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MEASURING COSTS AND OUTCOMES IN HEALTH CARE

The Risks of Health Insurance Company Mergers

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Big insurers are taking a break from the new — figuring out how to pay for value, rather than volume, of care — and going for the tried and true: gobbling up smaller insurers. The action thus far involves national for-profit firms, like the proposed acquisitions of Cigna by Anthem and Humana by Aetna. (http://money.cnn.com/2015/07/24/news/companies/anthem-cigna-merger/, http://www.forbes.com/sites/dandiamond/2015/07/03/aetna-buys-humana-for-34-billion-but-deal-doesnt-add-up/)

Almost nothing excites Wall Street like the intrigue of M&A, and merger proponents are promising lower costs, better quality, and higher stock prices. But if history is any guide, mergers in the insurance industry should give consumers (indeed, all purchasers of insurance) cause for concern. (http://www.hmpi.org/pdf/HMPI%20-%20Guardado,%20Emmons,%20Kane,%20Price%20Effects%20of%20a%20Larger%20Merger%20of%20Health%20Insurers.pdf)

Will a smaller number of larger health insurers better provide what consumers really want — affordable insurance that meets their health needs? Before addressing that question directly, let's start with some basic premises:

- Consumers need an ample choice of innovative, well-priced insurance products.
- If mergers do generate cost reductions, consumers ought to benefit in the form of some combination of lower premiums, better service, or more-generous plans.
- Achieving higher-quality care requires more collaboration across the many practitioners and facilities that deliver it.

With that context, we can explore how insurers expect to lower costs and improve quality by merging. (I don't name actual mergers because my analysis relies on broadly applicable principles that will persist long after the latest deals are blocked, closed, or abandoned.)

AIM 1: LOWER COSTS

Consider two main buckets of cost: Administrative expenses (about 10% of the pie) and medical spending (roughly 80% to 90%). (http://economix.blogs.nytimes.com/2009/09/25/how-much-money-do-insurance-companies-make-a-primer/?_r=0, http://ahip.org/Issues/Medical-Loss-Ratio.aspx)

Administrative expenses are what most merging companies emphasize. The pitch goes something like this: "*Synergies will reduce overhead by eliminating duplicative management positions and spreading IT and marketing costs across more members.*" Merging firms rarely reveal how they'll achieve such savings (and certainly avoid mentioning potential layoffs). (http://www.publicintegrity.org/2015/07/06/17621/coming-health-insurance-mergers-will-cost-consumers) Furthermore, I know of no public analyses that document savings realized from prior large mergers. The savings might occur — but they might not. To respond to stakeholders who wonder about the value of these

transactions, insurers should provide evidence that mergers of similar scale have achieved the desired administrative cost reductions — and should commit to a plan for achieving the projected savings. Their analyses should explicitly identify the *net costs* associated with realizing the anticipated synergies. After all, consulting fees and transition costs add up.

With regard to the much larger cost bucket — medical spending — insurers point to their bargaining clout: *"Like Walmart, we will negotiate better prices from providers because our merged entity will represent a larger share of providers' business."* Some evidence suggests that larger insurers pay providers less. (http://www.ncbi.nlm.nih.gov/pubmed/20478106, http://content.healthaffairs.org/content/30/9/1728.full.html) But while Walmart uses its purchasing power to reduce prices to consumers, there is no evidence that savings from health-plan mergers are passed through to consumers in the form of lower premiums.

AIM 2: RAISE QUALITY

With respect to quality, the promise about prospective mergers is best summarized like this: *"With our bigger share of the local patient market, across all customer segments, we can convince providers to invest in our new chronic-disease-management programs and novel payment schemes that reward quality and reduce unnecessary spending. And we'll have an incentive to pursue those approaches because we'll reap enough of the rewards."*

For 25 years, the jury has been out on whether disease-management programs from national payers can improve quality and achieve real savings. (http://www.nejm.org/doi/full/10.1056/NEJMsa1011785) The best examples of payer-driven quality improvements come from nonprofit regional payers, such as the Alternative Quality Contract (AQC) implemented by Blue Cross Blue Shield of Massachusetts. (http://www.ncbi.nlm.nih.gov/pubmed/25354104) Researchers found spillover benefits of the AQC for non-BCBS enrollees. (http://jama.jamanetwork.com/article.aspx?articleid=1733718) That might sound good, but when any one insurer invests in reforming the practice of medicine, providers start making those changes across the board — and not just for that insurer's enrollees. The result: the insurer's rivals also benefit. If an insurer is large enough to reap more of the reward for its own efforts, the argument goes, it should be more likely to innovate. This is an intriguing idea but, so far, only a theoretical one.

The bit of evidence we have on how competition affects the quality of health plans comes from the Medicare HMO program. A 2003 study of the program found that, all other factors being equal, the more rivals in a geographic area, the greater the availability of prescription drug benefits. (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=463787) (That was before enactment of Medicare Part D, which funded drug benefits for nearly all Medicare enrollees.)

WILL THE PAST BE PROLOGUE?

My research colleagues and I have found that having fewer insurers leads to higher premiums, both for the large employer segment and the individual exchange market. (http://www.mitpressjournals.org/doi/pdf/10.1162/AJHE_a_00003) In short, premiums actually go *up*, not down, when insurance markets become more concentrated. Other researchers report similar conclusions with respect to Medicare HMO premiums. (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=463787)

Indeed, I'm aware of no peer-reviewed, published analyses that show that insurance mergers, on average, benefit consumers. But has the landscape changed since the Affordable Care Act was passed?

Some observers argue that potential premium increases related to mergers are limited by the ACA's "minimum loss ratio" regulation, which requires that insurers spend at least 80 cents of each premium dollar on medical expenses (the cutoff is 85 cents for large group insurance). (http://www.wsj.com/articles/a-healthy-side-of-insurer-mega-mergers-1440628597) But what counts as a medical expense is a gray area. And does anyone doubt that a stronger, more concentrated insurance industry wouldn't try to repeal this ACA provision? Competition may be more reliable than regulation when it comes to constraining pricing in this private market.

What about providers — the hospitals, physicians, and myriad facilities that actually produce medical services? They may benefit

from the simplicity of dealing with fewer insurers, but they also have less bargaining clout. The American Hospital Association and the American Medical Association have already expressed their displeasure with some of the proposed mergers. (http://www.ama-assn.org/ama/pub/news/news/2015/2015-07-24-insurance-mergers-reduce-competition-choice.page)

Should consumers care about disgruntled providers? Under certain circumstances they should, specifically in regions where a more concentrated insurance sector can cause providers to reduce the supply or the quality of "necessary" services.

Clearly, we need additional systematic research to address the many unanswered questions about whether and where consolidation might harm or help consumers. But the evidence to date points to a real potential risk for higher premiums — with no evidence of commensurate improvements in quality. Discriminating consumers need more facts to be convinced that payers' promises are more than sweet talk.

Note: On September 22, 2015, Leemore Dafny testified on the subject of insurance consolidation before the U.S. Senate Judiciary subcommittee on Antitrust, Competition Policy, and Consumer Rights. (http://www.judiciary.senate.gov/meetings/examining-consolidation-in-the-health-insurance-industry-and-its-impact-on-consumers)