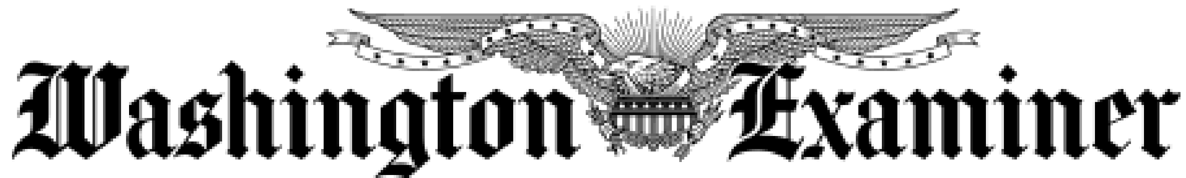

Post-Obamacare insurance consolidation has raised healthcare costs

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Recent health insurance market consolidation linked to Obamacare regulations has raised premiums for employers and individuals.

Consolidation happens when either producers in a market leave or two or more producers merge into one company. Either way, it means a larger market share for the companies that remain.

In recent years, consolidation due to insurers exiting a market has become more common, especially in the Obamacare exchanges. According to data from the conservative think tank Heritage Foundation, 345 insurers offered coverage on the exchanges in 2013. By 2019, that had fallen to 202.

Consolidation in the large employer market has been less dramatic but has still increased. In 2011, the top large employer insurer enrolled 45% of the market. That increased to 51% by 2019, according to the Kaiser Family Foundation.

Most of the consolidation took place through firms exiting the relevant markets rather than by mergers. Health insurance mergers have been rare ever since the U.S. Justice Department opposed the mergers of Anthem and Cigna and of Aetna and Humana in 2016. In 2017, a federal judge blocked both mergers.

“Fewer insurers means it is harder to negotiate lower premiums,” said Elizabeth Mitchell, president and CEO of Purchaser Business Group on Health, a nonprofit coalition that advances healthcare quality and affordability. Its members include Bank of America, Microsoft, Pacific Gas & Electricity, and Walmart.

KFF found the annual premium for a larger employer family plan rose 54% from $13,375 in 2009 to $20,576 in 2019. The average premium on the exchanges more than doubled from $244 per month in 2013 to $558 per month in 2019, according to the Heritage Foundation.

Some consolidation does create efficiencies, such as when an inefficient insurer goes out of business or a large insurer buying a smaller one, which creates a more efficient provider network. Yet, rising premiums suggest inefficient consolidation is much more common.

“When inefficient consolidation persists, it is almost always the result of bad policy decisions that encourage it,” said Michael Cannon, director of health policy studies at the libertarian Cato Institute.

Cannon said there are many of them, but he singled out Obamacare’s medical loss ratios as one that is particularly bad for smaller insurers. Under Obamacare’s MLRs, insurers in the exchanges can spend no more than 20% of their revenue on administrative expenses over a three-year period. For insurers of large employers, it is 15%. The remainder must be spent on medical claims.

Obamacare supporters argue the MLR regulation protects consumers by requiring insurers to commit more of their premium revenue to the healthcare of their enrollees instead of overhead and profits. Insurers that exceed those limits must issue rebates to their customers.

Larger insurers will have less variability in their administrative expenses year-to-year because they have many customers. Large groups of customers tend to behave more predictably and have similar amounts of medical claims most years, making it easier for a large insurer to comply with Obamacare’s MLR.

“It’s the law of large numbers,” Cannon said. “The smaller an insurance company, the more variability there will be in medical claims. If a small insurer gets a disproportionate number of low-cost enrollees in one year, it will violate the MLR regulation. That happens far less frequently for large insurers.”

In general, Cannon said government regulation rewards bigger companies over smaller ones. The cost of hiring people to comply with regulations is often high. It is easier for large companies to absorb them than smaller companies.

But others think the drive to consolidate is built into healthcare markets.

“To be an insurer, you have to have enough customers because you can spread the risk,” said Lovisa Gustafsson, vice president of controlling healthcare costs for the liberal Commonwealth Fund. “You need to have enough customers so that hospitals and other providers will take the time to contract with you.”

She added that providers, such as hospitals, are also consolidating, which puts pressure on insurers to do the same. The larger an insurer is, the more power it has to negotiate rates with providers.

Further, she said the fact that many of these companies are publicly traded puts additional pressure on them to grow via merger.

“These companies have growth targets they have to hit, and it is hard to grow organically. If you have an employer client, they are not going to hire lots of new employees each year,” Gustafsson said. “Buying other insurers is a lot faster way to grow.”

For Mitchell, quality is another casualty of consolidation.

“Our members … are primarily focused on quality and experience care,” she said. “We’ve been able to prove that better care actually does cost less. But even getting health plans to adopt the measures we care about has been very challenging.”

One initiative the PBGH has been pushing for is to change payment primary care away from fee-for-service to a system of prospective, flexible payment. Under fee-for-service, physicians often spend less time with patients. Under a prospective system, physicians could take more time with patients and would keep any savings they achieve from keeping the patient healthy.

Thus far, PBGH has been unable to get insurers interested in a prospective system.