Merge ahead: understanding the impact of consolidation in the healthcare industry

Our healthcare experts examine the causes and effects of mergers and acquisitions in the healthcare insurance industry—and what it really means for payors, providers, and consumers.

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INTRODUCTION

In 2015, the health insurance industry saw two massive acquisitions that have narrowed the field of major health insurers in the US from five to just three: Aetna, Blue Cross Blue Shield, and UnitedHealth Group.

Much of the immediate commentary about the causes and effects of the consolidation tells a story that leaves out many of the nuances of healthcare reform and recent market trends. It posits that the resulting decreased competition and increased negotiating power will raise the cost of insurance to consumers in the form of higher premiums. Premium rates, particularly for individual plans sold on the exchange, have increased since last year, but the increase is likely not a direct result of consolidation and nor is it likely indicative of continually climbing rates.

Whether you're a payor, provider, or consumer, navigating the new healthcare landscape requires an understanding of the complex pressures facing today's healthcare players.

Cost pressures for payors are mounting

Payors have sustained significant financial losses on their individual plans and are looking for short-term solutions to improve their balance sheets.[1] Some payors, like United Healthcare, are reacting to losses from individual plans and have considered exiting the Exchange marketplace.

The losses are due, in part, to the rising cost of providing healthcare, particularly for the 15 million newly insured Americans. Spending has increased because more people are accessing healthcare services. In 2014, national spending on healthcare shot up more than 5 percent—likely due to an increase of service utilization coinciding with the implementation of the Affordable Care Act (ACA).[2]

In addition to the increased number of individuals accessing healthcare, this newly insured population is sicker and less familiar with navigating the healthcare system. They may also be accessing care in high-cost settings, like the emergency room. This patient population will be seeking care for problems that may have been exacerbated when they were uninsured, and now they require costlier intervention.

Additionally, costs have likely increased because providers are charging more for the services,

1 Bob Herman, "UnitedHealth considers ditching ACA's exchanges due to giant losses," Modern Healthcare, November 19, 2015, http://www.modernhealthcare.com/article/20151119/NEWS/151119858

2 Melanie Evans, "Data suggest hospital consolidation drives higher prices for privately insured," Modern Healthcare, December 15, 2015, http://www.modernhealthcare.com/article/20151215/NEWS/151219906/

much of which is a result of the vertical and horizontal integration in the provider space.

The consolidation pendulum has swung

Payor consolidation is a predictable reaction to the furious M&A activity amongst providers in the wake of healthcare reform. In the past five years, provider consolidation has occurred in a number of ways, from acquisition to participation in government or commercial accountable care organizations (ACOs), to the formation of clinically integrated networks (CINs).

Many of these value-based models link a provider's reimbursement to quality and efficiency measures. Armed with increased value supported by data, providers have an improved negotiating position with payors.

Additionally, providers have begun to assume financial risk for the cost of caring for their populations. To more effectively manage this risk, providers have integrated or merged horizontally to increase the number of covered lives in a given patient population. Vertical integration of primary care physicians, hospitals, and ancillary care centers is also intended to help providers control costs and improve care coordination and quality across the care continuum.

While these provider consolidations were driven by a healthcare reform movement aimed at reducing the cost of healthcare, much of the provider M&A activity has had the opposite effect. Providers with an improved negotiating position are able to charge higher prices, and as high-cost provider systems buy up smaller provider groups, the overhead expenses are often driven up for these previously lower-cost providers and facilities. As outlined in a 2012 Robert Wood Johnson Foundation (RWJF) literature review on the effect of consolidation on hospital prices, the increases, which were greater than 20 percent in many studies, were either picked up by the insurer, or passed on to consumers.[3]

These increases may not be altogether troubling for healthcare costs in the long term; the promise of population health is that these investments will lead to better patient health outcomes, ultimately saving dollars. However, as the same RWJF review found, this consolidation across hospitals and physicians has not yet led to significant cost savings. In the meantime, the higher prices are putting pressure on payors to react now.

Payors have merged as a strategy for cutting costs, but not through increasing consumer-pricing power

Payors have turned to consolidation as a strategy to gain efficiencies after the losses that they have sustained on the Exchanges. Payor mergers can be characterized as horizontal in nature (the acquisition of a direct competitor) versus vertical (the acquisition of another player in the value chain).

3 Martin Gaynor, PhD and Robert Town, PhD, The Synthesis Project Policy Brief No. 9, "The impact of hospital consolidation—Update," The Robert Wood Johnson Foundation, June 2012, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261

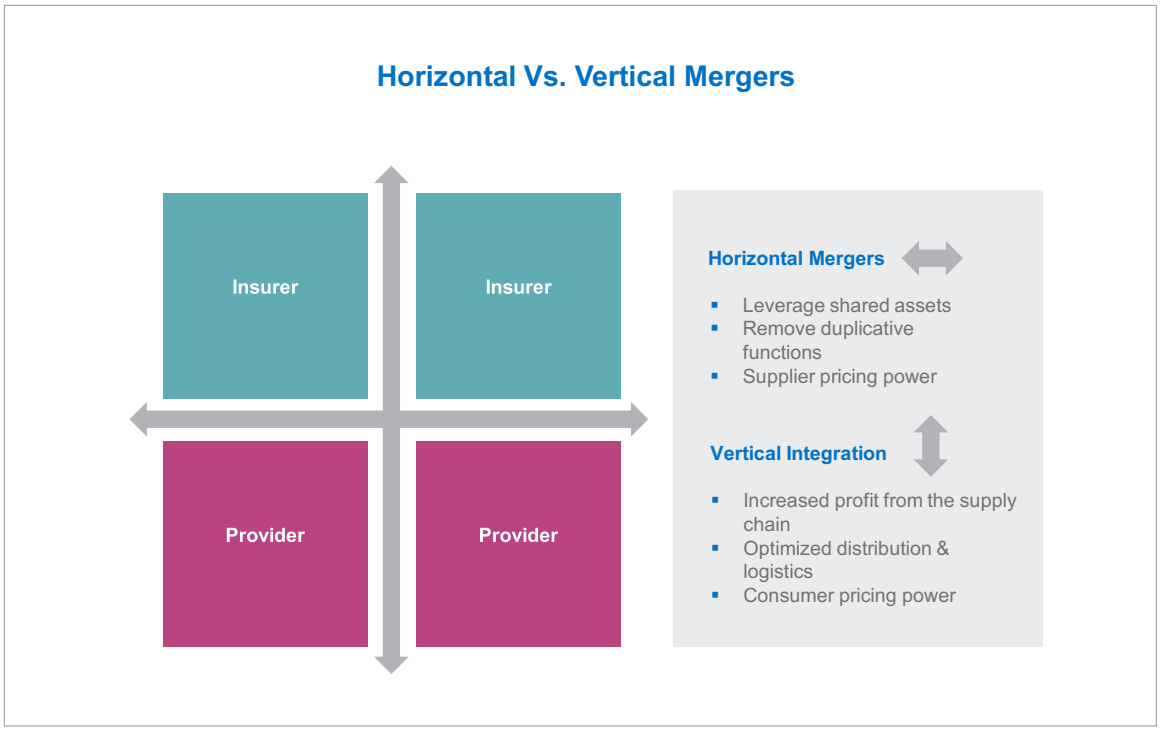

Figure 1: Horizontal vs. vertical mergers.

Historically, in both healthcare and other industries, horizontal mergers are more "defensive" and lead to gained efficiencies through both costs and revenue. Synergies in "fixed costs" include elimination of duplicative functions, consolidation of procurement, optimization of business processes, and higher productivity from shared assets and functions. From a revenue perspective, the merged companies seek to realize opportunities in cross-selling products, optimizing access to markets, and leveraging superior brands.

Horizontal mergers also typically change pricing power dynamics. In this case, the payor benefits from an improved negotiating position with providers. In industries with less stringent regulations, the payor mergers would also provide them increased consumer pricing power (in other words, the ability to raise premiums). However, in the ACA-regulated environment, insurance providers are significantly limited in their ability to exercise this pricing advantage over consumers, particularly in the individual market.

ACA Regulations limit insurers' ability to drive up premiums

The post-ACA retail marketplace has received particular attention as these consolidations coincided temporally with insurance companies requesting

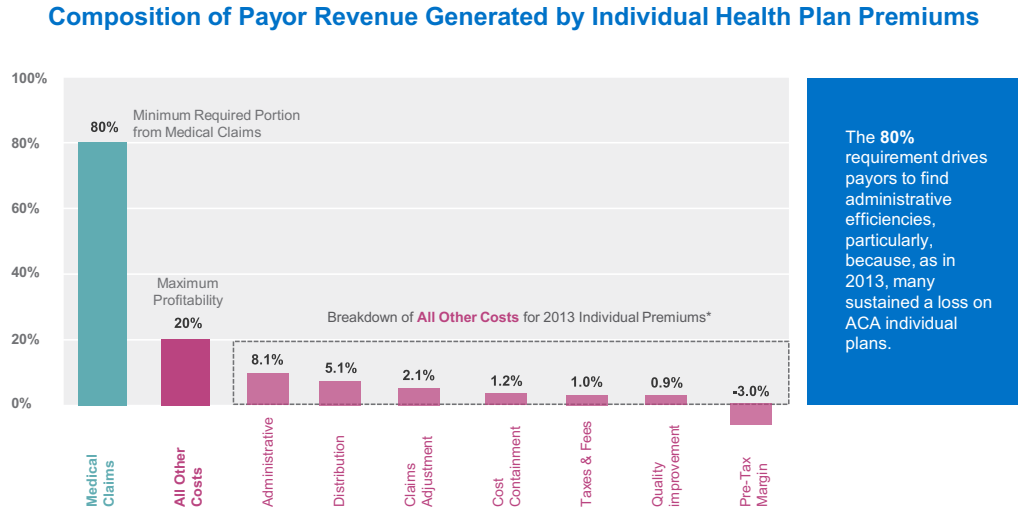

Figure 2. Payor revenue generated by individual health plan premiums.

filing rates with the state regulatory agencies for the ACA 2016 plans. The significant increase in these filing rates seemed to validate the hypothesis that market consolidation is, in fact, increasing premium rates for consumers.[4] Some states requested rate hikes as high as 60 percent to improve the profitability of 2016 individual plans sold on the Exchange. The final average rate change of the Second Lowest Cost Silver Plan across all states was a 7.5 percent rate increase, much less dramatic than the 50-60 percent increases proposed.[5]

The ACA's regulatory requirements likely reined in the proposed increases. The most important ACA regulation that prevents insurers from arbitrarily increasing premiums is the rule that requires at least 80 percent of the cost of an individual health plan premium (85 percent for group plans) to go toward the cost of medical claims.

If more than 20 percent of premium revenue is not spent on claims, the medical loss ratio

4 Robert Laszewski, "Why Are the 2016 Obamacare Rate Increases So Large?", Forbes, http://www.forbes.com/sites/realspin/2015/06/10/why-are-the-2016-obamacare-rate-increases-so-large/#1008cf39194b.

5 "2016 Marketplace Affordability Snapshot," CMS.gov, October 26, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-26-2.html

triggers premium rebates. This prohibits insurance companies from increasing premiums to directly drive up profit margins. Figure 2 shows the breakdown of premiums for individual plans in 2013. Insurance companies are limited to getting their profit from the 20 percent of premiums that are not covering medical costs.

Furthermore, state and federal regulatory agencies require extensive prior review processes for double-digit increases.[6] These include actuarial reporting from an objective third party and usually drive a negotiation process between payors and the states. These review processes contributed to smaller than expected premium increases for 2016 open enrollment.

What does this mean for the affordability of health insurance?

The recent consolidation of insurance companies means that single companies will be covering more members under fewer plans. While the cost of member services will likely rise proportionally with the growing number of covered members, the fixed administrative costs within insurance companies will be combined and reduced. These administrative costs are all included in the 20 percent of payors' revenue shown in Figure 2—and they may help companies make up some of their negative margins.

However, the main driver of premium costs is medical claims. If payor mergers afford payors a more favorable negotiating position with providers, the cost of medical claims could be reduced—which could actually stabilize premium prices. Additionally, the newly insured's use of services may level off as this population becomes more adept at navigating the healthcare system. As the newly insured receives care over time, they may access that care in lower-cost settings with in-network providers, receive more preventive care, and require fewer expensive services. Their medical claims will be reduced, driving down the cost of premiums.

However, one area where consumers could be subjected to unexpected costs is through cost-sharing in the form of copays, deductibles, and coinsurance.[7] Consumers should look carefully at how costs for prescription drugs and point-of-service charges have changed in their plans and consider their expected utilization patterns.

Conclusion: Refocus on Innovation

Mergers are a predictable reaction to the rising costs of care and provider consolidation. With the administrative efficiencies and pricing power that providers typically gain from these mergers, payors stand to benefit.

However, the ACA's regulatory requirements limit any consumer pricing power that they might gain with the 80 percent rule, as well as the state and federally regulated rate review processes for premium hikes.

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6 "Rate Review," HealthCare.gov, https://ratereview.healthcare.gov/

7 Matthew Ray, Larry Levitt, Gary Claxton, Cynthia Cox, Michelle Long, and Anthony Damico, "Patient Cost-Sharing in Marketplace Plans, 2016," The Kaiser Family Foundation, November 13, 2015, http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/

The main driver of premium prices is the cost of care provided to a patient population. That's why providers and payors should work to develop partnerships to provide high-quality care at a lower cost, including alternative value-based care payment arrangements, improved coordination of care across the continuum (particularly for the newly insured population), and the technology to adequately support these initiatives.

The intense M&A activity in the healthcare industry is not new, but the results of M&A in healthcare will be representative of industry-specific regulation and trends. Payors, providers, and consumers must seek out equally unique and innovative strategies and solutions to thrive in the new healthcare environment.

About Slalom

Slalom designs and builds strategies and systems to help clients solve some of their most complex and interesting business challenges.

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