West Virginia 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.

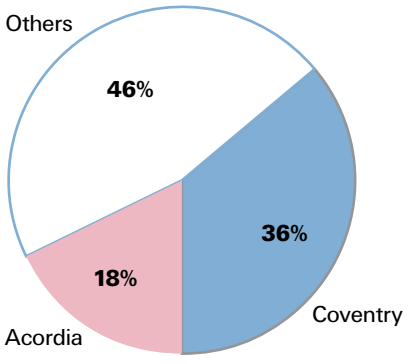
West Virginia Consumers Pay the Price For Health-Insurance Market Failure

A FEW PRIVATE health insurance companies have built a near-monopoly in the West Virginia market, burdening families and businesses with premiums that grew four times faster than wages from 2000 to 2007.[1] The state's 2 largest health insurers hold a 54 percent share of the West Virginia market, according to a 2008 study by the American Medical Association.[2] Under a U.S. Justice Department rating system the state is considered "highly concentrated."[3,4]

Some argue that health insurance industry competition across the U.S. is ample. In fact, research shows a startling and consistent absence of competition as the industry consolidates with more mergers and acquisitions. For example, according to a nationwide survey by the Government Accountability Office, 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.[5] Americans pay for this consolidation in the form of higher health plan premiums, surging insurance company profits, and a growing number of uninsured people.

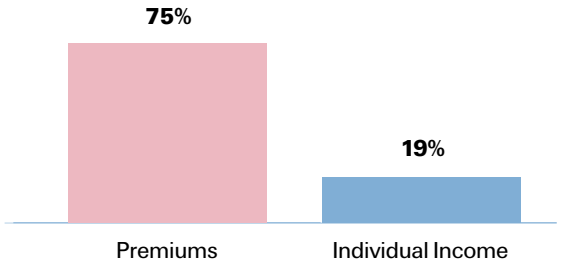
The negative effects of consolidation are most visible when viewed at the local level. In the Charleston area, for example, the top insurer controls a 45 percent share of the market, including self-funded employer-sponsored health plans.[6] In many metropolitan areas across the nation, dominant health insurers have prevented new competitors from entering the market and allowed the most powerful hospitals and doctors to raise rates with minimal resistance. Contrary to the insurance industry's assertions, the low level of health insurance industry competition across the U.S. is unhealthy for individuals, businesses and the

West Virginia Health Insurance Market Concentration



Source: American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2008 Update."

Percent Increase in Premiums vs Income in West Virginia, 2000–2007



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

economy. Freedom from genuine competition allows West Virginia insurers to reap oversized profits and raise premiums with impunity.[7,8]

In West Virginia:

- Coventry Health Care Inc., the state's biggest health insurer, controls 36 percent of the West Virginia market. Together with Acordia Inc., the second largest, they control 54 percent of the market.[9]
- Some local markets are more concentrated. In Charleston, Coventry and Aetna Inc. together hold 67 percent of the market.[10]
- Health insurance premiums for West Virginia working families have skyrocketed, increasing 75 percent from 2000 to 2007.[11]
- For family health coverage in West Virginia during that time, the average annual combined premium for employers and employees rose from $6,844 to $11,970.[12]
- For family health coverage in West Virginia, the average employer's portion of annual premiums rose 81 percent, while the average worker's share increased 56 percent.[13]
- From 2000 to 2007, the median earnings of West Virginia workers increased 19 percent, from $19,876 to $23,599. During that time health insurance premiums for West Virginia working families rose four times faster than median earnings.[14]

If one company holds more than a 42 percent share of a market the U.S. Justice Department would consider that market "highly concentrated."[15] The U.S Justice Department uses a rating system based on market share to determine if a market is concentrated or highly concentrated. If the market is rated from 1,000 to 1,800, it is considered to be "concentrated." Markets rated higher than 1,800 are deemed 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.[16]

West Virginia Insurance Market Consolidation by Metro Area, 2008

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	U.S. Justice Department Market Competition Rating*
Charleston	Coventry Health Care Inc.	45	Aetna Inc.	22	67	2781
Huntington-Ashland	Aetna Inc.	29	UnitedHealth Group Inc.	17	46	1576
Parkersburg-Marietta-Vienna	Aetna Inc.	36	Cigna Corp.	13	49	1871
Wheeling	Aetna Inc.	27	Coventry Health Care Inc.	20	47	1,896

*1,000-1,800 is "concentrated"; greater than 1,800 is "highly concentrated"
Source: American Medical Association, "Competition in health insurance: A comprehensive study of U.S. markets: 2008 update."

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.

A National Problem

LACK OF HEALTH INSURANCE COMPETITION is an important cause of the meteoric rise in health care costs, which has dramatically outpaced income growth. 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.[17] 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.[18] Families and employers—and the U.S. economy as a whole—cannot sustain that kind of cost growth."The consequences of lax [antitrust] enforcement for consumers are clear," then-Senator Barack Obama said in a September 2007 address to the American Antitrust Institute. "The number of insurers has fallen by just under 20 percent since 2000. These changes were supposed to make the industry more efficient, but instead premiums have skyrocketed."[19]

Anti-Competitive Behavior

Lack of competition in the insurance marketplace poses unique dangers to consumers. David Balto, former policy director of the Bureau of Competition of the Federal Trade Commission, said of the health insurance industry that a "vital component to assuring the competitive marketplace is protecting the ability of consumers to choose between alternatives. Antitrust enforcement against anticompetitive mergers and exclusionary conduct is essential to a competitive marketplace. This unprecedented level of concentration and the lack of antitrust enforcement pose serious policy and health care concerns."[20] Other experts agree, saying increases in the number of competitors are associated with lower health plan costs and premiums and that decreases in the number of competitors are associated with higher plan costs and premiums.[21]

On May 5, 2009, the Senate Finance Committee held a roundtable discussion on health reform. Scott Serota, the chief executive officer of the Blue Cross and Blue Shield Association, asserted that "it is a mischaracterization to indicate the markets are not competitive today. The median number of competitors in any market today is 27, so there are sufficient competitors today in the marketplace to create a competitive market."[22] The same Government Accountability Office study that counted the 27 competitors in each state's market for small group coverage also concluded that there isn't enough competition. The median market share for Blue Cross Blue Shield carriers in 38 states was about 51 percent, up from 44 percent in 2005 and 34 percent in 2002, the GAO said.[23]

The median market share of the largest carrier that provides small-group coverage increased to about 47 percent in 2008 from the 43 percent reported in 2005 and the 33 percent reported in 2002, according to the GAO report. 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 two to 39 percentage points.[24] 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.[25]

Health insurers play a unique role as both sellers of insurance and buyers of health care services. These companies use their power as buyers against the smaller medical providers while cooperating with larger providers to increase profits for both.[26,27] With only a handful of large insurers, physician practices often have no choice but to accept the prices offered without bargaining effectively. Larger providers, such as academic medical centers, can use their size and stature to negotiate rates. However, as long as insurers can continue to pass costs on to consumers in the form of higher premiums and cost-sharing, insurers are not necessarily hurt by paying higher fees to select providers; insurers would only be affected if other insurance companies were to get the same medical services for less and use the savings to woo away customers. Without competition among insurers, insurers have no reason to drive costs down, and without additional choices in the marketplace, consumers have no choice but to continue to pay inflated prices.

These are not theoretical behaviors. Insurers have been exposed numerous times rigging the system. An investigation by the Boston Globe in December 2008 exposed a, "gentleman's agreement that accelerated [the] health cost crisis."[28] 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.[29]

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.[30]

In a separate matter UnitedHealth agreed to pay $400 million to settle multiple suits alleging price fixing and other anti-competitive behavior.[31,32] 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."[33] Numerous other insurers were implicated in the same scheme, including Aetna Inc., Cigna Corp. and WellPoint Inc.[34]

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."[35] 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.[36]

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."[37] 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.[38]

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 year.[39]

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

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. Secutiries 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.

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.

Insurers have demonstrated through their actions that they do not use consolidation to bring efficiency to the health insurance marketplace.[40] 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.[41]

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 have more than doubled in the last nine years, a rate four times faster than wage increases.[42] A study by McKinsey Global Institute of widening income gaps among U.S. households found that workplace health plan premiums consume a disproportionate 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.[43]

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.[44] 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.[45] 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.[46] For a typical family that moves from group to individual coverage with identical benefits, annual premiums will rise by more than $2,000.[47] 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.[48,49]

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.

Creating Healthy Competition

A public health insurance plan option would introduce a healthy dose of competition in the arenas of cost and quality. 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."[50] Establishing a public health insurance plan, according to Commonwealth, would introduce "a new competitive dynamic in insurance markets and provide a strong foundation for payment and system reforms."[51]

In a March 2009 report, the Center for American Progress said, "Fortunately, our nation's health insurance market can be fixed with a big dose of what fixes most sectors of our economy—healthy, well-supervised competition. One of the best ways to introduce this much-needed competition is for the federal government to offer a public health insurance plan that can compete with private insurers within an insurance "exchange" that ensures public and private health insurance plans compete equally and transparently in the public marketplace."[52] The public health insurance plan would induce innovations in treatment, thereby improving the quality of care received by patients, according to the Urban Institute.[53]

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 introduction of real competition by means of a public health insurance plan, 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."[54]

Private and public insurance plans should compete side-by-side on a level playing field to reward those that deliver better value and do the best job of improving their enrollees' health. Public health insurance can offer a benchmark for private plans and a source of stability for enrollees, especially those with the greatest medical needs. Private plans would provide an alternative for those who feel public insurance wouldn't serve their needs, as well as maintain pressure for the public plan and other private competitors to find innovations in benefit design and care management.[55] A critical element of a functional competitive marketplace is to protect the ability of consumers to choose between genuine alternatives. The highly consolidated health insurance industry we have today, with its unacceptable concentration of market power, does not permit this.

ENDNOTES

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