

Nebraska Health-Plan Premiums Soar As Insurers Face Less Competition

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Lack of Competition Denies Nebraskans Meaningful Choice in Health Care

THE CURRENT HEALTH INSURANCE MARKET fails to provide enough choices to allow all Nebraskans to access the health care they need. Decreasing competition in the health insurance market has contributed to increasing health costs and created a market that has left 460,000 Nebraskans without enough coverage and more than 220,000 Nebraskans uninsured.¹ Insurance is often too expensive to buy for increasing numbers of Nebraska families. The co-payments and deductibles can be unaffordable, causing families to put off treatment.

Lack of health insurance competition is an important cause of the meteoric rise in health costs, which have dramatically outpaced income growth. In the past 13 years there have been more than 400 mergers involving health insurers, resulting in local markets being dominated by a small number of companies.² 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.³ 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.^{4,5}

Families and employers—and the U.S. economy as a whole—cannot sustain that kind of cost growth. Without real competition, and a real choice in different plans, insurers will be able to increase rates and reap oversized profits with impunity.^{6,7}

Health care reform should create real choice for Nebraskans. Increasing competition through reforms, including a public health insurance

plan option, is critical to improving health care for all Nebraskans.

The Benefits of Competition

Lack of competition in the insurance marketplace poses unique dangers to consumers. Increases in the number of competitors are associated with lower health plan costs and premiums while decreases in the number of competitors are associated with higher plan costs and premiums.⁸ 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.”⁹

On May 5, 2009 the Senate Finance Committee held a roundtable discussion on health reform. It was noted by one of the insurance industry panelists that the Government Accountability Office has found that the median number of competitors in any market today is 27 and reflects a sufficiently competitive marketplace.^{10,11} However, according to that GAO report, the median market share of the largest carrier that provides small-group coverage increased to about 47 percent in 2008 from 43 percent in 2005 and 33 percent in 2002. 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.¹² The combined market share of the five largest small group carriers represented at least three-quarters of the market in 34 of 39 states, compared to 26 of 34 states in 2005 and 19 of 34 states in 2002.¹³ This is further evidence that market concentration is growing.

The current incentives in the insurance market underscore the need for more competition. Health insurers play a unique role as both sellers of insurance and buyers of health care services. For example, many insurers want to include flagship hospitals in their networks to help attract more enrollees.¹⁴ Those hospitals have little incentive to negotiate lower prices with the insurer. The insurer in turn is able to pass those costs on to their consumers through increased premiums and other cost-sharing.¹⁵ 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 lower premiums and woo away customers. As long as insurers can make deals with providers to stifle this competitive influence, insurers can let prices go as high as they want with consumers having no choice of a cheaper product.

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.”¹⁶ The chiefs of the largest provider group in Massachusetts and the state’s largest health insurer made a handshake deal in which Blue Cross Blue Shield of Massachusetts pledged to increase payments in exchange for the provider group, Partners HealthCare, to ensure that no other health plan would be charged less.¹⁷

In a separate matter UnitedHealth agreed to pay \$400 million to settle multiple suits alleging price fixing and other anti-competitive behavior.^{18,19} 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.”²⁰ Numerous other insurers were implicated in the same scheme, including Aetna Inc., Cigna Corp. and WellPoint Inc.²¹

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.”²² As noted above, insurers are able to pass the costs of provider rates on to consumers.²³ Further, large insurers do not face pressure from smaller insurers which “shadow” the premium pricing of those of dominant insurers.

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.”²⁴ 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 consumers 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 under Medicare—a 37 percent difference.²⁵

Competition in Nebraska

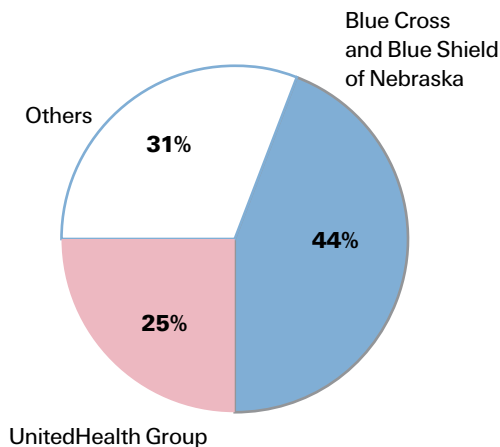
Nebraska's largest health insurer, Blue Cross and Blue Shield, controls 44 percent of the state market, and Blue Cross and UnitedHealth Group Inc. together have a 69 percent share of the market.²⁶ The U.S. Justice Department considers a market "highly concentrated" if one company holds more than a 42 percent share of that market.

In some metropolitan areas, health-insurer market power is more concentrated than that. In the Lincoln area, for example, the top insurer controls a 60 percent share of the market.²⁷ Some argue that the health insurance industry now has ample competition across the U.S. However, research shows a startling absence of competition as the health insurance industry continues a trend of consolidation. Americans are paying for this consolidation in the form of higher health premiums, surging profits for insurance companies and a rising number of uninsured people.

In many metropolitan areas, the commercial health insurance business is dominated by a few companies. Freedom from genuine competition allows insurers to reap oversized profits and raise premiums.^{28,29} The negative effects of consolidation in the health insurance industry are most visible when viewed at the local level.

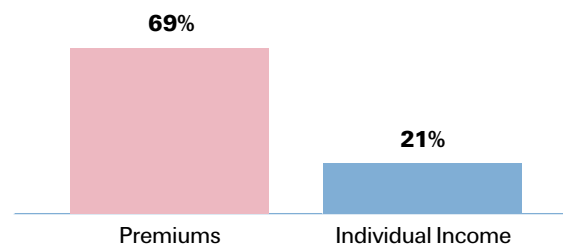
- Blue Cross and Blue Shield of Nebraska, the state's biggest health insurer, controls 44 percent of the state market for health insurance. Together with UnitedHealth Group Inc., they control 69 percent of the market.³⁰
- Health insurance premiums for Nebraska working families have skyrocketed, increasing 69 percent from 2000 to 2007.³¹
- For family health coverage in Nebraska during that time, the average annual combined premium for employers and employees rose from \$6,760 to \$11,434.³²
- For family health coverage in Nebraska from 2000 to 2007, the average employer's portion of annual premiums rose 69 percent, and the average worker's share also grew by 69 percent.³³

Nebraska 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 Nebraska, 2000–2007



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

- From 2000 to 2007, the median earnings of Nebraska workers increased 21 percent, from \$21,255 to \$25,802. During that time health insurance premiums for Nebraska working families rose 3.2 times faster than median earnings.³⁴

When a company has a more than 42 percent share of a single market, the U.S. Justice Department considers that market to be “highly concentrated.”³⁵

Nebraska 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
Lincoln	Blue Cross and Blue Shield of Nebraska	60	UnitedHealth Group Inc.	28	88
Omaha–Council Bluffs	Blue Cross and Blue Shield of Nebraska	34	UnitedHealth Group Inc.	28	62

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

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.³⁶

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. 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.

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.

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 six times faster than cumulative wage increases.³⁷ A study by McKinsey Global Institute of widening income gaps among U.S. households found that rising employer-paid health insurance premiums constitute a much larger share of the income of lower-paid employees than higher-paid ones. Not only does coverage consume a bigger share of the household budget for lower income individuals, they are less likely to be offered coverage in the first place. McKinsey found that in the bottom income group only one in five workers is covered. Moreover, their share of employer paid premiums to household income is 20 percent. The top income group spent 3.3 percent of household income on premiums. 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 insured workers' ability to afford premiums and out-of-pocket health care costs.³⁸

As premiums have skyrocketed, many businesses have found themselves unable to offer their workers health benefits. One result is that more than 47 million people, or one out of seven Americans under age 65, are uninsured.³⁹ Low-wage workers are especially hard hit. The McKinsey survey found that 78 percent of low-wage workers are not covered by their employers.⁴⁰ 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 coverage premiums on sex, age and health status, and they deny applications at a higher rate because risk usually isn't pooled effectively.⁴¹ Annual premiums for a typical family that moves from group to individual coverage with identical benefits will rise by more than \$2,000.⁴² The real 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 practice of rejecting applications or aggressively raising rates wasn't limited to the chronically ill; it also affected people who don't consider themselves to be sick, such as women who have had a cesarean section.^{43,44}

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 generate oversized profits while the country foots the bill through high premiums and poor 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.”⁴⁵ Establishing a public plan, according to Commonwealth, would introduce “a new competitive dynamic in insurance markets and provide a strong foundation for payment and system reforms.”⁴⁶ The public plan would drive innovations in treatment, improving the quality of care received by patients, according to the Urban Institute.⁴⁷

In a report for the Institute for America’s Future, 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 in the form of a public health insurance plan, he 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.”⁴⁸

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.⁴⁹ 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 allow this.

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