

U. S. Healthcare Financing Reform: The Consolidation of the Health Insurance Industry

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Abstract

Equitable distribution of healthcare services and administrative efficiency are lacking in the current American healthcare system. A high concentration and a lack of competition in the health insurance industry suggests the feasibility of a single government health insurer, which could be achieved using a mergers and acquisition strategy, thus removing the wasteful complexity in healthcare financing. In this study, the enterprise value, market share, and financial characteristics of commercial health insurers are used to estimate that an investment of \$714 billion would be needed to consolidate the health insurance industry. We estimate that, with an annual administrative cost savings of \$405B, there would be a payback period of two years. Merging state medical assistance programs and acquiring the private health insurers to reform the Medicare program would be the most effective method of achieving affordability, equitable access, and cost savings in healthcare.

Keywords: healthcare financing, health insurance, Medicare, Medicaid, mergers and acquisitions

Introduction

Mergers and acquisitions (M&A) are common business practices used to acquire customers, achieve economies of scale, and reduce expenses. The Federal Government, the largest health insurer in the country and the largest customer of private health insurance, has a financial incentive to use an M&A strategy to merge state medical assistance programs and acquire private health insurers to reform the Medicare program.

The purpose of this study is to analyze the synergy that could be achieved by federalizing the cost of state medical assistance programs and consolidating the health insurance industry into a single government health insurer. Economists have extensively studied the savings in administrative costs that can be achieved by replacing the multi-insurer system with a single government health insurer.¹ In the present study, the financial characteristics and market share

of private health insurers are examined to determine the feasibility and expected cost to the Federal Government of acquiring the entire private health insurance industry. The payback period method, which measures the number of years it takes to return the initial investment, is used to value the M&A strategy.

The estimated payback period shows that the Federal Government has the opportunity to invest and consolidate the industry, and thus reduce the wasteful complexity of health insurance. The Medicare program that we propose would simplify billing and health insurance-related (BIR) activities, resulting in a more efficient healthcare financing system.² Using income-related actuarial premiums and family size in reforming the Medicare program would make health insurance affordable while adding social value.³

Background

The Centers for Medicare & Medicaid Services (CMS) manages both the Medicare and Medicaid programs, each of which provides health services in different ways to different groups of people.

The CMS describes the Medicare program as the largest health insurer in the United States.⁴ Medicare provides health insurance to over 56 million people, and is available to those who are aged 65 and over or have permanent disabilities or End-Stage Renal Disease.⁵

Medicaid consists of three medical assistance programs including Medicaid, Expanded Medicaid, and the Children's Health Insurance Program (CHIP) that provide health insurance coverage to about 73 million low-income individuals.⁶ Hospital care, medical services, and prescription drugs account for 75 percent of Medicaid spending.⁷ Medicaid programs are jointly funded by federal and state governments, and administered by states according to federal requirements. Under the original Medicaid, the federal government pays, on average, 59 percent of costs for children, pregnant women, parents, seniors and individuals with disabilities, and 93.8 percent of the CHIP costs.^{8,9} The federal share of Expanded Medicaid for adults aged under 65 is 100 percent in 2016 with the federal contribution to be phased down to 90 percent by 2020.¹⁰

Medicare and Medicaid therefore together provide health insurance coverage to 129 million individuals, approaching 40 percent of the population, with the majority of the funding provided by the Federal Government.¹¹

The Federal Government is also the largest purchaser of private health insurance. The 2015 Health Insurance Industry Analysis Report shows Medicaid with 25.2 percent of direct premiums written followed by Medicare at 24.8 percent. The Federal Employees Health Benefits (FEHB) Program is the largest employer-sponsored group health insurance program in the United States, covering over 9 million individuals.¹² The government's share of FEHB premiums is equal to 72 percent of the weighted average premium of all plans, not to exceed 75 percent of any given plan's premium.¹³ FEHB accounts for 6.2 percent of direct premiums written, as illustrated in Table 1.

Table 1
2015 Direct Premiums Written

Line of business	Amount (\$ B)	Percent
Medicaid	\$148.4	25.2%
Medicare	\$146.1	24.9%
FEHB	\$36.5	6.2%
Medicare Supplement	\$9.4	1.6%
Individual and Group	\$216.2	36.7%
Other Health	\$31.9	5.4%
TOTAL	\$588.5	100.0%

Source: National Association of Insurance Commissioners & the Center for Insurance Policy and Research. 2015 Health Insurance Industry Analysis Report [Internet]. 2015. Available at: http://www.naic.org/documents/topic_insurance_industry_snapshots_2015_ann_health_ins_ind_report.pdf

In addition, the Federal Government subsidizes private health insurance coverage. Subsidies include tax exclusions, deductions, and credits. The Congressional Budget Office estimates the cost for these subsidies at \$300 billion in fiscal year 2016.¹⁴

Private Health Insurers' Concentration

Private health insurers are highly concentrated. An American Medical Association (AMA) study found 14 states had a single health insurer with at least a 50 percent share of the commercial health insurance market. Forty-six states had two health insurers with at least a 50 percent share. In nearly 40 percent of the metropolitan areas studied, a single health insurer had at least a 50 percent share of the commercial health insurance market.¹⁵

The AMA study further reported that 70 percent of 388 metropolitan areas had a Herfindahl-Hirschman Index (HHI) greater than 2,500. The HHI is calculated by summing the squares of the market shares of individual firms. HHI scores in excess of 2,500 indicate a highly concentrated market and low level of competition.¹⁶

A Blue Cross Blue Shield (BCBS) licensee is the largest insurer in 44 states in the individual market, 38 states in the small group market, and 40 states in the large group market.¹⁷ BCBS companies cover more than 107 million people, which represents nearly one-in-three Americans.¹⁸ Nationally, nonprofit BCBS affiliates, treated as a single firm, have a 37 percent market share including the number of privately insured lives in fully and self-insured plans. The publicly-traded Anthem BCBS has a 15 percent market share. The next three largest publically-traded insurers include United Healthcare with 13 percent, Aetna with 11 percent and Cigna with 6 percent. The remaining 17 percent is comprised of multiple smaller for-profit and nonprofit health insurers.¹⁹

Health Insurance Consolidation and Valuation

Currently, publicly-traded and nonprofit health insurers are pursuing growth and synergy through mergers and acquisitions in an already highly concentrated industry.^{20,21} As the largest health insurer and a major customer of private health insurance, the Federal Government can follow the same mergers and acquisitions strategy. By acquiring the private health insurers and merging the state Medicaid medical assistance programs into Medicare, the Federal Government can achieve the optimal cost reduction synergy. The cost of acquiring a publicly-traded health insurer is the enterprise value.

Enterprise Value = market value of common stock (market capitalization) + debt at market value + minority interest at market value + preferred equity at market value + unfunded pension liabilities – value of associate companies – cash and cash equivalents.
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Non-profit health insurers are valued by comparison with a publicly-traded insurer having similar financial characteristics. The total enterprise value for the four largest publicly-traded health insurers is \$238.4B with a direct premiums written market share of 33.4 percent. Dividing the enterprise value by the market share, results in an estimated \$714B enterprise value for all private health insurers, both for-profit and not-for-profit, as shown in Table 2.

Table 2
Private Health Insurance Enterprise Value

HEALTH INSURER	ENTERPRISE VALUE JUNE 2016 (\$ B)	2015 DIRECT PREMIUMS WRITTEN MARKET SHARE
UnitedHealth Group (UNH)	\$147.80	11.35%
Anthem (ANTM)	\$30.37	9.23%
Humana (HUM)	\$19.5	8.67%
Aetna (AET)	\$40.72	4.12%
TOTAL	\$238.41	33.37%
Adjusted total	\$714.44 (238.41/0.3337)	100%

Source: YAHOO! FINANCE. Key Statistics. Valuation measures. Enterprise Value. Accessed 1 June 2016 at: <https://finance.yahoo.com/quote/UNH/key-statistics?p=UNH> <https://finance.yahoo.com/quote/ANTM/key-statistics?p=ANTM> <https://finance.yahoo.com/quote/HUM/key-statistics?p=HUM> <https://finance.yahoo.com/quote/AET/key-statistics?p=AET>

U.S. Department of the Treasury and Federal Insurance Office. Annual Report on the Insurance Industry (September 2016) [Internet]. Figure 7: Health Insurance Groups by 2015 U.S. Health Lines Direct Premiums Written, page 16. https://www.treasury.gov/initiatives/fio/reports-and-notice/Reports/2016_Annual_Report.pdf

When the current multi-insurer system is replaced with a single government health insurer with no cost sharing, an estimated \$375B in BIR administrative costs savings would be realized.¹ This figure excludes BIR spending by individuals and employers, and the total cost associated with government regulation of private health insurance. By eliminating the \$30B BIR administrative cost caused by the Affordable Care Act (ACA), the total BIR cost savings becomes \$405B.²² Dividing the enterprise value for all private health insurers by the BIR administrative cost savings, the payback period for the investment is just under two years ($\$714/\$405\text{B}=1.77$ years). By comparison, this payback period far outstrips that realized by the Troubled Asset Relief Program (TARP), which disbursed \$429.7B with a six year payback period.²³

Medicare Reform and Financing Simplification

Medicare consists of Part A Hospital Insurance, Part B Medical Insurance, and Part D Prescription Drug Coverage. Medicare is funded primarily from three sources: general revenues (42%), payroll taxes (37%), and beneficiary premiums (13%).²⁴

In simplifying healthcare financing, the current Medicare program for ages 65 and older could be modified to eliminate the need for Medicare Supplement Insurance (Medigap) policies and Prescription Drug Plans (Part D). A single income-related actuarial premium would cover Part B medical services, Part D prescription drugs and deductibles, copayments, and coinsurance, including Part A hospital inpatient cost sharing.²⁵ Payroll taxes would remain the primary source for Part A Hospital Insurance. Appropriations from general revenues would remain the primary source for Parts B and D.

The cost for those beneficiaries currently enrolled in both Medicaid and Medicare (with dual eligibility) would be federalized to cover Parts A, B, and D premiums. Public financing and the lead role of state governments in long-term care services and supports would remain unchanged. The annual federal general revenue appropriations would continue for the federalized dual eligible medical assistance program and long term services and support.

A new no cost-sharing Medicare Part E would expand the current Medicare program to include those aged under 65. Part E would provide hospital, medical services, and prescription drug coverage. The funds would come from annual actuarially determined health premiums and a reallocation of appropriations from general revenues that currently go to Medicaid medical assistance programs. The premium for Part E would be collected as an earmarked graduated income tax based on the federal poverty level, family size, and income. The tax would be refunded or owed on the annual federal individual income tax return.

Discussion and Conclusion

Equitable distribution of healthcare services and administrative efficiency are lacking in the current American healthcare system. The ACA healthcare reform is focused on preserving a highly concentrated health insurance industry whose business model is based on avoiding high-risk consumers in the individual market and transferring risk in the group market. The ACA healthcare reform has failed to recognize the need for healthcare financing reform.

Multiple health insurers; cost shifting between employers and employees, and insurers and consumers; provider cost shifting between health insurers; and state healthcare provider taxes for additional federal Medicaid funds are together driving the wasteful complexity in today's healthcare financing system. The fragmentation of healthcare financing has also led to a delivery system that lacks coordination and efficiency in the allocation of resources.

It is the responsibility of government to act when the private sector fails to achieve equity and efficiency. The fact that there is only a two year payback period for a \$714 billion investment suggests that there is an opportunity for the Federal Government to develop a new financing

scheme that would remove wasteful complexity in healthcare financing and make the allocation of healthcare resources equitable and efficient. The expansion of health insurance coverage with income-related actuarial premiums, and hence the reallocation of the current mandatory appropriations from general revenues to the proposed Medicare program, would be the most effective method to achieve affordability, equitable access, and cost savings.

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