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A Framework for Understanding Health Insurance Consolidations

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Consolidation in the health insurance industry is not a new phenomenon. However, recent announcements about pending insurer mergers have raised concerns about the potential impact of such transactions on competition in the industry and effects on stakeholders, such as health care providers and consumers. While Congress has no direct role in regulating these transactions (the Department of Justice [DOJ] typically conducts federal reviews of insurer mergers), Congress may still have an interest, especially in areas where it has enacted legislation or has oversight responsibilities.

Background

Like any viable business sector, the health insurance industry is dynamic. Insurers employ numerous strategies to achieve enterprise objectives, including mergers and acquisitions (M&A). While the specific motivations for each transaction vary, insurers pursue M&A to enhance (predicted) value, such as larger revenues or greater efficiencies.

Consolidation concerns are rooted in the concept of market power (i.e., the ability to raise prices by affecting supply, demand, or both). Insurers exert market power as *buyers* of services from health care providers and as *sellers* of health plans to purchasers (individuals, employers, and governments). To the extent that any one insurer may dominate a market (*market concentration*), it may influence negotiations with providers, affecting payments for services. Insurers incorporate these payments in the determination of premiums. Since the majority of premium revenue is spent on medical claims, a change in provider payments may lead to premium adjustments. Thus, the final premiums charged to purchasers may reflect an insurer's market power.

Concerns about market power underlie the pending mergers that involve several of the largest U.S. health insurers: Aetna, Inc. and Humana, Inc., and Anthem, Inc. and Cigna Corporation. Aetna and Humana each already has national presence, and a combined Anthem and Cigna would create the largest insurer, by health enrollment. However, health care generally is obtained at the local level, focusing attention on the impact of mergers in local health insurance markets (a notable exception is a multistate market for "administrative services only" services for large businesses that self-insure).

Issues to Consider

Does consolidation lead to greater market concentration? It depends. A market is defined by the products sold within a geographic area. Many insurers sell a variety of insurance products. Which of their products constitute a market? One approach is to consider products that are substitutes for each other. Given that health plans vary across a number of important features, determining which plans are substitutes may not be obvious. Similarly, the appropriate geographic area may vary. Economic studies have defined the market at the state level, at the metropolitan statistical area level, and by insurer rating area. Market concentration is generally measured according to the Herfindahl-Hirschman Index (HHI). Regulators use HHI calculations as a first step in determining the potential impact of mergers on competition (i.e., interactions among buyers and sellers in a market in which no one participant can set prices or reduce output to affect prices).

The bottom line is that insurer consolidation *may* lead to market concentration, *depending* on the products and geographic areas. For example, UnitedHealth Group Inc. (UNH) merged with Sierra Health Services Inc. (Sierra) in 2008. Although UNH was (and is) the largest insurer selling many health plans in multiple states and Sierra was the largest insurer in Nevada, DOJ's antitrust complaint focused narrowly on the availability of Medicare Advantage plans in two Nevada counties.

What is the potential impact of increased market concentration on competition, and how might it affect stakeholders? The effects of increased market concentration on competition vary and depend on the subsequent actions of the insurer. For instance, consider a market in which there are many insurers, each with a small market share. The consolidation of two insurers results in one fewer competitor, but the incremental change in market concentration may not be sufficient to affect competition. In contrast, an insurer may use its market power, due to a substantial increase in market concentration post-merger, to reduce provider payments. Additionally, a merger may result in operational efficiencies and other benefits (*synergies*), which may also reduce costs. For example, companies with duplicative staff (e.g., marketing) may be able to streamline, reducing overhead. Insurers may pass on savings from lower provider payments and/or synergies in the form of lower premiums to purchasers, or they may be able to take advantage of increased market power to raise premiums.

In addition to insurer consolidations, other factors may affect competition, stakeholder effects, or both. One such factor is consolidation among providers, mostly hospitals. Generally, consolidations between physicians and hospitals are undertaken to increase bargaining power with insurers, although the impact on prices is not clear. Hospital consolidations, however, generally lead to higher prices. The potential exists then for insurer consolidation to counteract the effects of provider consolidation on hospital prices.

Another relevant factor is the regulatory environment, especially the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). While states continue to be the primary regulators of insurance, the ACA has significantly reformed how private insurance is accessed, offered, priced, and purchased. The ACA includes provisions that may increase individual and employer demand for insurance and may expand both private and public options for obtaining health coverage, particularly for lower-income consumers. Simultaneously, the ACA imposes market reforms that directly or indirectly affect premiums and the management of insurance risk. While the ACA did not explicitly cap profit or limit premium increases, market reforms restrict insurers' ability to manage costs by prohibiting the avoidance of bad risk (due to health) through the guaranteed issue requirement and imposing minimum medical loss ratio standards. Insofar as insurers operate in a more heavily regulated industry, the ACA may be playing a role in the continuing trend in M&A. However, the history of insurer consolidations long precedes ACA enactment. And the impact of the ACA has not been fully realized. Some of the ACA's provisions came into effect just last year, while other provisions have yet to be completely implemented.