Market and competition policy challenges facing the insurance industry

Presented by
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The National Congress on Health Insurance Reform
Washington, DC
January 19-21, 2011

Roundtable: Competition and consumer protection enforcement in broken health insurance markets
The basic accounting of health insurance

$\text{Premiums} = \sum (\text{Price}_{\text{Medical}} \cdot \text{Quantity}_{\text{Medical}}) + \text{Admin} + \text{Profit}$

- Five ways for an insurer to increase its profits:
  1. **Increase premiums** relative to medical cost growth—insurer competition in local markets
  2. **Reduce prices** paid for healthcare—provider competition in local markets
  3. **“Manage” care**—reduce or redirect the quantity of healthcare services purchased
  4. **Reduce administrative costs**—new MLR regulations
  5. **Increase share** in the output market—lower premiums, innovation, differentiation

- What does it mean for “competition to be working”?
  - Insurers that do well on (3) and (4) also advance on (1) and (5)
  - Such advances are transitory, as current rivals emulate and leapfrog and new rivals enter
  - (2) can be a sign of competition or not, depending on the circumstances

- Managed vs. Accountable
  - **Managed care**: plans gain competitive advantage by better managing care
  - **Accountable care**: plans gain competitive advantage by contracting with and facilitating providers who better manage care
“Managed” care: a misalignment of incentives and information

- This slide describes traditional non-integrated insurers paying physicians primarily on a fee-for-service basis (PPOs and many modern HMOs)
  - PPO have accounted for more covered lives than HMOs since 1999

- Insurers have the financial incentive to see care efficiently delivered

- Compared to insurers, providers have the knowledge required to deliver efficient care
  - In some cases, providers also lack this information—consider rates of rare complications

- Paired with fee-for-service, utilization management was an attempt by insurers to implement a system of instructions for care
  - These instructions often operated against providers’ financial incentives
  - Insurers lacked ready access to the knowledge necessary to determine what forms of care are appropriate for a given patient

- Outcome predictable in hindsight!
  - Spent many millions of dollars to (1) alienate providers, (2) make patients/customers unhappy, and (3) approve 99% of claims anyway

- Health plans’ success—below-inflation spending growth in the early to mid 1990s—came primarily from lower prices (selective contracting), and much less from effective care management
“Accountable” care—what’s different?

• Accountable care is an attempt to replace *instructions* from insurers to providers with *financial incentives* from insurers to providers
  ▪ Co-locating the incentives and knowledge with providers
  ▪ Shared savings
  ▪ Episode-based payment
  ▪ Global capitation

• Very different from PPO/FFS model

• Less different from the capitated HMO model
  ▪ Both delegate decision-making and financial incentives to providers
  ▪ HMOs **keep profits** from cost savings and **incur losses** from overruns
  ▪ ACOs **keep half the profits** from cost savings and **incur no losses** from overruns (and perhaps outcome or process bonuses)
  ▪ But: modern IT expands what can be measured and rewarded and may lessen some of the complications of HMOs (e.g., no more referral slips)
Accountable care—will it work?

- It’s probably not going to make anything worse

- It may shift a number of business functions from insurers to providers
  - Effects will hinge upon whether providers can perform those functions more efficiently than insurers
  - And upon aligning the unit of payment with the unit of outcome measurement
    - In practice, quality (outcomes) can be difficult to measure and so payments will likely also be tied to process-based measures

- Consider global capitation:
  - Within the ACO: aligning incentives and allocating payments among PCPs, specialists, labs, hospitals, …
  - Outside the ACO: contracting with other providers, dealing with out of network payments
  - Similar issues apply in varying degrees to other ACO models

- At a minimum, taking over such tasks will be a difficult transition for providers
  - E.g., Capitation in the 1990s was very tough on many physician groups
Implications for competition policy?*

• Competitive insurance markets would push insurers to contract with ACOs that do a good job of managing care and compete and innovate on the dimension of facilitating effective ACOs

• If such ACOs exist in an area with little insurer competition, the insurer would reap a disproportionate share of the benefits of more efficient care
  ▪ Creates an opportunity for other insurers to enter, for smaller insurers to grow, and for ACOs to contract with such entrants
  ▪ *Unless* there are barriers to insurer entry and expansion

• **So the antitrust agencies will seek to:**
  1. Block health plan mergers they deem likely to lessen competition
  2. Oppose practices they deem likely to restrict health plan entry, expansion, or innovation

• But there’s not much news in this—it’s what they already do!

• Agencies will also remain focused on provider competition—even the most competitive of insurance markets will pass on high provider costs
  ▪ And, why undertake the hard work of becoming accountable if life is already good?

*The views expressed herein do not purport to be those of any actual antitrust agency!
More competition policy issues*

• Agencies will be asked to weigh the efficiency gains of vertical and horizontal integration in the name of forming ACOs
  ▪ But VI has not generally created efficiencies in the past and, not infrequently, the opposite
  ▪ Physician-Hospital Organizations (PHOs) in the 1990s
  ▪ Competitive effects of vertical integration less clear-cut than horizontal

• ACO status is conferred by CMS, which regulates prices
  ▪ FTC and DOJ, however, are highly concerned with negotiated prices
  ▪ Consistency?

• Private sector: Provider vs. provider litigation may increase
  ▪ ACOs form and some providers are left out
  ▪ Anticompetitive exclusionary conduct is recast as ACO formation
  ▪ Agencies also likely to be active in “conduct” (monopolization) investigations—how to distinguish exclusion from accountability?

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