

Vermont Health-Plan Premiums Soar As Insurers Face Less Competition

MAY 2009

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Acknowledgments

Health Care for America Now would like to thank Alex Lawson, Justin Berrier, Thomas M. Hunt, Deepika Mehta, Doneg McDonough, Diane Archer, Julie Chinitz, Monica Sanchez, Margarida Jorge, Dennis P. Osorio, Toby Chaudhuri, the Northwest Federation of Community Organizations and the Institute for America's Future.

Vermont Consumers Pay the Price For Health Insurance Market Failure

A FEW PRIVATE health insurance companies have built a near-monopoly in the Vermont market, burdening families and businesses with premiums that grew 3.7 times faster than wages from 2000 to 2007.¹ According to a 2007 report by the American Medical Association, Vermont's largest health insurer holds a 77 percent share of the market.² The U.S. Justice Department considers a market "highly concentrated" if one company holds more than a 42 percent share of that market.³

The problem is national. A nationwide survey by the Government Accountability Office found that the median statewide market share of the largest insurer selling coverage to small employer groups increased to 47 percent in 2008 from 33 percent in 2002.⁴ Of the 29 states providing information in the 2002 and 2008 surveys, 24 states saw increases in the market share of the top carrier. Those increases ranged from about 2 to 39 percentage points.⁵ The combined market share of the five largest insurers providing coverage to small business groups represented at least three-quarters of the market in 34 of 39 states, compared to 26 of 34 states reported in 2005 and 19 of 34 states reported in 2002.⁶

Without a public health insurance plan, the consolidation of private insurers will continue in its current trajectory. Health insurers play a unique role as both sellers of insurance and buyers of health care services. Unfortunately, these companies use their power as buyers against the smaller medical providers while cooperating with larger providers to increase profits for both.^{7,8} Insurers are not necessarily hurt by high prices from providers; insurers would only feel the pain if other insurance companies were to pay less for medical services

and use the savings to woo away customers. If Americans are forced to continue to depend on the private market for health insurance, insurers will continue to drive prices as high as they want with no fear of decreased demand—and consumers will continue to suffer from escalating rates and worse coverage.

These are not theoretical behaviors, and they underscore the fatal flaws in our national insurance market and the need for government intervention in the form of a public insurance option. Insurers have been exposed numerous times for rigging the system. An investigation by the Boston Globe in December 2008 exposed a, "gentleman's agreement that accelerated [the] health cost crisis."⁹ The chiefs of the largest provider group in Massachusetts and the state's largest health insurer made a handshake deal to avoid creating written evidence of the arrangement. In that agreement, Blue Cross Blue Shield of Massachusetts pledged to increase payments if the provider group, Partners HealthCare, ensured that no other health plan would be charged less.¹⁰

When small, independent providers want to negotiate with multiple health plans, large insurers exert enormous pressure to stop them. The statewide trade group for doctors in New York sued UnitedHealth Group Inc., the nation's second-largest health insurer by enrollment, for allegedly using illegal coercion in just such a scheme to limit competition.¹¹

In a separate matter, UnitedHealth agreed to pay \$400 million to settle multiple suits alleging price fixing and other anti-competitive behavior.^{12,13} The attorney general of New York, Andrew Cuomo, stated that this was "a huge scam that affected hundreds of millions

of Americans [who were] ripped off by their health insurance companies.”¹⁴ Numerous other insurers were implicated in the same scheme, including Aetna Inc., Cigna Corp. and WellPoint Inc.¹⁵

If they chose to, private insurers could use their market power to drive hard bargains and lower costs, but instead they have passed along these costs through higher premiums to enrollees and employers. John Holahan and Linda Blumberg of the Urban Institute note that “[d]ominant insurers do not seem to use their market power to drive hard bargains with providers.”¹⁶ Large insurers do not face pressure from smaller insurers, which use premiums that “shadow” those of dominant insurers. Consequently, insurers are able to pass costs on to individuals.¹⁷

The Medicare Payment Advisory Commission, a respected expert panel appointed by Congress, reported that while, “insurers appear to be unable or unwilling to ‘push back’ and restrain payments to providers, they have been able to pass costs on to the purchasers of insurance and maintain their profit margins.”¹⁸ In a recent paper Jacob Hacker of the University of California, Berkeley, showed that Medicare demonstrates it is possible for savings to be shared with individuals instead of being taken as profit. Between 1997 and 2006, private health insurance spending per enrollee grew at an annual rate of 7.3 percent, compared with an annual growth rate of 4.6 percent in Medicare—a 37 percent difference.¹⁹

Private Health Insurer Bad Behavior

In the past 13 years more than 400 mergers involving health insurers have led to local markets being dominated by a small number of companies. The American Medical Association reports that the number of health insurance companies has declined by nearly 20 percent since 2000, and as a result 94 percent of insurance markets in the United States are now highly concentrated.²⁰ The industry has sold these mergers to the public as a way to improve

efficiency, but the reality is that premiums have skyrocketed, increasing more than 87 percent, on average, over the past six years.²¹ Families and employers—and the U.S. economy as a whole—cannot sustain that kind of cost growth. Private health insurers have demonstrated by their actions they seek to profit through mergers and acquisitions, not by providing quality benefits.

Berkeley political scientist Jacob Hacker showed that “even within a reformed system, private plans will continue to have incentives to engage in activities that undermine health security, such as tailoring their benefits or provider networks to discourage less healthy people from enrolling.”²² Acting alone, private plans do not work to obtain greater value. This is due to their limited reach, inherent instability, and the frequent movement of patients in and out of their subscriber base, and the generally weak incentives to invest in broadly distributed information on quality or to share their performance data with other interested parties.²³

Oversized Profits, Executive Pay

Profits at 10 of the country’s largest publicly-traded health insurance companies in 2007 rose 428 percent from 2000 to 2007, from \$2.4 billion to \$12.9 billion, according to U.S. Securities and Exchange Commission filings. In 2007 alone, the chief executive officers at these companies collected combined total compensation of \$118.6 million—an average of \$11.9 million each. That is 468 times more than the \$25,434 an average American worker made that year²⁴

The rising premiums paid by employers and families not only generate oversized net earnings, they also fuel controversial financial maneuvers designed to pump up insurers’ stock prices, which in turn help executives reach their personal bonus targets. From 2003 through 2008 the seven largest publicly traded health insurers, which cover 116 million Americans, spent \$52.4 billion buying back their own shares. Buybacks

reduce the number of shares that are publicly traded, raising the value of existing shareholders' stakes. Companies make share repurchases with excess cash on hand or with borrowed funds. Buybacks are a way of removing money from a company's balance sheet for the benefit of investors, reflecting management's decision not to invest in improving a company's

operations, making the health system run more efficiently or reducing customers' premiums. The companies prefer to hand over the money to Wall Street investors and executives whose soaring compensation packages depend on reaching earnings-per-share goals that often would not be achieved without buybacks.

Profits and CEO Compensation for 10 Major Private Health Insurance Companies

Company	2000 Net Income (millions)	2007 Net Income (millions)	% Change 2007 vs. 2000	Chief Executive Officer 2007	Value of Total 2007 Compensation (millions)
Aetna	\$ 127	\$ 1,831	1,342	Ronald A. Williams	\$ 23.0
Amerigroup Corp.	19	116	511	Jeffrey L. McWaters*	8.2
Centene Corp.	7	73	943	Michael F. Neidorff	8.8
CIGNA Corp.	987	1,115	13	H. Edward Hanway	25.8
Coventry Health Care Inc.	61	626	926	Dale B. Wolf*	14.9
Health Net Inc.	164	194	18	Jay M. Gellert	3.7
Humana Inc.	90	834	827	Michael McCallister	10.3
UnitedHealth Group Inc	736	4,654	532	Stephen J. Hemsley	13.2
Universal American Corp.	23	84	265	Richard A. Barasch	1.6
WellPoint	226	3,345	1,380	Angela F. Braly	9.1
Total	\$ 2,440	\$ 12,873	428		\$ 118.6

Source: U.S. Securities and Exchange Commission filings. The companies are listed in the Corporate Library's "Insurance Health and Disability" category.

All companies are members of America's Health Insurance Plans, the industry trade group.

*No longer CEO.

Stock Repurchases (in millions)

	Aetna	Cigna	Coventry	Health Net	Humana	United Health Group	Wellpoint	Annual Total All
2003	\$ 445	\$ 0	\$ 6	\$ 288	\$ 44	\$ 1,607	\$ 217	\$ 2,608
2004	1,493	676	97	89	67	3,446	82	5,950
2005	1,650	1,618	17	0.4	2	2,557	333	6,178
2006	2,323	2,765	269	254	26	2,345	4,550	12,532
2007	1,696	1,185	439	232	27	6,599	6,151	16,330
2008	1,788	378	323	243	106	2,684	3,276	8,798
Total	\$ 9,394	\$ 6,622	\$ 1,152	\$ 1,106	\$ 273	\$ 19,238	\$ 14,611	\$ 52,396

Source: Annual 10-K filings, Securities and Exchange Commission.

Insurers have demonstrated through their actions that they do not use consolidation to bring efficiency to the health insurance marketplace.²⁵ Instead health insurance companies use their size to engage in anti-competitive behavior, to rig the system to impose premium increases that grow faster than individuals, families, and businesses can afford, and to ensure “astounding levels of profit” for themselves and their shareholders.²⁶ The only way that consumers can be guaranteed access to affordable, comprehensive benefits is if a public coverage option is created to meet consumers’ needs where the private insurance market has so clearly failed.

Premiums Rising Out of Reach

Rising health premiums are exacerbating income inequality and making coverage too costly for many Americans. The Kaiser Family Foundation found that employer-sponsored health insurance premiums more than doubled from 1999 to 2007, a rate four times faster than wage increases.²⁷ A study by the McKinsey Global Institute of widening income gaps among U.S. households found that workplace health plan premiums consume a disproportionately large share of the household budget for lower income individuals than for people in the top income category. McKinsey found that in the bottom income group only one in five workers is covered. Moreover, families in the lowest income category spend 20 percent of household income on contributions to employer-sponsored health plan premiums, compared with only 3.3 percent for families in the top income group. The report concludes that rising health costs, reflected by spiraling insurance premiums, are widening income-group discrepancies as measured by participation rates in employer-paid health plans and workers’ ability to afford premiums and out-of-pocket health care costs.²⁸

As premiums have skyrocketed, many businesses have found themselves unable to offer health benefits to their employees. One result is that more than 47 million people, or one out of seven Americans under age 65, are uninsured.²⁹ Low-wage workers are especially hard hit. The McKinsey survey found that 78 percent of low-wage workers don’t receive health benefits from their employers.³⁰ Those not offered employer-sponsored health coverage must find insurance in the individual market.

The individual market generally provides more expensive plans with less comprehensive benefits. Insurers base individual premiums on sex, age, and health status, and they deny applications at a higher rate because risk usually isn’t pooled effectively.³¹ For a typical family that moves from group to individual coverage with identical benefits, annual premiums will rise by more than \$2,000.³² The biggest losers in the individual market are those who are less healthy or coping with a chronic illness. Two-thirds of respondents in a recent survey said they found it difficult or impossible to find affordable coverage in the individual market. The chronically ill aren’t the only ones whose applications for coverage are rejected or whose rates are aggressively raised by insurers; people who don’t consider themselves sick, such as women with a history of cesarean section, are treated as if they have a disease.^{33,34}

With premiums rising faster than peoples’ ability to pay them, many Americans are being forced to choose between no coverage and inadequate coverage. Through a wave of consolidation, private health insurers have rigged the system to manufacture oversized profits while the country pays the price in the form of high premiums and poorer health.

Conclusion

Health insurance is not the first example of a public need that markets have failed to meet adequately. The predictable consolidation of the private insurance market and the inevitable use of financial maneuvering to build market share and drive up profits underscore permanent flaws in the health insurance market. These faults can only be addressed by the creation of a public insurance option. Giving people the choice of a public health insurance plan is an essential means of guaranteeing quality, affordable care, and setting a high standard for all health plans.³⁵ In a recent proposal the Commonwealth Fund recommended the creation of a public health insurance plan, saying it “plays a central role in harnessing markets for positive change.”³⁶ The public health insurance plan would induce innovations in treatment, thereby improving the quality of care received by patients, according to the Urban Institute.³⁷

Berkeley political scientist Jacob Hacker recently detailed how a public health insurance plan could be implemented on a level playing field with private health insurers, ensuring that quality of care would improve and cost growth would be slowed.

Without the establishment of a public insurance option that is designed to insure the most people with the best coverage possible instead of merely maximizing profits, private health insurers will continue to behave as they always have. Hacker concluded, “private health insurers, regardless of the degree of regulation, will still be able to game the system to maximize their profits while failing to provide health security over the long run—the same ‘heads, I win; tails, you lose’ deal we have seen in our financial sector.”³⁸

Insurance Market Concentration: Ranked List (2007)

Rank	State	Health Insurer with Largest Market Share	Market Share %	Health Insurer with No. 2 Market Share	Market Share %	Combined Market Share % of Top Two Insurers
1	Hawaii	Blue Cross Blue Shield HI	78	Kaiser Permanente	20	98
2	Rhode Island	Blue Cross Blue Shield RI	79	UnitedHealth Group Inc.	16	95
3	Alaska	Premera Blue Cross	60	Aetna Inc.	35	95
4	Vermont	Blue Cross Blue Shield VT	77	CIGNA Corp.	13	90
5	Alabama	Blue Cross Blue Shield AL	83	Health Choice	5	88
6	Maine	WellPoint Inc.	78	Aetna Inc.	10	88
7	Montana	Blue Cross Blue Shield MT	75	New West Health Services	10	85
8	Wyoming	Blue Cross Blue Shield WY	70	UnitedHealth Group Inc.	15	85
9	Arkansas	Blue Cross Blue Shield AR	75	UnitedHealth Group Inc.	6	81
10	Iowa	Wellmark BC and BS	71	UnitedHealth Group Inc.	9	80
11	Missouri	WellPoint Inc.	68	UnitedHealth Group Inc.	11	79
12	Minnesota	Blue Cross Blue Shield MN	50	Medica	26	76
13	South Carolina	Blue Cross Blue Shield SC	66	CIGNA Corp.	9	75
14	Indiana	WellPoint Inc.	60	M*Plan (HealthCare Group)	15	75
15	New Hampshire	WellPoint Inc.	51	CIGNA Corp.	24	75
16	Idaho	Blue Cross of ID	46	Regence BS of Idaho	29	75
17	Louisiana	Blue Cross Blue Shield LA	61	UnitedHealth Group Inc.	13	74
18	Michigan	Blue Cross Blue Shield MI	65	Henry Ford Health System	8	73
19	North Carolina	Blue Cross Blue Shield NC	53	UnitedHealth Group Inc.	20	73
20	Maryland	CareFirst Blue Cross Blue Shield	52	UnitedHealth Group Inc.	19	71
21	Oklahoma	BCBS OK	45	CommunityCare	26	71
22	Georgia	WellPoint Inc.	61	UnitedHealth Group Inc.	8	69
23	Kentucky	WellPoint Inc.	59	Health Partners	10	69
24	Illinois	HCSC (Blue Cross Blue Shield)	47	WellPoint Inc.	22	69
25	Nebraska	Blue Cross Blue Shield NE	44	UnitedHealth Group Inc.	25	69
26	Utah	Regence Blue Cross Blue Shield	47	Intermountain Healthcare	21	68
27	Massachusetts	Blue Cross Blue Shield MA	50	Tufts Health Plan	17	67
28	Connecticut	WellPoint Inc.	55	Health Net Inc.	11	66
29	Arizona	Blue Cross Blue Shield AZ	43	UnitedHealth Group Inc.	22	65
30	Delaware	CareFirst Blue Cross Blue Shield	42	Coventry Health Care Inc.	23	65
31	New Mexico	HCSC (Blue Cross Blue Shield)	35	Presbyterian Hlth	30	65
32	Tennessee	Blue Cross Blue Shield TN	50	Total Choice	12	62
33	Virginia	WellPoint Inc.	50	Aetna Inc.	11	61
34	Washington	Premera Blue Cross	38	Regence Blue Shield	23	61
35	Texas	HCSC (Blue Cross Blue Shield)	39	Aetna Inc.	20	59
36	New Jersey	Horizon Blue Cross Blue Shield	34	Aetna Inc.	25	59
37	Ohio	WellPoint Inc.	41	Medical Mutual of Ohio	17	58
38	Nevada	Sierra Health	29	WellPoint Inc.	28	57
39	Colorado	WellPoint Inc.	29	UnitedHealth Group Inc.	24	53
40	Oregon	Providence Health & Services	25	Regence Blue Cross Blue Shield	23	48
41	New York	GHI	26	Empire Blue Cross Blue Shield	21	47
42	Florida	Blue Cross Blue Shield FL	30	Aetna Inc.	15	45
43	California	Kaiser Permanente	24	WellPoint Inc.	20	44

Source: American Medical Association, "Competition in health insurance: A comprehensive study of U.S. Markets: 2007 Update."
Some states are not presented because available data does not reliably capture a sufficient portion of the insured population.

Appendix A

Results of Market Failure in Vermont

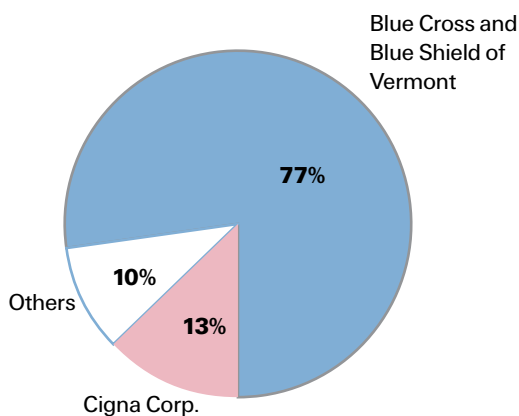
- Blue Cross and Blue Shield of Vermont, the state's dominant health insurer, holds 77 percent of the state's market. Together with Cigna Corp. they control 90 percent of the market.³⁹
- Health insurance premiums for Vermont working families have skyrocketed, increasing 75 percent from 2000 to 2007.⁴⁰
- For family health coverage in Vermont during that time, the average annual combined premium for employers and employees rose from \$7,054 to \$12,340.⁴¹
- For family health coverage in Vermont, the average employer's portion of annual

premiums rose 66 percent, while the average worker's share grew 115 percent.⁴²

- From 2000 to 2007, the median earnings of Vermont workers increased 20 percent, from \$22,155 to \$26,585. During that time health insurance premiums for Vermont working families rose 3.7 times faster than median earnings.⁴³

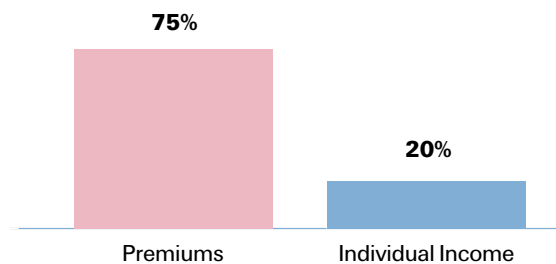
When a firm has more than a 42 percent share of a single market, the U.S. Justice Department considers that market to be "highly concentrated." This means that an insurer could raise premiums and/or reduce the variety of plans or quality of services offered to customers with impunity.⁴⁴

Vermont Health Insurance Market Concentration



Source: American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update."

Percent Increase in Premiums vs Income in Vermont, 2000–2007



Sources: Families USA, "Premiums Versus Paychecks," September 2008.

Vermont Insurance Market Consolidation by Metro Area, 2007

Metro Area	Health Insurer With Largest Market Share	Market Share %	Health Insurer With No. 2 Market Share	Market Share %	Combined Market Share % of Top Two Insurers
Burlington–South Burlington	Blue Cross and Blue Shield of Vermont	69	Aetna Inc.	20	89

Source: American Medical Association, "Competition in health insurance: A comprehensive study of U.S. markets: 2007 update."

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