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**Before the**

**Senate Committee on the Judiciary**

**Subcommittee on Antitrust, Competition Policy, and Consumer Rights**

**On**

**"Health Insurance Industry Consolidation:**
**What Do We Know From the Past, Is It Relevant in Light of the ACA, and**
**What Should We Ask?"**

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## Summary

Nearly two-thirds of the U.S. population under age 65 is enrolled in a private, comprehensive health insurance plan.[1] The private health insurance industry is also playing an increasingly important role in supplying coverage to enrollees in public insurance programs. The public interest in a competitive, robust marketplace has never been greater. Not only are private insurance premiums ($16,834 for the average family) and out of pocket spending ($800 per person)[2] high and projected to grow, but the individual health insurance mandate now requires those without public coverage to purchase private policies. Federal subsidies for the purchase of private insurance through the health insurance marketplaces are projected to total $32 billion in 2015, and $84 billion by 2020.[3] Given these stakes, there is a substantial public benefit to critically evaluating any significant changes in industry market structure.

There are two primary and complementary ways to assess the impact of consolidation: backward-looking (what has happened in the past?) and forward-looking (what is different, if anything, and how might those differences alter predictions based on the past?). This testimony addresses both. First, I review economic studies on the impact of insurance consolidation on premiums and other outcomes of potential interest to consumers. These studies suggest that consolidation leads to premium increases. This is true notwithstanding the growing body of research that finds insurers with larger local market shares pay lower rates to healthcare providers, particularly hospitals.[4] As I discuss below, lower provider rates can, under certain circumstances, also harm consumers directly. The evidence on the link between insurance market concentration and health plan quality is sparse, but at least one study suggests benefit generosity declines with fewer competitors.[5]

In sum, economic research demonstrates that insurance industry consolidation in the past has not tended to improve the lot of consumers. Any individual proposed merger may have different

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[1] National Center for Health Statistics, "Early Release of Selected Estimates Based on Data From the National Health Interview Survey, 2014," Table 1.2b, *available at* http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201506.pdf.

[2] Kaiser Family Foundation and Health Research & Educational Trust, *2014 Survey of Employer Health Benefits*, *available at* http://kff.org/health-costs/report/2014-employer-health-benefits-survey; Health Cost Institute, *2013 Health Care Cost and Utilization Report, available at* http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report.

[3] Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline*, March 2015, *available at* https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf.

[4] I discuss the evidence on this point below.

[5] Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.

effects and should be evaluated on its own potential merits, however these merits should be assessed with the context provided by this academic, refereed body of literature.[6]

Proponents of continued industry consolidation have introduced two primary arguments for why the existing research is not prescriptive in the post-ACA era. The first is that the Medical Loss Ratio (MLR) regulation[7] prevents merging insurers from reaping profits that might otherwise be possible as a result of a post-merger increase in market power. Essentially, this amounts to a claim that the MLR regulation provides a substitute for competition. There are a number of reasons to doubt this supposition. Chief among them: the MLR regulation does not pertain to the majority of privately-insured Americans, who are enrolled in self-insured plans (which are exempt from the regulation) [8]; it does not adequately address non-price competition; it is likely "gameable"; and the legislated minima may be below prevailing MLRs in certain markets and have no impact at all.

The second argument is subtle, and embraced to a greater extent by economists than industry: insurers with larger local market share have stronger incentive to invest in changing the healthcare delivery system through payment innovations because they can reap more of the rewards from their local investments. At the same time, providers can spread their costs of collaborating on these innovations across more lives. Although this argument has merit, there is also an important countervailing effect of size. An insurer with stronger market power has less of an incentive to invest in new products as it "replaces itself" in the market, i.e. there is less potential to "steal business" from rivals. In addition, there is no research showing that larger insurers are likelier to innovate.

In sum, I see no reason the evidence from the past should be discounted when evaluating current and future consolidation. I would also caution that consolidation that occurs now is unlikely to be undone if it later proves anticompetitive. History also suggests that vigorous competition by new entrants is unlikely to arise and offset such effects.

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[6] As the Horizontal Merger Guidelines state, merger analysis "is a fact-specific process." U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf.

[7] The ACA requires health insurers to maintain an MLR, defined as the proportion of premium revenues spent on clinical services and quality improvement, above 80% for fully-insured individual and small group plans and 85% for fully-insured large group plans. An insurer falling short of these minima must provide rebates to policyholders such that the MLR meets the prescribed level. *See*, e.g., Center for Consumer Information & Insurance Oversight, "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," Dec. 2, 2011, *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/mlrfinalrule.html.

[8] Approximately 54% of privately insured Americans are exempt from MLR requirements. (This figure is derived as the product of the share of privately insured Americans with employer-sponsored coverage–88 percent–and the share of covered workers enrolled a plan that is completely or partially self-funded–61 percent.) Kaiser Family Foundation and Health Research & Educational Trust, *2014 Survey of Employer Health Benefits*, *available at* http://kff.org/health-costs/report/2014-employer-health-benefits-survey. Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2015, *accessed* Sep. 9, 2015, http://kff.org/other/state-indicator/total-population.

My testimony concludes with a call for sunshine. It is unlikely that consolidation is "inherently bad" or "inherently good"; we need research that reveals how to protect against harms and unlock benefits. Current and historical data on various aspects of commercial health insurance (e.g., enrollment and costs) at a disaggregated level (e.g., by specific health plan, customer segment, and sub-state geographic market, such as the MSA) would enable research that would help us to understand whether and where consolidation is harmful or beneficial, and for whom. While such transparency is rare in many private industries, it is common where there is a strong public interest and substantial public regulation, both of which characterize this vital sector.

## 1. Concentration in the Health Insurance Industry Is High and Growing

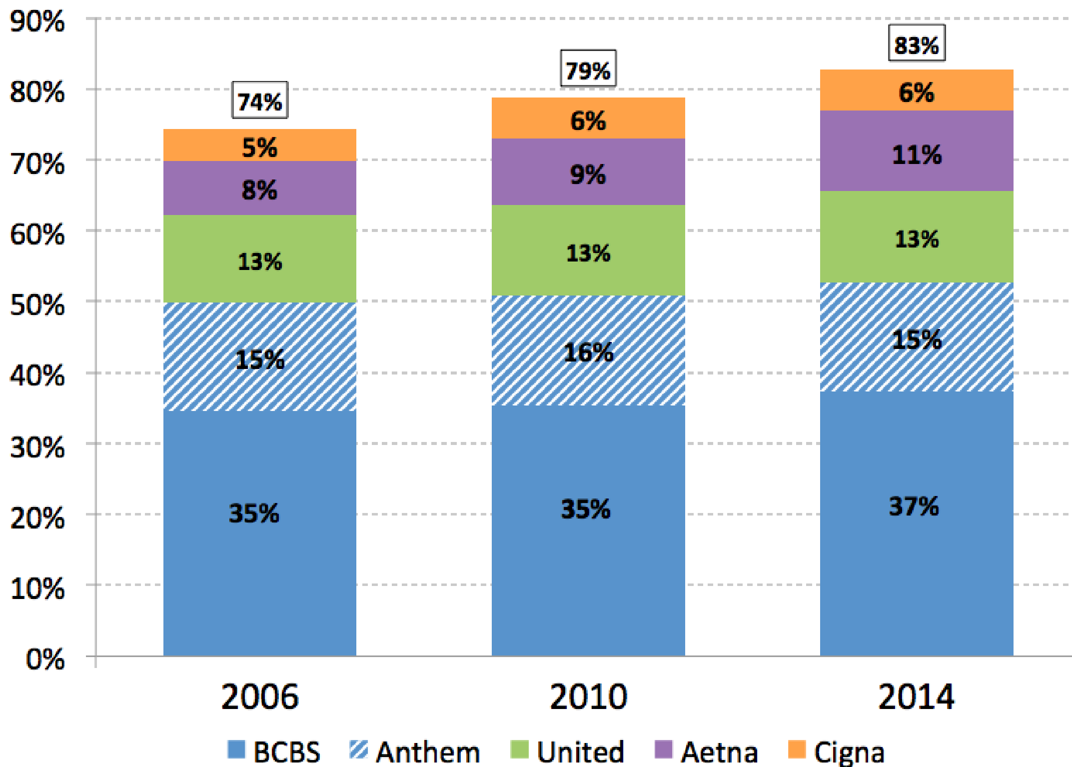
### *1.1 Private Health Insurance Plans*

Roughly 175 million Americans under age 65 purchased private insurance through their employers or via the individual insurance market in 2013, the most recent year for which data are available.[9] The industry has expanded since the introduction of the health insurance marketplaces in 2014.

Figure 1 contains my rough estimates of the national market share of the four largest insurers over the period 2006–2014. For most customers – national multisite employers being the primary exception – insurance markets are local, but these share estimates provide context for the changing landscape. In the figure, all 36 Blue Cross and Blue Shield (BCBS) companies are grouped together. With a few exceptions, BCBS affiliates have exclusive, non-overlapping market territories, and hence do not compete with one another. Shares for Anthem, Inc., the for-profit insurer (previously known as Wellpoint) that today operates BCBS plans in 14 states, are denoted separately.

[9] Per the U.S. Census Bureau's 2013 Current Population Survey (CPS) Annual Social and Economic (ASEC) Supplement, Table HI01, *available at* https://www.census.gov/hhes/www/cpstables/032014/health/h01R_000.htm.

**Figure 1. Estimated National Market Shares of 4 Largest Insurers, 2002–2014**[10]




The national four-firm concentration ratio (the sum of the leading four firms in terms of market share) for the sale of private insurance increased significantly between 2006 and 2014, from 74 to 83 percent. As a point of comparison, the four-firm concentration ratio for airlines is 62 percent.[11] BCBS affiliates collectively account for over half of privately-insured lives today, a position they have held throughout this period (following growth during the first half of the 2000s, not pictured). The figure also reflects some of the more significant mergers among non-BCBS insurers in recent history, including the acquisition of Coventry by Aetna (in 2013).

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[10] Figure 1 is constructed using the number of privately-insured lives reported in each insurer's annual reports. Consistency over time and across insurers in terms of products included is not assured. BCBS share (exclusive of Anthem) is estimated using enrollments reported by BCBS for 2010 and 2014, and extrapolating back to 2006 by applying the growth rate in BCBS enrollments from data supplied by the National Association of Insurance Commissioners (NAIC), and corrected for states not reporting or underreporting BCBS enrollment. The BCBS association reports total enrollment of 100 million in 2010 and 106 million in 2014 and may include non-comprehensive insurance. Unfortunately, NAIC reflects only fully-insured plans outside of California, whereas Figure 1 includes both full and self-insurance for all states. Anthem operates BCBS affiliates in CO, CT, KY, ME, NH, NV, OH, VA, IN, GA, MI, WA, CA, and NY. National market size in each year is the number of privately-insured lives, as estimated from the Current Population Survey. Current Population Survey, "Total people with private health insurance," 2002–2013, *available at* http://www.census.gov/cps/data/cpstablecreator.html.

[11] U.S. Department of Transportation Bureau of Transportation Statistics, "Airline Domestic Market Share July 2014–June 2015," *available at* http://www.transtats.bts.gov/.

Figure 1 does not necessarily reflect the degree of concentration in insurance markets that are relevant to most consumers. Commercial health plans are generally offered and priced differently for each customer segment (e.g., individual, small group, large group-fully insured, large group-self-insured – and perhaps others) in different geographic areas. These areas are generally smaller than the state (e.g., metropolitan and/or micropolitan statistical areas or ratings areas as defined for the state health insurance marketplaces).[12] There are many health plans with a significant local, but not a national, presence - Kaiser, Intermountain, and Geisinger among them. The degree of competition in any product and geographic market depends on the relevant market participants (current and potential), and on the characteristics of the plans they offer (or might offer).

The American Medical Association publishes an annual report containing commercial insurance market shares for the top 2 insurers, as well as corresponding market Herfindahl index (HHI), in 388 metropolitan statistical areas (MSAs). These reports show that concentration is generally higher within local markets than in the nation as a whole: the median population-weighted *two*-firm concentration ratio for 2012 is 0.65. Concentration within MSAs also appears[13] to be increasing over time. The median HHI increased from 1,716 in 2001 to 2,973 in 2012, well in excess of the threshold for "highly concentrated" (2,500) per the *Horizontal Merger Guidelines* issued jointly by the Department of Justice and the Federal Trade Commission.[14]

### *1.2 Medicare Advantage*

There are nearly 22 million Medicare beneficiaries enrolled in Medicare Advantage plans of various kinds.

Figure 2 presents the market shares of the four leading providers of Medicare Advantage plans in from 2007 to 2015. Again, these shares are provided for context and may not reflect market structure at the local level at which Medicare beneficiaries make plan selections. The four-firm concentration ratio increased markedly between 2011 and 2015, rising from 48 to 61 percent. The Medicare Advantage market has experienced significantly more turbulence than the private insurance sector, owing to myriad changes in regulations and reimbursement rules.[15] The

[12] For example, plans offered on the Health Insurance Marketplaces are priced at the rating area level. Rating areas are defined as one or more counties and are generally smaller than MSAs. *See, e.g.,* Kaiser Family Foundation, "Medicare Advantage," Jun. 29, 2015, *accessed* Sep. 9, 2015, http://kff.org/medicare/fact-sheet/medicare-advantage. CMS Center for Consumer Information and Consumer Oversight, "Market Rating Reforms," May 28, 2014, *accessed* Sep. 9, 2015, https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html.

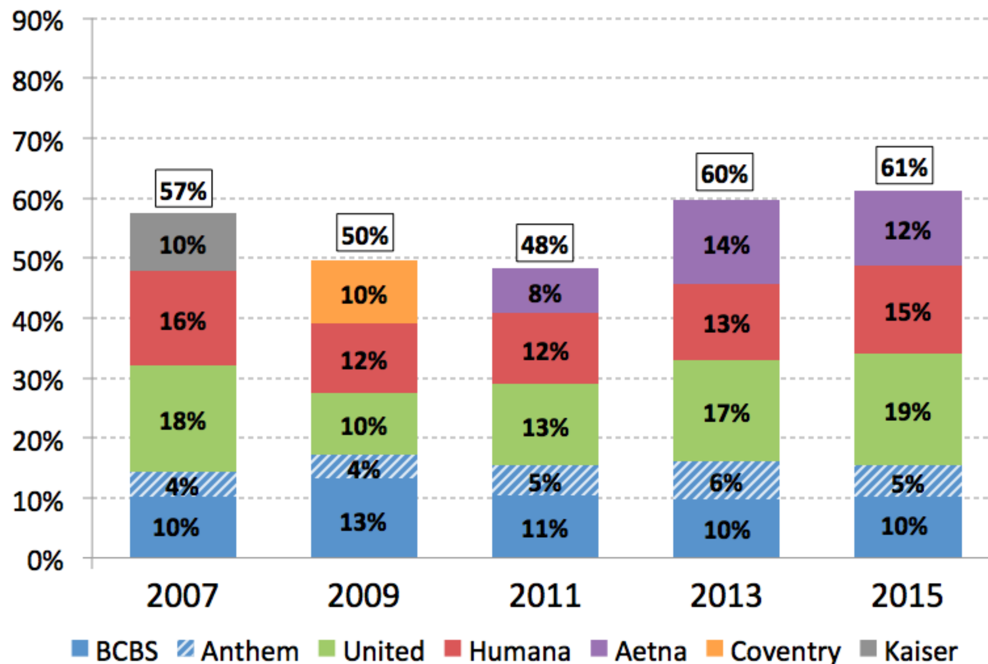
[13] The AMA reports are not strictly comparable over time due to changes in the number of MSAs included, and the inclusion of self-insured lives. The figures for 2012 include self-insured lives.

[14] U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, 2010, *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf.

[15] Total enrollment in Medicare Advantage has increased significantly over this period, from 9.3 million in 2007 to 22 million in 2015. Duggan, Starc and Vabson (2014) show that reimbursement is strongly linked to entry. They

national market leaders for Medicare Advantage are a bit different from those in the private insurance market (in Figure 1), although they are the same as the market leaders in the fully-insured segment of private insurance.[16]

**Figure 2. Medicare Advantage 4-firm Concentration Ratio, 2007–2015[17]**




Most of the research on insurance consolidation utilizes data from private insurance plans, hence my testimony focuses on this set of customers. Although Medicare Advantage and other health insurance products such as Medicaid Managed Care plans are clearly different – e.g., they face different regulatory requirements, and different challenges with regard to assembling provider networks and negotiating competitive provider rates – the insights from private insurance markets are clearly relevant in light of the similarities in the "production process" for insurance, as evidenced by the significant overlap in the suppliers across the different market types.

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estimate that for every dollar of additional reimbursement from the Medicare program, 20 cents is passed through to enrollees in the form of better coverage. Mark Duggan, Amanda Starc, and Boris Vabson, "Who Benefits When the Government Pays More? Pass-through in the Medicare Advantage Program," No. w19989, National Bureau of Economic Research, 2014.

[16] In 2013, these are United (14 percent), Anthem (11 percent), Aetna (7 percent) and Humana (4 percent). Source: 2013 CCIIO MLR data, *available at* https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

[17] Source: Centers for Medicare and Medicaid Services, Medicare Advantage Enrollment Data, 2007–2015, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html.

*1.3 Drivers of Industry Consolidation*

Industry consolidation arises from two sources: structural (i.e., entry, exit, and mergers), and non-structural (i.e., growth or decline of incumbent firms). There is little research on the relative contribution of each to rising concentration.[18] Most of the structural change has been driven by mergers, and the most significant non-structural development appears to be the growth in the market shares of the various BCBS affiliates.[19]

Insurance mergers over the past 20 years can be characterized by four phenomena: (1) attempts by regional insurers to gain broader service areas; (2) attempts by national insurers to obtain a presence in virtually all geographies; (3) acquisitions of local HMOs and provider-sponsored plans by incumbents; (4) consolidation of for-profit BCBS affiliates (into Anthem). Reported motivations include a desire to achieve economies of scale in administration, sales, and marketing; to achieve economies of scale (more lives) and scope (more product lines) with respect to pioneering novel care management and shared savings programs; to strengthen the insurer's negotiating position vis a vis providers (who are themselves growing more concentrated); and to diversify across revenue sources (e.g., government and non-government-insured lives). It is possible that the most recent merger wave is a "contagion" ignited by the announcement of some large acquisitions; to the extent that an insurer is contemplating a merger, learning of other suitors is a motivator to act quickly.

Some have posited that recent or proposed insurance mergers are the result of the Affordable Care Act (ACA). However, the figures above reveal consolidation was well underway before the ACA was passed. It is worth noting that, to the extent such consolidation is anticompetitive, it is at cross-purposes with the Act. As Professor Thomas Greaney recently observed in testimony before the House Subcommittee on Regulatory Reform, Commercial and Antitrust Law, the ACA "does not regulate prices for commercial health insurance or prices in the hospital, physician, pharmaceutical, or medical device markets. Instead the law relies on (1) competitive bargaining *between* payers and providers and (2) rivalry *within* each sector to drive price and quality to levels that best serve the public."[20]

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[18] Scanlon et al. (2005) find that non-structural fluctuations in enrollment accounted for more than one-third of the change in MSA-level HHI between 1998 and 2002. Scanlon, Chernew, Swaminatham, and Lee, "Competition in Health Insurance Markets: Limitations of Current Measures for Policy Analysis," *Medical Care Research and Review*, Vol. 63 No. 6, (Supplement to December 2006) 37S-55S. The insurer HHI data pertain only to HMOs.

[19] This growth precedes the period depicted in Figure 1. Per Ginsburg (2005), "the relative position of the Blues strengthened with the loosening of managed care because of the diminishing importance of HMOs, which were generally a weak point for the Blues. Blue plans' ability to negotiate lower rates with providers on the basis of their large market share became more important." Paul Ginsburg, "Competition in Health Care: Its Evolution Over the Past Decade," *Health Affairs* 24.6 (2005): 1512–1522.

[20] Thomas L. Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," United States House of Representatives Committee on the

In fact, the Act *promotes* competition in the insurance industry in several ways, including via regulatory reforms (e.g., product standardization and plan certification, which reduce the hurdle to entry posed by the need to establish a credible reputation) and via the health insurance marketplaces (which reduce marketing and sales costs, thereby raising the likelihood of entry). The Health Insurance Marketplaces were explicitly designed to facilitate competition among insurers. The notion that the ACA's MLR regulations, which place a floor on the share of premiums devoted to medical spending and quality improvement activities, provoke consolidation is inconsistent with profit-maximizing behavior. To the extent that scale reduces administrative costs, insurers would have benefited from such reductions in the absence of the regulation.

Even if the ACA *inadvertently* provoked consolidation – perhaps because of a surge of investor interest in growing private insurance markets, and the thirst for higher company valuations – the question before the committee today is whether this phenomenon is likely to be beneficial to consumers. To answer it, I begin by summarizing the empirical evidence on the effects of insurance consolidation.

## 2. What have we learned from the past?

### *2.1 If past is prologue, insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums.*

#### 2.1.1 Effects of consolidation on healthcare provider prices and health plan quality

Several health economists have studied the correlation between insurance market structure, typically measured by insurer HHI at the MSA level, and hospital prices.[21] Using different data sources and time periods, these studies generally find hospital prices are lower in areas with higher insurance HHIs (typically measured at the MSA level). This relationship also holds when

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Judiciary, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Sep. 10, 2015, *available at* http://judiciary.house.gov/_cache/files/0a0e88c8-0519-4a47-8fa8-4c2233c760c3/greaney-testimony.pdf.

[21] Glenn A. Melnick et al., "The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices," *Health Affairs*, 30, no. 9 (2011): 1728–1733; Asako S. Moriya, William B. Vogt, and Martin Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries." *Health Economics, Policy and Law* 5.04 (2010): 459-479.; and Erin E. Trish, and Bradley J. Herring, "How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics,* 42 (2015): 104-114. All three rely on estimates of insurer HHI calculated from InterStudy data. Melnick et al. find that hospital prices in 2001–2004 are lower in MSAs with higher insurer HHI, provided the insurer HHI exceeds 3,200. Moriya et al. find that increases in MSA-level insurer HHI between 2001 and 2003 are associated with decreases in hospital prices. Trish and Herring use more recent data (from 2006–2011) and find that hospital prices are lower among more concentrated insurance markets.

researchers study *changes* over time, i.e., areas experiencing faster growth in insurer HHI exhibit slower growth in hospital prices.

Lower prices for healthcare services will only benefit consumers if – and only if – they are ultimately passed through to consumers in the form of lower insurance premiums (and/or out-of-pocket charges); I discuss the lack of evidence for this pass-through below. However, it is worth noting that even if price reductions are in fact realized *and* passed through, if they are achieved as a result of monopsonization of healthcare service markets then consumers may experience an offsetting harm. Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal. [22]

There are a handful of studies that directly study monopsony. One study (of which I am a coauthor) finds such evidence in the wake of the Aetna and Prudential merger of 1999.[23] Post-acquisition, the combined entity covered 21 million lives. In the three-year period following the merger, we found relative reduction in healthcare employment and wages in those geographic areas where the two parties had more substantial pre-merger overlap. The implication is that the exercise of market power vis-a-vis healthcare providers reduced price *and* output – the hallmark of monopsony. Indeed, the DOJ had required Aetna and Prudential to divest health plans in two Texas markets before closing precisely because of concerns over post-merger monopsony power. This remedy proved effective: we found no evidence of monopsony in these markets following the merger.[24]

Whether monopsony is likely in the face of consolidation depends on the provider market in question. The textbook monopsony scenario described above pertains when there is a large buyer and fragmented suppliers, as is the case for physicians in some specialties within a given geographic area negotiating with dominant insurers. However, in settings where both sides possess market power and they bargain over prices, an increase in buyer power can reduce price without reducing output (or, equivalently, without leading to a deterioration in quality). Indeed, two other studies of monopsony focus on hospitals – an industry that is concentrated in many

[22] The way in which a monopsonistic insurance sector would achieve lower reimbursement rates is by setting a low market reimbursement rate, one which is beneath the value that some consumers place on those services. That is, there will be excess demand by consumers for services at this rate, and the monopsonist does not allow price to rise to expand output and equilibrate demand and supply.

[23] Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,” American Economic Review, 2012, 102(2): 1161–1185.

[24] The formal complaint alleged the merger “would enable Aetna to exercise monopsony power against physicians, allowing Aetna to depress physicians’ reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in quality of physicians’ services”. U.S. vs. Aetna Inc. (ND TX, 21 June 1999)

areas – and they find areas with higher insurer HHI have higher, not lower, hospital utilization.[25,26]

In sum, there is some empirical evidence that consumers may be harmed as a result of lower payments to healthcare *personnel,* however more research is needed on this subject.

There is very little published research on the link between consolidation and plan quality. The most relevant study to date pertains to the Medicare Advantage market. The study found that the availability of prescription drug benefits (before the enactment of Part D) was higher in areas with more rivals, all else equal.[27] There is a vast literature in other healthcare settings – e.g., hospitals – showing that quality does not improve when markets become more consolidated.[28] Although quality is often more difficult to evaluate than price, the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality.

#### 2.1.2 Insurance Premiums

There are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces,[29] the large group market (self- and fully-insured combined),[30] and Medicare Advantage.[31] A recent study suggests premiums for employer-sponsored fully-insured plans are increasing more quickly in areas where insurance market concentration is rising, controlling for other area characteristics such as the hospital market concentration.[32]

Arguably the most relevant research in light of the recent proposed mergers are two studies of consummated mergers. Both found that structural changes in market concentration led to higher insurance premiums. The first is the previously-mentioned study of the Aetna-Prudential merger

[25] Feldman and Wholey (2001) present evidence that prices are lower, but hospital utilization (a measure of quantity) is higher in markets with less competitive insurance markets. Similarly, McKellar et al. (2014) find in more concentrated insurer markets, health care prices are lower, utilization is higher, but overall spending is lower.
[26] It is worth noting that many health policy experts believe some types of health care services are overutilized. Where true, a quantity reduction arising from the exercise of monopsony power might be viewed as beneficial. However, this paternalistic approach to consumption is not ordinarily adopted by antitrust enforcers.
[27] Robert Town and Su Liu, "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* (2003): 719-736.
[28] See, for example, Gaynor, M. and R. Town (2012), "The Impact of Hospital Consolidation," *available at* http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html
[29] Steven Sheingold et al., ASPE Issue Brief, "Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums," U.S. Dept. of Health and Human Services, July 27, 2015, *available at* http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums.
[30] Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan. *Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry*. No. w15434. National Bureau of Economic Research, 2009.
[31] Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?" *The American Journal of Managed Care* 18.9 (2012): 546.
[32] Trish and Herring (2015). *Ibid.*

of 1999. Using detailed data on health insurance plans sponsored by large, mostly multi-site employers representing roughly 10 million lives, my coauthors and I found that premiums increased significantly more in areas with greater pre-merger overlap. Importantly, we were able to control for changes over time in the average premium for any given employer, so that these changes reflect relative differences across markets for the same firm. Moreover, premium increases were observed not just for the merging firms but for their rivals (in areas where the merging firms had substantial overlap). Thus, even though this particular merger was linked to lower healthcare personnel wages and employment, the cost savings were not passed on to consumers.

We used the estimate from the above paper to predict the impact of all (structural and non-structural) consolidation over the period 1998-2006. We estimate that large group premiums in 2007 were 7 percent (roughly $200 per person) higher than they would have been had local market concentration remained at its initial level. Although this is a small figure relative to the aggregate premium increase during the same period, it is large compared to typical operating margins of insurers – implying substantial consolidation-induced growth in profits.

A second study, Guardado et al. (2013), examined the effect of the 2008 merger between Sierra Health Services and United on small group premiums in two Nevada markets. As compared to control cities in the South and West, small group premiums in these markets increased by 13.7 percent the year following the merger.[33]

*2.2 There are substantial barriers to entry in the private health insurance industry, and consolidation-induced premium increases have not generally been offset by competition from new entrants.*

Over the past few decades, the private health insurance industry has seen relatively little entry by new firms. Barriers to entry include: (1) building networks of local providers and negotiating competitive reimbursement rates;[34] (2) establishing a credible reputation with area employers and consumers; (3) developing relationships with brokers, who serve as intermediaries for most purchasers; (4) achieving economies of scale in information technology, disease management, utilization review, and customer-service related functions. "Entry" into a given geographic market has tended to occur via acquisition. To wit, the most likely potential entrants in a market are incumbents in other product and/or geographic markets.[35] In light of the impediments to de

[33] Jose R. Guardado, David W. Emmons, and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" *Health Management, Policy and Innovation*, 2013: 16–35.

[34] This is a particularly salient barrier due to the "chicken and egg problem" of insurer-provider negotiations. Providers are generally willing to offer the most competitive rates to insurers with a large market share, however to gain market share an insurer needs to offer low premiums (and to do so sustainably, must have competitive provider rates).

[35] For example, recent entry in the private individual insurance market – sparked by the introduction of the Health Insurance Marketplaces and the individual mandate to carry insurance – has largely consisted of firms offering

novo entry, consolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate.

## 3. How relevant is what we have learned in light of changes arising from the Affordable Care Act?

### *3.1. Applicability of merger retrospectives*

A reasonable question to ask is whether the previously described retrospective analyses (of the Aetna-Prudential and United-Sierra mergers) are informative in light of the significant recent changes in the healthcare sector. The early evidence suggests that competition has its salutary effects on health insurance market even in the post-ACA world. One study (which I coauthored) finds that premiums on the individual exchanges in 2014 were more than 5 percent higher as a result of the decision by a large national insurer not to participate in federally-facilitated exchanges in that year.[36] Another study estimates that having an additional insurer in a given ratings area results in premium savings of nearly $500 per individual.[37]

### *3.2 The Medical Loss Ratio (MLR) regulations do not protect consumers from adverse consequences which may arise as a result of consolidation.*

The ACA enacted sweeping regulatory changes on the commercial insurance industry, including minimum product standards, a requirement that insurers take all comers ("guaranteed issue"), a ban on medical underwriting, and limits on age-based pricing. However, the provision that is most relevant to the subject of insurer consolidation and its consequences concerns Medical Loss Ratios (MLRs). As of 2011, insurers must devote at least 85 (80) percent of premium revenues – net of taxes and licensing fees – to medical claims and quality improvement for their large group (small group/individual) fully-insured lives. Insurers failing to satisfy these requirements in any given state and market segment must refund the amount of the shortfall to their enrollees in the relevant segment.

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Medicaid plans in those states. There are a number of new not-for-profit co-operatives as well, however entry of these organizations was subsidized by the federal government and many are not believed to be financially viable.

[36] Leemore Dafny, Jonathan Gruber, and Christopher Ody, "More Insurers, Lower Premiums: Evidence from Initial Pricing on the Health Exchanges," *American Journal of Health Economics,* Winter 2015: 53–81.

[37] Michael J. Dickstein, et al., "The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act," *American Economic Review*, 105.5 (2015): 120–25.

Some have argued[38] that these regulations mitigate concerns over potential anticompetitive consequences of consolidation in this sector. I do not find this argument convincing for at least five reasons.

First, more than half of privately-insured enrollees are in self-insured plans, and the minimum MLR regulations do not pertain to these plans.

Second, consumers are concerned with "value" for their health insurance dollar, and the minimum MLR restriction does not substitute for competition to provide value. Suppose there are two insurers competing in a given market segment, and both satisfy the MLR requirement for that segment. These insurers likely compete for enrollees on dimensions other than the share of spending devoted to medical claims and quality improvement activities, for example their product design, provider networks, customer service, and chronic disease management programs. Eliminating the competition (or potential competition) from this market via a merger relaxes or eliminates competition on these dimensions. Why expend effort in, say, developing shared savings programs to improve quality of care and reduce spending when you can still pocket the same margin per insured life?[39] In short, the MLR regulation attempts to cap industry profits, but it does not protect consumers from post-merger harm due to the loss of competition on a variety of relevant dimensions.

Third, for the MLR regulations to impact the usual analysis of consolidation effects, they must "bind": the statutory floors must be higher than we would otherwise see. For example, if insurers in a given market segment and state generally have MLRs above 90 percent, merging insurers benefiting from an increase in market power might still profitably raise profits and premiums by 5 percent. Although there are no published analyses of the MLR data that pinpoint where the regulations currently bind, a recent study by the non-profit Commonwealth Fund reports the following national MLRs for 2013: 85.9% (individual); 83.6% (small group); 88.6% (large group). These data suggest there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement.

In addition, because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLRs in another. For example, consider an insurer offering plans in a (hypothetical) competitive, urban individual exchange ratings area, where MLRs tend to be on the high side (e.g., 90 percent). This insurer could be an attractive target for another insurer who offers plans

[38] *See, e.g.,* CNBC, "Aetna, Humana CEOs Talk Antitrust Concerns," Jul. 6, 2015, *available at* http://video.cnbc.com/gallery/?video=3000394309.

[39] Reductions in the value of insurance provided may reduce the total volume of insurance purchased, and hence provide some constraint on the reduction in value that a profit-maximizing monopolist insurer would impose. However, the demand for health insurance is relatively inelastic, and particularly so in light of the new insurance mandates.

in less-competitive rural markets. Post-merger, the insurer might be able to lower MLRs in these markets and use the "excess" spending in the target's market to offset these new profits.

Fourth, it may be possible to legally "game" the MLR regulation by effectively labeling profits as medical costs. For example, insurers often have ownership stakes in healthcare facilities and provider organizations. Such insurers could adjust internal transfer payments to these groups to ensure MLR minima are satisfied. Similarly, many insurers engage in quality improvement efforts. It would seem possible to create a separate quality improvement arm and to charge the insurance arm fees that offset profits in excess of the MLR minima. Although these possibilities are speculative, the main point is that regulation is an imperfect substitute for competition in terms of keeping premiums low for consumers.

Fifth, the minimum MLR regulation could be repealed. If we permit transactions that would otherwise be deemed anticompetitive under the belief that the MLR regulation acts as a check on post-merger margin increases, where are we left if a more consolidated insurance industry successfully argues for its repeal? As is well known to the Subcommittee, it is an order of magnitude more difficult to dissolve a consummated merger that proves anticompetitive than to prevent the transaction in the first instance.

### *3.3. Reforms to the healthcare delivery system may give rise to new efficiencies from consolidation, but at present these efficiencies are speculative.*

The recent shift toward paying for value – rather than volume – of healthcare services will require significant changes in how insurers pay providers and how providers deliver and organize care. Some insurers have suggested that mergers will enhance their ability to develop and implement new value-based payment agreements.[40]

This claim embeds at least three possible sources of merger efficiencies (1) there are local economies of scale in implementation of value-based agreements; (2) there are non-local economies of scale in implementation of value-based agreements; (3) some insurers have a unique ability to implement such programs and others cannot replicate or access it without a merger.

Argument (1) implies that an insurer must have sufficient scale in a local market area to warrant the investment in changing practice patterns; if not, much of their investment in doing so will "spill over" and benefit rivals. Indeed, a recent study suggests the much-vaunted BCBS-MA Alternative Quality Contract for commercially-insured lives had a significant impact on

[40] For example, see Aetna's press release announcing the acquisition of Humana: "The combination will provide Aetna with an enhanced ability to work with providers and create value-based payment agreements that result in better care to consumers, and spread cutting-edge clinical practices and quality care." Aetna, "Aetna to Acquire Humana for $37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care," Jul. 3, 2015, *available at* https://news.aetna.com//news-releases/aetna-to-acquire-humana-for-37-billion-combined-entity-to-drive-consumer-focused-high-value-health-care/.

traditional fee-for-service Medicare enrollees.[41] BCBS-MA does not share in any savings generated for this population. At the same time, a provider can spread its fixed costs of collaborating with a given insurer across more lives the larger is that insurer. Although these are economically appealing arguments, at the moment they are theoretical. There is no evidence that larger insurers are more likely to implement innovative payment and care management programs. In addition, there is a countervailing force offsetting this heightened incentive to invest in payment and delivery system reform: more dominant insurers in a given insurance market are less concerned with ceding market share.

Argument (2) implies that scale across markets may be helpful in implementing value-based agreements. This might be true, for example, because of the ability to work with national employers to develop such programs. However, there is an opposing force that may also operate. Implementing new payment or care management models across disparate markets can introduce complexity and costs into national systems that are poorly designed for exceptions. For example, in early pilots of bundled payment programs, claims have been pulled for individual patients one-by-one out of claims payment processes. These costs are prohibitive and might lead to less, not more, innovation by payers with a cross-market presence. This reality may explain why concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems (sometimes vertically integrated with insurers) and non-national payers like Massachusetts Blue Cross and Blue Shield.

Argument 3 is a standard claim of merger proponents and subject to all the usual forms of skepticism. Efficiencies must be merger-specific and verifiable if they are to be credited against potential harm arising from diminished competition, and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition. Moreover, any short term gain from avoiding development costs for value-based programs may be offset by a reduction in long-term benefits arising from competition among insurers to develop better versions of these programs.

## 4. Next steps: How to assess proposed and potential consolidation going forward?

The Horizontal Merger Guidelines issued jointly by the FTC and DOJ explain how the DOJ will evaluate whether a proposed merger violates Section 7 of the Clayton Act. Some likely analyses include: (1) seeking detailed information on how costs will be trimmed *as a result* of any given transaction, and confirming they cannot be achieved in their absence or through means that are less likely to diminish competition; (2) soliciting input from state regulators and other informed stakeholders to gain an understanding of what mergers have proven beneficial in the past and the

[41] J. Michael McWilliams, Bruce E. Landon, and Michael E. Chernew, "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO Contract," *JAMA,* 310.8 (2013): 829–836.

characteristics of these mergers; (3) seeking data on MLRs at a granular level, so as to assess the relationship between prior or proposed mergers and MLRs; (4) seeking information from CMS on how Medicare Advantage (MA) is impacted by market structure (both in and outside of MA); (5) evaluating the impact of mergers on prospective entry, and the role of prospective entrants in disciplining premium growth historically; (6) considering the implications of cross-market overlap on insurance competition. This is but a short list of potential analyses.

As the Subcommittee knows, ascertaining whether a transaction violates competition law is a different matter from ascertaining whether it is in the public interest. For example, a merger that is likely to lead to price increases without offsetting benefits may not violate Section 7 if it cannot be shown that the merger lessens competition in a relevant market. Different stakeholders might also place different weights on the potential losses and gains for various affected parties. Given the significance of the insurance sector to our wallets and to the functioning of our healthcare system, the public deserves better data with which to evaluate these transactions as well as the industry more generally. As a start, I would explore avenues for requiring detailed reporting on insurance enrollment, plan design, premiums, and medical loss ratios at a fine unit of geography (e.g., zip code) and for every possible customer segment. This reporting must include self-insured plans (and specifically, the insurance administration charges associated with such plans), as more than half of the privately-insured are enrolled in these types of plans. With these data in hand, policymakers and regulators will be able to monitor market developments and to intervene, if necessary, based on better and more timely information. And researchers such as myself will, in the future, be able to provide much stronger guidance regarding the likely effects of consolidation.