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Why a Public Plan is Unnecessary to Stimulate Competition

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Abstract

Proponents of a public health insurance plan, including President Obama, claim it is needed to stimulate competition. This paper challenges that claim from a national, state and local perspective. The evidence shows that at the *national* level the health insurance market generally is highly competitive for the 61 percent of privately insured Americans who now purchase their coverage through large groups.

At the *state* level, concentration in health insurance markets appears less disturbing than it appears for two reasons. States generally are too large to constitute a meaningful market for purposes of assessing antitrust concerns, and the limited empirical evidence that is available does not suggest that states with a dominant insurer suffer any significant adverse consequences. First, most concentrated markets tend to be dominated by nonprofit plans (mostly Blue Cross/Blue Shield plans). Second, market concentration is not necessarily associated with adverse outcomes. For nonprofit Blue Cross/Blue Shield plans, increased market share historically has been associated with lower payments to providers, lower administrative costs and lower premiums. Even today market concentration among health insurers has a relatively small effect on current premium levels or recent rates of growth in health spending. The available evidence is inconsistent with the view that concentration is allowing health insurers to exploit their members. Instead, it squares with a more plausible view that concentration in the health insurance industry has provided a useful corrective to the more disturbing growth in concentration of hospital and physician markets over the past decade.

Even at the *local* level, roughly three-quarters of local markets that appear to have weak competition are dominated by nonprofit plans. Such plans are no different than a public plan in terms of profit motive. In areas where lack of competition adversely affects those seeking to purchase health insurance, policymakers should consider more effective tools to restore competition that would be superior to reliance on a public plan. These include more effective state regulation of the individual and small group markets, more aggressive antitrust enforcement and allowing interstate sales of health insurance.

Finally, real world experience with the Medicare drug benefit (where fierce competition among private health plans has contributed to cost savings of nearly 40 percent), the Federal Employee Health Benefits Program (which for decades generally has experienced lower premium growth than private health insurance and Medicare) and the State of California (whose market-oriented approach to health care has reduced its level of spending relative to the U.S. by nearly one-third in just twenty-five years) have demonstrated convincingly that competition among private insurers can work very effectively even without a public plan.

INTRODUCTION

Proponents of a public health insurance plan, including President Obama, claim it is needed to stimulate competition.¹ Leading proponents freely concede that “an overall distrust of private insurers is a central motivation for the public plan option.”² A public plan is said to be needed as a *benchmark* on cost and quality to encourage private insurers to offer value for money to members and “bargain more aggressively in consolidated provider markets.”³ Lack of competition in insurance markets is presumed to inhibit incentives to drive hard bargains with providers or squeeze out excess administrative costs. A separate concern is that a public plan be available to serve as a *backup* option to ensure financial and health security to individuals and small employers who might otherwise lack access to a reasonably priced private-sector plan. Advocates are skeptical that “regulations or contracts will ensure that private insurers comply with all reforms for all people” – whether these relate to take-all-comer rules (“guaranteed issue”) or refusals to pay for beneficial care. Even if they trusted private plans not to put their own bottom line ahead of quality care and patient safety, many advocates would not have confidence that private competition alone would ensure affordable coverage, especially in rural areas or those markets perceived to be dominated by only one or two private plans. Finally, proponents also view a public plan as a *backstop* “to bring down costs over time through innovations in payment and delivery, innovations that would be available to the private sector.”⁴

There are four good reasons to question these claims. This paper will demonstrate there is far more competition in private insurance markets than the above lines of criticism allege. Maintaining and strengthening such competition is a far more reliable strategy for achieving quality health care at an affordable cost than creating a dominant public plan that could undermine such competition and its beneficial effects. First, the evidence shows that, at the national level, the health insurance market generally is highly competitive for more than three-fifths of privately insured individuals. Second, the apparent lack of competition at the state level is irrelevant or benign. Most states that appear to lack competition are dominated by nonprofit plans. More importantly, states generally are too large to constitute a meaningful market area for purposes of assessing antitrust concerns, and the limited empirical evidence that is available does not suggest that states with a dominant insurer suffer appreciable adverse consequences. Third, insurer concentration in most local markets also has no adverse consequences. In reality, the vast majority of markets that appear to lack competition are dominated by nonprofit firms whose missions, motives, and economic incentives would be little different than those of a public plan. Moreover, the concentration of market power among just one or several health insurers may have served as a helpful counterweight to the growing market power of providers in recent years. Fourth, in local markets where lack of competition

among health insurers may be an issue, there are tools to restore competition that would be vastly superior to reliance on a public plan. This conclusion is based on real world experience that has demonstrated repeatedly that head-to-head competition among private insurers can produce sizable premium savings even without a public plan.

The sheer number of private health insurance companies (nearly 1300); ample alternatives to fully insured health benefits, such as self-funding or self-administration used by the majority of large employers; and modest profitability levels among private insurers together demonstrate that at the *national* level, the health insurance market generally is highly competitive for the 60 percent of privately insured Americans who now purchase their coverage through large employer groups. Thus, it makes little sense, as the current House-passed Affordable Health Care for America Act (H.R. 3962) does, to allow for the possibility of a public plan being offered to such groups.

At the *state* level, several different analyses have concluded that health insurance markets in most states either are “highly concentrated” or “concentrated” (antitrust terms of art denoting states where a handful of firms control a lion’s share of the market). But such state-level concentration in health insurance markets appears less disturbing than it appears for three reasons. As a practical matter, most states are too large to constitute a meaningful market for purposes of assessing whether one or more insurers maintain excessive market power.

Second, the limited empirical evidence available shows that apparent market concentration at the state level is not necessarily associated with adverse outcomes. One of the most detailed studies to examine this issue found that among nonprofit Blue Cross/Blue Shield plans (which tend to be the dominant insurers in states where market share is concentrated among just one or two firms), increased market share historically has been associated with lower payments to providers, lower administrative costs and lower premiums. This finding admittedly is based on data more than one-quarter century old, but even more recent data (through 2004) suggests that market concentration among health insurers has a relatively small effect on current levels or recent growth in health spending. Specifically, there is only a small relationship between the share of the market controlled by the two largest firms and state-level private per capita health spending. In addition, health insurance market concentration explains only a small part in the rates of increase in private per capita health spending between 1999 and 2004. These simple correlations are inconsistent with the view that lack of competition among private health insurers is a major factor that explains either the high level of health spending in the United States or its rapid growth.

A third strand of evidence comes from a multivariate analysis of the impact of conversions of Blue Cross plans to for-profit status. In states where such conversions occurred, there was a modest *decline* in health spending, risk of being uninsured, and increase in hospital profits relative to states in which no conversions occurred. This belies

the claim that for-profit insurers are using their market power to charge higher premiums or underpay hospitals in a ruthless pursuit of profits.

At the *local* level, where competition should matter more, roughly three-quarters of local markets that appear to have weak competition are dominated by nonprofit plans: such plans are similar in several important ways to a public plan in that they do not seek to maximize their operating margins; of equal importance, their statutory obligations to provide a “public benefit” presumably equip them to wield whatever market power they hold in a responsible fashion. In such cases, it is not all clear what the “value-added” of a strong public plan might be. But even in markets where for-profit health insurers are the dominant players, concentration alone does not prove that market power exists or is being abused. First, even highly concentrated markets with nonprofit plans do not necessarily result in excess market power when the credible threat of entry by other plans would preclude even for-profit plans from earning outsized profits. Second, in many markets, concentration in the health insurance industry may well be providing a useful corrective to the equally disturbing growth in concentration of hospital and physician markets over the past decade. But again, if this countervailing power already is being deftly wielded by private insurers in most markets, it is difficult to see what a strong public plan brings to the table.

Indeed, if the problem of sluggish private sector competition is limited in geographic scope to just select local markets, then creating a national public plan to address that problem is the wrong tool to address this. It would be preferable and far less risky to find more targeted solutions. In areas where lack of competition adversely affects those seeking to purchase health insurance, policymakers have ample tools to restore competition that would be superior to reliance on a public plan. These include more vigilant state regulation of the individual and small group markets, more aggressive antitrust enforcement and allowing interstate sales of health insurance.

The conclusion that reliance on competition among private health plans can be trusted to work is based on extensive real world experience. Examples include the Medicare drug benefit (where fierce competition among private health plans has contributed to cost savings of nearly 40 percent relative to originally projected levels), the federal employee health benefits program (which for decades generally has experienced lower premium growth than private health insurance and Medicare) [recheck this trend for recent years, see Walt Francis’ new book for us, and cite it, if applicable] and the State of California (whose generally market-oriented approach to health care reduced its level of spending relative to the United States as a whole by nearly one third over a period of just twenty-five years) have demonstrated convincingly that competition among private insurers can work very effectively even without a public plan.

Here’s the evidence to support those conclusions.

OVERVIEW

HEALTH INSURANCE MARKET CONCENTRATION

The argument for a public plan rests on the claim that vibrant competition in private health insurance markets is inhibited by widespread concentration in the health insurance industry. Such concentration allegedly provides private insurers with too much market power, allowing them to charge consumers higher premiums, deny more claims, increase their profit margins, and/or reward CEOs and top management with lavish salaries or perks that would not be possible in a more competitive market. The empirical basis for this claim will be examined shortly, but it is important to understand the meaning of the term “concentration.”

Concentration is a term of art used by antitrust enforcers and operationalized through the Herfindahl-Hirschman Index (HHI). The HHI equals the sum of squared market shares of each firm in a market. Thus, its maximum value, 10,000, occurs when there is a single monopolist ($100^2=10,000$). Under the most recent Federal Trade Commission (FTC)/Department of Justice (DOJ) Horizontal Merger Guidelines, markets with an HHI less than 1,000 are *not concentrated* (e.g., twenty firms with equal market shares of 5 percent each would have an HHI of $20 \times 5^2 = 500$).⁵ Where the HHI lies between 1,000 and 1,800, the market is considered “concentrated.” In such markets, any merger that increases the HHI by more than 100 points may be subject to challenge by antitrust regulators due to significant concerns about competitiveness. In a twenty-firm market where market shares are otherwise equally divided, just a single firm with a 32-percent market share would be sufficient to make that market concentrated. Finally, markets are considered “highly concentrated” when the HHI exceeds 1,800, a threshold met when a single firm has 42 percent of the market or when five firms have equal market shares. In such markets, any merger that increased HHI by more than 50 points would raise significant competitive concerns, while mergers boosting HHI by more than 100 points are presumed to be anti-competitive. Antitrust concerns can be overcome if there is evidence making it unlikely that a particular merger will create or enhance market power or facilitate its exercise, but the HHI parameters above at least provide a rough indicator of the relationship between market concentration and potential concerns about excess market power.

THE PRIVATE HEALTH INSURANCE MARKET – PRESENT AND FUTURE

The March 2009 Current Population Survey (CPS) shows that, collectively, employment-based health insurance (176.3 million), public coverage (87.4 million), and nongroup coverage (26.8 million) insure more than 290 million covered lives.⁶ Of course, there are overlaps in coverage that reduce this gross estimate to a net figure of 255.1 million, leaving 46.3 million people uninsured.⁷ Most discussions of private health

insurance simply differentiate between large groups (accounting for about 80 percent of private premiums), the small group market (about 15 percent of premiums) and the individual (nongroup) market (accounting for the remaining 5 percent)⁸.

Current health reform proposals do not use a consistent set of employer size boundaries. For example, the House-passed Affordable Health Care for America Act bill allows firms with twenty-five or fewer employees to buy coverage through a national insurance Exchange in 2013, firms with fifty or fewer employees in 2014, and firms with 100 or fewer workers in 2015. However, a newly established Health Choices Commissioner also “is permitted from this year forward to expand employer participation as appropriate, with the goal of allowing all employers access to the Exchange.”⁹ Tax credits are available for small firms with ten or fewer employees if average wages are \$20,000 or less, but these phase out for employers with twenty-five or more workers or if average wages reach \$40,000 or more.¹⁰

The Senate-passed Patient Protection and Affordable Care Act would create state-based exchanges for participants from the individual and small group markets. This proposal explicitly allows small businesses with up to 100 employees to purchase through state-based Small Business Health Options program (SHOP) exchanges starting in 2015, and gives states the option to allow larger firms to purchase SHOP coverage starting in 2017. However, firms with fifty or more employees that do not offer coverage would have to pay a penalty for any employees who obtain subsidized coverage through an exchange. The plan also provides small-employer tax credits for firms with fewer than twenty-five, largely mirroring the House proposal in terms of the firm eligibility criteria that determine where such tax credits start and stop.¹¹

Both the House and Senate reform proposals create at least one Exchange, but vary considerably in terms of who is eligible to purchase through this mechanism. The picture is further clouded in that administrative discretion is provided in some proposals to allow the maximum size of groups permitted to purchase through the Exchange to be increased without any firm upper limit. For purposes of discussion, it is easiest to think in terms of two different groups of insurance purchasers: large employer groups that already purchase in a national market and are the least likely candidates to need or want to purchase a public plan option, and smaller groups that purchase largely in single-state markets. But because of differences in how insurance is now regulated, various important subgroups are discussed separately within those two different geographically-defined (national vs. state) markets:

- **National Health Insurance Groups.** (four subgroups):
 - *Large Private Firms.* This includes private firms with 500 or more employees (a cutoff that is somewhat arbitrary, but is consistent with the threshold used in the National Compensation Survey¹²) regardless of

whether they self-fund their health benefits or purchase fully insured products.

- *Other Self-Insured Private Firms.* Self-funded health plans offered by employers are exempt from state regulation due to a longstanding federal law known as ERISA, which makes them subject to regulation by the U.S. Department of Labor.¹³ For this reason, self-funded plans for medium and small firms are another subgroup included as national purchasers (though such firms account for less than one-fifth of those with self-funded health benefits).
- *Public Employers.* This includes various health plans for public employees (federal, state and local), most of which are self-funded but some of which are fully insured health benefits plans purchased from private health insurers.
- *Military-Related Health Care.* This includes Tricare (formerly CHAMPUS), CHAMPVA and VA/military health care. Most of these health care arrangements consist of privately purchased health insurance, and the balance is provided through direct service delivery. Military care for active duty military is excluded from discussion since most such care is directly provided at DOD facilities, so these individuals will never be candidates for private insurance or participation in an Exchange.
- **State-Level Purchasers.** (three subgroups):
 - **Medium Employer Market.** This includes private firms with 51-499 employees that offer fully-insured health benefits. Some analyses lump such groups with the large employer market,¹⁴ but those who are not self-funded typically do not buy across state lines and hence are more reliant on the combination of market forces operating at the state or substate level and state-level health insurance regulation to ensure ready access to affordable health benefits.
 - **Small Group Market.** While others have lumped employers with as many as 100 to 249 employees into this category, a lower threshold is used for purposes of discussion in this paper, based on the regulatory practices of most states: firms with fifty or fewer employees.¹⁵ All states regulate the small group market to varying degrees, and the vast majority of states include firms with two to fifty workers under this regulatory umbrella (with nearly one-third of states including groups of one and a handful of states setting the upper bound at twenty-five or thirty-five workers).

- **Individual Market.** This includes those who purchase nongroup coverage, but excludes the many elderly who purchase private policies to supplement Medicare (also known as “Medi-gap” plans).

Each of these markets has unique characteristics and regulatory rules of the road that play an important role in how well private plan competition in each market plays out.

NATIONAL MARKET IS HIGHLY COMPETITIVE

At the national level, the private insurance market already is highly competitive, involving 138 million Americans who obtain employment-based health benefits through large employers or self-funded arrangements. These individuals represent 69 percent of those with private health insurance in the United States.¹⁶ Table 1 summarizes the number of individuals in each of the major subgroups within this category.

Table 1. National Health Insurance Groups				
Employer Class/Size	Employer-Based Coverage			
	Own Employer Plan			Total
	Active Workers*	Retirees	Dependents**	
Private Employers	37.9	7.5	41.5	86.9
Large Firms (500+ employees)	32.3	7.2	36.3	75.8
Self-insured	26.3	6.0	29.3	61.5
Fully-insured	6.1	1.2	7.1	14.3
Other Self-insured Firms	5.6	0.3	5.2	11.1
Small Firms (1-50)	2.2	0.1	2.0	4.2
Medium Firms (51-499)	3.4	0.3	3.2	6.9
Public Employers	16.5	4.7	18.8	40.0
Federal Government	2.3	0.8	4.7	7.8
State government	4.2	1.1	4.1	9.4
Local government	10.1	2.8	10.0	22.8
Military-Related Health Care***	NA	NA	NA	11.0
Tricare/CHAMPUS	NA	NA	NA	7.7
CHAMPVA	NA	NA	NA	0.3
VA/Military Health Care	NA	NA	NA	3.0
GRAND TOTAL	54.4	12.2	60.3	137.9

* Includes coverage from own employer; excludes workers covered only as dependents on an employer-based plan since such individuals may be covered by an employer in a class/size different than that of the worker.

** Excludes workers with own coverage who also are covered as dependents under an employer-based plan provided through a working spouse or other family member.

*** Excludes active-duty military, but include military retirees and dependents of active-duty and retired military; figures have been adjusted for slight over-counting.

Competition in this market is extremely robust First, there is extensive head-to-head competition among private health insurers. Second, large employers have alternatives to

fully-insured health benefits that amplify the pressures private plans face from head-to-head competition (or substitute for such competition in areas where it may be lacking). Third, private insurers in the national market exhibit only modest profitability levels.

HEAD-TO-HEAD COMPETITION

Nationwide, there are nearly 1,300 companies that provide health insurance coverage.¹⁷ This does not imply that all such plans are national, but the four largest publicly traded health insurance companies – WellPoint, UnitedHealth Group, Aetna, and CIGNA – and other large insurers such as Humana and Assurant operate plans in all or nearly all states, making them a very viable choice for any employer needing to provide nationwide coverage for employees located in numerous states.¹⁸ Even though nonprofit Blue Cross/Blue Shield plans are organizationally separate across state lines (or even within major regions of states such as New York and Pennsylvania), the Blue Cross Blue Shield Association’s BlueCard program essentially guarantees that members will get access to the preferred provider networks (and their companion discounts) negotiated by each individual plan. In addition, many large employers are regional in nature, thus expanding their range of choices to large regional plans such as Kaiser, Health Net, and Intermountain Healthcare.

At the national level, there is scant evidence of insurer concentration. Collectively, 65 million lives are covered by nonprofit Blue Cross/Blue Shield plans, representing 32.3 percent of the unduplicated count of persons with private coverage.¹⁹ But this involves enrollment in twenty-five independent plans, each of which serves non-overlapping geographic areas, i.e., making business decisions about product offerings, pricing and negotiating payment rates independently from one another. The five largest publicly traded firms together have a market share of 52.6 percent, with individual shares that are far smaller – including WellPoint (17.4 percent), UnitedHealth Group (16.4 percent), Aetna (8.8 percent), Cigna (5.8 percent) and Humana (4.2 percent).²⁰ Apart from the sheer number of plans available and lack of market concentration, there are other reasons competition is so intensive for the employers who rely on this market.

ALTERNATIVES TO FULLY-INSURED COVERAGE

While the reasons vary by group, each large purchaser has alternatives to fully-insured coverage that amplify the competitive pressures just described. In most cases, this takes the form of substantial purchasing clout that ensures private insurers serve their customers rather than the other way around. In other cases, it takes the form of private insurers displaced entirely – either by self-funded and self-administered benefits or medical services provided directly to eligible members. Large purchasers – whether private or public – generally have several advantages compared to smaller groups or

individuals. By self-funding, they can avert the “risk premium” associated with transferring uncertain health risks to a private insurer. Self-administration offers additional potential savings. But even if large purchasers pay a private insurer for administrative tasks, there are economies of scale in administration that allow the largest groups to save about 5 percent of total health benefits costs relative to medium-sized groups and more than 15 percent relative to the smallest groups.²¹ Their ability to deliver more ‘covered lives’ to an insurer is valuable in its own right, but also gives that insurer more bargaining power vis-à-vis prices paid to providers. Because their business is more valuable to win and keep, large purchasers tend to have the upper hand with private insurers, which act more as their agents in terms of taking prices rather than making them.

PRIVATE EMPLOYERS

The exemption from state health insurance regulation conferred by ERISA provides a powerful motivation for large private employers to self-insure/self-fund their health benefits. Companies with self-funded benefits do not have to comply with costly health insurance mandates, pay premium taxes, or sequester the large costly reserves that state regulators require of health insurers and managed care plans. They may elect to purchase administrative services only (ASO) from private health insurance carriers, but they also have the option of making use of roughly 400 third party administrators (though some say the true number of health-benefits TPAs is closer to 3,500²²). [You have not really explained the difference between TPA and ASO arrangements] Since TPAs claim to have corporate overhead costs as much as 40 percent lower than those of traditional insurance companies,²³ their inclusion in the competitive landscape provides another powerful incentive to keep administrative costs as low as possible. Moreover, insurers and TPAs alike know that companies with self-funded benefits always have the option of self-administering their benefits if they are dissatisfied with the performance of an outside administrator. That relatively few employers opt to do so is further evidence that competition in this market likely results in efficient health plan performance.

Thus, for nearly 87 million plan members who obtain their coverage through generally large and often multistate private employers with self-insured benefits, “the number and relative size of local health plans may be largely irrelevant.”²⁴ There is fierce competition among national insurers for this business. Although there has been some consolidation in subsequent years,²⁵ the most recent published figures for 2003 indicate that the largest insurer serving this multistate employer market had only a 15 percent market share, and the seven largest insurers in this market had a combined market share of only 75 percent.²⁶ As of 2005, TPAs collectively accounted for about 30 percent of the self-insured market.²⁷

But even large employers purchasing fully insured health plans from carriers such as Blue Cross/Blue Shield, Aetna, Kaiser and others – products that *are* subject to state

regulation – are still in a different league than small employers. The law of large numbers means that annual fluctuations in claims expense will be far less volatile than for a mom-and-pop grocery store, for whom an employee needing a \$250,000 liver transplant could result in a ruinous increase in the premiums it is charged in subsequent years. In contrast, a large employer with 50,000 covered lives could absorb such an expense with only a small uptick in premiums. Moreover, even if such employers do not currently self-insure, the very possibility ensures their health insurer will remain constantly attentive to their needs.

PUBLIC EMPLOYERS

This category includes health benefits provided to three large clusters of public workers:

- **FEHBP.** The Federal Employees Health Benefits Program includes 7.8 million federal employees, retirees and their dependents.²⁸
- **State Employees and Dependents.** This includes health plans that together cover 9.4 million individuals in health plans offered to workers in state government (and District of Columbia) – including those working in state-run universities and community colleges.
- **Local Employees/Schoolteachers.** This includes 22.8 million workers, retirees and dependents covered by health plans offered to local government employees—including those working for public school systems.²⁹

Although FEHBP is the nation’s largest employer-sponsored health insurance plan, the federal government does not self-fund these benefits. Instead, it contracts with nearly 300 different health plans across the country and incents employees to offer the best value for the money among plans that vary in benefit design, cost sharing and premiums. Strictly speaking, ERISA does not apply to health benefits plans provided to federal, state and local government.³⁰ However, in accordance with boundaries established by the Constitution, the federal Office of Personnel Management (OPM) does preempt state regulations that would otherwise affect its seventeen national plans, thereby permitting them to offer uniform benefits. However, it does not preempt state mandates that apply to more than 250 local FEHBP plans.³¹ Moreover, federal guidelines require the FEHBP standard option – which accounts for 48 percent of FEHBP enrollment in 2009³² – to offer a level of coverage similar to that available to most Americans with large employer health benefits. A recent comparison found that “with few exceptions, benefits in the FEHBP standard option either meet or exceed those that state mandates require.”³³ While the financial incentives to avoid the highest cost plans and enroll in the lowest cost plans are not as strong as in the past, most workers eligible for FEHBP coverage can choose among twenty or more plans in their local area³⁴ – a degree of choice far more generous than for even those employed by the largest private firms. The dominance of Blue Cross

plans (which cover 62 percent of FEHBP enrollees in 2009) is attributable to statutory restrictions on free entry of national plans, not lack of private plans that would be able and willing to serve this large group.³⁵

Likewise, in most states, the state employee group is quite typically the largest single group, ensuring its purchasing clout with both national and local plans. For the 59 percent of state and local workers in self-insured plans,³⁶ there should be no perverse incentives of private insurers to deny coverage or discriminate against high-risk plan members. But even in states with insured benefits, state employees tend to be the largest single insured group in the state, giving the state a high degree of leverage to protect the plan's members from any market abuses.

In Georgia, schoolteachers and retirees in all school districts are required to be part of the state employee health benefits plan. In twenty-one other states, participation in the state employee health benefits plan is voluntary for municipal employee groups, local school systems or both.³⁷ Actual participation rates by local government groups vary greatly across states offering this option (depending in part on the generosity of the state employee health benefits plan). Local employees and/or schoolteachers who are part of the state employee group enjoy the same sort of purchasing clout described above. Likewise, even groups that have opted not to participate will have more leverage in dealing with national or local health insurers by virtue of having an alternative not available to most private employers. Finally, in the remaining states where participation in the state employee plan is not offered, municipal employees and schoolteachers nevertheless have the option to create a large purchasing group simply by banding together to form large countywide, regional or statewide pools.

MILITARY HEALTH CARE

Military health care consists of three separate components:

- **TRICARE.** This program includes 9.5 million active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide.³⁸ While most receive direct medical services at hundreds of U.S. military treatment facilities around the world, all active duty military and activated National Guard and Reserve members are required to enroll (at no cost) in TRICARE Prime, a managed care plan that gives them access to a network of private providers throughout the U.S. Families of active duty military may also enroll in TRICARE Prime at no cost, but other TRICARE eligibles (e.g., military retirees) must pay a monthly premium for the Prime plan. Unless they elect to join the PRIME plan, all non-active duty TRICARE members throughout the United States are automatically enrolled at no cost in a fee-for-service plan called TRICARE Standard (out-of-network) and TRICARE Extra (a preferred-provider network with less cost sharing). TRICARE was formerly known as

CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services).

- **CHAMPVA.** The Civilian Health and Medical Program of the Department of Veterans Affairs is a health benefits program in which the Department of Veterans Affairs (VA) shares the cost of certain health care services and supplies with eligible beneficiaries, a total of more than 300,000 dependents and certain survivors of veterans.³⁹
- **VA Health.** VA Health includes care to veterans provided by the Health and Medical Program of the Department of Veterans Affairs and direct care provided by the Department of Veterans Affairs.⁴⁰ The VA does offer a standardized package of medical benefits, but generally veterans must be enrolled in the VA health care system to receive them. The VA operates the nation's largest integrated health care system with more than 1,400 sites of care, including hospitals, community clinics, community living centers, domiciliaries, readjustment counseling centers, and various other facilities. Priority is given to veterans based on their degree of service-connected disability, low income, POW status and other factors. The ability to obtain care therefore varies by medical center depending on the center's capacity vis-à-vis the priority status and utilization of veterans within that center's catchment area. Thus, while there are more than 20 million veterans, in 2008 the VA system reported serving 5.8 million unique patients,⁴¹ (and only 3.2 million reported having VA health benefits in the March 2009 CPS⁴²).

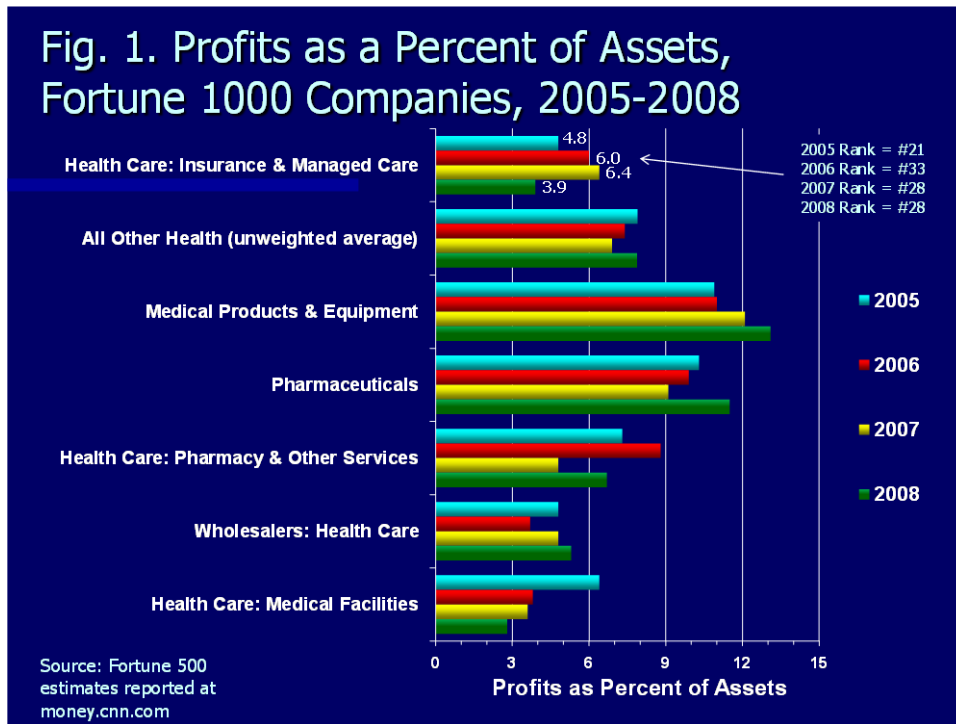
TRICARE is self-funded, but it contracts for administrative services with three different national or regional health insurers to provide in-network and out-of-network coverage under Prime, Standard and Extra. These insurers receive a share of any cost savings arising from lower-than-projected spending on benefits. The regional contracts facilitate on-going benchmarking of performance that can encourage improved performance from the health insurers that currently hold such contracts, as well as inform the standards used for future contracting (which is done at five-year intervals). In contrast, CHAMPVA is essentially self-funded and self-administered by the VA's Health Administration Center (HAC) in Denver, Colorado which processes CHAMPVA applications, determines eligibility, authorizes benefits, and processes medical claims. It generally pays Medicare/TRICARE rates to providers. Most VA health care is provided through direct services provided by the VA system. While the VA may authorize veterans to receive care at a non-VA health care facility when the needed services are not available at a VA health care facility, or when the veteran is unable to travel the nearest facility, such care must be pre-authorized in advance and is paid directly by the VA rather than a private health insurer.

MODEST PROFITABILITY LEVELS

Further evidence of the industry’s competitiveness is seen in its relatively modest profitability levels.

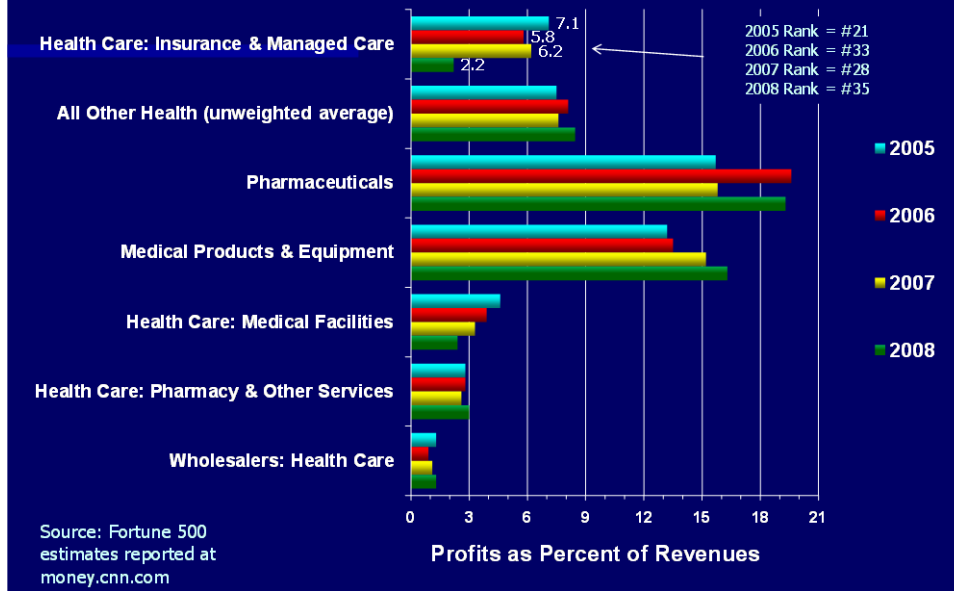
FOR-PROFIT HEALTH INSURERS

Despite recent industry consolidation,⁴³ the largest companies within the health care insurance/managed care industry (i.e., members of the Fortune 1000) earned a profit of only 3.9 percent of assets in 2008 (ranging from a low of -2.6 percent for Amerigroup to a high of 8.8 percent for HealthSpring). While critics have claimed that private health insurers “make more money than any other business in America today,”⁴⁴ the industry’s profitability ranked #28 among seventy-five industries compiled by *Fortune* magazine.⁴⁵ Even within the health care sector, there are few subsectors *less* profitable than health insurance/managed care (Figure 1).



For-profit health insurers fare even worse when net income is measured relative to revenues (Figure 2). Not only did their profit rate plummet in 2008 relative to the three prior years, but their ranking among all industries fell from #21 in 2005 to #35 in 2008. In contrast, notwithstanding general economic trends, most other parts of the health care sector saw a rebound in their profitability levels in 2008. Through mid-November 2009, for-profit health care plans had a net profit margin of 3.4 percent, ranking them #84 among 215 industries tracked by *Yahoo! Finance*.⁴⁶

Fig. 2. Profits as a Percent of Revenues, Fortune 1000 Companies, 2005-2008



Notwithstanding rhetoric from policymakers claiming health insurers are "making record profits, right now"⁴⁷ or that such profits are "obscene,"⁴⁸ annual figures over nearly two decades (1990-2008) show that net income as a percent of revenues for publicly traded hospital and medical service plans averaged only 3.3 percent, ranging from a low of just under 0 percent in 2002 to a high slightly above 6 percent in 1994.⁴⁹

NONPROFIT HEALTH INSURERS

The foregoing figures do not include nonprofit health insurers such as Blue Cross and Blue Shield plans—which covers nearly one third of those with private insurance—or large nonprofit HMOs such as Kaiser, which is the dominant insurer in the nation’s largest state. The latest figures show that the total margin (net income as a percent of revenues) for nonprofit Blues plans declined from 4.3 percent in 2007 to 2 percent in 2008.⁵⁰ But this includes income from investment revenues. Underwriting margins, which are calculated based only on premium income, were only 1.0 percent and 1.4 percent respectively during these years. This is consistent with historical data (1997-2001) showing that total margins for nonprofit Blue plans were 1-2 percentage points lower than those reported by for-profit Blue plans, with more than half this difference stemming from lower underwriting margins.⁵¹

INDUSTRY-WIDE PROFITS

Across the entire health insurance industry (i.e., inclusive of all for-profit companies, as well as nonprofit insurers), after-tax profits in 2006 amounted to 2.9 percent of

premiums (4.1 percent before taxes).⁵² The trends presented earlier suggest that profits are likely to be lower in 2009 than in 2006, but even if the profit rate remained the same, after-tax profits would amount to \$24.5 billion or about \$122 per private health plan member. Were health insurers truly able to exercise considerable market power, we would expect far fewer competitors and much higher levels of profitability. In light of this, and assuming a level playing field in which no plan is given special advantages (e.g., the legal power to impose payment rates tied to Medicare, being able to piggyback on Medicare's administrative structures or being made the automatic "fallback" insurer for those who fail to obtain coverage), adding one more public plan to this mix cannot credibly add to the fierce competitive pressures already felt in this market. It would be hard to justify giving large employer groups access to a public plan, especially when they have demonstrated by their own actions that private coverage is perfectly acceptable. Yet the House-passed health reform plan unaccountably allows (in Year 3 – 2015 – of the plan's implementation of the national health insurance exchange) employers of *any* size to purchase coverage through the national exchange in which the public plan will be offered.⁵³ It even sets as a goal "allowing all employers access to the Exchange." Admittedly, the House allows the "Health Choices Commissioner" to make this decision, while the Senate-passed health reform bill gives this discretion to individual states. But why does it make sense to leave that unnecessary choice to either a federal or state bureaucrat?

STATE-LEVEL CONCENTRATION IN HEALTH INSURANCE MARKETS IS RELATIVELY BENIGN

While there is some overlap with the 83 million Americans covered by public plans such as Medicare and Medicaid, there are up to 144 million Americans (including 46 million uninsured) who do, or could, purchase at least some private coverage in local markets that theoretically might be too concentrated for competition to enforce effective market discipline. Those purchasers include:

- **Medium-Sized Firms with Fully Insured Benefits.** Leaving aside those with fully insured health benefits from large private or public employers, there are 19 million Americans who obtain private coverage through fully insured health plans offered by medium-sized employers (51-499 workers).⁵⁴ Primarily because such plans do not enjoy the protection from costly state regulations and premium taxes accorded to their self-funded counterparts, they face higher costs and fewer choices than large companies in the multistate market.⁵⁵ Although they are not afforded any of the special protections provided by federal or state regulation in the small group and individual markets (see below), their size does give them some bargaining advantage that smaller employers lack, as well as more stability of claims experience.
- **Small Group Market.** Federal regulations under HIPAA require all health insurance for firms with two to fifty employees to be offered on a guaranteed-

issue, whole-group basis. All states (except the District of Columbia) impose additional regulations on the small-group market. Regardless of this greater regulatory scrutiny in terms of market conduct by small group insurers, small firms remain at a disadvantage relative to large firms. Due to differences in economies of scale, they must pay higher premiums than large firms to obtain identical levels of coverage. They have less bargaining power in negotiating prices. They also face much more volatility in annual premium increases related to experience rating in states that do not impose community rating or narrow rating bands. Small firms are much more likely than large firms to change carriers annually, subjecting them to new underwriting of coverage and attendant changes in their experience-based premiums.. Including more than 8 million self-employed workers/retirees/dependents who have employer-based coverage, a total of 32.0 million Americans in 2009 obtained fully-insured health coverage from employers with fewer than fifty workers.⁵⁶

- **Individual Health Insurance Market.** Excluding 10.3 million who purchase Medicare supplemental coverage, there were 16.4 million other Americans who had coverage through the nongroup market in March 2009.⁵⁷ Some federal regulations such as HIPAA portability rules apply to the entire market,⁵⁸ but state regulations vary widely.⁵⁹
- **Uninsured.** Of the 46.3 million uninsured reported by CPS, 12.0 million are workers or dependents of workers in small firms, 2.7 million are workers/dependents in medium firms, and another 23.9 million have work-based connections to large groups (including 2.9 million related to public sector jobs). This leaves only 7.7 million without any prospect of being able to obtain employer-based coverage – even if it is required under an employer mandate – who would automatically be candidates for the individual market. However, the reform proposals differ considerably in terms of whether the employers of uninsured individuals having work-based connections would be required to offer coverage or whether these particular uninsured individuals would qualify for coverage. Collectively, 62 percent of uninsured workers are in firms not offering health coverage, another 24 percent are ineligible for the coverage offered (e.g., being part-time workers or perhaps new on the job) and only 14 percent actually turned down offered coverage for which they are eligible.⁶⁰

While state-level health insurance market concentration has been the focus of concern for many advocates of a public plan,⁶¹ as a practical matter, the observed concentration is largely benign for several reasons. Most states that appear to lack competition are dominated by nonprofit plans. More importantly, states generally are too large to constitute a meaningful market for purposes of assessing antitrust concerns. Not surprisingly, the limited empirical evidence that is available does not suggest that states with a dominant insurer suffer appreciable adverse consequences.

MOST LOW-COMPETITION STATES DOMINATED BY NONPROFIT PLANS

Three recent studies have documented the extent of concentration in health insurance markets at the state level. However, closer analysis also shows that

nonprofit health plans tend to dominate in most states where concentration appears problematic.

STATE-LEVEL COMMERCIAL INSURANCE MARKETS

The first of these studies, conducted by Jamie Robinson, examined the overall market for commercial health insurance in 2002 and 2003. It included all types of insurers (for-profit and nonprofit), all markets (employer-based and nongroup), all employers (public and private, self-funded and fully insured) and all types of products (HMO, PPO, fee-for-service). Market share estimates could be calculated from data for all states except Alaska, Hawaii, and North Dakota.

- **Market Concentration.** Based on 1997 federal antitrust guidelines, thirty-four states had “highly concentrated” markets, another twelve states had “concentrated” markets, and only three were below the threshold for a low level of antitrust concern.⁶²
- **Nonprofit Plan Dominance in Concentrated Markets.** However, in twenty-six of the thirty-four “highly concentrated” states, the dominant insurer is a nonprofit Blue Cross plan (the eight exceptions are Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, and New Hampshire).⁶³
- **Dominant Insurer Market Share.** In forty-three states, the largest firm controlled 30 percent or more of the market; in sixteen states, this market share exceeded 50 percent.⁶⁴
- **Nonprofit Firm Dominance of Dominant Insurer Markets.** Nonprofit plans account for 79 percent of the first group (the nine exceptions being the eight states listed earlier plus Ohio) and 75 percent of the second (the exceptions being Connecticut, Maine, New Hampshire, and Virginia).⁶⁵

STATE-LEVEL HMO/PPO MARKETS

The second study is part of an annually-updated analysis from the American Medical Association (AMA) which examined the market in 2005 for HMO/PPO (Health Maintenance Organization; Preferred Provider Organization) products only. The analysis included all insurer-administered plans, including those that are self-funded, but excluded plans self-administered by employers. This information is reported for forty-four states (excluding the District of Columbia, Kansas, Mississippi, North Dakota, Pennsylvania, South Dakota, and West Virginia). This study was recently updated using 2006 data,⁶⁶ but because the findings are nearly identical and the report using 2005 data is readily available online for readers to examine for themselves, the analysis that follows is based primarily on the 2005 figures. Although the full report examines the PPO and HMO markets separately, the analysis below focuses on its reported figures for the combined HMO/PPO market. This approach comes closest to the comprehensive picture painted by Robinson and also is most relevant in a world in which both employers and individuals can choose between those alternative types of coverage.

It should be noted that by focusing on a subset of the market, the AMA estimates tend to exaggerate actual market shares. For example, the AMA figures for 2006 report an eighty-nine percent market share for Blue Cross Blue Shield of Alabama in that state, but based on CPS figures on the total number with private coverage and total enrollment reported by the company, the actual market share is closer to 75 percent.⁶⁷ However, the AMA figures are the only ones that also examine the extent of market concentration at the MSA (Metropolitan Statistical Area) level, so it is worth examining these figures despite their limitations. Thus, taking the numbers as reported and using the same 1997 antitrust guidelines cited earlier:

- **Market Concentration.** In 2005, forty-two states had “highly concentrated” markets and two states (New York and Oregon) were “concentrated.”⁶⁸
- **Nonprofit Plan Dominance in Concentrated Markets.** However, in 72 percent of the highly concentrated states and in both concentrated states, the largest insurer is a nonprofit plan.⁶⁹
- **Dominant Insurer Market Share.** In 2005, the largest firm controlled 30 percent or more of the market in thirty-six states. In twenty-five of the forty-four states examined, this market share exceeded 50 percent.⁷⁰ However, by 2006, the number of states having a dominant insurer holding half or more of the market had declined to fifteen of forty-two states analyzed.⁷¹
- **Nonprofit Firm Dominance of Dominant-Insurer Markets.** Of the twenty-five states with a single dominant insurer controlling at least half the market in 2005, all but nine are nonprofit plans (exceptions being in Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Virginia, and Wisconsin). Of the thirty-six states with a dominant insurer controlling 30 percent of the market, nonprofit plans account for 72 percent (i.e., excluding the nine plans just referenced plus the dominant insurer in Ohio).⁷²

STATE-LEVEL SMALL GROUP MARKETS

While the first two studies focused on broadly defined markets in which large and medium-sized firms are the dominant purchasers, a third study examines concentration in the small group market. Concerns about competition in this market (in conjunction with the individual market) are reflected in almost all the reform plans approved by various congressional committees in 2009. In one form or another, those plans proposed the “remedy” of giving small groups a public plan option offered through some type of Exchange. Thus, understanding how much competition actually occurs in this market, as opposed to the overall health insurance market, arguably is more pertinent to the rationale for a public plan. The GAO surveyed the small group market in December 2007, with forty-seven states reporting data (excluding Alaska, Michigan, New Mexico, and Pennsylvania).

- **Number of Health Plans.** The median state had twenty-seven different health plans providing coverage to small groups,⁷³ ranging from a low of four carriers in Rhode Island to a high of 328 in Indiana.⁷⁴
- **Dominant Insurer Market Share.** Excluding eight states without small group market share data (District of Columbia, Georgia, Hawaii, Indiana, Kansas, Nebraska, Nevada, and Virginia), the dominant insurer had 30 percent or more of the market in thirty-four states and 50 percent or more in seventeen states.⁷⁵
- **Nonprofit Plan Dominance of Dominant-Insurer Markets.** Of the seventeen states where a single plan had 50 percent or more of the market, all but two of these plans are nonprofit (Maine and New Hampshire are the exceptions). Thus, in one of the principal markets for which a new public plan is targeted, nonprofit insurers constitute 88 percent of the dominant insurers. Even if the definition of dominant insurers is extended to include all plans with a market share of 30 percent or more, nonprofit insurers still constitute 76 percent of the total (Connecticut, Kentucky, Missouri, Ohio, Vermont, and Wisconsin are the additional exceptions).⁷⁶

SUMMARY

Taking the Robinson and AMA studies together, it is worth noting that in *all* states except California, Nevada, New York, and Oregon, the largest health insurer is a Blue Cross or Blue Shield plan (and in California, New York, and Oregon, the largest plan is some other nonprofit plan). Likewise, in the GAO study of the small group market, “thirty-six of the 44 states supplying information on the top carrier identified a Blue Cross and Blue Shield (BCBS) carrier as the largest carrier, and in all but 1 of the remaining 8 states, a BCBS carrier was among the five largest carriers.”⁷⁷ GAO also found that BCBS market dominance had grown since 2002: “the median market share of all the BCBS carriers in 38 states reporting this information in 2008 was about 51 percent, compared to the 44 percent reported in 2005 and the 34 percent reported in 2002 for the 34 states supplying information in each of these years.”⁷⁸ As will be detailed more fully in the discussion of local market concentration, it is difficult to see how a public plan – especially if it takes the form of state-level nonprofit cooperatives – would be an improvement over nonprofit plans that have accumulated decades of experience and trust among both prospective members and providers.

Admittedly, in eleven of the forty-seven BCBS-dominated states identified in the Robinson and AMA compilations, the Blue plan is now for-profit (in Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Ohio, Virginia, and Wisconsin), but these figures highlight the extent to which the problem of market concentration originated in state policies (e.g., tax exemption) that favored certain types of plans rather than through natural market forces. Blue plans lost full federal tax exemption in 1986, but continue to enjoy more limited federal tax breaks worth about \$1 billion annually.⁷⁹ However, their tax-exempt status remains in some states. The scope of this tax exemption varies. In some cases, it extends not only to state income taxes, but also to other business taxes, sales and use taxes and real and personal property taxes;

even if a state does not extend full tax exemption, Blue plans often have lower requirements for premium taxes, guaranty fund assessments and high-risk pool assessments relative to for-profit health insurers.⁸⁰ If having a nonprofit Blue plan dominate a market is thought to be problematic, the most straightforward solution to this problem may be to revisit whether tax exemptions or similar privileges are warranted. On a related point, some have observed that small group reforms included under HIPAA have actually contributed to the high degree of volatility in the small group market – a recurring cycle in which insurers low-ball premiums to buy market share but then must rapidly increase premiums to stay afloat.⁸¹ There also is at least some evidence that federal and state regulation of the small group market has in some cases reduced the number of insurers or increased concentration in that market.⁸²

STATES ARE NOT RELEVANT GEOGRAPHIC MARKETS

Even if every state were dominated exclusively by for-profit plans, concentration at the state level is just not pertinent to determining whether excess market power is being exercised by private health insurers. For example, the Department of Justice Antitrust Division itself has stated: “[t]he relevant geographic markets in which HMO and HMO-POS health plans compete are...no larger than the local areas within which managed care companies market their respective HMO and HMO-POS plans...[because][p]atients seeking medical care generally prefer to receive treatment close to where they work or live, and many employers require managed care companies to offer a network that contains a certain number of health care providers within a specified distance of each employee’s home.”⁸³

Likewise, two experts who recently helped craft a comprehensive FTC report on competition in health care – David Hyman and William Kovacic – have stated even more bluntly: “there is no evidence that individual states constitute relevant geographic markets for health insurance – and there is considerable evidence to the contrary.”⁸⁴

THE IMPACT OF MARKET CONCENTRATION ON HEALTH SPENDING

Although it may seem counterintuitive, state-level market concentration in health insurance markets is not always associated with adverse outcomes. A study of nonprofit Blue Cross/Blue Shield plans, using state-level data from 1986 through 1988, found that higher market share for such plans (which often were the dominant plans in their respective states) was associated with:

- **Lower Provider Payments.** A 10-percent increase in market share was associated with an 11.6-percent reduction in payments to providers. In addition, a 10-percent increase in plan size (number of members) was correlated with a 5-percent reduction in provider payments.⁸⁵ This suggested that Blue plans had and were exercising monopsony power to hold down health care costs in the form of payments to providers.

- **Lower Administrative Costs.** Similarly, a 10-percent increase in market share produced a 6.9-percent reduction in administrative costs. A 10-percent increase in plan size was associated with a 1.66 percent reduction in such costs.⁸⁶
- **Lower Premiums.** A 10-percent increase in market share resulted in a 6.2-percent premium reduction.⁸⁷

Thus, for nonprofit Blue plans, market concentration appears to have the beneficial effect of allowing them to reduce provider payments and lower administrative costs, resulting in savings that evidently are passed along to plan members in the form of lower premiums. This is hardly a “problem” in need of a solution.

Admittedly, these results are only suggestive, as they do not address what happens in markets where a for-profit plan is the dominant insurer. Moreover, even for nonprofit plans, things may be different two decades later. Yet using state-level health spending data for the latest year for which is available (2004), the simple correlation between the state-level market share held by the two largest health plans and per capita private medical spending is only 0.33.⁸⁸ While statistically significant, it likely is biased upwards because it does not control for any other factors, including the possibility that the causal relationship is reversed (i.e., that high spending may result in a different market structure rather than higher concentration leading to higher spending). Nevertheless, even taken at face value, this relatively low level of correlation implies that market share explains only about 11 percent of the differences in private health spending across states. States with higher market shares for the two largest plans do tend to have higher levels of health expenditures, but what is of equal importance is the wide variation in outcomes even for states that are identical in the apparent degree of health insurer dominance. Other things apparently matter much more, such as the nature and scope of state efforts to regulate health insurance. In short, market concentration among insurers is far from the most important factor in explaining high health care costs. Moreover, the correlation between this same market share figure and the annualized increase in private health spending over the past five years is only 0.17, which is not even statistically significant.

While strong conclusions cannot be drawn from these back-of-the-envelope calculations unadjusted for other factors, one other study bears mentioning because it speaks directly to claims that, absent a public plan to “keep them honest,” for-profit plans may result in higher premiums. A recent longitudinal analysis of the impact of conversions of Blue Cross plans to for-profit status using state-level data from 1980 to 2004 found that such conversions were associated with a strong and consistent pattern of lower-than-expected per capita expenditures on physician services that persisted four or more years following conversion. A similar pattern was observed in for-profit conversions being associated with a lowering of the state’s uninsured rate relative to the national average. While transitory in duration, these conversions also were associated with an *increase* in hospital profitability, suggesting that those welfare gains do not

necessarily come at the expense of hospitals.⁸⁹ Such results belie the too-common belief that allowing profits in health insurance can only lead to mischief.

WHY LOCAL MARKET CONCENTRATION DOES NOT REQUIRE A PUBLIC PLAN SOLUTION

But the foregoing state-level look at competition does not tell the whole story. As suggested in the AMA study: “The realities of the delivery of health care, as well as the marketing and other business practices of health insurers, lead to a conclusion that health insurance markets are local. From the standpoint of the market for health insurance, most sellers (insurers) market locally, for the obvious reason that purchasers (employers) are interested in purchasing health insurance products that will service their employees in proximity to where they work and live.”⁹⁰ There is concentration in many local markets, but nonprofits plans dominate most of them. Highly concentrated markets with nonprofit plans do not necessarily result in excess market power, because the credible threat of entry by other plans precludes even for-profit plans from earning outsized profits. In many markets, concentration in the health insurance industry also may be providing a useful corrective to the equally disturbing growth in concentration of hospital and physician markets over the past decade. To the degree that concentration in local markets is thought to be a problem, there are far better more targeted solutions that do not pose the drawbacks of a public plan.

MOST LOW-COMPETITION LOCAL MARKETS DOMINATED BY NONPROFITS

Even when we examine competition from a city-level perspective, nonprofit firms again dominate the lion’s share of areas in which lack of competition appears to be a problem. The AMA study cited earlier also examined market concentration in the nation’s 313 Metropolitan Statistical Areas (MSAs):

- **Market Concentration.** Based on 1997 federal antitrust guidelines:
 - In 2005, 96 percent of 313 MSAs were classified as *highly concentrated* based on 1997 federal antitrust guidelines.⁹¹ In the update using 2006 data, 94 percent of 314 MSAs were so designated.⁹²
 - Likewise, in 96 percent of MSAs, one health plan accounted for at least 30 percent of the combined market in 2005.⁹³ This figure had declined to 89 percent of 314 MSAs in 2006.⁹⁴
- **Nonprofit Plan Dominance.** When the 2005 data are examined more closely, in 61.3 percent of those MSAs, a nonprofit Blue plan is dominant and in another 10.9 percent, the nonprofit Blue plan is the second largest competitor.⁹⁵ Thus,

for-profit plans represent the two largest plans in only 27.8 percent of local markets.

Since a “distrust of private insurers is a central motivation for the public plan option”⁹⁶ and a public plan purportedly would “be reassured by...an entity that was designed to break even, to not earn a profit,”⁹⁷ one might expect the public to have the same level of trust in a nonprofit plan as a public plan, because neither would be expected to make a profit – particularly in light of the evidence that high market share for nonprofit Blue plans appears to result in lower premiums. If so, then concerns about market concentration would be limited to only about one-quarter of the country.

EXCESS MARKET POWER NOT INEVITABLE IN CONCENTRATED MARKETS

But even that one-quarter of local markets estimate may substantially overstate the extent to which insurer concentration is really a problem. First, “high HHIs [i.e., concentration] do not demonstrate that market power exists or is being exercised.”⁹⁸ MSA-level concentration ratios of the sort calculated each year by the AMA are used by antitrust regulators only as a screening tool to identify where excess market power might be a problem. A high ratio itself is not grounds for antitrust enforcers to seek a remedy. Instead it is the starting point for a careful investigation of whether in fact a firm or even an entire industry wields excess market, including whether it attained such market power illegally.⁹⁹

While it may seem counterintuitive that highly concentrated health insurance markets would not necessarily give plans market power to obtain supra-normal profits, the standard explanation by health economists is that such markets are contestable.¹⁰⁰ Even in concentrated markets, the credible threat of entry can produce “competitive” market conditions, including lower prices, increased quantity and more efficient administrative cost structures. If the contestability of markets offers a powerful and reliable deterrent to abusing market power even to dominant health insurers, this further reduces the number of instances in which some way of restoring or enhancing competition is needed.

Rising concentration in health insurance markets also cannot be completely understood without the realization that “provider markets, particularly hospital markets, have also become increasingly concentrated in recent years.” Specifically, the fraction of large metropolitan area residents living in highly concentrated hospital markets rose from 71 percent in 1990 to 88 percent by 2003.¹⁰¹ There is substantial evidence that hospital rates are much higher in concentrated markets,¹⁰² suggesting that, absent countervailing power from insurers, patients might be just as vulnerable to exploitation by providers as they purportedly are to profit-motivated insurers. The previously cited study of nonprofit

Blue plans provided evidence that such plans used their monopsony power to reduce payments to providers, and they apparently passed those savings on to their members in the form of lower premiums. At least four more recent studies have demonstrated that greater insurer bargaining power results in lower hospital prices, while another has shown that health insurer concentration is associated with reductions in physician earnings.¹⁰³ But this suggests that increasing insurer competition while leaving in place concentrated markets for hospitals or doctors may well make patients *worse* off rather than better. Conversely, only in markets lacking provider concentration will enhancing competition among insurers be certain to improve matters.

Two recent studies paint a less rosy picture of consolidation. Both are based on a private national database of more than 800 employers (mostly large, multistate, publicly-traded firms) between 1998 and 2006. The first analysis, by Leemore Dafny, suggests that private health insurers both possess and exercise market power by charging high premiums to more profitable firms (holding all other factors constant). This effect is stronger in areas with greater concentration.¹⁰⁴ Such ability to exploit the reluctance of firms to change health plans during periods of high profits would not be expected in a competitive market.

The second study, by Dafny and several coauthors, documented that most local markets are becoming concentrated over time, with the share categorized as “highly concentrated” increasing from 68 percent in 1998 to 99 percent by 2006.¹⁰⁵ Even after controlling for an extensive set of health plan characteristics, premiums did not rise more rapidly in markets that experienced the largest increases in concentration. However, because increases in concentration are related to other determinants of premium growth, this study isolated the effect of concentration by examining changes in concentration that occurred due an arguably unexpected “shock” to the system: the merger of Aetna and Prudential. By comparing what happened in light of the widely varying changes in HHI across different markets that resulted from this merger, the authors isolated the “pure” effects of increases in concentration from other factors affecting premiums (including the long-term secular increase in concentration over this period). Once concentration is isolated in this fashion, the authors conclude that increased concentration does result in higher premiums. Applying their result to the observed increase in concentration from 1998 to 2006, the authors estimate that private health insurance premiums nationwide were 2.1 percent higher in 2006 than they would have been had concentration remained unchanged. Given that inflation-adjusted premiums doubled during this period, these findings imply – as suggested by the earlier back-of-the-envelope estimates — that consolidation accounts for “very little of the steep increase in health insurance premiums in recent years.”¹⁰⁶ The authors concede these results cannot necessarily be extrapolated to other markets such as those for small group or nongroup insurance, and they caution further that this finding is based on a single merger. Conversely, however, their analysis

only examined *increases* in concentration during the period studied and hence provided no indication of how much the level of consolidation already achieved by 1998 may have increased premiums relative to the levels that would have been observed in a more competitive market.

If the problem of sluggish private sector competition is limited in geographic scope, then creating a national public plan to address that problem is overkill, akin to squashing a gnat with a sledgehammer. It would be preferable and far less risky to find more targeted solutions. But these same solutions have merit even if concentration is viewed as a nationwide phenomenon.

COMPETITION CAN WORK WITHOUT A PUBLIC PLAN

SUPERIOR ALTERNATIVES TO ADDRESSING LACK OF COMPETITION

Admittedly, there are some public plan proponents who argue that public distrust of private insurers extends to nonprofit plans as well.¹⁰⁷ Federal tax exemption was taken away from Blue Cross plans more than two decades ago on grounds that they appeared little different from commercial insurers in terms of how they behaved in the market. More recent evidence that compares nonprofit Blue plans with for-profit Blue plans suggests that, on many dimensions, there are no significant differences in plan behavior or performance.¹⁰⁸ As illustrated earlier, there is a small but consistent pattern of nonprofit Blue plans having lower margins (by only 1-2 percent) than either their for-profit Blue counterparts or for-profit health insurers more generally. But this line of thinking raises the equally legitimate question of why a public plan – especially the “less muscular” versions embodied in the House or Senate bills – would be expected to behave any differently than a nonprofit plan. However, whether it is one-quarter of the country or nearly the entire country where weak competition is a concern, there are far more direct and less risky approaches to addressing this problem than establishing a public plan.

MORE VIGILANT INSURANCE REGULATION

First, to the extent that lack of competition is a problem, it is most keenly felt in the markets for nongroup and small group coverage. But these are the very markets where state regulatory oversight of market conduct already is (or could be) most intense. If, as public plan proponents claim, “key data about administrative costs and factors driving premiums are not publicly available,”¹⁰⁹ there is no reason in principle that state regulators could not require this of health plans serving the two markets already under regulatory scrutiny. Actions that have aroused the greatest public concern, such as having coverage cancelled (rescinded) when insured individuals get sick or refusals by insurers to authorize covered benefits, already are illegal. This suggests that better enforcement of existing laws, rather than enactment of new ones, may be warranted. Insurance

regulators might also do a better job of explaining to consumers the rationale for practices such as exclusions for pre-existing conditions and rescissions so that they better understand how such practices actually benefit consumers by ensuring the availability of affordable coverage. Likewise, the general public might benefit from being made more aware of its options for appealing disputes about medical necessity, experimental/investigative treatment, emergency room reimbursement or similar matters. Public distrust of insurers might well be placed in perspective if regulators did a better job of demonstrating how infrequently complaints are filed against health insurers relative to the huge number of claims processed or members served.

MORE AGGRESSIVE ANTITRUST ENFORCEMENT

But if public plan proponents truly are correct that “the insurance industry is hard to regulate,”¹¹⁰ then aggressive antitrust enforcement offers far greater promise for restoring competition than would a public plan. In a recent merger challenge, “the DOJ [Department of Justice] recognized that where a health plan accounts for more than 30 percent of a physician’s practice revenue, the health insurer can have monopsony power to the detriment of patients.”¹¹¹ But this concern would apply with equal force to a public plan that commanded a sizable market share. Indeed, it would seem rather contradictory to punish monopsonistic practices by private plans while simultaneously promoting these same practices in a public plan. The burden of proof is on public plan advocates to explain why a dominant public plan would be better for patients or providers than a private insurer in the same competitive position. In short, using the tools and criteria already developed by federal antitrust regulators to limit the size of health plans would be superior to simply replacing a private monopsony with a public one. Antitrust regulators also have the advantage of being able to use those same tools to focus on the problem of provider concentration. That would avoid the risk of unilaterally disarming a beneficial countervailing force in the insurance market that has been able to constrain the ability of providers to exercise their own market power.

INTERSTATE SALE OF HEALTH INSURANCE

Realistically, more rigorous antitrust enforcement could take a long time, especially if the problem of concentrated insurance markets is pervasive. For at least two decades, “the most important source of competitive pressure in health insurance has been the availability of new entrants, including start-up HMOs and carriers from adjacent geographic regions.”¹¹² But because the McCarran-Ferguson Act delegated authority to regulate insurance to the states more than six decades ago, insurance companies wanting to sell products across state lines must comply with a myriad of different state regulations, including mandated benefits, premium taxes, solvency requirements, and similar rules. Collectively, such state regulations are estimated to increase premiums by 10 to 96 percent.¹¹³ Those costs are in addition to the widespread geographic variations in

health spending that are related to differences in practice patterns. Together, these result in a nearly five-fold difference in average premiums across states.¹¹⁴ Removing regulatory barriers to cross-border sales thus offers the prospect of greatly increasing competition and reducing regulatory costs very quickly. It is even possible to imagine this strategy making some headway against practice variations by encouraging greater innovation in the use of regionally based practice guidelines or improved tools for monitoring and changing the behavior of outlier practice patterns. This is not an unprecedented idea. For example, Medicare law already generally preempts state regulation of Medicare Advantage (private) plans but allows the states to regulate plan solvency and licensure.¹¹⁵ There are several alternative approaches to reducing barriers to cross-border sales:

- **Interstate Sales of Insurance Plans.** One option, as illustrated by the Health Care Choice Act (H.R. 2355 and S.1015) proposed by Representative John Shadegg (R-AZ) and Senator Jim DeMint (R-SC), respectively, would allow interstate sales of private insurance plans while preserving states' primary responsibility for the regulation of health insurance.¹¹⁶ A recent analysis found that in some cases, New Jersey residents could achieve a premium savings of more than 50 percent simply by crossing the border to purchase the identical coverage in Pennsylvania, where regulatory costs are far lower.¹¹⁷ Nationally, this policy reform could reduce costs sufficiently to reduce the number of uninsured by about 12 million.¹¹⁸
- **Federal Certification of Health Plans.** This would allow health insurance plans that meet federal regulations governing large self-insured plans to offer plans on a nationwide basis free of state regulations (except perhaps those governing day-to-day market conduct). This approach would reduce health costs nationally by about 7 percent.¹¹⁹
- **Harness Competitive Federalism.** There are a variety of approaches to allowing cross-border sales while retaining regulatory authority at the state level along with suitable safeguards to ensure states handle such regulation even-handedly and responsibly.¹²⁰

The approaches just described are much more sensibly limited options that would address lack of competition where it exists without creating a public plan that simply duplicates the pressure of market forces for health insurers to provide good value for the money. And even if one believes that lack of competition among health insurers is a national phenomenon, these approaches offer excellent prospects for reducing costs without the corresponding risks posed by a public plan.

REAL-WORLD EXPERIENCE WITH PRIVATE PLAN COMPETITION

But how do we know that competition can be relied upon to produce the desired results? Because we have real-world experience with competition in health care:

MEDICARE PART D EXPERIENCE

Over strong objections from those who now argue most fervently for a public plan, the Medicare drug benefit, approved under the Medicare Modernization Act in 2003, was provided exclusively through private plans rather than through a Medicare-like public plan structure. What happened?

- **Widespread Choice of Drug Plans.** Since not a single private stand-alone drug plan existed when the drug benefit was enacted, “a major source of uncertainty was whether private insurers would be willing to sponsor stand-alone prescription-drug plans. Ultimately, *concern about the viability of the private drug plan market was unwarranted...* In 2006 and each year thereafter, beneficiaries across the country have had access to *dozens of stand-alone plans* and, in many counties, at least as many Medicare Advantage drug plans.”¹²¹ As of 2009, there were nearly 1,700 stand-alone drug plans and more than 2,000 Medicare Advantage plans from which to choose.¹²²
- **36 Percent Increase in Drug Coverage.** Despite deep misgivings about whether a voluntary benefit actually would significantly expand coverage, the number enrolled in drug plans surged. Sixty-six percent of Medicare enrollees had drug coverage in 2004, compared to 90 percent in 2009.
- **Massive Cost Savings.** There also was deep skepticism about whether private plans could possibly drive costs lower than if the government directly negotiated “take-it-or-leave-it” prices with drug manufacturers. Yet compared to original budget estimates for Medicare Part D, ten-year costs now are projected to be 38.5 percent lower than originally planned.¹²³ Eighty-five percent of this cost reduction has been attributed to “a direct result of competition and significantly lower Part D plan bids.”¹²⁴

No public plan was needed to stimulate the fierce private sector competition that produced these results. If pure private sector competition works this well for the elderly, it is incumbent on public plan proponents to explain why it would not work for the rest of the country.

FEHBP EXPERIENCE

For nearly six decades, the Federal Employees Health Benefits Program (FEHBP) has provided health coverage to the president, all members of Congress, federal employees and dependents (7.8 million people were covered in 2008).¹²⁵ Key features include:

- **No Standard Benefit.** Quite unlike Medicare, FEHBP offers no standardized health plan, but instead trusts its members to choose from a wide selection of plan choices ranging from high-deductible, consumer-directed health plans with companion health savings accounts to managed care plans to very comprehensive fee-for-service plans.
- **Numerous Plan Choices.** There are almost 300 health insurance plans available to members,¹²⁶ including a dozen national plans, over 250 health maintenance organization (HMO) options, and dozens of High-Deductible Plan

(HDP) options. Thus, workers have an ample selection of plan choices regardless of where they live.

- **Incentive to Shop Wisely.** Unlike many employers who may contribute 80, 90 or 100 percent of a plan's premium regardless of cost, the federal government pays either 72 percent of the average premium or 75 percent of the premium of the specific plan selected, whichever is less. This provides strong incentives to avoid the most expensive plans, but diminishes the incentive to select a plan whose costs are far below average.

By empowering nearly 8 million plan members to vote with their feet every year's open season for plan selection, FEHBP has stimulated a fierce competition among private health plans to provide good value for the money to its members (and the taxpayers who finance these public employee benefits). As a consequence:

- **Performance Superior to Private Insurance.** Annual growth in FEHBP spending per enrollee typically has been lower than in private health insurance plans with the exception of a few isolated time periods.¹²⁷ This should not be surprising given that 49 percent of employees with employer-provided health benefits do not get any choice among health plans.¹²⁸ Even among those given a choice of plan, less than one in five workers receive a fixed dollar contribution towards their health coverage and only a fraction of those employees are permitted to reap the full economic benefit of making cost-conscious choices.¹²⁹ But large employers such as Stanford University that have adopted models similar to FEHBP have reported premium savings of 43 percent relative to the cost of offering a single fee-for-service health plan.¹³⁰
- **Performance Superior to Medicare.** Its overall performance is best summed up by Harry Cain, a former vice president of the Blue Cross/Blue Shield Association with decades of experience with both the FEHBP and Medicare, who stated in 1999 that "the FEHBP has outperformed Medicare every which way – in containment of costs both to consumers and the government, in benefit and product innovation and modernization, and in consumer satisfaction."¹³¹ Indeed, an exhaustive comparison with Medicare has shown that FEHBP is superior on a variety of dimensions, including control of costs per enrollee, quality, stability and rate of improvement in benefits, and innovativeness.¹³²

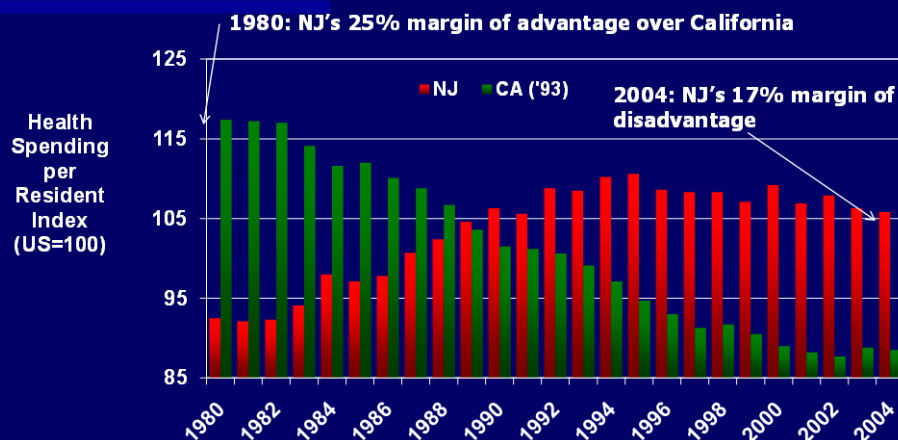
Moreover, because of extensive choice of plans, FEHBP has easily been able to accommodate occasional instances in which a participating health plan failed, with minimal disruption for the beneficiaries.¹³³ FEHBP has achieved all these benefits without ever including a public plan option. If members of Congress see no need for a public plan for themselves, why should it be necessary for any other Americans?

COMPETITION IN CALIFORNIA

While it has reversed itself to some extent in recent years, California for decades was widely viewed as having one of the most competitive health care markets in the entire country. In the mid-1980s, the state greatly deregulated its health system. It discarded

Certificate of Need (CON) and strongly encouraged a movement towards selective contracting with health providers that stimulated fierce head-to-head competition. In conjunction with becoming the first state to have its Blue Cross plan convert to for-profit status, California's policies transformed its health insurance market, culminating in fierce head-to-head insurer competition between nonprofit Kaiser, for-profit Wellpoint, and nonprofit Blue Shield, among others. In contrast, during the same period, New Jersey maintained one of the most highly regulated health sectors in the country and retained a nonprofit Blue plan as its dominant insurer.¹³⁴ What happened?

Fig. 3. A Tale of Two States:
Competition (CA) vs. Regulation (NJ)



Source: Analysis of CMS State Health Expenditure data by author

- **Performance Superior to National Average.** California's per capita health spending had been 18-20 percent above the national average from 1966 through 1980. By 2004, it had plummeted to 12 percent *below* the national average. Conversely, New Jersey began this period with a level of per capita spending that was 25 percent below California's, but by 2004, its spending level was 17 percent higher than California's.¹³⁵
- **Shrinking Burden of Health Spending.** Similarly whereas health spending in California as a percent of GSP (gross state product) was 4 percent higher than in the United States as a whole in 1980, by 2004 it was 17 percent lower. At the national level, health spending as a percentage of GDP increased by 11 percent between 1993 and 2004, California was a rare state in which this measure of the burden of health spending actually *declined* slightly during the same period.¹³⁶

Competition among private health plans is not just a theoretical ideal: it works on the ground. The experiences we've had with Medicare Part D, FEHBP and in the state of

California should leave little doubt that it is a strategy that can reap great rewards for the nation if it is given a chance.

CONCLUSIONS

Proponents of a public health insurance plan, including President Obama, claim it is needed to stimulate competition. Yet the evidence shows that at the *national* level the health insurance market generally is highly competitive for the 61 percent of privately insured Americans who now purchase their coverage through large groups.

At the *state* level, concentration in health insurance markets appears less disturbing than it appears for two reasons. States generally are too large to constitute a meaningful market for purposes of assessing antitrust concerns, and the limited empirical evidence that is available does not suggest that states with a dominant insurer suffer any significant adverse consequences. First, most concentrated markets tend to be dominated by nonprofit plans (mostly Blue Cross/Blue Shield plans). Second, market concentration is not necessarily associated with adverse outcomes. For nonprofit Blue Cross/Blue Shield plans, increased market share historically has been associated with lower payments to providers, lower administrative costs and lower premiums. Even today market concentration among health insurers has a relatively small effect on current premium levels or recent rates of growth in health spending. Specifically, there is only a small relationship between the share of the market controlled by the two largest firms and state-level, private per capita health spending. Health insurance market concentration also explains only a small portion of the rates of increase in private per capita health spending between 1999 and 2004. This is inconsistent with the view that concentration is allowing health insurers to exploit their members. Instead, it is consistent with a more plausible view that concentration in the health insurance industry has provided a useful corrective to the more disturbing growth in concentration of hospital and physician markets over the past decade.

Moreover, at the *local* level, roughly three-quarters of local markets that appear to have weak competition are dominated by nonprofit plans. Such plans are no different than a public plan in terms of profit motive. In areas where lack of competition adversely affects those seeking to purchase health insurance, policymakers should consider more effective tools to restore competition that would be superior to reliance on a public plan. These include more effective state regulation of the individual and small group markets, more aggressive antitrust enforcement and allowing interstate sales of health insurance.

Finally, real world experience with the Medicare drug benefit (where fierce competition among private health plans has contributed to cost savings of nearly 40 percent), the Federal Employee Health Benefits Program (which for decades generally has experienced lower premium growth than private health insurance and Medicare) and the State of California (whose market-oriented approach to health care has reduced its

level of spending relative to the U.S. by nearly one-third in just twenty-five years) have demonstrated convincingly that competition among private insurers can work very effectively even without a public plan.

NOTES

¹ Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform," Center for Health, Economic & Family Security, U.C. Berkeley School of Law, and Institute for America's Future, December 17, 2008), available at http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf (accessed January 22, 2010); Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Health Plan," New America Foundation, March 11 2009, available at http://www.newamerica.net/publications/policy/modest_proposal_competing_public_health_plan (accessed January 22, 2010).

² Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Health Plan," 5.

³ Jacob S. Hacker, "Public Plan Choice in Congressional Health Plans: The Good, the Not-So-Good and the Ugly," Institute for America's Future, August 20 2009, 1, available at http://www.ourfuture.org/files/Hacker_Public_Plan_August_2009.pdf (accessed January 22, 2010).

⁴ Ibid.

⁵ Federal Trade Commission (FTC) and Department of Justice (DOJ), "1992 Horizontal Merger Guidelines [with April 8, 1997 Revisions to Section 4 on Efficiencies]," FTC, April 8, 1997, available at <http://www.ftc.gov/bc/docs/horizmer.html> (accessed January 22, 2010).

⁶ Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, Pub. no. P60-236(RV), (Washington, D.C.: U.S. Department of Commerce, September 2009), available at <http://www.census.gov/prod/2009pubs/p60-236.pdf> (accessed January 22, 2010). All figures cited are from the March 2009 Current Population Survey, which has been the conventional source of the widely cited 46 million uninsured figure. There are alternative estimates of health insurance coverage from various annual surveys, including the Health Interview Survey (HIS), the Medical Expenditure Panel Survey (MEPS), and American Community Survey (ACS), each of which has strengths and weaknesses vis-à-vis CPS, which itself has known inaccuracies. For an extensive comparative discussion of all four sources, see State Health Access Data Assistance Center, *Comparing Federal Government Surveys That Count Uninsured People in America* (Minneapolis, MN: University of Minnesota, State Health Access Data Assistance Center, September 2009). Because the CPS figures are the most widely circulated and readers can see other published estimates of coverage in print and on-line to obtain further detail on the estimates reported here, this paper generally makes use of unadjusted CPS aggregates except where otherwise noted.

⁷ There is a fierce debate over the actual number of uninsured and the extent to which the CPS count exaggerates their true number. There are even standard methods for adjusting CPS estimates to correct for problems such as over-estimating the number of uninsured and underestimating the number on Medicaid. State Health Access Data Assistance Center, *Comparing Federal Government Surveys That Count Uninsured People in America*. A related issue is that even among the genuinely uninsured, a sizable fraction may be eligible but not enrolled (EBNE) in Medicaid, with some claiming that up to one-third of the uninsured reported by CPS meet that description. Blue Cross and Blue Shield Association, *The*

Uninsured in America (Washington, D.C.: BCBSA, 2001). While some deride the CPS number as a “myth” (Sally C. Pipes, *The Top Ten Myths of American Health Care: A Citizen’s Guide* (San Francisco: Pacific Research Institute, 2008)), others defend the figure as “a solid and respected estimate.” Timothy D. McBride, *Trying to Minimize a Crisis: The Myth That the Uninsured Estimate Is Overstated* (St. Louis: Washington University in St. Louis, 2009). As a practical matter, scholars have addressed both issues extensively for many years. Studies include: Kimball Lewis, Marilyn R. Ellwood, and John L. Czajka, *Counting the Uninsured: A Review of the Literature* (Washington, D.C.: Urban Institute, July 1, 1998); Pamela F. Short, “Counting and Characterizing the Uninsured,” University of Michigan, Economic Research Initiative on the Uninsured, December 4, 2001, available <http://www.rwjf-eriu.org/pdf/wp2.pdf> (accessed January 22, 2010); Congressional Budget Office (CBO), *How Many People Lack Health Insurance and for How Long?* (Washington, D.C.: CBO, May 2003); Michael J. O’Grady, “Commentary: Improving Federal Health Data: The Essential Partnership between Researcher and Policy Maker,” *Health Services Research* 41, no. 3 (2006): 1; Michael Davern et. al., “Are the Current Population Survey Uninsurance Estimates Too High? An Examination of the Imputation Process,” *Health Services Research* 42, no. 5 (2007); Kathleen T. Call, Michael Davern, and Lynn A. Blewett, “Estimates of Health Insurance Coverage: Comparing State Surveys with the Current Population Survey,” *Health Affairs* 26, no. 1 (2007); John L. Czajka and Gabrielle Denmead, *Income Data for Policy Analysis: A Comparative Assessment of Eight Surveys: Final Report*, (Washington, D.C.: Mathematica Policy Research, December 23, 2008); and Thomas P. Miller, “How What We Think We Know About the Uninsured Really Adds Up,” American Enterprise Institute, September 10, 2009, available at <http://www.aei.org/speech/100077> (accessed January 22, 2010). While the CPS appears to overestimate the number of uninsured compared to estimates from other national and state surveys, the CPS figure of 46.2 million is only slightly larger than the baseline estimate of 45 million uninsured in 2009 derived from a simulation model that the CBO uses to analyze the effects of various policy options on coverage and spending for health care. CBO, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington, D.C.: CBO, December 2008), Footnote 3. This is despite the fact that CBO grounds its estimates of coverage in the Survey of Income and Program Participation and explicitly corrects its uninsured figures for Medicaid undercounting. CBO, *CBO’s Health Insurance Simulation Model: A Technical Description* (Washington, D.C.: CBO, October 2007), 14. CBO acknowledges its figure includes individuals eligible for, but not enrolled in, Medicaid. CBO, “Additional Information Regarding the Effects of Specifications in the America’s Affordable Health Choices Act Pertaining to Health Insurance Coverage,” letter to Dave Camp, CBO, July 26, 2009, available at <http://www.cbo.gov/ftpdocs/104xx/doc10400/07-26-InfoOnTriCommProposal.pdf> (accessed January 26, 2010). Therefore, rather than take a side in this contentious debate, this paper, for purposes of discussion, uses the reported 46.3 million uninsured figure from CPS without adjustment.

⁸ All premium percentages are from CBO, “Cost Estimate for the Amendment in the Nature of a Substitute as Introduced on November 3, 2009,” letter to John A. Boehner, CBO, November 4, 2009, available at <http://www.cbo.gov/ftpdocs/107xx/doc10705/hr3962amendmentBoehner.pdf> (accessed January 26, 2010). The Boehner amendment adopted one frequently used standard practice by defining “small groups” as having an average of 2-50 employees, with all other firms relegated to the large employer category. *Amendment in the Nature of a Substitute to HR 3962 Offered by Mr. Boehner of Ohio* (2009), § 111 (c), available at http://rules-republicans.house.gov/Media/PDF/RepublicanAlternative3962_9.pdf (accessed January 22, 2010).

⁹ House Committees on Ways and Means, Energy and Commerce, and Education and Labor, “The Affordable Health Care for America Act: Section-by-Section Analysis,” October 29, 2009, available at http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf (accessed January 22, 2010).

¹⁰ House Committees on Ways and Means, Energy and Commerce, and Education and Labor, “Affordable Health Care for America Act--Detailed Summary,” October 29, 2009, 2, available at http://energycommerce.house.gov/Press_111/health_care/hr3962_DETAILEDSUMMARY.pdf (accessed January 22, 2010).

¹¹ The Henry J. Kaiser Family Foundation, “Side-by-Side Comparison of Major Health Care Reform Proposals,” kff.org, available at <http://www.kff.org/healthreform/sidebyside.cfm> (accessed November 23, 2009).

¹² Although the annual Kaiser/Health Research Education Trust (HRET) health benefits survey is much more widely known, the National Compensation Survey (NCS) conducted annually by the Bureau of Labor Statistics (BLS) provides similar estimates of employee access and enrollment in health benefits, based on a nationally representative survey of private firms and state and local agencies that is five times as large as the Kaiser/HRET survey. Bureau of Labor Statistics, "Employee Benefits in the United States, March 2009," news release, July 28, 2009, Appendix Table 1, available at <http://www.bls.gov/news.release/pdf/ebs2.pdf> (accessed January 22, 2010). NCS is sufficiently fine-grained and accurate that it is used by CBO to calibrate the wage distribution of workers across different firm sizes in the simulation model used to calculate the effects of health reform. CBO, *CBO's Health Insurance Simulation Model: A Technical Description*, 6. The published figures from NCS are reported for establishments with 1-49 workers, 50-99 workers, 100-499 workers, and 500 or more workers.

¹³ William L. Pierron and Paul Fronstin, "ERISA Pre-emption: Implications for Health Reform and Coverage," EBRI Issue Brief, No. 314, February 2008, available at <http://ssrn.com/abstract=1095824> (accessed January 22, 2010).

¹⁴ This was the historical practice of the Bureau of Labor Statistics, which in 1980 began an annual series of reports on *Employee Benefits in Medium and Large Firms* based on a survey of establishments with a minimum of 100 or 250 employees, depending on the industry (focusing on benefits for full-time workers only). Pamela F. Short, "Trends in Employee Health Benefits," *Health Affairs* 7, no. 3 (1988). This survey has now been superseded by the National Compensation Survey that includes all firm sizes and no longer excludes part-time workers. Bureau of Labor Statistics, "Employee Benefits in the United States, March 2009." More recently, in its analysis of health plan administrative costs, the financial advisory firm Sherlock Company included under large groups all groups with more than 50 eligible employees. Douglas B. Sherlock, "Administrative Expenses of Health Plans," Sherlock Company and Blue Cross and Blue Shield Association, 2009, available at <http://www.bcbs.com/issues/uninsured/Sherlock-Report-FINAL.pdf> (accessed January 26, 2010), Figure 5.

A recent analysis of health reform by management consulting firm Oliver Wyman used the identical threshold in defining large firms. Oliver Wyman, "Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability," October 14, 2009, 3, available at <http://www.bcbs.com/issues/uninsured/background/Oliver-Wyman-Report-Showing-Impact-of-Healthcare-Reform-on-Premiums-pdf.pdf> (accessed January 22, 2010).

¹⁵ The upper threshold for small groups is identical to that used by the Sherlock Company and Oliver Wyman analyses (both of which defined small groups as having 2-50 eligible employees). Douglas B. Sherlock, "Administrative Expenses of Health Plans," Figure 3; Oliver Wyman, "Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability," 3.

¹⁶ Authors' calculations are from 201 million reported to have private health insurance in the March 2009 CPS, as reported in Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, Table C-3. Technically, the CPS counts 11.6 million with military health care as "government health insurance" even though it is provided through private health insurance carriers. Conversely, however, we later exclude the 10.1 million elderly with non-group Medicare supplement plans since such coverage is secondary to their public coverage.

¹⁷ "About AHIP," America's Health Insurance Plans, available at <http://www.ahip.org/content/default.aspx?bc=31> (accessed July 15, 2009).

¹⁸ WellPoint operates as an independent licensee of the Blue Cross and Blue Shield Association in 14 states, but offers nationwide coverage through its UniCare subsidiary. U.S. maps showing the states in which each of the top 12 national health insurers operates are at "Health Insurer Insights," Mark Farrah Associates, 2009, available at <http://www.markfarrah.com/products/HealthInsurerInsights.asp> (accessed November 24, 2009).

¹⁹ The Blue Cross and Blue Shield Association reports that its 39 member plans cover 100 million lives. "About the Blue Cross and Blue Shield Association," Blue Cross and Blue Shield Association, 2009, available at <http://www.bcbs.com/about/> (accessed November 6, 2009). The 14 member plans that are part of WellPoint cover 35 million lives. Maura Reynolds, "Health Care: A Matter of Mandates," *CQ Weekly*

Online , November 2, 2009, available with subscription at <http://library.cqpress.com/> (accessed November 6, 2009).

²⁰ Maura Reynolds, "Health Care: A Matter of Mandates." Market shares calculated by authors based on membership figures for 2008.

²¹ Douglas B. Sherlock, "Administrative Expenses of Health Plans," Appendix Figure 3. Others have suggested a much steeper gradient in administrative economies of scale, but this author shows why these widely cited older estimates are incorrect and provides adjusted figures that are more realistic.

²² Frederick D. Hunt, Jr., "Everything You Wanted to Know About TPAs but Were Afraid to Ask," Society of Professional Benefit Administrators, available at <http://users.erols.com/spba/p0000010.html> (accessed November 4, 2009).

²³ Ibid.

²⁴ James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 17.

²⁵ James C. Robinson, "The Commercial Health Insurance Industry in an Era of Eroding Employer Coverage," *Health Affairs* 25, no. 6 (2006).

²⁶ James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 17.

²⁷ James C. Robinson, "The Commercial Health Insurance Industry in an Era of Eroding Employer Coverage," 1478. TPAs accounted for 12 percent of the combined private insurance market for employers and individuals in 2005. Applying this to the unduplicated count of 200.5 million with private coverage in the March 2009 CPS yields an estimated 24 million with TPA-provided health benefits. In addition to 64 million plan members in private self-insured health benefits plans shown in Table 1, 59% of those covered by state/local employee health benefits have self-funded plans, for a total of 80.4 million with self-funded coverage. ($24/80.4 = 30\%$).

²⁸ Government Accountability Office (GAO), *FEHBP Coverage of Specialty Prescription Drugs*, (Washington, D.C.: GAO, April 30, 2009), 2.

²⁹ Christopher J. Conover, "State/Local Employees," U.S. Health Policy Gateway, available at <http://ushealthpolicygateway.wordpress.com/payer-trade-groups/health-insurance-coverage/public-health-insurance/government-employee-health-benefits/statelocal-employee-plans/> (accessed August 1, 2009).

³⁰ William L. Pierron and Paul Fronstin, "ERISA Pre-Emption: Implications for Health Reform and Coverage," 3.

³¹ Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, D.C.: AEI Press, 2009), 56.

³² Ibid., 74.

³³ Allison Frey et al., "Setting a National Minimum Standard for Health Benefits: How Do State Benefit Mandates Compare with Benefits in Large-Group Plans?" The Commonwealth Fund, June 2009, 1, available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/Jun/Setting%20National%20Minimum%20Standards/1292_Frey_setting_nat_minimum_standard_hlt_benefits_ib_v5.pdf (accessed January 26, 2010).

³⁴ Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, 49.

³⁵ Ibid., 50.

³⁶ William L. Pierron and Paul Fronstin, *ERISA Pre-Emption: Implications for Health Reform and Coverage*, 11.

³⁷ John Moran and Ryan F. O'Neil, *Impact of Pooling State and Local Employee Health Insurance in Other States* (Hartford, CT: State of Connecticut, Office of Legislative Research, August 29, 2008).

³⁸ Authors' tabulations from March 2009 Current Population Survey, using DataFerrett, available at <http://dataferrett.census.gov>, weighted using March supplement weight.

³⁹ Ibid.

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- ⁴⁰ Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, Table C-3.
- ⁴¹ National Center for Veterans Analysis and Statistics, "VA Benefits & Health Care Utilization," United States Department of Veterans Affairs, August 3, 2009, available at http://www1.va.gov/vetdata/docs/4X6_summer09_sharepoint.pdf (accessed November 12, 2009).
- ⁴² Authors' tabulations from March 2009 Current Population Survey, using DataFerrett, weighted using March supplement weight.
- ⁴³ James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance."
- ⁴⁴ Quotation from Senator Harry Reid (D-NV) in Patrick O'Connor and Carrie Budoff Brown, "Democrats Launch Attack on Insurer Exemption," *Politico*, October 14, 2009, available at <http://www.politico.com/news/stories/1009/28276.html> (accessed January 22, 2010).
- ⁴⁵ "Fortune 500: Our Annual Ranking of America's Largest Corporations," *Fortune* 500, May 5, 2008, available at <http://money.cnn.com/magazines/fortune/fortune500/2008/industries/223/index.html>, (accessed July 20, 2009).
- ⁴⁶ "Industry Summary," Yahoo! Finance, available at http://biz.yahoo.com/p/sum_qpmd.html (accessed November 18, 2009).
- ⁴⁷ "One Health Insurance Company Turned a Profit, but Not a Record," *politifact.com*, 2009, available at <http://www.politifact.com/truth-o-meter/statements/2009/jul/23/barack-obama/health-insurance-company-turned-profit-not-rec/> (accessed November 18, 2009). The "record profits" comment was made by President Barack Obama at a July 22, 2009 press conference.
- ⁴⁸ "Pelosi Remarks at Press Availability on Health Insurance Reform," news release, Speaker Nancy Pelosi, July 27, 2009, available at <http://www.speaker.gov/newsroom/pressreleases?id=1296> (accessed November 18, 2009). The "obscene profits" comment was made by House Speaker Nancy Pelosi (D-CA) at a July 27, 2009 press conference.
- ⁴⁹ Compustat figures for SIC 6324, cited in Scott Harrington, "How Private Health Insurance Really Works," PowerPoint Presentation, October 21, 2009, slide 4, available at <http://www.aei.org/docLib/Harrington%20How%20Private%20Health%20Insurance%20Really%20Works.pdf> (accessed January 22, 2010).
- ⁵⁰ These figures are from a report by Goldman Sachs investment analyst Matthew Borsch, cited in Emily Berry, "Nonprofit Blues Plans Report Declining Earnings in 2008," *Amednews.com*, October 5, 2009, available at <http://www.ama-assn.org/amednews/2009/10/05/bisb1005.htm> (accessed January 22, 2010).
- ⁵¹ Christopher J. Conover and Mark A. Hall, "Section VI: Potential Impact of Conversion on Profitability," in *Assessment of Potential Impact on Accessibility and Affordability of Health Care: Report for North Carolina Department of Insurance* (2003), available at http://wiki.aas.duke.edu/hpolicy/_media/wiki/health_facilities_regulation/cr6-9/cr_6-9.pdf.
- ⁵² Calculated by authors from estimated 2006 profits of \$21 billion and taxes of \$9 billion reported in CBO, *Key Issues in Analyzing Major Health Insurance Proposals*, 69-70. The denominator used was the \$731.3 billion in private health insurance expenditures reported in Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), *National Health Expenditure Projections 2008-2018* (Washington, D.C.: Department of Health and Human Services (HHS), July 7, 2009), available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf> (accessed December 14, 2009).
- ⁵³ Jon Sheils and Randall Haught, "Analysis of the July 15 Draft of the American Affordable Health Choices Act of 2009," *The Lewin Group*, July 17, 2009, 2, available at <http://www.lewin.com/content/publications/LewinHouseBillAnalysisHeritageRev.pdf> (accessed January 22, 2010).
- ⁵⁴ Authors' tabulations from March 2009 Current Population Survey, using DataFerrett, weighted using March supplement weight and estimates of self-funding by firm size reported in Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2009 Annual Survey*, (Washington, D.C.: Kaiser Family Foundation, September 15, 2009).

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