KPMG LLP (KPMG) is pleased to present our 2010 Managed Care Industry Report, which is sponsored by the KPMG Healthcare & Pharmaceutical Institute. Our report analyzes the 2009 performance of major U.S. managed care companies. It also presents our assessment of the current state of the industry and the trends that affect it.
Overview

The U.S. managed healthcare industry is highly concentrated as only 50 companies account for 75 percent of industry revenues. The industry has approximately 1,000 companies with total 2009 annual revenue of US$465 billion.¹

Despite a struggling economy, the industry’s performance has been positive. During 2009, the S&P Managed Health Care sub-industry index exhibited 28 percent growth while the S&P 1500 Composite Index grew by 24.3 percent.²

Moody’s, in its report of healthcare insurers, indicated that the largest healthcare insurers used expense savings and realized capital gains to strengthen margins from 2008 to 2009. These actions offset adverse medical cost trends and attrition in enrollment.³

In 2009, the nation’s largest health insurers (WellPoint, UnitedHealth Group, Cigna, Humana, Kaiser, and Aetna) posted good performances as their combined profits stood at US$14.4 billion, an increase of 56 percent over 2008.⁴ The health insurance industry achieved robust profits even though it lost 2.7 million members who had health insurance the year before. However, these six companies are not expected to repeat their performance in 2010. The expected high unemployment rate in 2010 may further erode insurers’ highest-margin, commercial membership, which declined by 2.3 percent among publicly traded insurers in 2009. While nearly every company lost commercial members, primarily due to job reductions at employers,⁵ Aetna Inc. witnessed increased enrollment in 2009 with most of the growth coming in the ASO business.

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¹ Managed Healthcare, First Research, January 4, 2010
² "Managed Health Care," Standard & Poor's Industry Investment Reviews, April 10, 2010
³ "U.S. Health insurers face uncertainty in '10 despite Q4 '09," SNL Insurance Daily, February 22, 2010
⁴ “Most health insurers saw profits last year; Repeat of profitability unlikely in 2010 due to unemployment,” Business Insurance, March 22, 2010
⁵ "Most health insurers saw profits last year; Repeat of profitability unlikely in 2010 due to unemployment," Business Insurance, March 22, 2010

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Trends and Issues
Healthcare reform is expected to impact the managed care industry significantly. Health insurers with significant exposure to individual, small group, and Medicare Advantage markets could face greater pressures than others.6

Following are major challenges for the companies:

- Companies are expected to face increased competition from within the industry and reduced profit due to new laws. Companies will no longer be able to deny coverage or raise insurance rates to individuals based on preexisting conditions, which is expected to increase cost. The law also mandates insurers to spend 85 percent of revenue from premiums on medical care. UnitedHealth Group Inc. and WellPoint Inc. spent less than 85 percent on medical care in 2009.7 Additionally, WellPoint Inc. recently shifted its nurse hotlines and other wellness programs from the administrative-cost column to the medical-cost side of the ledger book.8 There is currently no industry consistent definition of medical-cost so until a regulatory definition is issued, historical medical cost ratios are not truly valid indicators of compliance with the 85 percent threshold.

- Medicare Advantage will see significant cuts starting in 2012. Federal assistance is expected to drop by 3 percent. The government announced the Medicare Advantage reimbursement rates will be flat for 2011 with this year’s levels. Companies with higher exposure to Medicare advantage, such as Humana, HealthSpring, and Universal American, will be hardest hit.9 Before the healthcare reform laws, the Congressional Budget Office (CBO) projected enrollment in Medicare Advantage plans to go from 10.6 million in 2009 to 13.9 million in 2019. Following reform, the CBO revised its projections to indicate a drop in enrollment to 9.1 million in 2019.10

The new laws also create opportunities in the industry, such as:

- The individual health insurance mandate, expanding coverage to 32 million uninsured Americans, will bring new customers to insurers.11

- The expansion of the Medicaid program in 2014 presents an opportunity for large insurers participating in the Medicaid program. UnitedHealth Group Inc. and WellPoint Inc. are among the largest Medicaid providers. Other companies that traditionally have focused on employer-based coverage may seek to enlarge their Medicaid plans. However, these opportunities also have potential risks. Payment cuts by states to health insurers due to mounting fiscal pressure and uncertainty on insuring a new type of population are some of the concerns.12
M&A activity: Healthcare deals dropped significantly after 2007, mainly due to tough economic conditions and concerns about healthcare reform. The improving economic conditions along with clarity in the healthcare regulations could make mergers among healthcare companies rise significantly. Deals in the managed care sector picked up in the second half of 2009, though still below the 2007 levels. Additionally, consolidation could also increase owing to economies of scale in administration and large provider networks of companies and increased focus on programs to manage chronic illness and increased expenditures on IT solutions.13

Rising healthcare cost: Rapid increase of healthcare cost remains a critical issue in the industry. The United States is struggling to contain the cost as the expenditure crossed US$2.3 trillion in 2008, which is 16 percent of the country’s GDP. This spending is more than three times the US$714 billion spent in 1990. U.S. healthcare spending averaged US$7,681 per person in 2008.14

Global opportunities: U.S. health insurers have primarily focused on the U.S. market. The United States accounts for 80 percent of the global health insurance market while it has only 4.6 percent of the world’s population. The profit pressures in the United States and attractive growth prospects in foreign markets may spur U.S. health insurers to expand their healthcare administration services and products in overseas markets. Asia and Europe represent the best near-term opportunities for U.S. health insurers.15 In a recent development, WellPoint Inc. is searching for a joint venture partner to set up a health insurance firm in China. The company’s president and CEO, Angela Braly, went to China recently for discussions with potential partners and the industry regulator.16

13 "Pick-Up In Health-Care Deals Seen As Overhaul Plan Stalls," Dow Jones Business News, January 30, 2010; Managed Healthcare, First Research, January 4, 2010
16 "WellPoint scouts for JV partner," China Daily, April 14, 2010

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Outlook

The U.S. health insurance market is expected to grow 7 percent annually from 2009 to 2011. However, operating margins will continue to be under pressure due to the reform measures and increasing healthcare costs. With the implementation of U.S. healthcare laws, health insurers face pressure to maintain their profitability. The industry is expected to witness premium increases, job cuts, administrative cost reduction, and increased M&A activity as companies prepare themselves for the new regulation.

Standard & Poor’s predicts the fundamental outlook for the managed healthcare industry for the next 12 months is positive. New costs and other challenges will be offset by the addition of 32 million customers over the period the reform laws become fully effective in 2014. Revenue growth in 2010 is forecasted to be modest due to commercial membership losses. The rising senior population presents growth in the Medicare segment, whereas the high unemployment rate presents growth in the Medicaid segment. Additionally, Fitch predicts that the many insurers will return to a stable outlook over the coming months as the companies have a long time frame to implement healthcare reform.

The effects of the reform laws remain to be seen in multiple areas:

- The impact that potential antislection resulting from the opening up of the individual market may have on prices and policy design. Is the cost to opt out of coverage enough to persuade currently healthy, uninsured individuals to seek coverage?

- Will the reductions in the Medicare Advantage program reimbursement rates force some writers out of the market and for those that remain in the market, what will the design of a profitable product look like?

- How will the excise tax based on market share as defined by premiums and the tax on premium plans (the “Cadillac” tax) impact the ability of insurers to write a profitable yet marketable product? Will these taxes be passed along to the consumer in the form of higher premiums and/or reduced benefits?

- Will the medical loss ratio floors (85 percent for large group products and 80 percent for individual and small group products) ultimately impact the profitability of the industry? Will the industry see an expansion in the definition of what a medical cost is?
Needless to say, the upcoming months and years will prove to be a time of change and realignment for the industry. Questions on how the regulations related to the reform laws will read and on how individual states that would have the option to form exchanges and otherwise influence the look of reform remain to be addressed.

Moody’s commented in its March 2010 publication on the credit rating impact of reform that it did not expect wholesale ratings movement in the short term. In fact, it was stated that given the longer time period before full implementation of many parts of the legislation that diversified insurers and/or those that have little exposure to the affected segments may not experience any negative impact. The notable exception to this would be insurers with a heavy concentration in Medicare Advantage products which could see a reduction in their ratings sooner than the rest of the industry.21
Nine U.S. managed care companies are included in this section. They represent a variety of operating models and focus markets. All are public companies with the exception of Kaiser Foundation Health Plan & Hospitals, a not-for-profit integrated delivery system. Aetna, UnitedHealth Group, and WellPoint are national companies offering a wide variety of products and services. AMERIGROUP primarily provides Medicaid managed care plans. HealthSpring primarily provides Medicare Advantage plans. The others provide diverse managed care products on a regional basis. This report not only analyzes the operating results of these companies, but it also shows how the differences in their operations affect their results.

The two issues that will likely have the greatest impact on managed care companies in 2010 are the state of the economy and the future impact of healthcare reform laws. As this is written in May 2010, the country continues a slow recovery from the recession, with much uncertainty still present in jobs growth. Many healthcare companies are finding that their businesses are less recession-resistant than previously thought, and the future is uncertain. Managed care companies are faced with declining enrollment as unemployment remains high in a tough pricing environment. This will undoubtedly be a challenging year for managed care companies.

We hope you will find this report useful.
After a decline in financial performance in 2008, the managed care industry saw an uptick in profitability in 2009.

Six of the nine companies in this report experienced growth in net income and other key measures.

Membership growth was flat at best, and several companies ended the year with fewer members than they had at the end of the previous year. Membership growth through acquisitions was also slow with no significant transactions in 2009.

Premiums rose during the year driven by increased medical costs. However, medical costs rose faster, resulting in mostly higher or flat medical cost ratios over 2008. Many companies were conservative in estimating the medical cost trend incurred in 2009, and showed profitability during the year. Much of this positive experience was due to a less severe than expected H1N1 impact.

The turnaround in the financial markets impacted investment performance for all managed care companies, but to varying degrees. All companies were affected by continued lower interest rates on invested assets, and a few also recorded losses on impaired debt and equity securities. The lower interest rates also drove increases in pension/benefit plan obligations.

Administrative costs were mostly flat or decreased in 2009. Employee productivity measures showed general improvement from 2008. Most companies experienced flat or reduced employee counts in 2009.

Stock market performance during 2009 was improved. Managed care company stocks rose along with the rest but rose faster and farther. The Morgan Stanley Healthcare Payor Index climbed almost 54 percent during 2009, compared to a 24 percent increase for the Standard & Poor’s 500 stock index. At December 31, 2008, the Morgan Stanley Healthcare Payor Index stood approximately 18 percent above its level five years earlier.

Membership growth in 2010 is expected to be modest, with organic growth in the low single digit percentage range. A potential positive for some companies would be increased membership growth through increased acquisition activity. A potential negative would be further membership losses due to unemployment. The trend toward employer-funded plans is expected to continue.

Industry pricing discipline remains strong. Managed care companies report that the market is competitive but rational. Competitors are unwilling to sacrifice margin for increased membership.

Assuming that current estimates of 2010 medical cost trends prove to be accurate, most managed care companies expect improved operating results in 2010. However, the improvements are not likely to be large for most companies.
Managed Care Company Analysis

The analysis contained in this report is derived from information about major U.S. managed care companies. Our analysis includes financial statement and other information available from public sources. The companies analyzed include the following:

- Aetna Inc. (Aetna)
- AMERIGROUP Corporation (AMERIGROUP)
- Coventry Health Care, Inc. (Coventry)
- Health Net, Inc. (Health Net)
- HealthSpring, Inc. (HealthSpring)
- Humana Inc. (Humana)
- Kaiser Foundation Health Plan and Hospitals (Kaiser)
- UnitedHealth Group Inc. (United)
- WellPoint, Inc. (WellPoint)

The data on which this analysis is based was obtained from annual reports, Securities and Exchange Commission filings, regulatory filings, and other public sources.

Annual data was collected for 2005 to 2009, when available. Since not all companies present financial information in the same manner, KPMG developed a standard template to enhance the consistency of our analysis. Operating statistics were calculated directly from this data and may differ from statistics calculated by the companies. Differences may result from the use of more aggregated data, different calculation methods, or imprecision caused by the use of annual data.

Details of the calculations are included in the Appendix.
• Membership growth slowed for most companies in 2006 and 2007, and most companies lost membership in 2008 and 2009.
• The only large business combination in 2008 was the acquisition of Sierra Health Services, Inc. by United. There were no large acquisitions in 2009.
• Several companies made smaller acquisitions in 2006 and 2007. Coventry, United, and WellPoint made large acquisitions in 2005.
• HealthSpring had 190,000 members at December 31, 2009, the smallest company by far. HealthSpring is included to show how Medicare Advantage plans differ from other types of health plans.
• The membership totals in the top chart exclude members in stand-alone Medicare prescription drug plans (PDPs).
• More than 50 percent of the membership of Aetna, United, and WellPoint is in nonrisk plans, in which employers are directly responsible for healthcare costs.
• As healthcare costs continue to increase, large employers continue the shift to nonrisk plans to better control future costs.
• Membership growth is expected to be slow for the managed care industry in 2010. However, acquisitions could increase growth rates for some companies. Since many of the declines in membership are due to declines in employment levels, the membership levels may increase if the employment situation improves in 2010.
• AMERIGROUP does have approximately 1 percent of its membership in non-Medicaid business. This is not fully presented in the membership graphs.
Membership (continued)

Membership by Type – December 31, 2009

- The mix of membership varies widely among major managed care companies.
- With the exception of AMERIGROUP, which primarily focuses on Medicaid, and HealthSpring, which focuses on Medicare, all these major companies focus on commercial business, including nonrisk business, which is mostly commercial.
- HealthSpring focuses primarily on Medicare Advantage plans. Most of the companies offer Medicare plans, but none focus on them to the degree that HealthSpring does.
- TRICARE is a federal program covering military dependents and retirees. Humana and Health Net participate in the TRICARE program. A significant portion of the TRICARE membership for these two companies is included in the nonrisk category.
- In 2010, there has been uncertainty with who the TRICARE providers in the northern and southern regions would ultimately be. The northern region contract was reconsidered with that contract going to incumbent Health Net and the southern region will be rebid.
- Medicaid managed care membership has increased dramatically over the past few years as states embraced managed care as a means of controlling the cost of healthcare. While most major managed care companies participate in the Medicaid program, AMERIGROUP and several companies not included in this report focus primarily on Medicaid.
- The top chart excludes Medicare supplement and prescription drug plan members.
- The introduction of the Medicare drug benefit in 2006 led several of the companies to establish stand-alone PDPs.
- Humana and United had the largest PDP membership at the end of 2009. Humana sharply decreased the enrollment in these plans in 2009 while Coventry continued to expand its operations in this market.
Membership (continued)

- The decline in membership at WellPoint is primarily in its commercial risk business. According to the company, these declines were due to current economic conditions—specifically, higher unemployment only partially offset by new sales. The decline at United in 2009 also stemmed from losses of members in its commercial risk and nonrisk business for many of the same reasons.

- The acquisition of Sierra by United was the only large acquisition to close in 2008.

- Humana’s membership growth in 2006 was the result of a significant increase in Medicare members.

- In 2005, Coventry acquired First Health, United acquired PacifiCare, and WellPoint acquired WellChoice, contributing significantly to their membership growth.

- In 2008, membership reductions at AMERIGROUP were primarily due to ASO contract terminations.
Most companies have increased premium revenue during the period as premium increases and membership growth offset any membership losses or transfers of risk business to nonrisk plans.

The large 2006 premium growth for United and WellPoint includes the first full year of revenue from their 2005 acquisitions.

Humana's 2006, 2007, and 2008 premium growth is largely due to the addition of new Medicare members.

Per-member-per-month (PMPM) measures are useful in comparing managed care companies of different sizes. PMPM measures reflect the revenue or cost of serving a single member for one month.

HealthSpring's large 2008 increase in PMPM premiums is mostly due to the loss of low premium commercial members. In 2009, this increase was primarily due to an increase in premium from its Medicare Advantage membership base.

PMPM premium levels are heavily influenced by product mix and member location.

Medicare rates are much higher than commercial rates in the same area. As a result, HealthSpring has much higher PMPM premiums than the other companies do.

Companies with a large proportion of Medicaid or TRICARE business have lower rates. As a result, AMERIGROUP and Health Net have lower PMPM premiums than the other companies do.

Premium increases are expected to moderate somewhat in 2010.
The medical cost ratio (MCR) is the ratio of medical costs to premiums.

Most companies had relatively volatile MCRs during the five-year period.

In 2009, most companies increased their MCRs from 2008 levels. The general trend remains toward higher MCRs.

Kaiser has higher MCRs than the other companies do, reflecting its not-for-profit status and its integrated delivery operating model. The integrated delivery model results in higher medical costs than commercial plans, since medical management and certain other costs are included in medical, rather than administrative, costs.

PMPM medical costs for most companies rose during the period but, in some cases, were at least partially offset by premium increases.

HealthSpring’s large increase in PMPM medical costs is mostly due to the loss of low-cost commercial members.

PMPM medical costs are also heavily influenced by product mix. For example, medical costs for Medicare members are higher than for commercial members as is demonstrated by HealthSpring’s high PMPM medical costs.

Medical costs are expected to increase in 2010. MCRs will also likely increase.
Administrative Costs

- The administrative cost ratio is the ratio of selling, general, and administrative costs to total revenue. This ratio is useful in assessing the performance of individual companies over time, but is of limited usefulness in comparing one company with another, due to variations in business mix.

- Aetna, Coventry, Humana, United, and WellPoint have a large amount of nonrisk business, which tends to increase the administrative cost ratio.

- PMPM administrative cost, a measure of operating efficiency, is based on total membership. No adjustment has been made for administrative cost differences between risk and nonrisk business.

- Medicare business requires high administrative costs. As a result, Humana’s, HealthSpring’s, and Coventry’s PMPM administrative costs are also high.

- HealthSpring’s increases in 2008 PMPM administrative costs are mostly due to the loss of low-cost commercial members.

- Kaiser has lower administrative costs than the other companies do, reflecting its not-for-profit status and its integrated delivery operating model. The integrated delivery model results in lower administrative costs than commercial plans, since medical management and other administrative costs related to healthcare delivery are included in medical rather than administrative costs.
Pretax Operating Profit (in millions)

Profitability

- Pretax operating profit is earnings before interest and taxes.
- Pretax operating profit generally increased in 2009. Margins changes were mixed.
- The decline in profitability was primarily due to the increased medical costs and reduced investment returns.
- The decline in pretax operating profit at Aetna and Coventry during 2009 was primarily due to increases in medical costs. Aetna’s increase in revenue of $3.8 billion in 2009 was more than offset by increases in medical cost expenses of $3.2 billion and SG&A expenses of $631 million. Likewise, Coventry’s $2.2 billion increase in revenues was offset by an increase in medical costs of $2.0 billion and a $256 million increase in SG&A expenses.
- Kaiser’s 2008 operating loss was caused by $2.3 billion in charges for other than temporary impairment of investments.
- WellPoint also had large impairment charges in 2008.
- AMERIGROUP’s 2008 profit was negatively impacted by a large legal settlement.
- Operating margins for most companies generally increased along with pretax operating profit for most companies. However, results were not reflected consistently across all companies.
Profitability (continued)

- PMPM operating profit varies widely among companies. The companies achieved PMPM pretax operating profit from less than $1 million to over $100 million in 2009.

- PMPM operating profit increased in 2009 for most companies in line with increases in pretax operating profit. However, overall growth rates were not robust and were influenced by returns to profitability at Kaiser and AMERIGROUP.

- HealthSpring’s PMPM operating profit is higher than the other companies in line with the high PMPM premiums and medical costs associated with its Medicare members. The increase in 2008 is mostly due to the loss of low-margin commercial members.

- PMPM operating profit at Aetna declined in 2009 due to an increase in membership months and total enrollment that was not offset by increase in operating profit. Operating profit in 2009 declined at the company primarily due to a 14 percent increase in medical costs during the year.
Net income for the group varied widely, but most companies had increased net income in 2009 compared to 2008. Only WellPoint, AMERIGROUP, and Humana have returned to or have exceeded the margin levels of 2007.

AMERIGROUP’s net loss in 2008 was caused by a large litigation settlement. Kaiser’s loss was caused by charges for other than temporary impairment of investments.

Net margin percentage in 2008 declined along with net income.

Most companies have relatively stable effective tax rates in the 35 to 40 percent range. As a not-for-profit, Kaiser is not subject to federal or state income taxes.

AMERIGROUP’s 2008 tax rate of negative 2,200 percent is not fully reflected in the chart. This rate was caused primarily by restated negative pretax income and nondeductible litigation costs.

Health Net’s negative 94 percent 2009 tax rate is not fully reflected in the chart. The tax rate is due to a relatively small net loss before taxes.

WellPoint’s low rate in 2008 was due to the favorable settlement of prior year tax audits.

Health Net’s high rate in 2007 was due to an increase in nondeductible expenses and setting up a valuation allowance on deferred tax assets.
Productivity

- The largest administrative expense for managed care companies is the salary and benefit costs of their employees.
- Kaiser has the most employees by far since it employs a significant number of healthcare providers as well as administrative employees.
- The number of employees includes employees who are not involved in health plan activities. Aetna, Coventry, United, and WellPoint have a significant number of employees involved in nonhealth plan operations.
- Members per employee is a measure of employee productivity that focuses on how many members are served by each employee. This measure is understated for companies that have employees involved in nonhealth plan operations.
- Members per employee varies widely among companies. Kaiser is the lowest, since it delivers much of the healthcare its members receive.
- Members per employee were relatively stable in 2009.
- Declines at Kaiser and United were due to increases in the number of employees at those companies in 2009, contrary to the trend at the other managed care companies.
Revenue per Employee (in thousands)

Pretax Operating Profit per Employee

Productivity (continued)

- Revenue per employee is a traditional productivity measure applied in many industries. It is of limited use in comparing one company with another due to the impact of product mix on revenue. However, it is useful in tracking the performance of individual companies over time.
- Pretax operating profit per employee is another traditional productivity measure. This statistic varies widely among managed care companies and for individual companies over time.
- Pretax operating profit is earnings before interest and taxes.
- Between 2005 and 2009, some of the companies increased their pretax operating profit per employee, while others declined.
- Revenue per employee for all companies except Kaiser was higher in 2009 than 2005. Kaiser’s ratio has been stable each year, reflecting its steady annual increases in employees each year.
Financial Management

Days in Accounts Receivable

- Effective receivables management is critical given the impact of receivables on cash flow and statutory capital.
- If available, premiums receivable are included in the days in accounts receivable calculations.
- Coventry and United do not break out premiums receivable separately, which leads to an overstatement of days in accounts receivable.
- The 2005 increase in Coventry's days in premiums receivable was caused by the acquisition of First Health and does not represent a true increase, since most of First Health’s revenue is fees rather than premiums.
- WellPoint includes receivables and payables for non-risk claims, which leads to higher levels in both days in accounts receivable and days in claims payable.
- Days in claims payable is based on the medical claim liability at the end of the year and total medical costs for the year.
- Kaiser performs most of the medical care for its members and, as a result, its days in claims payable is low.
- Since 2005, most companies have reduced their days in claims payable.

Days in Claims Payable
Most companies’ operating cash flow reflects their earnings and working capital management. Kaiser’s also reflects large depreciation expenses from its hospitals and medical office buildings. The cash generated from depreciation is reinvested in maintaining and improving these assets.

Cash flow is influenced by changes in membership. Companies with significant organic growth should be expected to grow cash flow faster than earnings. Companies that are reducing membership often suffer significant reductions in cash flow.

Setting medical claim reserves is a key area of management judgment. The accuracy and the level of conservatism of the estimates can have a significant impact on earnings and the strength of the balance sheet.

The reserve runout percentage chart above shows the percentage by which prior year reserves were overstated (+) or understated (-) based on information available one year later.
Risk

The ratio of long-term debt to capitalization is a measure of financial strength. A low ratio indicates relative strength. Capitalization is defined as long-term debt plus equity.

In 2009, most companies decreased this ratio indicating decreased financial leverage.

Historically, strong managed care companies generally have had a ratio of less than 35 percent, which enabled them to maintain high debt and claim payment ratings.

Since 2005, debt levels have increased significantly even though earnings have generally been strong. However, debt levels have been declining at most companies since 2007.

The increased debt levels are generally due to debt-financed acquisitions and the repurchase of common stock.

Kaiser issues debt to finance the construction of healthcare facilities.
Premiums to Book Value Ratio

- Stock repurchases are a tax-efficient way to distribute earnings to shareholders, which also have a positive impact on earnings per share.
- In 2009, stock repurchases were either flat or declined consistent with the early stages of a market rally.
- The premiums to book value ratio measures the companies’ ability to bear insurance risk. A low ratio indicates relative strength.
- In 2009, premiums to book value statistics ranged from less than two to more than eight, and the ratio increased or remained flat for most companies surveyed.
- The ratio of operating cash flow to net income is a measure of the quality of earnings over time.
- Companies that consistently have operating cash flow that is greater than net income are generally thought to have good earnings quality.
- In 2008, both AMERIGROUP and Kaiser had positive operating cash flow in spite of net losses. This resulted in a negative ratio.
- In 2008 and 2009, Health Net had net income but negative operating cash flow.

Operating Cash Flow to Net Income

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• Beta is a measure of stock price volatility over time. The stock market as a whole has a beta of one. A beta of greater than one implies that a stock price is more volatile than the market as a whole, and a beta of less than one implies the opposite. A negative beta implies that a stock moves in the direction opposite to the market as a whole.

• The beta measures were obtained from Yahoo!™ Finance as of March 17, 2010, March 17, 2009, February 29, 2008, July 16, 2007, and June 30, 2006. The beta measures are based on monthly price data for a three-year period, if available, relative to the S&P 500.

• As a not-for-profit company, Kaiser is not publicly traded and has no beta.

• The betas for all companies remained stable in 2009, with only slight increases or decreases from 2008, and most companies had a beta greater than one, indicating that managed care stocks were more volatile than the overall market.
• Public managed care companies outperformed the stock market as a whole during the 2004–2007 period by a substantial margin.

• However, both managed care company stock prices and the market as a whole declined significantly in 2008.

• During the five-year period, managed care companies, as represented by the Morgan Stanley Healthcare Payor Index, increased 18 percent, while the Standard & Poor’s index declined by 13 percent. The index includes all companies analyzed in this report except Kaiser and HealthSpring.

• The data in the top chart was obtained from the Aetna Form 10-K.

• Market capitalization is the total value of a company’s common stock.

• The market capitalization of most companies surveyed declined significantly during 2008 and recovered partially in 2009.

• As a not-for-profit, Kaiser has no common stock. Therefore, it has no market capitalization or other related data.
Valuation (continued)

- The price-earnings (PE) ratio reflects the market’s expectation of future earnings growth and risk. It is the ratio of a company’s stock price to its earnings per share.

- Industry PE ratios continued to decline in 2009 for most companies. Only Coventry has recovered to 2007 levels.

- Health Net’s year-end PE of negative 50 for 2009 is not reflected in the corresponding chart.

- Since AMERIGROUP had a net loss in 2008, its 2008 PE ratio is not meaningful and is not shown.

- As a not-for-profit company, Kaiser is not publicly traded and has no PE ratio.
• The market-to-book ratio is a measure of shareholder value creation.

• It is the ratio of market capitalization to equity. Both the market capitalization and equity are calculated as of year-end.

• In 2008 and 2009, all of the companies, except for Coventry, traded at a premium-to-book value. However, all companies had declines in this ratio during the past two years.

• As a not-for-profit company, Kaiser is not publicly traded and has no market-to-book ratio.

• Return on equity is a component of the market-to-book ratio, but it is useful to look at it separately.

• In 2009, most of the companies had higher returns on average equity.

• AMERIGROUP and Kaiser had negative returns on average equity in 2008 and Health Net in 2009 since they incurred net losses.
Market Value per Risk Member

- Market value per member has long been used to assess the reasonableness of prices for managed care company purchase transactions.
- Risk membership was formerly regarded as more valuable than nonrisk membership because the potential profitability was thought to be greater. However, this potential was often not realized, and nonrisk membership appears to have increased in value.
- The shift toward nonrisk membership by the larger companies complicates the analysis of this data.
- It is clear that the market values HealthSpring’s Medicare membership highly.
- The change in market value of total membership, both risk and nonrisk, varied by company in 2009 and continues to be substantially lower than 2007.

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Appendix: Managed Care Company Analysis
Computation Guide

The managed care company information included in this report was developed using year-end data from major managed care companies. This appendix explains how the various data were accumulated and how operating statistics were calculated.

Financial statement information was obtained from annual reports and regulatory filings. A standard template was developed and populated with five years of data for each company, if available.

Membership data was obtained from annual reports and regulatory filings. Separate data was obtained for commercial, Medicare, Medicaid, TRICARE, and employer-funded (nonrisk) membership. Risk membership is the total of commercial, Medicare, TRICARE, and Medicaid risk membership. Total membership is the total of risk and nonrisk membership.

Earnings per share, shares outstanding, and employee data were obtained from annual reports and regulatory filings. Shares outstanding are the weighted-average shares outstanding during the year.

Stock prices were obtained from the Yahoo! Finance database of historical stock prices.

Per-member-per-month (PMPM) information was developed by dividing the applicable financial statement amount by estimated member months. Member months were estimated by multiplying estimated average membership by 12. Average membership was estimated by weighting membership at the end of the year by three, adding it to membership at the end of the prior year, and dividing the total by four. Ending membership was weighted more heavily than prior-year membership because most companies have a large proportion of their membership renewing early in the year. Business combinations during the year or atypical member renewal patterns could distort these data.

Medical cost ratio was calculated by dividing medical cost expense by healthcare premiums.

Administrative costs are generally the amount disclosed in the financial statements. Administrative costs exclude depreciation, amortization, interest, and restructuring costs.

Pretax operating profit is income before interest and taxes.

Pretax operating margin is pretax operating profit divided by revenue.

Days in accounts receivable is premiums receivable divided by premium revenue multiplied by 365. Some companies do not separately disclose premiums receivable but combine them with other receivables. In these cases, which are noted in the report, this statistic will be overstated.

Days in claims payable is medical costs payable divided by medical cost expense multiplied by 365. There may be differences among companies regarding which costs are included in medical costs payable. If so, this statistic may not be comparable across companies.

Long-term debt to capitalization is long-term debt divided by the total of long-term debt and stockholders’ equity.

Premiums to book value is total premiums divided by ending equity.

Market capitalization is the weighted average shares outstanding during the year multiplied by the year-end stock price.

Price-earnings ratio is the year-end stock price divided by diluted earnings per share for the year.

Market-to-book ratio is market capitalization divided by stockholders’ equity.

Return on average equity is net income divided by the average of stockholders’ equity at the beginning and the end of the year.

Market value per risk member is market capitalization divided by risk membership.

Market value per member is market capitalization divided by total (risk and nonrisk) membership.

WellPoint had significant acquisitions at the end 2005. In 2005, membership acquired from WellChoice was excluded from the PMPM calculations.

Membership acquired by United from PaciﬁCare at the end of 2005 is excluded from the 2005 PMPM calculations.
For more information, please contact:

Ed Giniat  
National Line of Business Leader – Healthcare & Pharmaceuticals  
312-665-2073  
eginiat@kpmg.com

Marc Scher  
Audit Sector Leader  
314-444-1430  
mscher@kpmg.com

Sam McGarr  
Tax Sector Leader  
954-847-3939  
smcgarr@kpmg.com

Bill Baker  
Advisory Sector Leader  
214-840-2519  
billbaker@kpmg.com

Mark Drozdowski  
Audit Sector Leader  
973-912-6640  
mdrozdowski@kpmg.com

Frank Mattei  
Tax Sector Leader  
267-256-1910  
fmattei@kpmg.com

David Blumberg  
Advisory Sector Leader  
267-256-3270  
dblumberg@kpmg.com

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