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"Health Care Consolidation and Competition after PPACA"

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Mr. Chairman and members of the Committee, thank you for inviting me to testify on the subject of "Health Care Consolidation and Competition after PPACA."

My name is Edmund F. Haislmaier. I am Senior Research Fellow in Health Policy at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

My testimony today focuses on how I expect competition and consolidation to play out in the health insurance sector under the new rules and regulations established in the Patient Protection and Affordable Care Act (PPACA).

The PPACA significantly expands, both in scope and in detail, the federal regulation of commercial health insurers. A number of its provisions are likely, over time, to reduce competition in that sector. The reduction in competition will result from provisions in the PPACA that standardize coverage, increase premiums, raise barriers to market entry, and encourage industry consolidation.

Standardizing coverage

The first set of relevant provisions are those that have the effect of standardizing health insurance coverage.

When government imposes regulations that standardize a product, producers of the item are, obviously, less able to compete on the basis of product differentiation. The product becomes more of a commodity and competition among suppliers becomes focused mainly on price. Other factors, such as convenience or brand identity, may enable some producers to charge marginally higher prices, but even that pricing power is fairly limited in a commoditized market.

At least five provisions of the PPACA will intentionally standardize health insurance to varying degrees:

1. Section 1302 instructs the Department of Health and Human Services (HHS) to set, and periodically update, an “essential health benefits package” of minimum health insurance coverage requirements.

2. Section 1302 also limits deductibles for employer plans in the small-group market and limits total enrollee cost-sharing for all health plans to the levels specified in the tax code for qualified High Deductible Health Savings Account plans.

3. Section 1201(4) requires all individual and small group health insurance policies to provide coverage for the essential health benefits package.

4. Section 1001(5) requires health insurers and employer plans to cover numerous preventive services with no enrollee cost-sharing.

5. Section 1001(5) prohibits health insurers and employer plans from setting annual or lifetime coverage limits "on the dollar value of benefits."

In a commodity market where competition is focused principally on price, firms that are able to reduce their costs through economies of scale can generally offer better prices and thus gain market share at the expense of their competitors. As a result, markets for commodities tend to be dominated by a few, large firms. Those firms achieve their dominant size by either under-pricing smaller rivals or acquiring competitors.

The provisions of the PPACA that standardize and commoditize coverage are likely to drive a similar dynamic in the health insurance market. Furthermore, because these are new, federal standards, the effects will be national in scope. Even carriers that have long been dominant in a particular state or region will find it harder to maintain their position and keep larger, national players at bay.

Increasing coverage costs

The above provisions will not only standardize coverage, but in many cases will increase coverage costs as well. For example:

- The Administration conducted an economic analysis of the effects of their regulations implementing the PPACA's preventive services coverage requirement. They concluded that, "The Departments estimate that premiums will increase by approximately 1.5 percent on average for enrollees in non-grandfathered plans. This estimate assumes that any changes in insurance benefits will be directly passed on to the consumer in the form of changes in premiums."[1]

- In its regulations implementing the PPACA's provision that prohibits plans imposing annual limits on the dollar value of benefits after 2014, and sets minimum annual limits for prior years, HHS established a waiver process for years before 2014, "if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums."[2] HHS has granted temporary waivers of the annual limits provision to plans with a total of over 4 million enrollees.[3] Thus, when the complete prohibition on annual limits takes effect in 2014, at least 4 million individuals will be priced out of their current coverage, and it is likely that this provision will increase premiums for millions more.

- Congress instructed HHS to define and periodically update an "essential health benefits package." HHS has not yet proposed regulations specifying the initial

[1] Federal Register, Vol. 75, No. 137, July 19, 2010, p. 41738
[2] Federal Register, Vol. 75, No. 123, June 28, 2010, p. 37191.
[3] Total enrollment in plans granted waivers is 4,039,774. Lists of those waiver recipients, with enrollment figures, can be found at *Annual Limits Policy: Protecting Consumers, Maintaining Options, and Building a Bridge to 2014*, U.S. Department of Health and Human Services, at *http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html*.

design of the essential health benefits package and has only issued “bulletins” outlining the approaches that it is considering. Given that the statute requires coverage for some categories of benefits not typically included in most current health plans -- such as "habilitative" services -- it is likely that the eventual package of required benefits will increase premiums.

The significance of these increased costs is that they generate a dynamic for further plan standardization. The more expensive the required coverage becomes the more insurers will look to keep premiums in check by limiting or cutting benefits that are not required. Indeed, State governments have behaved exactly this way in managing their Medicaid programs. As the cost to states of paying for mandatory Medicaid benefits has increased, states have responded by limiting or discontinuing optional Medicaid benefits.

Similarly, it was fear of this same dynamic occurring that led Congress to amend the PPACA provision requiring coverage of preventive services so as to overrule the US Preventive Services Task Force's recommendation on breast cancer screening. At that time the USPSTF had just revised its recommendation on breast cancer screening from starting at age 40 to starting at age 50. Breast cancer groups were concerned that making coverage mandatory at age 50 would induce plans to no longer pay for screening for women between the ages of 40 and 50. Congress responded by amending the PPACA to require coverage of breast cancer screening using the prior recommendation of age 40.[4]

The foregoing example also illustrates another effect of the benefit mandates in the PPACA. Over time there is likely to be ever more detailed standardization of health insurance coverage as provider and patient groups lobby HHS and Congress to expand coverage requirements, while insurers and employers, looking to control rising plan costs, seek greater regulatory certainty with respect to the limits they may impose on required benefits.

Thus, by giving HHS authority that is both broad and discretionary to define what constitutes "essential benefits," Congress set in motion a dynamic that will result in increasing standardization of health insurance coverage. That increasing standardization shrinks the scope for competition among insurers and is likely to result in industry consolidation, as the regulated product becomes more of an undifferentiated commodity.

The "minimum loss ratio" regulation

Another provision of the PPACA that will likely have a major effect in reducing insurer competition and driving consolidation within the health insurance industry is the so-called "minimum loss ratio" (MLR) regulation.[5] This provision established, effective January 1, 2011, new federal rules governing how health insurers spend premium dollars. These rules are commonly referred to as “minimum loss ratio” regulations—meaning that

[4] New Section 2713(a)(5) of the Public Health Service Act (42 U.S. Code § 300gg-13(a)(5)) as added by PL 111–148 § 1001(5).
[5] New § 2718 of the Public Health Service Act (42 U.S. Code § 300gg–18) as added by PL 111-148 § 1001(5) and then amended by §10101(f).

they specify the minimum share of premium income that an insurer must spend on claims costs and "activities that improve health care quality."

The minimum levels are set in the PPACA at 85 percent for large group plans and 80 percent for small group and individual plans. The PPACA further stipulates that if an insurer spends less than the required minimum in a given year, then the insurer must refund the difference to policyholders. Thus, for example, if an insurer is required to spend 80 percent of premium income on claims costs for a particular product but only spends 75 percent, the insurer is required to rebate five percent of the premium collected to policyholders.

New barrier to market entry

One of the effects of the minimum loss ratio regulations is that they create a barrier to market entry for new carriers. As with many start-up companies, a substantial initial capital investment is required to create a new insurer. That investment is needed to fund initial marketing and sales efforts to attract paying customers, and to build-out the operational and administrative infrastructure for billing customers, paying claims, etc. Similar to other new businesses, a new insurer initially operates at a loss until it achieves enough "scale" -- that is, it acquires enough customers -- that revenues exceed expenses, and it become profitable.

The MLR regulations effectively constrain the amount, and delay the timing, of any excess premium revenues that a start-up health insurer could plan to either reinvest in growing its business (say, through additional marketing) or repaying its initial investors. Thus, the MLR regulations push further into the future a new company's projected "break-even" point, and may also necessitate additional start-up capital beyond what was previously projected.

Of course, it is uncertain whether a particular start-up insurer would succeed, even without having to deal with the constraints imposed by the MLR regulations. However, what is certain is that imposing the new MLR regulations raises the bar for an "in-process" start-up, and increases the risk and initial capital requirements for an "in-planning" start-up venture.

In at least one reported case investors decided to terminate an "in-process" start-up health insurer, at least in part, due to the effects of the new MLR regulations on its business plan.[6] What is unknowable are how many attempts to create new health insurers that were still in the planning stage were simply abandoned once investors determined that the added burden of complying with the new minimum loss ratio regulations make it too expensive or too risky to go forward.

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[6] Michael Schwartz, "Startup health insurer shutting," *Richmond BizSense*, June 4, 2010, at: http://www.richmondbizsense.com/2010/06/04/startup-health-insurer-shutting and Michael Schwartz, "With healthcare reform looming, nHealth was losing millions," *Richmond BizSense*, June 11, 2010, at: http://www.richmondbizsense.com/2010/06/11/with-healthcare-reform-looming-nhealth-was-losing-millions/

Market consolidation

A number of established companies that currently provide health insurance can also be expected to exit the market over the next several years. The ones most likely to leave are those with multiple lines of coverage, for which offering health insurance is just part of their larger business. In general, the minimum loss ratio regulations will make offering health insurance less profitable while, as previously noted, the benefit requirements will also make it more of a commodity business. Companies offering multiple lines of insurance will be inclined to discontinue, or sell to competitors, their health plans and focus instead on the other lines of insurance that they offer -- such as life, auto, property, or liability coverage -- or on non-insurance business opportunities.

The smaller the company, or the smaller the share of a company's total business represented by health insurance, the more likely it is that the company will exit the post-PPACA health insurance market.

For example, on September 30, 2010, Principal Financial Group, Inc. announced that it was exiting the major medical health insurance market and transferring its existing book of business to UnitedHealth Group.[7] Principal will instead focus on its other lines of business, which include managing retirement and investment plans, and offering life, disability, dental and vision insurance products (none of which are subject to the PPACA's new federal insurance regulations).

To be sure, such business decisions are often the product of multiple considerations, but the MLR provisions in the PPACA will certainly discourage companies with other options from continuing to offer health plans.

Favoring for-profit insurers

Still another unintended consequence of the minimum loss ratio regulations is that they will increase the competitive advantage of for-profit insurers over their non-profit rivals. Because the MLR requirement constrains the share of premium income that an insurer can "retain," it limits an insurer's ability to accumulate the capital needed to expand, either through increased marketing and sales efforts or by purchasing business from other carriers. Non-profit insurers have no other source of investment capital beyond whatever excess premium income they can accumulate after paying claims costs and administrative expenses. However, for-profit insurers can finance their capital needs by issuing equity shares. Since the proceeds of a share offering are not premium income, the MLR restrictions do not apply.

Thus, the minimum loss ratio regulation is likely to not only spur increased consolidation in the health insurance industry, but to also drive that consolidation toward a market

[7] Principal Financial Group, "The Principal Financial Group to Exit Medical Insurance Business," press release, September 30, 2010, at: http://phx.corporate-ir.net/phoenix.zhtml?c=125598&p=irol-newsArticle&ID=1477633&highlight=

dominated by a few, very large, for-profit, insurers. It is easy to envision large, for profit health insurers applying the same "roll-up" strategy of raising capital through equity offerings and then using the proceeds to buy smaller competitors that has been successfully applied in other sectors. Such an outcome is probably not something that the authors of the PPACA either intended or envisioned.

Multi-State plans

Another provision in the PPACA that favors large, national health insurers over smaller or regional ones is the requirement in Section 1334 that the Office of Personnel Management directly contract with a select number of insurers to offer "multi-state" plans. Section 1334 sets a four year schedule for offering multi-state plans in all the states, and specifies that multi-state plans are "deemed to be certified by an Exchange" as qualified plans. That deeming provision gives the multi-state plans a guarantee of access to the subsidized coverage market that is not guaranteed to their competitors.

Rate review

The insurer rate review provisions of the PPACA offer yet another incentive for smaller carriers to exit the health insurance market and big carriers to get bigger. While Congress did not give HHS authority to deny insurer rate increases, HHS has shown that it is willing to use its new rate review powers to "name and shame" insurers if they significantly increase premiums. Secretary Sebelius has also threatened to deny uncooperative insurers access to the federally subsidized exchange markets that are scheduled to open in 2014.[8]

The logical business strategy for surviving in that kind of a market is for a carrier to become big enough that it can retain some level of pricing power in the face of persistent government attempts to impose price regulations. Becoming "too big" or "too important" to fail will be the best strategy for a company seeking to protect itself against the threat that government price regulation could make its business unprofitable.

Combined effects

Collectively, these regulations mean that the PPACA has unleashed a market dynamic that will drive toward greater consolidation in the health insurance industry, eventually resulting in fewer and larger carriers dominating the market -- with a consequent reduction in choice and competition for consumers. How this new market dynamic will likely play out can be seen from past experience in other sectors where "consolidators" -- such as Staples and Office Depot -- built market-dominating firms through a strategy of raising investment capital and then deploying it to acquire small and mid-sized competitors.

Indeed, a prominent supporter of the PPACA explicitly, and correctly, wrote that the

[8] Letter of Health and Human Services Secretary Kathleen Sebelius to Karen Ignagni, President and CEO of America's Health Insurance Plans, September 9, 2010.

legislation "fundamentally transforms health insurance" into "a regulated industry … that, in its restructured form, will therefore take on certain characteristics of a public utility."[9]

What was left unsaid is that the characteristics of public utility economics are markets dominated by a few large firms, with low rates of return and captive customers, in which the firms' pricing power is constrained by government regulation, but government's exercise of regulatory power is constrained by the need to keep the remaining firms profitable to avoid the widespread social and economic dislocation that would occur should they be driven out of existence. In essence, this is a prescription for achieving market equilibrium through an economic "mutually assured destruction" stand off -- with little or no remaining consumer choice or product innovation.

Mr. Chairman, this concludes my prepared testimony. I thank you and the rest of the Committee for inviting me to testify before you on this issue. I will be happy to answer any questions that you or members of the Committee may have.

[9] Sara Rosenbaum, J.D., *A "Broader Regulatory Scheme" — The Constitutionality of Health Care Reform*, New England Journal of Medicine, 10.1056/NEJMp1010850, October 27, 2010, at NEJM .org.

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