CFRA

Industry Surveys

Managed Health Care

MARCH 2023

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CHARTS & FIGURES

NEW THEMES

What's Changed: We updated our Financial Metrics to include 2022 results and included our estimates for 2024. Check out pages 6 and 7.

What's Changed: The U.S. government intends to officially end the public health emergency related to the Covid-19 pandemic on May 11, 2023. For an overview of the major health-related Covid-19 federal emergency declarations, see pages 17 and 18.

EXECUTIVE SUMMARY

CFRA has a neutral outlook for the managed health care industry. We think the progression of labor conditions will continue to dictate the evolution of employer-sponsored and Medicaid coverage going forward. The proliferation of cheaper, off-brand drugs, and vertical integration should both help contain costs, while we see the emergence of telehealth as a new trend positively impacting cost trends. The progression of medical costs will be an important indicator in determining the trajectory of profitability and EPS growth. We expect further normalization in medical utilizations as 2023 progresses, due to lower Covid-19 related costs. We also think risks associated with higher acuity due to deferred care may result in increasing medical costs. We anticipate the Inflation Reduction Act 2022 will have the potential to benefit managed care companies in the near term. While the demise of Haven Health could provide short-term relief for the industry, we think Amazon Pharmacy and Amazon's ongoing acquisition of One Medical could potentially be disruptors for managed care firms in the long run.

The Evolution of the Labor Market Is the Main Driver

We see a recovery in the labor market as economic activity improves. A corresponding rise in Medicaid enrollments, although with a lag, was a counterbalance to the termination of millions employer-sponsored insurance plans during the pandemic. Managed care organizations (MCOs) with high exposure to employer-sponsored coverage should see their outlook improve, in our view, as the unemployment rate falls and labor force participation rate continues to rise. Meanwhile, MCOs with high Medicaid coverage, who were beneficiaries earlier in the pandemic, may have a less rosy outlook.

Proliferation of Cheaper, Off-brand Drugs

Managed care firms benefited in 2022 from a surge in FDA approvals of first generics and biosimilars. These drugs are priced materially lower than their brand-name competitors, leading to lower drug costs for managed care firms as they shift health plan members to these cheaper versions.

Integration with Pharmacy Benefit Managers (PBMs) Remains Imperative

Managed care firms with integrated PBMs will likely continue growing, by CFRA analysis, as their cost advantage creates an opportunity for them to take market share from competitors with higher costs when customers become more selective on price. Among the largest managed care firms, UnitedHealth, Cigna, Humana, Centene, and Elevance Health will likely benefit from this competitive advantage, in our opinion. Yet, we think the emergence of Amazon Pharmacy could become a long-term threat to PBMs.

Telehealth's Positive Impact on Costs Is Emerging as a New Trend

Managed care companies might benefit in the long run from emerging technologies in the telemedicine space. We expect telemedicine tools to help cut down on unnecessary patient and emergency room visits. In 2022, telehealth utilization flattened relative to the prior year, even as Covid-19 infection severity declines.

Enactment of Inflation Reduction Act 2022, Efforts to Repeal the Affordable Care Act (ACA), and the Future of Medicare-for-All Proposals

The Inflation Reduction Act enacted in August 2022 will help to lower prescription drug prices and benefit MCOs, in our opinion. The Supreme Court overturned a challenge to the ACA in mid-2021, after a federal judge in Texas ruled the ACA to be unconstitutional in 2018. This decision eliminated uncertainty and headline risk, and is beneficial to MCOs, in our view.

Although Medicare for All Is a Risk for the Industry, We Find It Unlikely to Materialize

Medicare for All appears to be gaining increased public support, yet we think it is highly unlikely to become law in the near future. With the current moderate-leaning Senate set-up, we do not expect Congress to easily opt for a universal health care system.

Managed Health Care

Outlook: Neutral

MARKET CAP BREAKDOWN*

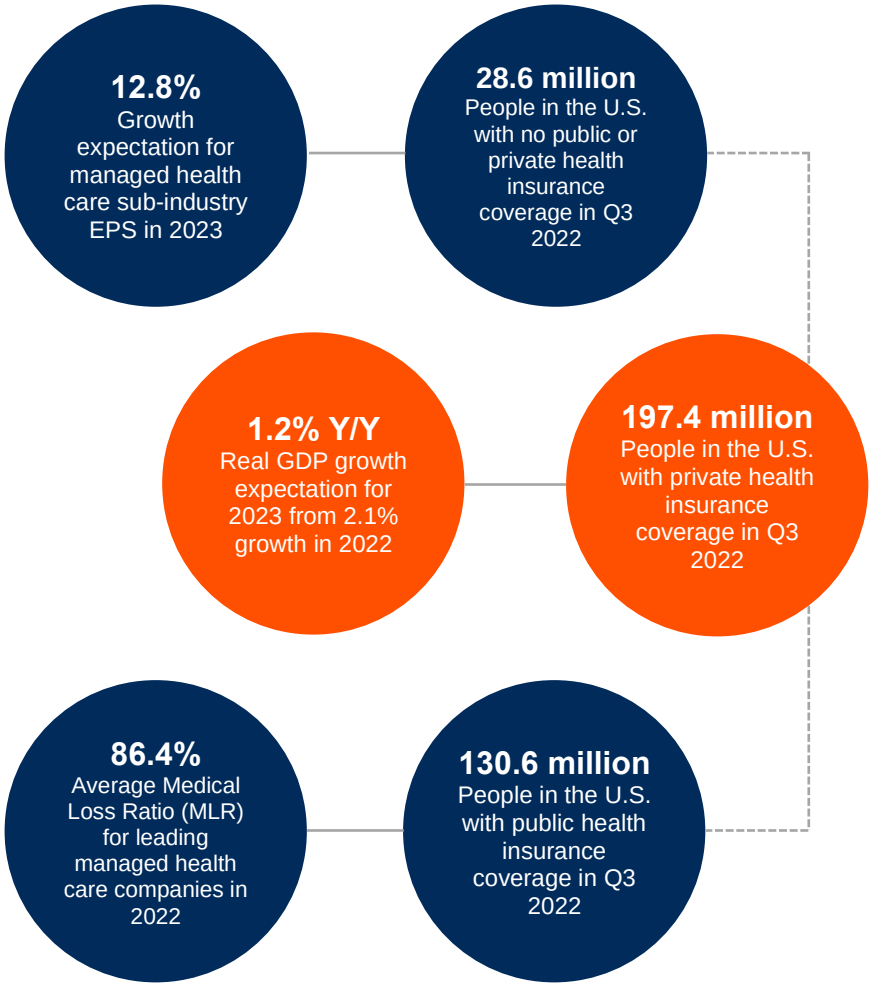
RANK NO.	COMPANY NAME	MARKET CAP ($ billion)
1	UnitedHealth Group	451.6
2	Elevance Health	113.1
3	Cigna	88.0
4	Humana	63.3
5	Centene	38.6
	Others†	23.8

Source: CFRA, S&P Global Market Intelligence.
**Data as of February 28, 2023.*
†Refer to the "Comparative Company Analysis" section of this survey for the list of companies.

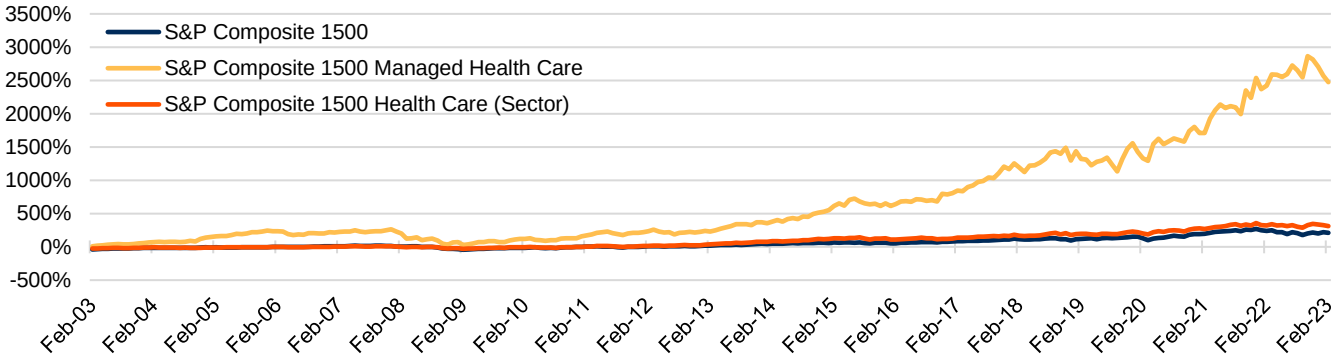
ETF FOCUS

XLV Health Care Select Sector SPDR Fund	AUM ($M) 40,719.8	Expense Ratio 0.10
VHT Vanguard Health Care	AUM ($M) 17,162.0	Expense Ratio 0.10
IYH iShares U.S. Healthcare	AUM ($M) 3,278.0	Expense Ratio 0.39
IHF iShares U.S. Healthcare Providers	AUM ($M) 1,418.4	Expense Ratio 0.39
XHS SPDR S&P Health Care Services	AUM ($M) 116.6	Expense Ratio 0.35

BY THE NUMBERS



20-YEAR INDEX PERFORMANCE*

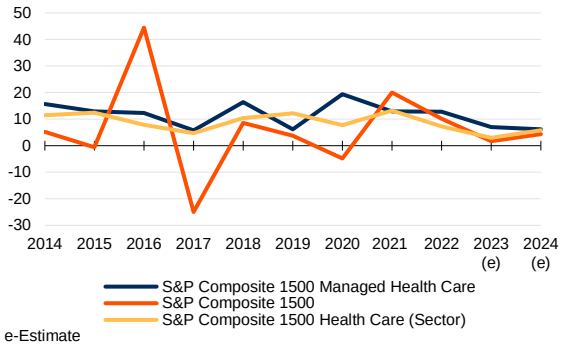


*Data through February 28, 2023.
Source: S&P Global Market Intelligence.

FINANCIAL METRICS

Revenue Growth

(percent change, Y/Y)

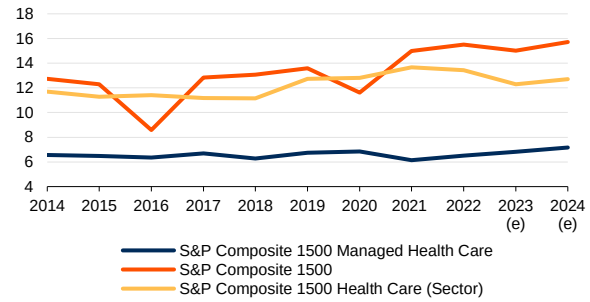


e-Estimate
Source: CFRA, S&P Global Market Intelligence.

- Revenue growth for the managed health care industry is expected to slow to 7.1% in 2023, compared to a 12.8% growth in the prior year, due to the impact of a weaker economic environment amid recessionary pressures.
- Under similar circumstances, we expect revenue for the health care industry to grow 3.0% in 2023 and 5.8% in 2024.

EBIT Margin

(percent)

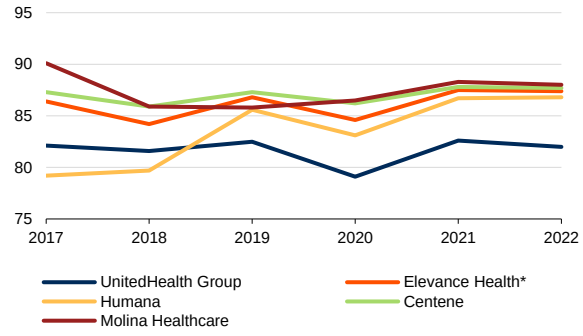


e-Estimate
Source: CFRA, S&P Global Market Intelligence.

- We expect EBIT margin for the industry to grow to 6.8% in 2023 and 7.2% in 2024, as care patterns and medical utilizations return to normalized levels.
- The progression of medical costs will continue to be an important indicator to determine the trajectory of profitability. Medical costs are on a rising trend due to normalizing care patterns.

Medical Loss Ratio

(percent)

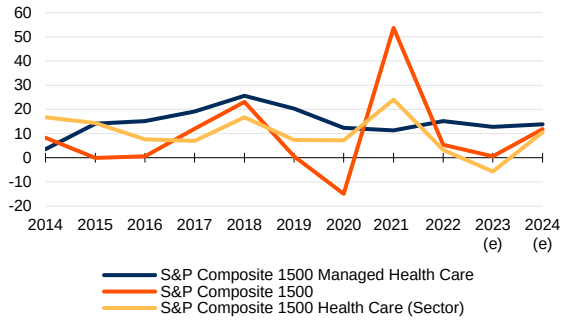


*Previously known as Anthem.
Source: Company reports.

- The industry's Medical Loss Ratios (MLR, the proportion of medical claims to premiums) trended marginally downward in 2022, driven by lower claims on Covid-19 related costs.
- The leading managed health care companies reported higher MLRs at the end of 2021, mainly due to higher Covid-19 related costs and the repeal of health insurance tax.
- Looking forward to 2023, we expect MLRs to trend higher as we expect more normalized medical utilizations. We also see cost inflation remaining an important risk going forward, with the potential to negatively impact margin trends. We think continued inflationary pressures may result in higher labor, medical supply, and services costs.

EPS Growth

(percent change, Y/Y)

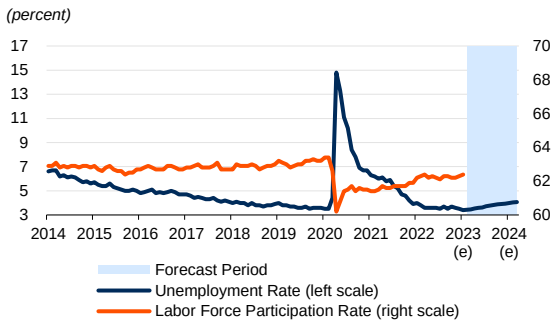


e-Estimate
Source: CFRA, S&P Global Market Intelligence.

- We forecast industry EPS growth to remain in the mid-teens range with 12.8% growth in 2023 and 13.9% in 2024, supported by stabilization of MLRs.
- We expect the pursuit of value-based care by health care providers, higher Medicare payments, and lower Covid-19-related costs to support earnings growth, though we note that some uncertainty on the economy remains.

KEY INDUSTRY DRIVERS

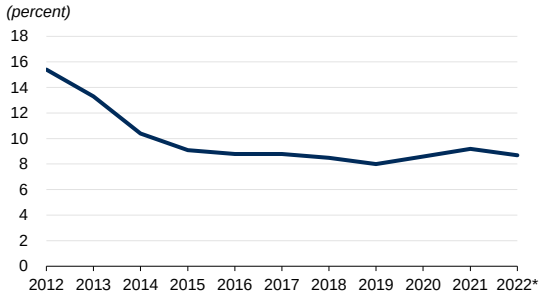
Unemployment Rate



*Actual data through January 2023, forecasted unemployment data by Action Economics in shaded area.
Source: U.S. Bureau of Labor Statistics, Action Economics.

- The labor market has recently demonstrated signs of improvement supported by progressive job growth, contributing to a 53-year low unemployment rate of 3.4% versus the previous market estimate of 3.6% in January 2023.
- Action Economics calculates the civilian unemployment rate to average at 3.8% in 2023 and 4.2% in 2024.

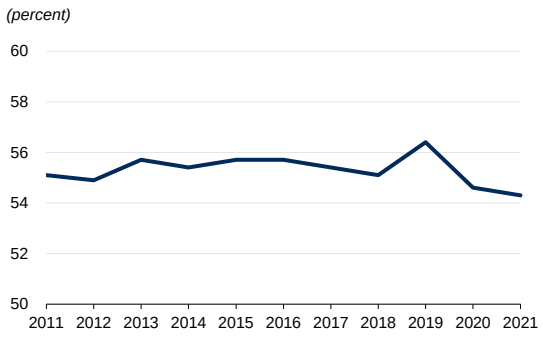
Uninsured Rate



*As of Q3 2022.
Source: U.S. Census Bureau, CDC.

- The industry has benefited in recent years from a decrease in uninsured Americans. The percentage of people with health insurance increased to 91.0% as of the third quarter of 2022 (latest available), compared to 86.7% in 2013, with the majority having private health insurance coverage (60.2%).
- We believe the improving unemployment rate will lower the uninsured rate in 2023 and 2024.

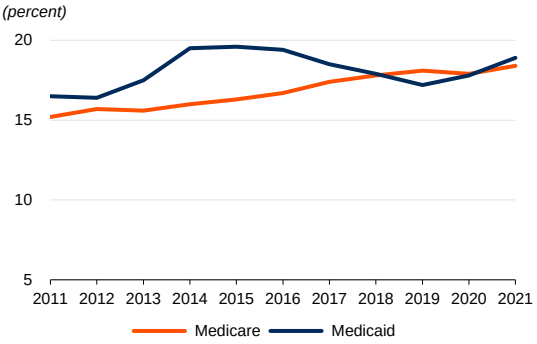
Employer-sponsored Health Insurance Coverage of the U.S. Population*



*Latest available data.
Source: Kaiser Family Foundation.

- Employer-sponsored health insurance coverage has been on a constant trend, with a marginal increase from 2013 to 2019. The percentage of employer-sponsored health insurance coverage slightly declined to 54.3% in 2021 (latest available) from 54.6% in 2020.
- We expect employer-sponsored health insurance coverage to recover in 2023 and 2024, supported by healthy unemployment rate forecasts in both years.

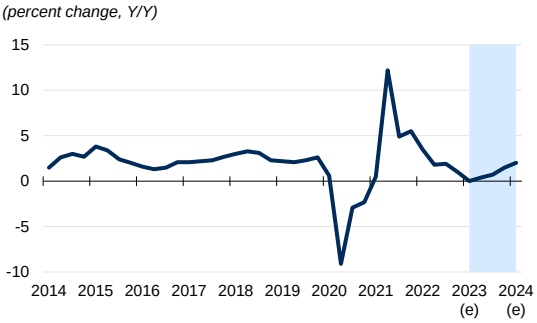
Health Insurance Coverage of the U.S. Population*



*Latest available data.
Source: Kaiser Family Foundation.

- The percentage of the U.S. population covered by Medicare had steadily increased since 2010, compared to the growth of Medicaid.
- The percentage of Medicare and Medicaid coverage grew by 18.4% and 18.9%, respectively, in 2021 from 2020, reflecting recovery from the pandemic.
- We forecast the percentage of Medicare and Medicaid coverage could potentially improve in the medium to long term, depending on future changes on health care policy.

U.S. Real GDP Growth Rate*



*Actual data as of Q4 2022. Forecast by Action Economics in shaded area.
Source: Bureau of Economic Analysis, Action Economics.

- Action Economics projects U.S. real GDP growth to decelerate to 1.2% in 2023, compared with 2.1% in 2022, amid economic uncertainty with a possible recession.
- Under the scenario of faster-than-anticipated economic recovery and improvement in the labor market, we estimate managed health care companies could achieve 2023 revenue growth in the low-teens, vs. the 7.1% currently expected by CFRA.

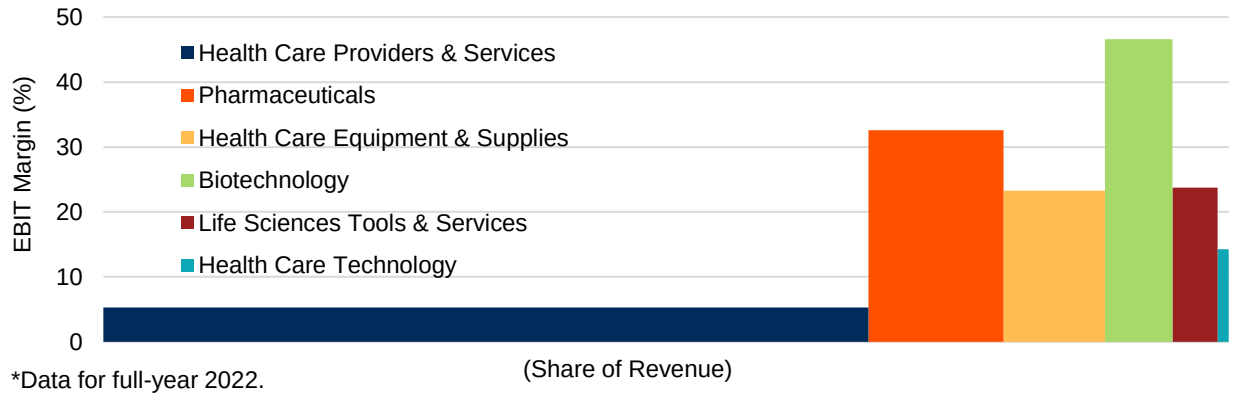
INDUSTRY TRENDS

Competitive Environment

INDUSTRY PROFIT SHARE MAP

The managed health care sub-industry falls under the health care providers & services industry. In the last five years, the sub-industry made up 34.2% of total health care providers & services industry revenue and 23.4% of the broader health care sector's total revenue. The average EBIT margin for the health care providers & services industry stands at 5.3% and the managed health care sub-industry is estimated to reach an EBIT margin of 6.8% in 2023.

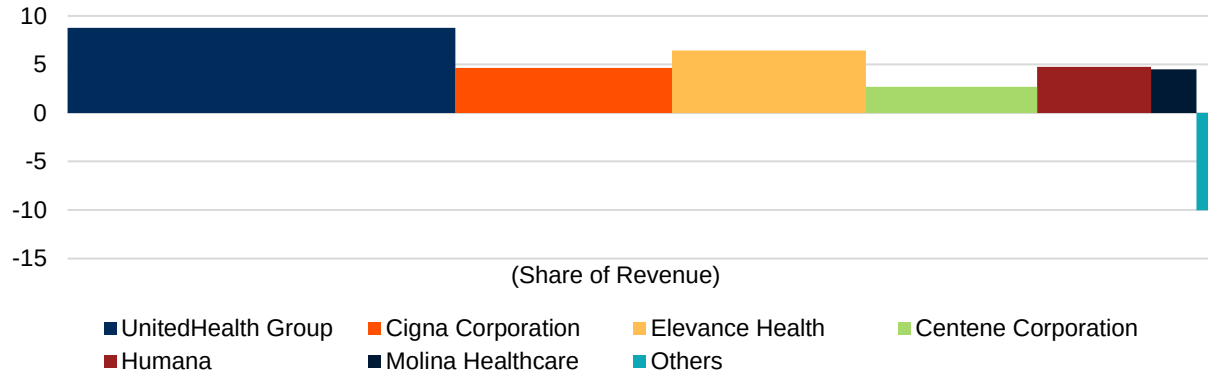
PROFIT SHARE MAP OF THE HEALTH CARE SECTOR*
(5-year average)



*Data for full-year 2022.
Source: CFRA, S&P Global Market Intelligence.

Within the managed health care sub-industry, UnitedHealth Group contributed most in terms of revenue (34.5%) and had the highest profit margin at 8.8%, while Cigna Corporation contributed the second highest revenue at 19.2%. Although GICS categorizes Cigna Corporation to be in the health care services sub-industry, it is also a significant player in the managed health care sub-industry, in our view.

PROFIT SHARE MAP OF THE MANAGED HEALTH CARE SUB-INDUSTRY*
(EBIT margin, %)



*Data for full-year 2022 (Clover Health's latest available data as of Q3 2022).
Source: CFRA, S&P Global Market Intelligence.

The Threat from Amazon

In January 2021, Amazon, Berkshire Hathaway, and JP Morgan announced that they will disband Haven Healthcare, the nonprofit health care venture that they launched together in 2018 to provide more affordable and simpler health care to their U.S. employees and their families. When it was first launched, Haven Healthcare was perceived as a significant threat to existing managed health care companies, as it aimed to use technology to cut health care costs and make high-quality health care easier to understand and access. Due to the challenges related to diverse locations, different priorities, costs, and fast executive turnover, the venture was dissolved in February 2021. CFRA thinks the announcement comes as a relief for the managed health care sub-industry, eliminating a significant threat.

Yet, we think the emergence of Amazon Pharmacy has the potential to be a disruptor for managed care companies' pharmacy benefit managers (PBMs) in the long run. Launched in November 2020, Amazon Pharmacy is a new service offering by Amazon that allows customers to complete pharmacy transactions, such as filling prescriptions, via their desktop or mobile platform. The launch timing was very appropriate for Amazon, as people have been extensively using the internet during the pandemic and might enjoy the convenience offered by Amazon to order from home, particularly for Prime members, who can get free two-day delivery services and some other privileges. The biggest threat for the system may be the transparency, as Amazon Pharmacy shows in its platform the copay price for a drug with insurance and the lowest price without insurance.

In August 2022, Amazon stated that it was shutting down its retail virtual health care program, Amazon Care, just six months after announcing a nationwide expansion of its virtual health care services. The program offered virtual and in-person appointments with medical professionals, and included services for blood draws, vaccinations, and Covid-19 testing. Despite the end of Amazon Care, Amazon announced in July 2022 that it was acquiring primary care start-up One Medical for $3.9 billion. In early December 2022, Amazon signed an agreement to acquire One Medical, with the goal to "reinvent" health care. One Medical has more than 125 clinic locations nationwide while Amazon also intends to launch a virtual health service, Amazon Clinic, to serve people in 32 states. CFRA thinks this competitive advantage could be a threat to the existing managed care companies in the industry. In our view, Amazon's business strategy of tapping digital health and managed care space could be significantly disruptive in the long run as it may capture some market share from existing players.

PORTER'S FIVE FORCES

Threat of New Entrants (Low)

The threat of new entrants is low in this industry due to scale, which is frequently a necessity to achieve profitability. Existing companies in this industry have a thorough understanding of the health care system and have developed critical industry connections for the success of their business. The necessary expertise and network capabilities are difficult for new entrants to develop.

Threat of Substitutes (Low)

Purchasers of managed care services can easily substitute for self-paid health care (*i.e.*, no health plan), which involves paying for medical costs as they come up. Companies purchasing health plans can also provide their own insurance plans. However, most Americans have limited choice in either employer-provided managed health care or government-provided managed health care (Medicare or Medicaid).

Bargaining Power of Customers (Low)

Buyers of managed care services and offerings tend to be companies and individuals, both of whom tend to wield low power because of geographic limitations and information asymmetry. While large corporate customers have some bargaining power, retail customers usually do not have much control over insurance prices. However, the cost of switching to other insurance providers is low, which gives customers some negotiation power.

Bargaining Power of Suppliers (Moderate)

Suppliers often include companies that sell drugs, medical devices, and medical supplies. These companies often wield moderate negotiation power as most of them have significant scale or provide a unique product. Suppliers that provide commoditized goods are less likely to wield significant negotiation power.

Degree of Rivalry (High)

Competition can be fierce among companies that compete in the same markets or on a national level in markets where rivalry is strong. Markets tend to be oligopolistic because scale is often necessary to achieve profitability. Lower costs resulting from PBMs make integrated managed care firms more competitive. With lower medical costs derived through their own PBMs, integrated firms have generally been more competitive in winning managed care contracts and increasing earnings, in our view. This is because their lower costs allow them to maintain profits with lower premiums than their peers utilizing third-party PBMs. In turn, more competitive premiums bring in more managed care contract wins.

MAJOR COMPANIES IN THE MANAGED HEALTH CARE SUB-INDUSTRY

	COMPANY	2022 REVENUE (in $ million)	BUSINESS DESCRIPTION
1)	UnitedHealth Group Incorporated	324,162	UnitedHealth Group operates as a diversified health care company in the U.S. It operates through four segments: UnitedHealthcare, OptumHealth, OptumInsight, and OptumRx. The UnitedHealthcare segment offers consumer-oriented health benefit plans and services. The OptumHealth segment provides access to networks of care provider specialists, health management services, care delivery, consumer engagement, and financial services. The OptumInsight segment offers software and information products, advisory consulting arrangements, and services outsourcing contracts. The OptumRx segment provides pharmacy care services and programs.
2)	Cigna Corporation	180,642	Cigna offers medical, dental, disability, life and accident insurance, and related products and services. The company's segments include Global Health Care, Global Supplemental Benefits, Group Disability and Life, and Other Operations and Corporate. Its Global Health Care segment aggregates the commercial and government operating segments. Its commercial operating segment encompasses the U.S. commercial and certain international health care businesses serving employers and their employees, other groups, and individuals. Its Global Supplemental Benefits segment offers supplemental health, life, and accident insurance products in selected international markets and in the U.S. Its Group Disability and Life segment provides group long-term and short-term disability insurance, group life insurance, accident and specialty insurance, and related services.
3)	Elevance Health, Inc.	155,660	Elevance Health operates as a health benefits company. It supports consumers, families, and communities across the entire care journey connecting to the care, support, and resources to lead healthier lives. It serves approximately 118 million people through a portfolio of medical, digital, pharmacy, behavioral, clinical, and care solutions. The company was formerly known as Anthem Inc. and changed its name to Elevance Health Inc. in June 2022. Elevance Health was founded in 1944 and is headquartered in Indianapolis, Indiana.
4)	Centene Corporation	144,547	Centene operates as a multinational health care enterprise that provides programs and services to under-insured and uninsured individuals in the U.S. Its Managed Care segment offers health plan coverage to individuals through government-subsidized programs. The company's Specialty Services segment provides a vast variety of services (*e.g.,* PBM services, care management software, and technical components of care management programs) to a number of governmental, non-governmental, and business organizations. The company provides its services through primary and specialty care physicians, hospitals, and ancillary providers. In January 2021, Centene announced its decision to acquire Magellan Health, a large managed health care company with a focus on specialty health care and pharmacy management, for a total enterprise value of $2.2 billion.
5)	Humana Inc.	92,870	Humana operates as a health and well-being company in the U.S. It operates through Retail, Group and Specialty, and Healthcare Services segments. The company offers medical and supplemental benefit plans to individuals. It also has a contract with the Centers for Medicare and Medicaid Services to administer the Limited Income Newly Eligible Transition prescription drug plan program; and contracts with various states to provide Medicaid, dual eligible, and long-term support services benefits. In addition, the company provides commercial fully insured medical and specialty health insurance benefits to individuals and employer groups, as well as military services. Further, it offers pharmacy solutions, provider services, predictive modeling and informatics services, and clinical care services.
6)	Molina Healthcare, Inc.	31,609	Molina provides managed health care services to low-income families and individuals under the Medicaid and Medicare programs and through the state insurance marketplaces. The company operates in two segments: Health Plans and Other. The company offers its health care services for its members through contracts with a network of providers, including independent physicians and physician groups, hospitals, ancillary providers, and pharmacies.

7)	Oscar Health, Inc.	4,924	Oscar Health provides health insurance products and services in the U.S. The company offers Individual & Family, Small Group, and Medicare Advantage plans, as well as +Oscar, a full stack technology platform. It also provides reinsurance products. The company was formerly known as Mulberry Health Inc. and changed its name to Oscar Health, Inc.
8)	Clover Health Investments, Corp.*	3,367	Clover Health Investments operates as a Medicare Advantage insurer in the U.S. Through its software platform, the company provides preferred provider organization and health maintenance organization health plans for Medicare-eligible consumers.
9)	HealthEquity, Inc.	857	HealthEquity provides technology-enabled services platforms to consumers and employers in the U.S. The company offers cloud-based platforms for individuals to make health-related saving and spending decisions. It also provides a mutual fund investment platform and online-only automated investment advisory services. In addition, the company offers flexible spending accounts, health reimbursement arrangements, and Consolidated Omnibus Budget Reconciliation Act continuation services, and also administers pretax commuter benefit programs.

*Latest available data as of Q3 2022.
Source: CFRA, S&P Global Market Intelligence.

Membership Evolution

Managed health care revenues are primarily driven by membership enrollment in health care insurance plans and increases in premiums charged to consumers of health care services. The growth in enrollees in the last several years has been aided by the addition of new hires to company-sponsored health plans, which sharply slowed down in 2020 with massive numbers of layoffs (due to Covid-19). In 2022, managed health care companies benefited from membership growth and premium increases with 3.6% year-over-year growth. Despite a lower growth rate compared to 2021's 4.6% growth, we think that the growth reflects a healthy recovery from the pandemic as unemployment wanes.

MANAGED HEALTH CARE MEMBERSHIP ENROLLMENT
(in thousands)

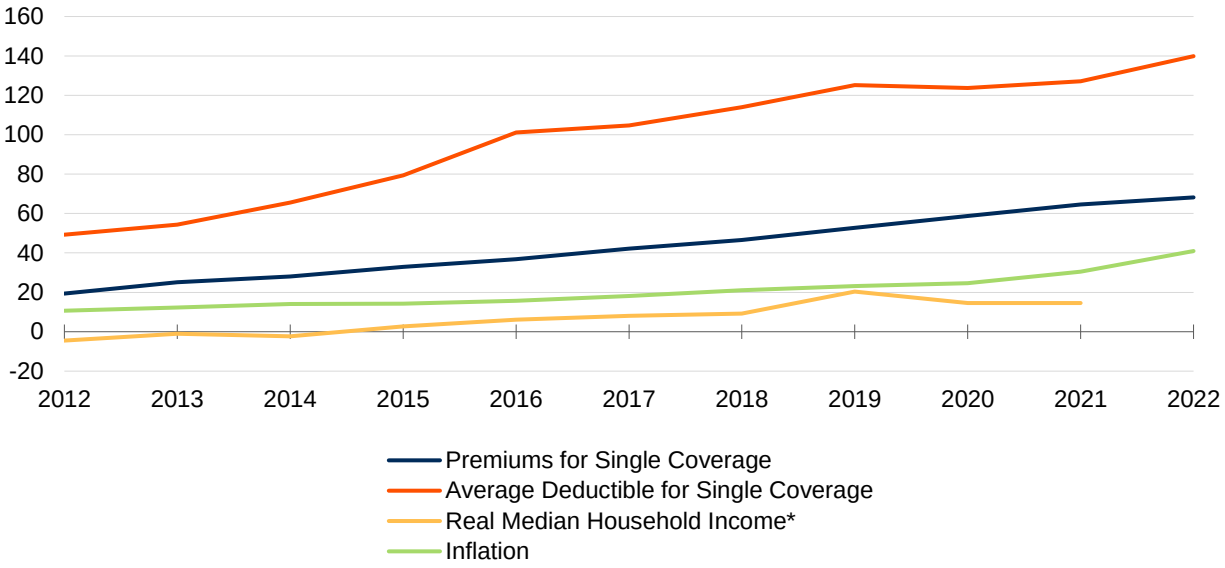
RANK NO.	COMPANY NAME	TOTAL MEMBERSHIP ENROLLMENT *(in millions)*						PERCENT CHANGE *(%)*				
		2017	2018	2019	2020	2021	2022	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
1	UnitedHealth Group	49,525	49,075	49,150	48,435	50,630	51,965	(0.9)	0.2	(1.5)	4.5	2.6
2	Elevance Health	40,299	39,938	41,000	42,925	45,374	47,531	(0.9)	2.7	4.7	5.7	4.8
3	Centene†	12,207	14,020	15,242	25,523	26,611	27,061	14.8	8.7	67.5	4.3	1.7
4	CVS Health Corp§	22,237	22,101	22,908	23,412	23,848	24,396	(0.6)	3.7	2.2	1.9	2.3
5	Humana	14,003	16,577	16,667	16,832	17,067	17,079	18.4	0.5	1.0	1.4	0.1
6	Cigna	16,377	16,961	17,145	16,650	17,081	18,004	3.6	1.1	(2.9)	2.6	5.4
7	HealthEquity	3,403	3,994	5,344	5,384	5,782	7,207	17.4	33.8	0.7	7.4	24.6
8	Molina Healthcare	4,453	3,821	3,331	4,032	5,199	5,258	(14.2)	(12.8)	21.0	28.9	1.1
9	Clover Health*	N/A	N/A	43	58	68	87	N/A	N/A	36.3	17.3	27.2
	TOTAL	162,504	166,486	170,830	183,251	191,660	198,588	2.5	2.6	7.3	4.6	3.6

**Previously known as Anthem. †Centene acquired Magellan Health in January 2022. §CVS Health Corporation acquired Aetna in November 2018.
Source: Company reports.

According to the Kaiser Family Foundation (KFF), 88% of covered workers had a deductible plan in 2022, compared to 85% in 2021 and 74% in 2011. For those workers who have a plan with a deductible, the average single deductible in 2022 was $1,763, compared to $1,669 in 2021 and $917 in 2010. Additionally, from 2012 to 2022, average premiums for single coverage increased 40.9% to $7,911, and the average deductible for single covered workers in health plans increased 60.7% to $1,763.

Meanwhile, real household income only increased 20% in the 2011-2021 period (latest available). Higher deductibles and premiums are one reason Americans may be inclined to forgo health insurance and health expenditures, but potentially stronger job market in the near term could help to reverse the trend, in our view.

CUMULATIVE GROWTH IN HEALTH INSURANCE COSTS HAS SIGNIFICANTLY OUTPACED WAGE GROWTH
(in percent)



*Latest available data as of 2021.
Source: Kaiser Family Foundation, Federal Reserve Economic Data, Bureau of Labor Statistics, Minneapolis Fed.

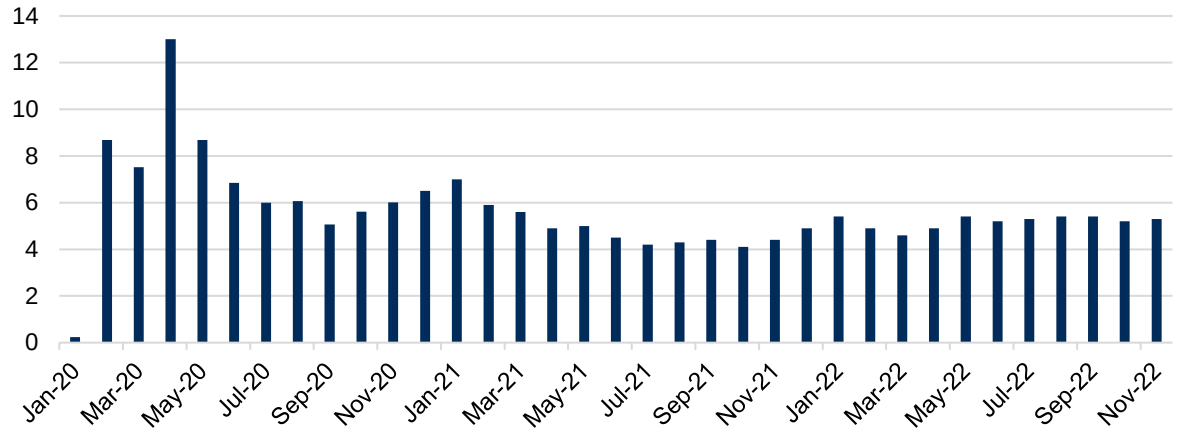
Telehealth's Positive Impact on Costs a New Trend

We see the emergence of telehealth (visiting a health care provider via a computer instead of in person) as a new trend that could positively impact the managed health care sub-industry's cost trends in the long run. Managed care companies have been increasing the use of telemedicine tools since the beginning of the Covid-19 pandemic due to stay-at-home orders and social distancing recommendations. Despite early reluctance from patients, the country is now experiencing an increase in telehealth utilization as people progressively see it as a better and more comfortable experience with the added benefit of obtaining it at a lower cost. The U.S. telehealth market reached around $83.5 billion at the end of 2022, according to Grand View Research. Going forward, this growth is nowhere near stopping. For the 2023-2030 period, the U.S. telehealth market is expected to grow at a 24% CAGR, according to Grand View Research.

UnitedHealth, Elevance Health, Humana, Cigna, Centene, and Molina might benefit in the long run from emerging technologies in the telemedicine space. We expect telemedicine tools will help cut down on unnecessary patient and emergency room visits. Based on a study conducted by Teladoc – the largest publicly traded telemedicine company – employers save 28% on health-benefit costs, including a 35% reduction in visits to hospitals, by employing telemedicine. Moreover, patients may be more willing to engage in regular "virtual" dialogue with their primary care physicians, according to the Teladoc study, which could also reduce long-term health care costs, in our view.

Recent data from FAIR Health, a nonprofit health care information provider, indicates that telehealth comprised 5.3% of medical claim lines in November 2022 (latest available). Between May 2021 and November 2022, the data suggests that telehealth, as a percentage of medical claims, has remained stable within a range of 4% to 6% of medical claims.

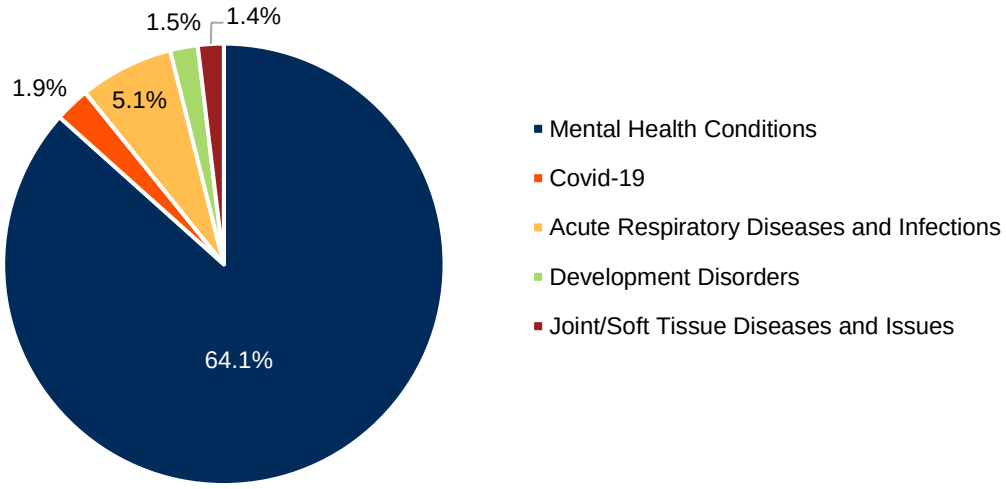
TELEHEALTH MEDICAL CLAIM LINES*
(in percent)



*Latest available data.
Source: FAIR Health.

In addition, telehealth has also expanded its services to treat multiple diagnosis, with behavioral and mental health accounting for more than 64% of total telehealth utilization, according to data from FAIR Health.

PERCENTAGE OF TOTAL TELEHEALTH SERVICES BY DIAGNOSIS*
(in percent)



*Data as of November 2022.
Source: FAIR Health, Washington Analysis.

The End of Public Health Emergency

The government played a vital role in addressing the Covid-19 pandemic when it declared a public health emergency (PHE) on January 27, 2020. On January 3, 2023, President Joe Biden announced the government's intention to officially end the PHE on May 11, 2023, related to the Covid-19 pandemic. The government also provided an overview on the major health-related Covid-19 federal emergency declarations that have been formed and summarized the flexibilities trigged by some areas as per the tables on the following pages:

COVERAGE, COSTS, AND PAYMENT FOR COVID-19 TESTING, TREATMENTS, AND VACCINES

DESCRIPTION	EXPIRATION
MEDICARE	
Beneficiaries in traditional Medicare and Medicare Advantage pay no cost sharing for Covid-19 at-home testing (up to eight tests per month), testing-related services, and certain treatments, including oral antiviral drugs (such as Paxlovid).	End of the PHE, except coverage and costs for oral antivirals, where changes were made in the Consolidated Appropriations Act 2023.
MEDICAID AND CHIP	
Enrollees receive coverage of Covid-19 vaccines and vaccine administration without cost sharing.	No longer tied to the PHE; provisions in the IRA require Medicaid and CHIP programs to cover all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines for adults, including the Covid-19 vaccine, and vaccine administration without cost sharing as a mandatory Medicaid benefit (coverage of ACIP-recommended vaccines for children in Medicaid and CHIP was already required).
Enrollees receive coverage of coronavirus testing, including at-home, and Covid-19 treatment services without cost sharing.	Last day of the first calendar quarter beginning one year after end of the PHE.
New eligibility pathway to cover Covid-19 testing and testing-related, vaccinations, and treatment services for uninsured individuals; coverage group elected at state option with 100% federal matching funds.	End of the PHE.
PRIVATE HEALTH INSURANCE	
Group health plans and individual health insurance plans are required to cover Covid-19 tests and testing-related services without cost sharing or prior authorization or other medical management requirements. Beginning January 15, 2022, this requirement applies to over-the-counter (OTC) Covid-19 tests authorized, cleared, or approved by the FDA. Health plans must cover up to 8 free OTC at-home tests per covered individual per month, and no physician's order or prescription is required. Plans may limit reimbursement to no less than the actual or negotiated price or $12 per test (whichever is lower). Plans can set up a network of providers, such as pharmacies or retailers, to provide OTC tests for free rather than having patients to pay up front and submit claims for reimbursement, but the coverage requirement applies whether or not consumers get tests from participating providers.	End of the PHE.
Group health plans and individual health insurance (including grandfathered plans) must reimburse out-of-network providers for tests and related services.	End of the PHE.
Plans and issuers must cover Covid-19 vaccines without cost sharing even when provided by out-of-network providers and must reimburse out-of-network providers a reasonable amount for vaccine administration; federal regulations specify the Medicare reimbursement rate for vaccine administration is a reasonable amount.	End of the PHE.

Source: Kaiser Family Foundation.

TELEHEALTH

DESCRIPTION	EXPIRATION
MEDICARE	
Among the major changes to Medicare coverage of telehealth during the PHE: • Medicare beneficiaries in any geographic area can receive telehealth services, rather than beneficiaries living in rural areas only. • Beneficiaries can remain in their homes for telehealth visits reimbursed by Medicare, rather than needing to travel to a health care facility. • Telehealth visits can be delivered via smartphone in lieu of equipment with both audio and video capability. • An expanded list of Medicare-covered services can be provided via telehealth.	The Consolidated Appropriations Act 2023 extended these flexibilities through December 31, 2024, regardless of the status of the PHE; previously these flexibilities were set to expire after 151 days after the end of the PHE.
Federally qualified health centers and rural health clinics can provide telehealth services to Medicare beneficiaries (*i.e.*, can be distant site providers), rather than limited to being an originating site provider for telehealth (*i.e.*, where the beneficiary is located).	The Consolidated Appropriations Act 2023 extended these flexibilities through December 31, 2024, regardless of the status of the PHE; previously these flexibilities were set to expire after 151 days after the end of the PHE.
MEDICAID AND CHIP	
All 50 states and DC expanded coverage and/or access to telehealth services in Medicaid. States have broad authority to cover telehealth in Medicaid and CHIP without federal approval, including flexibilities for allowable populations, services and payment rates, providers, technology, and managed care requirements.	Various; may be tied to federal and/or state public health emergencies. Most states have made, or plan to make, some Medicaid telehealth flexibilities permanent.
CROSSPAYER	
All states and D.C. temporarily waived some aspects of state licensure requirements, so that providers with equivalent licenses in other states could practice via telehealth.	Various; in some states; these waivers are still active and tied to the end of PHE, in others they have expired. Some states have made allowances for long-term or permanent interstate telemedicine.
HHS waived potential penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies during the Covid-19 nationwide public health emergency, which allows for widely accessible services like FaceTime or Skype to be used for telemedicine purposes, even if the service is not related to Covid-19.	End of the PHE.
DEA-registered providers can use telemedicine to issue prescriptions for controlled substances to patients without an in-person evaluation, if they meet certain conditions.	End of the PHE, unless DEA specifies an earlier date.

Source: Kaiser Family Foundation.

Operating Environment

In the long term, a shift in demographics toward an older population will likely drive higher levels of demand for managed health care. The proportion of the U.S. population aged 65 and over is projected to increase to 94.7 million by 2060 from 55.7 million in 2020 (latest available), according to the U.S. Administration on Aging.

Health Care Spending: Declining for Physician Services, Rising for Prescription Medicine

In the fourth quarter of 2022, the 1.1% year-over-year increase in GDP was largely attributable to an increase in personal consumption expenditures (PCE), led by an incline in food services and accommodations, recreation services, and health care spending on the services front. Health care, which falls under household consumption expenditures, contributed 15.7% of the net year-over-year increase in the fourth quarter of 2022 GDP.

It is important to note that PCE in health care comprises physician services (physician offices and care center revenues) and hospital, as well as nursing home services (hospitals, nursing, and residential care facilities revenue). Therefore, this drop mainly has implications on managed care as it is related to the decrease in elective procedures due to delays and cancellations resulting from stay-at-home and social distancing recommendations. The impact was worst in April 2020 and showed improvement in the subsequent months as states reopened and elective procedures returned, albeit slowly, in our view.

During 2016-2021, the payer net spending on prescription medicine in the U.S. increased 4.8%, attributed by the increase of negotiated discounts and rebates to payers and providers in competitive markets, according to the latest report, “The Use of Medicines in the U.S.,” published by IQVIA in April 2022. Future global spending on prescription medicines is estimated to grow at a compound annual growth rate (CAGR) of 3% to 6% through 2026, reaching a total market size of about $1.8 trillion. Centers for Medicare and Medicaid Services (CMS) projections estimate that prescription drug spending will experience an average growth of 5.9% from 2022 through 2028, up from 4.8% in 2021.

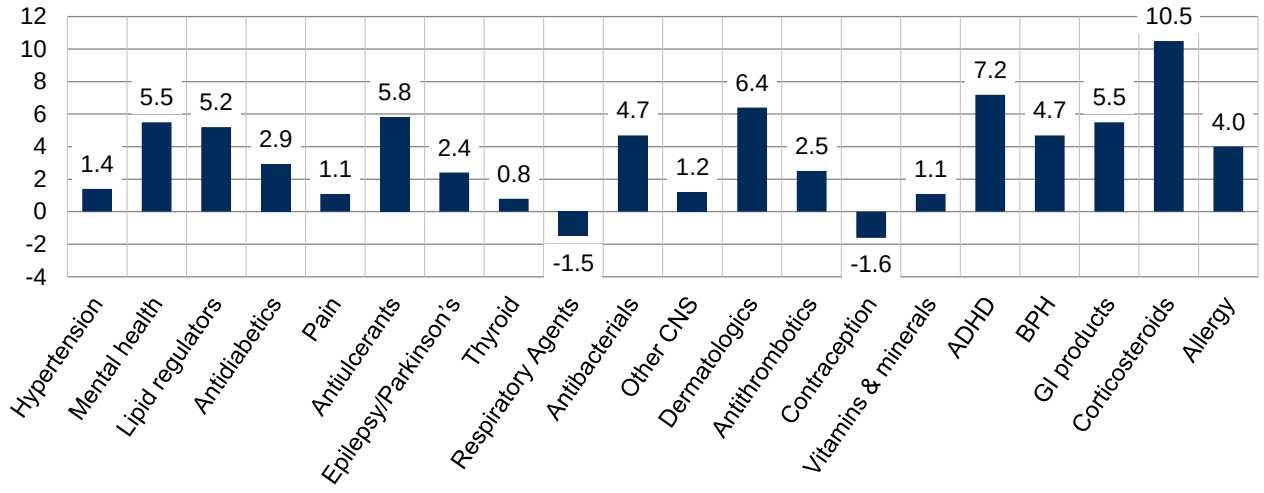
GROWTH IN NATIONAL HEALTH CARE EXPENDITURES, BY SOURCE
(annual growth rates, in percent)

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Consumer out-of-pocket	3.7	4.4	(3.7)	4.6	6.1	5.5	5.2	4.7	4.3	4.0	4.0	3.9	3.8
Total health insurance	4.8	4.3	3.0	9.1	6.9	5.5	5.8	6.0	5.8	5.7	5.9	5.8	4.8
Private health insurance	4.8	3.1	(1.2)	6.3	8.3	7.1	6.2	5.4	4.9	4.5	4.6	4.7	4.6
Employer-sponsored PHI	3.9	3.5	(1.6)	6.0	9.3	7.9	6.0	4.8	4.3	4.1	4.4	4.4	4.6
Direct Purchase	12.1	(0.5)	1.6	8.7	1.0	1.1	8.2	10.3	10.2	8.0	6.4	6.5	4.5
Public funds	4.5	5.4	5.7	6.1	6.6	6.4	6.2	6.5	6.7	6.5	6.4	0.0	0.0
Medicare	6.3	6.9	3.5	11.3	7.5	5.9	7.0	7.4	7.6	7.3	7.3	7.1	4.3
Medicaid	3.1	3.0	9.2	10.4	5.7	2.7	4.0	5.1	5.1	5.7	6.3	5.7	5.8
CHIP	3.1	7.0	6.9	3.7	1.1	4.7	6.0	6.0	6.0	6.0	6.0	6.0	6.0
Other public funds	4.0	4.1	71.3	(13.3)	(10.0)	(0.1)	(0.1)	2.7	3.6	4.2	4.6	4.7	4.8
Total health expenditures	4.6	4.3	9.7	4.2	4.6	5.0	5.1	5.4	5.3	5.3	5.5	5.4	4.7

Source: Centers for Medicare and Medicaid Services.

In 2021, dispensed prescriptions in the U.S. reached $6.4 billion (latest available), with an average growth of 2.1% over the past five years, according to IQVIA.

DRUG PRESCRIPTION GROWTH*
(for 2021, in percent)



*Latest available data.
Source: IQVIA.

Drug pricing has been under increased scrutiny in the past few years, with politicians, doctors, and health care providers saying that many prescriptions are inaccessible to patients. Lowering drug prices has become a complex issue in the U.S. despite bipartisan support for more affordable drug prices for Americans. We think there is political will on both sides, as both Republicans and Democrats agree on the idea of lowering U.S. drug prices, as it has consistently been a topic of public concern.

President Joe Biden aims to enable Medicare to negotiate drug prices with pharmaceutical companies instead of having the companies freely set the prices themselves. In order to limit high drug prices, the Biden-Harris administration also aims to limit high launch prices of novel specialty drugs, have drug price increases linked to inflation or an International Pricing Index, and allow drug imports from other countries.

President Biden has been pushing the issue and has been vocal during the summer of 2021 about prescription drug prices being too expensive in the U.S. compared to other developed countries. He stated that he aims for Medicare to be able to negotiate lower drug prices and put penalties in place for pharmaceutical companies that increase their prices above the inflation rate.

In July 2021, President Biden issued an executive order to increase the competitiveness of the U.S. economy and lowering prescription drug prices was part of the order. He announced his intention to increase efforts to allow states to import drugs from Canada, where the cost of prescription drugs is lower, and to increase the availability of generic drugs and biosimilars, which are cheaper versions of branded drugs.

In October 2021, President Biden announced a $1.75 trillion social spending package called Build Back Better Framework. The bill includes ambitions to expand insurance coverage to all Americans, reduce prescription drug prices, and improve maternal and public health. According to Washington Analysis, the bill is expected to impose changes in drug pricing in terms of targeted government negotiation of Medicare drugs, Part B/D inflation caps, Part D maximum out-of-pocket policy, Part D redesign of coverage and liability, Part B biosimilar reimbursement, limits on insulin cost sharing caps, and PBM transparency.

In August 2022, President Biden announced the enactment of the Inflation Reduction Act that aims to curb inflation and consists of an initiative in lowering prescription drug prices. We believe that this effort will benefit the managed health care industry in the near future. (See further explanations under "Regulatory Updates.")

Even though the government is currently Democrat-aligned, any major proposals would likely require Republican support, in our view. Political gridlock may limit significant legislative action, although we think that there is increasing pressure on politicians to enact policies that will lower drug prices.

Health Care IT: Technology Investments Continue to Drive Lower Costs

Improved health care information technology (HCIT) capabilities have driven costs lower for health care providers and services companies and could continue to do so, positively impacting managed care companies. The 2009 economic stimulus package, called the American Recovery and Reinvestment Act, provided $20 billion for investments and incentives between 2011 and 2015 to spur the adoption of HCIT. The market capitalization for the S&P 1500 Health Care Technology industry is at $4.9 billion as of February 8, 2023. Aggregate industry revenues increased significantly to $1.7 trillion in 2022, from $4.0 billion in 2010. The industry is much more mature now than in 2010, but we think there is still room for innovation.

Studies have indicated that HCIT and electronic health records (EHRs) will likely improve health care quality, care effectiveness, and patient safety – improvements that should lead to lower costs. Ideally, HCIT and EHRs should work seamlessly with all medical devices, instruments, and systems to enable real-time health information from multiple sources and providers, including medical records, test results, and prescription drug information. Comprehensive real-time data and information should enable a physician to make the most informed medical decisions. In addition, the system should be able to detect and warn a physician or other health care practitioner of potential issues that may arise, such as adverse drug-to-drug interaction, medication errors, or drug allergies.

Accountable Care Organizations

In an effort to combat the rising cost of providing health care, the ACA introduced the concept of an "accountable care organization," or ACO. An ACO is an organization run by a group of health care providers, in which the participating providers are collectively responsible for the care of an enrolled population. The goal of coordinated care is to ensure that patients get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program.

Regulatory Updates

Health care has long been a critical issue for American voters. There has been a fierce, ongoing debate between the Republican and Democratic parties over the best way to provide health care to the nation. Republicans have generally been trying to reduce health care regulation by attempting to weaken and repeal health care reform (*i.e.*, ACA) passed in 2010, while Democrats have generally been trying to expand the government's role in health care.

As of February 2023, the Democrats have the majority in the House, and the new 50-50 Senate is Democrat-aligned by virtue of Vice-President Kamala Harris' constitutional power to cast tie-breaking votes. President Joe Biden is a Democrat. With the narrow control of the House and the Senate by the Democrats, CFRA thinks it will be difficult to pass any radical health insurance legislation.

With the 2020 U.S. presidential election behind us, Medicare for All will be less of a topic of great interest, in our view. While there are several definitions as to what counts as Medicare for All, the general idea is

to expand health care coverage to most Americans. We think that many of the bolder Medicare for All proposals have almost no chance of becoming law. With the Senate's new split set-up, we expect the status quo to be maintained on most issues.

However, in the medium to long term, Biden's key proposals to lower Medicare eligibility to 60, increase Medicaid subsidies, and strengthen the ACA – if enacted – could be beneficial for certain managed health care companies. CFRA thinks Molina Healthcare and Elevance Health would be key beneficiaries due to their large exposure to government-sponsored programs and Medicaid. On the other hand, managed care companies (such as Cigna) that generate the majority of their revenue from commercial customers would be at a disadvantage.

In January 2022, the Biden-Harris administration announced the requirement for insurance companies and group health plans to bear the cost of over-the-counter (OTC) and at-home Covid-19 tests. Starting from January 15, 2022, individuals enrolled in a private insurance coverage or group health plan can get their plan or insurance to cover the purchase of any FDA-approved OTC Covid-19 tests. Insurance companies and health plans need to cover eight free OTC at-home tests per each covered individual per month, which allows a family of four enrolled on the same plan to obtain up to 32 tests covered per month. In addition, the administration is encouraging insurers and group health plans to establish programs that permit people to obtain OTC tests directly through preferred pharmacies, retailers, or other entities with no out-of-pocket costs, eradicating the need for consumers to submit a claim for reimbursement. In any case where consumers need to purchase tests outside of the network, they are still able to submit claims at a rate of up to $12 per individual test (or the cost of the test, if less than $12) from their insurance companies. This initiative is a part of the administration's ongoing efforts to make free testing available to all Americans including people with private health insurance coverage.

The Affordable Care Act (ACA)

The ACA, commonly known as Obamacare, has been a significant force in the health care sector over the past decade. Signed into law in March 2010, the ACA set regulations to govern the health care sector and strengthen the overall U.S. health care system. This reform has affected all health care stakeholders, but CFRA thinks it has had a disproportionately large impact on the managed care industry. In spite of the numerous concessions and additional fees and taxes imposed on the health care sector, a total of nearly 16 million insured patients as of January 2023 have been a net benefit for the managed care industry.

The Biden-Harris administration has a strong stance on enabling affordable health insurance access for all Americans and bolstering the ACA. Unlike Bernie Sanders' proposal, which aimed at a gradual termination of existing private health insurance plans, Biden/Harris proposes to maintain them but provide more choices. We do note that the program includes adding a government-sponsored public health insurance option that would compete with private insurers.

Shortly after he took office, President Biden signed an executive order in January 2021 with the aim of providing insurance access to people who are uninsured. With this order, a new open enrollment period was announced, from February 15 to May 15, 2021, for ACA exchanges in 36 states to expand ACA for lower-income Americans.

On June 17, 2021, the Supreme Court overturned a challenge to the ACA, which was initially filed by the Republican state attorneys general and Republican governors back in 2018. The Court reached a decision the preserve the status quo for the ACA to remain fully in effect and the law will continue to function as it has since the individual penalty was set to $0 beginning in 2019.

Inflation Reduction Act 2022

On August 16, 2022, President Biden signed into law the Inflation Reduction Act 2022, which consists of an extensive package of health, tax, and climate change provisions. The law includes some provisions to

reduce prescription drug costs for Medicare beneficiaries and lower drug spending by the federal government.

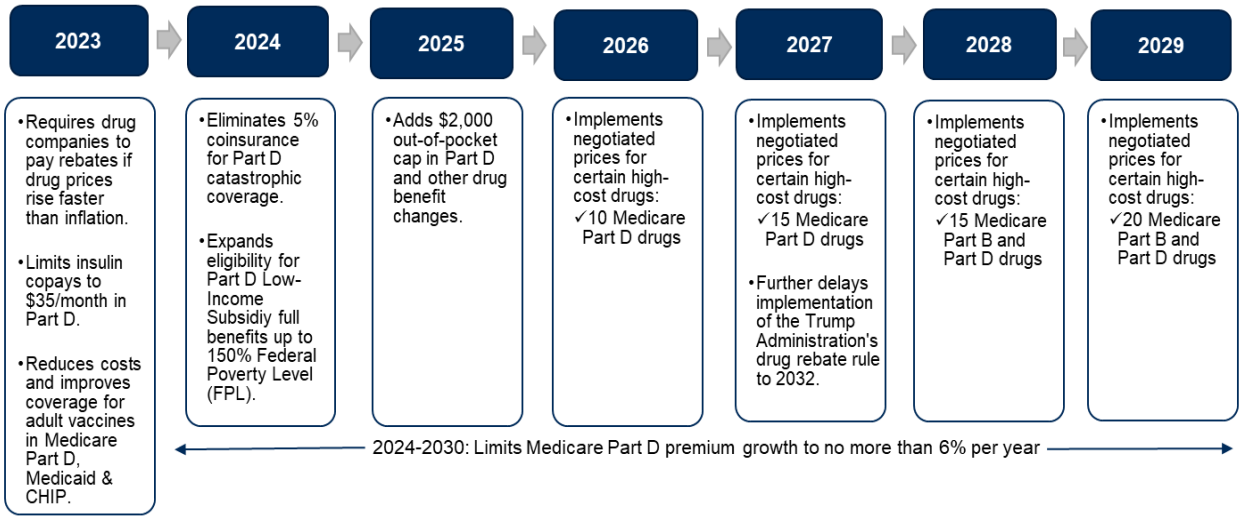
The law also includes two policies that will have a direct impact on overall drug prices. One of the policies requires the federal government to negotiate prices for some high-cost drugs covered under Medicare. This will affect the Medicare Part D and B drug spending, where the spending is highly concentrated among a relatively small share of covered drugs, primarily those without generic or biosimilar competitors. Under the Inflation Reduction Act, negotiations are eligible for brand-name and biologic drugs without generic or biosimilar equivalents covered under Medicare Part D (retail prescription drugs) or Part B (administered by physicians) that are among the highest-spending Medicare-covered drugs. In order to be eligible for negotiation, the drugs should also be nine or more years (small-molecule drugs) or 13 or more years (biologicals) from FDA approval, according to the law. CFRA believes some drug manufacturers may offer extra high markups of new drugs to compensate for drugs still under patent that are subject to negotiated prices from Medicare. If so, however, we think managed care companies may not cover the new drugs with inflated pricing.

The second policy covered under the Act requires drug manufacturers to pay rebates to Medicare if they raise prices faster than inflation for drugs used by Medicare beneficiaries. According to Kaiser Family Foundation (KFF), half of all drugs covered by Medicare saw prices hike above the inflation rate of 1% over the period from 2019 to 2020. On top of that, one-third of these drugs also had price increases of 7.5% or more than the annual inflation rate in early 2022. The inflation rebate provision will be executed in 2023 where 2021 will be used as the base year for establishing price changes relative to inflation.

In addition, the Inflation Reduction Act also includes some provisions that will help to lessen out-of-pocket spending for Medicare beneficiaries. One of the provisions consists of a cap on Medicare beneficiaries' out-of-pocket spending under the Medicare Part D benefit, where coinsurance above the catastrophic threshold will be eliminated in 2024 and a $2,000 cap on spending will be added in 2025. Furthermore, the law also limits cost sharing for insulin to $35 per month for Medicare beneficiaries starting in 2023, including covered insulin products in Medicare Part D and for insulin furnished through durable medical equipment under Medicare Part B. As of 2023, the law discards cost sharing for adult vaccines covered under Medicare Part D and enhances access to adult vaccines under Medicaid and Children's Health Insurance Program (CHIP). In 2024, the eligibility for full Part D Low-Income Subsidies (LIS) will be expanded to low-income beneficiaries, with incomes up to 150% of poverty and modest assets and the partial LIS benefit currently in place for individuals with incomes between 135% and 150% of poverty will also be revoked.

The Inflation Reduction Act also encompasses a provision that will take effect in 2027, delaying the implementation of the rebate rule until 2032. The rebate rule would eradicate the anti-kickback safe harbor protections for prescription drug rebates negotiated between drug manufacturers and PBMs or health plan sponsors in Medicare Part D. In our view, the Act will help managed care companies to attract more customers, benefitting the managed health care industry in the near term. Had the rule taken effect, it would've likely increased premiums for Medicare Part D participants.

IMPLEMENTATION TIMELINE OF DRUG PROVISIONS IN THE INFLATION REDUCTION ACT



Source: KFF.

M&A Environment

Industry Consolidation and Capital Allocation
Many managed care companies have turned to vertical integration to have greater scale and more influence over suppliers and customers to contain medical costs and offset industry headwinds.

Cost Advantage for Managed Care Firms That Integrate PBMs
Several of the largest managed care firms use their own integrated PBMs, giving them the benefit of the PBMs' improved negotiating position with drug makers since the ACA was passed. Conversely, managed care firms that contract with third-party PBMs are less likely to experience lower drug costs to the same extent. In our view, this is due to a desire on the part of independent PBMs to retain as much of the improved pricing or drug rebates as possible. We think evidence of this exists in the divergence in medical cost ratio trends for the five largest managed care firms: UnitedHealth, Cigna, Humana, Centene, and Elevance Health.

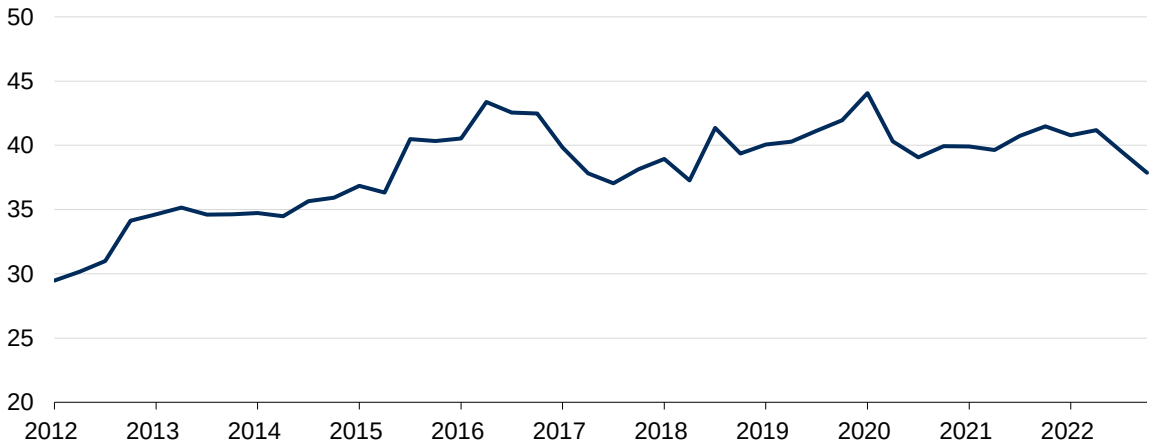
UnitedHealth, Humana, and Centene all utilize their own PBMs and, since 2015, they have all maintained or reduced their medical cost ratios, which we view as a positive trend. On the other hand, Elevance Health has historically contracted third parties (CVS and Express Scripts, respectively). However, this changed when IngenioRx – Elevance Health's joint venture with CVS – started operations in the second quarter of 2019.

Vertical integration with PBMs and health care providers will likely continue to help contain medical costs for managed care firms in 2022. PBMs establish covered drug lists for health plans and earn income by keeping some price rebates they negotiate with drug makers, which are often largest for expensive brands. Accordingly, we think integration with PBMs allows managed care firms to capture full rebate value and eliminate perverse incentives for PBMs to steer patients toward expensive brands with large rebates when cheaper generics are available. Over the past two years, major PBM integrations have included CVS Health, which purchased Aetna and formed a partnership with Elevance Health, and Cigna, which purchased Express Scripts.

We also see significant vertical integration with health care providers, especially non-hospital treatment facilities and primary care networks, including UnitedHealth's $4.3 billion acquisition of DaVita Medical Group in June 2019. We think this strategy serves insurers well as they can better control medical expenses when health plan members are steered to affiliated providers.

The debt-to-capital ratios increased gradually between 2017 and 2020 as companies took advantage of low interest rates. Companies have used debt to fund strategic expansions, merger and acquisition (M&A) activities, and stock repurchases. The ratios have been in 39%-41% range from 2021 through 2022, driven by renewal in business confidence in the industry. Going forward, however, we foresee a potential cutback in M&A activities due to uncertain economic environment propelled by recessionary pressures.

DEBT-TO-CAPITAL RATIO
(in percent, quarterly)



Source: CFRA, S&P Global Market Intelligence.

M&A ACTIVITY

Centene Concludes Acquisition of Magellan Health

In January 2021, Centene announced its decision to acquire Magellan Health, a large managed health care company with a focus on specialty health care and pharmacy management, for a total enterprise value of $2.2 billion. CFRA thinks the transaction, which closed in January 2022, will considerably increase Centene's behavioral health capabilities – creating one of the largest behavioral health platforms in the U.S. Magellan Health's acquisition is expected to bring 5.5 million new members on government-sponsored plans, 2 million PBM members, and 16 million medical pharmacy members – significantly increasing Centene's scale and reach.

UnitedHealth Acquired Change Healthcare Inc.

In January 2021, UnitedHealth announced its decision to acquire Change Healthcare Inc., a major health care technology company, for $13 billion. With this transaction, UnitedHealth plans to combine Change Healthcare with Optum, its health care services provider. This is the right strategic move, in our view, to expand UnitedHealth's technological processes and support capabilities while achieving cost synergies. Nevertheless, the acquisition, which was initially set to close in the second half of 2021, encountered a roadblock due to a lawsuit filed by the U.S. Department of Justice (DoJ). On February 24, 2022, the DoJ sued to block the deal in accordance with the Biden administration's recent initiative to suppress large takeovers. The lawsuit was centered around concerns on the acquisition's impact on the level of competition and data control in the industry. The trial commenced on August 1, 2022, and was closed in September 2022 as a federal judge gave the green light for both companies to conclude the deal. The acquisition was officially completed on October 3, 2022.

Molina Healthcare Completes Acquisition of Magellan Complete Care and Passport Health's Medicaid Plan Assets

In December 2020, Molina Healthcare completed the acquisition of Magellan Complete Care (MCC), a managed care organization operating in six states, for a $820 million transaction price. The MCC acquisition added roughly 200,000 new members to Molina Healthcare. The MCC acquisition was also a key growth driver, increasing Molina's total membership to 6 million in government-sponsored programs in 18 states in 2021. With the additional membership from MCC and revenue contributions from Passport Health's Medicaid line of business (certain assets from this business were acquired in September 2020), Molina's top-line revenue increased 47% in 2021 from the previous year.

HOW THE INDUSTRY OPERATES

Managed Care Plans

A managed care plan is a type of health insurance plan that has contracts with hospitals, health care providers (HCPs), and medical facilities to provide care for members at a reduced price. The plan includes health management organizations, preferred provider organizations (PPOs), and point-of-service (POS), the first two being the most popular type of managed care organizations (MCOs) in the U.S.

Health Maintenance Organizations (HMO)

HMOs are the most restrictive type of health insurance plan, but they are the least expensive for members. They typically require a flat monthly premium and a minimal co-payment from members seeking services – often between $10 and $40 per primary care physician visit, and a higher amount for a specialist visit – and do not make members pay deductibles. HMOs employ or contract networks of doctors, hospitals, and other professionals, as well as organizations in a city or region to service members in that geographic area. The members have to use providers in the HMO's network, which enables the HMO to leverage its size to obtain favorable contracts with providers. Providers, in turn, are guaranteed a large volume of patients.

HMOs often have favored capitated contracts, which pay providers a fixed monthly fee for a range of services, regardless of the quantity of services or treatments. The provider generally subcontracts with specialists and others to furnish the necessary services that it cannot perform. Capitated contracts may encourage providers to focus on prevention. They may also reduce unnecessary services by shifting (to doctors and hospitals) some of the risks that reimbursements will not cover all treatment costs. However, an HMO with many capitated providers will have to step in to cover services if those providers become insolvent.

In the end, the HMO is responsible for paying for health care coverage for its members, and it may incur unexpected costs in meeting that obligation. HMOs enter into a variety of contracts, depending on what is legally allowable from region to region. For example, the HMO operations of Health Net Inc. (now owned by Centene Corp.) place physicians and medical groups in California under capitation contracts. In contrast, most HMOs outside California from these or other companies reimburse physicians according to a discounted fee-for-service (FFS) schedule. Nevertheless, some capitation contracts do exist. The non-physician components of all hospital services, which are generally contracted for multi-year terms, are covered by capitation, per diem rates, case rates, and discounted FFS schedules.

Preferred Provider Organizations (PPO)

Less restrictive than HMOs, PPOs allow enrollees to select physicians either within or outside the plan's network. However, use of out-of-network providers typically means the patient pays higher fees. PPOs are similar to HMOs because participating providers agree to use procedures implemented by plan administrators and to accept the insurer's reimbursement structure and payment levels. PPOs often limit the size of their participating provider networks. By requiring a lower co-payment for in-network visits, the PPO helps to increase the volume of patients for in-network providers.

Point-Of-Service (POS) Plan

Many HMOs offer a POS plan. Like an HMO, such a plan allows patients to see physicians within the network for a small co-payment. However, like a PPO, POS plans permit patients to see physicians outside the network, for which the patients pay a percentage of the fee after meeting a deductible. POS plans tend to charge higher monthly premiums than HMOs do.

The Role of the Government

Because the U.S. federal government is responsible for financing health care services for elderly and poor citizens through Medicare and Medicaid, the federal government is a major force in shaping a health care system.

U.S. health care spending is projected to increase by an average of 7.3% annually from 2022 to 2030, according to the CMS. National health spending grew 2.7% to $4.3 trillion in 2021 and is forecasted to reach $6.8 trillion by 2030. Further, health spending is expected to advance 1.1% faster than GDP per year over this period. Health care's share of GDP is forecasted to rise from 18.3% in 2021 (latest available) to 19.6% by 2030.

PERSONAL HEALTH CARE EXPENDITURES
(in $, billions)

	2018	2019	2020	2021	2022	2025	2026	2027	2028	2029	2030	2029	2030
Hospital care	1,123	1,194	1,270	1,342	1,435	1,516	1,601	1,696	1,792	1,890	2,002	2,114	2,210
Professional services	979	1,022	1,069	1,144	1,201	1,272	1,347	1,424	1,503	1,582	1,664	1,751	1,827
Physician and clinical services	737	768	810	850	903	959	1,016	1,077	1,140	1,202	1,268	1,337	1,398
Other professional services	105	111	117	128	132	140	149	157	165	174	183	192	200
Dental services	138	143	142	166	166	173	182	191	199	206	214	222	230
Home health care	106	113	124	122	129	139	149	160	172	184	198	213	226
Nursing and continuing care facilities	168	174	197	182	188	198	208	218	228	239	250	262	273
Retail outlet sales	456	476	489	510	535	560	589	619	650	683	718	754	792
Prescription drugs	324	338	348	365	380	398	419	440	462	486	511	539	567
Medical products	132	138	141	146	155	162	170	179	188	197	206	216	225
Durable medical equipment	54	57	55	57	60	63	66	70	73	77	81	84	88
Non-durable medical products	78	81	86	89	95	100	104	110	115	120	126	131	137
Other personal health care	191	196	209	220	232	244	257	271	285	300	316	334	352
Total Expenditures	3,022	3,175	3,358	3,521	3,720	3,929	4,150	4,387	4,630	4,878	5,149	5,428	5,681

Source: Centers for Medicare and Medicaid Services.

These figures are expected to rise in the coming years as the baby boomer generation increasingly joins the Medicare program. Baby boomers are the approximately 75 million Americans born between 1946 and 1964. The CMS Office of the Actuary predicts that government sources will fund about 41.9% of projected domestic health care expenditures by 2030, more than the 34% in 2021 (latest available).

Medicare

As part of the Social Security Amendments of 1965, Medicare legislation established a program of health insurance to complement the retirement, survivor, and disability insurance benefits provided under other titles of the Social Security Act.

Medicare is the largest public payer of health care. Medicare spending grew 8.4% to $900.8 billion in 2021 (latest available) and is expected to increase 7.6% annually from 2019 through 2028, according to the CMS. The increase in expenditures is driven primarily by trends in disposable personal income, increases in prices for medical goods and services, and shifts in enrollment from private health insurance to Medicare that result from the continued aging of the baby-boom generation into Medicare eligibility.

Medicare is a federally funded program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons, and persons with end-stage renal disease. The program consists of four parts: hospital insurance, also known as Part A; supplemental medical insurance (Part B); Medicare Advantage (Part C); and the prescription drug benefit (Part D). In total, Medicare had 63 million beneficiaries in 2022, and that number is projected to grow to about 77 million by 2030 and 110 million by 2096.

◆ **Part A.** This usually is provided automatically to persons 65 years of age or over and to most persons who are disabled for at least 24 months and are entitled to Social Security or Railroad Retirement benefits. Part A covers inpatient care in skilled nursing facilities, critical access hospitals, and hospitals. Hospice and home health care are also covered by Part A. The 2023 budget for the U.S. Department of Health and Human Services (HHS) called for $211.7 billion in expenditures for Part A, slightly down from $214.2 billion in the prior year.

◆ **Part B.** This is medical insurance to pay for medically necessary services and supplies provided by Medicare. Most people pay a premium to receive this coverage. Part B covers outpatient care, doctor's services, physical or occupational therapists, and additional home health care. Nearly all persons enrolled in Part A also enroll in Part B, which primarily covers physician-based medical services. Part B costs have been rising rapidly and are expected to continue at an annual rate of 10.3% from 2022 to 2026, according to the "2022 Medicare Trustees Report." The HHS budget for 2023 called for $227.2 billion in expenditures for Part B, compared to $221.2 billion in 2022.

◆ **Part C.** This program – also referred to as Medicare Advantage – is offered by private companies that are approved by Medicare. These plans are required to provide all Medicare-covered benefits, but are permitted to vary the benefit design as long as the core benefit package is comparable. The most common benefit of such plans is reduced cost sharing for benefits through lower insurance premiums. As of August 2022, the CMS estimates that 28.4 million, or 48% of Medicare enrollees, enrolled in a Medicare Advantage plan, and the percentage of enrollment is growing faster than enrollment in traditional Medicare. In 2022, a total of 3,834 Medicare Advantage plans are available nationwide for individual enrollment, an 8% increase from 2021. The HHS budget for 2023 called for $459 billion in expenditures for Part C compared to $433 billion the previous year.

◆ **Part D.** This program – part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) – offers prescription drug coverage to beneficiaries. Part D benefits began on January 1, 2006, and are available to anybody entitled to Medicare Part A or enrolled in Medicare Part B. Beneficiaries choose among several private plans or Medicare-approved MCO or HMO plans; the beneficiaries are charged an extra premium each month to join one of these plans. Part D is expected to experience a 7.4% annual increase in expenditures from 2022 to 2026, according to the "2022 Medicare Trustee Report." The HHS budget for 2023 called for $124.5 billion in expenditures for Part D, up from $127.5 billion the previous year.

How Medicare Is Funded

Medicare Part A is financed through mandatory payroll deductions. These deductions include Federal Insurance Contributions Act (FICA) taxes of 1.5% of taxable earnings paid by employees (and another 1.5% paid by employers), and a 2.9% tax from self-employed persons who pay into the hospital insurance trust fund. Part A also carries a patient deductible before benefits are covered. Part B funds come from payment of premiums, which are usually deducted from monthly Social Security benefit checks of those who are voluntarily enrolled, and through significant contributions from the general revenues of the U.S. Treasury. Part D is funded by a combination of federal general revenues and beneficiaries' contributions. Assistance is provided to qualifying low-income individuals. Part D is also financed from the increase in monthly premiums for Part B beneficiaries.

Medicare funding levels for physicians are tied to the sustainable growth rate formula devised in 1997 by Congress to tie Medicare reimbursement levels to the overall economy. However, Medicare has consistently paid out more than it intended, accruing a substantial liability. Legislation to adjust rates to undo that liability has been set aside multiple times since 2001, which has only exacerbated the problem. In June 2022, Medicare trustees warned that the Medicare program's hospital insurance trust fund could face a shortage of funds by 2028.

Medicaid

Medicaid is a program designed to provide medical assistance to eligible needy persons and is jointly funded by the federal and state governments. It is administered by individual states operating within federal guidelines.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares a state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed for a smaller share of their costs. By law, the FMAP cannot be lower than 50% or higher than 83%.

Medicaid operates as a vendor payment program, with states paying providers directly. Participating providers must accept the Medicaid reimbursement level as payment in full. Each state has broad discretion in determining the reimbursement methodology and resulting rate for services as long as such rates are within federally imposed upper limits and restrictions. There are three exceptions: first, for institutional services, payment may not exceed amounts that would be paid under Medicare payment rates. Second, different limits apply for "disproportionate share" hospitals – hospitals that accept Medicaid or uninsured patients. However, most hospitals accept such patients, whom they bill according to a sliding scale of charges. Finally, rates for hospice care services cannot be lower than Medicare rates.

The 50 U.S. states, the District of Columbia, and Puerto Rico all offer some form of managed Medicaid, such as an accountable care organization. Each state designates a single agency that is responsible for its Medicaid program operations. The federal government sets broad national guidelines, under which individual states establish their own eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment for such services; and administer their own programs. Because of this structure, Medicaid programs vary considerably from state to state, as well as within each state over time.

Most state Medicaid payments are made under a prospective payment system or under programs that negotiate payment levels with individual hospitals. In general, Medicaid reimbursement is substantially less than a hospital's cost of service, so this business segment creates a drag on a facility's overall profit margins.

Owing to both federal and state budget deficits, the federal government and most states constantly consider ways to reduce the level of Medicaid funding – for example, by cutting payments to providers – while still maintaining the list of Medicaid benefits that are covered. Therefore, Medicaid revenues for those participating in the program are likely to fall in coming years.

ACA Expands Medicaid Eligibility

Under the Affordable Care Act (ACA), Medicaid eligibility was expanded to cover all non-Medicare-eligible individuals under age 65 with incomes of less than 138% of the federal poverty level, depending on the number of persons in the household. States were able to, if they so desired, expand coverage beginning April 2010. For most states, all newly eligible adults are guaranteed a basic benefit package equal to those provided via the exchanges. As of February 2023, a total of 40 states have expanded their Medicaid programs and 11 states have not adopted the expansion, according to Kaiser Family Foundation.

HOW TO ANALYZE A COMPANY IN THIS INDUSTRY

When evaluating a company in the managed care industry, it is important to consider that company's fundamental strengths and weaknesses, its business strategy, its competitive advantages, and the broad industry-level forces at play. Membership enrollment is crucial to managed care companies.

What is the outlook for the managed care business? The managed care business matters to all companies in the health care providers and services industry because managed care organizations (MCOs) tend to be a payer for most health care services and are also the largest constituent of the health care providers and services industry. Lately, managed care companies have been focused on cost containment, as mounting health care costs have been a key concern for the public and the federal government.

At times of significant MCO premium rate hikes, employers tend to initiate benefit design changes and buydowns (*i.e.,* revisions in benefit plans that lower costs, such as instituting higher member co-payments to reduce the employer's premiums). MCOs are usually aggressive in their negotiations with health care providers, trying to push lower payment rates.

Despite the challenges and increased financial risk associated with managed care contracts, these contracts can generate significant value for health care facilities. Although MCOs typically pay less on a per-patient basis, the admission volumes that MCOs generate for hospitals – both inpatient and outpatient – can expand net patient revenues substantially.

What are the company's primary competitive advantages? For most companies in the managed care industry, size has become one of the key factors driving both revenue growth and operating margin expansion. The increasing scale and influence of MCOs in the U.S. has been a driving force behind consolidation in other parts of health care. Most firms that offer health care benefits employ cost sharing, meaning that employees make a portion of premium payments, usually deducted from their paychecks. According to the "2021 Employer Health Benefits Survey" published by the KFF, 85% of covered workers had a general annual deductible, with the average general annual deductible being $1,644 for single coverage. The deductible must be paid out-of-pocket before most services are paid for by plans that are offered. In addition, the average annual deductible for single coverage varies by firm size – $2,379 for workers in small firms compared with $1,972 for workers in large firms.

Financial Analysis

A number of items on the income statement and balance sheet are important in the analysis of a company in the managed care industry. Given the industry's diversity in terms of geography, sources of revenue, scope of operations, and methods of growth, these items must be evaluated on a company-by-company basis.

Revenues. Gauge whether premium trends are moving up or down.

Watch Out! *For certain policy types, MCO's premiums are based on the actual claims incurred. Due to the lag in reporting claims for these types of policies, management must estimate the revenue related to incurred but not reported claims as well as the expense. When management is estimating revenues, we think extra scrutiny of those revenues is appropriate.*

Operating margins. How does the company compare with others in its industry segment?

Medical cost ratio. The medical cost ratio (MCR) is an expense ratio in the health care sector that correlates inversely to the gross profit margin. Sometimes referred to as the medical loss ratio (MLR), it is determined by dividing a company's total amount of direct medical costs **–** such as pharmaceutical, doctor, outpatient, and hospital-related costs **–** by its premium revenues. Traditionally, this ratio has been used to determine a company's effectiveness in managing its enrollees; it can indicate management's ability to control costs and predict future costs in an era of rapid medical cost inflation.

Historically, an MCO with an MCR of about 80% (*i.e.*, spending 80 cents of each premium dollar on medical costs) has been seen as adequately managing its patient base. When looking at the MCR, the investor should focus on its principal components, including pharmaceutical expenditures, hospital utilization (as measured by annualized bed-days per thousand members), outpatient services, and physician costs. Each MCO uses its own methods to predict cost trends and control utilization among members. For those able to accurately gauge medical cost patterns, annual rate settings generally cover medical costs and generate an adequate profit margin. Conversely, those that underestimate service usage will suffer as their MCRs rise.

SG&A expenses: The remaining expense items on an income statement relate to selling, general, and administrative (SG&A) spending. SG&A expenses include expenses for functions such as marketing, billings, collections, database maintenance, customer service, malpractice, and other costs.

Earnings per share: It's useful to know whether a company has a strong track record of meeting its earnings per share (EPS) targets and whether the rate of revenue growth is in line with earnings growth. Comparing these growth rates can reveal whether an MCO is sacrificing profits to expand membership.

Watch Out! *Companies record special charges for unusual or infrequent items, e.g., restructuring charges. Such charges are often excluded from non-GAAP earnings, and therefore provide dishonest management with the ability to enhance analysts' perception of its profitability through aggressive use of these special charges. Significant and/or recurring use of special charges is a red flag that a company may be using special charges to flatter non-GAAP results. Specifically, we caution that companies may boost non-GAAP earnings in the current period by bundling normal, recurring costs into the special charges.*

The impact of acquisitions: It is important to know whether an MCO's sales and earnings growth is acquisition-driven or internally (organically) driven. Internal growth shows that a company can effectively manage and innovate within its existing geographic territory and facilities. If growth is acquisition-driven, it is important to examine such areas as membership growth, MLRs, and other relevant statistics on a "same-store" basis. Growth generated via acquisitions often masks underlying performance trends in revenue growth and margins.

Watch Out! *A company can manipulate earnings by using the adjustment to fair market value of a target company's assets and liabilities in an acquisition to understate assets and overstate liabilities, thereby allocating a greater portion of the purchase price to goodwill.*

Behind the Balance Sheet

Balance Sheet Integrity

While the income statement shows financials over periods of time, the balance sheet is a snapshot of a company's financial position at a specific moment. This picture can be useful in determining the stability and soundness of a firm.

◆ **Debt-to-capitalization ratio.** This is the ratio of a company's total debt to its total capitalization, which is commonly equal to the sum of interest-bearing debt and shareholder's equity. Debt can typically be found on the balance sheet as short-term debt, under current liabilities, and as long-term debt, under non-current liabilities. Many analysts tend to use the ratio of long-term debt-to-total capital. Companies with a lower debt-to-capitalization ratio typically have more financial flexibility as they can usually borrow at lower rates and they are usually less burdened by existing interest and principal payments.

Watch Out! *Some companies engage in supplier financing arrangements (aka reverse factoring). There are several variations of these programs, but basically, a company arranges for a financial institution to pay its suppliers and the company repays the financial institution later. This effectively lengthens the supplier payment terms and thus improves working capital, which can result in overstated cash flows and understated leverage ratios.*

The acquisition environment in the managed care industry has been robust in recent years. Many companies have chosen to increase debt levels to gain scale and competitive advantage. Companies with high debt levels tend to be riskier than those with low debt levels because when cash flows weaken or economic conditions change for the worse, it can become difficult for debt-burdened companies to make interest and principal payments.

GLOSSARY

Accountable care organization (ACO)—An organization run by a group of health care providers, in which the participating providers are collectively responsible for the care of an enrolled population.

Affordable Care Act (ACA)—The name for the comprehensive health care reform law and its amendments. The law addresses health insurance coverage, health care costs, and preventive care. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010.

Benefit design—The complex process of determining levels of coverage and types of services to be included in a health plan, at specified rates of reimbursement.

Biosimilars—A biologic medical product (also known as biologic) highly similar to another already approved biological medicine.

Capitation—A compensation method under which a health maintenance organization (HMO) pays doctors and other health care providers (HCPs) a fixed monthly fee for performing a range of services for each HMO member under their care, regardless of the actual level of service usage.

Co-payment—A nominal, flat fee that a plan member pays when he or she receives services or drugs. Co-payments are generally aimed at covering administrative costs.

Cost sharing—A method of reimbursement that holds a patient partially responsible for the payment of medical services or therapies. Cost sharing is used as a cost containment strategy as it restrains consumer demand for certain medical care.

Deductible—The amount a plan member pays for covered health care services before their insurance plan starts paying. After paying their deductibles, members usually pay only a co-payment for covered services.

Elective procedures—Procedures that patients need, but don't have to be done right away.

Electronic health record (EHR)—A digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

Fee-for-service (FFS)—A method of payment in which providers are compensated for each service they perform.

Generic drug—A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs.

Health care information technology (HCIT)—HCIT solutions target every element of the health care value chain with many applications ranging from workflow optimization and revenue management to care delivery and patient engagement.

Health plan—A type of insurance that you buy in order to pay for the cost of medical treatment if you are ill or injured.

Health maintenance organization (HMO)—A health plan that both pays for and provides (or arranges to provide) access to a comprehensive range of medical services. To belong to an HMO, members pay a fixed monthly premium that does not vary based on the level of service utilization.

Managed care organization (MCO)—A system of provider networks implementing a method of delivering and paying for health care. Managed care plans include HMOs, preferred provider organizations (PPOs), point-of-service (POS) plans, and similar coordinated plan networks.

Medicaid—A health benefit program for low-income U.S. residents who are aged, blind, disabled, or members of families with dependent children. The program also pays nursing home costs for indigent elderly patients. Although state and federal governments jointly fund Medicaid, each state sets eligibility standards.

Medical cost trends—The increases or decreases over time in costs of medical services and treatments. MCOs consider medical cost trends when setting premium rates for health insurance plans.

Medical loss ratio (MLR)—Also known as medical cost ratio (MCR), this is the percentage of premium revenue that a plan uses to pay for medical care covered by the plan. The MLR is an important indicator of insurance companies' abilities to control medical expenditures and match their premium rates with their projected expenses. A ratio of 0.80 means that 80% of a plan's premiums were used to cover medical costs.

Payer net spending—Calculated after supply chain discounts, manufacturer rebates, and patient out-of-pocket costs are deducted, and markups and margins by intermediaries are added.

Personal consumption expenditures (PCE)—The value of the goods and services purchased by, or on the behalf of, U.S. residents.

Pharmacy benefit manager (PBM)—A third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.

Point-of-service (POS)—A managed care plan in which members may receive services from providers both inside and outside the plan's network. When members seek treatment outside the network, they are more likely to have to pay for some of the treatment out-of-pocket.

Preferred provider organization (PPO)—A health care organization that pays almost completely for services obtained from its network of preferred providers but pays only partially for services obtained from out-of-network providers.

Prescription drugs—Drugs and medications that, by law, require a prescription.

Public health emergency (PHE) —An emergency need for health care services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack, or other significant or catastrophic events.

Rebates—A form of price concession paid by a pharmaceutical manufacturer to the health plan sponsor or the PBM working on the plan's behalf.

Telehealth—Providing health care remotely by means of telecommunications technology.

Vertical integration—The combination in one firm of two or more stages of production normally operated by separate firms.

INDUSTRY REFERENCES

PERIODICALS

Healthcare Finance News
healthcarefinancenews.com
Industry's business newspaper, offering health care financial managers comprehensive news coverage of the health care finance industry.

RESEARCH AND CONSULTING FIRMS

Action Economics
actioneconomics.com
Research firm that provides in-depth analysis of economic data and projections.

Blue Cross Blue Shield Association
bcbs.com
A federation of 35 independent and locally operated Blue Cross Blue Shield companies that deliver health insurance coverage to Americans.

FAIR Health
fairhealthconsumer.org
Nonprofit organization that provides health care costs and health coverage to consumers.

Grand View Research
grandviewresearch.com
Research firm that provides syndicated research reports, customized research reports, and consulting services.

The Henry J. Kaiser Family Foundation
kff.org
Nonprofit foundation dedicated to studying and reporting on the U.S. health care system. Publishes reports on government programs, medical spending trends, and various policy initiatives.

IQVIA
iqvia.com
Consulting firm that specializes in health care analysis, services, and solutions.

Kaiser Health News
khn.org
Nonprofit news organization whose mission is to provide high-quality coverage of health policy issues and developments at the federal and state levels.

Washington Analysis (A CFRA Business)
washintonanalysis.com
An independent institutional research firm specializing in identifying risks and opportunities across asset classes emanating from courts, Congress, and regulators, at both the state and federal levels.

GOVERNMENT AGENCIES

Centers for Diseases Control and Prevention
cdc.gov
One of the major operating components of the U.S. Department of Health & Human Services that conducts critical science and provides health information.

Centers for Medicare & Medicaid Services
cms.gov
A division of the U.S. Department of Health & Human Services that oversees the administration of the Medicare and Medicaid programs and sets compensation rates for participating providers.

Congressional Budget Office
cbo.gov
Nonpartisan federal agency that produces independent analyses of budgetary and economic issues to support the Congressional budget process.

The Medicare Payment Advisory Commission
medpac.gov
Nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program.

U.S. Bureau of Economic Analysis
bea.gov
Agency that provides U.S. macroeconomic data and industry statistics.

U.S. Bureau of Labor Statistics
bls.gov
A division of the U.S. Department of Labor; the principal fact-finding agency of the federal government in the broad fields of labor, economics, and statistics. Its major programs include the consumer price, producer price, and employment cost indices and the national compensation survey.

U.S. Census Bureau
census.gov
Agency that provides data about developments in the U.S. population and economy.

U.S. Department of Health & Human Services
hhs.gov
Cabinet-level federal agency that is the U.S. government’s principal overseer of health-related issues. Among other things, the HHS funds medical research, works to control infectious diseases, provides immunization services, ensures food and drug safety, and administers Medicare and Medicaid.

U.S Department of Labor
dol.gov
Cabinet-level federal agency that fosters, promotes, and develops the welfare of the wage earners, job seekers, and retirees of the U.S.; improves working conditions; advances opportunities for profitable employment; and assures work-related benefits and rights.

COMPARATIVE COMPANY ANALYSIS

Operating Revenues

Ticker		Company		Yr. End	Million $ 2022	2021	2020	2019	2018	2017	2016	CAGR (%) 10-Yr.	5-Yr.	1-Yr.	Index Basis (2012=100) 2022	2021	2020	2019	2018	2017
MANAGED HEALTH CARE																				
ELV	[]	ELEVANCE HEALTH INC.		DEC	156,595.0	138,643.0	121,868.0	104,212.0	92,091.0	90,049.0	84,862.0	9.8	11.7	12.9	185	163	144	123	109	106
CNC	[]	CENTENE CORPORATION		DEC	136,758.0	118,176.0	104,176.0	70,807.0	56,688.0	45,810.0	37,693.0	33.3	24.5	15.7	363	314	276	188	150	122
HQY	†	HEALTHEQUITY, INC.	#	JAN	0.0	756.6	733.6	532.0	287.2	229.5	178.4	NA	33.5	3.1	0	424	411	298	161	129
HUM	[]	HUMANA INC.		DEC	92,870.0	84,193.0	77,155.0	64,888.0	56,912.0	53,767.0	54,379.0	9.0	11.6	10.3	171	155	142	119	105	99
MOH	[]	MOLINA HEALTHCARE, INC.		DEC	31,974.0	26,984.0	18,375.0	16,340.0	18,144.0	19,445.0	17,022.0	18.7	10.5	18.5	188	159	108	96	107	114
UNH	[]	UNITEDHEALTH GROUP INCORPORATED		DEC	324,162.0	287,597.0	257,141.0	242,155.0	226,247.0	201,159.0	184,840.0	11.4	10.0	12.7	175	156	139	131	122	109

Note: Data as originally reported. CAGR-Compound annual growth rate.
[]Company included in the S&P 500. †Company included in the S&P MidCap 400. §Company included in the S&P SmallCap 600. #Of the following calendar year.
Souce: S&P Capital IQ.

Net Income

Ticker		Company		Yr. End	Million $ 2022	2021	2020	2019	2018	2017	2016	CAGR (%) 10-Yr.	5-Yr.	1-Yr.	Index Basis (2012=100) 2022	2021	2020	2019	2018	2017
MANAGED HEALTH CARE																				
ELV	[]	ELEVANCE HEALTH INC.		DEC	6,025.0	6,104.0	4,572.0	4,807.0	3,750.0	3,843.0	2,470.0	8.5	9.4	-1.3	244	247	185	195	152	156
CNC	[]	CENTENE CORPORATION		DEC	1,202.0	1,347.0	1,808.0	1,321.0	900.0	828.0	562.0	89.6	7.7	-10.8	NM	NM	NM	NM	NM	NM
HQY	†	HEALTHEQUITY, INC.	#	JAN	0.0	-44.3	8.8	39.7	73.9	47.4	26.4	NA	NM	NM	0	-168	33	150	280	180
HUM	[]	HUMANA INC.		DEC	2,806.0	2,933.0	3,367.0	2,707.0	1,683.0	2,448.0	614.0	8.7	2.8	-4.3	457	478	548	441	274	399
MOH	[]	MOLINA HEALTHCARE, INC.		DEC	792.0	659.0	673.0	737.0	707.0	-512.0	52.0	55.2	NM	20.2	1523	1267	1294	1417	1360	-985
UNH	[]	UNITEDHEALTH GROUP INCORPORATED		DEC	20,120.0	17,285.0	15,403.0	13,839.0	11,986.0	10,558.0	7,017.0	13.8	13.8	16.4	287	246	220	197	171	150

Note: Data as originally reported. CAGR-Compound annual growth rate.
[]Company included in the S&P 500. †Company included in the S&P MidCap 400. §Company included in the S&P SmallCap 600. #Of the following calendar year.
Souce: S&P Capital IQ.

Ticker		Company		Yr. End	Return on Revenues (%) 2022	2021	2020	2019	2018	2017	Return on Assets (%) 2022	2021	2020	2019	2018	2017	Return on Equity (%) 2022	2021	2020	2019	2018	2017
MANAGED HEALTH CARE																						
ELV	[]	ELEVANCE HEALTH INC.		DEC	3.8	4.4	3.8	4.6	4.1	4.3	5.9	6.3	5.3	6.2	5.2	5.4	16.6	17.6	14.1	16.0	13.6	14.9
CNC	[]	CENTENE CORPORATION		DEC	0.9	1.1	1.7	1.9	1.6	1.8	1.6	1.7	2.6	3.2	2.9	3.8	4.7	5.0	9.3	11.0	10.0	12.5
HQY	†	HEALTHEQUITY, INC.	#	JAN	0.0	NM	1.2	7.5	25.7	20.6	NA	NM	0.3	1.5	14.5	12.8	0.0	NM	0.7	5.3	18.0	15.6
HUM	[]	HUMANA INC.		DEC	3.0	3.5	4.4	4.2	3.0	4.6	6.5	6.6	9.6	9.3	6.6	9.0	17.8	19.7	26.1	24.4	16.8	23.9
MOH	[]	MOLINA HEALTHCARE, INC.		DEC	2.5	2.4	3.7	4.5	3.9	NM	6.4	5.4	7.1	10.9	9.9	NM	28.3	27.9	33.2	40.9	47.4	NM
UNH	[]	UNITEDHEALTH GROUP INCORPORATED		DEC	6.2	6.0	6.0	5.7	5.3	5.2	8.2	8.1	7.8	8.0	7.9	7.6	25.4	24.1	23.8	24.1	22.9	23.5

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Souce: S&P Capital IQ.

Ticker	Company		Yr. End	Current Ratio 2022	2021	2020	2019	2018	2017	Debt/Capital Ratio (%) 2022	2021	2020	2019	2018	2017	Debt as a % of Net Working Capital 2022	2021	2020	2019	2018	2017
MANAGED HEALTH CARE																					
ELV	[] ELEVANCE HEALTH INC.		DEC	1.4	1.5	1.6	1.7	1.6	1.6	38.5	37.4	36.8	37.3	41.4	43.5	142.0	132.0	118.6	119.3	153.5	148.1
CNC	[] CENTENE CORPORATION		DEC	1.1	1.1	1.1	1.6	1.0	0.9	42.5	40.1	38.9	51.6	37.8	40.9	NM	661.7	914.2	183.0	24,800.0	NM
HQY	† HEALTHEQUITY, INC.	#	JAN	0.0	2.3	2.2	2.0	13.6	13.0	NA	33.2	40.1	53.4	0.0	0.0	NA	465.3	361.8	812.9	0.0	0.0
HUM	[] HUMANA INC.		DEC	1.5	1.6	1.8	1.8	1.7	1.9	46.8	44.4	35.3	32.3	42.9	34.6	126.9	123.6	68.1	61.3	90.8	63.3
MOH	[] MOLINA HEALTHCARE, INC.		DEC	1.5	1.4	1.6	1.8	1.5	1.4	42.3	45.2	50.4	38.7	38.2	49.6	67.4	72.0	73.1	45.8	46.0	67.5
UNH	[] UNITEDHEALTH GROUP INCORPORATED		DEC	0.8	0.7	0.7	0.6	0.7	0.7	40.9	35.7	36.6	37.6	38.1	35.8	NM	NM	NM	NM	NM	NM

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Souce: S&P Capital IQ.

Ticker	Company		Yr. End	Price/Earnings Ratio (High-Low) 2022	2021	2020	2019	2018	2017	Dividend Payout Ratio (%) 2022	2021	2020	2019	2018	2017	Dividend Yield (High-Low, %) 2022	2021	2020	2019	2018	2017
MANAGED HEALTH CARE																					
ANTM	ELEVANCE HEALTH INC.		DEC	22 - 17	18 - 11	18 - 10	17 - 12	20 - 15	16 - 10	20.4	18.1	20.9	17.0	20.7	18.3	1.2 - 1.0	1.2 - 0.9	1.6 - 1.0	2.2 - 1.0	1.4 - 1.0	1.4 - 1.0
CNC	[] CENTENE CORPORATION		DEC	47 - 35	37 - 25	23 - 14	21 - 13	32 - 22	21 - 12	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
HQY	† HEALTHEQUITY, INC.	#	JAN	NM - NM	765 - 341	143 - 88	84 - 42	69 - 50	108 - 35	0.0	0.0	0.0	0.0	NM	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
HUM	[] HUMANA INC.		DEC	25 - 16	21 - 16	18 - 8	18 - 12	29 - 20	15 - 12	14.0	12.1	9.6	10.7	15.7	9.0	0.7 - 0.6	0.8 - 0.6	0.7 - 0.6	1.2 - 0.6	0.9 - 0.6	0.8 - 0.5
MOH	[] MOLINA HEALTHCARE, INC.		DEC	27 - 19	28 - 18	19 - 9	13 - 9	13 - 6	NM - NM	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
UNH	[] UNITEDHEALTH GROUP INCORPORATED		DEC	26 - 21	27 - 18	22 - 12	20 - 15	23 - 17	21 - 14	29.8	30.5	29.8	28.4	27.7	26.3	1.4 - 1.2	1.5 - 1.1	1.5 - 1.2	2.2 - 1.4	2.0 - 1.3	1.5 - 1.2

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Souce: S&P Capital IQ.

Ticker	Company		Yr. End	Earnings per Share ($) 2022	2021	2020	2019	2018	2017	Tangible Book Value per Share ($) 2022	2021	2020	2019	2018	2017	Share Price (High-Low, $) 2022	2021	2020	2019	2018	2017
MANAGED HEALTH CARE																					
ANTM	ELEVANCE HEALTH INC.		DEC	24.8	24.7	18.0	18.5	14.2	14.4	6.7	5.0	8.6	10.1	-3.8	-4.3	549.5 - 420.7	470.0 - 286.0	338.2 - 171.0	318.0 - 227.2	300.6 - 215.5	236.4 - 140.5
CNC	[] CENTENE CORPORATION		DEC	2.1	2.3	3.1	3.1	2.3	2.3	-3.0	-1.4	-2.2	8.7	4.0	2.0	98.5 - 73.2	85.4 - 57.2	74.7 - 44.0	69.2 - 41.6	74.5 - 48.8	52.3 - 28.0
HQY	† HEALTHEQUITY, INC.	#	JAN	0.0	-0.5	0.1	0.6	1.2	0.8	0.0	-9.1	-9.3	-15.3	6.3	4.2	79.2 - 44.0	93.3 - 36.8	88.8 - 34.4	85.1 - 50.3	101.6 - 46.1	55.3 - 37.6
HUM	[] HUMANA INC.		DEC	22.1	22.7	25.3	20.1	12.2	16.8	49.4	18.2	69.5	60.0	44.4	46.0	571.3 - 351.2	475.4 - 370.2	474.7 - 208.3	372.9 - 225.7	355.9 - 248.0	264.6 - 186.3
MOH	[] MOLINA HEALTHCARE, INC.		DEC	13.5	11.3	11.2	11.5	10.6	-9.1	27.1	21.7	18.1	27.7	22.6	16.2	374.0 - 249.8	328.1 - 199.8	224.0 - 102.9	159.0 - 105.3	154.1 - 71.1	80.7 - 42.6
UNH	[] UNITEDHEALTH GROUP INCORPORATED		DEC	21.2	18.1	16.0	14.3	12.2	10.7	86.0	-18.8	-21.0	-22.5	-20.0	-18.2	558.1 - 445.7	509.2 - 320.4	368.0 - 187.7	300.0 - 208.1	287.9 - 208.5	231.8 - 156.1

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