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Critics of health insurance mergers misapply the evidence and misinterpret the market
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Geoffrey A. Manne

As regulatory review of the merger between Aetna and Humana hits the homestretch, merger critics have become increasingly vocal in their opposition to the deal. This is particularly true of a subset of healthcare providers concerned about losing bargaining power over insurers.

Fortunately for consumers, the merger appears to be well on its way to approval. California recently became the 16th of 20 state insurance commissions that will eventually review the merger to approve it. The U.S. Department of Justice is currently reviewing the merger and may issue its determination as early as July.

Only Missouri has issued a preliminary opinion that the merger might lead to competitive harm. But Missouri is almost certain to remain an outlier, and its analysis simply doesn't hold up to scrutiny.

The Missouri opinion echoed the Missouri Hospital Association's (MHA) concerns about the effect of the merger on Medicare Advantage (MA) plans. It's important to remember, however, that hospital associations like the MHA are not consumer advocacy groups. They are trade organizations whose primary function is to protect the interests of their member hospitals.

In fact, the American Hospital Association (AHA) has mounted continuous opposition to the deal. This is itself a good indication that the merger will benefit consumers, in part by reducing hospital reimbursement costs under MA plans.

More generally, critics have argued that history proves that health insurance mergers lead to higher premiums, without any countervailing benefits. Merger opponents place great stock in a study by economist Leemore Dafny and co-authors that purports to show that insurance mergers have historically led to seven percent higher premiums.

But that study, which looked at a pre-Affordable Care Act (ACA) deal and assessed its effects only on premiums for traditional employer-provided plans, has little relevance today.

The Dafny study first performed a straightforward statistical analysis of overall changes in concentration (that is, the number of insurers in a given market) and price, and concluded that "there is no significant association between concentration levels and premium growth." Critics never mention this finding.

The study's secondary, more speculative, analysis took the observed effects of a single merger — the 1999 merger between Prudential and Aetna — and extrapolated for all changes in concentration (i.e., the number of insurers in a given market) and price over an eight-year period. It concluded that, on average, seven percent of the cumulative increase in premium prices between 1998 and 2006 was the result of a reduction in the number of insurers.

But what critics fail to mention is that when the authors looked at the *actual* consequences of the 1999 Prudential/Aetna merger, they found effects lasting only two years — and an average price increase of only *one half of one percent*. And these negligible effects were restricted to premiums paid under plans purchased by large employers, a critical limitation of the studies' relevance to today's proposed mergers.

Moreover, as the study notes in passing, over the same eight-year period, average premium prices increased in total by 54 percent. Yet the study offers no insights into what was driving the vast bulk of premium price increases — or whether those factors are still present today.

Few sectors of the economy have changed more radically in the past few decades than healthcare has. While extrapolated effects drawn from 17-year-old data may grab headlines, they really don't tell us much of anything about the likely effects of a particular merger today.

Indeed, the ACA and current trends in healthcare policy have dramatically altered the way health insurance markets work. Among other things, the advent of new technologies and the move to "value-based" care are redefining the relationship between insurers and healthcare providers. Nowhere is this more evident than in the Medicare and Medicare Advantage market at the heart of the Aetna/Humana merger.

In an effort to stop the merger on antitrust grounds, critics claim that Medicare and MA are distinct products, in distinct markets. But it is simply incorrect to claim that Medicare Advantage and traditional Medicare aren't "genuine alternatives."

In fact, as the Office of Insurance Regulation in Florida — a bellwether state for healthcare policy — concluded in approving the merger: "Medicare Advantage, the private market product, competes directly with Traditional Medicare."

Consumers who search for plans at Medicare.gov are presented with a direct comparison between traditional Medicare and available MA plans. And the evidence suggests that they regularly switch between the two. Today, almost a third of eligible Medicare recipients choose MA plans, and the majority of current MA enrollees switched to MA from traditional Medicare.

True, Medicare and MA plans are not *identical*. But for antitrust purposes, substitutes need not be perfect to exert pricing discipline on each other. Take HMOs and PPOs, for example. No one disputes that they are substitutes, and that prices for one constrain prices for the

other. But as anyone who has considered switching between an HMO and a PPO knows, price is not the only variable that influences consumers' decisions.

The same is true for MA and traditional Medicare. For many consumers, Medicare's standard benefits, more-expensive supplemental benefits, plus a wider range of provider options present a viable alternative to MA's lower-cost expanded benefits and narrower, managed provider network.

The move away from a traditional fee-for-service model changes how insurers do business. It requires larger investments in technology, better tracking of preventive care and health outcomes, and more-holistic supervision of patient care by insurers. Arguably, all of this may be accomplished most efficiently by larger insurers with more resources and a greater ability to work with larger, more integrated providers.

This is exactly why many hospitals, which continue to profit from traditional, fee-for-service systems, are opposed to a merger that promises to expand these value-based plans. Significantly, healthcare providers like Encompass Medical Group, which have done the most to transition their services to the value-based care model, have offered letters of support for the merger.

Regardless of their rhetoric — whether about market definition or historic precedent — the most vocal merger critics are opposed to the deal for a very simple reason: They stand to lose money if the merger is approved. That may be a good reason for some hospitals to wish the merger would go away, but it is a terrible reason to actually stop it.

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