ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

STATEMENT OF GEORGE SLOVER
SENIOR POLICY COUNSEL
CONSUMERS UNION

BEFORE THE

SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY AND CONSUMER RIGHTS
SENATE COMMITTEE ON THE JUDICIARY

ON

EXAMINING CONSOLIDATION IN THE HEALTH INSURANCE INDUSTRY AND ITS IMPACT ON CONSUMERS

September 22, 2015

Chairman Lee, Ranking Member Klobuchar, Subcommittee Members, thank you for the opportunity to be here today, and to discuss our concerns with the impact on consumers from undue consolidation in the health insurance industry.

Consumers Union is the public policy and advocacy arm of Consumer Reports. Our mission is to work for a fair, just, and safe marketplace for all consumers, and to empower consumers to protect themselves. And one key to empowering consumers to protect themselves is working to ensure meaningful consumer choice, through effective competition.

By meaningful choice, we mean easy for consumers to understand and compare, and sensitive to what's important to consumers. When consumers have meaningful choice, businesses are stimulated to provide more affordability, better quality, and new thinking.

From our founding almost 80 years ago, one of our top priorities has been to make health care available and affordable for all Americans. We are actively engaged at the federal and state level in working for policies to better ensure that consumers' health care and health insurance options are understandable and affordable, and in educating consumers. As part of these efforts, we've recently launched the Health Care Value Hub website, a networking and resource center for consumer advocates and others working to improve health care value for consumers.

The health care marketplace is complex in how it operates and how it motivates providers, insurers, and consumers. And a regulatory framework has developed over many years – and is still evolving – to work within and shape that complex environment, and help safeguard consumers, help keep costs under control, and help make a full range of health care services available. A century or more of experience shows you can't run the health care system on competition alone and just allow the free market to go where it will.

For example, we needed to legally prohibit insurance companies from lowering their costs by denying coverage for pre-existing conditions. This is a key consumer protection that the free market had shown it was unlikely to take care of on its own. Another example is setting minimum coverage requirements for health insurance

policies sold on the new exchanges. In these and numerous other ways, regulation can promote improved health care delivery and improved cost control.

But while our regulatory framework sets important minimum coverage and other requirements and safeguards, and it standardizes plan and benefit descriptions for easier comparison, consumers benefit from also having effective competition, at all levels in the supply chain. Even the best regulatory framework works better where competition, within appropriate regulatory limits, gives businesses an additional incentive to want to improve service while holding down prices and providing better value.

Regulation and competition both work best when they work hand in hand.

Some collaboration, coordination, and even consolidation can be good for consumers, and consistent with effective competition, when the result is to make it easier to provide service more efficiently and affordably – and when those benefits actually reach consumers. One very basic example is a group doctor practice that allows doctors to better serve more patients by ensuring patients are covered 24-7 even when their main doctor can't be reached.

Our regulatory framework accommodates, even encourages various forms of collaboration and integration for more effective delivery of health care and more effective cost control. And within limits, these can be beneficial to the overall functioning of the health care system, and beneficial to consumers.

But when there's too much concentration, among hospitals, or doctors, or insurers, it can undermine the overall functioning of the system, and harm consumers. Dominant players can start dictating to others, closing off choices consumers want, increasing the prices consumers pay, and impairing the quality of what consumers receive.

Health insurers play a key role in helping make the health care system work for consumers. We see that every time we look at a medical bill and read the markdown for the disallowed portion – the difference between what the provider would like to charge us, and what it is willing to accept to be part of our health care plan's network.

But a dominant insurer could force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need. Competition, at all levels, helps keep incentives to control costs from being misdirected into degrading quality of care and service.

As the Justice Department has explained, where there is effective competition, insurers compete against each other by offering plans with lower premiums, reducing copayments, lowering or eliminating deductibles, lowering annual out-of-pocket maximum costs, managing care, improving drug coverage, offering desirable benefits, and making their provider networks more attractive to potential members.[1]

We want those motivations to stay strong. Providing all these benefits costs the insurance plans more than not providing them. What makes it in their interest to provide them all anyway is that doing so attracts customers who might otherwise go elsewhere. For that to work, there needs to be an elsewhere for customers realistically to go.

There is ample evidence that high market concentration among sellers of health insurance, like high market concentration among sellers of hospital or medical services – or of any other product or service, for that matter – leads to increased costs for consumers, and more broadly, to less value. Health care markets, for all their complexities and special characteristics, are no exception to this fundamental experience.

It is with all this in mind that we look at concentration in health insurance, and the proposed Aetna/Humana and Anthem/Cigna mergers. The Justice Department's investigations are just getting underway. But there are strong indicators, to us, that these mergers could create too much concentration, in too many markets, and cause too much harm to consumer choice.

---

[1] Competitive Impact Statement, United States v. Humana, United States v. Humana Inc. and Arcadian Management Services, Inc., No. 12-cv-464 (D.D.C., March 27, 2012), at 8, available at www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.

There would be large increases in concentration in many of the local markets where health care services are provided and paid for. These markets are not just defined by geographic area. There are submarkets in each local area, different kinds of insurance coverage where competition won't cross over much if at all. For example, seniors aren't going to give up their Medicare Advantage policy and switch over to an individual policy on the state health insurance exchange. Each of these submarkets – individual, small employer, associational, large employer, Administrative Services Only, Medicare Advantage, etc. – will need to be examined separately and carefully.

It's important to look not just at a snapshot of where competition is happening now in each of those submarkets, and what current competition would be immediately eliminated, but also to look over the next hill, at what these mergers mean for future competition. A consummated merger can't be easily unwound to restore lost competition.

These four insurance companies all offer health insurance in a wide range of markets throughout the country, in various degrees of direct competition with each other. They all participate to a greater or lesser extent in the state exchanges. And they are in prime position to expand on their own into other state exchanges, and other markets. After all, they not only have the expertise and experience; they also have the financial resources to more easily get through the start-up period of building relationships with providers, and marketing to consumers.

These are the chicken-and-egg building blocks of starting up that create the biggest barriers to entry. You need good provider networks to attract consumers, and you need a large pool of consumers to attract providers.

Taking the longer view is also important because, if the Justice Department were to stand by and allow concentration to increase right up to the very brink of obvious and immediate harm, there's no margin for error, or for all-too-foreseeable developments beyond the control of the antitrust laws or anyone else. What if one of the current key players later decides to downsize or close shop? The antitrust laws don't force someone to work, and they don't force a company to stay in business.

The antitrust laws, and the Justice Department's own Merger Guidelines, recognize the importance of taking potential competition and market uncertainties into account. And the Clayton Act itself is written to prohibit mergers that "may" substantially lessen competition, or "tend to" create a monopoly. That gives the Justice Department plenty of latitude for taking the longer view – and we believe that's particularly important here.

It's also important to be skeptical of claims that the prospect of new market entry by unspecified others takes care of the concerns. If these four insurance giants are seeking the merger short-cut to expansion, because they've decided that expanding on their own is not as convenient for them, not worth the trouble, how can we be confident that expansion by other, smaller, or even nonexistent insurance companies is going to be there to effectively hold the market power of the giants in check?

And it's also important to be skeptical of claims that the problems with these mergers can be solved by having the merging insurance companies spin off, or divest, some of the operations in markets where they currently compete against each other. First of all, in these two cases, it looks like there are just too many markets and submarkets affected, especially if you include – as you should – markets and submarkets where these companies haven't entered yet but are in a good position to.

Second, divestitures don't always work. Empirical studies and experience indicate that many divestiture remedies have not lived up to their promise. The promise is that there's this other company standing ready to take over the operation, with the same commitment and the same capability to give the same level of competition, now and into the future. That's always going to be a roll of the dice. After all, if this new company is really so capable and committed, why isn't it in the market already? Even under the best of circumstances, there's no guarantee that the new company taking over will stay committed, and actually prove to have the capability, to compete over the long haul. Often, it doesn't.

One justification we've heard for approving these mergers is that giving these insurance companies more market power will offset the market power of hospitals

and doctor groups. We are certainly aware of, and concerned about, increased concentration that has been taking place in provider markets – and how it can lead to less choice for consumers, and higher premiums and costs, and less value.

But the solution to too much provider market power is not to give health insurers their own market power and then hope they'll take care of us. This has come to be referred to in antitrust circles as the "sumo wrestler theory" – that somehow adding market power at one level of the supply chain "stands up to" and offsets market power at another level.

But the actual result is just more market power, with more of all the harmful effects that flow from it. The two sumo wrestlers typically end up deciding to shake hands – that is, they find an accommodation that benefits them both – and they go after everybody else. And the everybody else, those who don't have market power – and that includes consumers with a ring-side seat, as well as smaller hospitals, local clinics, and medical practices – get tossed around, sat on, sometimes mercilessly crushed.

We want doctors, hospitals, and clinics to be motivated to look for ways to lower rates without cutting corners on quality of care and other aspects of service that consumers value. That's the difference between providers wanting to trim costs to compete, versus being forced to cut service to the bone in hopes to survive. It's the difference between responding to incentives that flow from competition, versus knuckling under to a market dictator.

Taking aggressive enforcement action to stop the creation, augmentation, or further entrenchment of this kind of insurance market power is entirely consistent with recognizing that an insurer of a certain size can often better attract more willingness from providers to accept lower rates, because the insurer offers network access to enough patients to make it worthwhile. But these four insurance giants would seem to be already well past that threshold. And in specific local markets where they aren't at that size yet, you would think they could get there by expanding on their own – that they wouldn't need to join forces with their most able competitors.

And again, being of a size and reach to offer that advantage, to attract providers and consumers, is different from having the power to make them an offer they can't refuse. One contributes to consumer choice; the other snuffs it out.

It is perhaps understandable that some health insurers, in reacting to the new challenges and opportunities in the evolving health care marketplace, would seek to gain more leverage, to ease their way to meeting those challenges and taking advantage of those opportunities, by merging to increase their market power. But while they may see that as in their interest, that doesn't mean it's in consumers' interest.

Competition at the insurance level will help ensure that the business interests of health insurers in their dealings with providers, large and small, are more closely aligned with the interests of consumers.

If the anticompetitive merger route is cut off, we would hope to see those profit-seeking energies redirected to expanding into underserved markets, and to improving quality, safety, and customer service. All of these will improve meaningful choice for more consumers – and ultimately, will improve consumer health, and the health of our pocketbooks.

The Justice Department's investigations are just getting underway. There are a lot of market details to examine. And we are not here to prejudge the outcome of these investigations. But we want both investigations to be thorough. At this point, we have a hard time seeing how these mergers could pass muster under the Clayton Act. And the stakes for consumers are high. If somehow these mergers do get a pass, or if either of them does, we'll want the Justice Department to explain why.

Thank you again for the opportunity to testify on this important issue for consumers.