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Joint Hearings on Health Care and Competition Law and Policy

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The Myth of Health Plan Monopsony Power

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INTRODUCTION

My name is Stephanie Kanwit, and I am General Counsel and Senior Vice President, Public Policy and Research, for the American Association of Health Plans (AAHP). AAHP is the principal national organization representing HMOs, PPOs, and other network-based health plans. Our member organizations provide health care coverage to approximately 170 million individuals nationwide. AAHP member health plans contract with large and small employers, state and local governments, as well as with public programs, including the Medicare, Medicaid, Federal Employee Health Benefits Plan (FEHBP), and State Children's Health Insurance (SCHIP) programs.

We appreciate the opportunity to participate in this discussion of competition and monopsony power in health care markets. As I have stated previously, competition among health care organizations is critical to promote efficiency and improve quality in the health care system. Competition among health plans has led to innovation in the development of new products and to the establishment of a variety of quality improvement and disease management programs to keep consumers healthy.

Today's hearing examines the topic of whether health plans have monopsony power in the markets where they operate. I'm especially interested in this topic, as a former antitrust litigator with merger experience, as well as a former Director of the Chicago office of the Federal Trade Commission. What I see out there is overuse of negative terms like "monopsony" –the mirror image of monopoly-- to characterize one of the most highly competitive markets in the country, namely the health plan market. I also see the misuse of the antitrust term "market power" to deductively come to whatever conclusion the proponent wants.

The market we should be looking at has to be a "relevant market" in the antitrust sense, which in this context is all methods of health care financing, not just specific health plan products or delivery systems (like HMOs or PPOs). To do an appropriate analysis, the antitrust agencies should not be looking at the share of a doctor's business that a particular insurer represents.[1] Antitrust enforcement needs to be concerned with the health insurance and physician markets in the "macro" sense, to ensure that there is efficient resource allocation, progressive technology, and conservation of scarce resources, among other ends.[2] Ideally, it should also

[1] Grimes, W. (2001). The Sherman Act's unintended bias against lilliputians: Small player collective action as a counter to relational market power, *69 Antitrust L.J.* 195.
[2] Sullivan, L. *Antitrust*. West Publ. Co. 21.

foster desired social goals, including dispersal of private power and ensuring the "widest possible degree of economic opportunity" through facilitating entry into a given market. [3] An approach which concentrates on one physician or one practice group and their managed care contracts fills none of these goals and fails to protect consumers as well as competitors.[4]

What we should be looking at is the physician market in the macro sense, namely the ability of physicians generally (and increasingly larger physician groups, sometimes in coordination with massive hospital systems) to sell their services to a myriad of buyers. Those buyers include insurers, employers which self-insure, patients, as well as publicly funded (and representing enormous dollar) health care programs like Medicare and Medicaid. In short, for a specific health plan to possess monopsony power in a given area, an individual physician or group must have no alternative buyer for services—an impossibility when the fact is that physicians on average obtain less than *half of their practice revenues from managed care contracts*,[5] and the *average physician contracts with about a dozen health*

[3] Ibid.
[4] See, e.g., *FTC v. Sperry & Hutchinson Co*., 92 S.Ct. 898 (1972).
[5] Strunk, B. and Reschovsky, J. (2002). Kinder and gentler: Physicians and managed care, 1997-2001. *Results from the Community Tracking Study*. No. 5. 1-3. Center for Studying Health System Change. Washington, D.C. (Primary care physicians derived 49.7% of their revenue from managed care plans in 2001, while specialists derived 43.1%); Noether, M., et al. (2002). *Competition in Health Insurance and Physician Market: A Review of "Competition in Health Insurance: A Comprehensive Study of U.S. Market" by the American Medical Association.* Charles River Associates. Boston, MA.

care plans—with that number rising.[6]

In two of its recent reports, the American Medical Association (AMA) totally misleads by contending that "in many parts of the country, health insurance markets are dominated by a few companies that have significant power over the marketplace,"[7] creating allegedly unequal bargaining power between physicians, as sellers of medical services, and health plans, as purchasers of those services, resulting in "artificially" low prices for physician services.[8] Indeed, these reports, claiming that health plans had the requisite market power, erroneously concluded that markets are concentrated based on the HMO and PPO markets only, while excluding (1) POS plans – an option chosen by 22% of individuals with employer-sponsored coverage in 2001,[9] (2) indemnity plans, in which 7% of employees are enrolled, and (3) the wide range of options available under employer self-insured arrangements, which provide coverage for half of all individuals with employer-sponsored coverage. When these coverage options are appropriately accounted for, the data clearly show a competitive market with

[6] Norbut, M. (December 2, 2002). Managed care brings more income, less from capitation. *amednews.com*. Available at : http://www.ama-assn.org/sci-pubs/amnews/pick_02/bisb1202.htm.
[7] American Medical Association (2001). *Competition in Health Insurance, A Comprehensive Study of U.S. Markets*. See also 2nd Edition, 2003.
[8] Ibid.
[9] Gabel, J., et al. (2003). Self-insurance in times of growing and retreating managed care. *Health Affairs*. 22(2). 202-210.

many choices for employers and consumers – quite the opposite of what we would find in a monopsony.

Defining Monopsony Power

True monopsony power, of course, requires more than simply purchaser concentration, which has been defined as "a market in which there is only one buyer who thus can exercise market power in purchasing a particular supply or input, by restricting its purchases and thus paying a lower-than-competitive price."[10] In practice, a market is considered a monopoly/monopsony if a seller/buyer has a market share of 60-70%.[11] In addition to a substantial market share, two structural factors must be present: (1) market elasticity of supply and elasticity of demand among non-monopsonist firms must be low, and (2) substantial barriers to entry must prevent new purchasers from entering the market.

WHAT THE DATA SHOW

Our research and the experiences of our member plans in the market

[10] Miles, J. (2002). *1 Health Care and Antitrust Law*. §1:4.
[11] See, e.g., *Fineman v. Armstrong World Indus., Inc*., 980 F. 2d 171, 201 (3d Cir. 1992) (55% market share is insufficient to constitute monopoly power), *cert. denied*, 507 U.S. 921, 113 (1993); *Domed Stadium Hotel, Inc. v. Holiday Inns, Inc*., 732 F. 2d 480, 489 (5th Cir. 1984) (99% is enough, 60% is not likely to suffice, and 33% is insufficient) (citations omitted); *Lektro-Vend Corp. v. Vendo Co*., 660 F. 2d 255 (7th Cir. 1981), *cert. denied*, 455 U.S. 921 (1982); *United States v. Aluminum Co. of Am*., 148 F. 2d 416, 424 (2d Cir. 1945) (In widely quoted dicta, Judge Learned Hand stated that while a 90% market share "is enough to constitute a monopoly; it is doubtful whether 60 or 64% would be enough; and certainly 33% is not").

show clearly that the conditions that constitute a monopsony do not exist, and, in fact, today's market conditions represent a situation that is precisely the opposite of a monopsony. Instead, the picture is of the highly competitive markets both for health insurance and for physician services.

Contrary to the case where monopsony power existed, where firms would restrict their "output" on a number of dimensions, for example, by limiting the number of products offered to employers and consumers and perhaps by reducing the size of their provider networks,[12] what we are seeing instead is *vigorous competition and an increase in the variety of new products*. This is consistent with statements by the two former top antitrust officials at the FTC and the Department of Justice, who indicated in testimony before Congress that health plans continue to enter local markets, expanding the options available to employers and consumers.[13]

Discussed below are three key findings that emerge from these empirical data on markets, namely:

- There are multiple competing health plans "purchasing" physician services in every major metropolitan area in the United States,

[12] Miles, J. (2002).

[13] In a statement before the House Judiciary Committee in June 1999, Joel Klein, former head of the Justice Department's Antitrust Division, said, "Although there have been several mergers of health plans over the last few years, in our view there still exists a significant number of competing insurance plans, none of which dominates, and there has been new entry into various local markets." Likewise, in a statement at the same hearing, former FTC Chairman Robert Pitofsky said, "…the evidence does no support the suggestion that most (or even many) areas have only one or two health plans."

each offering multiple products to consumers and employers.

- The market leverage of providers has been increasing, as a result of joint contracting, increased consolidation, and the availability of numerous buyers for services, including multiple health plans.

- No major barriers to entry exist that would limit the number of competitors or number of products available to employers and consumers.

Each of these findings is discussed in more detail below.

(A) There are multiple competing health insurance sellers "purchasing" physician services in every major metropolitan area in the United States, each offering multiple products to consumers and employers.

No health plan has the requisite share of a properly defined market sufficient to constitute a "monopsony." In fact, national data on health plan markets show that in all of the major metropolitan areas in the U.S., there are multiple competing health insurance companies. *There are eight or more managed care companies in each of the top 40 metropolitan statistical areas (MSA) in the country* --according to the Health Industry Market Intelligence survey, conducted twice a year by Atlantic Information Services (AIS), an independent publishing and information company, as of July 2002. For

example, there are 11 in Atlanta; 15 in Baltimore; 14 in Dallas; 16 in Boston-Lawrence-Worcester; and 22 in Washington, D.C. These companies participate in Medicare, Medicaid, SCHIP,[14] and the commercial market (see Appendix A).[15]

Individual Plans Offer Multiple Products

The AIS data show that health plans offer a large variety of products, or coverage models, providing employers and consumers with a broad range of choices among HMO, PPO, point-of-service (POS), and indemnity options under both self-funded and fully insured arrangements. The AIS data found that the average number of options for each company in each market ranged from 2.67 in Baltimore (where there are 15 competing managed care companies) to 4.75 in the San Diego market (where there are 12 competing companies).[16]

Within These Products, Multiple Choices Exist For Buyers

Even these impressive numbers do not tell the whole story, since within each of these product lines there are a myriad of differentiated

[14] SCHIP is funded jointly by the federal and state governments to provide health insurance to low-income, uninsured children. Enhanced matching funds are made available to states that establish SCHIP programs that conform to federal criteria; every state currently operates a SCHIP plan.
[15] Atlantic Information Services. *Major MSAs and Their Managed Care Enrollment.* Chart based on July 2002 Health Industry Market Intelligence survey. Available at aishealth.com/MarketData/DataSummaries/MajorMSAs.html.
[16] Ibid.

products that employers can choose from. The dynamics of the marketplace require health plans to customize design elements to fit the preferences of particular employers as well as the ultimate consumers of that health care, and hence an employer with a younger than average population will normally choose to include services that meet the needs of that population, such as obstetrical services. Mix-and-match elements include: specialty dental and vision networks; behavioral health; tiered network products; pharmacy benefits; networks of alternative medicine providers; networks with varying levels of copays and deductibles; and discount arrangements with a variety of providers. AAHP's own Annual Survey of Health Plans, for example, show that some plans even offer their members, through an external vendor and other networks, such services as dental care, routine vision care, acupuncture and even fitness centers.

Health Plans Are Increasing, Not Restricting, Their Product Offerings

In a true monopsony, health plans could limit the number of products available in each market, and they could restrict the size of their provider networks to keep their costs low. Again, the empirical data provide no evidence of such a trend. The average number of coverage models offered by managed care companies in the 40 MSAs included in the Atlantic Information Service's Health Industry Market Intelligence Survey remained

stable from July 2001 to July 2002, and the number increased slightly in nearly half of these regions (See Appendix B).[17]

Health Plans Are Broadening Their Provider Networks

Health plans not only are offering a broad range of product offerings, they also are increasing the number of physicians and hospitals in their networks for these products. In the past five years, the average number of physician contracts for HMOs increased by approximately 58%, from 3,044 in 1997 to 4,822 in 2001.[18] The average number of PPO provider contracts increased by about 18%, from 7,508 in 1997 to 8,881 in 2001.[19] From 2000-2001 alone, the average number of HMO provider contracts increased 10%, to more than 4,800, and the average number of PPO provider contracts grew 5.4%, to nearly 8,900.

The Center for Studying Health System Change found that consumer preferences have been a major impetus to this trend toward broadening of networks. Employers are responding to this worker preference for more choice by purchasing "less restrictive" forms of managed care, giving workers more opportunity to enroll in a PPO or POS plan, for example. The

[17] Atlantic Information Services (2001, 2002). Health Industry Market Intelligence Database. Washington, D.C.
[18] Aventis Pharmaceuticals (1998, 1999, 2000, 2001, 2002). *HMO-PPO/Medicare-Medicaid Digest*. Managed Care Digest Series.
[19] Ibid.

data show that the percentage of workers who can choose a PPO option has risen from 45% in 1996 to 71% in 2001, while the percentage of workers who can choose an HMO has fallen from 64% in 1996 to 45% in 2002.[20] Like the consolidation trend described earlier in these hearings, these consumer preferences have increased providers' market leverage and ultimately have caused an increase in provider charges. The Center reported that:

> Consumers' and purchasers' preference for broad and stable [health plan] networks give providers the upper hand in contract negotiations with plans…With their new clout,…providers are pressuring plans to pay more and reduce the scope of risk in risk-contracting arrangements; others are pressuring plans to replace risk payment with fee-for-service payments (for physicians) or per-diem and case-rate payments (for hospitals).[21]

(B) The market leverage of providers has been increasing, as a result of joint contracting, increased consolidation, and the availability of numerous buyers for services, including multiple health plans.

Monopsony theory predicts that dominant buyers can, in effect, hold sellers "captive," exerting powerful leverage over all interactions in the market due to their dominant status. But this ignores the fact that physicians (as well as some hospitals and hospital systems) have their own market power, and that less than half of the revenues for average physician practice

[20] Kaiser Family Foundation/HRET (2001). *Employer Health Benefits—2001 Annual Survey*. Washington, D.C.
[21] Draper, D., et al. (2002). The changing face of managed care. *Health Affairs*. 21(1). 11-23.

comes from managed care contracts.

Physicians Often Contract With Managed Care Entities Through Group Practices

The solo practitioner model of physician practice no longer is the norm. What we have seen in the past few decades is a shift from the solo practice model to large physician groups and IPAs, often with hundreds of doctors. The Kaiser Family Foundation, using AMA data, notes that the "physician marketplace has changed dramatically since 1983, when 41% of physicians were self-employed in solo practice," whereas by 1999 only 26% of physicians worked on their own, and 33% worked in group practices."[22] Indeed, the Directory for Physician Groups identifies many physician organizations with over 1000 physicians.[23] These large physician groups often exert strong leverage in the market, in some cases refusing to contract with plans unless they obtain double-digit increases in payment.[24]

Physicians Are Not Dependent Solely On Health Plans For Revenue

Physicians (and other providers) can and do sell their services not just to "managed care" entities, but also to a variety of other buyers, including to government programs such as Medicare ($215 billion expended in 2000);

[22] Kaiser Family Foundation (2002). *Trends and Indicators in the Changing Health Care Marketplace, 2002-Chartbook.*
[23] Center for Healthcare Information and IPA Association of America (1998). *1998 Directory of Physician Groups and Networks*.
[24] Weber, J. (January 28, 2002). The new power play in health care. *Business Week*. 90-91.

Medicaid ($197 billion); workers' compensation; and TRICARE (for military personnel).[25] The upshot is as mentioned above: the average physician practice derives less than half its revenues from managed care contracts.[26]

Physicians Normally Contract with Multiple Health Plans

Far from one or even a few health plans acting as a predominant buyer of medical services in a given area, the facts show that individual providers can and do contract with multiple health plans. A survey by the Center for Studying Health System Change found that the average number of managed care contracts per physician increased from 12.4 in 1997 to 13.1 in 2001.[27] Because physicians have many options in choosing health plans with which to contract, they are not dependent on any single plan, further debunking the myth of monopsony power.

Consolidation Has Given Providers Increased Negotiating Leverage

Consolidation of independent hospitals into large hospital systems has given them significantly more leverage in contract negotiations – making it possible for them to gain substantially higher payments from health plans, as

[25] TRICARE is the Department of Defense's health care program for 8.6 million active duty and retired service members, and costs about $26 billion a year. TRICARE currently has 7 contractors operating in 11 regions, soon to be 3 regions and 3 contractors. TRICARE uses military health care facilities as the main delivery system, but augments it with a civilian network of providers and facilities.
[26] Noether, M., et al. (2002). See also Strunk, B. and Reschovsky, J. (2002).
[27] Norbut, M. (December 2, 2002).

determined by the Center for Studying Health System Change site visits to 12 nationally representative communities in 2001.[28]

The Center noted that:

> After years of consolidating market share and strengthening their brand names, some providers now enjoy "must-have" status in plans' networks. At the same time, newly developing inpatient capacity constraints – especially among hospitals with strong reputations – have increased hospitals' leverage, leaving them more likely to walk away from contracts with plans.[29]

According to the Center, in communities across the country, "prominent providers [have] challenged health plans and demonstrated willingness to terminate or simply not renew contracts."[30]

As a result of the new leverage gained through consolidation, providers are demanding rate increases as high as 40 to 60% for some services,[31] and it is not uncommon to see charges increase by 15-20% in one year. Clearly what we are seeing is increased leverage on the part of health care providers, and *not* a situation in which plans are able to hold providers "captive."

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[28] Strunk, B., et al. (2001). Tracking health care costs: Hospital care surpasses drugs as the key cost driver. *Health Affairs*. Web Exclusive. W39-W50.
[29] Strunk, B., et al. (2001). Health plan-provider showdowns on the rise. *HSC Issue Brief #40*. Washington, D.C.
[30] Ibid.
[31] Freudenheim, N. (May 25, 2001). Medical costs surge as hospitals force insurers to raise payments. *New York Times.*

In short, data showing multiple plans and products in every major MSA in the country, a variety of contracting options for physicians, and consolidation among providers paint a picture of health care markets where competition is vigorous. The data show a market in which physicians and hospitals are exerting increased leverage, leading to increased health care costs for employers, consumers, and government health benefit programs.

(C) There are no major barriers to entering health plan markets that would limit the number of competitors or number of products available to employers and consumers.

While the potential for market entry would be minimized in a monopsony, the data suggest that entry into managed care markets is relatively easy.[32] As indicated earlier, the major markets around the country have eight or more competing plans, each of which have three to four general products, including HMO, PPOs, and POS options, as well as myriad benefit options within those choices.

In addition to large, national health plans, a multitude of small, single-state and regional plans have entered and grown in markets around the country -- a phenomenon that would not be occurring if barriers to entry were insurmountable. AAHP, for example, has about 150 members who are "smaller size" plans, representing under 1 million enrollees, and many have

[32] Noether, M., et al. (2002).

under 100,000 enrollees. In addition, because health insurance is regulated at the state level, a state can choose to allow a health plan or health system to expand into other product lines within that licensing area.

Health plans and insurers have faced and are facing competition not only from other plans, but also from *de novo* entry into markets by provider groups and large health systems.[33] For example, provider-owned managed care plans exist, where providers or groups of providers or hospital systems band together and form a licensed managed care entity. Another example are PSO-type arrangements, where physicians join together to contract directly with purchasers to provide members of a specific population with a broad range of medical services. Indeed, an HMO recently made famous by the Supreme Court was owned by physicians, not a "brand-name" insurer or health plan.[34]

New Models Of Health Care Financing Continue To Emerge—Like Consumer Directed Health Plans

The emergence of consumer-directed health plan products provides additional evidence that barriers to entering health plan markets are relatively low. In the late 1990s, a number of start-up companies entered health plan markets to offer these products, which allow consumers to

[33] Ibid.
[34] See *Pegram v. Herdrich*, 530 U.S. 211(2000).

choose major elements of their benefit packages as well as their own health care providers. These plans typically consist of an employer-funded health spending account; a high-deductible health insurance policy; a component which requires consumers to pay out-of-pocket the difference between the amount in the account and the deductible; and an informational component which is often Internet-based, to guide and empower consumers to make more informed health care decisions.

In response to growing interest among employers, a number of large, national health plans have begun offering consumer-directed products as well; about a third of large employers will offer such a health plan option in 2003. It has been estimated that enrollment in consumer-directed plans could account for 20% of individuals with employer-sponsored coverage by 2005.[35]

Self-Funding Remains an Option

The ability of many employers to self-fund adds to the mix of options available in the market and thus increases competition. As I mentioned earlier, 50% of all workers were enrolled in self-funded plans in 2001. Sixty-eight percent of workers in indemnity plans were covered through

[35] Gabel, J., et al. (November 2002). Consumer-driven health plans: Are they more than talk now? *Health Affairs* – Web Exclusive. Available at http://www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_112002.htm.

self-funded arrangements, and 62% of workers in PPO plans were covered through employer self-funding.[36]

In short, the growing number of managed care companies and products available in local markets, the increasing diversity of products, and the availability of the self-funding option for employers clearly show the competitive nature of the health care marketplace and the lack of any "monopsony" power.

CONCLUSION

Health plan markets throughout the country remain highly competitive. An exhaustive review of the research -- and AAHP member plans' experience in the markets where they operate -- provide no evidence whatsoever of health plan monopsony power. In fact, just the opposite is occurring: the data show a highly competitive marketplace, with insurers and health plans competing vigorously in terms of price as well as quality. Physicians are contracting with multiple health plans, joining larger and larger group practices, and engaging in more and more commercial ventures in the health care arena, such as starting physician-owned specialty hospitals

[36] Gabel, J., et al. (2003).

to carve out lucrative cardiac and orthopedic care.[37]

One of the concerns regarding monopsony, of course, is that falling prices paid by the buyer with market power will not be passed on to the consumer. In today's health care market, we are seeing not falling provider prices but rather, double-digit increases in provider charges. Yet employers are continuing to shop for the best value they can find on behalf of their employees. Through creative initiatives such as those instituted by the Pacific Business Group on Health and others, employers continue to promote competitive pricing while fostering health plan accountability for quality improvement.[38] Our health plans are cooperating in the endeavor to promote patient quality and safety, maintain a competitive market that provides consumers with a broad range of choices, and keep health care affordable.

We appreciate the opportunity to testify at these hearings. Thank you.

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[37] BNA, Inc. (April 23, 2003). *Health Plan & Provider Report.* 9(17). 429. (11 specialty hospitals have emerged since 1997 in 12 local health care markets, according to Center for Studying Health System Change; Congress proposing legislation to address the trend toward physician-owned hospitals that specialize in cardiac and orthopedic care, with possible dire implications for competitors like community hospitals)

[38] Pacific Business Group on Health. Negotiating alliance: Promoting value-based purchasing through pooled purchasing and collaboration. Available at: http://www.pbgh.org/programs/negotiating_alliance.asp.

Appendix A

Managed Care Penetration in Major MSAs (July 2002)				
MSA Name	**Number of Managed Care Companies[39] Marketing in Area**	**Average Number of Products[40] Per Managed Care Company**	**Total Population**	**Population Enrolled in Managed Care in MSA**
Atlanta	11	3.36	4,262,584	2,491,697
Austin-San Marcos	14	3.71	1,313,231	302,622
Baltimore	15	2.67	2,592,945	1,124,983
Boston-Worcester-Lawrence	16	4.38	6,997,089	2,387,047
Buffalo-Niagara Falls	8	3.88	1,162,917	846,862
Charlotte-Gastonia-Rock Hill	13	4.46	1,544,944	649,713
Chicago-Gary-Kenosha	16	3.25	9,233,053	2,784,190
Cincinnati-Hamilton	11	4.45	1,994,521	344,176
Cleveland-Akron	17	4.18	2,942,641	1,514,793
Columbus	12	4.25	1,559,597	822,461
Dallas-Fort Worth	14	3.71	5,400,467	1,869,153
Denver-Boulder-Greeley	14	4.00	2,653,476	891,907
Detroit-Ann Arbor-Flint	23	2.70	5,478,262	3,501,871
Houston-Galveston-Brazoria	14	3.64	4,795,974	1,870,316
Indianapolis	13	2.92	1,632,452	641,441
Jacksonville, FL	11	4.00	1,131,490	500,924
Kansas City, MO	12	4.42	1,803,445	1,459,478
Las Vegas	11	3.82	1,660,516	534,168
Los Angeles-Riverside-Orange County	20	3.70	16,700,693	9,108,387
Miami-Fort Lauderdale	19	3.89	3,958,243	1,740,444
Milwaukee-Racine	14	3.50	1,692,074	662,901
Minneapolis-St. Paul	11	3.91	3,015,573	1,490,807
New Orleans	10	4.40	1,332,694	286,992

[39] The survey defines "managed care company" to include companies that provide HMO products (including products with a point-of-service (POS) option) as well as PPOs, and indemnity products. The survey includes companies participating in Medicare, Medicaid, SCHIP, and the commercial market.
[40] Products include HMO, HMO with POS, PPO, and indemnity plans. They do not include non-risk PPO networks. Some of these products are offered under a self-funded arrangement. However, self-insured business is not counted as a separate product in the calculation

Appendix A

Managed Care Penetration in Major MSAs (July 2002) – cont'd

MSA Name	Number of Managed Care Companies Marketing in Area	Average Number of Products Per Managed Care Company	Total Population	Population Enrolled in Managed Care in MSA
New York-Northern New Jersey-Long Island	42	3.45	20,959,919	11,201,944
Norfolk-Virginia Beach-Newport News	11	3.91	1,583,170	747,488
Orlando	14	4.29	1,707,175	740,035
Philadelphia-Wilmington-Atlantic City	15	4.40	6,215,629	3,583,045
Phoenix-Mesa	16	3.69	3,383,644	1,684,144
Pittsburgh	8	4.00	2,347,163	1,466,320
Portland-Salem	15	3.67	2,317,384	727,219
Sacramento-Yolo	13	4.08	1,874,683	1,210,141
Salt Lake City-Ogden	10	2.90	1,348,606	194,354
San Antonio	10	4.60	1,626,538	772,511
San Diego	12	4.75	2,862,819	1,760,523
San Francisco-Oakland-San Jose	23	3.30	7,073,361	3,284,986
Seattle-Tacoma-Bremerton	15	4.13	3,605,124	985,397
St. Louis	11	3.55	2,617,637	1,605,198
Tampa-St. Petersburg-Clearwater	14	4.43	2,450,337	1,204,676
Washington, DC	22	2.86	5,166,839	3,531,500
West Palm Beach-Boca Raton	17	3.94	1,165,049	534,528

Source: *HEALTH INDUSTRY MARKET INTELLIGENCE Database*
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Appendix B

Average Number of Products Offered by MCOs in the Top 40 MSAs July 2001-July 2002

	Average Number of Products Offered	
MSA	**July 2001**	**July 2002**
Atlanta	3.82	3.36
Austin-San Marcos	4.58	3.71
Baltimore	3.07	2.67
Boston-Worcester-Lawrence	3.78	4.38
Buffalo-Niagara Falls	4.44	3.88
Charlotte-Gastonia-Rock Hill	4.13	4.46
Chicago-Gary-Kenosha	3.21	3.25
Cincinnati-Hamilton	4.00	4.45
Cleveland-Akron	3.94	4.18
Columbus	3.56	4.25
Dallas-Fort Worth	3.75	3.71
Denver-Boulder-Greeley	3.47	4.00
Detroit-Ann Arbor-Flint	2.50	2.70
Houston-Galveston-Brazoria	4.93	3.64
Indianapolis	2.87	2.92
Jacksonville, FL	4.17	4.00
Kansas City, MO	4.46	4.42
Las Vegas	3.25	3.82
Los Angeles-Riverside-Orange County	4.09	3.70
Miami-Fort Lauderdale	3.44	3.89
Milwaukee-Racine	3.88	3.50
Minneapolis-St. Paul	3.92	3.91
New Orleans	4.18	4.40
New York-Northern New Jersey-Long Island	3.47	3.45
Norfolk-Virginia Beach-Newport News	3.62	3.91
Orlando	3.82	4.29
Philadelphia-Wilmington-Atlantic City	4.35	4.40
Phoenix-Mesa	3.73	3.69
Pittsburgh	5.11	4.00
Portland-Salem	4.13	3.67
Sacramento-Yolo	5.21	4.08
Salt Lake City-Ogden	4.00	2.90
San Antonio	5.40	4.60
San Diego	4.92	4.75
San Francisco-Oakland-San Jose	3.84	3.30
Seattle-Tacoma-Bremerton	4.23	4.13
St. Louis	3.50	3.55
Tampa-St. Petersburg-Clearwater	4.25	4.43
Washington, DC	2.78	2.86
West Palm Beach-Boca Raton	3.76	3.94

Source: HEALTH INDUSTRY MARKET INTELLIGENCE Database
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