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**BEFORE THE U.S. SENATE  
Committee on the Judiciary  
Subcommittee on Antitrust, Competition Policy and Consumer Rights**

**Hearing on “Examining Consolidation in the Health Insurance Industry  
and its Impact on Consumers”**

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\* The views expressed in this testimony are those of the author and do not necessarily represent the views of any of his organizational affiliations.

Chairman Lee, Ranking Member Klobuchar and members of the Subcommittee, thank you for the opportunity to testify on consolidation in the health insurance industry and possible consumer impact of the pending mergers of Anthem and Cigna and Aetna and Humana. I am the Norman Topping Chair in Medicine and Public Policy at the Sol Price School of Public Policy at the University of Southern California (USC). I also serve as Director of Public Policy at the USC Schaeffer Center for Health Policy and Economics. Previously, I founded and led the Center for Studying Health System Change (HSC) from 1995 to 2013. At HSC, we studied changes in the financing and delivery of health care and their impact on people, with a particular emphasis on understanding health care market dynamics. My goal today in testifying is to point out how the pending mergers of large national health insurers fit into ongoing and future changes in health care financing and delivery.

I will begin with brief comments about the complexity involved in analyzing health plan mergers. Then, I will provide some context about health insurance markets and the pending mergers with the caveat that the Department of Justice will conduct a detailed analysis of the possible effects of these mergers on competition. I raise a general point that governments affect the degree of competition among health care providers and insurers in many ways and analyzing these pending mergers should spur more attention to making policies more “pro-competitive.” In the context of the risk of higher prices that could result from increases in insurance market concentration from these mergers, I sketch out possible upsides for consumers from the mergers for your consideration. Finally, in response to a Subcommittee staff request, I discuss how the Affordable Care Act (ACA) may have influenced health plan decisions to pursue mergers.

## **Perspectives on Insurance Mergers**

Compared to mergers in other industries, health insurer mergers are particularly challenging to analyze because insurers play an intermediary role and compete in numerous distinct market segments. As intermediaries between healthcare providers and health care purchasers, insurers purchase medical services from a wide range of providers and sell insurance to cover these services to a wide range of customers, including employers, governments and individual consumers. Health plan mergers are likely to influence prices paid to providers, which in turn could affect premiums charged to purchasers. However, the competitiveness of insurance markets plays an important role in whether lower provider prices gained from insurer consolidation are passed on to purchasers of insurance.

Insurers also operate in numerous market segments that are distinct but related to each other in complex ways. Insurance markets are distinguished by the nature of the purchaser—individuals, small employers, large employers that purchase insured products and large employers that self-insure, or bear the financial risk for the cost of covered services, and purchase only administrative services. These administrative services typically include claims processing, access to provider networks, utilization management and specialized care management for

seriously ill patients with high medical costs. In addition, Medicare Advantage (MA), Medicare supplemental coverage and Medicaid managed care insurance markets are distinct.

With the exception of the market for large self-insured employers, these markets are distinct for geographic areas. In contrast, the market for the largest self-insured employers is national. The proposed mergers are likely to have more impact on certain market segments than others. In addition, some market segments tend to be much more competitive than others, with the national market for self-insured employers particularly competitive and the individual market historically less competitive, although the ACA appears to have increased competition in the individual market.

It is the job of the Department of Justice (DOJ) to conduct an in-depth analysis of the proposed mergers to assess the potential impact on competition and consumers. And, any DOJ approval is likely to be conditioned on specific divestitures in local markets where the merging firms both already have significant market share. While I do not have a position on whether these mergers should be approved or not, I do have a number of ideas about how Members of Congress—and the DOJ—might think about these mergers.

## **Effects on Competition**

The effects of mergers in health care on prices and quality of care has received a great deal of attention from economists. Much of the research has focused on mergers among providers, especially hospitals, and clearly shows that hospital mergers have led to higher prices without measurable effects on quality.<sup>1</sup> Research is only beginning on the impact of hospital acquisition of physician practices on prices and quality, although early studies indicate that such acquisitions lead to higher prices.<sup>2</sup>

Less research has focused on insurer mergers, which are particularly complicated to study for the previously cited reasons. Several studies have shown that insurance mergers have led to lower prices paid to providers.<sup>3</sup> Fewer studies have looked at the impact of insurance mergers on prices for insurance. My fellow panelist Leemore Dafny conducted a well-known study of the late-1990s merger between Aetna and Prudential and found that higher insurance prices resulted.<sup>4</sup> In her article, she also explained how the Aetna-Prudential merger offered an exception from inherent difficulties in studying the impact of insurer mergers with time series

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<sup>1</sup> Gaynor, M., and R. Town, *The Impact of Hospital Consolidation – Update*, Robert Wood Johnson Foundation Synthesis Report (June 2012).

<sup>2</sup> Baker, L. C., M.K Bundorf and D.P. Kessler, “Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending,” *Health Affairs*, Vol. 35, No 5 (May 2014).

<sup>3</sup> Melnick, G., Y. Shen and V. Wu, “The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices,” *Health Affairs*, Vol. 30, No. 9 (September 2011).

<sup>4</sup> Dafny, L., M. Duggan and S. Ramanarayanan, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry.” *American Economic Review*, Vol. 102, No. 2 (April 2012).

data. A recent study by Trish and Herring, using cross-sectional data for 2011, found that more concentrated insurer markets led to lower prices paid to providers, but savings were not passed on to insurance purchasers in the form of lower premiums. Instead, the study found that lower prices paid to providers and higher margins on insurance products roughly offset one another.<sup>5</sup> But a result with particular relevance to the Anthem-Cigna merger is that self-insured employers got lower prices for health benefits in areas where insurer concentration was higher.

The two mergers being discussed today appear to have less in the way of significant increases in concentration in market segments than other mergers among large insurers, such as the Aetna-Prudential merger in the late-1990s. Potentially problematic impacts of the Aetna-Humana merger appear mostly in the Medicare Advantage market, where some local markets would become substantially more concentrated. These impacts can be addressed through divestitures. Medicare Advantage stands out from other insurance markets in a number of ways. Since these plans are alternatives to traditional Medicare, some beneficiaries will respond to any resulting price increases by returning to traditional Medicare. The structure of the MA market and regulations governing it mean that mergers will not lead to lower hospital prices, which are indirectly linked to payment rates in the traditional program.<sup>6</sup> Finally, the federal government controls how much it pays to MA plans, so mergers do not pose a specific risk to federal outlays, in contrast to the public exchange environment. This does not mean that increased concentration in MA should not be taken seriously; the program is highly concentrated and more concentration likely would lead beneficiaries to pay higher premiums or receive less in the way of additional benefits.<sup>7</sup>

Turning to the Anthem-Cigna merger, the most significant area where concentration would increase is in the national market for large self-insured employers. Increased concentration in that market might have less impact than in other market segments because of the sophistication of the purchasers, who are human resource executives in large companies. Wall Street analysts indicate that this market tends to be highly competitive and that profit margins on the administrative fees charged to large employers are relatively low. Thus, even a substantial increase in these margins would not have a large percentage impact on what large employers pay for coverage. Note that the Trish and Herring study referenced previously found that increased insurer concentration led to lower payments for large self-insured employers, although that is only one study.

Antitrust policy is not the only public policy that affects the degree of competition in health care markets. In some cases, concentrated health care markets can be made substantially more

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<sup>5</sup> Trish, E.E., and B.J. Herring, "How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics*, Vol. 42 (July 2015).

<sup>6</sup> Berenson, R., et al., "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices," *Health Affairs*, Vol. 34, No. 8, (August 2015).

<sup>7</sup> Biles, B., G. Casillas and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?*, The Commonwealth Fund, New York, N.Y. (August 2015)

competitive. Take for example, the bidding process for Medicare Advantage. Instead of setting the benchmark that determines the Medicare payment on the basis of experience in the traditional Medicare program, a process that sets the benchmark on the basis of health plan bids would likely make MA markets more competitive and lead to savings for the Medicare program.

Another example of policies that can make markets more competitive is from provider markets. The publicly run insurance exchanges created by the ACA have proved fertile ground for health plans to offer products with limited-provider networks. These products typically have premiums about 15 percent lower than comparable plans with broader provider networks, some savings coming from excluding high-price providers and some from providers negotiating lower rates to be included in the limited network.<sup>8</sup> The design of the exchanges was a factor in these products gaining substantial enrollment, but policies on network adequacy, now under development in states and led by the National Association of Insurance Commissioners, could inadvertently limit this tool.<sup>9</sup>

Some trends only indirectly related to policy are increasing the competitiveness of health insurance markets. Some large health care systems are entering the insurance business, either by creating an insurance subsidiary or through joint ventures with existing insurers. Often the insurance products sold have limited- or tiered-provider networks, with the sponsoring or partnering health system in a favored position. A recent Avalere Health analysis reports that 15 of the 28 new entrants into MA between 2012 and 2015 are health systems and 37 provider sponsored plans offer coverage on public exchanges.<sup>10</sup> Individual insurance markets under the ACA have seen substantial entry by new insurers or existing insurers entering selected geographic markets.<sup>11</sup> The recent development of private exchanges, which are being adopted by many employers to give employees a wider choice of health plans, will also likely make the health insurance market more competitive. They have gotten off to a fast start and could play a large role in the employer market in the future.

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<sup>8</sup> Bauman, N., et al., *Hospital Networks: Evolution of the Configurations on the 2015 Exchanges*, McKinsey Center for U.S. Reform (April 2015).

<sup>9</sup> Since those shopping for insurance on the exchanges pay out of pocket the full difference in premiums among plans, even those who are subsidized, consumers are highly sensitive to premium difference. In addition, since plans are chosen by individuals rather than for groups, the typical “one-size-fits-all” constraint in employer-based coverage does not apply.

<sup>10</sup> *New Market Entrants: Growth and Diversification in U.S. Health Insurance*, Avalere Health (September 2015).

<sup>11</sup> Oatman, J.E., P. Finn and E.H. Coe, *The Emerging Story on New Entrants to the Individual Health Insurance Exchanges*, McKinsey & Company (September 2015).

A National Academy of Social Insurance panel of experts—which I served on—recently published a report exploring numerous opportunities for governments at the federal and state level to take steps to lower health care prices through policies to increase competition.<sup>12</sup>

## Potential Upside from Mergers

Insurance mergers do pose risks that purchasers of insurance will pay higher prices for coverage. Policymakers' willingness to accept these risks will depend in part on whether they believe the mergers have sufficient potential to improve health care delivery. Wall Street analysts believe that these mergers will lead to substantial administrative cost reductions for the insurers. One firm estimates that by the second year of an Anthem-Cigna merger, “synergies” will reduce operating costs for Cigna by 20 percent.<sup>13</sup> Savings might be achieved in information technology, network negotiation, regulatory compliance and other areas. These are true efficiencies from scale economies, but it is uncertain what portion would be captured by shareholders and what portion passed on to insurance purchasers.

Health plan mergers are likely to facilitate movement to alternative payment models for providers. Plans with a large number of enrollees in a market are likely to be more attractive contracting partners for providers. Not only will the potential upside of such a relationship be larger in relation to the provider management resources that would have to be devoted to the relationship, but the risk to providers of investing to change delivery in ways that increase value while still having a large part of revenues come from traditional fee-for-service payment would be diminished. When I interview hospital and physician leaders, they often use analogies like “one foot in the boat and the other on the dock” to explain a key challenge they face in transitioning from traditional payment mechanisms to value payment mechanisms such as global budgets, accountable care organizations, bundled payment and patient-centered medical homes. The ability to pursue these changes with Medicare, Medicaid and one or more large insurers makes the transition more feasible. From the health plan perspective, mergers could make it more feasible to devote resources to develop contracting approaches and the essential real-time feeds of claims data to providers that are needed for these payment approaches to succeed.

In recent years, insurers have invested in using claims data in real time to identify enrollees undergoing treatment for potentially expensive conditions where additional care management can lead to better outcomes and lower costs. For example, care coordination can be offered to patients seeing numerous physicians. Or accommodations can be made to allow some patients to recuperate at home rather than in a skilled nursing facility. Mergers allow economies of scale to spread the fixed costs of developing the analytics to support these interventions.

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<sup>12</sup> National Academy of Social Insurance, *Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Market*, Washington, D.C. (April 2015).

<sup>13</sup> Goldman Sachs, *Updating Pro Forma Analysis Following ANTM-CI Merger Agreement* (July 28, 2015).

More controversial is the potential for mergers to lower provider prices. Providers are arguing against insurer mergers because the potential for lower prices is real. But international comparisons of health spending suggest that higher prices are the key reason why the United States spends so much more for health services as a percentage of GDP than other advanced countries.<sup>14</sup> Of course, lower prices will benefit the public only if they are passed through to insurance purchasers in the form of lower premiums.

## **The Affordable Care Act and Insurance Mergers**

The ACA likely has played a role in the mergers being considered today, some of which should be seen in a positive light. The impact of the most controversial portions of the ACA—tax credits to purchase private insurance on public exchanges and Medicaid expansions—are likely not major factors behind these mergers. As discussed previously, the key focus of the two mergers being discussed today is the market for self-insured plans for large employers and the Medicare Advantage market.

In contrast to promoting mergers, tax credits to purchase private insurance on public exchanges expanded the market for individually purchased insurance and made that market more competitive. As a result of the exchanges, this market is easier to enter; there has been entry of both new insurers and existing insurers that had not entered this market in the past. It also has made it easier for health plans sponsored by large health care systems to get a foothold in insurance markets.

One ACA provision that stands out is the floor on medical loss ratios (MLR). This limits the percentage of the premium dollar that can go for expenses other than what is paid to providers on claims. My understanding is that the MLR regulations are binding in many market segments but not in others. Analysis of the two mergers that this hearing is focusing on suggests a potential to reduce administrative costs, potentially easing the challenge of complying with the MLR regulation without incurring losses. Opportunities to reduce administrative costs have become a higher priority to pursue.

Somewhat along the same lines, cuts in Medicare Advantage payment rates likely have increased pressure on insurers in this market to become more efficient. Motivated by a concern that Medicare was paying more for beneficiaries in the MA program than for those in the traditional Medicare program, cuts began before enactment of the ACA, but the law pushed the cuts further. So if merging MA businesses across two carriers can reduce costs through scale economies, the cuts in payment rates would be seen as a catalyst for a merger.

A potentially important ACA influence on mergers is Medicare provisions that have led to very extensive experimentation with alternative payment models. The ACA authorized Medicare

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<sup>14</sup> McKinsey Global Institute, *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More* (December 2008).

Shared Savings Programs for accountable care organizations and established a Center for Medicare and Medicaid Innovation with authority and funding to pilot innovations, many in the area of alternative payment. The Congress showed broad bipartisan interest in alternative payment models in Medicare when it passed the Medicare Access and Chip Reauthorization Act of 2015 (MACRA) by substantial margins. A key MACRA provision offers higher payment rates for physicians who are sufficiently involved with alternative payment models. With Medicare aggressively pursuing alternative payment models, this may help serve as a catalyst for private insurers to ramp up their efforts in this area. As discussed previously, mergers have the potential to facilitate private insurer efforts in this area.

Two other ACA provisions may be contributing to private insurer activity to promote alternative payment models. The ACA's reduction in future hospital payment rates for Medicare patients appears to have contributed to hospitals' interests in alternative payment models. With strong constraints on payment rates for admissions, broader payment units provide additional opportunities to be rewarded for cost reduction. It reminds me of hospital support in 1983 for the rapid transition from a system of cost reimbursement with increasingly restrictive limits on what could be reimbursed to the inpatient prospective payment system, where per case payments offered rewards to hospitals with lower costs per admission, such as through lower lengths of stay.

The so-called Cadillac tax provision—a 40 percent excise tax on high-cost health benefits—which is getting so much attention today, has increased employer attention to keeping the cost of their health benefits down. While employers are taking a wide variety of steps, including increasing deductibles and experimenting with private exchanges, one of the areas of interest has been shifting provider payment to emphasize value.

## **Conclusion**

In summary, health insurance mergers in general are complex and difficult to analyze, particularly because of the intermediary role that these companies play between providers of health care and purchasers of insurance. The risks that consumers will pay more for coverage as a result of mergers are real, which makes a Department of Justice analysis of the proposed mergers and what conditions to impose so important. The two mergers being discussed at this hearing have a mix of market segments in which little increase in concentration is likely to occur, while others do raise concerns. The mergers have some potential upsides through reduced administrative costs and possible acceleration of alternative payment, but it is important to ensure that some of the potential upside will be passed on to purchasers of insurance and ultimately consumers. And while some ACA provisions may have contributed to insurers' interest in merging, many should be seen in a positive light.