005p	$2,372.3	$74.1	$14.7	$423.7	$62.8	674%	$59.3
2006p	$2,657.0	$77.4	$10.9	$434.7	$70.4	618%	$66.4
2007p	$2,975.8	$81.3	$6.9	$441.6	$78.8	560%	$74.4
2008p	$3,332.9	$86.0	$2.7	$444.3	$88.3	503%	$83.3
High total premium growth (15 percent)							
2004p	$2,174.9	$71.8	$17.4	$409.4	$57.7	710%	$54.4
2005p	$2,501.1	$78.1	$15.5	$425.0	$66.4	640%	$62.5
2006p	$2,876.3	$83.7	$11.8	$436.8	$76.3	572%	$71.9
2007p	$3,307.7	$90.3	$7.7	$444.5	$87.8	506%	$82.7
2008p	$3,803.9	$98.2	$3.1	$447.6	$100.9	443%	$95.1

Note: ACL is projected based on the 2003 ratio of ACL to total earned premium. Projections based on low, intermediate, and high premium growth assume that the 2003 ACL/premium ratio is incremented per year by 0.1 percent, 0.15 percent, and 0.2percent respectively.

TABLE E.3. SIMULATED GHMSI SURPLUS WITH 3 PERCENT OF PREMIUM FOR COMMUNITY BENEFIT: ALTERNATIVE PREMIUM GROWTH ASSUMPTIONS, 2004-2008
($millions)

	Premiums earned	Surplus build-up	Surplus buildup minus % of premium for community benefit	Net total adjusted capital (TAC)	Authorized control level (ACL) risk-based capital	TAC/ACL	Expenditure for community benefit
Low total premium growth (8 percent)							
2004p	$2,042.5	$67.4	$6.2	$398.2	$54.0	738%	$61.3
2005p	$2,205.9	$68.9	$2.7	$400.9	$58.3	687%	$66.2
2006p	$2,382.4	$69.4	($2.1)	$398.7	$63.0	633%	$71.5
2007p	$2,572.9	$70.3	($6.9)	$391.8	$68.0	576%	$77.2
2008p	$2,778.8	$71.7	($11.6)	$380.2	$73.4	518%	$83.4
Intermediate total premium growth (10 percent)							
2004p	$2,118.1	$69.9	$6.4	$398.4	$56.1	710%	$63.5
2005p	$2,372.3	$74.1	$2.9	$401.3	$62.8	639%	$71.2
2006p	$2,657.0	$77.4	($2.4)	$398.9	$70.4	567%	$79.7
2007p	$2,975.8	$81.3	($8.0)	$390.9	$78.8	496%	$89.3
2008p	$3,332.9	$86.0	($14.0)	$377.0	$88.3	427%	$100.0
High total premium growth (15 percent)							
2004p	$2,174.9	$71.8	$6.6	$398.6	$57.7	691%	$65.2
2005p	$2,501.1	$78.1	$3.0	$401.6	$66.4	605%	$75.0
2006p	$2,876.3	$83.7	($2.5)	$399.1	$76.3	523%	$86.3
2007p	$3,307.7	$90.3	($8.9)	$390.2	$87.8	445%	$99.2
2008p	$3,803.9	$98.2	($15.9)	$374.3	$100.9	371%	$114.1

Note: ACL is projected based on the 2003 ratio of ACL to total earned premium. Projections based on low, intermediate, and high premium growth assume that the 2003 ACL/premium ratio is incremented per year by 0.1 percent, 0.15 percent, and 0.2percent respectively.