Podcast Transcript

Who are the 'Big Six' taking over America's health care?

Dispatcher: *911, what's your emergency?*

Caller: *America's healthcare system is broken and people are dying! (ambulance siren)*

Welcome to Code WACK!, where we shine a light on our callous healthcare system, how it hurts us and what we can do about it. I'm your host **Brenda Gazzar**. This time on Code WACK! What is the health insurance industry's game plan for the future? What role is Medicare playing in that plan - and what does that mean for us? To find out, we recently spoke to health insurance industry whistleblower and New York Times bestselling author **Wendell Potter.** Wendell is the former VP of corporate communications for the health insurance giant CIGNA. Today, he's a strong and informed voice for Medicare for All and is the co-founder of Business Leaders for Health Care Transformation.

Welcome back to Code WACK! Wendell.

(00:46):

Potter: Thank you very much. Thanks for having me back.

(00:48):

Q: Oh, it's great to see you again. So it's been 12 years since the Affordable Care Act was signed into law. Unfortunately, most of us are paying a lot more for health insurance today than we were before then. And the health insurance industry seems to be loaded with extra money to invest in mergers and acquisitions. Is the industry consolidating and if so, what does this mean?

(01:10):

Potter: The industry absolutely is consolidating. In fact, it's been consolidating for many years, certainly since the Affordable Care Act was passed in 2010. Not only have they been buying smaller competitors, they have been engaging in what's referred to as “vertical integration.” Big insurance companies have been merging with big pharmacy benefit management companies in recent years. Aetna merged with CVS, which owns the big PBM Caremark. It is now the fourth largest company in America. The number five largest company is now United Healthcare, which has grown over the years because of mergers and acquisitions. It also operates one of the country's largest PBMs.

Cigna, where I worked, is number 13 on the Fortune 500 of American companies. It merged with Express Scripts, which was yet another big PBM and those companies together control about 80% of the PBM market and an enormous percentage of the health insurance market. Since the Affordable Care Act has passed, they've grown so much that their revenues have quadrupled and their profits have grown from something like $12 billion in 2010 to over $60 billion dollars last year so these companies have become massive, massive companies.

(02:27):

Q: Wow – and why is that a concern?

(02:29):

Potter: It’s a concern because as they bulk up, they are more and more in control of our healthcare system. They are not only insurers. In fact, that's not even an appropriate term for them anymore because of the way they've changed. They refer to themselves often as health services companies. They've been buying up physician practices. United (Healthcare) is the biggest employer of physicians in the country and CVS of course operates retail facilities and

clinics around the country so they're getting more and more and more into healthcare delivery. So they will be able to control and already are controlling not only our health insurance, but steering us to providers that they own and/or operate. So that's one concern. The other is that they – as they get bigger and bigger – they have more money to spend, to influence public opinion, to lie to us, essentially, and to influence public policy and campaigns. They spend huge, huge sums of money more than they ever had before because they have more of it to influence the outcome of elections and the outcome of public policy.

(03:32):

Q: Hmmm, wow. So you recently completed a financial study of the six biggest health insurance companies. Who are they and how have they fared?

(03:40):

Potter: The Big Six as I refer to them or we can just collectively call them Big Insurance. They're United Health, CVS, which owns Aetna. You've got Anthem, which owns a lot of the Blue Cross/Blue Shield plans around the country. You've got Cigna, where I used to work. You've got Humana, where I used to work and you've got Centine, which is a company that probably of those six is less known, but they're pretty big in California and elsewhere. They bought Health Net some years ago, which was a significant player in California and Centene in particular is a big player in the Medicaid managed care arena. They manage the Medicaid programs for a lot of states and they have a big chunk of the California business.

(04:20):

Q: Hmmm, right. So with all of the insurance industries, soaring revenues and profits, you'd think we would all have amazing health coverage. Ha! Has our taxpayer investment in the Affordable Care Act, which was originally estimated to be around $1 trillion paid off for consumers in terms of healthcare affordability and security?

(04:41):

Potter: We are paying so much more for our health insurance now than we were back in 2010. The Affordable Care Act might have slowed the rate of increase in premiums for a while but the average premium for a family through the workplace is over $21,000 now. We and our employers, if we get our coverage through the workplace, pay that and it keeps going up every

year, and it's not just that. These companies are making us pay more and more and more out of our own pockets through cost-sharing requirements, deductibles, co-payments, co-insurance before they all pay a dime. So that's one of the ways they've been able to amass these enormous profits.

They are not paying nearly the same percentage of claims or the amount of claims they used to pay because of their ability to shift more and more of the cost to us. Now, the Affordable Care Act did put a cap on how much we will have to pay out-of-pocket, but it's an extraordinarily high cap and most American families, or many of them don't even have $400 in the bank, much less over $17,000, which is the maximum out-of-pocket for a family policy. So more and more people who have insurance are filing for bankruptcy when they get care because they just simply don't have the money to cover their medical expenses.

(06:01):

Q: So unfortunate. You've noted that there's been some growth in commercial health plan enrollment, but the growth in government plan enrollment has been exponential. Are you referring to employer-sponsored group plans vs. Medicaid and Medicare Advantage plans and how much growth are we talking about?

(06:22):

Potter: Yeah, we're talking about really anemic growth when you're looking on the commercial side or private paying customers. A couple of those big insurers actually lost commercial membership over the past 12 years and the others, the gains have been relatively insignificant, almost 90% of the enrollment growth of these Big Six companies over the past 12 years, 90% has come through government programs through Medicare Advantage programs, through managing state Medicaid programs like Centene does, and Anthem does and many other of these big insurers manage state Medicaid programs. They sell Medicare supplement policies, and some of them are in the military health insurance business, Tricare and federal and state employees. So they get most of their revenues these days from us as taxpayers, not from us as private citizens buying health insurance from them.

(07:17):

Potter: And why is that?

(07:19):

Potter: It's because the Medicare program in particular has become a big cash cow for these companies. It wasn't always that way. Republicans wanted to privatize the Medicare program. They have for years. And back in the eighties and nineties, they tried to encourage private insurance companies to offer policies that competed with the Medicare program and they attracted some business, but not much, and in fact, the program was languishing until 2003, when George W. Bush was in the White House and Republicans controlled Congress. That year Congress passed what was called the Medicare Modernization Act of 2003, among other things that established the Medicare part D program, the pharmacy benefit for Medicare beneficiaries. Much of that part of the bill was written by lobbyists for insurance companies and drug companies but the other significant part of that bill – really for insurance companies – was revamping that Medicare program to make it more enticing for private insurance companies. They renamed it Medicare Advantage, and it just changed the landscape over the years, to the point that about 45% of Medicare-eligible people in this country, if not more, are now enrolled in a private Medicare Advantage plan and they're lured into these plans. These, you know, the commercials that we all see every fall make them sound like it's the best thing since sliced bread. It's almost too good to be true, but people fall for it. They enroll in these plans without knowing the downsides and there are plenty of downsides.

(08:57):

Q: Right. Thank you for speaking to that. That's so important. The health insurance industry is certainly thriving, but like all corporations, they never seem to be satisfied. They always want more and more profits. Do you think the health insurance industry has a strategic plan for the future? And if so, what might that be?

(09:15):

Potter: Well, they absolutely have a strategic plan. The individual companies do and frankly, as an industry, there is a strategy certainly to maintain their grip on us and on our healthcare system but individually they have a strategy to get us to Medicare for All to be honest with you – and their version of that would have all of us in privately operated Medicare Advantage plans. In fact, the former chief executive of Kaiser Permanente is out there trying to get people to sign on to the notion that “Medicare Advantage for All” is a way to go and is gathering some steam and Medicare Advantage has a lot of fans and us on both sides of the aisle. So that's one thing we

need to worry about. And I think it does worry a lot of people who support Medicare for All. I think more and more of them are waking up to the very real threat that we might get there in a way that we do not want. In my view, the worst case scenario would be for these private companies to really control the program, the Medicare program and we're just a couple of years away at most if current trends continue before more than half of Medicare beneficiaries are enrolled in these private plans. That means … the traditional program is going to be weaker and weaker and less and less popular. That scares me a lot and should scare a lot of folks who support single-payer healthcare or Medicare for All.

(10:40):

Q: Wow. And so if everybody had Medicare Advantage, what do you think the impact would be on people who are really sick, for example?

(10:49):

Potter: Well, it would be very bad. People who enroll in these plans are sold on the notion that they can get into these plans and not pay anything more, zero premium plans. You've probably seen those advertised. But they operate just like private plans do because they are private plans. They're just like private commercial plans except the government and we taxpayers are picking up the fare. They engage in prior authorization, which the traditional Medicare program does not do – does very rarely – and that means that if you were on a Medicare Advantage plan and your doctor prescribed something for you, whether it's a treatment or a medication there's a very good chance that your Medicare Advantage insurer will say, 'no, we're not going to approve that.' And so that's called prior authorization. Sometimes it's just a delay in getting the treatment or the medication your doctor says you need, but often it's a flat "no."

(11:45):

Potter: And most people don't realize they can appeal that and get it overturned but that's one thing. The other is limited networks. The traditional Medicare program doesn't have networks. Just about every doctor, just about every hospital, every facility in the country participates in the Medicare program. Of course, they're vetted to make sure that they are quality providers, but there is no network like private insurance companies operate. So you can be in a Medicare Advantage plan and the doctor that you would like to see or had been seeing might not be in your network and the thing that a lot of folks don't realize is that some of these provider

networks can be very, very skimpy and inadequate, particularly as you get older and there have been a lot of studies that have shown that a lot of people, as they age into their seventies, eighties, and even nineties and their health begins to deteriorate and they need more care, including skilled nursing care, find that the facilities are few and far between.

(12:49):

Potter: And a lot of them go back into the traditional Medicare program. My mother was one of them. That happened to her because of just what I described and it took a while to get that accomplished. People need to know that there are a lot of facilities that are not in these Medicare Advantage networks and the facilities, the doctors that you might want to see, might not be in there and most of these plans do not provide any coverage, zero coverage for out of network care. That's one thing.

The other thing to keep in mind, too, (is) these plans just like private plans have in some cases considerable cost-sharing requirements. Now, so does the traditional Medicare program and that's one of the things that I've been trying to get changed and there was an opportunity to do that this year when the House of Representatives passed the Build Back Better Bill. Included in that (bill) was a provision that capped the Medicare Part D out-of-pocket requirements at $2,000 a year. That bill's not going to pass the Senate. There may be some bill that's some version of that that does pass. So there's work that we need to do on the traditional Medicare program too to improve out-of-pocket requirements. We can do that but the point here is that Medicare Advantage plans, they have all of these barriers that can be in your way of getting the care that you need, that your doctor says you need.

(14:09):

Q: Wow. And when you talked about Medicare Advantage for All that would be for even people under 65, correct?

(14:18):

Potter: Yes, exactly. And when you see that almost all of the enrollment gains for these big companies has been in these federal or state programs, you can see they figured out how to make a lot of money on this. The thing is the federal government back during the Bush administration began to overpay private insurance companies to participate in this. They wanted to provide some incentive for private insurance companies to come into this space. Those

overpayments never stopped. They're less now than they were because the Affordable Care Act did eliminate or reduce some of the overpayments, but they continue. So we, as taxpayers, are paying more to these private insurance companies. It costs more to ensure a Medicare beneficiary in the Medicare Advantage program than it does traditional Medicare and they've gamed the system through a mechanism called risk scoring that enables them to collect more money from the federal government if the insurance company makes the case that the people enrolled in their health plan are sicker than they anticipated they would be. So they game it by saying that you might have some medical condition that means that you will need more expensive care than you thought you would, or that you actually do. So they've, they figured out how to game the system that way, too..

(15:39):

Q: Ooh. In 2021, health spending accounted for nearly 20% of the nation's Gross Domestic Product, or $12,530 for every person, up from 17% in 2012. This trend does not sound good for our economy. What can you tell us about this?

(15:57):

Potter: Well, it's true. It keeps going up. The percentage that we spend on health care keeps going up, and there's no reason to expect that's going to stop. It's just been a trend that keeps going in the same direction. What that means, I mean, some people will say, “well, so what, that's our choice. That's what we decide to do.” We don't decide that, but it is the way the system is structured that enables or encourages prices to continue to go up in health care.

Private insurance companies cannot nor do they really want to control healthcare costs so as a consequence, prices go up every year and that's why it becomes an increasing component of gross domestic product. We spend I think about $4.3 trillion dollars all together on health care in this country. That's the figure that is used to compute that nearly 20% of GDP.

My own calculations as I was looking over these dozen years of those financial disclosures to the Big Six companies (is) about one of every $4 of that now flows through just those six companies. Their total revenues last year totaled to $1.1 trillion dollars. So you see a lot of this money flows right through these big companies. They take a chunk of that to convert to profits, to reward their shareholders and their top executives, and to have a big bucket of money to spend on propaganda and campaign contributions and lobbying.

(17:25):

Thank you, Wendell Potter. Tune in next time to hear Wendell talk about how health insurance industry practices are affecting businesses.

Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at heal-ca.org.

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