A Symptom; Not the Sickness: Understanding Health Insurance Consolidation

Statement for the Record

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"Examining Consolidation in the Health Insurance Industry and its Impact on Consumers"

U.S. Senate Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights

September 21, 2015

Chairman Lee, Ranking Member Klobuchar, thank you for the opportunity to submit this testimony on the impact of mergers in the health insurance industry. The two combinations of greatest concern are Anthem's announced takeover of Cigna and Aetna's announced takeover of Humana. Although tis hearing is narrowly focused on antitrust as enforced by the Department of Justice, it is also necessary to understand Obamacare as a cause of this consolidation.

One indicator regulators use to determine whether a business combination will reduce competition is whether there are significant barriers to entry in the industry. If there are, new competitors will not exploit openings created by incumbents' consolidation. The CEOs of Anthem and Aetna have each (independently) pointed to Oscar, a new health insurer with highly pedigreed investors, as evidence that health insurance is an easy business to enter.

Oscar is indeed an interesting enterprise, which has attracted fawning coverage in the business press both for its innovation and the quality of its investors. Nevertheless, Oscar is a curious start up, because it focuses exclusively on a market – Obamacare exchanges – in which insurers are losing money.

Insurers' negative experiences in Obamacare exchanges are somewhat due to Congress having protected taxpayers being exposed to unlimited liability for those losses. The administration had previously asserted unlimited liability for taxpayers. However, subsequent to Congressional hearings about Obamacare's "three Rs" – risk adjustment, reinsurance, and risk corridors – at which I testified orally, Congress acted to limit taxpayers' exposure.

Obamacare exchanges are poorly designed, so they motivate insurers to compete by offering plans attractive to healthy people, not sick people. Unfortunately (for the insurers), they largely fail to achieve this goal, disproportionately enrolling sick people instead. Because Congress finally managed to limit taxpayers' liability for health plans' losses in Obamacare's exchanges, participating insurers have been losing lots of money. This is why double-digit premium hikes have been announced for 2016. In 2017, the taxpayer-funded training wheels come off the exchanges, and participating insurers will have to cover their losses solely by moving money among themselves.

Into this minefield springs Oscar, which came into existence specifically to compete in Obamacare exchanges. In 2014, Oscar's revenue (earned entirely through New York's Obamacare exchange) was $56.9 million, of which it lost $27.6 million.

Some of the press around Oscar reads like we're talking about Zappos, the online shoe store. Apparently, its online greeting of "High, we're Oscar" and "minimalist" website count as remarkable innovation for health insurance. That is true, but does describe a path to profitability. It is important that Oscar offers free Misfit activity trackers and Amazon gift cards as rewards to beneficiaries who stay fit, because that increases the likelihood that Oscar attracts healthy, not sick, applicants. Nevertheless, its first-year experience in New York shows this is not enough.

Other new entrants include Obamacare's subsidized CO-OPs (Consumer-Oriented and Operated Plans), about which my colleague Devon Herrick testified orally to a Congressional Committee in 2014. Dr. Herrick published subsequent research this June predicting large-scale failure of CO-OPs. This outcome is unravelling before our eyes. In September, the New York Department

of Insurance ordered Health Republic Insurance, a CO-OP, to shutter due to pending insolvency. Two hundred thousand New Yorkers have lost coverage as a result.

Other new entrants include provider-based health plans, that is, health plans established by hospital systems. Like the CEOs of Anthem and Aetna, advocates of provider-based plans assert that they want to improve care co-ordination, moving beyond the Fee-For-Service (FFS) system that dominates both private insurance and Medicare. Whether the emerging crop of provider-based plans can design payment models that overcome the conflict of interest between insurance executives, hospital executives, and physicians is yet to be seen. Nevertheless, this does not change the fact that hospital systems themselves are consolidating. Therefore, it is unlikely that provider-based systems will increase the overall level of insurance competition.

Further, the whole notion of care co-ordination as a panacea for rising health costs is an unproven and very shaky hypothesis. It has been championed by business leaders for years now. While there are idiosyncratic examples of large businesses containing increases in health benefit costs through care co-ordination, there is no measurable systemic impact. The costs of group health benefits are still growing fast. The latest Kaiser Family Foundation/Health Research Education Employer Health Benefits Survey reports:

> Since 2010, both the share of workers with deductibles and the size of those deductibles have increased sharply. These two trends together result in a 67 percent increase in deductibles since 2010, much faster than the rise in single premiums (24%) and about seven times the rise in workers' wages (10%) and general inflation (9%).

The most precisely measured care co-ordination occurs in Medicare, where Accountable Care Organizations (ACOs) were launched by the Affordable Care Act (Obamacare). The Centers for Medicare & Medicare Services (CMS) have released results of Pioneer ACO's third year of operation and 2014 results for Medicare Shared Savings Program (MSSP) ACOs which launched in 2012 through 2014.

After paying out bonuses, MSSP ACOs have saved taxpayers $383 million in 2013 and $465 million in 2014. When put in perspective, these savings are trivial. Total Medicare benefit payments amounted to $577 *billion* in 2013 and $597 *billion* in 2014. So, MSSP ACO's savings are effectively irrelevant to current Medicare spending – less than one tenth of one percent. Further, the early entrants into the ACO program are surely the ones with "low-hanging fruit," that is, the ones that could easiest find savings.

In conclusion, the idea that mergers of health insurers will lead to significant savings through care co-ordination is highly speculative and unlikely based on current experience. Nor is it likely that the crop of new entrants will significantly increase competition.

On the other hand, forbidding these mergers or browbeating the insurers cannot change the reality that Obamacare continues to drive up the cost of health care. Repealing and replacing it with patient-centered health reform, rather than focusing on narrow measurements of industry consolidation, is the only way to solve this problem.