Communication from Public

Name: Concerned Healthcare Provider
Date Submitted: 11/11/2025 02:17 PM
Council File No: 25-0583
Comments for Public Posting: The Council should adopt an ordinance approving Board Order 611 from the Board of Transportation Commissioners. This is crucial to continuing to attract the needed private capital investment in non-emergency ambulance services, which are essential to the proper functioning of the healthcare system in the city of Los Angeles. A failure to approve Board Order 611 is likely to lead to further exit of private investment in essential non-emergency ambulance services in the city of Los Angeles, ultimately placing an enormous financial burden on taxpayers for such services. A failure to approve Board Order 611 would also be an action that only favors the bottom-line profit interests of a small number of multi-billion-dollar insurers and hospitals, which, if left unregulated, could exercise monopsony-like power over ambulance rates in the city of Los Angeles. This would be to the great detriment of the availability and quality of non-emergency ambulance services in Los Angeles. For further explanation and support of this position, please see the submitted attachment. Thank you.

FROM A CONCERNED HEALTHCARE PROVIDER

November 11, 2025

To Honorable Members of The Los Angeles City Council
Transportation Committee

In re Council File: 25-0583: 2024-25 Private Ambulance Service Rate Adjustment

This public comment is submitted in support of the Council adopting an ordinance approving Board Order 611 from the Board of Transportation Commissioners (hereinafter "Board Order 611"), which establishes the legal rates charged by private ambulance service in the City of Los Angeles and a new methodology for future rate adjustments, and rescinds Board Order 609 regarding the previous legal rates.

I am a frontline healthcare provider who works providing non-emergency ambulance transportation services to patients at all levels of care (BLS, ALS, and CCT) in Los Angeles. I know firsthand how important these services are to the functioning of the healthcare system and to the well-being of the patients. My identity is not important, and I have chosen to submit this anonymously in the interest of protecting the interests of those who may be associated with me. Anything expressed herein is entirely attributable to me alone. Nothing herein has been solicited, reviewed, authorized, or approved by anyone else, including any employer or association I may be affiliated with. I am not being compensated in any way for submitting this public comment.

I, and many other workers in the non-emergency ambulance services sector, support Board Order 611 because it is in the best interests of the patients, the healthcare providers, and taxpayers of the city of Los Angeles.

I. EXECUTIVE SUMMARY

The Council should adopt an ordinance approving Board Order 611 from the Board of Transportation Commissioners. This is critical to continuing to attract the investment of private capital in non-emergency ambulance services that are necessary to the proper functioning of the healthcare system in the city of Los Angeles. A failure to approve Board Order 611 is likely to lead to the further exit of private investment in essential non-emergency ambulance services in the city of Los Angeles and place the enormous financial burden for such services onto the taxpayer. A failure to approve Board Order 611 would also be an action only favoring the bottom-line profit interests of a small number of multi-billion dollar insurers and hospitals who can, if left unregulated, exercise monopsony-like power over ambulance rates in the city of Los Angeles. This would be to the great detriment of the availability and quality of non-emergency ambulance services in Los Angeles.

II. LOS ANGELES NEEDS QUALITY NON-EMERGENCY AMBULANCE SERVICES

I believe this proposition is not in controversy. Those organizations that have submitted comments have acknowledged that "the non-emergency transport of patients between health facilities is an integral part of the patient continuum of care".

III. THE ESTABLISHMENT AND MAINTENANCE OF NON-EMERGENCY AMBULANCE SERVICE SUFFICIENT TO MEET THE NEEDS OF THE RESIDENTS OF THE CITY OF LOS ANGELES REQUIRES A VERY LARGE AND ONGOING CAPITAL INVESTMENT.

Although I am not personally involved in the financial aspects of delivering non-emergency ambulance services, I do have some general knowledge of them. Specifically, establishing and operating a non-emergency ambulance service is a very expensive endeavor.

There are numerous costs involved, many of which result from legal compliance with regulations at all levels of government designed to ensure quality service and care for patients. See e.g., Los Angeles County Code Title 7, Business Licenses, Division 2, Chapter 7.16 Ambulances. An example of a substantial cost here in Los Angeles County is the requirement that ambulances be taken out of service after a certain number of years. See Los Angeles County Code Title 7, Business Licenses, Division 2, Chapter 7.16.210. The cost of acquiring, equipping, and licensing a new ambulance to replace one that has been taken out of service typically ranges in the hundreds of thousands of dollars. See e.g., attachment 1, the City of Pasadena 01/10/2022 fire department proposal to acquire three new ambulances at an estimated cost not to exceed $1,029,844 (or approximately $343,000 per ambulance). Establishing and operating an ambulance company with even a small fleet of ambulances (e.g., ten ambulances) requires a substantial capital investment of millions of dollars.

That capital investment has to come from somewhere, and presently, the source of that capital is largely private investment. See, e.g., Attachment 2 (Sandton Capital's private equity investment of $50 million in a non-emergency ambulance operator). It is worth noting that around the time of the attached Sandton Capital announcement, there was an ownership change in one of the larger and more established non-emergency ambulance operators in the City of Los Angeles to Sandton Capital. So, perhaps the $50 million capital investment by Sandton Capital was made in the city of Los Angeles.

Even a rough calculation suggests that establishing and maintaining sufficient ambulances to meet the city of Los Angeles' (with a population of 3,898,747, according to the 2020 census) essential non-emergency ambulance transportation needs involves a capital investment of hundreds of millions of dollars. If the city of Los Angeles expects private firms to invest substantial amounts of capital in meeting the non-emergency ambulance needs of its residents, then it is incumbent upon the city to maintain a regulatory environment that encourages such investment. This means having appropriate regulations in place to ensure that private investors are not exposed to an excessive risk of financial loss when investing in the essential services of non-emergency ambulance transport.

For the reasons explained below, simply allowing the private insurance companies in the city of Los Angeles to "negotiate" the rate they pay for non-emergency ambulance services will likely discourage private investment, significantly reduce the number and quality of private non-emergency ambulance service providers, and, if the city of Los Angeles wants quality non-emergency ambulance services for its residents, probably shift the financial burden onto the Los Angeles taxpayer for providing the required capital.

IV. NON-EMERGENCY AMBULANCE SERVICES ARE OFTEN FACED WITH LOW NET PROFIT MARGINS, AND LOW GROWTH POTENTIAL, MAKING IT CHALLENGING TO ATTRACT PRIVATE CAPITAL INVESTMENT

Industry reports indicate that non-emergency ambulance services in California generally operate with modest profit margins, typically ranging from 2% to 8%, although efficient, high-volume providers may reach profit margins of 10%–15%. Margins are constrained by low reimbursement rates, particularly from Medi-Cal and Medicare, as well as by operational costs such as labor, vehicle maintenance, fuel, and insurance. Non-emergency transports often involve long distances, wait times, and empty return trips, which reduce revenue per trip. Profitability depends heavily on payer mix, utilization, and efficient operations. Providers with a higher share of commercially insured patients and optimized logistics are more likely to achieve positive margins, while those serving primarily government-funded patients may operate at or near break-even. Overall, non-emergency ambulance services balance financial sustainability with the challenges of low reimbursement and high operating costs.

It is generally accepted that the reimbursement rates for non-emergency ambulance services provided by Medicare and Medi-Cal are often *below* the cost of providing the service. See e.g., Attachment 3 *Takeaways from the First CMS Data Collection Report on Ambulance Services – And What we Need to Do About It* - February 18, 2025. Accordingly, private ambulance providers in Los Angeles face an excessive risk of *losing* money when reimbursed for their services at Medicare and Medi-Cal rates. At least one major private ambulance service has recently ceased providing non-emergency ambulance services in Los Angeles as a result. See

attachment 4: *Cost Issues Lead AMR to Shut Down Non-Emergency Ambulance Division in LA County* - 09/13/2022 (AMR had been providing 28,000 non-emergency transports annually, which it was forced to stop providing on account of financial losses).

For patients who are self-pay or uninsured, private ambulance providers are legally prohibited in California from billing such patients "more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater". See California Health & Safety Code §1797.233. For privately insured patients in California, the law requires that an "out of network" ambulance provider can not recover from the patient more than the in-network cost-sharing amount. See California Health & Safety Code §1371.56. In many cases, the "in-network cost-sharing amount" owed by the insured patient will be less than the cost to the ambulance provider of providing the ambulance service.

Accordingly, services provided by a private ambulance company to patients in California who are uninsured, covered only by Medicare or Medi-Cal, or who are covered by a private insurer with which the ambulance company does not have a contract, pose a high risk of financial losses for the ambulance company in many, if not most, cases. This high risk of losing money on such transports is not attractive to an investment of private capital.

Once government payers (such as Medicare and Medi-Cal) and self-pay patients are excluded, the remaining purchasers of ambulance services in Los Angeles are the private health insurers. It is from these insurance payers that privately funded companies offering non-emergency ambulance services must receive sufficient revenue to cover their costs and generate a sufficient return to attract the needed capital investment and remain in business.

However, the health insurers in the city of Los Angeles exercise monopsony-like power, which poses substantial risks that the "negotiated" rates from these health insurers may be insufficient to cover costs and generate a sufficient return on investment to attract the capital needed to maintain such essential services.

V. IF UNREGULATED, THE HEALTH INSURERS IN THE CITY OF LOS ANGELES COULD EXERCISE MONOPSONY-LIKE POWER OVER AMBULANCE PROVIDER REIMBURSEMENT RATES, DRIVING AWAY NEEDED CAPITAL INVESTMENT

When evaluating whether private payers of ambulance services in Los Angeles operate as a monopsony, it is important to first define the term. A monopsony occurs when there is only one—or very few—buyers in a market with many sellers, giving the buyer substantial power to determine the price or terms of exchange. In such markets, the dominant buyer can pay less than the competitive price, limit the quantity purchased, or impose unfavorable contract conditions on suppliers. See, e.g., Attachment 5, *"Roundtable on Monopsony and Buyer Power"* (OECD, 2008). In the context of ambulance services, the "buyers" are the payers—usually insurance companies—that reimburse ambulance providers for emergency transport.

The Los Angeles health insurance market is among the most concentrated in the United States. According to recent data from the American Medical Association, the largest insurer in the region, Kaiser Permanente, holds roughly one-third of the market. See attachment 6, American Medical Association, *Competition In Health Insurance - A Comprehensive Study of U.S. Markets*, at page 17. Elevance (formerly Anthem) and Blue Shield of California together control nearly half of the remaining share. *Id.* at 28. This means that three major insurers dominate more than 75 percent of the private insurance market. Such high concentration gives these firms significant bargaining power over healthcare providers, including ambulance companies.

On the seller side, the city of Los Angeles has approximately 35 licensed ambulance providers, many of which are small providers. While there are multiple non-emergency ambulance providers, the market remains fragmented, and each ambulance provider often relies heavily on payments from a very small number of large insurers.

This market structure—few powerful buyers and many dependent sellers—creates the conditions for what economists call an oligopsony, a market with several buyers who collectively

exert monopsony-like influence. Insurers use their size and bargaining power to determine reimbursement rates for ambulance transports, which may be well below cost. Because patients rarely choose their ambulance provider or have any control over who is dispatched to transport them, insurers face little competitive pressure from patient preferences. The combination of insurer concentration, provider dependence, and limited patient choice enables these insurance payers, in an unregulated market, to dictate payment terms with minimal negotiation.

Although the city of Los Angeles ambulance market does not meet the strict textbook definition of a monopsony—since there is not a single buyer—it clearly exhibits many of the same economic effects. Non-emergency ambulance companies face downward pressure on reimbursement rates, delayed payments, and regulatory constraints that limit their ability to offset low payments from insurers. Over time, such insurance buyer power can discourage investment, reduce service quality, or threaten financial sustainability for ambulance providers.

In summary, if left unregulated, private insurers in the city of Los Angeles would likely form an oligopsony in the market for non-emergency ambulance services. Their collective market dominance gives them monopsony-like power over reimbursement, shaping prices and access in ways that resemble a true monopsony, even if the structure is not perfectly singular.

VI. THE LONG-ESTABLISHED LAW IN THE CITY OF LOS ANGELES FOR ESTABLISHING NON-EMERGENCY AMBULANCE RATES HELPS TO ATTRACT NECESSARY PRIVATE CAPITAL INVESTMENT IN NON-EMERGENCY AMBULANCE SERVICES AND SHOULD BE MAINTAINED

A substantial non-emergency ambulance fleet is required to serve the needs of the nearly four million residents of the city of Los Angeles. As explained above, the establishment and operation of such a fleet requires a very substantial investment of capital. Unless such capital is to be provided at enormous cost by the city's taxpayers, it will need to be obtained from private sources. Those private sources will, of course, require a reasonable return on their investment.

Given the historically low net operating margins of ambulance providers, expecting private investment, particularly of the magnitude required here in the city of Los Angeles with a population of nearly four million people, necessitates a regulatory framework that establishes a reasonably low-risk investment for the private provision of these essential services, while also protecting Angelenos from excessive rates. The current regulatory scheme in the city of Los Angeles helps accomplish this.

The current regulations empower the Board of Transportation Commissioners to set non-negotiable rates for non-emergency ambulance services. This helps to assure those who invest substantial capital in providing Angelenos with essential, quality non-emergency ambulance services that they can charge, at least to private insurers, what is necessary to cover their costs and generate a reasonable rate of return. It is simply unrealistic to expect the substantial investment of private capital needed in providing these essential services if an oligopoly of wealthy private health insurers in the city is allowed to use their monopsony-like power to "negotiate" the prices. That would present a very sizable risk to any prospective investor of private capital, as the oligopoly of private insurers would likely refuse to pay for these essential ambulance services at a rate that even covers costs, let alone generates a reasonable rate of return.

The rates for non-emergency ambulance services set by the city of Los Angeles are required to be just, reasonable, non-discriminatory, non-preferential, and not in violation of any provision of law. See Los Angeles Municipal Code 71.25(c). It has been so for decades. The rates set have been established after extensive evidence gathering and analysis by the LADOT, as well as a public hearing, during which all members of the public were free to participate and contribute, including private insurers. There is no evidence presented that the rates previously set, or currently proposed Board Order 611, or the proposed new methodology, do not satisfy the above-stated municipal code requirements.

VII. CONCLUSION: THE COUNCIL SHOULD APPROVE BOARD ORDER 611

The opponents of Board Order 611 include private insurers and hospitals. They don't want to pay the new rates. There is no evidence on record to suggest that these opponents can't pay the proposed rates in Board Order 611. Kaiser, for example, has $67 billion in financial reserves. See attachment 7 *New Report Details Kaiser Permanente's $67 Billion In Financial Reserves* - October 2025. That is a $27.4 billion increase from four years ago. *Id.*

There is also no evidence presented by the opponents that the proposed new rates and methodology in Board Order 611 are not entirely warranted and reasonable. Board Order 611 was arrived at after an extensive evidence-gathering investigation and analysis, as well as a public hearing, during which all members of the public, including opponents, had ample opportunity to participate and contribute. Given the complete lack of evidence provided by the opponents that Board Order 611 fails to satisfy the municipal code requirements for setting new rates, perhaps the Council should give some deference to the findings and conclusions of the Board set forth in Board Order 611.

Patients in the city of Los Angeles expect and deserve quality non-emergency ambulance transportation, which everyone agrees is critical to the proper functioning of the healthcare system. Approval of Board Order 611 will help provide this by continuing to encourage the investment of the private capital needed to provide such services in the city of Los Angeles. A failure to approve Board Order 611 or regulate prices, however, is likely to lead, at least eventually, to a substantial decline in private capital investment in these services, leaving the financial burden of providing such services ultimately to the taxpayers.

Thank you for taking the time to consider these comments.

ATTACHMENT 1

Agenda Report

January 10, 2022

TO: Honorable Mayor and City Council

FROM: Fire Department

SUBJECT: **AUTHORIZATION TO ENTER INTO A PURCHASE ORDER CONTRACT WITH EMERGENCY VEHICLE GROUP, INC. FOR THE PURCHASE OF THREE REPLACEMENT 2022 ROAD RESCUE ULTRAMEDIC RESCUE AMBULANCES FOR A TOTAL AMOUNT NOT TO EXCEED $1,029,844**

RECOMMENDATION:

It is recommended that the City Council:

1. Find that this action is exempt under the California Environmental Quality Act (CEQA) in accordance with Section 15061 (b)(3), the General Rule that CEQA only applies to projects that may have an effect on the environment;

2. Authorize the City Manager to enter into a purchase order contract with Emergency Vehicle Group, Inc. for the purchase of three Road Rescue Ultramedic Rescue Ambulances in an amount not to exceed $1,029,844. Competitive Bidding is not required pursuant to City Charter Section 1002(H) contracts with other governmental entities or their contractors for labor, materials, supplies or services; and

3. Grant the proposed contract an exemption from the Competitive Bidding process pursuant to Pasadena Municipal Code Section 4.08.049(8), contracts for which the City's best interests are served

BACKGROUND:

The Pasadena Fire Department (PFD) is an "All Hazard" response agency which responds to all calls for public assistance including emergency medical service, fires, technical rescues and other hazards. In fiscal year (FY) 2021, the PFD responded to 17,023 emergency call for service, of which 14,575 (86%) were medical-related emergencies.

The PFD currently operates ten (10) rescue ambulances (RAs), five (5) of which are front line RAs and five (5) in reserve status. Front line RA units #0966, #0967 and #0968, assigned to Fire Stations, 32, 33 and 34 respectively, have exceeded their useful lives and have been deemed eligible for replacement. The ambulances replacing these units are new models of the existing RAs currently in use. Replacing these vehicles eliminates the need for costly repairs due to the ages and conditions of the vehicles. Upon delivery of the replacement RAs, the existing units will be moved into reserve status; reserve RA units #0956, #0957 and #0958 will be salvaged. The salvage value will be returned to the Department's Fleet Replacement Fund. Attachments A and B contain the vehicle condition reports.

In preparation for this purchase, the PFD created a committee to develop the vehicle specifications based on current and future departmental needs. This committee was comprised of a diverse selection of departmental staff, Fire Captains, firefighter paramedics, and other experienced personnel including mechanics from Fleet Maintenance. The committee solicited input from the entire Department and consulted with personnel to be assigned to this equipment to determine the capabilities and features required of the new RAs. Fire Department and Fleet Maintenance personnel also conducted site visits to Glendale, San Marino and Alhambra Fire Departments to view their new RAs and to address the maintenance, functionality, and serviceability of these vehicles. Based on the existing fleet of RAs and specific needs of the PFD, the Road Rescue Ultramedic model was determined by the committee to be the best fit.

Purchasing the requested RAs utilizing the Houston Galveston Area Council (HGAC) contract is in the City's best interest as it reduces the amount of time required to take delivery of new equipment and eliminates the need to solicit for items that are already competitively priced. Moreover, the fact that HGACBuy awarded its contract through a competitive bidding process ensures the cost competitiveness of the purchase. The HGAC is one of the largest regional planning commissions in the country and focuses on providing purchasing solutions to jurisdictions. One such effort managed by HGAC is HGACBuy, a nationwide government procurement service which aims to make the process more efficient. HGACBuy awards contracts through a public competitive procurement process; contracts are available to participating members such as the City of Pasadena. On April 2, 2018, HGACBuy issued an invitation to submit competitive bids for "Ambulances, EMS, & other Special Service Vehicles." The bid process closed on May 7, 2020 and twenty bids were received. The HGACBuy staff evaluated all the proposals and authorized contracts with the lowest responsible bidders for product items across multiple categories. As a result of the HGACBuy staff evaluation, HGACBuy extended a contract to Road Rescue for the AM20XA10 Ultramedic model rescue ambulance.

Baseline pricing was established by HGACBuy using the competitive solicitation process outlined above. After the PFD determined the Road Rescue Ultramedic model was the appropriate fit, personnel reconvened to discuss optional modifications to the baseline specification. Two such options were the inclusion of a powered lift gurney system and cot, as well as an internal built-in air purification system. Powered lifts in

RAs are becoming an industry standard, and are necessary as the City's medical call volume continues to increase. Powered lift systems reduce repetitive injuries and costly workers compensation claims. Additionally, the air purification system kills 99% of pathogens in the air and on surfaces, including SARS COV2 which causes COVID-19. This delivers a safer cab environment for our crews.

Emergency Vehicle Group (EVG) is the sole source provider of the Road Rescue RAs in the States of California, Arizona, and Nevada. The City has had prior contracts with EVG amounting to approximately $1,045,000 since 2015 for the purchase of three RAs and other replacement parts. EVG has agreed to extend the prices, terms, and conditions to the City of Pasadena for the purchase of three new 2022 Road Rescue Ultramedic RAs, using HGACBuy Contract #AM10-20. The vehicles will be delivered within 240 days after receipt of the purchase order.

COUNCIL POLICY CONSIDERATION:

The proposed contract furthers the City Council's strategic planning goal to ensure public safety.

ENVIRONMENTAL ANALYSIS:

This purchase complies with all South Coast Air Quality Management District rules and regulations for engine emissions and clean air standards in the South Coast basin.

FISCAL IMPACT:

The cost of this action is $1,029,844. Funding for this action will be addressed in the FY 2023 operating budget as the Public Works Department's Building Systems and Fleet Management Division will be appropriating Year 2 of the 3-Year Fleet Replacement Plan in account 50322060-850500. Indirect and support costs such as maintenance and repair are anticipated to be $130,000 per vehicle over the lifecycle of the vehicles, and will be addressed annually by utilization of budgeted appropriations in the Fire Department's operating budget account 10131016-861600.

Respectfully submitted,

Chad Augustin

CHAD AUGUSTIN
Fire Chief
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Cynthia J. Kurtz

CYNTHIA J. KURTZ
Interim City Manager

Attachment A – Vehicles No. 0966, 0967 and 0968 Condition Reports
Attachment B – Vehicles No. 0956, 0957 and 0958 Condition Reports

ATTACHMENT 2

SANDTON
CAPITAL PARTNERS

Sandton has purchased $40mm in debt and provided an additional $5mm of growth capital to a leading ambulance operator

- Large non-emergency ambulance transport service with operations across the US
- COVID pandemic created unprecedented challenges for ambulance operators as healthcare activity dropped dramatically
- Demand for non-emergency services has slowly recovered as lock downs have been lifted
- The company recently won a large new contract, but its existing stakeholders were unwilling to fund the necessary capital
- Sandton purchased the existing debt and funded $5MM of equipment purchases and working capital necessary for growth

Colby Gibbins, Sandton Capital Partners said:

> *"Sandton's unique understanding of the healthcare industry and willingness to creatively structure new funding in to an over-leveraged balance sheet was critical in getting this complex transaction closed. The transaction allows the company to not only continue to operate, but actually capitalize on growth opportunities coming out of an unprecedented challenging operating environment."*

Contact us:

For further information, please contact:

Colby Gibbins

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Email: **cgibbins@sandtoncapital.com.**

ATTACHMENT 3

Takeaways from the First CMS Data Collection Report on Ambulance Services – And What we Need to Do About It

(MECHANICSBURG, PA) February 18, 2025 – by PWW|AG Matt Zavadsky and PWW|AG Doug Wolfberg

On **December 19th**, CMS released the first report on the Medicare Ground Ambulance Data Collection System (GADCS).

The report, prepared for CMS by the RAND Corporation, summarized data collected from 3,694 ambulance agencies that completed and submitted their reports for the years 2022 and 2023, representing 85% of the agencies selected to provide this data. This high response rate is likely due to the excellent engagement process used by RAND, in partnership with numerous national associations, such as the American Ambulance Association (AAA), Academy of International Mobile Healthcare Integration (AIMHI) National Association of Emergency Medical Technicians (NAEMT), International Association of Fire Chiefs (IAFC).i

On January 21, 2025, PWW Advisory Group (PWW|AG) conducted a national webinar highlighting the most important findings from the report, including an analysis conducted by PWW|AG summarizing the cost and revenue data contained in the GADCS report. Joining PWW|AG on the webinar was Dr. Andrew Mulcahy, RAND Health Care's Lead Author of the GADCS Report.

Here are the ***top findings*** from the report that EMS and policy makers need to know – and do something about.

Finding: Across all provider types, the average cost to the agency for an ambulance transport is $2,673.

Discussion: The GADCS report calculated that across all respondents, the mean cost to complete an ambulance transport was $2,673. For governmental agencies, the mean cost is $3,127 and for private-for-profit agencies, the mean cost is $1,778.

Action: It's important for agencies to quantify and share their cost of service delivery based on per transport, per response and even a per staffed ambulance hour (Unit Hour) basis. This information will help you articulate funding needs and assure you are billing fees are established at a level that helps cover as much of your costs as possible.

Finding: Across all provider and payer types, the mean reimbursement per transport is $1,147.

Discussion: This means that across all payer classifications, Medicare, Medicaid, commercial insurance, self-pay, etc., on average, ambulance agencies are under reimbursed $1,526 per transport. We should find ways to maximize revenue by billing fees that attempt to result in a net reimbursement that is close to our cost per transport.

Action: Ambulance agencies should know how to calculate their revenue per transport and implement strategies to enhance their reimbursement.

Finding: On average, across all provider types, Medicare under reimburses ambulance service by $2,344.

Discussion: Using Medicare payment data, the average Medicare *reimbursement* across all billing codes is $328.89.(ii) This means that on average, Medicare is under-reimbursing ambulance services by $2,334 per transport. The difference between the overall reimbursement and the Medicare reimbursement articulates the 'revenue' shift in ambulance service, with commercial insurers reimbursing EMS at a higher rate.

Action: Indications are that CMS may not be motivated by the data in this report to change the Medicare allowable fee to a level that more fairly compensates EMS for the costs of services provided. It is likely that any change in the Medicare Ambulance Fee Schedule (AFS) will require legislative action. Ambulance agencies should support national EMS organizations that advocate for enhanced reimbursement from Medicare for services provided.

Finding: 56% of all ambulance transports were at the BLS level and 44% were at the ALS level.

Discussion: Recent peer-reviewed, evidence-based research seems to support this finding that more than half the patients treated by ambulance agencies received BLS level care.

Action: With many systems considering tiered deployment models using both BLS and ALS ambulances to more closely align resources with patient acuity levels, agencies should thoroughly evaluate both the cost and revenue impact when implementing a tiered deployment strategy.

Finding: 11.5% of participating agencies reported receiving revenue from payers for non-transport EMS/medical services

Discussion: Under current CMS rules, Medicare does not reimburse for ambulance response, treatment and no transport services (HCPCS Code A0998). However, other payers are reimbursing for this service. A recent analysis of revenue data from a large Public Utility Model revealed that 74% of billed charges for Treatment in Place (TIP) were paid by commercial insurers and 58% were paid by Managed Medicare payers. Of 5,317 TIP bills sent, the agency received $759,268.

Action: As the EMS economic crisis continues, ambulance agencies should review policies related to billing for TIP services. The cost for an agency to respond to a call in which a patient was treated, but not transported, are similar to the costs for a transport.

Finding: 26% of ambulance services cannot break out their payer mix.

Discussion: EMS is healthcare, and analytics related to revenue cycle is crucial for making informed decisions. Payer mix (the percentage of patients treated by payer classification or percentage of revenues received) is vital to this analysis. Many communities across the country are facing growing financial challenges and are beginning to closely evaluate the costs and revenues related to EMS delivery.

Action: EMS leaders should have information available to help local public officials make informed decisions about costs and revenues related to ambulance service delivery.

Practical Takeaways for EMS

The results from the GADCS provide significant opportunities for the EMS profession. The representative data, from over 3,000 diverse agencies, quantifies the large gap between the costs of providing ambulance service and the revenue generated from that service. Here are several overall actions we should take to improve service delivery sustainability.

Advocate for Change: Use the information contained in this report to advocate for improved reimbursement from Medicare, Medicaid and commercial insurance payers. This could be done through lobbying members of Congress to require CMS to change the Medicare Ambulance Fee Schedule, including payments for TIP services, and assuring commercial insurers adequately reimburse for EMS. The same could be done at the state level with state Medicaid fee schedules and state level commercial insurance regulations. Be active in state and national EMS associations that are working for change.

Diversify Revenues: The GADCS report provides strong evidence, externally evaluated by a respected research and data analytics firm, that expenses outpace revenues for ambulance services in the United States. Whether the federal or state governments will use this data to change ambulance reimbursement remains to be seen. However, instead of waiting for reimbursement increases, ambulance services should address economic sustainability within their own service model. This should include billing for TIP services or contracting with payers, facilities or other potential customers to provide Mobile Integrated Healthcare (MIH) services.

Innovate for Sustainability: Transformative agencies are dramatically changing their EMS systems to enhance sustainability. Changing from all ALS to tiered deployment models using BLS ambulances, using local data and evidence-based research to change response time expectations, implementing pre-dispatch disposition modalities, and reducing Ambulance Patient Offload Times (APOT) are ways ambulance agencies can enhance service levels and reduce costs of service delivery.

Note: *To view a recording of the PWW|AG GADCS webinar, and get a copy of the handouts, click here.*

i It should also be noted that Federal law allows CMS to deduct 10% from the Medicare reimbursement paid to a supplier that fails to submit its data, which likely also contributed to the high participation rate.

ii Medicare Physician & Other Practitioners by Provider dataset provides information on use, payments, submitted charges and beneficiary demographic and health characteristics organized by National Provider Identifier (NPI) Accessed here.

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ATTACHMENT 4

Cost Issues Lead AMR to Shut Down Non-Emergency Ambulance Division in LA County

9.13.2022

The closure will take place over the next 180 days. AMR will redirect these non-emergency resources to support core emergency operations.

American Medical Response (AMR), which has served Los Angeles County for over 50 years, has made the difficult decision to close the Company's Los Angeles County non-emergency operations. The closure will take place over the next 180 days. This division employs over 170 employees, including EMTs, paramedics, dispatchers, and nurses, and provides approximately 28,000 non-emergency ambulance transports a year.

California has not increased Medi-Cal reimbursement for private ambulance operators since the late 1990s. The current Medi-Cal base rate for private ambulance services sits just above $100, which is far below our cost of providing the transport. The State's Medi-Cal reimbursement rate is one of the lowest in the country, but it also has the highest operational costs for ambulance transports. What's more, we are not subsidized by taxpayer funds like public agencies, and almost 80% of our patients pay nothing or below cost for our services. When you combine current reimbursement shortfalls with recent inflationary pressures, our Los Angeles division is on course to have an operational deficit of over $3.5 million.

With the support of our labor unions, including the United EMS Workers - AFSCME and National Association of Government Employees (NAGE), AMR and other ambulance providers throughout the State made requests to the legislature for a Medi-Cal increase tied to higher wages for EMTs, paramedics, and dispatchers. But despite a billion-dollar budget surplus no funding was approved in this year's State budget for an increase. Instead, the State moved forward to increase fire department's Medi-Cal reimbursement for ambulance transports to over $1000 even though taxpayers already cover the cost to provide these services. In addition, the legislature denied private EMTs and paramedics the healthcare worker bonus because they were determined to be non-essential to the COVID response even though private industry provides 70% of California's emergency and non-emergency ambulance services.

“As we continue to experience the financial impacts of low Medi-Cal reimbursement, a tight labor market, and recent federal, state, and local policy decisions that have negatively impacted our ability to provide both emergency and non-emergency ambulance services, AMR has no choice but to work diligently and swiftly to protect our core emergency 911 operations to ensure we can meet the needs of our patients and communities we serve,” said Ken Liebman, Regional Director of Operations for AMR.

AMR intends to move as much of the workforce as possible from the impacted non-emergency division over to the emergency side of our operations in the County. AMR management will also work with the County and other stakeholders to minimize the impact on the healthcare system as they seek out other providers to cover the 28,000 yearly transports currently provided by AMR’s non-emergency division.

Back to News Center
View next article

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ATTACHMENT 5

Organisation de Coopération et de Développement Économiques
Organisation for Economic Co-operation and Development

13-Oct-2008

English text only

DIRECTORATE FOR FINANCIAL AND ENTERPRISE AFFAIRS
COMPETITION COMMITTEE

DAF/COMP/WD(2008)79
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ROUNDTABLE ON MONOPSONY AND BUYER POWER

-- Note by the United States --

This note is submitted by the United States to the Competition Committee FOR DISCUSSION at its forthcoming meeting to be held on 21-23 October 2008.

JT03252799

English text only

1. Introduction

1. The 1890 debates in both houses of the United States Congress demonstrated concern with the exercise of market power on both the buying and selling sides of the market.[1] Many legislators singled out large meat packers for condemnation, and they were condemned as much for reducing the prices paid to cattle farmers as for raising prices to consumers.[2] In response, Congress passed the Sherman Act, "aimed at preserving free and unfettered competition as the rule of trade."[3] "The Act is comprehensive in its terms and coverage, protecting all who are made victims of the forbidden practices by whomever they may be perpetrated."[4]

2. The Sherman Act prohibits anticompetitive agreements and exclusionary conduct and both may be found unlawful on the basis of effects on the buying side of the market. Buyer cartels are unlawful per se and prosecuted criminally. Other collaborations among competing buyers may be unlawful if they create market power on the buying side of the market. Single-competitor exclusionary conduct is unlawful if it maintains, creates, or threatens to create, a high degree of market power on the buying side of the market.

3. The Clayton Act prohibits mergers and acquisitions "having demonstrable anticompetitive effects"[5] and authorises the injunction of a proposed merger on the basis of a "prediction of the merger's impact on competition."[6] Mergers may be found unlawful on the basis that they are likely to create or enhance market power on the buying side of the market.

2. Monopsony and Buyer Power Concepts

4. A "monopsony" is a single (or dominant) buyer dealing with multiple sellers. In important respects, monopsony is the mirror image of monopoly.[7] In the simple textbook treatment, a monopolist forces up the market price for what it sells by restricting the amount it produces and thus moves up the market demand curve; a monopsonist forces down the market price for what it buys by restricting the amount it buys and thus moves down the input supply curve. Although output reduction is generally associated with both monopoly and monopsony, it need not occur with either. By practicing price discrimination, with all-or-nothing offers, a monopolist can extract the maximum from consumers, and a monopsonist can extract the maximum from suppliers, without any reduction in output.[8]

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1 *See* 21 CONGRESSIONAL RECORD 2461 (1890) (statement of Sen. John Sherman) ("These trusts and combinations . . . operate as a double-edged sword. They increase beyond reason the cost of necessaries of life and business, and they decrease the cost of raw material, the farm products of the country. They regulate prices at will, depress the price of what they buy and increase the price of what they sell.").

2 *See id.* at 2470 (statement of Sen. John H. Reagan), 2606 (statement of Sen. William M. Stewart), 4098 (statement of Rep. Ezra B. Taylor), 4099 (statement of Rep. Richard P. Bland); 4101 (statement of Rep. John T. Heard).

3 *National Collegiate Athletic Ass'n v. Board of Regents of University of Oklahoma*, 468 U.S. 85, 104 n.27 (1984) (quoting *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 4 (1958)).

4 *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 472 (1982) (quoting *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219, 236 (1948)).

5 *Brown Shoe Co. v. United States*, 370 U.S. 294, 319 (1962).

6 *Federal Trade Commission v. Procter & Gamble Co.*, 386 U.S. 568, 577 (1967).

7 Ways in which monopsony does not mirror monopoly as a practical matter are discussed by Jonathan M. Jacobson & Gary J. Dorman, *Joint Purchasing, Monopsony and Antitrust*, 36 ANTITRUST BULLETIN 1, 10–17 (1991); Jonathan M. Jacobson & Gary J. Dorman, *Monopsony Revisited: A Comment on Blair & Harrison*, 37 ANTITRUST BULLETIN 151, 154–58 (1992); Roger G. Noll, *"Buyer Power" and Economic Policy*, 72 ANTITRUST L.J. 589 (2005).

8 *See* ROGER D. BLAIR & JEFFREY L. HARRISON, MONOPSONY: ANTITRUST LAW AND ECONOMICS 73–74 (1993).

5. The economic impact of monopsony depends somewhat on the monopsonist's position as a seller in the associated output market. If the monopsonist is a monopolist in the output market, restricting input purchases leads to reduction in output, which raises the price to downstream consumers. In contrast, if the monopsonist has no ability to affect the price in the output market, restricting input purchases has no impact on downstream consumers. This latter scenario can arise if the geographic scope of the relevant input market is far narrower than the geographic scope of the relevant output market. It also can arise if the monopsonist employs a different technology, using different inputs, than its output-market rivals.

6. In both economics and law, "market power" refers to the ability of a seller profitably to charge more than the competitive price for what it sells or to the ability of a buyer profitably to pay less than the competitive price for what it purchases. Market power is a matter of degree and is not of concern unless present to a significant degree. The degree of market power on the selling side of the market is determined mainly by the market demand curve, especially its elasticity. The degree of market power on the buying side of the market is determined mainly by the input supply curve, especially its elasticity. Substantial and durable market power on the part of a seller is "monopoly power," and substantial and durable market power on the part of a buyer is "monopsony power."

7. The term "buyer power" describes either market power or "bargaining power" on the buying side of the market.[9] The latter form of buyer power is the ability of a buyer to negotiate a favourable price that is nevertheless above the competitive level.[10] The term "countervailing power" was coined to describe the latter form of buyer power when it has the effect of mitigating the adverse effects of seller power on the opposite side of the same market.[11]

3. Buyer Cartels

8. Cartels have always been a major focus of antitrust enforcement in the United States, and buyer cartels have always been treated just as seller cartels. One of the earliest Sherman Act cases involved, among other things, a conspiracy among meat packers to reduce the price they paid for cattle.[12] The per se rule against cartel activity began to emerge in the early decisions interpreting the Act,[13] and it has never distinguished between seller cartels and buyer cartels.[14] All cartel activity is prohibited because of its "threat to the central nervous system of the economy."[15]

9. In 1948 the Supreme Court of the United States specifically addressed price fixing by competing buyers.[16] Within a highly localised market, growers of sugar beets could sell to only three refiners, and the three refiners entered into a price-fixing arrangement. Because the refiners sold sugar in competition with other refiners throughout the United States, their price fixing affected the price they paid to growers but not the price at which they sold refined sugar. The Supreme Court held that: "It is clear that the agreement is the sort of combination condemned by the [Sherman] Act, even though the price-fixing was by purchasers,

9 *See, e.g.*, ANTITRUST MODERNIZATION COMMISSION, REPORT AND RECOMMENDATIONS 323 (2007).

10 *See, e.g.*, Zhiqi Chen, *Buyer Power: Economic Theory and Antitrust Policy*, *in* 22 RESEARCH IN LAW AND ECONOMICS 17, 19–20 (2007).

11 JOHN K. GALBRAITH, AMERICAN CAPITALISM: THE CONCEPT OF COUNTERVAILING POWER 111–23 (1952).

12 *United States v. Swift & Co.*, 122 F. 529 (C.C.N.D. Ill. 1903), *aff'd*, 196 U.S. 375 (1905).

13 *See United States v. Joint Traffic Ass'n*, 171 U.S. 505 (1898); *United States v. Trans-Missouri Freight Ass'n*, 166 U.S. 290, 331 (1897).

14 *See United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940) ("Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se.").

15 *Id.* at 225 n.59.

16 *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219 (1948).

and the persons specially injured . . . are sellers, not customers or consumers."[17] The Court also declared that the effects of the price fixing "fall squarely within the Sherman Act's prohibitions, creating the very injuries they were designed to prevent."[18] Modern court decisions agree that the per se rule against cartel activity makes no distinction between seller cartels and buyer cartels.[19]

10. The U.S. Department of Justice makes no distinction between seller cartels and buyer cartels in its cartel enforcement program. During the 11-year period 1997–2006, the Department brought 70 criminal cases against buyer cartels. All involved collusion among bidders in auctions; 51 involved real estate foreclosure auctions. The limited evidence on buyer cartels in auction settings suggests that they have had substantial competitive effects. A study of real estate auctions found that bid rigging reduced winning bids an average of 32%.[20] A study of auctions for used police cars found that bid rigging reduced winning bids by 17–28%.[21]

4. Purchaser Collaborations Other than Cartels

11. Section 1 of the Sherman Act prohibits any "contract, combination . . . or conspiracy, in restraint of trade." The three named forms of conduct "are understood to embrace a single concept"—that of an agreement among distinct economic entities,[22] and Section 1 is read "to outlaw only unreasonable restraints."[23] The "criterion to be used in judging the validity of a restraint of trade is its impact on competition."[24] A "horizontal restraint—an agreement among competitors on the way in which they will compete with one another"[25]—is the type of restraint most likely to be found unreasonable. Horizontal restraints other than cartels can be deemed unreasonable per se, but "[r]esort to *per se* rules is confined to restraints . . . 'that would always or almost always tend to restrict competition and decrease output.' To justify a *per se* prohibition a restraint must have 'manifestly anticompetitive' effects and 'lack . . . any redeeming virtue.'"[26]

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17 *Id.* at 235 (footnotes omitted).

18 *Id.* at 242.

19 *See, e.g.*, *Todd v. Exxon Corp.*, 275 F.3d 191, 201 (2d Cir. 2001) ("a horizontal conspiracy among buyers to stifle competition is as unlawful as one among sellers"); *Vogel v. American Society of Appraisers*, 744 F.2d 598, 601 (7th Cir. 1984) (Posner, J.) ("[B]uyer cartels, the object of which is to force the prices that suppliers charge the members of the cartel below the competitive level, are illegal per se. Just as a sellers' cartel enables the charging of monopoly prices, a buyers' cartel enables the charging of monopsony prices."); *International Outsourcing Services, LLC v. Blistex, Inc.*, 420 F. Supp. 2d 860, 864 (N.D. Ill. 2006) ("The broad prohibition against price fixing also extends to the less common situation of price fixing among horizontal competitors who are buyers.").

20 John E. Kwoka, Jr., *The Price Effect of Bidding Conspiracies: Evidence from Real Estate "Knockouts*," 42 ANTITRUST BULLETIN 503 (1997).

21 Jon P. Nelson, *Comparative Antitrust Damages in Bid-Rigging Cases: Some Findings from a Used Vehicle Auction*, 38 ANTITRUST BULLETIN 369 (1993).

22 6 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 1400a, at 1; ¶ 1403 (2d ed. 2003).

23 *State Oil Co. v. Khan*, 522 U.S. 3, 10 (1997).

24 *National Collegiate Athletic Ass'n v. Board of Regents of University of Oklahoma*, 468 U.S. 85, 104 (1984). *See Board of Trade of the City of Chicago v. United States*, 246 U.S. 231, 238 (1918) ("The true test for legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.").

25 *National Collegiate Athletic Ass'n v. Board of Regents of University of Oklahoma*, 468 U.S. 85, 99 (1984).

26 *Leegin Creative Leather Products, Inc. v. PSKS, Inc.*, 127 S. Ct. 2705, 2713 (2007) (quoting *Business Electronics Corp. v. Sharp Electronics Corp.*, 485 U.S. 717, 723 (1988); *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 50 (1977); and *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 289 (1985)).

12. Relatively few cases have considered non-cartel horizontal restraints by competing buyers.[27] An important recent case involved a rule adopted by an organisation of colleges effectively limiting wages paid to a category of basketball coaches.[28] The court of appeals held that the per se rule did not apply because the organisation's rules "serve the procompetitive purpose of making college sports available;"[29] however, the court held that an anticompetitive effect had been shown through evidence of reduced salaries for some coaches.[30] Consequently, the court held that the restraint was unlawful unless adequately justified, and the court rejected the organisation's proffered justifications. The court rejected the justification that the rule reduced the schools' costs because doing otherwise would permit "any group of competing buyers [to] agree on maximum prices" and thereby "rob[] the suppliers of the normal fruits of their enterprises."[31]

13. A common form of horizontal restraint imposed by competing buyers involves a purchasing cooperative. The Supreme Court has observed that "purchasing cooperatives . . . are not a form of concerted activity likely to result in predominantly anticompetitive effects" but rather increase economic efficiency.[32] The federal enforcement agencies in the United States have advised that purchasing cooperatives generally "do not raise antitrust concerns and indeed may be procompetitive" because they "may enable participants to centralise ordering, to combine warehousing or distribution functions more efficiently, or to achieve other efficiencies."[33] The agencies are concerned, however, about the possibility that purchasing cooperatives "create or increase market power" in purchasing.[34] But this concern arises only if the cooperative accounts for a significant share of total purchases. In the context of "joint purchasing arrangements among hospitals or other health care providers," the agencies have stated that, absent extraordinary circumstances, they will not challenge joint purchasing on the basis of buyer market power if "the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market."[35]

5. Merger Enforcement

14. Section 7 of the Clayton Act prohibits mergers and acquisitions the effect of which may be "substantially to lessen competition." Section 7 is enforced principally by the federal enforcement agencies, which have promulgated guidelines explaining how they assess the likely competitive effects of mergers.[36] The guidelines state that their "unifying theme . . . is that mergers should not be permitted to

27 An exhaustive survey of the cases is presented by Jonathan M. Jacobson & Gary J. Dorman, *Joint Purchasing, Monopsony and Antitrust*, 36 ANTITRUST BULLETIN 1, 25–36 (1991).

28 *Law v. National Collegiate Athletic Ass'n*, 134 F.3d 1010 (10th Cir. 1998).

29 *Id.* at 1016–19.

30 *Id.* at 1019–20.

31 *Id.* at 1022.

32 *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 295 (1985).

33 FEDERAL TRADE COMMISSION & U.S. DEPARTMENT OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS § 3.31(a) (April 2000), *available at* http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf.

34 *Id.* The agencies also are concerned about the possibility that purchasing cooperatives "may facilitate collusion by standardizing participants' costs or by enhancing the ability to project or monitor a participant's output level through knowledge of its input purchases." *Id.*

35 U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE statement 7 (August 1996), *available at* http://www.usdoj.gov/atr/public/guidelines/1791.pdf. The Department of Justice had long applied this rule more broadly, as stated in a October 21, 1985 speech by Deputy Assistant Attorney General Charles F. Rule. To guard against the possibility that joint purchasing facilitates downstream pricing coordination, the agencies apply a second condition, which is that "the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement."

36 U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, HORIZONTAL MERGER GUIDELINES (April 1992, revised

create or enhance market power or to facilitate its exercise" and indicate that market power encompasses both the ability of sellers to maintain prices above the competitive level and the ability of buyers to maintain prices below the competitive level."[37] Rather than detailing the agencies' approach to the assessment of buying-side competitive effects, the guidelines just state that the agencies "apply an analytical framework analogous to the framework" set out for assessing selling-side effects.[38]

15. The delineation of the relevant market for the analysis of buying-side competitive effects is very similar to the delineation of the relevant market for the analysis of selling-side competitive effects. The process begins by identifying a product of interest and the location at which it is bought. For example, with an agricultural product, that location could be a processing facility. One then asks whether a hypothetical monopsonist at that location would maximise profits by reducing the price paid below prevailing levels. The answer normally is no, because there is an actual monopsonist at the location, and it already is maximising its profit. Assuming that the product scope of the market already is fairly clear, one then gradually expands the region within which there is a hypothetical monopsonist, continually asking whether it would maximise profits by reducing the price paid below prevailing levels. The smallest region for which the answer is yes, or some slightly larger region, is the relevant geographic market for the starting location.

16. The primary factual issues in delineating the geographic scope of the relevant market for the analysis of buying-side competitive effects typically relate to transportation. In most cases, sellers can find alternative purchasers, but if they are too far away, they may not be economically viable alternatives. The time frame for analysis also is important in evaluating sellers' alternatives. Over a very short period of time, sellers of an already produced perishable product may be easily exploited, but one-time exploitation is not properly viewed as the exercise of market power. The relevant time frame may be a year or more for determining whether sellers can adjust their production levels and possibly reallocate resources to the production of other products. Monopsony power exists only if the relevant productive resources (what the monopsonist buys or what is used to produce what the monopsonist buys) can be exploited over a long period of time because they cannot easily be moved or converted to other productive uses.

17. A relatively small number of mergers have been challenged wholly or partially on the basis that they would create or enhance market power on the buying side of the market. The most recent example is the merger of two companies offering competing health insurance plans. The U.S. Department of Justice challenged the merger on the basis of likely anticompetitive effects in the sale of health insurance and also in the purchase of physicians services.[39] In an earlier case, the Department challenged the merger of two of the largest purchasers of grain in the United States. The complaint alleged that competition would be lessened substantially in the purchase of particular grains within five specific areas within which the companies proposing to merge accounted for a large portion, and in some cases nearly all, of total purchases.[40] The Federal Trade Commission challenged the merger of two large oil companies, alleging

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April 1997), *available at* http://www.usdoj.gov/atr/public/guidelines/hmg.pdf.

37 *Id.* § 0.1.

38 *Id.*

39 *United States v. UnitedHealth Group Inc. and PacifiCare Health Systems* (filed Dec. 20, 2005), http://www.usdoj.gov/atr/cases/f213800/213815.pdf (complaint), 71 FEDERAL REGISTER 13,991 (2006) (competitive impact statement), 2006-1 Trade Cases (CCH) ¶ 75,255 (final judgment). A similar case is *United States v. Aetna Inc. and The Prudential Insurance Co. of America* (filed June 21, 1999), http://www.usdoj.gov/atr/cases/f2500/2501.pdf (complaint), 64 FEDERAL REGISTER 44,946 (1999) (competitive impact statement), 1999-2 Trade Cases (CCH) ¶ 72,730 (revised final judgment).

40 *United States v. Cargill, Inc. and Continental Grain Co.* (filed July 8, 1999), http://www.usdoj.gov/atr/cases/f2500/2552.htm (complaint), 64 FEDERAL REGISTER 44,046 (1999) (competitive impact statement), 2000-2 Trade Cases (CCH) ¶ 72,967 (final judgment).

that the merger would lessen competition in, among other things, bidding for rights to explore the Alaskan North Slope.[41]

18. In recent decades, only one government merger challenge clearly focused on the buying side of the market was litigated to judgment.[42] In 1984 the Department of Justice challenged a transaction involving rice milling operations. The Department alleged that it would substantially lessen competition in two relevant markets in which the merging firms competed as sellers and one relevant market in which they competed as buyers. The court held the merger unlawful solely on the basis of its likely anticompetitive effects in this third market—the "purchase or other acquisition for milling of paddy rice grown in California."[43]

19. Although mergers are rarely challenged in the United States on the basis that they create or enhance market power on the buying side of the market, the subject of buyer power often is raised nonetheless. Mergers that are challenged on the basis of anticompetitive effects on the selling side of the market often are defended on the basis that buyer power will mitigate or even preclude those effects. The federal enforcement agencies, however, have concluded that: "Large buyers rarely can negate the likelihood that an otherwise anticompetitive merger between sellers would harm at least some buyers. Most markets with large buyers also have other buyers against which market power can be exercised even if some large buyers could protect themselves. Moreover, even very large buyers may be unable to thwart the exercise of market power."[44] Although buyer power has been cited by several decisions as one factor supporting the rejection of merger challenges,[45] other decisions have explained that the presence of powerful buyers is apt to affect only the pattern of anticompetitive price increases following a merger.[46]

41 *In re BP Amoco, p.l.c.* , FTC Docket No. C-3938 (filed Aug. 25, 2000). Materials related to the case are available at http://www.ftc.gov/os/caselist/c3938.shtm.

42 In another litigated case, the Department of Justice argued that the anticompetitive effects of the consummated merger of motion picture exhibitors were largely in the licensing of films from distributors. The district court, however, was confused about what was being argued, and the court of appeals held against the Department on the basis that entry would prevent any lasting anticompetitive effects. *United States v. Syufy Enterprises*, 712 F. Supp. 1386 (N.D. Cal. 1989), *aff'd*, 903 F.2d 659 (9th Cir. 1990).

43 *United States v. Rice Growers Ass'n of California*, 1986-2 Trade Cases (CCH) ¶ 67,288 (E.D. Cal. 1986).

44 U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, COMMENTARY ON THE HORIZONTAL MERGER GUIDELINES 17–18 (Mar. 2006), *available at* http://www.usdoj.gov/atr/public/guidelines/215247.pdf.

45 *Federal Trade Commission v. Foster*, 2007-1 Trade Cases (CCH) ¶ 75,725, at 107,991–92 (D.N.M. 2007); *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1422 (S.D. Iowa 1991); *United States v. Country Lake Foods, Inc.*, 754 F. Supp. 669, 674 (D. Minn. 1990).

46 *See Federal Trade Commission v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 59–61 (D.D.C. 1998); *United States v. United Tote, Inc.*, 768 F. Supp. 1064, 1085 (D. Del. 1991); *Federal Trade Commission v. Bass Brothers Enterprises, Inc.*, 1984-1 Trade Cases (CCH) ¶ 66,041, at 68, 614–15 (N.D. Ohio 1984).

6. Single-Firm Exclusionary Conduct

20. Section 2 of the Sherman Act makes it unlawful to "monopolize, or attempt to monopolize," and both offenses entail the use of "anticompetitive" or "exclusionary" practices.[47] Modern decisions hold that "a practice is 'anticompetitive' only if it harms the competitive process."[48] Single-firm exclusionary conduct can take myriad forms. Some involve the use of buyer power in dealing with key input suppliers to negotiate exclusive arrangements or otherwise to disadvantage rivals.[49] Very few cases have addressed single-firm exclusionary conduct designed to create or preserve monopsony power.[50]

21. In one of the very few monopolisation cases, the Supreme Court reversed a court of appeals decision upholding a jury verdict finding Weyerhaeuser Co. had unlawfully obtained a monopsony in the purchase of red alder logs.[51] Red alder is the most commercially important species of hardwood in the western United States. Specialised sawmills convert red alder logs into lumber used to manufacture items such as furniture and kitchen cabinets. After several years of increasing prices for logs and decreasing lumber prices, one of Weyerhaeuser's rivals exited the market and filed suit alleging "predatory bidding," which the court of appeals defined as a scheme in which "a firm pays more for materials in the short term" to "squeeze out" competitors and "[i]n the long run . . . recoup the higher costs by paying less for the materials."[52]

22. The Supreme Court observed that "predatory bidding mirrors predatory pricing" in several important respects.[53] Like predatory pricing, the Court explained, a successful predatory bidding scheme is unlikely to occur because it "requires a buyer of inputs to suffer losses today on the chance that it will reap supracompetitive profits in the future."[54] Like the aggressive price cutting in predatory pricing, "actions taken in a predatory-bidding scheme are often the very essence of competition."[55] The Court stressed in particular that aggressive bidding, or pricing, may be "essential to competition and innovation on the buy

47 The elements of the monopolization offense are: "the possession of monopoly power in the relevant market" and "the acquisition or maintenance of that power" through anticompetitive conduct. *Verizon Communications Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 407 (2004). The elements of the attempt to monopolize offense are: "(1) that the defendant has engaged in predatory or anticompetitive conduct with (2) a specific intent to monopolize and (3) a dangerous probability of achieving monopoly power." *Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447, 456 (1993).

48 *Town of Concord v. Boston Edison Co.*, 915 F.2d 17, 21 (1st Cir. 1990) (Breyer, C.J.). *See United States v. Microsoft Corp.*, 253 F.3d 34, 58 (D.C. Cir. 2001) (en banc) ("to be deemed as exclusionary, a monopolist's act must have an 'anticompetitive effect.' That is, it must harm the competitive *process* and thereby harm consumers.").

49 *See, e.g.*, *Schine Chain Theatres v. United States*, 334 U.S. 110, 114–16 (1948); *United States v. Griffith*, 334 U.S. 100, 104–05 (1948); *United States v. Crescent Amusement Co.*, 323 U.S. 173, 181–82 (1944); *Toys 'R' Us, Inc.*, 126 F.T.C. 415, 592–96 (1998), *aff'd*, 221 F.3d 928 (7th Cir. 2000); Steven C. Salop, *Anticompetitive Overbuying by Power Buyers*, 72 ANTITRUST L.J. 669 (2005).

50 Of interest is *Telecor Communications, Inc. v. Southwestern Bell Telephone Co.*, 305 F.3d 1124 (10th Cir. 2002). The case involved monopolization of pay phone services and focused on harm to those who derived income from allowing their property to be used as pay phone locations. The court specifically held that no adverse effect need be shown on pay phone users. *Id*. at 1133–34.

51 *Confederated Tribes of Siletz Indians v. Weyerhaeuser Co.*, 411 F.3d 1030 (9th Cir. 2005). The jury found that Weyerhaeuser had not monopolized the downstream lumber market.

52 *Id.* at 1037–38.

53 *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 127 S. Ct. 1069, 1077 (2007).

54 *Id.*

55 *Id.*

side of the market,"[56] and it observed that "[h]higher prices for inputs obviously benefit existing sellers of the inputs."[57]

23. The Supreme Court reasoned that the "general theoretical similarities of monopoly and monopsony combined with the theoretical and practical similarities of predatory pricing and predatory bidding" lead to applying the same sort of test for both.[58] Thus, the Court held that a plaintiff "must prove that . . . the predator's bidding on the buy side . . . caused the cost of the relevant output to rise above the revenue generated in the sale of those outputs" and "that the defendant has a dangerous probability of recouping the losses incurred in bidding up input prices through the exercise of monopsony power."[59] The Court thus rejected jury instructions used by the trial court that would have permitted the jury to find an antitrust violation if it found that Weyerhaeuser merely "purchased more logs than it needed or paid a higher price for logs than necessary, in order to prevent [the plaintiff] from obtaining the logs [it] needed at a fair price."

7. Buyer Power in Distribution

24. Recent academic and policy discussions of the impact of buyer power in distribution bring a fresh perspective and refined tools to issues debated in the United States throughout much of the last century in connection with the rise of chain stores. Their growth, and the discounts and other concessions they negotiated from suppliers, led to intense scrutiny by Congress and the federal enforcement agencies. In 1936 this scrutiny resulted in the Robinson-Patman Act. Subject to defences, it prohibits charging different prices to competing retailers as well as offering retailers various other concessions.[60] The wisdom of the Robinson-Patman Act has been questioned many times,[61] and last year a bipartisan commission appointed by Congress and the President recommended its repeal.[62]

25. Particular attention was focused on the Great Atlantic & Pacific Tea Co. (A&P), which operated over ten thousand grocery stores during much of the 1920s and 1930s. In 1938 the Federal Trade Commission issued a cease and desist order against A&P to prevent it from accepting discounts and other concessions from suppliers in violation of the Robinson-Patman Act.[63] In 1944 the U.S. Department of Justice charged that A&P violated sections 1 and 2 of the Sherman Act. The Department alleged, and the court found, that many of A&P's practices were unlawful, including extracting concessions from suppliers.[64] The wisdom of the Department's case was hotly debated for more than a decade, after which no academic consensus emerged.[65] What did emerge was agreement that "on average it was probably true

56 *Id.*

57 *Id.* at 1077 n.4.

58 *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 127 S. Ct. 1069, 1077–78 (2007).

59 *Id.* at 1078.

60 *See generally* ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS 483–548 (6th ed. 2007).

61 In 1977 the Department of Justice concluded that the Act had produced significant anticompetitive effects to the detriment of competition and consumers. U.S. DEPARTMENT OF JUSTICE, REPORT ON THE ROBINSON-PATMAN ACT 99–100, 260 (1977). For economic analyses with similar conclusions, see Daniel P. O'Brien & Greg Shaffer, *The Welfare Effects of Forbidding Discriminatory Discounts: A Secondary Line Analysis of Robinson-Patman*, 10 JOURNAL OF LAW, ECONOMICS, & ORGANIZATION 296 (1994); Marius Schwartz, *The Perverse Effects of the Robinson-Patman Act*, 31 ANTITRUST BULLETIN 733 (1986).

62 ANTITRUST MODERNIZATION COMMISSION, REPORT AND RECOMMENDATIONS 311–32 (2007).

63 *Great Atlantic & Pacific Tea Co. v. Federal Trade Commission*, 106 F.2d 667 (3d Cir. 1939) (affirming order).

64 *United States v. New York Great Atlantic & Pacific Tea Co.*, 67 F. Supp. 626 (1946), *aff'd*, 173 F.2d 79 (7th Cir. 1949). *See generally* MORRIS A. ADELMAN, A&P: A STUDY IN PRICE-COST BEHAVIOR AND PUBLIC POLICY (1959).

65 With respect to buyer power issues, two notable scholarly contributions were: Morris A. Adelman, *The A&P Case: A Study in Applied Economic Theory*, 63 QUARTERLY JOURNAL OF ECONOMICS 238, 247–57 (1949); Joel B. Dirlam & Alfred E. Kahn, *Antitrust Law and the Big Buyer: Another Look at the A&P Case*, 60 JOURNAL OF POLITICAL ECONOMY

that the countervailing power of the chains was no more than enough to extract from suppliers what they saved them in cost."[66]

26. Recent scholarship on buyer power in distribution applies the tools of modern economics. For example, buyer power now is often approached from the perspective of the economic theory of bargaining.[67] A critical insight from economic theory is that the negotiation between a buyer and seller is over the division of their incremental gains from making the sale.[68] The incremental gains depend on the alternatives the buyer and seller have to dealing with each other. A buyer or seller is in a strong bargaining position if it can make a comparable deal on good terms with another party.

27. It was long assumed that larger buyers necessarily would be in a stronger bargaining position than smaller ones, but recent scholarship teaches that large size is neither necessary nor sufficient to confer a strong bargaining position.[69] Suppose that, if a seller fails to strike a deal with a particular large buyer, the seller's best alternative is not to produce the particular product at all, and therefore not to incur the associated fixed costs. In that situation, the large buyer ends up paying a share of the seller's fixed costs, while the remaining buyers do not because the fixed costs will be incurred even if no deal is struck with them.[70] Alternatively, suppose that, if a seller fails to strike a deal with any particular buyer, its best alternative is to reduce production by the amount the buyer would have purchased. In that event, larger buyers can end up paying more per unit if the seller's marginal cost is decreasing because the average cost of producing the incremental units sold to the large buyer exceed the average cost of the incremental units sold to smaller buyers.[71] Empirical research finds that this latter phenomenon exists with respect to cable television advertising, so larger cable operators pay more.[72]

28. Recent scholarship on buyer power has identified a potential effect from the exercise of buyer power that had not been considered previously.[73] This so-called "waterbed effect" operates through feedback between competition in the input market and competition in the output market.[74] According to proponents of this theory, a lower input price for a powerful retailer reduces its retail price, which increases

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118 (1952).

66 JOEL B. DIRLAM & ALFRED E. KAHN, FAIR COMPETITION: THE LAW AND ECONOMICS OF ANTITRUST POLICY 239 (1954).

67 *See, e.g.*, Roman Inderst & Nicola Mazzarotto, Buyer Power in Distribution, *in* 3 ISSUES IN COMPETITION LAW AND POLICY 1953 (W. Dale Collins ed., 2008); Chris Doyle & Roman Inderst, *Some Economics on the Treatment of Buyer Power in Antitrust*, 28 EUROPEAN COMPETITION LAW REVIEW 210 (2007).

68 For an accessible presentation of bargaining theory, see, e.g., SAMUEL BOWLES, MICROECONOMICS: BEHAVIOR, INSTITUTIONS, AND EVOLUTION 167–83 (2004). For more technical treatments, see MARTIN J. OSBORNE & ARIEL RUBINSTEIN, BARGAINING AND MARKETS (1990); John C. Harsanyi, *Bargaining*, *in* 1 THE NEW PALGRAVE: A DICTIONARY OF ECONOMICS 190 (John Eatwell et al. eds., 1987).

69 *See, e.g.*, Zhiqi Chen, *Buyer Power: Economic Theory and Antitrust Policy*, *in* 22 RESEARCH IN LAW AND ECONOMICS 17, 31 (2007).

70 *See* Alexander Raskovich, *Pivotal Buyers and Bargaining Position*, 51 JOURNAL OF INDUSTRIAL ECONOMICS 405 (2003).

71 *See* Tasneem Chipty & Christopher M. Snyder, *The Role of Firm Size in Bilateral Bargaining: A Study of the Cable Television Industry*, 81 REVIEW OF ECONOMICS AND STATISTICS 326 (1999).

72 *Id.*

73 Recent scholarship also formalizes and clarifies effects that were already reasonably well understood. For example, the exercise of buyer power can allow a large buyer to grow and enhance its buyer power. *See* Roman Inderst, *Leveraging Buyer Power*, 25 INTERNATIONAL JOURNAL OF INDUSTRIAL ORGANIZATION 908 (2007). In addition, if seller profitability is reduced by the exercise of buyer power, the result over time may be reduced investment and innovation.

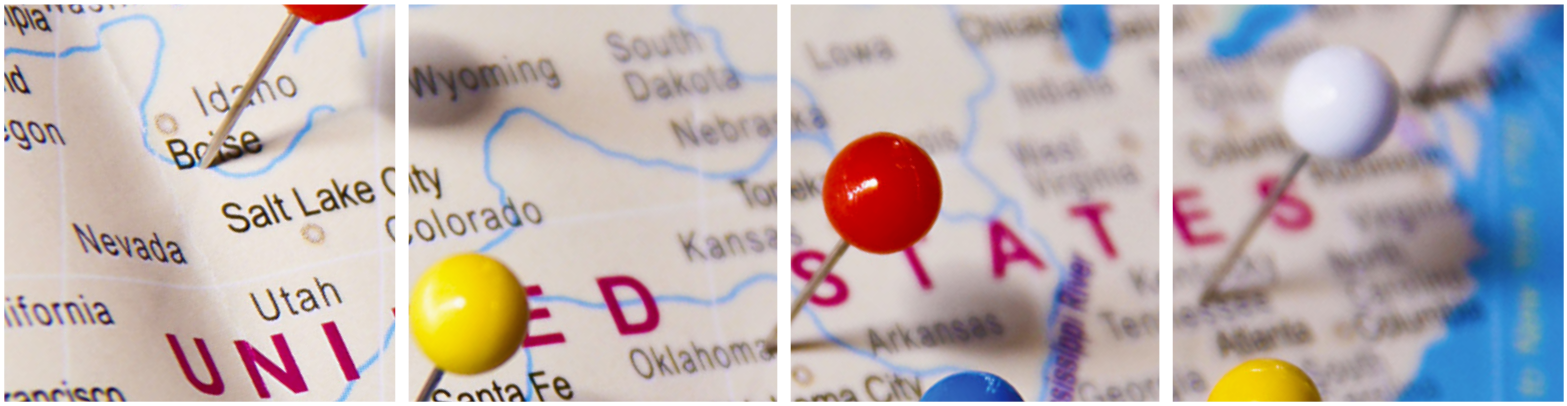
74 *See* Paul W. Dobson & Roman Inderst, *The Waterbed Effect: Where Buying and Selling Power Come Together*, 2008 WISCONSIN LAW REVIEW 331; Paul W. Dobson & Roman Inderst, *Differential Buying Power and the Waterbed Effect: Do Strong Buyers Benefit or Harm Consumers?*, 28 EUROPEAN COMPETITION LAW REVIEW 393 (2007); Roman Inderst & Tommaso M. Valletti, Buyer Power and the "Waterbed Effect," CEIS Research Paper No. 107 (January 2008), *available at* http://ssrn.com/abstract=1113318.

its sales, and that reduces the bargaining power of already less powerful downstream rivals and so weakens competition in the relevant retailing markets. These proponents suggest an effect that is based on the assumption that larger size confers upon a retailer greater bargaining power, although they acknowledge that there is no particular reason to believe that is true.

29. Recent scholarship does not indicate that competitive concerns relating to buyer power in distribution warrant either broad limitations on the purchasing practices of large retailers or any sort of presumption that a particular practice by a large retailer is anticompetitive. In addition, there may not be a sound basis for reliably concluding in a particular case that the waterbed effect has occurred. Yet there is ample reason to believe that errors in imposing liability or in formulating remedies could undermine price competition.

ATTACHMENT 6

2024 UPDATE



COMPETITION in HEALTH INSURANCE

A comprehensive study of U.S. markets

AMA
AMERICAN MEDICAL ASSOCIATION

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Table of contents

I. Introduction and background

This is the 23rd edition of the American Medical Association's "Competition in health insurance: A comprehensive study of U.S. markets." This study presents new data on the degree of competition in health insurance markets across the country. It is intended to help researchers, policymakers, and federal and state regulators identify markets where mergers and acquisitions involving health insurers may cause competitive harm to consumers and providers of care.

This study addresses the following questions: Are health insurance markets competitive or do health insurers possess market power? Are proposed mergers involving insurers likely to maintain, enhance or create such power?

These are important questions of public policy because the use of market power harms society in both output and input markets. When an insurer exercises market power in its output market (the sale of insurance coverage), premiums are higher and quantity of coverage is lower than in a competitive market. When an insurer exercises market power in its input market (e.g., physician services), payments to providers and the quantity of health care are below competitive levels. In short, the exercise of market power adversely affects health insurance coverage and health care.

A first step in assessing the existence of or the potential for market power is to examine market concentration, as high concentration tends to lower competition and facilitate the exercise of market power. The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) examine market shares and market concentration when evaluating proposed mergers. The DOJ and FTC revised their Merger Guidelines in December of 2023. Those Guidelines state that "Market concentration and the change in concentration due to the merger are often useful indicators of a merger's risk of substantially lessening competition.[1] Thus, it is critical to have this type of information readily available.

In this study, we present new information on market concentration in the health insurance industry. Using 2023 data from Decision Resources Group—the most comprehensive and consistent source of data on enrollment in preferred provider organization (PPO), health maintenance organization (HMO), point-of-service (POS), public health exchange (EXCH), consumer-driven health plans (CDHP),[2] and Medicare Advantage (MA) plans—we report the two largest insurers' commercial and MA market shares and Herfindahl-Hirschman Indices (HHIs) for 382 metropolitan statistical areas (MSAs), the 50 states and the District of Columbia.[3] This edition of the study is based on the revised DOJ/FTC Merger Guidelines. Importantly, those guidelines lowered the threshold for a market to be considered highly concentrated from 2500 to 1800.

Key findings show that, based on the DOJ/FTC Merger Guidelines, 95% of MSA-level commercial markets were highly concentrated (HHI>1800) in 2023. The average commercial market was also highly concentrated, with an HHI of 3458. Other findings are that in 89% of MSA-level markets, at least one insurer had a commercial market share of 30% or greater, and in 47% of markets, a single insurer's share was at least 50%.

We also calculate changes in commercial market concentration between 2014 and 2023.[4] Fifty-one percent of markets experienced an increase in the HHI, and in 26% of markets the increase was at least 500 points. In markets with a rise in the HHI, the average increase was 652 points. Health insurance markets have remained stubbornly highly concentrated over time, with the vast majority being so designated in the last 10 years. The share of commercial markets that are highly concentrated was 95% in both 2014 and 2023 and hovered between 95% and 96% in that 10-year period. The average HHI fluctuated in either direction in the intervening years. However, because there were more increases than decreases, and the decreases were smaller, the average

1. U.S. Department of Justice and the Federal Trade Commission, Merger Guidelines. Issued Dec. 18, 2023.
2. We do not report CDHP enrollments as a separate plan type. CDHP lives are bolted on to the other plan types, most frequently to PPO plans.
3. For convenience, the District of Columbia is classified as a "state" in this study.
4. There was a change in MSA definitions between the 2016 and 2017 data. For a detailed description of this change, see footnote 5 in the AMA's 2018 "Competition in health insurance" study.

HHI rose by 135 points between 2014 and 2023.[5] Interestingly, the decreases were generally driven by the exchanges. In fact, excluding the exchanges from the analysis, the average HHI rose in nine of the last 10 years—by 264 points between 2014 and 2023.

There is evidence of increases in concentration in commercial markets that were already highly concentrated in 2014 as well as in those that were not. Almost half (49%) of the markets that were highly concentrated in 2014 became even more concentrated by 2023. Sixty-nine percent (i.e., 11 of the 16 markets) that were not highly concentrated experienced an increase in the HHI large enough to place them in the highly concentrated category by 2023. Another four also had an increase, though not large enough to make them highly concentrated.

We now turn to the key findings on MA in 2023 and compare them to results for 2017. Note that this is an increasingly important product market to study. In 2024, 54% of eligible Medicare beneficiaries were enrolled in Medicare Advantage—up from 19% in 2007.[6] We find that 97% of MA markets were highly concentrated in 2023—a slight decrease from 99% of markets in 2017. On average, MA markets were also highly concentrated with an HHI of 3129—down from 3923 in 2017. Interestingly, however, the decrease in the average HHI in 2023 was the smallest year-to-year change observed over the seven-year study period. At the MSA-level, the average number of MA insurers has been going up and the average market share has been going down over time. In contrast, the *national-level* market share of the largest insurer (UnitedHealth Group) actually increased from 25% in 2017 to 29% in 2023.

High concentration levels in health insurance markets are largely the result of consolidation (i.e., mergers and acquisitions), which can lead to the exercise of market power and, in turn, harm to consumers and providers of care. Both consummated and proposed mergers and acquisitions involving health insurers should raise serious antitrust concerns. Conceptually, mergers and acquisitions can have beneficial and/or harmful effects on consumers. However, only the latter has been observed. It appears that consolidation has resulted in the possession and exercise of health insurer monopoly power—the ability to raise and maintain premiums above competitive levels—instead of the passing of any benefits obtained through to consumers.

Research suggests that health insurers exercise market power and that competition among them lowers health plan premiums. One study assessed whether health insurers charge higher premiums to employers that earn higher profits—i.e., whether they engage in direct price discrimination. This would imply that insurers exercise market power. The study found evidence of this behavior and concluded that health insurers possess and exercise market power in an increasing number of geographic markets.[7] Another study examined the effect of changes in market concentration (HHI) on premiums across the United States. Using the 1999 merger between Aetna and Prudential as an instrumental variable for the HHI, it found that changes in market concentration were positively associated with premiums.[8] A 2013 case study examined the 2008 merger between UnitedHealth and Sierra Health Services, which led to a large increase in concentration in Nevada health insurance markets. The study concluded that premiums in Nevada markets increased in the wake of the merger.[9] Finally, other research found evidence that competition in the public health exchanges—in the form of more insurers—also lowered premiums.[10]

High barriers to entry into health insurance markets also enable insurers to exercise market power.[11] Examples of barriers include state regulatory requirements, the cost

5. The change in MSA definitions noted in footnote 4 above factors into the long-term measurement of changes in HHI. However, we believe the impact to be minor. For further details, see footnote 34 below.
6. KFF. Medicare Advantage in 2024: Enrollment Update and Key Trends. 2024. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/ Accessed Oct. 31, 2024.
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10. Dafny, L., Gruber, J., Ody, C. More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. Am J Health Econ. 2015;1(1):53–81, and Abraham, J., Drake, C., McCullough J., Simon, K. What Drives Insurer Participation and Premiums in the Federally-Facilitated Marketplace? Int J Health Econ Manag. 2017; Apr 2017:1–18.
11. Robinson J. Consolidation and the transformation of competition in health insurance. Health Aff. 2004;31(6):12–24.

of developing a provider network and the development of sufficient business to permit the spreading of risk. Evaluating entry barriers is critical to antitrust analysis. If entry were easy, neither high market shares nor high concentration levels would necessarily translate into higher premiums because potential entry would force insurers to keep premiums in check. However, barriers to entry allow insurers with market power to charge premiums above competitive levels for an extended period of time.

Health insurer consolidation can also lead to the exercise of another type of market power. Where health insurers have market power in their output market (i.e., monopoly power), it is very likely they also have market power in their input market (e.g., in the purchasing of physician services). This is because, geographically, these markets roughly coincide.[12] Market power in input markets is known as monopsony power—the ability to reduce and maintain input prices (e.g., prices paid to physicians) below competitive levels. Monopsony is the mirror image of monopoly. The exercise of monopsony power would also reduce the quantity (or quality) of health care below competitive levels and in turn harm consumers. Research finds evidence that insurer consolidation leads to the exercise of monopsony power vis-à-vis physicians in the form of lower physician earnings and employment.[13] For these reasons, proposed mergers that create or increase insurers' monopsony power should also raise antitrust concerns.[14]

In fact, the DOJ has challenged three health insurer mergers based in part on the merging entity's potential to exercise monopsony power over physicians.[15],[16] In the Aetna-Prudential and the United-Pacificare cases, the DOJ focused on the increased difficulty a physician practice could face in replacing business should the merged insurer terminate its contract. The DOJ considered two buy-side shares—the share of individual practice revenue accounted for by the merging insurers, and insurers' locality-wide post-merger share of patients.[17] A high post-merger share of physician practice revenue increases monopsony power by making it more costly for the practice to replace lost patients. This effect is reinforced in markets with a high post-merger share of patients as it would shrink the pool of potential replacement patients in the event of a contract termination. As we have found in the past, this "Competition in health insurance" edition strongly suggests that most markets are characterized by insurers with high market shares of patients, which increases the risk of the exercise of monopsony power.

Another factor that increases this risk is that most physicians work in small practices. Fifty-two percent of those providing patient care are still in practices with 10 or fewer physicians.[18] Under antitrust law, independent physicians cannot negotiate collectively with health insurers. This imbalance in relative size leaves most physicians with a weak bargaining position relative to commercial payers. To the extent there is anticompetitive behavior by insurers, this would compromise the quantity and quality of care.

In the third, and perhaps most important of those merger cases, the DOJ and state attorneys general from multiple states filed suit in July 2016 to block Anthem's acquisition of Cigna.[19] Among other things, the plaintiffs alleged that "Anthem's high market shares already give it significant bargaining leverage with doctors and hospitals," and that "…this merger would substantially increase Anthem's ability to dictate the reimbursement it pays providers, threatening the availability and quality of medical care." Notably, Anthem did not dispute that it would lower provider reimbursement, but instead claimed that those

12. See e.g., Capps, C. Buyer Power in Health Plan Mergers. J Comp Law and Econ. 2009;6:375–391.
13. Dafny L., Duggan, M., Ramanarayanan, S. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. Am Econ Rev. 2012;102(2):1161–1185.
14. Schwartz, M. Buyer Power Concerns and the Aetna-Prudential Merger. Fifth Annual Health Care Antitrust Forum, Northwestern University School of Law, Chicago, Ill., October 1999. www.justice.gov/atr/public/speeches/3924.pdf. Accessed Oct. 31, 2024.
15. See Complaints, U.S. v. Aetna Inc. (June 21, 1999), U.S. v. UnitedHeath Group Inc. (Dec. 20, 2005) and U.S. and multiple states v. Anthem, Inc. and Cigna Corp. (July 21, 2016).
16. In another proposed merger in 2010, the DOJ announced that it would file an antitrust lawsuit to block Blue Cross Blue Shield of Michigan from acquiring Physicians Health Plan of Mid-Michigan. As a result, the companies abandoned the acquisition. The DOJ argued that the merger would allow the merged entity to control physician payment and thereby lower the quality of care. See DOJ. Press release. March 8, 2010. justice.gov/atr/public/press_releases/2010/256259.htm. Accessed Oct. 31, 2024.
17. Capps, C. Buyer Power in Health Plan Mergers. J Comp Law and Econ. 2009;6:375–391.
18. Kane C. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022. Policy Research Perspectives, 2023–4. https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf. Published July 2023. Accessed Oct. 31, 2024.
19. See Complaint at https://www.justice.gov/opa/file/877886/download. Accessed Oct. 31, 2024.

savings would result from efficiencies, which it could then pass through to consumers as lower premiums. However, the courts found that those purported efficiencies were not cognizable.[20] In February 2017, the U.S. District Court sided with the plaintiffs, and this decision was affirmed by the Second Circuit Court of Appeals. Although Anthem continued its attempt to acquire Cigna, the merger was ultimately abandoned in May 2017.

In sum, we find that the vast majority of health insurance markets in the United States are highly concentrated. Coupled with external evidence on their anticompetitive behavior, this strongly suggests that health insurers are exercising market power in many parts of the country and, in turn, causing competitive harm to consumers and providers of care.

20. See the blog Code Red: Two Economists Examine the U.S. Healthcare System, The Anthem-Cigna Merger. Available at https ://coderedblog .com/2017/07/18/the-anthem-cigna-merger/ Accessed Oct. 1, 2018.

II. Data and methodology

A. Product and geographic market definition

In order to calculate firms' market shares, we first define the market in which competition takes place. Markets are characterized by two aspects: a product market and a geographic market. A product market is a product or group of products for which there are no adequate substitutes. In the commercial health insurance industry, the main product types are PPO, HMO, POS and the exchanges. Because it is not clear whether they are substitutes, we examine each of these products separately as well as a combined PPO+HMO+POS+EXCH product market. As of the 2023 study update, we no longer report results separately for HMO and POS. Additionally, we examine Medicare Advantage (MA) as a separate product type. However, we exclude enrollments in Programs of All-Inclusive Care for the Elderly (PACE) plans and Health Care Prepayment Plans (HCCP). We also exclude enrollments of insurers that only provide special needs plans (SNP) or only dual eligible plans in a given geographic area.[21]

The other dimension that needs to be defined is the relevant geographic market. The geographic market is the area within which consumers can turn to alternative producers in response to an increase in price. In determining the extent of the market for health insurance, distance is a critical consideration. The local nature of health care delivery and the marketing and other business practices of health insurers strongly suggest that health insurance markets are local. Consumers buy coverage that serves them close to where they work and live. Thus, the 2023 "Competition in health insurance" study reports data at the MSA level as well as the state level.

B. Data

The data used for this study were obtained from the Decision Resources Group (DRG) Managed Market Surveyor. The data for the PPO, HMO, POS and MA products are as of Jan. 1, 2023, and for the exchanges as of July 1, 2023. DRG collects commercial medical enrollment data from managed care organizations (MCO) through the DRG National Medical and Pharmacy Census. MCOs are asked for their national, state and county level enrollment for each product type (e.g., PPO) and funding type (e.g., fully insured). In cases where MCOs do not provide county level enrollment, DRG may use previously reported enrollment data to calculate county level shares of state enrollment. The county level enrollment is then aggregated to the state level. Commercial enrollment is based on the membership's residence and includes Individual, Group, Federal Employee Health Benefit Plan, Consumer Driven Health Plan (CDHP),[22] State/Local Employee Plan, Blue Card HOME, Student Health, EPO and public health exchange lives.

DRG started collecting public exchange data as of its January 2014 Census.[23] Those data are based on enrollees who paid premiums for coverage. We include data on individuals and families but exclude Small Business Health Insurance Option Program (SHOP) lives. Finally, DRG's MA data are from the Centers for Medicare & Medicaid Services (CMS). CMS reports the MA data at the county and insurer subsidiary levels. DRG aggregates those CMS enrollments up to the state and MSA levels as well as to the parent insurer level.

Our objective is to present data on competition in health insurance markets. Accordingly, we report market shares and HHIs for a combined PPO+HMO+POS+EXCH commercial product market as well as for PPO, exchange and MA markets separately. The key variables we use from

21. We don't consider PACE, HCCP, SNP and dual-eligible plans to belong in the MA product market; they are not substitutes for regular MA plans. Sometimes insurers of regular MA plans also provide SNP or dual-eligible plans. Although ideally we would also exclude such enrollments, it is very difficult if not impossible to disentangle them from the regular plan enrollments in the DRG data.
22. CDHP-covered lives are not reported as a separate category but are instead bolted on to the other product types, most frequently to PPO plans.
23. When exchange lives were not available from the health insurers or secondary research, DRG estimated enrollment using a regression model.

the DRG Managed Market Surveyor to obtain this information are:

- Commercial PPO enrollment
- Commercial HMO enrollment
- Commercial POS enrollment
- Public exchange enrollment
- MA enrollment

For each MSA and state, we use enrollment in those products to calculate:

- Health insurer market shares
- Market-level Herfindahl-Hirschman Indices (HHIs)

We seek to calculate market shares and HHIs based on enrollment in fully and self-insured plans.[24] To do so, however, we do not use the entire database as provided by DRG; we exclude certain MCOs and geographic areas. First, with one exception, we exclude insurers' enrollment from states where they are not licensed to sell insurance. Blue Cross Blue Shield Association (BCBS) companies that use the Blue brand typically do not compete with one another. Yet some BCBS insurers report enrollment in other Blue insurers' states where they are not licensed.[25] We exclude that enrollment because there is no competition among branded companies.

In other cases, a Blue company (e.g., Independence Health Group) may own a subsidiary that does not use the Blue brand (e.g., AmeriHealth). Because branded and non-branded insurers can compete with each other, we do not exclude the non-branded companies. For example, Independence uses the Blue brand in the Philadelphia area and southeastern Pennsylvania. Its subsidiary—AmeriHealth—sells insurance without using the Blue brand in a few other states (e.g., New Jersey), which are the territories of other Blue insurers. Because AmeriHealth is unbranded, we do not exclude it from those other states.

The exception to these out-of-state exclusions is that we do not remove commercial enrollment of non-BCBS insurers in states adjacent to their license-state. This is because the data are based on the membership's residence.[26,27]

Our intent is to present market shares and HHIs for areas where the enrollment data plausibly capture a reasonable fraction of the insured population. This gives rise to another set of exclusions. To implement these, we calculate the ratio of total commercial enrollment reported by all health insurers in an area to an estimate of the commercially insured population, and only present areas where this ratio is between 30% and 150%.[28] In this edition, two MSAs are excluded because of this criterion (>150%). The data perform well in capturing insured lives. On average, the state- and MSA-level data respectively capture 90% and 91% of the commercially insured populations.[29]

For PPO and the combined product markets, we only present data for areas where there are at least 5,000 reported enrollees in that product across all insurers. However, no areas were excluded because of this criterion. For the exchanges and MA, we only present data in areas where there are at least 1,000 reported enrollees. We do not report exchange data for two MSAs due to that restriction.[30] In addition, no MA data are presented for

24. The distinction of fully versus self-insured only pertains to PPO, HMO and POS plans. By definition, the individual public exchange is only fully insured.
25. This is due to the BlueCard® program, which enables members of one BCBS company to get health care while traveling or living in another BCBS company's service area. It is designed for members who have a child attending an out-of-state school, have family members living in different service areas, have a long-term work assignment in another state, or are retirees with dual residence. Claims payment, adjustments, and issue resolutions are done by the local Blue. See: https://www.bcbsil.com/pdf/standards/manual/bluecard_program_manual.pdf. Accessed Oct. 31, 2024.
26. For example, an insurer may be licensed in New York, but could also report enrollees in New Jersey. We keep the New Jersey enrollees in the data because they may work in New York but live in New Jersey. However, we do not include BCBS enrollments reported in neighboring states because that enrollment is often too large to plausibly represent neighboring states' residents—it most likely is due to the BlueCard® program—and because they do not compete with the Blue affiliate in the neighboring state.
27. We make one other increasingly unimportant minor exclusion. Self-insured employers typically use third-party administrators (TPA) to administer benefits. If TPAs are also risk-bearing insurers, they are included in this study. We exclude other non-risk-bearing MCOs—typically known as PPO rental networks—since they are not insurers—i.e., never bear risk—and to avoid double counting enrollees. These have become virtually non-existent in the DRG data. There was only one of them in the 2023 DRG data so the implications of their exclusions are negligible.
28. The commercially insured population (INS) was calculated as: INS = POP – UNINS – (MEDICARE + MEDICAID – DUAL), where POP is population, UNINS is number of uninsured persons, MEDICARE is number of Medicare beneficiaries, MEDICAID is the number of Medicaid beneficiaries, and DUAL represents persons eligible for both Medicare and Medicaid benefits.
29. The distributions of these ratios are as follows. States: Fourteen percent of states, ≥ 0.50 and < 0.70; 31% of states ≥ 0.70 and < 0.90, and 55% of states >= 0.90. MSAs: One percent of MSAs, >= 0.30 and < 0.50; 13% of MSAs, ≥ 0.50 and < 0.70; 36% of MSAs ≥ 0.70 and < 0.90, and 50% of MSAs >= 0.90.
30. Although we do not present data for areas where there are fewer than 1000 enrollees in the exchanges, we still include those enrollments in the calculation of the combined product market (PPO+HMO+POS+EXCH).

Alaska given that currently there are no MA plans available in that state.

After implementing these restrictions, the numbers of states and MSAs for which we report data differ by product market. Data for the combined PPO+HMO+POS+EXCH market and the PPO market are reported for 382 MSAs and 51 states (including the District of Columbia), exchange data are reported for 380 MSAs and 51 states, and MA data are reported for 382 MSAs and 50 states.

C. Market share and HHI calculations

This study reports competition data for four product markets (PPO+HMO+POS+EXCH; PPO; EXCH; and MA). For each product market, we calculate the market share in a geographic area by dividing an insurer's enrollment by the sum of all insurers' enrollment and multiplying the result by 100.

We also present the market-level HHI for each product market. The HHI is a measure of market concentration, which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The DOJ and FTC use the HHI as an aid in assessing the potential for anticompetitive effects of proposed mergers. Higher HHIs indicate greater concentration.

The HHI is the sum of the squared market shares of all firms in a market. To illustrate, suppose a market consisted of four firms and that each one held a 25% share. The HHI for that market would be 2500:

$$25^2 + 25^2 + 25^2 + 25^2 = 2{,}500$$

If the number of firms in a market increased, the HHI would generally decrease, and vice versa. The largest value the HHI can reach is 10,000, which is obtained when there is a single firm in the market—i.e., a monopoly.

D. DOJ/FTC merger guidelines

This section is based on the new Merger Guidelines issued in December 2023 and thus differ from those reported in previous editions of this study.[31] Guideline 1 of the revised Merger Guidelines is:

Guideline 1: Mergers Raise a Presumption of Illegality When They Significantly Increase Concentration in a Highly Concentrated Market.

Guideline 1 further indicates that *market concentration* and the change in concentration due to the merger are often useful indicators of a merger's risk of substantially lessening competition. The Agencies generally measure concentration levels using the HHI. Guideline 1 states that:

- Markets with an HHI greater than 1,800 are highly concentrated.
- A change in the HHI of more than 100 points is a significant increase.
- A merger that creates or further consolidates a highly concentrated market that involves an increase in the HHI of more than 100 points is presumed to substantially lessen competition or tend to create a monopoly.

The Agencies also may examine the *market share* of the merged firm:

- A merger that creates a firm with a share over 30% is also presumed to substantially lessen competition or tend to create a monopoly if it also involves an increase in HHI of more than 100 points.

The guideline states that, when exceeded, these concentration metrics indicate that a merger's effect may be to eliminate substantial competition between the merging parties and may be to increase coordination among the remaining competitors after the merger.

31. See Section 2.1 of the Department of Justice and the Federal Trade Commission Merger Guidelines. Issued Dec. 18, 2023. The language in this section is a summary (almost verbatim) of language from the Merger Guidelines.

III. Summary of findings and conclusion

A summary of the MSA-level findings on market shares and market concentration is presented below in Section A. National-level market shares are presented and discussed in Section B. Detailed results for each state and MSA are presented in this study's Appendix. Tables A-1 to A-4 in the Appendix report market shares of the two largest insurers, as well as the HHI in each state and MSA. Table A-1 presents this information for the combined PPO+HMO+POS+EXCH product market while Table A-2, Table A-3 and Table A-4 pertain to the PPO, exchange and MA markets, respectively. Finally, Table A-5 reports the HHIs by product type for all states and MSAs, as well as the mean and median HHI for each product across MSAs. The PPO, HMO, POS and MA data are from Jan. 1, 2023, and the exchange data are from July 1, 2023.

A. MSA-level summary

Tables 1–4 summarize the MSA-level results on market concentration. Table 1 pertains to the combined PPO+HMO+POS+EXCH product market, and tables 2–4 are product-type-specific. Focusing on the combined product, Table 1 shows that 95% (364) of MSA-level markets were highly concentrated in 2023. In 89% of markets, at least one insurer had a market share of at least 30%, and in 47% of markets, one insurer had a share of 50% or more. The average MSA-level market was highly concentrated, with a mean HHI of 3458 and a median of 3174. Analogous results are presented for each product type in tables 2–4. The average market—and virtually all of those markets—are highly concentrated as well.

Table 1. Market concentration, combined PPO+HMO+POS+EXCH product market (2023)

Market characteristic	% of MSA-level markets	# of MSA-level markets
Highly concentrated	95%	364
An insurer's market share >=30%	89%	339
An insurer's market share >=50%	47%	181
An insurer's market share >=70%	11%	41

	Mean	Median
HHI	3458	3174

Table 2. MSA-level market concentration, PPO product market (2023)

Market characteristic	% of MSA-level markets	# of MSA-level markets
Highly concentrated	99%	379
An insurer's market share >=30%	97%	371
An insurer's market share >=50%	66%	253
An insurer's market share >=70%	29%	109

	Mean	Median
HHI	4407	4070

Table 3. MSA-level market concentration, exchanges (2023)

Market characteristic	% of MSA-level markets	# of MSA-level markets
Highly concentrated	99%	376
An insurer's market share >=30%	95%	361
An insurer's market share >=50%	64%	245
An insurer's market share >=70%	24%	90

	Mean	Median
HHI	4642	4397

Table 4. MSA-level market concentration, Medicare Advantage market (2023)

Market characteristic	% of MSA-level markets	# of MSA-level markets
Highly concentrated	97%	372
An insurer's market share >=30%	91%	347
An insurer's market share >=50%	30%	116
An insurer's market share >=70%	4%	16

	Mean	Median
HHI	3129	2891

We also calculate changes in MSA-level commercial market concentration (HHI) between 2014 and 2023. There are interesting findings here as well. Starting with the combined PPO+HMO+POS+EXCH markets, we find that 51% of markets experienced an increase in the HHI. Among those markets, the average increase was 652 points.[32] Forty-eight percent of markets experienced an increase in the HHI of at least 100 points, and in 26% of markets, the HHI increase was 500 points or more. Almost half (49%) of markets that were already highly concentrated in 2014 became even more concentrated by 2023. Of those 16 markets that were not highly concentrated in 2014, 69% (11) experienced an increase in the HHI large enough to make them highly concentrated by 2023. Another four also had an increase, though not big enough to make them highly concentrated.

Health insurance markets have remained stubbornly highly concentrated over time, with the vast majority of them being so in the last 10 years. The share of commercial markets that are highly concentrated was 95% in both 2014 and 2023 and hovered between 95% and 96% in that 10-year period. The average HHI fluctuated in either direction in the intervening years. However, because there were more increases than decreases, and the decreases were smaller, the average HHI rose by 135 points between 2014 and 2023.[33] Interestingly, the decreases were

32. This increase and the statistics in the rest of this paragraph are based on the 316 MSAs with identical codes in 2014 and 2023.

33. The change in MSA definitions in the data for 2017 and subsequent years factors into the long-term measurement of changes in HHI. However, we believe the impact to be minor. First, the areas around some of the largest U.S. cities were, through 2016, represented in the data as metropolitan divisions—i.e., components of MSAs. After 2016 they were instead included as a smaller number of MSAs "proper." This change from a greater number of less populous areas (which tend to have higher HHIs) to a smaller number of more populous areas (which tend to have lower HHIs) likely leads to an understatement in the average HHI increase over time. Second, about 7% of MSAs are "new" in the data for 2017–2023. Previously they were micropolitan statistical areas. They did not have population counts large enough to be considered metropolitan. These relatively lower-population areas tend to be more concentrated and their movement into the MSA category likely leads to an overstatement in the average HHI increase over time. Because they account for a small share of MSAs, we expect that their upward influence is small. Indeed, when we compared only the 316 areas that were considered MSAs and had identical codes in 2014 and 2023, the increase in the average HHI was slightly lower (87). The comparison of the 316 areas, however, has the drawback of also excluding some areas whose codes changed for the reason of "name alone" or who had only minor changes in their geographic boundaries. Thus, making comparisons on the full set of data in both years is our preferred approach.

generally driven by the exchanges. In fact, excluding the exchanges from the analysis, the average HHI actually rose in nine of the last 10 years, and by a total of 264 points between 2014 and 2023.

There have been large changes over time in exchange market concentration. After the average HHI decreased after the exchanges' first year in operation (2014), average concentration went up annually until 2018, when it reached a high of 6873. Since 2018, however, the average exchange market HHI has fallen each year down to 4642 in 2023—nonetheless still highly concentrated.

Finally, we assess changes in MA market concentration between 2017 and 2023.[34] We find that MA market concentration has tended to fall gradually since 2017. Notably, the decrease of 53 points between 2022 and 2023 was the smallest one-year change over the study period. In 2023, the average MSA-level market had an HHI of 3129—down from 3923 in 2017 though still highly concentrated. Moreover, the proportion of highly concentrated MSA-level markets fell slightly from 99% in 2017 to 97% in 2023.

B. National-level market shares

Health insurance markets are generally local. This is why the main purpose and focus of this study is to report market shares and concentration levels at the MSA and state levels, with particular emphasis on the former. National-level market shares do not necessarily reflect the degree of concentration that is relevant to most consumers.[35] Nonetheless, they are a useful summary measure, paint a succinct picture that complements local-level market shares and may be relevant in the case of national accounts.

Tables 5–7 report the national-level market shares of the 10 largest health insurers in the U.S. Table 5 pertains to the combined PPO+HMO+POS+EXCH product market, Table 6 is for the exchanges, and Table 7 is for MA.

Table 5. Largest health insurers in the U.S. at the national level (2014 and 2023)

Insurer	Market share (%) 2014	Insurer	Market share (%) 2023
UnitedHealth Group	16	UnitedHealth Group	15
Anthem	13	Elevance Health	12
Aetna	11	CVS (Aetna)	12
Cigna	8	Cigna	11
HCSC (BCBS)	6	HCSC (BCBS)	7
Kaiser	5	Kaiser	7
BCBS MI	2	BCBS FL	2
Humana	2	BCBS MI	2
BCBS FL	2	Centene	2
BS of CA	2	BS of CA	2
Combined Blues	44	Combined Blues	42

Data are based on commercial, combined PPO+HMO+POS+EXCHANGE product markets. Market shares are based on total enrollments in the U.S., which we summed from the insurers' state-level enrollments.

34. Although we have data from earlier years, 2017 was the first year in which we started to examine the MA market using a methodology consistent with that used for the commercial market (specifically, excluding the Blues in areas where they are not licensed to provide coverage).

35. Dafny L. Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience. Issue Brief. Commonwealth Fund pub. 1845 Vol. 33. November 2015. That study also reports national-level market shares. Given that BCBS insurers generally do not compete with one another, it combines them into one firm and calculates a single share for them. Dafny (2015) focuses on market concentration (four-firm concentration ratio (CR4), while we focus on the individual insurers' shares. Nonetheless, following Dafny (2015), we also report combined market shares at the bottom of Table 5. Using those, we calculate CR4s of 79% in both 2014 and 2023.

Table 5 shows that there has been little change in insurers' commercial market shares, resulting in a similar makeup of the biggest 10 insurers. In fact, the largest six insurers have identical rankings in 2014 and 2023. UnitedHealth Group has the largest market share in both years, with shares of 16% and 15%, respectively, while Elevance Health (formerly Anthem) is second with shares of 13% and 12%.[36]

Most of the 10 largest insurers have small shares at the national level. Only the top four had a share of 10% or more in 2023. However, this is because there are very few "national" insurers. Most insurers' enrollments are concentrated geographically, as they are licensed in a single state, while a small number are regional and operate in a few states.

For example, three of the 10 insurers in Table 5 (BCBS MI, BCBS FL and BS of CA) are licensed in a single state but appear large nationally due to large markets and high market shares. California and Florida are the first and third largest markets, and although Michigan is the eighth, it is nonetheless a large market and BCBS MI has a 67% share there. Health Care Service Corporation (BCBS) is in five states, including two of the five largest state-level markets (Texas and Illinois) and the third, fourth and sixth largest MSA-level markets in the U.S.

These results mask the findings at the local (MSA and state) levels, where market shares are significantly higher (i.e., as shown in Table 1). Most notably, they mask the large market shares that BCBS insurers have in the vast majority of local markets. Because most BCBS insurers are licensed in a single state, they generally appear small at the national level. In contrast, in 41 states and in 83% (317) of MSAs, a BCBS insurer holds the largest market share. In fact, combining BCBS insurers into one firm yields national-level market shares of 44% and 42% in 2014 and 2023 for the combined Blues, respectively.

One of these BCBS insurers is Elevance Health, which has the largest market share in 80 MSAs—many more and the most MSAs among any insurer. Health Care Service Corporation (BCBS) is second in this ranking, as the largest insurer in 45 MSAs, including 25 in Texas, and Highmark is third with 25 MSAs. BCBS of Florida is fourth as the largest in 22 MSAs, UnitedHealth Group—the largest insurer nationally—is the biggest in 20 MSAs, and Kaiser has 19 MSAs.

There are a couple of interesting exceptions to the stability of commercial market shares and rankings over time in Table 5. One is that Humana was no longer in the largest 10 list in 2023 and actually fell to 29th with a less than 0.6% share. The other is that Centene grew from 76th largest in 2014 to the 9th biggest insurer in 2023, which was largely driven by acquisitions and entry into the exchanges.

The 10 largest health insurers in the exchanges nationally are reported in Table 6.[37] As indicated above, there have been very large changes in average market concentration in the exchanges over time. Part of this is attributable to significant entry and exit of insurers, including entry by Centene. By 2023, not only had Centene made it to the largest 10 list in the combined product market, but it is the largest insurer in the exchanges nationally with a 17% share—much larger than the next largest insurer, BCBS FL, which has a 9% share.

36. Anthem changed its name to Elevance Health in 2022.

37. Table 6 also includes 2015 data because 2014 was the first year of the exchanges and because there were two states (NY, MA) with missing 2014 exchange DRG data.

Table 6. Largest health insurers in the exchanges at the national level (2014, 2015, 2023)

Insurer	Market share (%) 2014	Insurer	Market share (%) 2015	Insurer	Market share (%) 2023
Anthem	14	Anthem	11	Centene	17
Humana	7	UnitedHealth Group	11	BCBS FL	9
BCBS FL	7	Aetna	9	CVS (Aetna)	8
HCSC (BCBS)	6	HCSC (BCBS)	7	HCSC (BCBS)	6
Aetna	6	Humana	5	Kaiser	6
Kaiser	6	Kaiser	4	Oscar	5
BS of CA	6	BS of CA	3	Elevance Health	5
Health Net	5	BCBS FL	3	UnitedHealth Group	3
BCBS NC	4	BCBS NC	3	BS of CA	3
Independence BC	3	Molina	2	Cigna	3

Data are based on the individual exchanges. Market shares are based on total enrollments in the U.S., which we summed from the insurers' state-level enrollments.

There is much more volatility in insurers' market shares and rankings over time in the exchanges than in the combined product market. Anthem went from having the largest share in 2014 (14%) and 2015 (11%) to being the seventh largest with a 5% share in 2023, while UnitedHealth Group went from being the second largest with an 11% share in 2015 to the 31st largest with less than a 0.6% share in 2021. However, United has rebounded to become the 8th largest exchange insurer with a 3% share in 2023. Aetna, which was the third largest in 2015 with a 9% share, exited the exchanges in 2018. Aetna reentered the exchanges in 2022, when it ranked 36th with a 0.4% share. However, it made a dramatic comeback and increased in ranking to third with an 8% share in 2023. Much of this increase was due to an opportunity that arose with the exit of the fourth largest exchange insurer—Bright Health—in 2022. Bright Health had been entering new markets, acquiring insurers and increasing its share since entering the exchanges in 2017 and growing each year to reach the fourth spot with a 7% share in 2022. However, Bright Health exited the exchanges in 2023 and largely exited the health insurance business altogether with only a presence in Medicare Advantage in California, though it will be exiting that market in 2024 as well. Humana—the fifth largest in 2015—also exited the exchanges in 2018 and has not reentered. In contrast, in addition to Centene, some other insurers that were smaller in the earlier years also went up in the rankings by 2023. BCBS FL went from eighth to second, increasing its share from 3% to 9% between 2015 and 2023. Finally, Oscar has also been entering new markets and became the sixth largest insurer with a 5% share by 2023.

The exchanges are slowly rising in importance since their inception in 2014. There has a been a gradual increase in exchange penetration into commercial health insurance markets over time. In 2014, only 4% of enrollees in the commercial insurance market nationally were in the exchanges. This fraction increased to and remained at about 7% from 2015 to 2020. Since then, however, it has been slowing growing and reached 10% of the commercial market in 2023.

Table 7. Largest health insurers in Medicare Advantage at the national level (2017 and 2023)

Insurer	Market share (%) 2017	Insurer	Market share (%) 2023
UnitedHealth Group	25	UnitedHealth Group	29
Humana	18	Humana	18
Kaiser	8	CVS (Aetna)	11
Aetna	8	Kaiser	6
Anthem	4	Elevance Health	6
WellCare HP	3	Centene	5
Cigna	2	Cigna	2
BCBS MI	2	BCBS MI	2
Highmark	2	Highmark	1
Centene	1	SCAN	1

Data are based on Medicare Advantage markets. Market shares are based on total enrollments in the U.S., which we summed from the insurers' state-level enrollments. We exclude Programs of All-Inclusive Care for the Elderly (PACE) plans, Health Care Prepayment Plans (HCCP), special needs-only plans (snp-only), and dual eligible-only plans.

In contrast to the exchanges, there has been much less volatility in the national-level market shares and rankings of the 10 largest MA insurers. As in the commercial market, UnitedHealth Group is also the largest MA insurer in the country. In fact, it's relatively much bigger in the MA market than in the commercial market. Its national-level MA market share was 29% in 2023—up from 25% in 2017. Humana remained in second place with an 18% share in 2023. CVS (Aetna) increased its share to become the third largest insurer with an 11% share by 2023. Largely through its acquisition of WellCare HP, Centene went from the 10th to the sixth largest insurer. That combination made room for a newcomer named SCAN to take the 10th spot in 2021—a spot it has retained since.

A comparison of the largest commercial and MA insurers nationally (Table 5 and Table 7) yields some interesting observations. One is that some insurers are large in both markets. Most remarkably, UnitedHealth Group is the largest insurer in both commercial and MA markets. Focusing on 2023, CVS (Aetna) is the third largest in both markets, and Kaiser is fifth and fourth with 7% and 6% shares, respectively.

In contrast, some insurers tend to specialize or are relatively bigger in one market than the other. Humana's enrollment and share have been shrinking in the commercial market, while its enrollment has been growing in MA. Humana was the second largest MA insurer in both 2017 and 2023. It appears that Humana has been shifting its focus to MA. Cigna is the fourth largest commercial insurer with an 11% market share, but the seventh largest MA insurer with a 2% share.

As a group, it appears that BCBS insurers have tended to specialize or be relatively bigger in the commercial market. In fact, as indicated above, they dominate local commercial markets. Nationally, there are five BCBS insurers among the 10 largest in the commercial market, but only three in MA. Of those, whereas Elevance Health is the second largest insurer in the commercial market with a large 12% share, it is the fifth largest in insurer in MA with a 6% share in 2023—though up slightly from 4% in 2017. HCSC (BCBS) is the fifth largest commercial insurer (7% share) but the 19th largest MA insurer with a 0.5% share. Although BCBS insurers have tended to specialize in the commercial market, there are hints that MA markets may be becoming more attractive to enter. For example, BCBS ND and CareFirst BCBS entered the MA market in 2021, and Wellmark (BCBS) entered in 2022.

C. Conclusion

In this study, we present data on competition in health insurance markets across the United States. Specifically, we report market share and concentration (HHI) data for 51 states (including the District of Columbia) and 382 MSAs. This is the most complete picture available of

competition in health insurance markets. Our data are based on commercial enrollment in PPO, HMO, POS, and public exchange plans, including participation in consumer-driven health plans, as well as enrollment in MA plans.

We find that the vast majority of U.S. health insurance markets are highly concentrated. In fact, health insurance markets have remained stubbornly highly concentrated over time, with the vast majority of them being so in the last 10 years. The share of commercial markets that are highly concentrated was 95% in both 2014 and 2023 and hovered between 95% and 96% over that 10-year period. The average HHI fluctuated in either direction in the intervening years. However, because there were more increases than decreases, and the decreases were smaller, the average HHI rose by 135 points between 2014 and 2023. Interestingly, the decreases were generally driven by the exchanges. In fact, if we exclude the exchanges, the average HHI actually rose in nine of the last 10 years—by a total of 264 points between 2014 and 2023.

There have been large changes in exchange market structure over time. Notably, after undergoing large increases in average market concentration each year between 2015 and 2018, concentration has been falling year-to-year since then, especially in 2021, though the decreases having been shrinking in magnitude.

MA markets have undergone a consistent but gradual decrease in average concentration since 2017. Notably, the decrease between 2022 and 2023 was the smallest in magnitude over the study period. The MA average HHI fell from 3923 in 2017 to 3129 in 2023. Nonetheless, the fraction of MA markets that are highly concentrated fell only slightly, from 99% to 97%.

The decrease in average MA market concentration masks some recent merger activity. Notable among these was Centene's acquisition of WellCare. Although both insurers provided MA coverage in several states prior to the merger, with a few exceptions their market shares were small and there was not much significant market overlap. Thus, while the merger generally did not have large effects at the local level, it increased Centene's share at the national level from 1% to 4% and moved it up the rankings from 10th to sixth between 2017 and 2023. Mergers such as this can evade antitrust concerns in part due to a lack of significant market overlap. However, by acquiring an insurer in another geographic market where they did not previously provide coverage, some insurers have been able to grow their total enrollment. This is the way Elevance Health got large nationally in commercial markets. In 2004, Anthem (its name at the time) acquired WellPoint, and before that, both Anthem and WellPoint had acquired other insurers as well. More recently, Highmark (BCBS) acquired BCBS insurers in New York state and, in 2023, BCBS of Michigan acquired BCBS of Vermont.

Given the uncertainty in predicting the competitive effects of consolidation, some mergers that are allowed cause competitive harm. For example, in 2008 a merger between UnitedHealth and Sierra was allowed under the condition that UnitedHealth divest most of its Medicare Advantage business in the Las Vegas area.[38] Nevertheless, we found in other work that premiums in the commercial health insurance markets in Nevada increased in the wake of the merger.[39] Retrospective studies on health insurer consolidation add to our understanding of its competitive effects.[40] Such retrospective studies complement the present methodology of predicting the competitive effects of mergers at the time of announcement and, in turn, help guide merger enforcement policy.

After years of largely unchallenged consolidation in the health insurance industry, a few subsequent attempts to consolidate have received closer scrutiny. In 2007, a merger proposed by Independence Blue Cross and Highmark was called off because the Pennsylvania Insurance Department insisted that one of them drop its Blue brand. The companies refused and instead called off the merger. In 2010, Blue Cross Blue Shield of Michigan called off its acquisition of Physicians Health Plan of Mid-Michigan because the DOJ announced it would file a lawsuit to block the acquisition.

38. See Final Judgement at: http://www.justice.gov/atr/cases/f237600/237613.htm. Accessed Oct. 31, 2024.

39. Guardado, J., Emmons, D., Kane, C. The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra. HMPI. 2013;1(3):16-35. Available at http://hmpi.org/wp-content/uploads/2017/02/HMPI-Guardado-Emmons-Kane-Price-Effects-of-a-Larger-Merger-of-Health-Insurers.pdf. Accessed Oct. 31, 2024.

40. Ashenfelter, O.C., Hosken D., Weinberg M. Generating Evidence to Guide Merger Enforcement. National Bureau of Economic Research Working Paper 14798; March 2009.

Most notably, in 2015, two mergers involving four of the largest health insurers in the country were announced. Anthem attempted to acquire Cigna, and Aetna sought to acquire Humana. Proposed mergers of this magnitude are precisely the motivation for this study—to help identify markets where mergers would cause competitive harm. Upon announcement of these mergers, we used data from previous editions of the "Competition in health insurance" study to assess their competitive effects. Specifically, we calculated the changes in market concentration (HHI) that would result from the mergers and, according to the 2010 DOJ/FTC Horizontal Merger Guidelines, classified markets based on how anti-competitive the mergers would be. We found that the mergers would be deemed anticompetitive in numerous markets across the United States.[41] Consistent with our findings and after close to a year of antitrust scrutiny, the DOJ and attorneys general from multiple states sued to block both acquisitions.[42] After intense battle in the courts, the DOJ and state attorneys general ultimately prevailed, and both mergers were abandoned by the merging parties.

The successful blocking of those mergers seems to have chilled subsequent horizontal merger attempts between health insurers. Instead, health insurers have been increasingly turning to vertical mergers, such as with pharmacy benefit managers and other participants in health care markets. The Aetna-CVS merger is an illustrative example.

The majority of health insurance markets are ripe for the exercise of health insurer market power. Our studies will continue to monitor competition in health insurance markets and assess the competitive effects of proposed health insurer mergers.

41. See https://www.ama-assn.org/about/competition-health-insurance-research. Accessed Nov. 13, 2023.

42. See lawsuits announcement at https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s. Accessed Nov. 13, 2023.

Appendix: State and MSA tables

Table A-1. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023

Combined PPO+HMO+POS+EXCH (total) product markets

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	7387	BCBS AL	86	UnitedHealth Group	5
Anniston-Oxford, AL	8406	BCBS AL	92	Cigna	3
Auburn-Opelika, AL	6702	BCBS AL	81	Cigna	5
Birmingham-Hoover, AL	7236	BCBS AL	85	UnitedHealth Group	7
Daphne-Fairhope-Foley, AL	6133	BCBS AL	78	UnitedHealth Group	9
Decatur, AL	7844	BCBS AL	88	Cigna	4
Dothan, AL	7621	BCBS AL	87	UnitedHealth Group	5
Florence-Muscle Shoals, AL	7270	BCBS AL	85	Cigna	4
Gadsden, AL	7881	BCBS AL	89	UnitedHealth Group	4
Huntsville, AL	7236	BCBS AL	85	Cigna	5
Mobile, AL	6847	BCBS AL	82	UnitedHealth Group	7
Montgomery, AL	7939	BCBS AL	89	UnitedHealth Group	5
Tuscaloosa, AL	8341	BCBS AL	91	Triton (Viva Hlth)	3
Alaska	4113	Premera	46	CVS (Aetna)	45
Anchorage, AK	3920	Premera	51	CVS (Aetna)	36
Fairbanks, AK	4283	Premera	50	CVS (Aetna)	43
Arizona	2281	UnitedHealth Group	28	BCBS AZ	25
Flagstaff, AZ	4922	BCBS AZ	69	Cigna	8
Lake Havasu City-Kingman, AZ	3882	BCBS AZ	57	UnitedHealth Group	21
Phoenix-Mesa-Chandler, AZ	2283	UnitedHealth Group	28	CVS (Aetna)	24
Prescott Valley-Prescott, AZ	3999	BCBS AZ	59	UnitedHealth Group	16
Sierra Vista-Douglas, AZ	2735	BCBS AZ	46	UnitedHealth Group	19
Tucson, AZ	2569	UnitedHealth Group	38	BCBS AZ	25
Yuma, AZ	3531	BCBS AZ	54	CVS (Aetna)	16
Arkansas	2840	BCBS AR	45	UnitedHealth Group	20
Fayetteville-Springdale-Rogers, AR	2933	BCBS AR	46	Centene	21
Fort Smith, AR-OK	1970	BCBS AR	27	UnitedHealth Group	24
Hot Springs, AR	2980	BCBS AR	47	UnitedHealth Group	19
Jonesboro, AR	3183	BCBS AR	49	Centene	20
Little Rock-North Little Rock-Conway, AR	2840	BCBS AR	43	UnitedHealth Group	24
Pine Bluff, AR	4369	BCBS AR	63	UnitedHealth Group	14
California	2244	Kaiser	37	Elevance Health	24
Bakersfield, CA	2725	Elevance Health	37	Kaiser	28
Chico, CA	4379	Elevance Health	58	BS of CA	32
Fresno, CA	2262	Elevance Health	30	Kaiser	25
Hanford-Corcoran, CA	2765	Elevance Health	42	BS of CA	26
Los Angeles-Long Beach-Anaheim, CA	2136	Kaiser	33	Elevance Health	26
Madera, CA	2555	Elevance Health	35	Kaiser	29
Merced, CA	3831	Elevance Health	58	BS of CA	18

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Modesto, CA	3369	Kaiser	51	Elevance Health	26
Napa, CA	4401	Kaiser	64	Elevance Health	16
Oxnard-Thousand Oaks-Ventura, CA	2381	Elevance Health	35	Kaiser	25
Riverside-San Bernardino-Ontario, CA	2820	Kaiser	46	Elevance Health	20
Sacramento-Roseville-Folsom, CA	3048	Kaiser	50	Elevance Health	19
Salinas, CA	3138	Elevance Health	45	BS of CA	32
San Diego-Chula Vista-Carlsbad, CA	1649	Kaiser	29	Elevance Health	19
San Francisco-Oakland-Berkeley, CA	2916	Kaiser	49	Elevance Health	15
San Jose-Sunnyvale-Santa Clara, CA	2287	Kaiser	40	Elevance Health	19
San Luis Obispo-Paso Robles, CA	3762	Elevance Health	53	BS of CA	27
Santa Cruz-Watsonville, CA	2132	Elevance Health	31	Kaiser	26
Santa Maria-Santa Barbara, CA	3429	Elevance Health	49	BS of CA	31
Santa Rosa-Petaluma, CA	4443	Kaiser	64	Elevance Health	15
Stockton, CA	3942	Kaiser	59	Elevance Health	19
Vallejo, CA	4952	Kaiser	69	Elevance Health	12
Visalia, CA	4174	Elevance Health	60	BS of CA	21
Yuba City, CA	2794	Elevance Health	45	Kaiser	20
Colorado	2037	UnitedHealth Group	24	Elevance Health	24
Boulder, CO	2149	Elevance Health	28	Cigna	25
Colorado Springs, CO	2102	Elevance Health	29	UnitedHealth Group	23
Denver-Aurora-Lakewood, CO	2032	UnitedHealth Group	26	Cigna	23
Fort Collins, CO	2630	Elevance Health	42	Cigna	21
Grand Junction, CO	2896	UnitedHealth Group	38	Cigna	29
Greeley, CO	2246	Elevance Health	32	Cigna	25
Pueblo, CO	2320	Elevance Health	29	UnitedHealth Group	28
Connecticut	2409	Elevance Health	37	UnitedHealth Group	20
Bridgeport-Stamford-Norwalk, CT	2271	UnitedHealth Group	28	Elevance Health	28
Hartford-East Hartford-Middletown, CT	2618	Elevance Health	42	Cigna	19
New Haven-Milford, CT	2468	Elevance Health	38	Cigna	22
Norwich-New London, CT	3252	Elevance Health	48	UnitedHealth Group	27
Delaware	3984	Highmark	56	CVS (Aetna)	26
Dover, DE	4432	Highmark	62	CVS (Aetna)	20
District of Columbia	1910	CareFirst	31	CVS (Aetna)	17
Washington-Arlington-Alexandria, DC-VA-MD-WV	1599	CareFirst	22	Cigna	17
Florida	2180	BCBS FL	36	UnitedHealth Group	18
Cape Coral-Fort Myers, FL	2719	BCBS FL	43	CVS (Aetna)	19
Crestview-Fort Walton Beach-Destin, FL	4587	BCBS FL	66	UnitedHealth Group	13
Deltona-Daytona Beach-Ormond Beach, FL	2696	BCBS FL	44	UnitedHealth Group	23
Gainesville, FL	4899	BCBS FL	69	CVS (Aetna)	11
Homosassa Springs, FL	4120	BCBS FL	60	UnitedHealth Group	21
Jacksonville, FL	3382	BCBS FL	53	UnitedHealth Group	15

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lakeland-Winter Haven, FL	2171	BCBS FL	33	Cigna	21
Miami-Fort Lauderdale-Pompano Beach, FL	1828	BCBS FL	26	CVS (Aetna)	23
Naples-Marco Island, FL	3177	BCBS FL	49	Cigna	19
North Port-Sarasota-Bradenton, FL	2884	BCBS FL	45	CVS (Aetna)	21
Ocala, FL	3769	BCBS FL	58	UnitedHealth Group	15
Orlando-Kissimmee-Sanford, FL	1870	BCBS FL	27	Cigna	22
Palm Bay-Melbourne-Titusville, FL	2304	BCBS FL	32	Cigna	30
Panama City, FL	5576	BCBS FL	73	UnitedHealth Group	11
Pensacola-Ferry Pass-Brent, FL	4226	BCBS FL	61	UnitedHealth Group	19
Port St. Lucie, FL	2768	BCBS FL	44	Cigna	21
Punta Gorda, FL	2822	BCBS FL	46	UnitedHealth Group	17
Sebastian-Vero Beach, FL	4064	BCBS FL	60	UnitedHealth Group	16
Sebring-Avon Park, FL	2627	BCBS FL	43	UnitedHealth Group	19
Tallahassee, FL	7207	BCBS FL	85	UnitedHealth Group	6
Tampa-St. Petersburg-Clearwater, FL	2100	BCBS FL	32	UnitedHealth Group	24
The Villages, FL	4408	BCBS FL	64	UnitedHealth Group	15
Georgia	1915	Elevance Health	33	Cigna	19
Albany, GA	3046	Elevance Health	50	UnitedHealth Group	13
Athens-Clarke County, GA	3054	Elevance Health	50	Cigna	17
Atlanta-Sandy Springs-Alpharetta, GA	1765	Elevance Health	28	Cigna	20
Augusta-Richmond County, GA-SC	2112	Elevance Health	37	BCBS SC	18
Brunswick, GA	2547	Elevance Health	45	Centene	13
Columbus, GA-AL	2923	Elevance Health	51	Cigna	12
Dalton, GA	2831	Cigna	45	Elevance Health	22
Gainesville, GA	2211	Elevance Health	31	Cigna	29
Hinesville, GA	2375	Elevance Health	42	Cigna	17
Macon-Bibb County, GA	2533	Elevance Health	44	UnitedHealth Group	15
Rome, GA	2312	Elevance Health	35	Cigna	28
Savannah, GA	2470	Elevance Health	42	Cigna	19
Valdosta, GA	3653	Elevance Health	57	Centene	12
Warner Robins, GA	3491	Elevance Health	56	Centene	10
Hawaii	4505	HMSA (BCBS HI)	63	Kaiser	20
Kahului-Wailuku-Lahaina, HI	3739	Kaiser	51	HMSA (BCBS HI)	32
Urban Honolulu, HI	4722	HMSA (BCBS HI)	66	Kaiser	15
Idaho	2317	BC of ID	42	Cambia	15
Boise City, ID	2080	BC of ID	39	Cambia	14
Coeur d'Alene, ID	2144	BC of ID	38	Cambia	20
Idaho Falls, ID	2840	BC of ID	49	Intermountain	11
Lewiston, ID-WA	2100	Premera	30	BC of ID	24
Pocatello, ID	3278	BC of ID	54	Cambia	12
Twin Falls, ID	2149	BC of ID	40	Intermountain	15

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Illinois	4294	HCSC (BCBS)	63	UnitedHealth Group	14
Bloomington, IL	4207	HCSC (BCBS)	61	CVS (Aetna)	20
Carbondale-Marion, IL	3293	HCSC (BCBS)	53	Carle Health	14
Champaign-Urbana, IL	4179	Carle Health	61	HCSC (BCBS)	17
Chicago-Naperville-Elgin, IL-IN-WI	4117	HCSC (BCBS)	61	UnitedHealth Group	13
Danville, IL	3535	HCSC (BCBS)	50	Carle Health	31
Davenport-Moline-Rock Island, IA-IL	2641	UnitedHealth Group	38	HCSC (BCBS)	30
Decatur, IL	5365	HCSC (BCBS)	72	UnitedHealth Group	11
Kankakee, IL	4991	HCSC (BCBS)	69	UnitedHealth Group	12
Peoria, IL	3329	HCSC (BCBS)	48	UnitedHealth Group	29
Rockford, IL	5365	HCSC (BCBS)	72	UnitedHealth Group	11
Springfield, IL	3312	HCSC (BCBS)	52	Carle Health	16
Indiana	3557	Elevance Health	56	UnitedHealth Group	16
Bloomington, IN	4314	Elevance Health	63	IU Health	15
Columbus, IN	4350	Elevance Health	62	S.E. Indiana Hlth	20
Elkhart-Goshen, IN	4506	Elevance Health	65	UnitedHealth Group	12
Evansville, IN-KY	4603	Elevance Health	66	UnitedHealth Group	12
Fort Wayne, IN	2891	Elevance Health	49	UnitedHealth Group	15
Indianapolis-Carmel-Anderson, IN	3668	Elevance Health	56	UnitedHealth Group	18
Kokomo, IN	4417	Elevance Health	64	UnitedHealth Group	13
Lafayette-West Lafayette, IN	3743	Elevance Health	57	IU Health	17
Michigan City-La Porte, IN	3594	Elevance Health	56	UnitedHealth Group	18
Muncie, IN	3557	Elevance Health	55	IU Health	18
South Bend-Mishawaka, IN-MI	2825	Elevance Health	49	BCBS MI	13
Terre Haute, IN	4785	Elevance Health	68	UnitedHealth Group	11
Iowa	3073	Wellmark (BCBS)	47	UnitedHealth Group	27
Ames, IA	4464	Wellmark (BCBS)	63	UnitedHealth Group	20
Cedar Rapids, IA	3290	Wellmark (BCBS)	52	UnitedHealth Group	18
Davenport-Moline-Rock Island, IA-IL	2641	UnitedHealth Group	38	HCSC (BCBS)	30
Des Moines-West Des Moines, IA	3018	Wellmark (BCBS)	39	UnitedHealth Group	37
Dubuque, IA	2815	Wellmark (BCBS)	43	UnitedHealth Group	27
Iowa City, IA	4219	Wellmark (BCBS)	63	UnitedHealth Group	10
Sioux City, IA-NE-SD	2030	Wellmark (BCBS)	32	UnitedHealth Group	27
Waterloo-Cedar Falls, IA	2940	UnitedHealth Group	42	Wellmark (BCBS)	30
Kansas	2664	BCBS KS	45	UnitedHealth Group	14
Lawrence, KS	3459	BCBS KS	55	CVS (Aetna)	13
Manhattan, KS	5934	BCBS KS	76	UnitedHealth Group	7
Topeka, KS	5777	BCBS KS	75	UnitedHealth Group	10
Wichita, KS	3245	BCBS KS	50	CVS (Aetna)	20

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Kentucky	4719	Elevance Health	67	Humana	12
Bowling Green, KY	4667	Elevance Health	66	Humana	15
Elizabethtown-Fort Knox, KY	4960	Elevance Health	68	Humana	15
Lexington-Fayette, KY	5377	Elevance Health	72	Humana	12
Louisville/Jefferson County, KY-IN	4378	Elevance Health	64	UnitedHealth Group	11
Owensboro, KY	5135	Elevance Health	69	UnitedHealth Group	13
Louisiana	4657	BCBS LA	66	UnitedHealth Group	16
Alexandria, LA	4886	BCBS LA	67	UnitedHealth Group	17
Baton Rouge, LA	5134	BCBS LA	70	UnitedHealth Group	12
Hammond, LA	5185	BCBS LA	70	UnitedHealth Group	14
Houma-Thibodaux, LA	5151	BCBS LA	69	UnitedHealth Group	20
Lafayette, LA	5191	BCBS LA	70	UnitedHealth Group	16
Lake Charles, LA	4869	BCBS LA	68	UnitedHealth Group	14
Monroe, LA	4977	BCBS LA	67	UnitedHealth Group	20
New Orleans-Metairie, LA	4234	BCBS LA	61	UnitedHealth Group	20
Shreveport-Bossier City, LA	4893	BCBS LA	68	UnitedHealth Group	14
Maine	2580	Elevance Health	43	CVS (Aetna)	16
Bangor, ME	2759	Elevance Health	45	Cigna	20
Lewiston-Auburn, ME	2476	Elevance Health	40	Cigna	22
Portland-South Portland, ME	2398	Elevance Health	40	CVS (Aetna)	17
Maryland	2662	CareFirst	43	Cigna	17
Baltimore-Columbia-Towson, MD	3078	CareFirst	49	Cigna	18
California-Lexington Park, MD	3284	CareFirst	52	CVS (Aetna)	15
Cumberland, MD-WV	2268	CareFirst	31	Cigna	25
Hagerstown-Martinsburg, MD-WV	1856	UnitedHealth Group	21	CareFirst	21
Salisbury, MD-DE	2842	Highmark	42	CareFirst	27
Massachusetts	2510	BCBS MA	35	Point32Health	33
Barnstable Town, MA	3643	Point32Health	52	BCBS MA	30
Boston-Cambridge-Newton, MA-NH	2204	BCBS MA	32	Point32Health	31
Pittsfield, MA	2666	BCBS MA	43	Baystate	21
Springfield, MA	2005	Baystate	27	BCBS MA	24
Worcester, MA-CT	2022	BCBS MA	33	Point32Health	25
Michigan	4699	BCBS MI	67	Corewell (Priority)	12
Ann Arbor, MI	6505	BCBS MI	80	Corewell (Priority)	7
Battle Creek, MI	5703	BCBS MI	74	Corewell (Priority)	9
Bay City, MI	6150	BCBS MI	78	Henry Ford (HAP)	8
Detroit-Warren-Dearborn, MI	5094	BCBS MI	70	Henry Ford (HAP)	8
Flint, MI	5233	BCBS MI	71	Henry Ford (HAP)	11
Grand Rapids-Kentwood, MI	3840	BCBS MI	52	Corewell (Priority)	33
Jackson, MI	5773	BCBS MI	75	Corewell (Priority)	10
Kalamazoo-Portage, MI	4938	BCBS MI	68	UnitedHealth Group	15

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lansing-East Lansing, MI	5896	BCBS MI	75	U-M Health (PHP)	16
Midland, MI	5919	BCBS MI	75	CVS (Aetna)	17
Monroe, MI	5489	BCBS MI	73	Cigna	6
Muskegon, MI	4525	BCBS MI	62	Corewell (Priority)	26
Niles, MI	5624	BCBS MI	74	Corewell (Priority)	8
Saginaw, MI	5439	BCBS MI	72	Henry Ford (HAP)	11
Minnesota	2403	BCBS MN	38	HealthPartners	22
Duluth, MN-WI	2276	BCBS MN	37	HealthPartners	21
Mankato, MN	3892	BCBS MN	56	Medica	26
Minneapolis-St. Paul-Bloomington, MN-WI	2135	BCBS MN	32	HealthPartners	26
Rochester, MN	3974	BCBS MN	56	Medica	27
St. Cloud, MN	2850	BCBS MN	43	HealthPartners	23
Mississippi	3192	BCBS MS	50	UnitedHealth Group	17
Gulfport-Biloxi, MS	3220	BCBS MS	52	UnitedHealth Group	14
Hattiesburg, MS	3436	BCBS MS	51	UnitedHealth Group	25
Jackson, MS	4079	BCBS MS	61	UnitedHealth Group	14
Missouri	1946	Elevance Health	29	UnitedHealth Group	25
Cape Girardeau, MO-IL	3254	Elevance Health	47	UnitedHealth Group	31
Columbia, MO	3629	UnitedHealth Group	49	Elevance Health	35
Jefferson City, MO	4403	Elevance Health	62	UnitedHealth Group	23
Joplin, MO	3036	Elevance Health	49	UnitedHealth Group	20
Kansas City, MO-KS	2511	BCBS KS City	41	UnitedHealth Group	19
Springfield, MO	2159	Elevance Health	37	UnitedHealth Group	21
St. Joseph, MO-KS	3146	BCBS KS City	52	UnitedHealth Group	13
St. Louis, MO-IL	2316	Elevance Health	31	UnitedHealth Group	31
Montana	3154	HCSC (BCBS)	50	Cigna	21
Billings, MT	3126	HCSC (BCBS)	48	Cigna	27
Great Falls, MT	4167	HCSC (BCBS)	61	Cigna	17
Missoula, MT	3135	HCSC (BCBS)	48	Cigna	25
Nebraska	2956	BCBS NE	45	UnitedHealth Group	26
Grand Island, NE	3635	BCBS NE	56	UnitedHealth Group	19
Lincoln, NE	3376	BCBS NE	50	UnitedHealth Group	28
Omaha-Council Bluffs, NE-IA	2627	BCBS NE	35	UnitedHealth Group	34
Nevada	2288	UnitedHealth Group	36	Elevance Health	25
Carson City, NV	1746	UHS (Prominence HP)	26	Elevance Health	23
Las Vegas-Henderson-Paradise, NV	2862	UnitedHealth Group	46	Elevance Health	22
Reno, NV	1756	Elevance Health	27	UnitedHealth Group	19
New Hampshire	2966	Elevance Health	48	Cigna	19
Manchester-Nashua, NH	3164	Elevance Health	50	Cigna	16

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
New Jersey	2649	Horizon BCBS	39	CVS (Aetna)	27
Atlantic City-Hammonton, NJ	6106	Horizon BCBS	77	CVS (Aetna)	9
Ocean City, NJ	5673	Horizon BCBS	74	Independence Hlth Grp	9
Trenton-Princeton, NJ	2960	Horizon BCBS	42	CVS (Aetna)	31
Vineland-Bridgeton, NJ	4659	Horizon BCBS	64	CVS (Aetna)	22
New Mexico	3096	HCSC (BCBS)	48	Presbyterian	24
Albuquerque, NM	2725	HCSC (BCBS)	38	Presbyterian	32
Farmington, NM	3066	HCSC (BCBS)	47	UnitedHealth Group	22
Las Cruces, NM	4060	HCSC (BCBS)	61	Presbyterian	12
Santa Fe, NM	2875	HCSC (BCBS)	38	Presbyterian	34
New York	1473	UnitedHealth Group	26	Elevance Health	16
Albany-Schenectady-Troy, NY	1984	CDPHP	32	UnitedHealth Group	22
Binghamton, NY	3339	Lifetime Hlthcare	51	UnitedHealth Group	25
Buffalo-Cheektowaga, NY	3037	Highmark	41	Independent Hlth	35
Elmira, NY	4790	Lifetime Hlthcare	64	UnitedHealth Group	26
Glens Falls, NY	1769	Elevance Health	25	CDPHP	20
Ithaca, NY	3204	CVS (Aetna)	45	Lifetime Hlthcare	31
Kingston, NY	1772	UnitedHealth Group	25	Elevance Health	21
New York-Newark-Jersey City, NY-NJ-PA	1657	UnitedHealth Group	26	CVS (Aetna)	17
Poughkeepsie-Newburgh-Middletown, NY	1971	UnitedHealth Group	29	Elevance Health	26
Rochester, NY	6074	Lifetime Hlthcare	77	MVP Hlth Care	7
Syracuse, NY	4614	Lifetime Hlthcare	65	UnitedHealth Group	16
Utica-Rome, NY	3338	Lifetime Hlthcare	48	UnitedHealth Group	29
Watertown-Fort Drum, NY	3216	Lifetime Hlthcare	48	UnitedHealth Group	23
North Carolina	3025	BCBS NC	48	UnitedHealth Group	17
Asheville, NC	2651	BCBS NC	43	CVS (Aetna)	20
Burlington, NC	2990	BCBS NC	46	CVS (Aetna)	19
Charlotte-Concord-Gastonia, NC-SC	2087	BCBS NC	32	UnitedHealth Group	19
Durham-Chapel Hill, NC	3176	BCBS NC	48	CVS (Aetna)	24
Fayetteville, NC	3517	BCBS NC	54	UnitedHealth Group	19
Goldsboro, NC	5813	BCBS NC	75	UnitedHealth Group	9
Greensboro-High Point, NC	2937	BCBS NC	45	UnitedHealth Group	24
Greenville, NC	5954	BCBS NC	76	Cigna	9
Hickory-Lenoir-Morganton, NC	3752	BCBS NC	57	UnitedHealth Group	19
Jacksonville, NC	5585	BCBS NC	73	Cigna	9
New Bern, NC	5843	BCBS NC	75	Cigna	11
Raleigh-Cary, NC	2799	BCBS NC	42	CVS (Aetna)	19
Rocky Mount, NC	5129	BCBS NC	70	UnitedHealth Group	11
Wilmington, NC	3580	BCBS NC	51	UnitedHealth Group	27
Winston-Salem, NC	2973	BCBS NC	46	Cigna	21

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
North Dakota	3446	BCBS ND	48	Sanford	33
Bismarck, ND	3477	BCBS ND	48	Sanford	34
Fargo, ND-MN	2105	BCBS ND	33	Sanford	23
Grand Forks, ND-MN	2259	BCBS ND	34	Sanford	24
Ohio	1978	Elevance Health	31	Cigna	22
Akron, OH	2059	Cigna	31	Medical Mutual	23
Canton-Massillon, OH	2068	Cigna	30	Medical Mutual	25
Cincinnati, OH-KY-IN	3295	Elevance Health	52	UnitedHealth Group	22
Cleveland-Elyria, OH	2179	Cigna	33	Medical Mutual	24
Columbus, OH	1996	Elevance Health	28	UnitedHealth Group	25
Dayton-Kettering, OH	3002	Elevance Health	49	UnitedHealth Group	20
Lima, OH	2279	Elevance Health	36	Cigna	25
Mansfield, OH	2430	Cigna	30	Elevance Health	30
Springfield, OH	2912	Elevance Health	48	UnitedHealth Group	18
Toledo, OH	1861	Cigna	25	Elevance Health	23
Weirton-Steubenville, WV-OH	1774	Highmark	28	Elevance Health	20
Youngstown-Warren-Boardman, OH-PA	1725	Elevance Health	28	Cigna	20
Oklahoma	3661	HCSC (BCBS)	57	UnitedHealth Group	14
Enid, OK	4725	HCSC (BCBS)	66	Cigna	14
Lawton, OK	5673	HCSC (BCBS)	75	UnitedHealth Group	7
Oklahoma City, OK	3368	HCSC (BCBS)	54	UnitedHealth Group	14
Tulsa, OK	3068	HCSC (BCBS)	49	UnitedHealth Group	23
Oregon	1420	Cambia	21	Kaiser	18
Albany-Lebanon, OR	1405	Cambia	25	PacificSource	14
Bend, OR	2109	Cambia	37	PacificSource	20
Corvallis, OR	2004	Cambia	37	Cigna	18
Eugene-Springfield, OR	1904	PacificSource	32	Cambia	21
Grants Pass, OR	1728	PacificSource	26	Cambia	22
Medford, OR	1760	Cambia	28	PacificSource	19
Portland-Vancouver-Hillsboro, OR-WA	1660	Kaiser	26	Providence Hlth	19
Salem, OR	1899	Kaiser	31	Cambia	21
Pennsylvania	1803	Highmark	31	CVS (Aetna)	18
Allentown-Bethlehem-Easton, PA-NJ	1751	Highmark	27	Capital BC	20
Altoona, PA	3172	Highmark	46	UPMC	29
Bloomsburg-Berwick, PA	3772	Geisinger	56	Highmark	19
Chambersburg-Waynesboro, PA	2616	Highmark	40	Capital BC	27
East Stroudsburg, PA	2804	Highmark	46	UnitedHealth Group	17
Erie, PA	3837	Highmark	56	UPMC	24
Gettysburg, PA	2326	Highmark	38	Capital BC	23
Harrisburg-Carlisle, PA	2915	Highmark	46	Capital BC	22
Johnstown, PA	3532	Highmark	52	UPMC	24

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lancaster, PA	3036	Highmark	44	Capital BC	29
Lebanon, PA	3654	Highmark	55	Capital BC	22
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	2261	Independence Hlth Grp	36	CVS (Aetna)	24
Pittsburgh, PA	3205	Highmark	45	UPMC	32
Reading, PA	2424	Highmark	33	Capital BC	30
Scranton—Wilkes-Barre, PA	3737	Highmark	55	Geisinger	24
State College, PA	3416	Highmark	49	Capital BC	29
Williamsport, PA	2963	Highmark	46	Geisinger	22
York-Hanover, PA	2485	Highmark	40	Capital BC	23
Rhode Island	2747	BCBS RI	42	UnitedHealth Group	28
Providence-Warwick, RI-MA	1718	BCBS RI	23	BCBS MA	20
South Carolina	3862	BCBS SC	59	UnitedHealth Group	12
Charleston-North Charleston, SC	4188	BCBS SC	62	Cigna	14
Columbia, SC	4313	BCBS SC	63	UnitedHealth Group	10
Florence, SC	3743	BCBS SC	57	UnitedHealth Group	15
Greenville-Anderson, SC	3539	BCBS SC	55	UnitedHealth Group	14
Hilton Head Island-Bluffton, SC	4106	BCBS SC	61	Cigna	11
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	2264	BCBS SC	39	BCBS NC	16
Spartanburg, SC	4146	BCBS SC	61	UnitedHealth Group	13
Sumter, SC	3845	BCBS SC	59	Cigna	12
South Dakota	2612	Avera Hlth	33	Wellmark (BCBS)	31
Rapid City, SD	2817	Wellmark (BCBS)	44	Avera Hlth	21
Sioux Falls, SD	2387	Wellmark (BCBS)	30	Avera Hlth	28
Tennessee	2668	BCBS TN	42	Cigna	23
Chattanooga, TN-GA	2297	BCBS TN	36	Cigna	24
Clarksville, TN-KY	1946	BCBS TN	32	Elevance Health	23
Cleveland, TN	2987	BCBS TN	46	Cigna	25
Jackson, TN	2636	BCBS TN	40	Cigna	26
Johnson City, TN	4084	BCBS TN	60	Cigna	15
Kingsport-Bristol, TN-VA	2466	BCBS TN	37	Elevance Health	23
Knoxville, TN	3071	BCBS TN	47	UnitedHealth Group	20
Memphis, TN-MS-AR	2430	Cigna	37	BCBS TN	28
Morristown, TN	3691	BCBS TN	56	Cigna	16
Nashville-Davidson—Murfreesboro—Franklin, TN	2327	BCBS TN	35	Cigna	22
Texas	2659	HCSC (BCBS)	44	UnitedHealth Group	18
Abilene, TX	5142	HCSC (BCBS)	70	UnitedHealth Group	14
Amarillo, TX	2886	HCSC (BCBS)	47	Cigna	18
Austin-Round Rock-Georgetown, TX	2296	HCSC (BCBS)	36	UnitedHealth Group	21
Beaumont-Port Arthur, TX	3494	HCSC (BCBS)	54	UnitedHealth Group	20
Brownsville-Harlingen, TX	4829	HCSC (BCBS)	67	UnitedHealth Group	13
College Station-Bryan, TX	5059	HCSC (BCBS)	70	Baylor Scott & White	9

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Corpus Christi, TX	3309	HCSC (BCBS)	51	UnitedHealth Group	20
Dallas-Fort Worth-Arlington, TX	2561	HCSC (BCBS)	40	UnitedHealth Group	21
El Paso, TX	2884	HCSC (BCBS)	38	CVS (Aetna)	35
Houston-The Woodlands-Sugar Land, TX	2286	HCSC (BCBS)	37	UnitedHealth Group	19
Killeen-Temple, TX	2786	HCSC (BCBS)	45	Baylor Scott & White	24
Laredo, TX	5434	HCSC (BCBS)	72	UnitedHealth Group	12
Longview, TX	4478	HCSC (BCBS)	64	UnitedHealth Group	17
Lubbock, TX	4028	HCSC (BCBS)	60	UnitedHealth Group	14
McAllen-Edinburg-Mission, TX	4572	HCSC (BCBS)	65	UnitedHealth Group	14
Midland, TX	5018	HCSC (BCBS)	69	UnitedHealth Group	12
Odessa, TX	4706	HCSC (BCBS)	67	UnitedHealth Group	9
San Angelo, TX	4318	HCSC (BCBS)	63	UnitedHealth Group	13
San Antonio-New Braunfels, TX	2617	HCSC (BCBS)	39	CVS (Aetna)	25
Sherman-Denison, TX	3486	HCSC (BCBS)	53	UnitedHealth Group	20
Texarkana, TX-AR	3507	HCSC (BCBS)	57	BCBS AR	10
Tyler, TX	3991	HCSC (BCBS)	60	UnitedHealth Group	15
Victoria, TX	3838	HCSC (BCBS)	58	UnitedHealth Group	17
Waco, TX	3356	HCSC (BCBS)	54	Baylor Scott & White	14
Wichita Falls, TX	5462	HCSC (BCBS)	72	UnitedHealth Group	13
Utah	2743	Intermountain	46	Cambia	14
Logan, UT-ID	3163	Intermountain	52	UnitedHealth Group	13
Ogden-Clearfield, UT	2662	Intermountain	45	Cambia	16
Provo-Orem, UT	3598	Intermountain	57	Cigna	13
Salt Lake City, UT	2673	Intermountain	45	Cigna	15
St. George, UT	3209	Intermountain	52	Cigna	15
Vermont	3901	BCBS VT	57	Cigna	23
Burlington-South Burlington, VT	4075	BCBS VT	59	Cigna	23
Virginia	2436	Elevance Health	43	CVS (Aetna)	14
Blacksburg-Christiansburg, VA	4653	Elevance Health	65	CVS (Aetna)	18
Charlottesville, VA	2921	Elevance Health	41	CVS (Aetna)	33
Harrisonburg, VA	4357	Elevance Health	63	Sentara Health	15
Lynchburg, VA	4163	Elevance Health	62	Centra (Piedmont)	14
Richmond, VA	4052	Elevance Health	60	Cigna	14
Roanoke, VA	3911	Elevance Health	58	CVS (Aetna)	21
Staunton, VA	4636	Elevance Health	66	CVS (Aetna)	11
Virginia Beach-Norfolk-Newport News, VA-NC	3318	Elevance Health	51	Sentara Health	23
Winchester, VA-WV	2871	Elevance Health	47	Cigna	17
Washington	1660	Kaiser	21	Cambia	21
Bellingham, WA	2119	Kaiser	31	Cambia	24
Bremerton-Silverdale-Port Orchard, WA	1879	Cambia	28	Kaiser	26
Kennewick-Richland, WA	2196	Kaiser	31	Premera	30

Table A-1 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Combined PPO+HMO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Longview, WA	2925	Kaiser	49	Premera	18
Mount Vernon-Anacortes, WA	2088	Kaiser	30	Cambia	24
Olympia-Lacey-Tumwater, WA	1982	Kaiser	36	Premera	17
Seattle-Tacoma-Bellevue, WA	1683	Premera	22	Cambia	21
Spokane-Spokane Valley, WA	2156	Premera	33	Kaiser	28
Walla Walla, WA	1997	Premera	30	Kaiser	26
Wenatchee, WA	2752	Premera	47	Carle Health	17
Yakima, WA	1967	Premera	28	Kaiser	26
West Virginia	3232	Highmark	52	Cigna	14
Beckley, WV	4095	Highmark	62	Cigna	10
Charleston, WV	3579	Highmark	56	Cigna	13
Huntington-Ashland, WV-KY-OH	2558	Elevance Health	38	Highmark	30
Morgantown, WV	3484	Highmark	55	CVS (Aetna)	16
Parkersburg-Vienna, WV	3513	Highmark	56	CVS (Aetna)	13
Wheeling, WV-OH	1802	Highmark	26	Elevance Health	26
Wisconsin	1430	UnitedHealth Group	27	Elevance Health	20
Appleton, WI	2013	UnitedHealth Group	33	Elevance Health	25
Eau Claire, WI	1800	Elevance Health	31	Marshfield (Security HP)	18
Fond du Lac, WI	1898	UnitedHealth Group	31	Quartz	19
Green Bay, WI	1674	UnitedHealth Group	28	Elevance Health	23
Janesville-Beloit, WI	1899	Medica	25	Elevance Health	24
La Crosse-Onalaska, WI-MN	2275	Quartz	39	Cigna	22
Madison, WI	2032	Medica	31	Quartz	21
Milwaukee-Waukesha, WI	2924	UnitedHealth Group	48	Elevance Health	22
Oshkosh-Neenah, WI	2198	UnitedHealth Group	39	Elevance Health	20
Racine, WI	3210	UnitedHealth Group	51	Elevance Health	23
Sheboygan, WI	2882	UnitedHealth Group	48	Elevance Health	21
Wausau-Weston, WI	1829	Elevance Health	27	UnitedHealth Group	26
Wyoming	2671	Cigna	40	BCBS WY	27
Casper, WY	3389	Cigna	53	BCBS WY	17
Cheyenne, WY	3044	Cigna	43	BCBS WY	32

Notes:

1. Source: Managed Market Surveyor Suite | MSA Medical | Program | Jan. 1, 2023 | Enterprise, Managed Market Surveyor Suite | Managed Market Surveyor | Selected Geography(ies) | Jan. 1, 2023 | Enterprise, and Managed Market Surveyor | Data Extraction © 2023 DR/Decision Resources, LLC. All rights reserved.
2. Data point for the exchanges is July 1, 2023.
3. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the combined PPO+HMO+POS+EXCH (TOTAL) product market are reported.
4. Data are based on enrollments in both fully and self-insured health plans.

Table A-2. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023

PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	8408	BCBS AL	92	Cigna	4
Anniston-Oxford, AL	8754	BCBS AL	93	Cigna	3
Auburn-Opelika, AL	7981	BCBS AL	89	Cigna	6
Birmingham-Hoover, AL	8300	BCBS AL	91	Cigna	4
Daphne-Fairhope-Foley, AL	7613	BCBS AL	87	Cigna	6
Decatur, AL	8585	BCBS AL	93	Cigna	5
Dothan, AL	9002	BCBS AL	95	Cigna	2
Florence-Muscle Shoals, AL	8455	BCBS AL	92	Cigna	5
Gadsden, AL	9126	BCBS AL	95	Cigna	2
Huntsville, AL	7842	BCBS AL	88	Cigna	6
Mobile, AL	8333	BCBS AL	91	Cigna	5
Montgomery, AL	8741	BCBS AL	93	Cigna	3
Tuscaloosa, AL	9230	BCBS AL	96	Cigna	2
Alaska	4396	CVS (Aetna)	49	Premera	44
Anchorage, AK	4204	Premera	50	CVS (Aetna)	41
Fairbanks, AK	4471	Premera	48	CVS (Aetna)	46
Arizona	2949	BCBS AZ	34	CVS (Aetna)	32
Flagstaff, AZ	6506	BCBS AZ	80	Cigna	9
Lake Havasu City-Kingman, AZ	4102	BCBS AZ	60	Cigna	17
Phoenix-Mesa-Chandler, AZ	2978	CVS (Aetna)	33	Cigna	32
Prescott Valley-Prescott, AZ	4523	BCBS AZ	64	CVS (Aetna)	15
Sierra Vista-Douglas, AZ	4221	BCBS AZ	62	Cigna	12
Tucson, AZ	3091	BCBS AZ	44	CVS (Aetna)	28
Yuma, AZ	4067	BCBS AZ	59	Cigna	18
Arkansas	4340	BCBS AR	62	Cigna	21
Fayetteville-Springdale-Rogers, AR	4311	BCBS AR	61	Cigna	22
Fort Smith, AR-OK	2590	BCBS AR	35	HCSC (BCBS)	27
Hot Springs, AR	4312	BCBS AR	62	Cigna	19
Jonesboro, AR	5116	BCBS AR	68	Cigna	23
Little Rock-North Little Rock-Conway, AR	4486	BCBS AR	62	Cigna	24
Pine Bluff, AR	6549	BCBS AR	80	Cigna	10
California	3269	Elevance Health	50	BS of CA	20
Bakersfield, CA	4925	Elevance Health	67	BS of CA	21
Chico, CA	5147	Elevance Health	66	BS of CA	27
Fresno, CA	3594	Elevance Health	49	BS of CA	30
Hanford-Corcoran, CA	5005	Elevance Health	65	BS of CA	27
Los Angeles-Long Beach-Anaheim, CA	3239	Elevance Health	49	BS of CA	22
Madera, CA	4618	Elevance Health	63	BS of CA	24
Merced, CA	5077	Elevance Health	68	BS of CA	21
Modesto, CA	4316	Elevance Health	61	BS of CA	20
Napa, CA	3703	Elevance Health	54	BS of CA	24

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Oxnard-Thousand Oaks-Ventura, CA	4032	Elevance Health	59	BS of CA	19
Riverside-San Bernardino-Ontario, CA	3393	Elevance Health	52	BS of CA	20
Sacramento-Roseville-Folsom, CA	4300	Elevance Health	62	BS of CA	16
Salinas, CA	4051	Elevance Health	55	BS of CA	32
San Diego-Chula Vista-Carlsbad, CA	2561	Elevance Health	39	BS of CA	20
San Francisco-Oakland-Berkeley, CA	2723	Elevance Health	41	BS of CA	20
San Jose-Sunnyvale-Santa Clara, CA	3021	Elevance Health	45	CVS (Aetna)	22
San Luis Obispo-Paso Robles, CA	5841	Elevance Health	75	BS of CA	15
Santa Cruz-Watsonville, CA	3965	Elevance Health	58	BS of CA	22
Santa Maria-Santa Barbara, CA	4516	Elevance Health	62	BS of CA	24
Santa Rosa-Petaluma, CA	3762	Elevance Health	55	BS of CA	23
Stockton, CA	3595	Elevance Health	54	CVS (Aetna)	18
Vallejo, CA	3701	Elevance Health	56	BS of CA	15
Visalia, CA	5744	Elevance Health	73	BS of CA	18
Yuba City, CA	5269	Elevance Health	70	BS of CA	18
Colorado	3270	Cigna	42	Elevance Health	35
Boulder, CO	3531	Cigna	43	Elevance Health	40
Colorado Springs, CO	3313	Elevance Health	40	Cigna	38
Denver-Aurora-Lakewood, CO	3357	Cigna	46	Elevance Health	31
Fort Collins, CO	3873	Elevance Health	53	Cigna	31
Grand Junction, CO	3799	Cigna	49	Elevance Health	37
Greeley, CO	3456	Elevance Health	42	Cigna	38
Pueblo, CO	3694	Elevance Health	43	Cigna	42
Connecticut	2821	Elevance Health	36	Cigna	29
Bridgeport-Stamford-Norwalk, CT	2590	Cigna	30	Elevance Health	28
Hartford-East Hartford-Middletown, CT	3062	Elevance Health	40	Cigna	30
New Haven-Milford, CT	2859	Elevance Health	37	Cigna	32
Norwich-New London, CT	4032	Elevance Health	58	Cigna	21
Delaware	**4400**	**Highmark**	**60**	**CVS (Aetna)**	**25**
Dover, DE	5204	Highmark	70	CVS (Aetna)	16
District of Columbia	**2198**	**CareFirst**	**32**	**CVS (Aetna)**	**23**
Washington-Arlington-Alexandria, DC-VA-MD-WV	2160	Cigna	28	Elevance Health	25
Florida	2884	BCBS FL	38	Cigna	28
Cape Coral-Fort Myers, FL	2779	BCBS FL	35	CVS (Aetna)	30
Crestview-Fort Walton Beach-Destin, FL	4857	BCBS FL	68	CVS (Aetna)	13
Deltona-Daytona Beach-Ormond Beach, FL	2758	BCBS FL	36	CVS (Aetna)	26
Gainesville, FL	5806	BCBS FL	75	CVS (Aetna)	15
Homosassa Springs, FL	4429	BCBS FL	64	Cigna	13
Jacksonville, FL	4033	BCBS FL	57	CVS (Aetna)	23
Lakeland-Winter Haven, FL	3026	Cigna	35	BCBS FL	35
Miami-Fort Lauderdale-Pompano Beach, FL	2985	Cigna	32	CVS (Aetna)	32

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Naples-Marco Island, FL	3317	BCBS FL	43	Cigna	35
North Port-Sarasota-Bradenton, FL	2877	BCBS FL	40	CVS (Aetna)	30
Ocala, FL	4706	BCBS FL	66	CVS (Aetna)	17
Orlando-Kissimmee-Sanford, FL	2763	Cigna	42	BCBS FL	21
Palm Bay-Melbourne-Titusville, FL	3693	Cigna	53	BCBS FL	26
Panama City, FL	6522	BCBS FL	80	Cigna	8
Pensacola-Ferry Pass-Brent, FL	4830	BCBS FL	67	CVS (Aetna)	13
Port St. Lucie, FL	3650	BCBS FL	50	Cigna	31
Punta Gorda, FL	2834	BCBS FL	41	Cigna	23
Sebastian-Vero Beach, FL	4482	BCBS FL	63	Cigna	19
Sebring-Avon Park, FL	3147	BCBS FL	47	CVS (Aetna)	22
Tallahassee, FL	5350	BCBS FL	71	CVS (Aetna)	11
Tampa-St. Petersburg-Clearwater, FL	2879	Cigna	34	BCBS FL	32
The Villages, FL	4045	BCBS FL	61	Cigna	12
Georgia	3023	Elevance Health	38	Cigna	29
Albany, GA	5197	Elevance Health	70	Cigna	14
Athens-Clarke County, GA	2931	Elevance Health	40	Cigna	32
Atlanta-Sandy Springs-Alpharetta, GA	3014	Elevance Health	34	CVS (Aetna)	31
Augusta-Richmond County, GA-SC	2532	Elevance Health	38	BCBS SC	25
Brunswick, GA	4246	Elevance Health	61	Cigna	21
Columbus, GA-AL	3766	Elevance Health	56	Cigna	20
Dalton, GA	4453	Cigna	63	Elevance Health	14
Gainesville, GA	3221	Cigna	43	Elevance Health	30
Hinesville, GA	3783	Elevance Health	56	Cigna	22
Macon-Bibb County, GA	3889	Elevance Health	55	Cigna	27
Rome, GA	3610	Cigna	48	Elevance Health	33
Savannah, GA	3461	Elevance Health	49	Cigna	29
Valdosta, GA	4088	Elevance Health	59	Cigna	20
Warner Robins, GA	4715	Elevance Health	66	Cigna	16
Hawaii	6122	HMSA (BCBS HI)	77	Univ Hlth Alliance	9
Kahului-Wailuku-Lahaina, HI	4485	HMSA (BCBS HI)	63	Univ Hlth Alliance	19
Urban Honolulu, HI	5810	HMSA (BCBS HI)	75	Univ Hlth Alliance	9
Idaho	2930	BC of ID	49	Cambia	16
Boise City, ID	2735	BC of ID	46	Cambia	15
Coeur d'Alene, ID	2047	BC of ID	31	Cambia	26
Idaho Falls, ID	3871	BC of ID	60	Cambia	10
Lewiston, ID-WA	2291	Premera	33	Cambia	25
Pocatello, ID	3829	BC of ID	59	Cambia	11
Twin Falls, ID	3052	BC of ID	50	Cambia	15

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Illinois	5137	HCSC (BCBS)	69	CVS (Aetna)	16
Bloomington, IL	5249	HCSC (BCBS)	69	CVS (Aetna)	22
Carbondale-Marion, IL	4415	HCSC (BCBS)	63	Cigna	17
Champaign-Urbana, IL	2725	HCSC (BCBS)	34	Carle Health	33
Chicago-Naperville-Elgin, IL-IN-WI	4569	HCSC (BCBS)	65	CVS (Aetna)	13
Danville, IL	5269	HCSC (BCBS)	71	Carle Health	10
Davenport-Moline-Rock Island, IA-IL	3171	HCSC (BCBS)	51	Wellmark (BCBS)	16
Decatur, IL	6847	HCSC (BCBS)	82	Cigna	6
Kankakee, IL	6672	HCSC (BCBS)	81	CVS (Aetna)	10
Peoria, IL	3844	HCSC (BCBS)	54	UnitedHealth Group	28
Rockford, IL	6680	HCSC (BCBS)	81	CVS (Aetna)	10
Springfield, IL	4644	HCSC (BCBS)	65	Cigna	16
Indiana	5668	Elevance Health	74	Cigna	12
Bloomington, IN	8091	Elevance Health	90	Cigna	4
Columbus, IN	8136	Elevance Health	90	Cigna	4
Elkhart-Goshen, IN	6236	Elevance Health	78	Cigna	14
Evansville, IN-KY	6288	Elevance Health	78	CVS (Aetna)	8
Fort Wayne, IN	4694	Elevance Health	65	Cigna	18
Indianapolis-Carmel-Anderson, IN	5749	Elevance Health	74	Cigna	13
Kokomo, IN	6525	Elevance Health	80	Cigna	12
Lafayette-West Lafayette, IN	7427	Elevance Health	86	Cigna	6
Michigan City-La Porte, IN	6049	Elevance Health	77	Cigna	11
Muncie, IN	6907	Elevance Health	83	Cigna	9
South Bend-Mishawaka, IN-MI	4208	Elevance Health	62	BCBS MI	14
Terre Haute, IN	6600	Elevance Health	80	Cigna	10
Iowa	4379	Wellmark (BCBS)	62	Cigna	20
Ames, IA	7001	Wellmark (BCBS)	83	Cigna	8
Cedar Rapids, IA	4351	Wellmark (BCBS)	60	Cigna	26
Davenport-Moline-Rock Island, IA-IL	3171	HCSC (BCBS)	51	Wellmark (BCBS)	16
Des Moines-West Des Moines, IA	4027	Wellmark (BCBS)	58	Cigna	23
Dubuque, IA	4527	Wellmark (BCBS)	63	Cigna	22
Iowa City, IA	6662	Wellmark (BCBS)	81	Cigna	10
Sioux City, IA-NE-SD	2654	Wellmark (BCBS)	45	Cigna	18
Waterloo-Cedar Falls, IA	4107	Wellmark (BCBS)	49	Cigna	41
Kansas	3321	BCBS KS	52	CVS (Aetna)	18
Lawrence, KS	4103	BCBS KS	59	CVS (Aetna)	19
Manhattan, KS	6345	BCBS KS	79	CVS (Aetna)	7
Topeka, KS	7177	BCBS KS	84	CVS (Aetna)	7
Wichita, KS	4543	BCBS KS	61	CVS (Aetna)	29

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Kentucky	6118	Elevance Health	77	Humana	11
Bowling Green, KY	5711	Elevance Health	74	Humana	13
Elizabethtown-Fort Knox, KY	6036	Elevance Health	76	Humana	13
Lexington-Fayette, KY	6621	Elevance Health	80	Humana	11
Louisville/Jefferson County, KY-IN	5954	Elevance Health	76	Humana	10
Owensboro, KY	6752	Elevance Health	81	Humana	11
Louisiana	6036	BCBS LA	77	Cigna	9
Alexandria, LA	6819	BCBS LA	82	Cigna	7
Baton Rouge, LA	6462	BCBS LA	79	Cigna	10
Hammond, LA	6329	BCBS LA	79	Cigna	9
Houma-Thibodaux, LA	6978	BCBS LA	83	Cigna	7
Lafayette, LA	6436	BCBS LA	79	Cigna	9
Lake Charles, LA	6549	BCBS LA	80	Cigna	9
Monroe, LA	6534	BCBS LA	80	Cigna	8
New Orleans-Metairie, LA	5953	BCBS LA	76	Cigna	9
Shreveport-Bossier City, LA	6362	BCBS LA	79	Cigna	8
Maine	3054	Elevance Health	44	CVS (Aetna)	25
Bangor, ME	3239	Elevance Health	45	Cigna	31
Lewiston-Auburn, ME	2958	Elevance Health	38	Cigna	31
Portland-South Portland, ME	2886	Elevance Health	41	CVS (Aetna)	27
Maryland	3200	CareFirst	41	Cigna	33
Baltimore-Columbia-Towson, MD	3430	CareFirst	44	Cigna	34
California-Lexington Park, MD	2787	Cigna	39	CareFirst	30
Cumberland, MD-WV	2784	Cigna	37	CareFirst	33
Hagerstown-Martinsburg, MD-WV	2419	Cigna	30	Highmark	28
Salisbury, MD-DE	3451	Highmark	51	CareFirst	25
Massachusetts	2581	Point32Health	33	BCBS MA	33
Barnstable Town, MA	4178	Point32Health	60	BCBS MA	22
Boston-Cambridge-Newton, MA-NH	2161	BCBS MA	30	Point32Health	28
Pittsfield, MA	2849	BCBS MA	41	Cigna	30
Springfield, MA	2313	Cigna	34	BCBS MA	22
Worcester, MA-CT	1935	Point32Health	25	BCBS MA	25
Michigan	6204	BCBS MI	78	CVS (Aetna)	8
Ann Arbor, MI	7978	BCBS MI	89	CVS (Aetna)	4
Battle Creek, MI	7325	BCBS MI	85	Corewell (Priority)	4
Bay City, MI	6736	BCBS MI	81	Henry Ford (HAP)	8
Detroit-Warren-Dearborn, MI	6537	BCBS MI	80	CVS (Aetna)	6
Flint, MI	6662	BCBS MI	81	Henry Ford (HAP)	7
Grand Rapids-Kentwood, MI	5550	BCBS MI	73	Corewell (Priority)	10
Jackson, MI	7402	BCBS MI	86	Henry Ford (HAP)	7
Kalamazoo-Portage, MI	7410	BCBS MI	86	Cigna	5

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lansing-East Lansing, MI	8054	BCBS MI	90	CVS (Aetna)	3
Midland, MI	5762	BCBS MI	73	CVS (Aetna)	21
Monroe, MI	6680	BCBS MI	81	Cigna	8
Muskegon, MI	6317	BCBS MI	79	Corewell (Priority)	10
Niles, MI	6926	BCBS MI	83	CVS (Aetna)	6
Saginaw, MI	6233	BCBS MI	78	Henry Ford (HAP)	11
Minnesota	2881	BCBS MN	44	HealthPartners	21
Duluth, MN-WI	2865	BCBS MN	43	HealthPartners	23
Mankato, MN	4431	BCBS MN	59	Medica	29
Minneapolis-St. Paul-Bloomington, MN-WI	2484	BCBS MN	38	HealthPartners	26
Rochester, MN	4464	BCBS MN	60	Medica	28
St. Cloud, MN	3448	BCBS MN	50	HealthPartners	21
Mississippi	5895	BCBS MS	75	Cigna	14
Gulfport-Biloxi, MS	5693	BCBS MS	74	Cigna	12
Hattiesburg, MS	7167	BCBS MS	84	Cigna	6
Jackson, MS	6901	BCBS MS	83	CVS (Aetna)	6
Missouri	2411	Elevance Health	39	Cigna	18
Cape Girardeau, MO-IL	4695	Elevance Health	67	UnitedHealth Group	10
Columbia, MO	4845	Elevance Health	67	Cigna	14
Jefferson City, MO	6454	Elevance Health	80	Cigna	10
Joplin, MO	4784	Elevance Health	67	CoxHealth	15
Kansas City, MO-KS	3566	BCBS KS City	54	Cigna	19
Springfield, MO	3239	Elevance Health	52	CoxHealth	17
St. Joseph, MO-KS	4290	BCBS KS City	63	CVS (Aetna)	13
St. Louis, MO-IL	2812	Elevance Health	44	Cigna	25
Montana	3693	HCSC (BCBS)	54	Cigna	26
Billings, MT	3675	HCSC (BCBS)	51	Cigna	31
Great Falls, MT	4919	HCSC (BCBS)	67	Cigna	19
Missoula, MT	3645	HCSC (BCBS)	51	Cigna	30
Nebraska	4762	BCBS NE	66	CVS (Aetna)	17
Grand Island, NE	6080	BCBS NE	77	CVS (Aetna)	8
Lincoln, NE	5664	BCBS NE	74	CVS (Aetna)	14
Omaha-Council Bluffs, NE-IA	3910	BCBS NE	58	CVS (Aetna)	23
Nevada	2270	Elevance Health	36	CVS (Aetna)	22
Carson City, NV	2051	Elevance Health	29	UHS (Prominence HP)	23
Las Vegas-Henderson-Paradise, NV	2271	Elevance Health	36	CVS (Aetna)	21
Reno, NV	2287	Elevance Health	36	CVS (Aetna)	21
New Hampshire	3186	Elevance Health	40	Cigna	37
Manchester-Nashua, NH	3464	Elevance Health	49	Cigna	29

Table A-2 (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
New Jersey	2997	CVS (Aetna)	42	Horizon BCBS	29
Atlantic City-Hammonton, NJ	5429	Horizon BCBS	72	CVS (Aetna)	15
Ocean City, NJ	4020	Horizon BCBS	58	CVS (Aetna)	21
Trenton-Princeton, NJ	3569	CVS (Aetna)	52	Horizon BCBS	23
Vineland-Bridgeton, NJ	4076	Horizon BCBS	57	CVS (Aetna)	27
New Mexico	4588	HCSC (BCBS)	65	Presbyterian	13
Albuquerque, NM	3506	HCSC (BCBS)	53	Presbyterian	21
Farmington, NM	4567	HCSC (BCBS)	64	Cigna	18
Las Cruces, NM	6112	HCSC (BCBS)	77	Cigna	9
Santa Fe, NM	4188	HCSC (BCBS)	60	Cigna	17
New York	1449	Elevance Health	18	CVS (Aetna)	18
Albany-Schenectady-Troy, NY	1793	CDPHP	24	UnitedHealth Group	24
Binghamton, NY	3595	Lifetime Hlthcare	54	UnitedHealth Group	23
Buffalo-Cheektowaga, NY	1745	Highmark	25	Independent Hlth	20
Elmira, NY	5683	Lifetime Hlthcare	73	UnitedHealth Group	18
Glens Falls, NY	1931	Elevance Health	32	UnitedHealth Group	19
Ithaca, NY	3336	CVS (Aetna)	47	Lifetime Hlthcare	30
Kingston, NY	1859	UnitedHealth Group	23	EmblemHealth	23
New York-Newark-Jersey City, NY-NJ-PA	1700	CVS (Aetna)	24	Elevance Health	19
Poughkeepsie-Newburgh-Middletown, NY	1987	Elevance Health	29	UnitedHealth Group	24
Rochester, NY	6714	Lifetime Hlthcare	81	CVS (Aetna)	5
Syracuse, NY	5104	Lifetime Hlthcare	70	UnitedHealth Group	13
Utica-Rome, NY	3672	Lifetime Hlthcare	53	UnitedHealth Group	26
Watertown-Fort Drum, NY	3581	Lifetime Hlthcare	53	UnitedHealth Group	22
North Carolina	4211	BCBS NC	59	Cigna	22
Asheville, NC	3655	BCBS NC	53	Cigna	23
Burlington, NC	3912	BCBS NC	56	Cigna	21
Charlotte-Concord-Gastonia, NC-SC	2831	BCBS NC	40	Cigna	28
Durham-Chapel Hill, NC	4093	BCBS NC	57	CVS (Aetna)	26
Fayetteville, NC	5630	BCBS NC	74	Cigna	13
Goldsboro, NC	7385	BCBS NC	85	Cigna	8
Greensboro-High Point, NC	4539	BCBS NC	63	Cigna	23
Greenville, NC	6872	BCBS NC	82	Cigna	11
Hickory-Lenoir-Morganton, NC	5733	BCBS NC	73	Cigna	19
Jacksonville, NC	5619	BCBS NC	73	Cigna	12
New Bern, NC	6330	BCBS NC	78	Cigna	13
Raleigh-Cary, NC	3895	BCBS NC	54	Cigna	24
Rocky Mount, NC	6478	BCBS NC	79	Cigna	12
Wilmington, NC	4106	BCBS NC	56	Cigna	28
Winston-Salem, NC	4074	BCBS NC	54	Cigna	32

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
North Dakota	6047	BCBS ND	77	Medica	6
Bismarck, ND	5989	BCBS ND	77	Medica	7
Fargo, ND-MN	3001	BCBS ND	45	BCBS MN	25
Grand Forks, ND-MN	3217	BCBS ND	46	BCBS MN	28
Ohio	2593	Elevance Health	36	Cigna	28
Akron, OH	2514	Cigna	36	Elevance Health	24
Canton-Massillon, OH	2625	Cigna	35	Medical Mutual	27
Cincinnati, OH-KY-IN	5073	Elevance Health	69	Cigna	12
Cleveland-Elyria, OH	2654	Cigna	38	Medical Mutual	24
Columbus, OH	2458	Elevance Health	35	Cigna	26
Dayton-Kettering, OH	4037	Elevance Health	60	Cigna	17
Lima, OH	2953	Elevance Health	42	Cigna	29
Mansfield, OH	2894	Cigna	34	Elevance Health	32
Springfield, OH	3988	Elevance Health	59	Cigna	18
Toledo, OH	2610	Cigna	32	Elevance Health	29
Weirton-Steubenville, WV-OH	2201	Highmark	31	Elevance Health	23
Youngstown-Warren-Boardman, OH-PA	2146	Elevance Health	32	Cigna	24
Oklahoma	4923	HCSC (BCBS)	67	CVS (Aetna)	15
Enid, OK	5621	HCSC (BCBS)	72	Cigna	20
Lawton, OK	6653	HCSC (BCBS)	81	Cigna	7
Oklahoma City, OK	4749	HCSC (BCBS)	66	Cigna	17
Tulsa, OK	4845	HCSC (BCBS)	67	CVS (Aetna)	16
Oregon	1891	Cambia	29	Providence Hlth	20
Albany-Lebanon, OR	1911	Cambia	33	PacificSource	18
Bend, OR	2308	Cambia	40	PacificSource	16
Corvallis, OR	2607	Cambia	43	Cigna	22
Eugene-Springfield, OR	2192	PacificSource	32	Cambia	25
Grants Pass, OR	2166	PacificSource	32	Cambia	28
Medford, OR	1994	Cambia	32	PacificSource	21
Portland-Vancouver-Hillsboro, OR-WA	2118	Providence Hlth	29	Cambia	26
Salem, OR	2342	Cambia	34	Cigna	29
Pennsylvania	2162	Highmark	36	CVS (Aetna)	22
Allentown-Bethlehem-Easton, PA-NJ	2177	Highmark	34	Capital BC	21
Altoona, PA	3784	Highmark	54	UPMC	28
Bloomsburg-Berwick, PA	3239	Geisinger	48	Highmark	26
Chambersburg-Waynesboro, PA	2991	Highmark	44	Capital BC	27
East Stroudsburg, PA	3446	Highmark	52	CVS (Aetna)	22
Erie, PA	4548	Highmark	62	UPMC	24
Gettysburg, PA	2700	Highmark	44	Capital BC	22
Harrisburg-Carlisle, PA	3302	Highmark	50	Capital BC	22
Johnstown, PA	4064	Highmark	58	UPMC	22

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lancaster, PA	3316	Highmark	47	Capital BC	29
Lebanon, PA	4011	Highmark	59	Capital BC	21
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	2389	Independence Hlth Grp	32	CVS (Aetna)	31
Pittsburgh, PA	3646	Highmark	51	UPMC	30
Reading, PA	2754	Highmark	35	Capital BC	32
Scranton—Wilkes-Barre, PA	4511	Highmark	64	Geisinger	15
State College, PA	3981	Highmark	55	Capital BC	30
Williamsport, PA	3506	Highmark	54	UPMC	16
York-Hanover, PA	2804	Highmark	44	Capital BC	23
Rhode Island	4110	BCBS RI	61	Cigna	12
Providence-Warwick, RI-MA	2274	BCBS RI	38	Point32Health	17
South Carolina	4891	BCBS SC	67	Cigna	17
Charleston-North Charleston, SC	5134	BCBS SC	69	Cigna	19
Columbia, SC	5377	BCBS SC	71	CVS (Aetna)	14
Florence, SC	5107	BCBS SC	67	Cigna	22
Greenville-Anderson, SC	4452	BCBS SC	62	Cigna	18
Hilton Head Island-Bluffton, SC	4828	BCBS SC	66	Cigna	17
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	2740	BCBS SC	43	Cigna	20
Spartanburg, SC	5454	BCBS SC	72	Cigna	13
Sumter, SC	4825	BCBS SC	66	Cigna	18
South Dakota	3937	Wellmark (BCBS)	56	Avera Hlth	26
Rapid City, SD	5451	Wellmark (BCBS)	73	Cigna	10
Sioux Falls, SD	3526	Wellmark (BCBS)	51	Avera Hlth	29
Tennessee	3784	BCBS TN	52	Cigna	29
Chattanooga, TN-GA	3461	BCBS TN	49	Cigna	29
Clarksville, TN-KY	2590	BCBS TN	39	Elevance Health	27
Cleveland, TN	4421	BCBS TN	58	Cigna	31
Jackson, TN	3640	BCBS TN	48	Cigna	31
Johnson City, TN	5811	BCBS TN	74	Cigna	18
Kingsport-Bristol, TN-VA	3170	BCBS TN	43	Cigna	27
Knoxville, TN	4457	BCBS TN	61	Cigna	26
Memphis, TN-MS-AR	3377	Cigna	46	BCBS TN	33
Morristown, TN	5624	BCBS TN	72	Cigna	21
Nashville-Davidson—Murfreesboro—Franklin, TN	3372	BCBS TN	47	Cigna	28
Texas	4041	HCSC (BCBS)	58	CVS (Aetna)	19
Abilene, TX	7316	HCSC (BCBS)	85	Cigna	5
Amarillo, TX	3983	HCSC (BCBS)	56	Cigna	26
Austin-Round Rock-Georgetown, TX	3476	HCSC (BCBS)	49	CVS (Aetna)	28
Beaumont-Port Arthur, TX	4936	HCSC (BCBS)	68	CVS (Aetna)	13
Brownsville-Harlingen, TX	6983	HCSC (BCBS)	83	CVS (Aetna)	8
College Station-Bryan, TX	6503	HCSC (BCBS)	80	Cigna	9

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Corpus Christi, TX	5402	HCSC (BCBS)	71	CVS (Aetna)	16
Dallas-Fort Worth-Arlington, TX	3974	HCSC (BCBS)	56	Cigna	25
El Paso, TX	3705	HCSC (BCBS)	51	CVS (Aetna)	30
Houston-The Woodlands-Sugar Land, TX	3595	HCSC (BCBS)	50	Cigna	24
Killeen-Temple, TX	3264	HCSC (BCBS)	51	Baylor Scott & White	18
Laredo, TX	7589	HCSC (BCBS)	87	CVS (Aetna)	6
Longview, TX	6145	HCSC (BCBS)	77	Cigna	15
Lubbock, TX	5902	HCSC (BCBS)	75	CVS (Aetna)	12
McAllen-Edinburg-Mission, TX	7205	HCSC (BCBS)	84	CVS (Aetna)	8
Midland, TX	6721	HCSC (BCBS)	81	Cigna	12
Odessa, TX	6591	HCSC (BCBS)	80	CVS (Aetna)	9
San Angelo, TX	5762	HCSC (BCBS)	74	CVS (Aetna)	14
San Antonio-New Braunfels, TX	3903	HCSC (BCBS)	55	CVS (Aetna)	27
Sherman-Denison, TX	4443	HCSC (BCBS)	63	Cigna	20
Texarkana, TX-AR	4978	HCSC (BCBS)	69	BCBS AR	10
Tyler, TX	5974	HCSC (BCBS)	76	Cigna	15
Victoria, TX	4740	HCSC (BCBS)	66	Cigna	17
Waco, TX	4639	HCSC (BCBS)	66	Cigna	12
Wichita Falls, TX	6315	HCSC (BCBS)	78	Cigna	12
Utah	2336	Intermountain	37	Cigna	20
Logan, UT-ID	2795	Intermountain	45	Cigna	21
Ogden-Clearfield, UT	2353	Intermountain	36	Cambia	24
Provo-Orem, UT	3161	Intermountain	49	Cigna	22
Salt Lake City, UT	2352	Intermountain	36	Cigna	23
St. George, UT	2352	Intermountain	36	Cigna	25
Vermont	3791	Cigna	52	BCBS VT	31
Burlington-South Burlington, VT	3683	Cigna	51	BCBS VT	31
Virginia	3468	Elevance Health	52	Cigna	20
Blacksburg-Christiansburg, VA	5147	Elevance Health	68	CVS (Aetna)	21
Charlottesville, VA	3633	CVS (Aetna)	44	Elevance Health	40
Harrisonburg, VA	5905	Elevance Health	75	CVS (Aetna)	11
Lynchburg, VA	5361	Elevance Health	72	Cigna	10
Richmond, VA	4400	Elevance Health	61	Cigna	20
Roanoke, VA	4661	Elevance Health	62	CVS (Aetna)	27
Staunton, VA	5693	Elevance Health	73	CVS (Aetna)	14
Virginia Beach-Norfolk-Newport News, VA-NC	4680	Elevance Health	66	Cigna	15
Winchester, VA-WV	3733	Elevance Health	55	Cigna	19
Washington	2202	Cambia	30	Premera	29
Bellingham, WA	2359	Cambia	36	Premera	21
Bremerton-Silverdale-Port Orchard, WA	2231	Cambia	39	Premera	15
Kennewick-Richland, WA	2896	Premera	47	CVS (Aetna)	18

Table A-2 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *PPO product markets*

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Longview, WA	2688	Premera	43	Cigna	24
Mount Vernon-Anacortes, WA	2431	Cambia	36	Premera	27
Olympia-Lacey-Tumwater, WA	1849	Premera	28	Cambia	20
Seattle-Tacoma-Bellevue, WA	2293	Premera	30	Cambia	28
Spokane-Spokane Valley, WA	3219	Premera	52	CVS (Aetna)	13
Walla Walla, WA	2996	Premera	46	Cambia	26
Wenatchee, WA	3331	Premera	52	Carle Health	20
Yakima, WA	2803	Premera	42	Cambia	26
West Virginia	4307	Highmark	62	Cigna	17
Beckley, WV	5346	Highmark	71	Cigna	13
Charleston, WV	4744	Highmark	65	Cigna	17
Huntington-Ashland, WV-KY-OH	3122	Elevance Health	44	Highmark	32
Morgantown, WV	4463	Highmark	62	CVS (Aetna)	20
Parkersburg-Vienna, WV	4657	Highmark	65	CVS (Aetna)	16
Wheeling, WV-OH	2363	Elevance Health	31	Highmark	30
Wisconsin	2316	Elevance Health	41	Cigna	18
Appleton, WI	3454	Elevance Health	50	Cigna	30
Eau Claire, WI	3236	Elevance Health	53	Cigna	14
Fond du Lac, WI	2555	Elevance Health	42	Medica	22
Green Bay, WI	3003	Elevance Health	47	Cigna	25
Janesville-Beloit, WI	3615	Elevance Health	57	UnitedHealth Group	10
La Crosse-Onalaska, WI-MN	2245	Cigna	37	Quartz	23
Madison, WI	2286	Elevance Health	40	Cigna	17
Milwaukee-Waukesha, WI	2971	Elevance Health	49	Cigna	16
Oshkosh-Neenah, WI	3144	Elevance Health	44	Cigna	33
Racine, WI	3069	Elevance Health	49	Cigna	20
Sheboygan, WI	3302	Elevance Health	54	Cigna	15
Wausau-Weston, WI	4201	Elevance Health	63	Cigna	12
Wyoming	3791	Cigna	57	BCBS WY	16
Casper, WY	5023	Cigna	69	CVS (Aetna)	11
Cheyenne, WY	3998	Cigna	57	BCBS WY	27

Notes:
1. Source: Managed Market Surveyor Suite | MSA Medical | Program | Jan. 1, 2023 | Enterprise, Managed Market Surveyor Suite | Managed Market Surveyor | Selected Geography(ies) | Jan. 1, 2023 | Enterprise License © 2023 DR/Decision Resources, LLC. All rights reserved.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the PPO product market are reported.
3. Data are based on enrollments in both fully and self-insured health plans.

Table A-3. Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023
Exchanges

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	7685	BCBS AL	87	Centene	10
Anniston-Oxford, AL	10000	BCBS AL	100	-	-
Auburn-Opelika, AL	6176	BCBS AL	74	Centene	26
Birmingham-Hoover, AL	9163	BCBS AL	96	UnitedHealth Group	4
Daphne-Fairhope-Foley, AL	5667	BCBS AL	71	Centene	25
Decatur, AL	9163	BCBS AL	96	UnitedHealth Group	4
Dothan, AL	5667	BCBS AL	71	Centene	25
Florence-Muscle Shoals, AL	5666	BCBS AL	71	Centene	25
Gadsden, AL	5667	BCBS AL	71	Centene	25
Huntsville, AL	9163	BCBS AL	96	UnitedHealth Group	4
Mobile, AL	5680	BCBS AL	71	Centene	25
Montgomery, AL	9851	BCBS AL	99	Centene	1
Tuscaloosa, AL	9588	BCBS AL	98	Centene	2
Alaska	6595	Premera	78	Moda Health	22
Anchorage, AK	6415	Premera	77	Moda Health	23
Fairbanks, AK	6416	Premera	77	Moda Health	23
Arizona	2289	Centene	32	CVS (Aetna)	24
Flagstaff, AZ	5013	Centene	67	CVS (Aetna)	19
Lake Havasu City-Kingman, AZ	10000	BCBS AZ	100	-	-
Phoenix-Mesa-Chandler, AZ	2470	Centene	34	CVS (Aetna)	26
Prescott Valley-Prescott, AZ	7972	BCBS AZ	89	Cigna	11
Sierra Vista-Douglas, AZ	6013	Centene	76	BCBS AZ	15
Tucson, AZ	3122	CVS (Aetna)	39	Centene	32
Yuma, AZ	5216	BCBS AZ	60	CVS (Aetna)	40
Arkansas	5000	Centene	50	BCBS AR	50
Fayetteville-Springdale-Rogers, AR	5000	Centene	50	BCBS AR	50
Fort Smith, AR-OK	3249	Centene	36	BCBS AR	35
Hot Springs, AR	5000	Centene	50	BCBS AR	50
Jonesboro, AR	5000	Centene	50	BCBS AR	50
Little Rock-North Little Rock-Conway, AR	5000	Centene	50	BCBS AR	50
Pine Bluff, AR	5000	Centene	50	BCBS AR	50
California	2396	Kaiser	35	BS of CA	29
Bakersfield, CA	5434	BS of CA	70	Kaiser	21
Chico, CA	5049	BS of CA	55	Elevance Health	45
Fresno, CA	5255	BS of CA	67	Kaiser	26
Hanford-Corcoran, CA	7480	BS of CA	86	Elevance Health	7
Los Angeles-Long Beach-Anaheim, CA	2046	BS of CA	28	Kaiser	24
Madera, CA	4925	BS of CA	63	Kaiser	30
Merced, CA	7282	Elevance Health	84	BS of CA	16
Modesto, CA	4733	Kaiser	63	Elevance Health	23
Napa, CA	5919	Kaiser	75	BS of CA	11

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Oxnard-Thousand Oaks-Ventura, CA	5721	BS of CA	70	Kaiser	29
Riverside-San Bernardino-Ontario, CA	2328	Kaiser	29	BS of CA	27
Sacramento-Roseville-Folsom, CA	4640	Kaiser	64	BS of CA	22
Salinas, CA	6261	BS of CA	77	Valley Hlth	17
San Diego-Chula Vista-Carlsbad, CA	1837	Kaiser	23	Sharp HealthCare	23
San Francisco-Oakland-Berkeley, CA	5773	Kaiser	73	BS of CA	21
San Jose-Sunnyvale-Santa Clara, CA	3917	Kaiser	56	Valley Hlth	26
San Luis Obispo-Paso Robles, CA	9512	BS of CA	97	Elevance Health	2
Santa Cruz-Watsonville, CA	5144	Kaiser	61	BS of CA	38
Santa Maria-Santa Barbara, CA	9234	BS of CA	96	Elevance Health	4
Santa Rosa-Petaluma, CA	5526	Kaiser	73	Western Hlth Advantage	11
Stockton, CA	5745	Kaiser	73	Elevance Health	16
Vallejo, CA	7396	Kaiser	86	Western Hlth Advantage	6
Visalia, CA	5230	Elevance Health	64	BS of CA	33
Yuba City, CA	4014	BS of CA	47	Elevance Health	41
Colorado	2140	Elevance Health	32	Kaiser	22
Boulder, CO	2265	Kaiser	26	Elevance Health	25
Colorado Springs, CO	3447	Kaiser	47	Elevance Health	33
Denver-Aurora-Lakewood, CO	1999	Kaiser	27	Cigna	22
Fort Collins, CO	3668	Elevance Health	51	Cigna	25
Grand Junction, CO	5996	UnitedHealth Group	73	Elevance Health	25
Greeley, CO	3310	Elevance Health	40	Cigna	36
Pueblo, CO	5955	Elevance Health	75	Kaiser	18
Connecticut	5505	EmblemHealth	66	Elevance Health	34
Bridgeport-Stamford-Norwalk, CT	6305	EmblemHealth	76	Elevance Health	24
Hartford-East Hartford-Middletown, CT	5633	EmblemHealth	68	Elevance Health	32
New Haven-Milford, CT	5811	EmblemHealth	70	Elevance Health	30
Norwich-New London, CT	5762	Elevance Health	70	EmblemHealth	30
Delaware	8870	Highmark	94	CVS (Aetna)	6
Dover, DE	8721	Highmark	93	CVS (Aetna)	6
District of Columbia	6747	CareFirst	80	Kaiser	20
Washington-Arlington-Alexandria, DC-VA-MD-WV	2051	Kaiser	31	CareFirst	24
Florida	3004	BCBS FL	48	Oscar	17
Cape Coral-Fort Myers, FL	5101	BCBS FL	68	Centene	16
Crestview-Fort Walton Beach-Destin, FL	7877	BCBS FL	88	Centene	6
Deltona-Daytona Beach-Ormond Beach, FL	3131	BCBS FL	47	Oscar	24
Gainesville, FL	6444	BCBS FL	79	Oscar	11
Homosassa Springs, FL	7632	BCBS FL	87	Oscar	8
Jacksonville, FL	5314	BCBS FL	71	Oscar	12
Lakeland-Winter Haven, FL	4427	BCBS FL	56	Centene	36
Miami-Fort Lauderdale-Pompano Beach, FL	2336	BCBS FL	32	CVS (Aetna)	27

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Naples-Marco Island, FL	5608	BCBS FL	70	CVS (Aetna)	26
North Port-Sarasota-Bradenton, FL	4854	BCBS FL	66	CVS (Aetna)	20
Ocala, FL	4499	BCBS FL	61	Oscar	23
Orlando-Kissimmee-Sanford, FL	3055	BCBS FL	46	Oscar	24
Palm Bay-Melbourne-Titusville, FL	4843	BCBS FL	67	Oscar	14
Panama City, FL	8120	BCBS FL	90	Oscar	6
Pensacola-Ferry Pass-Brent, FL	8407	BCBS FL	92	Oscar	5
Port St. Lucie, FL	2757	BCBS FL	44	CVS (Aetna)	18
Punta Gorda, FL	5062	BCBS FL	68	CVS (Aetna)	16
Sebastian-Vero Beach, FL	6809	BCBS FL	82	CVS (Aetna)	11
Sebring-Avon Park, FL	5034	BCBS FL	63	Centene	33
Tallahassee, FL	6698	BCBS FL	81	Centene	11
Tampa-St. Petersburg-Clearwater, FL	3736	BCBS FL	54	Oscar	23
The Villages, FL	8438	BCBS FL	91	Centene	9
Georgia	2328	Centene	40	Cigna	21
Albany, GA	4794	Centene	58	CVS (Aetna)	37
Athens-Clarke County, GA	3744	Centene	54	Cigna	24
Atlanta-Sandy Springs-Alpharetta, GA	2133	Centene	32	Cigna	28
Augusta-Richmond County, GA-SC	3627	Centene	54	BCBS SC	22
Brunswick, GA	5040	Centene	54	CareSource	46
Columbus, GA-AL	3337	Centene	53	Oscar	18
Dalton, GA	4908	Centene	55	Alliant Hlth Plans	43
Gainesville, GA	4412	Alliant Hlth Plans	52	Cigna	41
Hinesville, GA	2692	Centene	34	Cigna	28
Macon-Bibb County, GA	6357	Centene	78	Alliant Hlth Plans	15
Rome, GA	4785	Centene	58	Alliant Hlth Plans	38
Savannah, GA	3198	Centene	50	Cigna	17
Valdosta, GA	4440	Centene	63	Elevance Health	15
Warner Robins, GA	7666	Centene	87	Alliant Hlth Plans	11
Hawaii	5425	HMSA (BCBS HI)	65	Kaiser	35
Kahului-Wailuku-Lahaina, HI	5000	HMSA (BCBS HI)	50	Kaiser	50
Urban Honolulu, HI	5815	HMSA (BCBS HI)	70	Kaiser	30
Idaho	2561	Intermountain	38	BC of ID	26
Boise City, ID	2563	Intermountain	42	Cambia	20
Coeur d'Alene, ID	4064	BC of ID	56	Cambia	29
Idaho Falls, ID	3326	Intermountain	50	Cambia	22
Lewiston, ID-WA	3314	BC of ID	49	Cambia	23
Pocatello, ID	4217	BC of ID	56	Cambia	32
Twin Falls, ID	3420	Intermountain	53	Montana Health CO-OP	16

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Illinois	4570	HCSC (BCBS)	65	Centene	16
Bloomington, IL	5051	Carle Health	55	HCSC (BCBS)	45
Carbondale-Marion, IL	5012	HCSC (BCBS)	52	Carle Health	48
Champaign-Urbana, IL	10000	Carle Health	100	-	-
Chicago-Naperville-Elgin, IL-IN-WI	4510	HCSC (BCBS)	63	Centene	21
Danville, IL	7663	Carle Health	86	HCSC (BCBS)	14
Davenport-Moline-Rock Island, IA-IL	2827	Wellmark (BCBS)	41	HCSC (BCBS)	29
Decatur, IL	4857	Carle Health	53	HCSC (BCBS)	45
Kankakee, IL	3474	HCSC (BCBS)	51	Carle Health	24
Peoria, IL	5085	Carle Health	57	HCSC (BCBS)	43
Rockford, IL	5761	HCSC (BCBS)	73	MercyCare	16
Springfield, IL	4990	Carle Health	57	HCSC (BCBS)	41
Indiana	3437	CareSource	42	Centene	38
Bloomington, IN	4357	CareSource	57	Elevance Health	30
Columbus, IN	5053	CareSource	55	Centene	45
Elkhart-Goshen, IN	3350	CareSource	36	Centene	33
Evansville, IN-KY	3426	CareSource	45	Centene	29
Fort Wayne, IN	5114	Centene	58	CareSource	42
Indianapolis-Carmel-Anderson, IN	2984	Centene	42	CareSource	31
Kokomo, IN	3540	CareSource	48	Centene	26
Lafayette-West Lafayette, IN	4254	CareSource	49	Elevance Health	42
Michigan City-La Porte, IN	5665	CareSource	68	Centene	32
Muncie, IN	3940	Elevance Health	44	CareSource	42
South Bend-Mishawaka, IN-MI	3928	Centene	45	CareSource	43
Terre Haute, IN	4674	Centene	63	CareSource	22
Iowa	5758	Wellmark (BCBS)	73	Medica	19
Ames, IA	6745	Wellmark (BCBS)	80	Medica	20
Cedar Rapids, IA	6548	Wellmark (BCBS)	78	Medica	20
Davenport-Moline-Rock Island, IA-IL	2827	Wellmark (BCBS)	41	HCSC (BCBS)	29
Des Moines-West Des Moines, IA	4729	Wellmark (BCBS)	64	Oscar	20
Dubuque, IA	4691	Wellmark (BCBS)	63	Oscar	20
Iowa City, IA	6747	Wellmark (BCBS)	80	Medica	20
Sioux City, IA-NE-SD	2153	Wellmark (BCBS)	37	Medica	18
Waterloo-Cedar Falls, IA	4818	Wellmark (BCBS)	65	Oscar	19
Kansas	4111	Centene	47	BCBS KS	44
Lawrence, KS	4923	BCBS KS	54	Centene	45
Manhattan, KS	4852	BCBS KS	53	Centene	46
Topeka, KS	5005	BCBS KS	54	Centene	45
Wichita, KS	3851	BCBS KS	46	Centene	40

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Kentucky	4109	CareSource	46	Elevance Health	43
Bowling Green, KY	7977	Elevance Health	89	Centene	11
Elizabethtown-Fort Knox, KY	5483	Elevance Health	70	CareSource	23
Lexington-Fayette, KY	5687	CareSource	72	Elevance Health	22
Louisville/Jefferson County, KY-IN	3730	CareSource	52	Centene	23
Owensboro, KY	8049	Elevance Health	89	Centene	10
Louisiana	5920	BCBS LA	75	Centene	16
Alexandria, LA	5039	BCBS LA	54	CHRISTUS	46
Baton Rouge, LA	5218	BCBS LA	64	Centene	33
Hammond, LA	9193	BCBS LA	96	UnitedHealth Group	4
Houma-Thibodaux, LA	10000	BCBS LA	100	-	-
Lafayette, LA	9193	BCBS LA	96	UnitedHealth Group	4
Lake Charles, LA	3586	CHRISTUS	44	BCBS LA	35
Monroe, LA	9196	BCBS LA	96	UnitedHealth Group	4
New Orleans-Metairie, LA	5375	BCBS LA	67	Centene	30
Shreveport-Bossier City, LA	5128	BCBS LA	58	CHRISTUS	42
Maine	3291	Community Hlth Options	35	Elevance Health	33
Bangor, ME	3466	Elevance Health	39	Community Hlth Options	37
Lewiston-Auburn, ME	3395	Elevance Health	37	Point32Health	36
Portland-South Portland, ME	3242	Point32Health	37	Elevance Health	31
Maryland	4470	CareFirst	59	Kaiser	29
Baltimore-Columbia-Towson, MD	4907	CareFirst	65	Kaiser	24
California-Lexington Park, MD	7092	CareFirst	82	UnitedHealth Group	18
Cumberland, MD-WV	4302	CareFirst	61	Highmark	18
Hagerstown-Martinsburg, MD-WV	3460	CareFirst	42	Highmark	38
Salisbury, MD-DE	4731	Highmark	61	CareFirst	32
Massachusetts	4221	Point32Health	60	BMC (WellSense HP)	25
Barnstable Town, MA	4668	Point32Health	63	BMC (WellSense HP)	24
Boston-Cambridge-Newton, MA-NH	3536	Point32Health	54	BMC (WellSense HP)	22
Pittsfield, MA	3634	Point32Health	54	BMC (WellSense HP)	22
Springfield, MA	3849	Point32Health	56	BMC (WellSense HP)	24
Worcester, MA-CT	2147	Point32Health	35	Baystate	24
Michigan	3562	BCBS MI	55	Corewell (Priority)	19
Ann Arbor, MI	2610	BCBS MI	42	U-M Health (PHP)	17
Battle Creek, MI	3814	BCBS MI	55	Corewell (Priority)	20
Bay City, MI	4204	BCBS MI	58	Corewell (Priority)	22
Detroit-Warren-Dearborn, MI	3175	BCBS MI	50	Corewell (Priority)	18
Flint, MI	3105	BCBS MI	49	Corewell (Priority)	18
Grand Rapids-Kentwood, MI	3016	BCBS MI	48	Corewell (Priority)	18
Jackson, MI	4255	BCBS MI	58	Corewell (Priority)	21
Kalamazoo-Portage, MI	3734	BCBS MI	54	Corewell (Priority)	20

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lansing-East Lansing, MI	3530	BCBS MI	53	Corewell (Priority)	19
Midland, MI	5754	BCBS MI	71	Corewell (Priority)	26
Monroe, MI	3988	BCBS MI	56	Corewell (Priority)	21
Muskegon, MI	3219	BCBS MI	50	Corewell (Priority)	18
Niles, MI	4257	BCBS MI	58	Corewell (Priority)	21
Saginaw, MI	4205	BCBS MI	58	Corewell (Priority)	22
Minnesota	2972	UCare	44	BCBS MN	22
Duluth, MN-WI	2685	UCare	43	HealthPartners	18
Mankato, MN	4137	UCare	56	BCBS MN	28
Minneapolis-St. Paul-Bloomington, MN-WI	3168	UCare	47	HealthPartners	23
Rochester, MN	3124	BCBS MN	41	Quartz	28
St. Cloud, MN	3330	UCare	49	HealthPartners	23
Mississippi	7738	Centene	88	Cigna	5
Gulfport-Biloxi, MS	6020	Centene	76	Cigna	17
Hattiesburg, MS	7267	Centene	85	Cigna	7
Jackson, MS	8240	Centene	91	UnitedHealth Group	4
Missouri	3256	Centene	51	Elevance Health	24
Cape Girardeau, MO-IL	5737	Centene	71	Elevance Health	27
Columbia, MO	3547	Centene	47	Elevance Health	33
Jefferson City, MO	4887	Elevance Health	60	Centene	35
Joplin, MO	6303	Centene	78	UnitedHealth Group	10
Kansas City, MO-KS	3607	Centene	56	CVS (Aetna)	18
Springfield, MO	5506	Centene	73	UnitedHealth Group	10
St. Joseph, MO-KS	7621	Centene	87	BCBS KS City	8
St. Louis, MO-IL	2428	Elevance Health	36	Centene	30
Montana	3660	HCSC (BCBS)	42	Montana Health CO-OP	39
Billings, MT	3659	HCSC (BCBS)	42	Montana Health CO-OP	39
Great Falls, MT	3660	HCSC (BCBS)	42	Montana Health CO-OP	39
Missoula, MT	3660	HCSC (BCBS)	42	Montana Health CO-OP	39
Nebraska	3572	Centene	43	Medica	39
Grand Island, NE	3572	Centene	42	Medica	39
Lincoln, NE	3572	Centene	42	Medica	39
Omaha-Council Bluffs, NE-IA	3159	Centene	39	Medica	37
Nevada	3070	UnitedHealth Group	49	Centene	22
Carson City, NV	3831	Centene	49	Elevance Health	35
Las Vegas-Henderson-Paradise, NV	4025	UnitedHealth Group	60	Centene	17
Reno, NV	1991	Centene	25	UnitedHealth Group	25
New Hampshire	5093	Elevance Health	63	Centene	33
Manchester-Nashua, NH	5192	Elevance Health	65	Centene	30

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
New Jersey	3778	Horizon BCBS	43	Independence Hlth Grp	43
Atlantic City-Hammonton, NJ	4367	Horizon BCBS	46	Independence Hlth Grp	46
Ocean City, NJ	5000	Horizon BCBS	50	Independence Hlth Grp	50
Trenton-Princeton, NJ	3666	Horizon BCBS	42	Independence Hlth Grp	42
Vineland-Bridgeton, NJ	4211	Independence Hlth Grp	45	Horizon BCBS	45
New Mexico	3270	HCSC (BCBS)	48	Presbyterian	25
Albuquerque, NM	3802	HCSC (BCBS)	51	Presbyterian	32
Farmington, NM	3951	HCSC (BCBS)	55	Molina Hlthcare	27
Las Cruces, NM	3276	Molina Hlthcare	35	HCSC (BCBS)	34
Santa Fe, NM	4874	Presbyterian	65	HCSC (BCBS)	23
New York	2188	Centene	41	Healthfirst	15
Albany-Schenectady-Troy, NY	3047	Centene	44	CDPHP	23
Binghamton, NY	4859	Centene	58	Lifetime Hlthcare	39
Buffalo-Cheektowaga, NY	3934	Independent Hlth	54	Centene	27
Glens Falls, NY	4431	Centene	63	MVP Hlth Care	16
Ithaca, NY	8437	Lifetime Hlthcare	91	MVP Hlth Care	9
Kingston, NY	4472	Centene	62	MVP Hlth Care	20
New York-Newark-Jersey City, NY-NJ-PA	1873	Horizon BCBS	27	Independence Hlth Grp	27
Poughkeepsie-Newburgh-Middletown, NY	5092	Centene	68	MVP Hlth Care	20
Rochester, NY	3945	Lifetime Hlthcare	54	MVP Hlth Care	27
Syracuse, NY	4743	Centene	50	Lifetime Hlthcare	47
Utica-Rome, NY	4056	Centene	50	Lifetime Hlthcare	37
North Carolina	3279	BCBS NC	47	CVS (Aetna)	28
Asheville, NC	2724	BCBS NC	37	CVS (Aetna)	33
Burlington, NC	4176	BCBS NC	47	CVS (Aetna)	44
Charlotte-Concord-Gastonia, NC-SC	2768	CVS (Aetna)	35	BCBS NC	32
Durham-Chapel Hill, NC	3290	BCBS NC	39	CVS (Aetna)	38
Fayetteville, NC	3196	BCBS NC	38	CVS (Aetna)	36
Goldsboro, NC	5072	BCBS NC	66	CVS (Aetna)	26
Greensboro-High Point, NC	2575	BCBS NC	43	Centene	20
Greenville, NC	5313	BCBS NC	69	CVS (Aetna)	23
Hickory-Lenoir-Morganton, NC	3299	BCBS NC	49	Centene	27
Jacksonville, NC	9848	BCBS NC	99	Cigna	1
New Bern, NC	5876	BCBS NC	74	CVS (Aetna)	19
Raleigh-Cary, NC	3377	CVS (Aetna)	45	BCBS NC	32
Rocky Mount, NC	5765	BCBS NC	73	CVS (Aetna)	18
Wilmington, NC	8555	BCBS NC	92	UnitedHealth Group	8
Winston-Salem, NC	3809	BCBS NC	54	Centene	29

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
North Dakota	5495	BCBS ND	69	Sanford	26
Bismarck, ND	6001	BCBS ND	72	Sanford	28
Fargo, ND-MN	3672	BCBS ND	55	Sanford	21
Grand Forks, ND-MN	3837	BCBS ND	57	Sanford	22
Ohio	1616	Centene	25	CareSource	18
Akron, OH	1976	Centene	24	CareSource	22
Canton-Massillon, OH	2511	Aultman Hlth	45	CareSource	10
Cincinnati, OH-KY-IN	2513	Centene	41	Molina Hlthcare	19
Cleveland-Elyria, OH	1963	Medical Mutual	25	CareSource	22
Columbus, OH	2224	Elevance Health	36	Centene	19
Dayton-Kettering, OH	3450	Elevance Health	54	Centene	19
Lima, OH	3172	Centene	41	CareSource	31
Mansfield, OH	2695	Medical Mutual	35	Elevance Health	27
Springfield, OH	2852	Elevance Health	44	Centene	26
Toledo, OH	2500	CareSource	41	Centene	23
Weirton-Steubenville, WV-OH	4117	CareSource	60	Highmark	15
Youngstown-Warren-Boardman, OH-PA	1677	Centene	26	UPMC	21
Oklahoma	5365	HCSC (BCBS)	72	Oscar	7
Enid, OK	7477	HCSC (BCBS)	86	Friday Health	8
Lawton, OK	6228	HCSC (BCBS)	78	Centene	9
Oklahoma City, OK	4097	HCSC (BCBS)	60	Oscar	19
Tulsa, OK	4469	HCSC (BCBS)	65	St Francis-CommunityCare	12
Oregon	2118	Providence Hlth	28	Kaiser	22
Albany-Lebanon, OR	2973	Cambia	36	Providence Hlth	34
Bend, OR	3822	PacificSource	47	Cambia	36
Corvallis, OR	3022	Cambia	40	Providence Hlth	32
Eugene-Springfield, OR	2126	Kaiser	26	Cambia	25
Grants Pass, OR	6862	Moda Health	82	PacificSource	9
Medford, OR	5415	Moda Health	72	Providence Hlth	11
Portland-Vancouver-Hillsboro, OR-WA	2277	Kaiser	31	Providence Hlth	30
Salem, OR	3166	Kaiser	48	Providence Hlth	20
Pennsylvania	2204	Independence Hlth Grp	31	Highmark	26
Allentown-Bethlehem-Easton, PA-NJ	2621	Capital BC	44	Highmark	20
Altoona, PA	7141	UPMC	83	Highmark	14
Bloomsburg-Berwick, PA	4843	Geisinger	62	Capital BC	32
Chambersburg-Waynesboro, PA	4996	Capital BC	51	Highmark	49
East Stroudsburg, PA	3979	Highmark	55	Geisinger	28
Erie, PA	5005	UPMC	52	Highmark	48
Gettysburg, PA	4383	Capital BC	53	Highmark	39
Harrisburg-Carlisle, PA	4103	Capital BC	51	Highmark	38
Johnstown, PA	4976	UPMC	55	Highmark	44

Table A-3 (continued)
Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lancaster, PA	3859	Highmark	44	Capital BC	43
Lebanon, PA	4005	Highmark	45	Capital BC	44
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	5292	Independence Hlth Grp	71	Horizon BCBS	10
Pittsburgh, PA	5177	UPMC	59	Highmark	41
Reading, PA	3240	Highmark	43	Capital BC	31
Scranton—Wilkes-Barre, PA	4017	Highmark	51	Geisinger	36
State College, PA	3339	Capital BC	44	Geisinger	34
Williamsport, PA	3354	UPMC	37	Geisinger	33
York-Hanover, PA	4244	Capital BC	47	Highmark	45
Rhode Island	6209	Neighborhood HP	75	BCBS RI	25
Providence-Warwick, RI-MA	3079	Neighborhood HP	46	Point32Health	25
South Carolina	4804	BCBS SC	61	Centene	32
Charleston-North Charleston, SC	4692	BCBS SC	60	Centene	32
Columbia, SC	4781	BCBS SC	61	Centene	32
Florence, SC	4847	BCBS SC	61	Centene	32
Greenville-Anderson, SC	4940	BCBS SC	62	Centene	32
Hilton Head Island-Bluffton, SC	4846	BCBS SC	61	Centene	32
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	3180	BCBS SC	46	Centene	24
Spartanburg, SC	4846	BCBS SC	61	Centene	32
Sumter, SC	4845	BCBS SC	61	Centene	32
South Dakota	3648	Sanford	45	Avera Hlth	34
Rapid City, SD	6220	Wellmark (BCBS)	77	Sanford	13
Sioux Falls, SD	5103	Sanford	57	Avera Hlth	43
Tennessee	3443	Centene	51	BCBS TN	26
Chattanooga, TN-GA	4642	Centene	66	BCBS TN	14
Clarksville, TN-KY	2825	Centene	49	Cigna	11
Cleveland, TN	4582	Centene	64	BCBS TN	18
Jackson, TN	4062	Centene	59	BCBS TN	20
Johnson City, TN	4149	Centene	54	BCBS TN	33
Kingsport-Bristol, TN-VA	2709	Centene	38	BCBS TN	30
Knoxville, TN	3914	Centene	49	BCBS TN	37
Memphis, TN-MS-AR	3494	Centene	51	BCBS TN	26
Morristown, TN	4030	Centene	54	BCBS TN	31
Nashville-Davidson—Murfreesboro—Franklin, TN	3167	Centene	51	Cigna	17
Texas	1637	HCSC (BCBS)	28	Centene	19
Abilene, TX	5000	HCSC (BCBS)	50	Baylor Scott & White	50
Amarillo, TX	3542	Baylor Scott & White	45	HCSC (BCBS)	30
Austin-Round Rock-Georgetown, TX	1390	Ascension	20	CVS (Aetna)	17
Beaumont-Port Arthur, TX	2173	HCSC (BCBS)	30	Centene	24
Brownsville-Harlingen, TX	3525	HCSC (BCBS)	44	Centene	36
College Station-Bryan, TX	2616	HCSC (BCBS)	30	Baylor Scott & White	29

Table A-3 (continued)

Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Corpus Christi, TX	3269	CVS (Aetna)	41	CHRISTUS	37
Dallas-Fort Worth-Arlington, TX	1710	HCSC (BCBS)	26	Centene	20
El Paso, TX	4936	CVS (Aetna)	69	HCSC (BCBS)	9
Houston-The Woodlands-Sugar Land, TX	1781	HCSC (BCBS)	23	Centene	19
Killeen-Temple, TX	3452	Baylor Scott & White	44	HCSC (BCBS)	32
Laredo, TX	3525	HCSC (BCBS)	44	Centene	36
Longview, TX	5167	HCSC (BCBS)	66	Centene	28
Lubbock, TX	4085	HCSC (BCBS)	45	Baylor Scott & White	44
McAllen-Edinburg-Mission, TX	3525	HCSC (BCBS)	44	Centene	36
Midland, TX	5000	HCSC (BCBS)	50	Baylor Scott & White	50
Odessa, TX	3542	Baylor Scott & White	45	HCSC (BCBS)	30
San Angelo, TX	5049	HCSC (BCBS)	55	Centene	45
San Antonio-New Braunfels, TX	4323	CVS (Aetna)	63	HCSC (BCBS)	14
Sherman-Denison, TX	5049	HCSC (BCBS)	55	Centene	45
Texarkana, TX-AR	3156	CHRISTUS	46	HCSC (BCBS)	25
Tyler, TX	3446	HCSC (BCBS)	41	Centene	33
Victoria, TX	5050	HCSC (BCBS)	55	Centene	45
Waco, TX	3038	Baylor Scott & White	41	HCSC (BCBS)	28
Wichita Falls, TX	10000	HCSC (BCBS)	100	-	-
Utah	7607	Intermountain	87	Cambia	7
Logan, UT-ID	7916	Intermountain	88	Cambia	9
Ogden-Clearfield, UT	7335	Intermountain	85	Cambia	9
Provo-Orem, UT	7415	Intermountain	86	Cambia	9
Salt Lake City, UT	7192	Intermountain	84	Cambia	9
St. George, UT	9092	Intermountain	95	Univ of Utah Health	4
Vermont	5125	BCBS VT	58	MVP Hlth Care	42
Burlington-South Burlington, VT	5125	BCBS VT	58	MVP Hlth Care	42
Virginia	1759	Elevance Health	31	Sentara Health	15
Blacksburg-Christiansburg, VA	4266	Elevance Health	58	Centra (Piedmont)	23
Charlottesville, VA	3837	Elevance Health	50	Sentara Health	32
Harrisonburg, VA	5196	Sentara Health	60	Elevance Health	40
Lynchburg, VA	4200	Centra (Piedmont)	47	Elevance Health	43
Richmond, VA	2433	Elevance Health	33	Cigna	25
Roanoke, VA	3374	Elevance Health	49	Centra (Piedmont)	26
Staunton, VA	4616	Elevance Health	62	Centra (Piedmont)	23
Virginia Beach-Norfolk-Newport News, VA-NC	4254	Sentara Health	53	Elevance Health	38
Winchester, VA-WV	2903	Elevance Health	41	Cigna	26
Washington	1890	Centene	26	Kaiser	20
Bellingham, WA	3624	Kaiser	43	Premera	38
Bremerton-Silverdale-Port Orchard, WA	2174	Centene	29	Kaiser	23
Kennewick-Richland, WA	2620	Centene	40	Premera	23

Table A-3 (continued)

Market concentration (HHI) and largest insurers' market shares, as of July 1, 2023 *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Longview, WA	3231	Kaiser	46	Molina Hlthcare	27
Mount Vernon-Anacortes, WA	3802	Kaiser	50	Premera	30
Olympia-Lacey-Tumwater, WA	2032	Centene	29	Kaiser	22
Seattle-Tacoma-Bellevue, WA	2045	Centene	29	Molina Hlthcare	23
Spokane-Spokane Valley, WA	2851	Centene	43	Molina Hlthcare	25
Walla Walla, WA	2954	Centene	42	Premera	25
Wenatchee, WA	4145	Centene	55	Premera	30
Yakima, WA	2935	Centene	48	Community Hlth Plan	16
West Virginia	5469	Highmark	65	CareSource	35
Beckley, WV	5032	Highmark	54	CareSource	46
Charleston, WV	5387	Highmark	64	CareSource	36
Huntington-Ashland, WV-KY-OH	3691	Highmark	48	CareSource	36
Morgantown, WV	5700	Highmark	69	CareSource	31
Parkersburg-Vienna, WV	5133	CareSource	58	Highmark	42
Wheeling, WV-OH	3647	CareSource	55	Highmark	17
Wisconsin	1603	Common Ground	28	Medica	21
Appleton, WI	2862	Common Ground	47	Children's WI (CCHP)	17
Eau Claire, WI	4848	Marshfield (Security HP)	62	Medica	31
Fond du Lac, WI	4656	Medica	62	Common Ground	28
Green Bay, WI	3208	Common Ground	51	Children's WI (CCHP)	18
Janesville-Beloit, WI	2744	Medica	38	GHC of S.C. WI	25
La Crosse-Onalaska, WI-MN	4916	Quartz	63	Medica	30
Madison, WI	4823	Medica	66	GHC of S.C. WI	16
Milwaukee-Waukesha, WI	3008	Common Ground	46	Elevance Health	26
Oshkosh-Neenah, WI	2882	Common Ground	48	Children's WI (CCHP)	17
Racine, WI	3399	Common Ground	52	Elevance Health	18
Sheboygan, WI	4497	Common Ground	64	Children's WI (CCHP)	19
Wausau-Weston, WI	2633	Aspirus Health	40	Marshfield (Security HP)	24
Wyoming	6109	BCBS WY	74	Montana Health CO-OP	26
Casper, WY	6109	BCBS WY	74	Montana Health CO-OP	26
Cheyenne, WY	6108	BCBS WY	74	Montana Health CO-OP	26

Notes:

1. Source: Managed Market Surveyor | Data Extraction | Enterprise License © 2023 DR/Decision Resources, LLC. All rights reserved.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the exchange are reported.
3. We do not present data for geographic areas with fewer than 1,000 reported exchange enrollees.

Table A-4. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023

Medicare Advantage (MA) markets

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	2662	UnitedHealth Group	43	BCBS AL	18
Anniston-Oxford, AL	2844	UnitedHealth Group	43	Triton (Viva Hlth)	24
Auburn-Opelika, AL	3172	Humana	42	UnitedHealth Group	34
Birmingham-Hoover, AL	2441	UnitedHealth Group	38	BCBS AL	22
Daphne-Fairhope-Foley, AL	3147	UnitedHealth Group	47	BCBS AL	21
Decatur, AL	2634	UnitedHealth Group	42	BCBS AL	21
Dothan, AL	3989	UnitedHealth Group	59	Humana	18
Florence-Muscle Shoals, AL	2645	UnitedHealth Group	38	Humana	26
Gadsden, AL	2011	UnitedHealth Group	28	Humana	22
Huntsville, AL	2775	UnitedHealth Group	44	BCBS AL	19
Mobile, AL	2964	UnitedHealth Group	47	Humana	20
Montgomery, AL	3718	UnitedHealth Group	57	Triton (Viva Hlth)	17
Tuscaloosa, AL	2804	Humana	38	UnitedHealth Group	32
Arizona	2847	UnitedHealth Group	48	Humana	19
Flagstaff, AZ	3203	UnitedHealth Group	47	Humana	29
Lake Havasu City-Kingman, AZ	3373	Humana	52	UnitedHealth Group	20
Phoenix-Mesa-Chandler, AZ	2828	UnitedHealth Group	48	Humana	17
Prescott Valley-Prescott, AZ	2848	UnitedHealth Group	46	Humana	21
Sierra Vista-Douglas, AZ	2635	Centene	41	Humana	20
Tucson, AZ	4380	UnitedHealth Group	65	Humana	11
Yuma, AZ	2347	Centene	26	Banner Health	26
Arkansas	2790	UnitedHealth Group	42	Humana	26
Fayetteville-Springdale-Rogers, AR	2705	Humana	36	UnitedHealth Group	31
Fort Smith, AR-OK	2948	Humana	41	UnitedHealth Group	32
Hot Springs, AR	2522	UnitedHealth Group	39	Humana	22
Jonesboro, AR	2470	UnitedHealth Group	34	Humana	27
Little Rock-North Little Rock-Conway, AR	2886	UnitedHealth Group	46	Humana	20
Pine Bluff, AR	4168	UnitedHealth Group	58	Humana	25
California	2386	Kaiser	43	UnitedHealth Group	17
Bakersfield, CA	1830	Kaiser	34	Elevance Health	15
Chico, CA	5763	Elevance Health	73	UnitedHealth Group	21
El Centro, CA	4388	Bright Health	63	UnitedHealth Group	13
Fresno, CA	2101	Kaiser	37	Bright Health	20
Hanford-Corcoran, CA	2613	Humana	43	UnitedHealth Group	17
Los Angeles-Long Beach-Anaheim, CA	1912	Kaiser	35	SCAN	16
Madera, CA	3079	Kaiser	51	UnitedHealth Group	13
Merced, CA	3435	UnitedHealth Group	50	Imperial Health	23
Modesto, CA	2268	Kaiser	30	Alignment Hlth	28
Napa, CA	6780	Kaiser	82	UnitedHealth Group	6
Oxnard-Thousand Oaks-Ventura, CA	2220	Kaiser	41	Elevance Health	15
Redding, CA	4911	Elevance Health	61	UnitedHealth Group	34

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Riverside-San Bernardino-Ontario, CA	2090	Kaiser	35	UnitedHealth Group	20
Sacramento-Roseville-Folsom, CA	4153	Kaiser	61	UnitedHealth Group	20
Salinas, CA	5838	Montage Health	75	UnitedHealth Group	10
San Diego-Chula Vista-Carlsbad, CA	2141	Kaiser	36	UnitedHealth Group	26
San Francisco-Oakland-Berkeley, CA	4898	Kaiser	68	UnitedHealth Group	15
San Jose-Sunnyvale-Santa Clara, CA	4007	Kaiser	61	Elevance Health	10
San Luis Obispo-Paso Robles, CA	2311	UnitedHealth Group	31	Alignment Hlth	28
Santa Cruz-Watsonville, CA	3293	UnitedHealth Group	46	Kaiser	29
Santa Maria-Santa Barbara, CA	3371	BS of CA	43	UnitedHealth Group	38
Santa Rosa-Petaluma, CA	5992	Kaiser	76	UnitedHealth Group	12
Stockton, CA	2818	Kaiser	49	Humana	10
Vallejo, CA	6879	Kaiser	82	UnitedHealth Group	10
Visalia, CA	3526	Humana	55	UnitedHealth Group	15
Yuba City, CA	3291	Elevance Health	48	Kaiser	27
Colorado	3374	UnitedHealth Group	50	Kaiser	23
Boulder, CO	3857	UnitedHealth Group	53	Kaiser	31
Colorado Springs, CO	3615	UnitedHealth Group	53	Humana	25
Denver-Aurora-Lakewood, CO	3486	UnitedHealth Group	48	Kaiser	33
Fort Collins, CO	4023	UnitedHealth Group	58	Humana	22
Grand Junction, CO	3323	UnitedHealth Group	44	Humana	33
Greeley, CO	3242	UnitedHealth Group	47	Humana	28
Pueblo, CO	4240	UnitedHealth Group	60	Humana	23
Connecticut	2721	UnitedHealth Group	37	CVS (Aetna)	33
Bridgeport-Stamford-Norwalk, CT	3046	UnitedHealth Group	42	CVS (Aetna)	33
Hartford-East Hartford-Middletown, CT	2685	UnitedHealth Group	38	CVS (Aetna)	31
New Haven-Milford, CT	2597	CVS (Aetna)	36	UnitedHealth Group	30
Norwich-New London, CT	2833	UnitedHealth Group	43	CVS (Aetna)	26
Delaware	2669	UnitedHealth Group	37	CVS (Aetna)	27
Dover, DE	2738	UnitedHealth Group	38	Humana	26
District of Columbia	3843	UnitedHealth Group	53	Kaiser	31
Washington-Arlington-Alexandria, DC-VA-MD-WV	2545	Kaiser	35	UnitedHealth Group	32
Florida	2055	Humana	31	UnitedHealth Group	29
Cape Coral-Fort Myers, FL	2799	UnitedHealth Group	45	Humana	18
Crestview-Fort Walton Beach-Destin, FL	3093	UnitedHealth Group	49	Humana	22
Deltona-Daytona Beach-Ormond Beach, FL	2571	Humana	40	UnitedHealth Group	25
Gainesville, FL	3203	UnitedHealth Group	43	Humana	34
Homosassa Springs, FL	1942	UnitedHealth Group	27	Humana	26
Jacksonville, FL	2459	UnitedHealth Group	38	Humana	24
Lakeland-Winter Haven, FL	2201	Humana	36	UnitedHealth Group	25
Miami-Fort Lauderdale-Pompano Beach, FL	2084	Humana	35	UnitedHealth Group	23
Naples-Marco Island, FL	2780	UnitedHealth Group	42	CVS (Aetna)	23

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
North Port-Sarasota-Bradenton, FL	2429	UnitedHealth Group	32	CVS (Aetna)	29
Ocala, FL	2357	UnitedHealth Group	36	Humana	26
Orlando-Kissimmee-Sanford, FL	2237	Humana	35	UnitedHealth Group	25
Palm Bay-Melbourne-Titusville, FL	2258	Health First Hlth	34	UnitedHealth Group	25
Panama City, FL	2712	UnitedHealth Group	39	Humana	28
Pensacola-Ferry Pass-Brent, FL	2113	UnitedHealth Group	33	Humana	19
Port St. Lucie, FL	2468	Humana	37	UnitedHealth Group	29
Punta Gorda, FL	2494	UnitedHealth Group	35	CVS (Aetna)	26
Sebastian-Vero Beach, FL	2407	UnitedHealth Group	42	Humana	18
Sebring-Avon Park, FL	3453	UnitedHealth Group	48	Humana	32
Tallahassee, FL	4044	BCBS FL	56	UnitedHealth Group	27
Tampa-St. Petersburg-Clearwater, FL	2102	Humana	34	UnitedHealth Group	23
The Villages, FL	3872	UnitedHealth Group	59	BCBS FL	12
Georgia	2422	UnitedHealth Group	34	Humana	31
Albany, GA	2959	UnitedHealth Group	38	Humana	32
Athens-Clarke County, GA	2872	Humana	40	UnitedHealth Group	32
Atlanta-Sandy Springs-Alpharetta, GA	2096	Humana	31	UnitedHealth Group	26
Augusta-Richmond County, GA-SC	2931	Humana	37	UnitedHealth Group	36
Brunswick, GA	2736	UnitedHealth Group	34	Humana	34
Columbus, GA-AL	2717	Humana	35	UnitedHealth Group	34
Dalton, GA	4342	Humana	50	UnitedHealth Group	42
Gainesville, GA	2693	UnitedHealth Group	36	CVS (Aetna)	27
Hinesville, GA	2777	Humana	42	UnitedHealth Group	24
Macon-Bibb County, GA	3001	UnitedHealth Group	42	Humana	33
Rome, GA	3002	UnitedHealth Group	38	Humana	36
Savannah, GA	2448	Humana	32	UnitedHealth Group	31
Valdosta, GA	3941	UnitedHealth Group	55	Humana	26
Warner Robins, GA	3132	UnitedHealth Group	41	Humana	36
Hawaii	2192	UnitedHealth Group	28	HMSA (BCBS HI)	24
Kahului-Wailuku-Lahaina, HI	2676	Kaiser	36	Humana	31
Urban Honolulu, HI	2340	UnitedHealth Group	32	HMSA (BCBS HI)	25
Idaho	2349	UnitedHealth Group	33	BC of ID	32
Boise City, ID	2831	UnitedHealth Group	46	BC of ID	23
Coeur d'Alene, ID	1916	BC of ID	29	UnitedHealth Group	18
Idaho Falls, ID	4211	BC of ID	60	UnitedHealth Group	24
Lewiston, ID-WA	3863	Cambia	55	BC of ID	24
Pocatello, ID	4260	BC of ID	61	UnitedHealth Group	20
Twin Falls, ID	2352	BC of ID	35	UnitedHealth Group	22
Illinois	2008	Humana	29	UnitedHealth Group	23
Bloomington, IL	2517	Humana	38	CVS (Aetna)	23
Carbondale-Marion, IL	1678	Carle Health	21	UnitedHealth Group	19

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Champaign-Urbana, IL	4785	Carle Health	67	Centene	11
Chicago-Naperville-Elgin, IL-IN-WI	2065	Humana	33	UnitedHealth Group	22
Danville, IL	3649	Carle Health	56	CVS (Aetna)	15
Davenport-Moline-Rock Island, IA-IL	3496	UnitedHealth Group	53	CVS (Aetna)	21
Decatur, IL	4413	CVS (Aetna)	64	Humana	16
Kankakee, IL	1787	Humana	26	CVS (Aetna)	21
Peoria, IL	2725	Humana	43	CVS (Aetna)	23
Rockford, IL	3129	CVS (Aetna)	45	Humana	28
Springfield, IL	3961	CVS (Aetna)	59	Humana	17
Indiana	2747	UnitedHealth Group	38	Humana	27
Bloomington, IN	2328	UnitedHealth Group	31	Humana	26
Columbus, IN	3250	Humana	42	UnitedHealth Group	31
Elkhart-Goshen, IN	3393	UnitedHealth Group	44	Humana	32
Evansville, IN-KY	2665	Humana	34	UnitedHealth Group	31
Fort Wayne, IN	3135	UnitedHealth Group	44	Humana	31
Indianapolis-Carmel-Anderson, IN	2895	UnitedHealth Group	43	Humana	24
Kokomo, IN	3003	UnitedHealth Group	43	Humana	24
Lafayette-West Lafayette, IN	2456	UnitedHealth Group	34	Humana	26
Michigan City-La Porte, IN	2631	Elevance Health	34	Humana	28
Muncie, IN	2468	UnitedHealth Group	33	Humana	29
South Bend-Mishawaka, IN-MI	2804	UnitedHealth Group	43	Humana	25
Terre Haute, IN	2936	Elevance Health	38	UnitedHealth Group	31
Iowa	2911	UnitedHealth Group	43	CVS (Aetna)	27
Ames, IA	3293	UnitedHealth Group	45	CVS (Aetna)	30
Cedar Rapids, IA	2613	CVS (Aetna)	34	UnitedHealth Group	29
Davenport-Moline-Rock Island, IA-IL	3496	UnitedHealth Group	53	CVS (Aetna)	21
Des Moines-West Des Moines, IA	3423	UnitedHealth Group	47	CVS (Aetna)	32
Dubuque, IA	6652	Medical Associates	79	UnitedHealth Group	19
Iowa City, IA	2468	UnitedHealth Group	36	CVS (Aetna)	27
Sioux City, IA-NE-SD	3137	CVS (Aetna)	41	UnitedHealth Group	34
Waterloo-Cedar Falls, IA	5000	UnitedHealth Group	68	CVS (Aetna)	13
Kansas	2737	UnitedHealth Group	39	CVS (Aetna)	25
Lawrence, KS	3254	UnitedHealth Group	45	CVS (Aetna)	27
Manhattan, KS	4413	Humana	63	UnitedHealth Group	17
Topeka, KS	2716	CVS (Aetna)	34	Humana	31
Wichita, KS	3012	UnitedHealth Group	40	CVS (Aetna)	32
Kentucky	2876	Humana	43	Elevance Health	24
Bowling Green, KY	2699	Humana	40	UnitedHealth Group	20
Elizabethtown-Fort Knox, KY	2628	Humana	38	Elevance Health	27
Lexington-Fayette, KY	3138	Humana	47	UnitedHealth Group	24
Louisville/Jefferson County, KY-IN	3022	Humana	45	Elevance Health	24
Owensboro, KY	2913	Humana	40	Elevance Health	30

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Louisiana	3371	Humana	48	UnitedHealth Group	30
Alexandria, LA	2599	Humana	42	UnitedHealth Group	16
Baton Rouge, LA	3836	Humana	53	UnitedHealth Group	30
Hammond, LA	3646	Humana	47	UnitedHealth Group	36
Houma-Thibodaux, LA	3893	UnitedHealth Group	53	Humana	31
Lafayette, LA	2717	Humana	42	UnitedHealth Group	25
Lake Charles, LA	3822	Humana	56	CVS (Aetna)	16
Monroe, LA	3086	BCBS LA	40	Humana	32
New Orleans-Metairie, LA	3983	Humana	50	UnitedHealth Group	38
Shreveport-Bossier City, LA	3614	Humana	52	UnitedHealth Group	24
Maine	1965	Martin's Point HC	30	UnitedHealth Group	20
Bangor, ME	1758	Martin's Point HC	24	Centene	19
Lewiston-Auburn, ME	2232	Martin's Point HC	37	UnitedHealth Group	19
Portland-South Portland, ME	2460	Martin's Point HC	38	CVS (Aetna)	21
Maryland	2166	Kaiser	33	UnitedHealth Group	28
Baltimore-Columbia-Towson, MD	1778	Kaiser	25	UnitedHealth Group	23
California-Lexington Park, MD	7355	UnitedHealth Group	85	CVS (Aetna)	13
Cumberland, MD-WV	4475	Humana	64	UnitedHealth Group	15
Hagerstown-Martinsburg, MD-WV	3240	Humana	48	UnitedHealth Group	26
Salisbury, MD-DE	2022	UnitedHealth Group	32	CVS (Aetna)	22
Massachusetts	1845	UnitedHealth Group	26	Point32Health	26
Barnstable Town, MA	2757	BCBS MA	37	Point32Health	33
Boston-Cambridge-Newton, MA-NH	2175	UnitedHealth Group	32	Point32Health	29
Pittsfield, MA	2437	UnitedHealth Group	36	Baystate	28
Springfield, MA	1720	CCA	25	BCBS MA	21
Worcester, MA-CT	1567	Point32Health	22	UnitedHealth Group	19
Michigan	2515	BCBS MI	43	Corewell (Priority)	19
Ann Arbor, MI	3725	BCBS MI	59	Corewell (Priority)	9
Battle Creek, MI	2044	BCBS MI	34	Corewell (Priority)	18
Bay City, MI	3010	BCBS MI	51	Henry Ford HS	13
Detroit-Warren-Dearborn, MI	2646	BCBS MI	47	Henry Ford HS	12
Flint, MI	3092	BCBS MI	51	Henry Ford HS	17
Grand Rapids-Kentwood, MI	4413	Corewell (Priority)	62	BCBS MI	23
Jackson, MI	3176	BCBS MI	50	Humana	21
Kalamazoo-Portage, MI	2462	Corewell (Priority)	33	BCBS MI	32
Lansing-East Lansing, MI	4174	BCBS MI	60	Humana	22
Midland, MI	2960	BCBS MI	43	CVS (Aetna)	27
Monroe, MI	2633	BCBS MI	46	Humana	16
Muskegon, MI	2631	Corewell (Priority)	37	BCBS MI	30
Niles, MI	2299	BCBS MI	31	Humana	29
Saginaw, MI	2350	BCBS MI	43	Henry Ford HS	13

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Minnesota	2070	BCBS MN	34	UCare	22
Duluth, MN-WI	2102	BCBS MN	34	Medica	23
Mankato, MN	2261	UCare	30	BCBS MN	30
Minneapolis-St. Paul-Bloomington, MN-WI	1798	BCBS MN	25	UCare	25
Rochester, MN	2483	BCBS MN	36	UCare	23
St. Cloud, MN	3729	BCBS MN	55	UCare	24
Mississippi	3201	Humana	49	UnitedHealth Group	21
Gulfport-Biloxi, MS	4301	Humana	62	UnitedHealth Group	16
Hattiesburg, MS	3617	Humana	49	Cigna	32
Jackson, MS	3300	Humana	44	Centene	32
Missouri	3094	UnitedHealth Group	51	CVS (Aetna)	14
Cape Girardeau, MO-IL	4598	UnitedHealth Group	64	Elevance Health	19
Columbia, MO	5421	UnitedHealth Group	72	Elevance Health	12
Jefferson City, MO	6140	UnitedHealth Group	77	Elevance Health	12
Joplin, MO	2653	UnitedHealth Group	40	Humana	21
Kansas City, MO-KS	2853	UnitedHealth Group	43	CVS (Aetna)	19
Springfield, MO	2359	UnitedHealth Group	35	Humana	21
St. Joseph, MO-KS	5462	UnitedHealth Group	72	BCBS KS City	15
St. Louis, MO-IL	3130	UnitedHealth Group	49	Lumeris	18
Montana	4618	Humana	63	HCSC (BCBS)	23
Billings, MT	4642	Humana	65	HCSC (BCBS)	14
Great Falls, MT	5677	Humana	71	HCSC (BCBS)	26
Missoula, MT	3890	Humana	50	HCSC (BCBS)	35
Nebraska	3652	UnitedHealth Group	57	CVS (Aetna)	15
Grand Island, NE	3718	UnitedHealth Group	55	Medica	24
Lincoln, NE	4388	UnitedHealth Group	63	CVS (Aetna)	16
Omaha-Council Bluffs, NE-IA	4366	UnitedHealth Group	62	CVS (Aetna)	18
Nevada	2475	UnitedHealth Group	38	Humana	28
Carson City, NV	2508	UHS (Prominence HP)	36	CVS (Aetna)	27
Las Vegas-Henderson-Paradise, NV	3352	UnitedHealth Group	46	Humana	33
Reno, NV	2543	Renown Hlth	41	UHS (Prominence HP)	23
New Hampshire	2167	UnitedHealth Group	38	CVS (Aetna)	17
Manchester-Nashua, NH	2040	UnitedHealth Group	35	Humana	15
New Jersey	2536	CVS (Aetna)	35	UnitedHealth Group	33
Atlantic City-Hammonton, NJ	2179	CVS (Aetna)	35	Clover Health	22
Ocean City, NJ	4007	CVS (Aetna)	60	UnitedHealth Group	15
Trenton-Princeton, NJ	3448	CVS (Aetna)	52	UnitedHealth Group	25
Vineland-Bridgeton, NJ	2547	CVS (Aetna)	44	Clover Health	15
New Mexico	2081	Presbyterian	27	Humana	25
Albuquerque, NM	2367	Presbyterian	40	Humana	18
Farmington, NM	2921	Humana	48	UnitedHealth Group	21

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Las Cruces, NM	4114	UnitedHealth Group	61	Humana	16
Santa Fe, NM	1855	UnitedHealth Group	26	Humana	23
New York	1224	UnitedHealth Group	24	Healthfirst	13
Albany-Schenectady-Troy, NY	2152	CDPHP	39	Humana	16
Binghamton, NY	2177	UnitedHealth Group	31	Lifetime Hlthcare	25
Buffalo-Cheektowaga, NY	2374	Independent Hlth	33	Highmark	28
Elmira, NY	2019	Lifetime Hlthcare	26	UnitedHealth Group	25
Glens Falls, NY	1767	Humana	26	UnitedHealth Group	20
Ithaca, NY	3361	CVS (Aetna)	42	Lifetime Hlthcare	38
Kingston, NY	2608	UnitedHealth Group	39	MVP Hlth Care	23
New York-Newark-Jersey City, NY-NJ-PA	1654	UnitedHealth Group	28	CVS (Aetna)	19
Poughkeepsie-Newburgh-Middletown, NY	2731	UnitedHealth Group	45	CVS (Aetna)	20
Rochester, NY	3003	Lifetime Hlthcare	45	UnitedHealth Group	27
Syracuse, NY	2198	UnitedHealth Group	32	Lifetime Hlthcare	22
Utica-Rome, NY	2381	Lifetime Hlthcare	36	Centene	24
Watertown-Fort Drum, NY	2333	UnitedHealth Group	34	Lifetime Hlthcare	23
North Carolina	**2767**	**Humana**	**39**	**UnitedHealth Group**	**31**
Asheville, NC	3159	Humana	42	UnitedHealth Group	35
Burlington, NC	2511	UnitedHealth Group	34	Humana	31
Charlotte-Concord-Gastonia, NC-SC	2712	UnitedHealth Group	36	Humana	32
Durham-Chapel Hill, NC	2745	Humana	39	UnitedHealth Group	28
Fayetteville, NC	2854	UnitedHealth Group	37	Humana	36
Goldsboro, NC	3224	Humana	44	UnitedHealth Group	32
Greensboro-High Point, NC	2612	UnitedHealth Group	38	Humana	28
Greenville, NC	3443	Humana	51	UnitedHealth Group	21
Hickory-Lenoir-Morganton, NC	2720	Humana	38	UnitedHealth Group	28
Jacksonville, NC	4611	Humana	63	UnitedHealth Group	22
New Bern, NC	3923	Humana	55	UnitedHealth Group	27
Raleigh-Cary, NC	2769	Humana	39	UnitedHealth Group	29
Rocky Mount, NC	2701	Humana	34	UnitedHealth Group	31
Wilmington, NC	5396	Humana	71	BCBS NC	14
Winston-Salem, NC	2876	UnitedHealth Group	38	Humana	35
North Dakota	3254	Medica	51	BCBS ND	17
Bismarck, ND	2853	Medica	46	Humana	16
Fargo, ND-MN	1854	Medica	30	Humana	22
Grand Forks, ND-MN	2067	Medica	27	Humana	25
Ohio	1819	Elevance Health	25	UnitedHealth Group	23
Akron, OH	1830	UnitedHealth Group	28	Elevance Health	22
Canton-Massillon, OH	1585	UnitedHealth Group	24	Aultman Hlth	17
Cincinnati, OH-KY-IN	2147	Humana	26	UnitedHealth Group	25
Cleveland-Elyria, OH	2005	UnitedHealth Group	31	Elevance Health	25

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Columbus, OH	1843	CVS (Aetna)	28	Elevance Health	19
Dayton-Kettering, OH	2703	Elevance Health	45	UnitedHealth Group	17
Lima, OH	2330	Elevance Health	32	UnitedHealth Group	25
Mansfield, OH	2233	UnitedHealth Group	28	Humana	25
Springfield, OH	1991	UnitedHealth Group	33	Elevance Health	20
Toledo, OH	1815	CVS (Aetna)	27	UnitedHealth Group	20
Weirton-Steubenville, WV-OH	1990	CVS (Aetna)	28	Humana	23
Youngstown-Warren-Boardman, OH-PA	2006	UnitedHealth Group	30	CVS (Aetna)	23
Oklahoma	3388	UnitedHealth Group	51	Humana	24
Enid, OK	2896	UnitedHealth Group	45	Humana	19
Lawton, OK	4623	Humana	58	UnitedHealth Group	35
Oklahoma City, OK	4309	UnitedHealth Group	61	Humana	23
Tulsa, OK	3098	UnitedHealth Group	43	St Francis-CommunityCare	31
Oregon	1496	UnitedHealth Group	27	Kaiser	16
Albany-Lebanon, OR	3087	UnitedHealth Group	50	Centene	15
Bend, OR	3651	PacificSource	57	Humana	18
Corvallis, OR	3540	UnitedHealth Group	56	Samaritan Hlth	15
Eugene-Springfield, OR	3426	UnitedHealth Group	54	Cambia	16
Grants Pass, OR	2383	Cambia	38	Centene	23
Medford, OR	2679	Cambia	43	CVS (Aetna)	21
Portland-Vancouver-Hillsboro, OR-WA	1967	Kaiser	29	UnitedHealth Group	25
Salem, OR	1876	UnitedHealth Group	30	Kaiser	22
Pennsylvania	1561	CVS (Aetna)	27	Highmark	18
Allentown-Bethlehem-Easton, PA-NJ	1825	CVS (Aetna)	25	Highmark	23
Altoona, PA	2913	UPMC	46	Highmark	21
Bloomsburg-Berwick, PA	5532	Geisinger	72	CVS (Aetna)	19
Chambersburg-Waynesboro, PA	2223	CVS (Aetna)	34	Highmark	23
East Stroudsburg, PA	2085	CVS (Aetna)	29	Geisinger	24
Erie, PA	2980	CVS (Aetna)	46	Highmark	20
Gettysburg, PA	2583	CVS (Aetna)	41	Highmark	26
Harrisburg-Carlisle, PA	2443	CVS (Aetna)	38	Highmark	28
Johnstown, PA	3618	UPMC	54	Highmark	20
Lancaster, PA	2418	CVS (Aetna)	37	Highmark	28
Lebanon, PA	2881	Highmark	38	CVS (Aetna)	36
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	1876	CVS (Aetna)	28	Independence Hlth Grp	25
Pittsburgh, PA	2616	UPMC	31	CVS (Aetna)	29
Reading, PA	1909	CVS (Aetna)	27	Highmark	25
Scranton--Wilkes-Barre, PA	2940	Geisinger	47	CVS (Aetna)	21
State College, PA	2910	Highmark	39	Geisinger	33
Williamsport, PA	2712	Geisinger	40	CVS (Aetna)	29
York-Hanover, PA	2620	CVS (Aetna)	43	Highmark	23

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Rhode Island	4682	BCBS RI	58	UnitedHealth Group	37
Providence-Warwick, RI-MA	3193	BCBS RI	43	UnitedHealth Group	36
South Carolina	2834	Humana	38	UnitedHealth Group	34
Charleston-North Charleston, SC	2931	Humana	38	UnitedHealth Group	36
Columbia, SC	2771	Humana	36	UnitedHealth Group	35
Florence, SC	3334	UnitedHealth Group	40	Humana	40
Greenville-Anderson, SC	2784	Humana	41	UnitedHealth Group	24
Hilton Head Island-Bluffton, SC	3279	UnitedHealth Group	47	Humana	28
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	2763	Humana	40	UnitedHealth Group	29
Spartanburg, SC	2883	Humana	47	UnitedHealth Group	19
Sumter, SC	3615	UnitedHealth Group	51	Humana	29
South Dakota	3465	Medica	53	Humana	19
Rapid City, SD	3325	Medica	39	Humana	38
Sioux Falls, SD	2722	Medica	43	UnitedHealth Group	24
Tennessee	2146	UnitedHealth Group	28	Humana	26
Chattanooga, TN-GA	2407	BCBS TN	35	UnitedHealth Group	23
Clarksville, TN-KY	1829	Humana	29	UnitedHealth Group	19
Cleveland, TN	2571	BCBS TN	33	UnitedHealth Group	27
Jackson, TN	2083	BCBS TN	29	UnitedHealth Group	24
Johnson City, TN	4629	UnitedHealth Group	64	Humana	17
Kingsport-Bristol, TN-VA	3129	UnitedHealth Group	40	Humana	28
Knoxville, TN	3727	Humana	53	UnitedHealth Group	26
Memphis, TN-MS-AR	1876	Humana	28	UnitedHealth Group	24
Morristown, TN	3171	Humana	42	UnitedHealth Group	34
Nashville-Davidson--Murfreesboro--Franklin, TN	1952	Cigna	29	UnitedHealth Group	21
Texas	3023	UnitedHealth Group	50	Humana	18
Abilene, TX	4379	UnitedHealth Group	55	Humana	36
Amarillo, TX	4275	UnitedHealth Group	58	Humana	29
Austin-Round Rock-Georgetown, TX	3446	UnitedHealth Group	52	Humana	24
Beaumont-Port Arthur, TX	2080	UnitedHealth Group	31	Centene	24
Brownsville-Harlingen, TX	3094	UnitedHealth Group	40	Cigna	36
College Station-Bryan, TX	3584	UnitedHealth Group	50	Humana	30
Corpus Christi, TX	5186	UnitedHealth Group	68	Humana	24
Dallas-Fort Worth-Arlington, TX	3884	UnitedHealth Group	59	Humana	16
El Paso, TX	3149	UnitedHealth Group	51	Humana	17
Houston-The Woodlands-Sugar Land, TX	2017	UnitedHealth Group	38	Centene	13
Killeen-Temple, TX	3169	UnitedHealth Group	41	Baylor Scott and White	31
Laredo, TX	2878	UnitedHealth Group	48	CVS (Aetna)	14
Longview, TX	3643	UnitedHealth Group	50	Humana	32
Lubbock, TX	3310	UnitedHealth Group	51	Humana	19
McAllen-Edinburg-Mission, TX	2519	UnitedHealth Group	38	Cigna	27

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Midland, TX	4235	UnitedHealth Group	55	Humana	32
Odessa, TX	3980	UnitedHealth Group	53	Humana	32
San Angelo, TX	4328	UnitedHealth Group	58	Humana	28
San Antonio-New Braunfels, TX	3630	UnitedHealth Group	56	Humana	20
Sherman-Denison, TX	4562	UnitedHealth Group	62	Humana	25
Texarkana, TX-AR	4963	Humana	62	UnitedHealth Group	33
Tyler, TX	3094	UnitedHealth Group	49	Humana	23
Victoria, TX	4364	UnitedHealth Group	60	Humana	25
Waco, TX	3727	UnitedHealth Group	55	Humana	20
Wichita Falls, TX	5291	UnitedHealth Group	66	Humana	31
Utah	3270	UnitedHealth Group	53	Intermountain	17
Logan, UT-ID	5144	UnitedHealth Group	70	Intermountain	13
Ogden-Clearfield, UT	3678	UnitedHealth Group	58	Intermountain	13
Provo-Orem, UT	3046	UnitedHealth Group	48	Intermountain	23
Salt Lake City, UT	3203	UnitedHealth Group	53	Intermountain	15
St. George, UT	3045	UnitedHealth Group	47	Humana	20
Vermont	3366	UnitedHealth Group	51	BCBS MI	23
Burlington-South Burlington, VT	4369	UnitedHealth Group	60	BCBS MI	23
Virginia	2285	Humana	32	UnitedHealth Group	28
Blacksburg-Christiansburg, VA	2522	Humana	32	UnitedHealth Group	28
Charlottesville, VA	2430	Humana	36	Elevance Health	24
Harrisonburg, VA	2539	Humana	33	Sentara Health	30
Lynchburg, VA	3095	UnitedHealth Group	44	Humana	27
Richmond, VA	2985	Humana	42	UnitedHealth Group	27
Roanoke, VA	2686	UnitedHealth Group	36	Humana	30
Staunton, VA	2381	UnitedHealth Group	32	Humana	28
Virginia Beach-Norfolk-Newport News, VA-NC	2645	Humana	40	Elevance Health	23
Winchester, VA-WV	3096	Humana	44	UnitedHealth Group	30
Washington	2037	UnitedHealth Group	36	Kaiser	20
Bellingham, WA	1988	Humana	30	Kaiser	23
Bremerton-Silverdale-Port Orchard, WA	2343	Kaiser	36	UnitedHealth Group	25
Kennewick-Richland, WA	3569	UnitedHealth Group	53	Humana	26
Longview, WA	3453	Kaiser	44	UnitedHealth Group	38
Mount Vernon-Anacortes, WA	2469	UnitedHealth Group	32	Kaiser	28
Olympia-Lacey-Tumwater, WA	2548	Kaiser	37	UnitedHealth Group	30
Seattle-Tacoma-Bellevue, WA	2337	UnitedHealth Group	41	Kaiser	17
Spokane-Spokane Valley, WA	2810	UnitedHealth Group	48	Kaiser	15
Walla Walla, WA	2162	UnitedHealth Group	32	Humana	29
Wenatchee, WA	5649	Carle Health	74	Community Hlth Plan	8
Yakima, WA	2596	UnitedHealth Group	39	Community Hlth Plan	29

Table A-4 (continued)
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2023 *Medicare Advantage (MA) markets*

State and MSAs	MA HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
West Virginia	3695	Humana	55	CVS (Aetna)	20
Beckley, WV	4105	Humana	55	CVS (Aetna)	31
Charleston, WV	3712	Humana	54	CVS (Aetna)	23
Huntington-Ashland, WV-KY-OH	2655	Humana	43	Elevance Health	16
Morgantown, WV	4055	Humana	59	UnitedHealth Group	17
Parkersburg-Vienna, WV	3526	Humana	52	UnitedHealth Group	19
Wheeling, WV-OH	1945	Humana	26	CVS (Aetna)	24
Wisconsin	2566	UnitedHealth Group	46	Humana	12
Appleton, WI	3398	Ascension	42	UnitedHealth Group	38
Eau Claire, WI	3079	Marshfield (Security HP)	46	Medica	25
Fond du Lac, WI	3729	Ascension	51	UnitedHealth Group	32
Green Bay, WI	4090	UnitedHealth Group	60	Ascension	17
Janesville-Beloit, WI	3120	UnitedHealth Group	48	Medica	22
La Crosse-Onalaska, WI-MN	4470	Quartz	63	UnitedHealth Group	22
Madison, WI	2436	Medica	32	UnitedHealth Group	29
Milwaukee-Waukesha, WI	4899	UnitedHealth Group	68	Humana	13
Oshkosh-Neenah, WI	3256	Ascension	42	UnitedHealth Group	36
Racine, WI	4813	UnitedHealth Group	67	Humana	16
Sheboygan, WI	3897	UnitedHealth Group	57	Ascension	23
Wausau-Weston, WI	3970	Marshfield (Security HP)	57	UnitedHealth Group	22
Wyoming	6473	UnitedHealth Group	79	CVS (Aetna)	11
Casper, WY	8514	UnitedHealth Group	92	CVS (Aetna)	5
Cheyenne, WY	7446	UnitedHealth Group	86	Humana	10

Notes:
1. Source: Managed Market Surveyor Suite | MSA Medical | Program | Jan. 1, 2023 | Enterprise, Managed Market Surveyor Suite | Managed Market Surveyor | Selected Geography(ies) | Jan. 1, 2023 | Enterprise License © 2023 DR/Decision Resources, LLC. All rights reserved.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the Medicare Advantage market are reported.
3. We exclude Programs of All-Inclusive Care for the Elderly (PACE) plans, Health Care Prepayment Plans (HCCP), special needs-only plans (snp-only), and dual eligible-only plans.

Table A-5. State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Alabama	7387	8408	7685	2662
Anniston-Oxford, AL	8406	8754	10000	2844
Auburn-Opelika, AL	6702	7981	6176	3172
Birmingham-Hoover, AL	7236	8300	9163	2441
Daphne-Fairhope-Foley, AL	6133	7613	5667	3147
Decatur, AL	7844	8585	9163	2634
Dothan, AL	7621	9002	5667	3989
Florence-Muscle Shoals, AL	7270	8455	5666	2645
Gadsden, AL	7881	9126	5667	2011
Huntsville, AL	7236	7842	9163	2775
Mobile, AL	6847	8333	5680	2964
Montgomery, AL	7939	8741	9851	3718
Tuscaloosa, AL	8341	9230	9588	2804
Alaska	4113	4396	6595	-
Anchorage, AK	3920	4204	6415	-
Fairbanks, AK	4283	4471	6416	-
Arizona	2281	2949	2289	2847
Flagstaff, AZ	4922	6506	5013	3203
Lake Havasu City-Kingman, AZ	3882	4102	10000	3373
Phoenix-Mesa-Chandler, AZ	2283	2978	2470	2828
Prescott Valley-Prescott, AZ	3999	4523	7972	2848
Sierra Vista-Douglas, AZ	2735	4221	6013	2635
Tucson, AZ	2569	3091	3122	4380
Yuma, AZ	3531	4067	5216	2347
Arkansas	2840	4340	5000	2790
Fayetteville-Springdale-Rogers, AR	2933	4311	5000	2705
Fort Smith, AR-OK	1970	2590	3249	2948
Hot Springs, AR	2980	4312	5000	2522
Jonesboro, AR	3183	5116	5000	2470
Little Rock-North Little Rock-Conway, AR	2840	4486	5000	2886
Pine Bluff, AR	4369	6549	5000	4168
California	2244	3269	2396	2386
Bakersfield, CA	2725	4925	5434	1830
Chico, CA	4379	5147	5049	5763
El Centro, CA	-	-	-	4388
Fresno, CA	2262	3594	5255	2101
Hanford-Corcoran, CA	2765	5005	7480	2613
Los Angeles-Long Beach-Anaheim, CA	2136	3239	2046	1912
Madera, CA	2555	4618	4925	3079
Merced, CA	3831	5077	7282	3435
Modesto, CA	3369	4316	4733	2268

Table A-5 (continued)
State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Napa, CA	4401	3703	5919	6780
Oxnard-Thousand Oaks-Ventura, CA	2381	4032	5721	2220
Redding, CA	-	-	-	4911
Riverside-San Bernardino-Ontario, CA	2820	3393	2328	2090
Sacramento-Roseville-Folsom, CA	3048	4300	4640	4153
Salinas, CA	3138	4051	6261	5838
San Diego-Chula Vista-Carlsbad, CA	1649	2561	1837	2141
San Francisco-Oakland-Berkeley, CA	2916	2723	5773	4898
San Jose-Sunnyvale-Santa Clara, CA	2287	3021	3917	4007
San Luis Obispo-Paso Robles, CA	3762	5841	9512	2311
Santa Cruz-Watsonville, CA	2132	3965	5144	3293
Santa Maria-Santa Barbara, CA	3429	4516	9234	3371
Santa Rosa-Petaluma, CA	4443	3762	5526	5992
Stockton, CA	3942	3595	5745	2818
Vallejo, CA	4952	3701	7396	6879
Visalia, CA	4174	5744	5230	3526
Yuba City, CA	2794	5269	4014	3291
Colorado	2037	3270	2140	3374
Boulder, CO	2149	3531	2265	3857
Colorado Springs, CO	2102	3313	3447	3615
Denver-Aurora-Lakewood, CO	2032	3357	1999	3486
Fort Collins, CO	2630	3873	3668	4023
Grand Junction, CO	2896	3799	5996	3323
Greeley, CO	2246	3456	3310	3242
Pueblo, CO	2320	3694	5955	4240
Connecticut	2409	2821	5505	2721
Bridgeport-Stamford-Norwalk, CT	2271	2590	6305	3046
Hartford-East Hartford-Middletown, CT	2618	3062	5633	2685
New Haven-Milford, CT	2468	2859	5811	2597
Norwich-New London, CT	3252	4032	5762	2833
Delaware	3984	4400	8870	2669
Dover, DE	4432	5204	8721	2738
District of Columbia	1910	2198	6747	3843
Washington-Arlington-Alexandria, DC-VA-MD-WV	1599	2160	2051	2545
Florida	2180	2884	3004	2055
Cape Coral-Fort Myers, FL	2719	2779	5101	2799
Crestview-Fort Walton Beach-Destin, FL	4587	4857	7877	3093
Deltona-Daytona Beach-Ormond Beach, FL	2696	2758	3131	2571
Gainesville, FL	4899	5806	6444	3203
Homosassa Springs, FL	4120	4429	7632	1942
Jacksonville, FL	3382	4033	5314	2459

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Lakeland-Winter Haven, FL	2171	3026	4427	2201
Miami-Fort Lauderdale-Pompano Beach, FL	1828	2985	2336	2084
Naples-Marco Island, FL	3177	3317	5608	2780
North Port-Sarasota-Bradenton, FL	2884	2877	4854	2429
Ocala, FL	3769	4706	4499	2357
Orlando-Kissimmee-Sanford, FL	1870	2763	3055	2237
Palm Bay-Melbourne-Titusville, FL	2304	3693	4843	2258
Panama City, FL	5576	6522	8120	2712
Pensacola-Ferry Pass-Brent, FL	4226	4830	8407	2113
Port St. Lucie, FL	2768	3650	2757	2468
Punta Gorda, FL	2822	2834	5062	2494
Sebastian-Vero Beach, FL	4064	4482	6809	2407
Sebring-Avon Park, FL	2627	3147	5034	3453
Tallahassee, FL	7207	5350	6698	4044
Tampa-St. Petersburg-Clearwater, FL	2100	2879	3736	2102
The Villages, FL	4408	4045	8438	3872
Georgia	1915	3023	2328	2422
Albany, GA	3046	5197	4794	2959
Athens-Clarke County, GA	3054	2931	3744	2872
Atlanta-Sandy Springs-Alpharetta, GA	1765	3014	2133	2096
Augusta-Richmond County, GA-SC	2112	2532	3627	2931
Brunswick, GA	2547	4246	5040	2736
Columbus, GA-AL	2923	3766	3337	2717
Dalton, GA	2831	4453	4908	4342
Gainesville, GA	2211	3221	4412	2693
Hinesville, GA	2375	3783	2692	2777
Macon-Bibb County, GA	2533	3889	6357	3001
Rome, GA	2312	3610	4785	3002
Savannah, GA	2470	3461	3198	2448
Valdosta, GA	3653	4088	4440	3941
Warner Robins, GA	3491	4715	7666	3132
Hawaii	4505	6122	5425	2192
Kahului-Wailuku-Lahaina, HI	3739	4485	5000	2676
Urban Honolulu, HI	4722	5810	5815	2340
Idaho	2317	2930	2561	2349
Boise City, ID	2080	2735	2563	2831
Coeur d'Alene, ID	2144	2047	4064	1916
Idaho Falls, ID	2840	3871	3326	4211
Lewiston, ID-WA	2100	2291	3314	3863
Pocatello, ID	3278	3829	4217	4260
Twin Falls, ID	2149	3052	3420	2352

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Illinois	4294	5137	4570	2008
Bloomington, IL	4207	5249	5051	2517
Carbondale-Marion, IL	3293	4415	5012	1678
Champaign-Urbana, IL	4179	2725	10000	4785
Chicago-Naperville-Elgin, IL-IN-WI	4117	4569	4510	2065
Danville, IL	3535	5269	7663	3649
Davenport-Moline-Rock Island, IA-IL	2641	3171	2827	3496
Decatur, IL	5365	6847	4857	4413
Kankakee, IL	4991	6672	3474	1787
Peoria, IL	3329	3844	5085	2725
Rockford, IL	5365	6680	5761	3129
Springfield, IL	3312	4644	4990	3961
Indiana	3557	5668	3437	2747
Bloomington, IN	4314	8091	4357	2328
Columbus, IN	4350	8136	5053	3250
Elkhart-Goshen, IN	4506	6236	3350	3393
Evansville, IN-KY	4603	6288	3426	2665
Fort Wayne, IN	2891	4694	5114	3135
Indianapolis-Carmel-Anderson, IN	3668	5749	2984	2895
Kokomo, IN	4417	6525	3540	3003
Lafayette-West Lafayette, IN	3743	7427	4254	2456
Michigan City-La Porte, IN	3594	6049	5665	2631
Muncie, IN	3557	6907	3940	2468
South Bend-Mishawaka, IN-MI	2825	4208	3928	2804
Terre Haute, IN	4785	6600	4674	2936
Iowa	3073	4379	5758	2911
Ames, IA	4464	7001	6745	3293
Cedar Rapids, IA	3290	4351	6548	2613
Davenport-Moline-Rock Island, IA-IL	2641	3171	2827	3496
Des Moines-West Des Moines, IA	3018	4027	4729	3423
Dubuque, IA	2815	4527	4691	6652
Iowa City, IA	4219	6662	6747	2468
Sioux City, IA-NE-SD	2030	2654	2153	3137
Waterloo-Cedar Falls, IA	2940	4107	4818	5000
Kansas	2664	3321	4111	2737
Lawrence, KS	3459	4103	4923	3254
Manhattan, KS	5934	6345	4852	4413
Topeka, KS	5777	7177	5005	2716
Wichita, KS	3245	4543	3851	3012

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Kentucky	4719	6118	4109	2876
Bowling Green, KY	4667	5711	7977	2699
Elizabethtown-Fort Knox, KY	4960	6036	5483	2628
Lexington-Fayette, KY	5377	6621	5687	3138
Louisville/Jefferson County, KY-IN	4378	5954	3730	3022
Owensboro, KY	5135	6752	8049	2913
Louisiana	4657	6036	5920	3371
Alexandria, LA	4886	6819	5039	2599
Baton Rouge, LA	5134	6462	5218	3836
Hammond, LA	5185	6329	9193	3646
Houma-Thibodaux, LA	5151	6978	10000	3893
Lafayette, LA	5191	6436	9193	2717
Lake Charles, LA	4869	6549	3586	3822
Monroe, LA	4977	6534	9196	3086
New Orleans-Metairie, LA	4234	5953	5375	3983
Shreveport-Bossier City, LA	4893	6362	5128	3614
Maine	2580	3054	3291	1965
Bangor, ME	2759	3239	3466	1758
Lewiston-Auburn, ME	2476	2958	3395	2232
Portland-South Portland, ME	2398	2886	3242	2460
Maryland	2662	3200	4470	2166
Baltimore-Columbia-Towson, MD	3078	3430	4907	1778
California-Lexington Park, MD	3284	2787	7092	7355
Cumberland, MD-WV	2268	2784	4302	4475
Hagerstown-Martinsburg, MD-WV	1856	2419	3460	3240
Salisbury, MD-DE	2842	3451	4731	2022
Massachusetts	2510	2581	4221	1845
Barnstable Town, MA	3643	4178	4668	2757
Boston-Cambridge-Newton, MA-NH	2204	2161	3536	2175
Pittsfield, MA	2666	2849	3634	2437
Springfield, MA	2005	2313	3849	1720
Worcester, MA-CT	2022	1935	2147	1567
Michigan	4699	6204	3562	2515
Ann Arbor, MI	6505	7978	2610	3725
Battle Creek, MI	5703	7325	3814	2044
Bay City, MI	6150	6736	4204	3010
Detroit-Warren-Dearborn, MI	5094	6537	3175	2646
Flint, MI	5233	6662	3105	3092
Grand Rapids-Kentwood, MI	3840	5550	3016	4413
Jackson, MI	5773	7402	4255	3176
Kalamazoo-Portage, MI	4938	7410	3734	2462

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Lansing-East Lansing, MI	5896	8054	3530	4174
Midland, MI	5919	5762	5754	2960
Monroe, MI	5489	6680	3988	2633
Muskegon, MI	4525	6317	3219	2631
Niles, MI	5624	6926	4257	2299
Saginaw, MI	5439	6233	4205	2350
Minnesota	2403	2881	2972	2070
Duluth, MN-WI	2276	2865	2685	2102
Mankato, MN	3892	4431	4137	2261
Minneapolis-St. Paul-Bloomington, MN-WI	2135	2484	3168	1798
Rochester, MN	3974	4464	3124	2483
St. Cloud, MN	2850	3448	3330	3729
Mississippi	3192	5895	7738	3201
Gulfport-Biloxi, MS	3220	5693	6020	4301
Hattiesburg, MS	3436	7167	7267	3617
Jackson, MS	4079	6901	8240	3300
Missouri	1946	2411	3256	3094
Cape Girardeau, MO-IL	3254	4695	5737	4598
Columbia, MO	3629	4845	3547	5421
Jefferson City, MO	4403	6454	4887	6140
Joplin, MO	3036	4784	6303	2653
Kansas City, MO-KS	2511	3566	3607	2853
Springfield, MO	2159	3239	5506	2359
St. Joseph, MO-KS	3146	4290	7621	5462
St. Louis, MO-IL	2316	2812	2428	3130
Montana	3154	3693	3660	4618
Billings, MT	3126	3675	3659	4642
Great Falls, MT	4167	4919	3660	5677
Missoula, MT	3135	3645	3660	3890
Nebraska	2956	4762	3572	3652
Grand Island, NE	3635	6080	3572	3718
Lincoln, NE	3376	5664	3572	4388
Omaha-Council Bluffs, NE-IA	2627	3910	3159	4366
Nevada	2288	2270	3070	2475
Carson City, NV	1746	2051	3831	2508
Las Vegas-Henderson-Paradise, NV	2862	2271	4025	3352
Reno, NV	1756	2287	1991	2543
New Hampshire	2966	3186	5093	2167
Manchester-Nashua, NH	3164	3464	5192	2040

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
New Jersey	2649	2997	3778	2536
Atlantic City-Hammonton, NJ	6106	5429	4367	2179
Ocean City, NJ	5673	4020	5000	4007
Trenton-Princeton, NJ	2960	3569	3666	3448
Vineland-Bridgeton, NJ	4659	4076	4211	2547
New Mexico	3096	4588	3270	2081
Albuquerque, NM	2725	3506	3802	2367
Farmington, NM	3066	4567	3951	2921
Las Cruces, NM	4060	6112	3276	4114
Santa Fe, NM	2875	4188	4874	1855
New York	1473	1449	2188	1224
Albany-Schenectady-Troy, NY	1984	1793	3047	2152
Binghamton, NY	3339	3595	4859	2177
Buffalo-Cheektowaga, NY	3037	1745	3934	2374
Elmira, NY	4790	5683	-	2019
Glens Falls, NY	1769	1931	4431	1767
Ithaca, NY	3204	3336	8437	3361
Kingston, NY	1772	1859	4472	2608
New York-Newark-Jersey City, NY-NJ-PA	1657	1700	1873	1654
Poughkeepsie-Newburgh-Middletown, NY	1971	1987	5092	2731
Rochester, NY	6074	6714	3945	3003
Syracuse, NY	4614	5104	4743	2198
Utica-Rome, NY	3338	3672	4056	2381
Watertown-Fort Drum, NY	3216	3581	-	2333
North Carolina	3025	4211	3279	2767
Asheville, NC	2651	3655	2724	3159
Burlington, NC	2990	3912	4176	2511
Charlotte-Concord-Gastonia, NC-SC	2087	2831	2768	2712
Durham-Chapel Hill, NC	3176	4093	3290	2745
Fayetteville, NC	3517	5630	3196	2854
Goldsboro, NC	5813	7385	5072	3224
Greensboro-High Point, NC	2937	4539	2575	2612
Greenville, NC	5954	6872	5313	3443
Hickory-Lenoir-Morganton, NC	3752	5733	3299	2720
Jacksonville, NC	5585	5619	9848	4611
New Bern, NC	5843	6330	5876	3923
Raleigh-Cary, NC	2799	3895	3377	2769
Rocky Mount, NC	5129	6478	5765	2701
Wilmington, NC	3580	4106	8555	5396
Winston-Salem, NC	2973	4074	3809	2876

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
North Dakota	3446	6047	5495	3254
Bismarck, ND	3477	5989	6001	2853
Fargo, ND-MN	2105	3001	3672	1854
Grand Forks, ND-MN	2259	3217	3837	2067
Ohio	1978	2593	1616	1819
Akron, OH	2059	2514	1976	1830
Canton-Massillon, OH	2068	2625	2511	1585
Cincinnati, OH-KY-IN	3295	5073	2513	2147
Cleveland-Elyria, OH	2179	2654	1963	2005
Columbus, OH	1996	2458	2224	1843
Dayton-Kettering, OH	3002	4037	3450	2703
Lima, OH	2279	2953	3172	2330
Mansfield, OH	2430	2894	2695	2233
Springfield, OH	2912	3988	2852	1991
Toledo, OH	1861	2610	2500	1815
Weirton-Steubenville, WV-OH	1774	2201	4117	1990
Youngstown-Warren-Boardman, OH-PA	1725	2146	1677	2006
Oklahoma	3661	4923	5365	3388
Enid, OK	4725	5621	7477	2896
Lawton, OK	5673	6653	6228	4623
Oklahoma City, OK	3368	4749	4097	4309
Tulsa, OK	3068	4845	4469	3098
Oregon	1420	1891	2118	1496
Albany-Lebanon, OR	1405	1911	2973	3087
Bend, OR	2109	2308	3822	3651
Corvallis, OR	2004	2607	3022	3540
Eugene-Springfield, OR	1904	2192	2126	3426
Grants Pass, OR	1728	2166	6862	2383
Medford, OR	1760	1994	5415	2679
Portland-Vancouver-Hillsboro, OR-WA	1660	2118	2277	1967
Salem, OR	1899	2342	3166	1876
Pennsylvania	1803	2162	2204	1561
Allentown-Bethlehem-Easton, PA-NJ	1751	2177	2621	1825
Altoona, PA	3172	3784	7141	2913
Bloomsburg-Berwick, PA	3772	3239	4843	5532
Chambersburg-Waynesboro, PA	2616	2991	4996	2223
East Stroudsburg, PA	2804	3446	3979	2085
Erie, PA	3837	4548	5005	2980
Gettysburg, PA	2326	2700	4383	2583
Harrisburg-Carlisle, PA	2915	3302	4103	2443
Johnstown, PA	3532	4064	4976	3618

Table A-5 (continued)
State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Lancaster, PA	3036	3316	3859	2418
Lebanon, PA	3654	4011	4005	2881
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	2261	2389	5292	1876
Pittsburgh, PA	3205	3646	5177	2616
Reading, PA	2424	2754	3240	1909
Scranton--Wilkes-Barre, PA	3737	4511	4017	2940
State College, PA	3416	3981	3339	2910
Williamsport, PA	2963	3506	3354	2712
York-Hanover, PA	2485	2804	4244	2620
Rhode Island	2747	4110	6209	4682
Providence-Warwick, RI-MA	1718	2274	3079	3193
South Carolina	3862	4891	4804	2834
Charleston-North Charleston, SC	4188	5134	4692	2931
Columbia, SC	4313	5377	4781	2771
Florence, SC	3743	5107	4847	3334
Greenville-Anderson, SC	3539	4452	4940	2784
Hilton Head Island-Bluffton, SC	4106	4828	4846	3279
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	2264	2740	3180	2763
Spartanburg, SC	4146	5454	4846	2883
Sumter, SC	3845	4825	4845	3615
South Dakota	2612	3937	3648	3465
Rapid City, SD	2817	5451	6220	3325
Sioux Falls, SD	2387	3526	5103	2722
Tennessee	2668	3784	3443	2146
Chattanooga, TN-GA	2297	3461	4642	2407
Clarksville, TN-KY	1946	2590	2825	1829
Cleveland, TN	2987	4421	4582	2571
Jackson, TN	2636	3640	4062	2083
Johnson City, TN	4084	5811	4149	4629
Kingsport-Bristol, TN-VA	2466	3170	2709	3129
Knoxville, TN	3071	4457	3914	3727
Memphis, TN-MS-AR	2430	3377	3494	1876
Morristown, TN	3691	5624	4030	3171
Nashville-Davidson--Murfreesboro--Franklin, TN	2327	3372	3167	1952
Texas	2659	4041	1637	3023
Abilene, TX	5142	7316	5000	4379
Amarillo, TX	2886	3983	3542	4275
Austin-Round Rock-Georgetown, TX	2296	3476	1390	3446
Beaumont-Port Arthur, TX	3494	4936	2173	2080
Brownsville-Harlingen, TX	4829	6983	3525	3094
College Station-Bryan, TX	5059	6503	2616	3584

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Corpus Christi, TX	3309	5402	3269	5186
Dallas-Fort Worth-Arlington, TX	2561	3974	1710	3884
El Paso, TX	2884	3705	4936	3149
Houston-The Woodlands-Sugar Land, TX	2286	3595	1781	2017
Killeen-Temple, TX	2786	3264	3452	3169
Laredo, TX	5434	7589	3525	2878
Longview, TX	4478	6145	5167	3643
Lubbock, TX	4028	5902	4085	3310
McAllen-Edinburg-Mission, TX	4572	7205	3525	2519
Midland, TX	5018	6721	5000	4235
Odessa, TX	4706	6591	3542	3980
San Angelo, TX	4318	5762	5049	4328
San Antonio-New Braunfels, TX	2617	3903	4323	3630
Sherman-Denison, TX	3486	4443	5049	4562
Texarkana, TX-AR	3507	4978	3156	4963
Tyler, TX	3991	5974	3446	3094
Victoria, TX	3838	4740	5050	4364
Waco, TX	3356	4639	3038	3727
Wichita Falls, TX	5462	6315	10000	5291
Utah	2743	2336	7607	3270
Logan, UT-ID	3163	2795	7916	5144
Ogden-Clearfield, UT	2662	2353	7335	3678
Provo-Orem, UT	3598	3161	7415	3046
Salt Lake City, UT	2673	2352	7192	3203
St. George, UT	3209	2352	9092	3045
Vermont	3901	3791	5125	3366
Burlington-South Burlington, VT	4075	3683	5125	4369
Virginia	2436	3468	1759	2285
Blacksburg-Christiansburg, VA	4653	5147	4266	2522
Charlottesville, VA	2921	3633	3837	2430
Harrisonburg, VA	4357	5905	5196	2539
Lynchburg, VA	4163	5361	4200	3095
Richmond, VA	4052	4400	2433	2985
Roanoke, VA	3911	4661	3374	2686
Staunton, VA	4636	5693	4616	2381
Virginia Beach-Norfolk-Newport News, VA-NC	3318	4680	4254	2645
Winchester, VA-WV	2871	3733	2903	3096
Washington	1660	2202	1890	2037
Bellingham, WA	2119	2359	3624	1988
Bremerton-Silverdale-Port Orchard, WA	1879	2231	2174	2343
Kennewick-Richland, WA	2196	2896	2620	3569

Table A-5 (continued)

State and MSA HHI by product type, as of Jan. 1, 2023

State and MSAs	TOTAL HHI	PPO HHI	EXCH HHI	MA HHI
Longview, WA	2925	2688	3231	3453
Mount Vernon-Anacortes, WA	2088	2431	3802	2469
Olympia-Lacey-Tumwater, WA	1982	1849	2032	2548
Seattle-Tacoma-Bellevue, WA	1683	2293	2045	2337
Spokane-Spokane Valley, WA	2156	3219	2851	2810
Walla Walla, WA	1997	2996	2954	2162
Wenatchee, WA	2752	3331	4145	5649
Yakima, WA	1967	2803	2935	2596
West Virginia	3232	4307	5469	3695
Beckley, WV	4095	5346	5032	4105
Charleston, WV	3579	4744	5387	3712
Huntington-Ashland, WV-KY-OH	2558	3122	3691	2655
Morgantown, WV	3484	4463	5700	4055
Parkersburg-Vienna, WV	3513	4657	5133	3526
Wheeling, WV-OH	1802	2363	3647	1945
Wisconsin	1430	2316	1603	2566
Appleton, WI	2013	3454	2862	3398
Eau Claire, WI	1800	3236	4848	3079
Fond du Lac, WI	1898	2555	4656	3729
Green Bay, WI	1674	3003	3208	4090
Janesville-Beloit, WI	1899	3615	2744	3120
La Crosse-Onalaska, WI-MN	2275	2245	4916	4470
Madison, WI	2032	2286	4823	2436
Milwaukee-Waukesha, WI	2924	2971	3008	4899
Oshkosh-Neenah, WI	2198	3144	2882	3256
Racine, WI	3210	3069	3399	4813
Sheboygan, WI	2882	3302	4497	3897
Wausau-Weston, WI	1829	4201	2633	3970
Wyoming	2671	3791	6109	6473
Casper, WY	3389	5023	6109	8514
Cheyenne, WY	3044	3998	6108	7446
Mean MSA-Level HHI	3458	4407	4642	3129
Median MSA-Level HHI	3174	4070	4397	2891

Notes:

1. Source: Managed Market Surveyor Suite | MSA Medical | Program | Jan. 1, 2023 | Enterprise, Managed Market Surveyor Suite | Managed Market Surveyor | Selected Geography(ies) | Jan. 1, 2023 | Enterprise, and Managed Market Surveyor | Data Extraction © 2023 DR/Decision Resources, LLC. All rights reserved.
2. Data point for the exchanges is July 1, 2023.
3. State and MSA-level Herfindahl-Hirschman Indices (HHIs) are reported. The "Total HHI" pertains to the combined PPO+HMO+POS+EXCH product market.
4. We do not present product-specific data for geographic areas with i) fewer than 5,000 reported enrollees in the TOTAL and PPO product markets or ii) fewer than 1,000 reported enrollees in the exchanges and Medicare Advantage markets.

ATTACHMENT 7

PRESS RELEASES OCT 20, 2025

NEW REPORT DETAILS KAISER PERMANENTE'S $67 BILLION IN FINANCIAL RESERVES

SHARE ON

FOR IMMEDIATE RELEASE
October 20, 2025

Contact:
Press@unacuhcp.org

NEW REPORT DETAILS KAISER PERMANENTE'S $67 BILLION IN FINANCIAL RESERVES

A new analysis highlights the scale of Kaiser Permanente's financial position, reporting that the health care system is currently holding $67.4 billion in reserves, up from $40 billion just four years ago. The findings

provide new context for ongoing conversations about the role and structure of large nonprofit health care systems in the United States.

Kaiser reported total gains of $5.5 billion from investments and other income in 2024, including $569 million in operating income, per The Center for Media and Democracy's report, published Saturday. A notable portion of this growth is tied to investment activity: between December 2023 and June 2025, Kaiser's allocations to hedge funds increased by $1.1 billion, and private equity holdings rose by $1.9 billion.

The report notes that Kaiser's large reserve levels are uncommon in scale among nonprofit health systems. Analysts suggest that this could contribute to ongoing discussions about how nonprofit health care organizations manage and deploy financial resources to support care delivery, infrastructure, and community investment.

Executive compensation is also outlined in the analysis. In 2023, CEO Greg Adams received nearly $13 million in total compensation. 18 additional executives earned more than $2 million, and three earned over $4 million. Such figures, while not unprecedented for large health systems, are likely to draw interest from policymakers and industry observers tracking trends in nonprofit governance and leadership pay.

Kaiser Permanente operates as an integrated health care system, combining health insurance, hospital services, and physician care under a single structure. While the health plan and hospitals are legally nonprofit entities, the affiliated medical group operates as a for-profit entity. The organization's governance includes leaders from across the private and nonprofit sectors.

The Center for Media and Democracy's analysis suggests that the size of Kaiser's reserves may play a significant role in future strategic and policy discussions, particularly as health systems face growing demands for investment in patient care, workforce development, and community health initiatives.

Kaiser Permanente is one of the largest integrated health care systems in the United States, headquartered in Oakland, California. Founded as a nonprofit health system, Kaiser serves more than 12 million members across multiple states and employs over 300,000 people.

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United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP) represents more than 40,000 registered nurses and healthcare professionals in California and Hawaii, including optometrists; pharmacists; physical, occupational and speech therapists; case managers; nurse midwives; social workers; clinical lab scientists; physician assistants and nurse practitioners; hospital support and technical staff. UNAC/UHCP is affiliated with the National Union of Hospital and Health Care Employees (NUHHCE) and the American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO.