Questions for the Record
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U.S. Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy and Consumer Rights
"Examining Consolidation in the Health Insurance Industry and its Impact on Consumers"
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In response to Senator Vitter's questions

1. What role do the ACA's medical loss ratio (MLR) requirements play in calculations and decisions of health insurers to consolidate?

Answer: See the attached fact sheet, "Why Medical Loss Ratio Requirements Aren't a Defense to Further Health Plan Consolidation."

Does the cap on operating expenses incentivize scale over competition, driving insurance industry consolidation?

Answer: No.

2. Do MLRs make market competition-driving high deductible health plans harder to provide, forcing insurers to avoid markets with greater moral hazard that may also have a greater need for higher administrative costs?

Answer: No.

3. Does this lack of competition result in higher health care costs for consumers? Will it do so in the future?

Answer: Yes. A lack of competition does result in higher health care costs for consumers and will impact them now and in the future. As Professor Leemore Dafny noted in her testimony at this hearing, claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. "Efficiencies must be merger-specific and verifiable…and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition" (p. 16). Professor Dafny also noted that insurance "consolidation that occurs now is unlikely to be undone if it later proves anticompetitive," as most expect it will (p. 3).

Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different (testimony of Professor Thomas L. Greaney, Before the House of Representatives Subcommittee on Regulatory Reform, Commercial and Antitrust Law, September 10, 2015).

With respect to the Medicare Advantage (MA) market, there is already an almost complete lack of competition, according to an August 2015 report by the Commonwealth Fund, which found that 97 percent of MA markets in U.S. counties are "highly concentrated." This confirms the findings of a recent report by the Kaiser Family Foundation (Medicare Advantage 2015 Spotlight: Enrollment Market Update, June 30, 2015) that also described MA markets as highly concentrated. That report also noted that, while the MA program has continued to grow in virtually all states, MA plans now provide less financial protection for enrollees and average out-of-pocket expenses have continued to climb; this is not an unexpected development in such highly-concentrated markets.

In response to Senator Tillis's questions

Much has been said of the potential ability of larger health insurers to act as a check on larger provider networks. In short, the argument goes that larger insurers can better negotiate with larger provider chains, thus creating a balance that will ultimately benefit consumers.

1. Do you agree with this justification?

Answer: No. As Professor Leemore Dafny noted in her testimony at this hearing, claims of offsetting efficiencies cannot ameliorate the competitive harm from this deal. "Efficiencies must be merger-specific and verifiable…and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition" (p. 16).

2. Further, do you believe that consolidation in the health insurance market is the inevitable result of consolidation in the provider market?

Answer: No. The seeming underlying business case for the insurance companies to consolidate – increasing "top-line" revenues and profits through acquisition rather than competition without offsetting demonstrable efficiencies – is fundamentally different than that for transactions in the hospital sector. The hospital sector is undergoing profound structural changes, driven by the need to take on risk as the field moves away from fee-for-service payments toward population health, offers integrated clinical care and provides financially failing facilities with the resources they require to survive and continue to serve their communities. Yet despite those pressures, the growth in hospital spending is at historic lows, which is entirely inconsistent with claims from commercial insurers about the impact of hospital transactions (Bureau of Labor Statistics Producer Price Index data, 2014-2015, for Hospitals (622)).

3. Finally, please opine as to whether the Affordable Care Act has hastened consolidation in health care markets, and if so, identify the features of the Act that are most responsible for this result.

Answer: The ACA is only one of many forces that are spurring realignment in the hospital field. The effort to replace a "siloed" health care system with a continuum of care is driven by the

hospital field and widely supported by both the government and private sector, as well as consumers. The effort to build a continuum has led to hospitals looking to join with other facilities, medical staff and others to improve quality and efficiency and adapt to new payment methods predicated on value.

Hospitals also are dealing with new competitors such as pharmacies, discount retailers and technology giants. This requires hospitals to be more nimble in reaching patients in the community where they live, not just an institutional setting. If hospitals are to successfully respond to these market forces, as well as government demands, they will have to do so by aligning with other hospitals and physician practices, often through mergers and acquisitions. While the antitrust agencies downplay this challenge, decades-old regulatory barriers still keep hospitals and doctors from working together when the physicians are not employed by the hospital. Real alignment to deliver population-based care takes the kind of commitment that only a fully integrated health care system can deliver.

In response to Senator Leahy's questions

Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.

1. Is there any justification for leaving this permanent antitrust exemption in place in its current form?

Answer: No.

2. Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?

Answer: As long as the McCarren-Ferguson exemption exists, insurers, including Anthem, Cigna, Aetna and Humana, will use it as a defense to anticompetitive conduct. The insurer raised it unsuccessfully when the United States sued Michigan Blue Cross Blue Shield for anticompetitive practices related to its use of most favored nation clauses to discourage entry by other insurers into the market (*U.S. et al., v. Blue Cross Blue Shield of Michigan*). In addition, they could claim that premium pricing and market allocation are protected (see statement of Christine A. Varney, Assistant Attorney General, Antitrust Division, DOJ, before the Senate Judiciary Committee, October 14, 2009, at 2-3, "It is fair to say that the McCarran-Ferguson Act antitrust exemption is very expansive with regard to anything that can be said to fall within 'the business of insurance,' including premium pricing and market allocation"). If so, this could allow for coordinated conduct, such as price fixing or market allocation agreements, among the few large national competitors that remain if these deals are permitted to go forward. The result for

consumers would be higher prices and fewer benefits, as well as reduced access to services, longer wait times and other unfortunate likely consequences of these deals.

Why Medical Loss Ratio Requirements Aren't a Defense to Further Health Plan Consolidation (Commercial Market)

The Affordable Care Act (ACA) imposes a federal minimum Medical Loss Ratio (MLR) requirement on fully-insured health insurance sold in the individual, small group and large group markets. The MLR is a measure of how much of each premium dollar (less taxes, licensing and regulatory fees) goes to pay for medical claims and activities to improve quality versus plan administration, marketing and insurer profit. The higher the MLR, the more value the policyholder receives for each dollar paid as premium to the insurer. ***A minimum MLR standard does not, however, limit the amount of premium that an insurer may charge for its health insurance plans.***

Background. Health insurers are required to publicly report MLRs each year in each state in which they operate. The federal minimum MLR standard for large insured group health insurance is 85 percent; for individual and small group insurance, it is 80 percent.[1] Through 2015, a state may define a large group as one with over 50 members; thereafter, a large group will be defined as having more than 100 members. Insurers of plans that do not meet these minimum required MLR thresholds must rebate excess premium amounts to their policyholders.

These provisions were established by the ACA with the intention of improving the value and transparency of health insurance coverage. As a result of the rebate requirement, consumers in the fully insured commercial market have recouped millions of dollars in excess premiums. However, *administrative and marketing expenses continue to account for a significant portion of premiums*. And despite the application of the MLR requirements and premium rebates beginning in 2011, insurers' profit margins experienced less than a 0.2 percentage point decline between 2011 and 2013, with the losses occurring in the individual market offset by increases in the small and large group markets.[2] In both 2013 and 2014, the performance of the large national insurers such as Aetna, UnitedHealth and Anthem was favorable, with profit margins exceeding 3.5 percent.[3]

Moreover, the ACA's MLR standards are not applied to all health coverage. The federal government estimated in 2010 that the MLR standards would protect up to 74.8 million insured Americans,[4] which was less than 40 percent of people with private health insurance that year.[5] Plans that are not subject to the MLR requirements include those that are fully- or partially self-insured, which comprise well over 50 percent of private sector employees. Also exempt are dental-only, accident-only and other "excepted benefits," as well as expatriate plans. In addition, a one-year deferral from the MLR is available to insurers that would otherwise be subject to the MLR limits but have a high proportion of new plans (representing at least half of their business in a given state). [6]

Why the MLR Doesn't Support Further Health Plan Consolidation. The MLR requirements have already surfaced as a defense to the proposed acquisitions of Cigna by Anthem and of Humana by Aetna. The argument to the Department of Justice's Antitrust Division (DOJ) and other federal and state regulators would be that the insurers are constrained from raising prices to

consumers because of the MLR margin (profit or net revenue) restrictions applicable in both the commercial and Medicare Advantage markets. This argument is unavailing and should be rejected for the several principle reasons:

1) **The ACA's MLR requirements apply to less than 50 percent of Americans under age 65 with health insurance coverage.**

As noted above, self-insured (self-funded) health plans, including self-insured association and trust plans, are not subject to the MLR standards, which means that nationwide nearly three out of every five workers are not in plans for which the MLR requirement applies.[7] Although the rate of self-insurance varies across the 50 states and the District of Columbia, in almost all states, more than 50 percent of private sector employees are covered by self-insured plans that are exempt from the MLR requirements.[8] Providing administrative services and stop-loss coverage to group health plans sponsored by employers and unions makes up a significant segment of revenues for companies such as Anthem, Aetna, and Cigna. Thus, even if the ACA's MLR requirements acted as some constraint on premiums for their fully insured lines of business, they would be able to raise the fees charged for services provided to self-funded customers. These increased fees would be passed along to employees as increased premiums or cost-sharing.

2) **The rules for reporting MLRs provide for a relatively high level of aggregation that may mask wide differences in the return on premium for an insurer's different health insurance products.**

The ACA's MLR is not based on each insurer's policy, but on an insurer's annual aggregate performance within each market (individual, small group, or large group) and state. A loss ratio computed separately for an insurer's specific book of business would be subject to more volatility due to unexpected utilization changes than would a measure across the insurer's entire book of business, for example. Yet the broader application of the measure, as required by the ACA's implementing regulations, masks potentially significant variation by market or type of plan. As such, the MLR allows insurers to offer products that do not meet the minimum MLR threshold.

3) **The MLR does not address the level of a premium. It only establishes that a minimum percentage of that premium must be used for medical claims and quality enhancing activities.**

Here are a few examples of ways that insurers can increase premiums while still meeting existing MLR standards, using an 85 percent illustrative standard and a starting premium of $1,000. *For simplicity, the example assumes that the MLR is reported for a specific health plan offered by an insurer but as discussed above, in fact, the MLR would be reported across all insured health plans offered by the insurer in its individual, small group or large group markets in a state.*

A. Plan is at MLR in Time 1

In this case, an insurer could raise the plan's premium by any amount. It would, however, need to ensure that the plan maintains its minimum MLR of 85 percent. In this example, it increases its premium by $100, increasing both its medical claims spending as well as other expenses to continue to comply with the MLR standard.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	$1,000		$1,100	
Payments for medical claims and quality activities	$850	85%	$935	85%
All other expenses	$150		$165	

B. Plan is above minimum MLR in Time 1

In this case, the plan is not impacted by the minimum MLR, since it already meets the standard. This plan can raise its premium by $60, potentially keeping all of it as profit, before becoming constrained by the MLR policy.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	$1,000		$1,060	
Payments for medical claims and quality activities	$900	90%	$900	85%
All other expenses	$100		$160	

C. Plan is below minimum MLR in Time 1

In this case, the plan is not meeting the MLR standard, so it must devote more of its premium to medical claims or quality activities. It can do this by:

- Raising spending on claims until such spending reaches the minimum standard, in this example, by raising premiums by $335.
- Providing a rebate of $50 to beneficiaries (the difference between the minimum standard of 85% or $850 and current spending on claims or $800), or
- Keeping the premium at its current level, and raising spending on medical claims (for example, by increasing provider payment rates) while simultaneously reducing administrative costs or profit.

	Time 1	Time 1 Loss Ratio	Time 2	Time 2 Loss Ratio
Premium	$1,000		$1335	
Payments for medical claims and quality activities	$800	75%	$1,135	85%
All other expenses	$200		$200	

The examples illustrate that there are many scenarios in which an insurer can raise rates that are not constrained by the current MLR requirements. A future administration or Congress also could alter the MLR requirements to make it even easier for plans to meet the regulatory criteria and still raise prices for consumers.

[1] Department of Health and Human Services, Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, *Federal Register,* December 1, 2010. Also note that the ACA gives states flexibility to impose higher minimum MLR requirements. At this point, some states do impose different (more rigorous MLR requirements than apply under federal law and regulations. Congressional Research Service, 2015. Also, HHS may, upon application, adjust the MLR standard in the individual market in a state if the Secretary determines an 80% standard would destabilize the individual market in that state. The Secretary in fact granted waivers to 7 out of 17 states that applied for waivers of the federal MLR standards for their individual markets for the years 2011-2013 on the basis that the federal minimum threshold could lead to de-stabilizing those markets. The states are GA, IA, KY, ME, NE, NH and NC. Department of Health and Human Services, "2011 Issuer MLR Rebate Estimates in States that Applied for an MLR Adjustment," Table of States Requesting Rebates, http://cciio.cms.gov/programs/marketreforms/mlr/rebateestimates.html.

[2] McCue, Michael J. and Mark A. Hall, The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3, The Commonwealth Fund, March 2015; http://www.commonwealthfund.org/~/media/files/publications/issuebrief/2015/mar/1808_mccue_med_loss_ratio_year_3_rb.pdf?la=en

[3] Mark Farrah Associates, *Enrollment Gains and Favorable Profits for Health Insurance Leaders in 2014,* May 15,2015, http://www.markfarrah.com/healthcare-business-strategy/Enrollment-Gains-and-Favorable-Profits-for-Health-Insurance-Leaders-in-2014.aspx

[4] Centers for Medicare & Medicaid Services, *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance,* www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/medical-loss-ratio.html; see also the Interim Final Rule impact statement at 75 FR 74896

[5] Calculated as 74.8 million/Population in 2010 with private health insurance. Percentage of U.S. population with private health insurance from http://www.census.gov/prod/2011pubs/p60-239.pdf. Total population from http://www.census.gov/quickfacts/table/PST045214/00

[6] Centers for Medicare & Medicaid Services, Medical Loss Ratio Requirement Under the Patient Protection and Affordable Care Act, Final Rule, May 16, 2012; 77 FR 28790; CMS, CCIIO, *May 24, 2012 FAQ,* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mlr-guidance-5-24-2012.pdf

[7] Kaiser Family Foundation and HRET, *2014 Employer Health Benefits Survey* http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report

[8] These rates are rounded to the nearest full percentage. AHRQ, Medical Expenditure Panel Survey, Table II.B.2.b.(1)(2014) Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State: United States, 2014, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2014/tiib2b1.pdf