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THE FIVE LARGEST U.S. health insurance companies sailed through the worst economic downturn since the Great Depression to set new industry profit records in 2009, a feat accomplished by leaving behind 2.7 million Americans who had been in private health plans. For customers who kept their benefits, the insurers raised rates and cost-sharing, and cut the share of premiums spent on medical care.[1] Executives and shareholders of the five biggest for-profit health insurers, UnitedHealth Group Inc., WellPoint Inc., Aetna Inc., Humana Inc., and Cigna Corp., enjoyed combined profit of $12.2 billion in 2009, up 56 percent from the previous year. It was the best year ever for Big Insurance.

The outsize earnings are a vivid reminder that without comprehensive national health care reform the gatekeepers of our broken health insurance system always will put the short-term interests of Wall Street before the needs of millions of patients and a national economy plagued by joblessness.

The 2009 financial reports from the nation's five largest insurance companies reveal that:

- The firms made $12.2 billion, an increase of $4.4 billion, or 56 percent, from 2008.
  - Four out of the five companies saw earnings increases, with CIGNA's profits jumping 346 percent.
- The companies provided private insurance coverage to 2.7 million fewer people than the year before.
  - Four out of the five companies insured fewer people through private coverage. United-Health alone insured 1.7 million fewer people through employer-based or individual coverage.
  - All but one of the five companies increased the number of people they covered through public insurance programs (Medicaid, CHIP and Medicare). UnitedHealth added 680,000 people in public plans.
- The proportion of premium dollars spent on health care expenses went down for three of the five firms, with higher proportions going to administrative expenses and profits.

It was clear from the earnings reports that reduced enrollment in private plans correlates with big gains in net income. Aetna, the lone company that substantially increased both membership and the share of premium revenue it spent on actual medical care, was the only one of the five companies to post net income that was less than it reported the previous year.

The shedding of 2.7 million members from private health plans is part of the industry's long-term shifting of responsibility for the care of millions of sick, older or lower-income customers to taxpayer-supported government health programs, such as Medicaid and the state Children's Health Insurance Plans. State and federal programs have increasingly been hiring big insurers to manage their care.

Insurance industry officials see great opportunity in serving government-run programs because other markets are not growing. That is because private buyers of insurance are steadily being priced out of the market. During 2009, the five insurers boosted enrollment in government-subsidized programs administered by private plans, including Medicare and Medicaid, by 688,000.[2] Medicaid growth is the biggest single driver of increased national health spending, according to a study released Feb. 4 by the policy journal Health Affairs. The authors project that by 2012 government health programs

will pay for half of the health care purchased in this country, up from 47 percent in 2008.[3]

Last year the five health insurers continued managing their capital resources carefully to benefit investors and corporate executives. Most of the companies reported that they wait six to eight weeks after receiving claims to pay doctors, hospitals and patients. The cash they hold during this period builds up company reserves and improves balance sheets, but the delay is yet another way that the managers of the existing system harm patients and health care providers. Secondly, most of the five insurers participate in share repurchase programs. Since 2003, the five companies have bought $55.4 billion of their own stock on the open market,[4] increasing earnings per share by reducing the number of shares outstanding, thereby boosting a company's stock price. 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, in making the health system run more efficiently or in giving customers rate relief when premiums are soaring. The companies prefer to hand over the money to Wall Street investors. Chief executive officers are primary beneficiaries of share buybacks because their soaring compensation packages depend on reaching earnings-per-share goals that often would be unachievable without repurchasing programs. Executives also are compensated with stock options that put enormous numbers of company shares in their hands, so they benefit personally and directly from everything that pushes share prices higher.

Big Insurance in 2009

The top five health insurers reported 2009 fourth quarter and full-year earnings between Jan. 21 and Feb. 5, 2010. Here are key points about each company based on new filings with the U.S. Securities and Exchange Commission and other sources.

WellPoint

Summary
Profit increased $2.3 billion, or 91 percent, from the previous year, and set a new record for annual net income, $4.75 billion.
Total enrollment fell 1.4 million, or 3.9 percent. • Private enrollment dropped 1 million (3.2 percent). • Public enrollment declined 348,000 (11 percent).
Medical loss ratio decreased by 1 percentage point, to 82.6 percent.

WellPoint, the largest health insurer by membership, posted record profit of $4.75 billion for 2009, an increase of $2.3 billion, or 91 percent, from a year earlier. The Indianapolis-based company, which operates market-dominating Blue Cross franchises in 14 states, ended the year with 33.67 million members, a decrease of 1.38 million, or 3.9 percent, from a year earlier. The decline in membership was most pronounced in the company's commercial products, which are sold directly to individuals and families or through employers that provide health benefits to workers and their dependents.

Enrollment in WellPoint private plans declined by 1.03 million, or 3.2 percent, to 30.72 million, and membership in government-sponsored insurance plans declined 348,000. The company's medical loss ratio fell 1 percentage point to 82.6 percent. For health care providers and patients, the average waiting time for payment for covered care was 42 days. The company devoted $2.64 billion to repurchasing its shares in 2009, the most of the five insurers, bringing WellPoint buybacks to $17.25 billion since 2003. WellPoint spent

$4.7 million last year to lobby in Washington against comprehensive national health reform proposals.[7] Since 2007, the insurer's political action committee and its employees have made $1.1 million in political contributions to advance the company's interests.[8]

UnitedHealth

Summary
Profit increased $845 million, or 28 percent, from the previous year, and reached $3.8 billion.
Total enrollment dropped 1 million, or 3.4 percent. • Private enrollment fell 1.7 million (6.5 percent). • Public enrollment rose 680,000 (17 percent).
Medical loss ratio increased slightly, 0.3 percentage point, to 82.3 percent.

UnitedHealth Group, based in Minnetonka, Minn., maintained its position as the largest health insurer by sales, with $87.1 billion in revenue in 2009. Profit rose 28 percent to $3.82 billion, compared with $2.98 billion in 2008. The strong performance came as total enrollment declined by 1.04 million, or 3.4 percent, to 29.32 million members.

Private health plan membership at UnitedHealth has been eroding in recent years while the company has used its national marketing muscle to attract more customers through government-subsidized programs. UnitedHealth's private enrollment decline of 1.72 million in 2009 was offset by a gain of 680,000 members in its Medicare and Medicaid plans. Across all lines of business, UnitedHealth's medical loss ratio (MLR)—the share of premiums used to pay doctors, hospitals and other health care providers—rose 0.3 percentage point to 82.3 percent. Despite the increase, that still leaves UnitedHealth's MLR lower than the unweighted average MLR of the five companies.

For health care providers and patients, the average waiting time for payment for covered care was 54 days. In 2009 UnitedHealth continued its industry-leading share repurchasing program with another $1.8 billion in buybacks. Since 2003, UnitedHealth has spent a remarkable $21 billion on share repurchases to raise the value of its shares.

UnitedHealth spent $4.5 million last year to lobby in Washington against comprehensive national health reform proposals.[5] Since 2007, the insurer's political action committee and its employees have made $1.6 million in political contributions to advance the company's interests.[6]

Cigna

Summary
Profit increased $1 billion, or 346 percent, from the previous year, and set a new a record for annual net income, $1.3 billion.
Total enrollment dropped 639,000, or 5.5 percent. • Private enrollment fell 656,000 (5.6 percent). • Public enrollment climbed 17,000 (49 percent).
Medical loss ratio slipped 0.5 percentage point, to 81.2 percent.

Profits rose 346 percent in 2009 compared with a year earlier for Philadelphia-based Cigna. Net income of $1.3 billion surged to an all-time company record after the insurer booked profit of only $292 million in 2008. Total enrollment plunged 5.5 percent to 11.04 million, with the decline attributable to a drop of 656,000 in private plan membership, offset by 17,000 more members in government-sponsored plans. Cigna's MLR fell 0.5 percentage point to 81.2 percent—the lowest consolidated MLR of the five companies. Cigna did not report share repurchases last year, leaving the total spent on boosting share prices for investors at $6.62 billion from 2003 through 2009.

Cigna spent $1.6 million last year to lobby in Washington against comprehensive national health reform proposals.[9] Since 2007, the insurer's political action committee and its employees have made $544,000 in political contributions to advance the company's interests.[10]

Big Insurance Broke Records With 2009 Profits

	Full Year 2008 Profit (in millions)	Full Year 2009 Profit (in millions)	2008-2009 Year-Over-Year Change in Profit
WellPoint	$2,491	$4,746	91%
UnitedHealth	$2,977	$3,822	28%
Humana	$647	$1,040	61%
Cigna	$292	$1,302	346%
Aetna	$1,384	$1,277	-8%
Totals	**$7,791**	**$12,186**	**56%**

Source: U.S. Securities and Exchange Commission filings.

Total Enrollment Fell in 2009*

	2008 Enrollment (in thousands of members)	2009 Enrollment (in thousands of members)	Change in Total Enrollment (in thousands of members)	Percentage Change in Total Enrollment
WellPoint	35,049	33,670	(1,379)	-3.9%
UnitedHealth	30,355	29,315	(1,040)	-3.4%
Humana	8,472	8,325	(147)	-1.7%
Cigna	11,679	11,040	(639)	-5.5%
Aetna	17,701	18,914	1,213	6.9%
Totals	**103,256**	**101,264**	**(1,992)**	**-1.9%**

*All enrollment figures include only medical care plans and exclude vision, dental, specialty, Medicare supplemental, and Medicare stand-alone prescription drug plans.
Source: U.S. Securities and Exchange Commission filings.

Employer-Sponsored, Individual Memberships Declined as Profits Rose*

	2008 Private Health Plan Enrollment (in thousands of members)	2009 Private Health Plan Enrollment (in thousands of members)	Change in Private Health Plan Enrollment (in thousands of members)	Percentage Change in Private Enrollment
WellPoint	31,753	30,722	(1,031)	-3.2%
UnitedHealth	26,345	24,625	(1,720)	-6.5%
Humana	3,601	3,381	(220)	-6.1%
Cigna	11,644	10,988	(656)	-5.6%
Aetna	16,488	17,435	947	5.7%
Totals	**89,831**	**87,151**	**(2,680)**	**-3.0%**

*All enrollment figures include only medical care plans and exclude vision, dental, specialty, Medicare supplemental, and Medicare stand-alone prescription drug plans.
Source: U.S. Securities and Exchange Commission filings.

Government-Sponsored Enrollment Grew in 2009*

	2008 Public Health Plan Enrollment (in thousands of members)	2009 Public Health Plan Enrollment (in thousands of members)	Change in Public Health Plan Enrollment (in thousands of members)	Percentage Change in Public Enrollment
WellPoint	3,296	2,948	(348)	-10.6%
UnitedHealth	4,010	4,690	680	17.0%
Humana	4,872	4,945	73	1.5%
Cigna	35	52	17	48.6%
Aetna	1,213	1,479	266	21.9%
Totals	**13,426**	**14,114**	**688**	**5.1%**

*All enrollment figures include only medical care plans and exclude vision, dental, specialty, Medicare supplemental, and Medicare stand-alone prescription drug plans.
Source: U.S. Securities and Exchange Commission filings.

Medical Loss Ratios Decreased or Remained Flat at Most Big Insurers

	2008 Consolidated Medical Loss Ratio	2009 Consolidated Medical Loss Ratio	Change in Medical Loss Ratio (in % points)
WellPoint	83.6%	82.6%	-1.0%
UnitedHealth	82.0%	82.3%	0.3%
Humana	84.5%	82.8%	-1.7%
Cigna	81.6%	81.2%	-0.5%
Aetna	81.5%	85.2%	3.7%

Source: U.S. Securities and Exchange Commission filings.

Health Insurers Held Money Owed for Claims Payments For Six to Eight Weeks

	Days in Claims Payable
UnitedHealth	54
WellPoint	42
Humana	55
Cigna	N/A
Aetna	44

Source: U.S. Securities and Exchange Commission filings.

Aetna

Summary
Profit declined $108 million, or 8 percent, from the previous year, to $1.28 billion.
Total enrollment increased 1.2 million, or 6.9 percent. • Private enrollment grew by 947,000 (5.7 percent). • Public enrollment climbed 266,000 (22 percent).
Medical loss ratio rose 3.7 percentage points, to 85.2 percent.

Aetna, based in Hartford, Conn., reported profit of $1.28 billion in 2009. It was the only one of the five biggest insurers whose net income fell short of the previous year's performance (by 8 percent) and whose enrollment expanded in 2009. The company said it had 18.91 million members on Dec. 31 after private plan enrollment grew by 947,000 and the company's Medicaid and Medicare managed care plans added 266,000 members. The MLR shot up 3.7 percentage points to 85.2 percent, the highest level among the five insurers.

The average waiting time for doctors, hospitals and patients to receive payment for covered services from Aetna was 44 days. Aetna bought $773 million in shares from the open market, raising the total stock buybacks since 2003 to $10.2 billion.

The health insurer spent $2.8 million last year to lobby in Washington against comprehensive national health reform proposals.[11] Since 2007, the insurer's political action committee and its employees have made $728,000 in political contributions to advance the company's interests.[12]

Humana

Summary
Profit increased $393 million, or 61 percent, from the previous year, and reached $1 billion.
Total enrollment dropped 147,000, or 1.7 percent. • Private enrollment dropped 220,000 (6.1 percent). • Public enrollment rose 73,000 (1.5 percent).
Medical loss ratio fell 1.7 percentage points, to 82.8 percent.

Humana, based in Louisville, Ky., reported that 2009 profit rose to $1.04 billion, a 61 percent increase from a year earlier. Enrollment fell by 147,000 to 8.33 million. Membership in private plans declined by 220,000 while government-supported plans added 73,000 members.

The company holds on to claims payments to doctors, hospitals and members for 55 days, the longest of the five insurers. Humana has bought back $296 million of shares since 2003, including $23 million last year.

Humana spent $3.2 million last year to lobby in Washington against comprehensive national health reform proposals.[13] Since 2007, the insurer's political action committee and its employees have made $747,000 in political contributions to advance the company's interests.[14]

Profits Soar Despite Loss of 2.7 Million Private-Sector Members

The biggest for-profit health insurers sidestepped the severe economic recession and broke profit records in 2009. In the process, they parted ways with 2.7 million Americans who had been in their private plans. For customers lucky enough to renew their benefits, the insurers raised rates and cost-sharing requirements, and cut the share of premiums spent on medical care.[15] Executives and shareholders of the five biggest for-profit insurers, WellPoint Inc., UnitedHealth Group Inc., Aetna Inc., Humana Inc., and Cigna Corp., enjoyed combined net income of $12.2 billion in 2009, a 56 percent increase from 2008. The companies set a new standard for profitability in the managed care industry.

The record earnings are a potent reminder that without comprehensive national health care reform the gatekeepers of our broken health insurance system can and will continue to put the short-term interests of Wall Street before the needs of millions of patients and a national economy plagued by joblessness.

Many of the 2.7 million Americans whose health benefits expired were casualties of an economy that has lost millions of jobs since 2007. But many others—the exact tallies are trade secrets—were victims of an industry practice called purging, in which sharply higher premiums push individuals with health problems or employers with sicker or older workforces away from continuing coverage. Typically these individuals and employers are asked at renewal time to pay double-digit premium increases they can't afford, forcing them to search elsewhere for coverage or to go without health benefits.

That's what California's biggest insurer, the Anthem Blue Cross subsidiary of WellPoint, did last week, according to the Los Angeles Times. The company is raising premiums 30 to 39 percent for many of its 800,000 customers who buy their policies directly from the company rather than through employers. Premium hikes on a similar scale were imposed 12 months ago. The impending 2010 monthly premiums shocked Blue Cross customers, some of whom say the new prices will exceed their mortgage payments. After being insured by Blue Cross for 30 years, one married couple in Los Angeles received notice that effective March 1 the annual rate will rise to $27,336 from $20,184. Customers were also outraged to learn that WellPoint for the first time is reserving the right to raise premiums at will in the middle of the policy year rather than following the established industry practice of doing so only once a year.[16]

Uninsured Population Keeps Growing

Faced with such onerous costs, many customers are winding up uninsured. Health insurance premiums have risen so high that experts forecast 52 million Americans will be without coverage this year.[17] Left alone to purchase a health plan directly from private insurers, many will have no choice but to remain uninsured or to buy cheap policies with inadequate benefits that leave them underinsured and at financial risk should they have a serious accident or illness. The states lack the will, skill, resources and power to address these insurance company practices.

Insurers also drive up the uninsured population by excluding applicants from obtaining coverage in the first place. The count of 2.7 million policyholders who lost coverage last year does not capture the full extent of the insurance industry's efforts to avoid sick patients. Millions of Americans apply for family policies and are excluded from coverage because they are sick or had a pre-existing

condition, and no line items about them can be found in corporate earnings statements. The Commonwealth Fund last year reported these disturbing survey data:

"Nearly half (47 percent) of adults who tried to purchase insurance in the individual market in the last three years found it very difficult or impossible to find a plan that fit their needs; 57 percent found it very difficult or impossible to find a plan they could afford; and 36 percent said they were turned down or charged a higher price because of a preexisting condition. Nearly three-quarters (73 percent) of respondents said they never bought a plan, with 61 percent of those who did not buy a plan in the individual market citing expensive premiums as the main reason."[18]

Profits Before Membership Growth

To insurance company CEOs and chief financial officers, elaborate efforts to avoid costly customers (an activity known as "underwriting," "lemon dropping," and "risk avoidance") are routine techniques that protect the bottom line. Most of the CEOs of the biggest insurance companies have publicly proclaimed their determination to move quickly to reduce enrollment, if necessary, to increase profits. In 2008, WellPoint CEO Angela Braly famously said, "We will not sacrifice profitability for membership."[19] Her comment echoed a 2003 remark by Humana CEO Michael McCallister: "If we have to choose between achieving our membership goals and achieving profitability goals, profits will win every time."[20]

Aetna was a leader in this approach beginning in 2000 after acquisitions had built its enrollment to 21 million, the largest in the country at the time. When executives realized they had taken on too many sick patients, they set about the job of getting rid of them. Aetna soon had purged 8 million members from its book of business.[21]

This industry strategy, which continues to go unchecked by the states, has created a uniquely American tragedy with a huge human toll. People without health insurance coverage are more likely to delay care, to get less care, and to die when they fall ill. Harvard Medical School researchers last year concluded that 44,789 Americans each year—123 people every day—die because they lack health insurance.[22] Others are driven to financial ruin. Medical debt was a key reason that 62 percent of personal bankruptcy filers sought court protection in 2007.[23] In 2008, there were 1.07 million non-business bankruptcies filed nationwide.[24] No other developed nation allows insurers to discriminate against the sick this way.

But the sickness and death inflicted on Americans is often camouflaged by the financial and medical complexity of care, the sensitive and private nature of health care, and the industry's lack of public accountability. As medical care grows more expensive and health insurance benefits more limited, millions of insured Americans are exposed to the catastrophic costs of accidents and illnesses—even when they think they are financially protected. More families are finding themselves without adequate health benefits just as the cost of coverage on the open market has climbed to record levels,[25] far outstripping growth in wages.[26]

Premium Growth Disconnected From Economic Conditions

Although the unfair system created by Big Insurance has left behind a huge swath of Americans who must fend for themselves, health insurers have relentlessly imposed higher premiums, deductibles and cost-sharing requirements for everyone else. The for-profit companies have pioneered these techniques, and their non-profit competitors have followed suit. A recent national survey by Buck Consultants, a human resources firm, forecasts more of the same premium growth in 2010. Buck surveyed insurers providing health benefits to 78 million Americans and concluded that premiums for the most popular medical plans will increase more than 10 percent this year.[27] As usual, this kind of cost growth is out of sync with broad trends in the wider economy, which has retrenched. Double-digit increases in health insurance premiums come as experts forecast that in 2010 the U.S. gross domestic product will rise 2.1 percent; the overall

personal consumption expenditures index will grow 1.4 percent; and the consumer price index will climb 1.6 percent.[28]

Most insurers continue to protect their profits by reducing the share of premium dollars spent on actual medical care, as opposed to marketing, underwriting, overhead, administration and gargantuan CEO salaries.[29] In 1993, the leading insurers used 95 cents of every premium dollar on medical benefits, according to the consulting firm PricewaterhouseCoopers.[30] Ever since, health insurance executives have pursued mergers, acquisitions and initial public offerings that turned the for-profit health insurance industry into a Wall Street juggernaut.[31] Many non-profits decided that if they couldn't beat the for-profits, they should join them, and conversions were rampant in the 1990s. Along the way, health insurers' medical loss ratios plummeted even as medical costs and premiums grew far more rapidly than overall inflation. By 2007 investor-owned health insurers had reduced spending on actual medical care to less than 85 percent of premiums collected, according to the analysis by PricewaterhouseCoopers. The unweighted average medical loss ratio of the five companies last year was 82.8 percent,[32] a figure some Wall Street analysts and investors consider too high. The pressure is already on to bring it down further, and that is achievable in the many states that permit much lower MLRs.

Private health insurers offer scant evidence that they have done or are willing to do anything to restrain the relentless upward march of health costs. The industry argues that premiums are rising because underlying health costs—what doctors and hospitals charge for tests, procedures, treatments, etc.—are skyrocketing. But the picture is not so simple. Insurers are willing players at the nexus of all health care transactions. Like banks, insurers benefit from handling and investing vast rivers of premium cash even if they don't get to keep all of it. The typical insurer keeps health care providers and patients waiting an average of nearly two months before paying off legitimate claims.[33] The money made by holding this money for so long is substantial. On one hand, insurers delay payments to hold the money and use it for corporate purposes that benefit shareholders, while on the other hand insurers are unwilling or unable to restrain the continual increases in providers' rates.[34] Exploiting these inefficiencies is a key pathway to profit.

Insurers Unwilling or Unable to Restrain Costs

If they chose to, private insurers could use their market power to drive hard bargains and lower costs. Instead they have passed along higher provider costs through higher premiums to enrollees and employers, generating enormous profits in the process. 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 in this environment do not face competitive pressure from smaller insurers, which cannot negotiate better rates with providers and so adopt premiums that "shadow" those of dominant insurers. Consequently, insurers are able to pass costs on to individuals.[36]

The inexorable growth in health spending, which happens with minimal resistance from the health insurance industry, puts our country at a tremendous disadvantage in the global marketplace, where the lowest employment cost structures determine which nations are more likely to attract investment and create jobs.

The difference in health care spending between the U.S. and other advanced nations is breathtaking, and thanks to the practices of Big Insurance it has climbed to a level never before seen in the developed world. For every dollar spent in the U.S. last year, 17.3 cents was devoted to health care, up 1.1 percentage points from the previous year and the largest single-year increase on record, according to actuaries at the U.S. Centers for Medicare and Medicaid Services (CMS).[37] Such rapid growth in relative spending, especially at a time when the economy is sputtering, is a hidden tax on families and businesses. It reduces the U.S. standard of living, keeps wages down, drains family bank accounts and weakens our ability to compete with other countries. Without comprehensive national

health insurance reform that will make quality, affordable care available to all, the portion of our economic output devoted to health care is projected to rise to a staggering 19.3 percent in 2019.[38]

"In the absence of change, the [CMS] report raises a grim prospect for the country—a health care system consuming an ever greater and potentially unsustainable share of the economy even as private health coverage lags," wrote health policy reporter Noam Levey in the Los Angeles Times.[39]

Defenders of the status quo claim the U.S. has the best medical care in the world, but government statistics say we don't even come close. We rank far below many nations in life expectancy and quality of life, according to the World Health Organization.[40,41]

Of the estimated $809 billion spent on private health insurance in 2009,[42] the five biggest for-profit companies—WellPoint, UnitedHealth, Aetna, Humana and Cigna—captured $232 billion.[43] Their share of the pie has increased steadily through mergers and acquisitions. Unless comprehensive national health reform is passed to rein in insurers, increase their accountability and require them to offer quality, affordable coverage, the U.S. faces a bleak economic future. Without national reform, consolidation will continue unabated, Big Insurance will gain greater market power and bigger profits, and a business model built on blatant discrimination against the sick and the unlucky will become more entrenched.

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