MYTH V. REALITY

The Anthem-CIGNA and Aetna-Humana mergers: Putting profits ahead of patients

MYTH: If approved, the mergers will lower patients' health insurance premiums.

REALITY: The mergers will likely result in higher health insurance premiums.

According to the American Medical Association's (AMA) most recent analysis for health insurance markets, *Competition in Health Insurance: A Comprehensive Study of US Markets*, 2015 update,[i] most commercial health insurance markets across the U.S. are already "highly concentrated." This means that in most health insurance markets only a few, large insurers compete against one another. In these markets there has already been a near collapse in competition in commercial markets. The mergers will not only reduce competition even further, but will also likely result in higher premiums for patients.

A growing body of peer-reviewed literature suggests that greater health insurer consolidation leads to price increases.[ii] Recent studies also suggest premiums for employer sponsored fully insured health benefit plans are rising more quickly in areas where insurance market concentration is increasing.[iii] These findings should not be surprising—when insurers face little if any competition in the sale of health insurance coverage, they lack the incentive to pass along cost savings to patients. On the other hand, research is finding that competition among insurers is associated with lower premiums.[iv]

MYTH: The mergers are needed in order to counter price increases imposed by powerful hospitals and integrated delivery systems.

REALITY: Instead of dealing with hospital market power by making health insurer markets even more concentrated, hospital market power is much better addressed by fostering entry into hospital markets.

The health insurers argue that they need the mergers to give them the countervailing market power that will enable them to counter the price increases imposed by dominant hospitals. There is, however, *no economic evidence* that the formation of bilateral hospital/health insurer monopolies—a battle between proverbial Sumo wrestlers—benefits patients. Such matches often end in a handshake and patients get crushed.

Rather than giving health insurers even more market power, the better response to hospital consolidation is to recognize that integrated care does not necessarily require hospital-led consolidation and that, by *encouraging entry* into hospital markets, hospital markets can be made competitive. For example, regulators can foster new entry by removing entry barriers such as the inflexible and outdated antitrust enforcement policies that hinder the ability of physician networks to engage in alternative payment models, and by eliminating of state certificate of need laws.

MYTH: Even if commercial health insurance markets are concentrated, the mergers present no anticompetitive concerns in the Medicare Advantage market because that market is competitive.

REALITY: Competitive conditions in Medicare Advantage markets appear to be *even more troubling* than in the commercial health insurance market studied by the AMA.

According to an August 2015 Commonwealth Fund study "there is little or no competition in Medicare Advantage insurance markets in 97% of U.S. counties." The study also found that even among the 100 counties that had the most Medicare beneficiaries, 81% of those counties did not have competitive Medicare Advantage markets. Competition was also found to be considerably worse in rural areas than in urban areas. [v]

MYTH: No one should be concerned about the mergers' impact on Medicare Advantage—if the mergers further reduce competition in Medicare Advantage and the quality of Medicare Advantage plans' suffers, Medicare beneficiaries can easily switch back to traditional Medicare. There's no real difference between traditional Medicare and Medicare Advantage.

REALITY: Further reduction of competition in Medicare Advantage is likely to be a *critical* issue for seniors enrolled in Medicare Advantage plans.

Vitally important distinctions separate Medicare Advantage from traditional Medicare. Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare. Seniors in Medicare Advantage plans can also receive a single plan covering a variety of benefits that seniors in traditional Medicare must assemble themselves. The combination of richer benefits and one-stop shopping accounts for the strong preference by many seniors for Medicare Advantage plans. For those patients, the closest competition to one Medicare Advantage insurer's plan is another insurer's Medicare Advantage plan--traditional Medicare is not an inadequate substitute. The US Department of Justice (DOJ) has concluded that traditional Medicare is not an adequate substitute for Medicare Advantage.[1] Consequently, the reduction in quality that further lessening of competition that the mergers' will cause in the Medicare Advantage market is likely to have a significant, negative impact on many seniors currently enrolled in Medicare Advantage plans.

MYTH: Medical loss ratio requirements will prevent health insurers from raising premiums above competitive levels.

REALITY: Medical loss ratio requirements only address how health insurers must allocate premium dollars, and provide no protection against premium increases.

The health insurers claim that because medical loss ratio (MLR) regulations require large health insurers to devote at least 85 percent of premium revenues to paying claims and quality improvement, patients will be protected from any premium increases resulting from the mergers. This is simply not true, for the following reasons:

[1] *See U.S. v. United Health Group and Sierra Health Services Inc.*, Civil No1:08 –cu-00322 (DDC2008).

- MLR requirements do not apply to more than half of Americans under age 65 with health insurance coverage because the MLR regulations do not apply to privately-insured enrollees in self-insured plans;
- Because the MLR is calculated at the state and market level, the merged insurers may be able to offset low MLRs in one geographic area or sub-segment with high MLR in another;[vi]
- The MLR requirements do not address the level of the premium increase, only the percentage used for claims and quality activities; and
- The MLR regulation does not address non-price dimensions of health insurer competition such as product design, provider networks, and customer service.

MYTH: The mergers will improve health plan quality.

REALITY: The mergers are more likely to *adversely affect* health insurance plan quality.

Insurers are already creating very narrow and restricted networks that force patients to go out-of-network to access care. If approved, the mergers would reduce pressures on insurers to offer broader networks to compete for members or respond to patients' access needs. The mergers will therefore make it even more likely that patients will find themselves in inadequate networks and be forced to access out-of-network care at some point. Similarly, it is very likely that patients will find themselves at in-network hospitals where, given restricted networks, many of the hospitals' physicians will not have been offered a contract by the merged insurers.

MYTH: The mergers will create new efficiencies and economies of scale that will benefit patients.

REALITY: Claims about the mergers' purported efficiencies are purely speculative, and based on previous evidence. If approved, it is highly unlikely that any of the mergers' real benefits will be passed on to consumers.

Although the health insurers claim that the mergers will benefit patients by creating greater efficiencies, e.g., via though economies of scale, these claims are merely speculative, and in no way offset the patient harm that the mergers will likely cause. And, even if the mergers generate some patient benefits, it is questionable whether the benefits produced by those efficiencies "will be passed through to consumers in light of that diminished competition."[vii] Unfortunately, insurers have a dismal track record of passing any savings from an acquisition on to patients, and there is no reason to believe that the merged insurers will act any differently.

MYTH: The mergers will enable the health insurers to make patient care innovations.

REALITY: Provider organizations and non-national payers have taken the lead in patient care innovations.

Contrary to the health insurers' claims, large insurers are *not* more likely to implement the innovative payment and care management programs that benefit employers and individual patients. In reality "concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems…and non-national payers," not commercial health insurers.[viii]

MYTH: The mergers will be good for patients because the health insurers will be able to control physician payments.

REALITY: The mergers will actually hurt patients by allowing insurers to depress physician payments below competitive levels.

Although the health insurers claim that the mergers will enable them to reduce patients' costs by controlling physician payments, the mergers will actually *harm* patients. This is because the merged insurers will likely have market power in the purchase of physician services, because the merged health insurer will be one of the biggest, if not the biggest, purchasers of physician services in its market. This market power would give those insurers overwhelming bargaining leverage over physicians, most of whom still work in practices with 10 or fewer physicians.[ix] Because there will be even fewer health insurers in the market post-merger, physicians simply will *have to do business* with the merged insurers, and the insurers will be able to force physicians to accept payment below competitive levels.

Physician payments below competitive levels can harm patients in a number of ways. Compensation below competitive levels:

- Hinders physicians' ability to invest in new equipment, training, staff and other practice infrastructure that could improve the access to, and quality of, patient care;
- May force physicians to spend less time with patients to meet practice expenses;
- Can reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding (which would exacerbate an already significant shortage of primary care physicians in the US); and
- When one or more health insurers dominate a market, physicians can be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

MYTH: There is no evidence supporting the claim that payments below competitive levels actually harm patients.

REALITY: Both state and federal regulators have successfully challenged health insurer mergers on the grounds that the post-merger insurer would be able to hurt patients by depressing physician payments below competitive levels.

For example, the DOJ has successfully challenged two health insurer mergers on the grounds that the mergers would have anticompetitive effects in the purchase of physician services.[x] In a third proposed health insurer merger in 2010, the insurers abandoned their merger plans when the DOJ complained that the merger "…would have given Blue Cross Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers."[xi]
Likewise, in 2008 the Pennsylvania Department of Insurance (DOI) was prepared to block a proposed health insurer merger, because the merger would have granted the merged insurer undue leverage over physicians and other health care providers. The DOI found that this leverage would be "to the detriment of the insurance buying public" and would result in "weaker provider networks for consumers who depend on these networks for access to quality healthcare."[xii] The DOI further concluded that "the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services."[xiii]

MYTH: The mergers will not be anticompetitive because other competing insurers will be able to enter the merged insurers' markets.

REALITY: It is highly unlikely that other insurers will be able to enter the merged insurers' markets.

The health insurers claim that the mergers will not harm patients because other insurers will be able to enter the merged insurers' markets and compete with merged insurers. It is, however, unlikely that other competing health insurers will be able to enter the insurers' markets because associated entry barriers are so imposing. These barriers include state regulatory requirements; the need for sufficient business to permit the spreading of risk; and contending with established insurance companies that have built long-term relationships with employers and patients.[xiv]

Further, state and federal regulators have recognized how daunting entry barriers are to health insurer entry. For example, a DOJ study of entry and expansion in the health insurance industry found that "brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates."[xv] And in its 2008 analysis of a proposed health insurance merger, the Pennsylvania DOI concluded that "on balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance insurers will be able to step in and replace the loss in competition."[xvi]

MYTH: Divestiture is an appropriate means of dealing with any concerns about the mergers' anticompetitive effects.

REALITY: Any action short of completely blocking both mergers will fail to protect patients.

Any remedy short of blocking the mergers would not adequately protect patients—divestiture will not protect patients because:

- No divestiture would protect against the loss of potential competition that occurs when two of the five largest health insurers are eliminated;
- Divesture could be highly disruptive to the marketplace and cause harm to patients, especially in MA markets where the elderly would be faced with a new insurer;
- Given the overwhelming number of markets that the mergers would adversely affect, it is unlikely that regulators will be able to find proposed buyers of assets that could supply health insurance at a cost and quality comparable to that of the merged insurers in the huge number of affected markets;
- Any qualified purchaser able to contract with a cost competitive network of hospitals and physicians, if found, would probably already be a market participant, and a divestiture to such an existing market participant would not likely return the market to even pre-merger levels of competition.

[i] See https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2680007&navAction=push
[ii] See Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10; 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; 1(3) 16-35.
[iii] Id. at 11.
[iv] "More Insurers, Lower Premiums? Evidence from Initial Pricing in the Health Insurance Marketplaces," *Kellogg Insight* (July 7, 2014), http://insight.kellogg.northwestern.edu/article/more_insurers_lower_premiums.
[v] B. Biles, G. Casillas, and S. Guterman, *Competition among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015.
[vi] Dafny at 14.
[vii] Id. at 11.
[viii] Id. at 16.
[ix] Carol K. Kane, PhD, American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.
[x] *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *see also U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at *http://www.usdoj.gov/atr/case/s/f2600/2648.pdf*; *United States v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at: www.usdoj.gov/atr/cases/f213800/213815.htm.
[xi] Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at: http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans.
[xii] *See* Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).
[xiii] Id.
[xiv] *See* Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July,2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).
[xv] Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., *Competition and Health Care: A Prescription for High-Quality, Affordable Care* 7 (Mar. 19, 2012) [hereinafter Pozen, *Competition and Health Care*], *available at* http://www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care.
[xvi] LECG Inc., "Economic Analyses of the Competitive Impacts from the Proposed Consolidation of Highmark and IBC." September 10 2008, Page 9.