COMPETITIVE HEALTH INSURANCE REFORM ACT OF 2017

HEARING

BEFORE THE

SUBCOMMITTEE ON
REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

ON

H.R. 372

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COMPETITIVE HEALTH INSURANCE REFORM ACT OF 2017

THURSDAY, FEBRUARY 16, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATORY REFORM,
COMMERCIAL AND ANTITRUST LAW
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:06 a.m., in room 2141, Rayburn House Office Building, the Honorable Blake Farenthold (Vice-Chairman of the Subcommittee) presiding.

Present: Representatives Marino, Goodlatte, Farenthold, Issa, Collins, Buck, Ratcliffe, Gaetz, Cicilline, Conyers, Johnson, Swalwell, Jayapal, and Schneider.

Staff Present: (Majority) Ryan Datilo, Counsel; Andrea Woodard, Clerk; and (Minority) Slade Bond, Minority Counsel.

Mr. FARENTHOLD. The Subcommittee on Regulatory Reform, Commercial and Antitrust Law will come to order.

Without objection, the Chair is authorized to declare a recess of the Committee at any time. We welcome everyone to today's hearing on H.R. 372, the "Competitive Health Insurance Reform Act of 2017."

We will start with my opening statement. This morning, the Subcommittee meets to examine H.R. 372, the "Competitive Health Insurance Reform Act of 2017." Historically, the business of insurance was viewed as not falling within interstate commerce and, thus, subject to State, not Federal regulation.

In 1944, the Supreme Court effectively reversed itself on this question, holding that Federal antitrust laws were applicable to an insurance association's interstate activities and restrain of trade. Both States and insurers were not happy with that change.

Congress responded with the McCarran-Ferguson Act, which exempts insurers from certain Federal antitrust laws. As we have seen in the recent rejection of both the Anthem-Cigna and Aetna-Humana mergers, Federal antitrust laws regarding mergers still clearly apply. The Competitive Health Insurance Reform Act would repeal the McCarran-Ferguson Act's Federal antitrust exemption, so that it no longer applies to the business of health insurance. The McCarran-Ferguson Act would remain in effect for other types of insurance, such as property, casualty, and automobile insurance.

The issue of repeal has been discussed by the House Judiciary Committee on several occasions, and various iterations of legislation to repeal it have been offered for decades. Within the broader ongoing discussions regarding efforts to repeal and replace ObamaCare, Affordable Care Act, the question of the continued necessity and viability of the McCarran-Ferguson Act has, once again, arisen.

In his planned outline for reforming ObamaCare, newly appointed Health and Human Services Secretary, Tom Price has called for permitting the sale of insurance across State lines. Similar thinking has been echoed by President Trump and is included in House Republicans' "A Better Way" plan. Opening up the market to cross-border of sales would increase both competition in insurance markets, and the choice of insurance products offered to consumers. The ability to sell insurance across State lines is often tied to discussions about the McCarran-Ferguson Act. In fact, interstate insurance sales are already legal under certain conditions.

A provision in the Affordable Care Act allows the states to establish what are called "healthcare choice compacts," which permit insurers to sell policies to individuals and small business in any State that participates in the compact. State regulatory agencies set rules and minimums insurers must meet to sell plans in their State.

Instances of cross-state sales to date, however, have been relatively limited. We have an excellent panel of witnesses before us today who will help update us to evaluate the issues more effectively, and place this litigation into the larger context of the looming healthcare discussion. I look forward to our witnesses' testimony on the merits of H.R. 372.

[The bill, H.R. 372, follows:]

I

115TH CONGRESS
1ST SESSION

H. R. 372

To restore the application of the Federal antitrust laws to the business of health insurance to protect competition and consumers.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 9, 2017

Mr. GOSAR (for himself, Mr. BRAT, Mr. BROOKS of Alabama, Mr. DESJARLAIS, Mr. DUNCAN of Tennessee, Mr. GOHMERT, Mr. JONES, Mr. KING of Iowa, Mr. ROE of Tennessee, Mr. AUSTIN SCOTT of Georgia, Mr. YOHO, Mr. FERGUSON, Mr. WITTMAN, Mr. BABIN, and Mr. SMITH of Texas) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To restore the application of the Federal antitrust laws to the business of health insurance to protect competition and consumers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Competitive Health Insurance Reform Act of 2017".

SEC. 2. FINDINGS.

The Congress finds the following:

(1) Open, free, and fair competition has made the United States the strongest economy in the world.

(2) As a general proposition, Government should ensure that no industry obtains an unfair competitive advantage and that the playing field is equal. The Congress should not play favorites with certain industries or special interest groups by exempting one group from the general application of the law.

(3) There is no factual basis supporting any further exemption of the health insurance industry from Federal antitrust and unfair competition laws.

(4) Enforcement of these laws is most appropriately done through the U.S. Department of Justice, and in the case of aggrieved individuals through private actions as set forth in the existing statutes.

SEC. 3. PURPOSE.

It is the purpose of this Act to ensure that health insurance issuers are subject to the same antitrust and unfair trade practices laws that all businesses have had to comply with and to more effectively ensure that these issuers would be subject to Federal laws against price fixing, bid rigging, or market allocations to the detriment of competition and consumers. This Act remedies a special

exemption provided by Congress in 1945 to respond to the United States Supreme Court decision entitled United States v. South-Eastern Underwriters Association, wherein the Court correctly held that the Federal Government could regulate insurance companies under the authority of the commerce clause in the Constitution. This Act would also retain enforcement of these laws with State and Federal law enforcement agencies and allow private causes of action by aggrieved consumers harmed by unfair trade practices.

SEC. 4. RESTORING THE APPLICATION OF ANTITRUST LAWS TO HEALTH SECTOR INSURERS.

(a) AMENDMENT TO MCCARRAN-FERGUSON ACT.—Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), commonly known as the McCarran-Ferguson Act, is amended by adding at the end the following:

"(c)(1) Nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance (including the business of dental insurance). For purposes of the preceding sentence, the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

"(2) For purposes of paragraph (1), the term 'business of health insurance (including the business of dental insurance)' does not include—

"(A) the business of life insurance (including annuities); or

"(B) the business of property or casualty insurance, including but not limited to, any insurance or benefits defined as 'excepted benefits' under paragraph (1), subparagraph (B) or (C) of paragraph (2), or paragraph (3) of section 9832(c) of the Internal Revenue Code of 1986 (26 U.S.C. 9832(c)) whether offered separately or in combination with insurance or benefits described in paragraph (2)(A) of such section.".

(b) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of health insurance without regard to whether such business is carried on for profit, notwithstanding the definition of "Corporation" contained in section 4 of the Federal Trade Commission Act.

○

Mr. FARENTHOLD. And I now recognize the Ranking Member, the gentleman from Rhode Island, Mr. Cicilline, for his opening statement.

Mr. CICILLINE. Thank you, Mr. Chairman. Before I begin my remarks, I would like to take a moment to thank Chairman Marino, who was detained on other matters this morning, for his gracious welcome to this new position. I want to recognize my immediate predecessor, Mr. Johnson, and thank him for being here, as well as the Ranking Member of the full Committee, Mr. Conyers, for being here as well.

As Ranking Member of the Subcommittee, it is my foremost priority to work with the majority wherever possible to be find pathways to lowering prices for consumers, promoting innovation in existing new markets, and ensuring that every business has a fair opportunity to compete on an even playing field. Free markets only work for consumers to improve standards of living where there are sufficient competition. As the Council of Economic Advisers under the Obama administration reported last year, robust enforcement of the antitrust laws is an important way in which the government makes sure the market provides the best outcomes for society with respect to choice, innovation, and price as well as fair labor and business markets.

This Subcommittee plays a vital role in ensuring this outcome through oversight of the antitrust agencies' competition policy and the antitrust laws. Just this month, the Justice Department has won two important civil antitrust lawsuits initiated under the Obama administration to prevent unprecedented consolidation in the health insurance market. According to the Justice Department, these transactions would have stifled competition, harming consumers by increasing health insurance prices, and slowing innovation aimed at lowering the cost of health care.

But long before the Justice Department filed a lawsuit to enjoin these transactions, this Subcommittee held an important oversight hearing of these mergers, providing the public with insight into the matter and underscoring the importance of hearings and other oversight activity conducted by the Subcommittee.

In terms of the immediate topic of today's hearing, there are few better examples of entrenched market power resulting in higher consumer costs than those found in the healthcare market. The McCarran-Ferguson Act was enacted more than 70 years ago in response to the Supreme Court's ruling in South-Eastern Underwriters Association. That insurance activity across State lines is commerce within the meaning of Article I of the Constitution and, therefore, subject to the antitrust laws.

To qualify for this exemption, an insurer must be engaged in the business of insurance that is not designed to boycott, coerce, and intimidate, and is regulated within the State. While these requirements somewhat constrain anticompetitive conduct by insurers, it has long been clear that they do not preclude the most egregious forms of anticompetitive conduct, such as price fixing, bid rigging and market allocation by health and medical malpractice insurance insurers.

Indeed, as then-Assistant Attorney General Christine Varney testified in 2009, decades of case law suggests that the McCarran-

Ferguson Act exempts many forms of anticompetitive conduct that occur within State regulation, no matter how toothless State regulatory schemes may be. It is, therefore, critical that we use every tool to preserve and promote competition in these markets. I believe that proposals to repeal McCarran-Ferguson Act, such as H.R. 372 and H.R. 182, Ranking Member Conyers' proposal, are important to achieving this result. But make no mistake, promoting competition in the State markets must not occur at the expense of strong regulatory protections that establish health insurance exchanges, make health markets more efficient, and ensure baseline protections against discrimination. Far from it.

As Professor Tom Greaney, a leading expert of competition in healthcare markets testified last year, the Affordable Care Act vastly improves conditions necessary for competition to take hold and flourish in these markets.

Lastly, I would be remiss if I did not renew my call for a hearing on drug price competition. There are few other issues that so directly affect the lives of working American families as the price and availability of prescription drugs. While this Subcommittee has held a hearing on competition in the market for opioid treatment medicine, we have not considered the broader issue of drug price competition, and it is my hope that we will.

With that, I thank the Chairman for holding today's hearing. I very much look forward to the testimony of our witnesses. And I want to particularly welcome our colleagues, Mr. Gosar, Mr. Scott, and I look forward to hearing your testimony.

And I yield back the balance of my time.

Mr. FARENTHOLD. Thank you very much, Mr. Cicilline.

We will now go to the Ranking Member of the full Committee, Mr. Conyers of Michigan, for his opening statement.

Mr. CONYERS. Thank you, Mr. Chairman. Welcome to our distinguished witnesses this morning. I am pleased that the Subcommittee's first hearing of this new Congress is on H.R. 372, the "Competitive Health Insurance Reform Act of 2017," which repeals the antitrust exemption in the McCarran-Ferguson Act for the health insurance business.

For many years, I have advocated for such a repeal, so I am heartened to see the bipartisan nature of the support for this position.

My own bill, H.R. 143, would similarly repeal the McCarran-Ferguson antitrust exemption from the health insurance business, and it does so for price fixing, bid rigging, and market allocation, the most egregious kinds of anticompetitive conduct there is.

Additionally, my legislation would repeal the exemption for the business of medical malpractice insurance, as this would be another key component ensuring competition in healthcare markets.

There are several important reasons why Congress should repeal this antitrust exemption. To begin with, there is no justification for continuing such a broad antitrust exemption for health insurance insurers.

Congress passed the McCarran-Ferguson Act in response to a 1944 Supreme Court decision finding that antitrust laws applied to the business of insurance, like everything else. Both insurance companies and the States express concern about that decision.

Insurance companies worry that it would jeopardize certain collective practices like joint rig setting and the pooling of historical data. And the States were concerned about losing their authority to regulate and tax the business of insurance.

To address this concerns, McCarran-Ferguson provided that Federal antitrust laws apply to the business of insurance only to the extent that it is not regulated by State law, which has resulted in a broad antitrust exemption. Industry and State revenue concerns rather than the key goals of protecting competition in consumers were the primary drivers of the Act.

In passing, McCarran-Ferguson, Congress, however, initially intended to provide only a temporary exemption and, unfortunately, gave little consideration to ensuring competition. Not surprisingly, three commissioners observed in the 2000 Southern Antitrust Modernization Commission report that McCarran-Ferguson should be repealed because it has outlived any utility it may have had and should be repealed.

And another commissioner stated that the Act is among the most ill-conceived and egregious examples of antitrust exemptions, that its repeal should not be delayed.

In addition, repeal would be timely, given that the health insurance industry is highly concentrated, the situation that exacerbates harms against consumers.

Although Federal courts have recently blocked two mergers among four of the Nation's largest health insurance companies, the situation before these proposed mergers look bleak.

The American Medical Association has warned that the health insurance markets are highly concentrated with mere total collapse of competition among health insurers. The blocking of these mergers in the already high level of market concentration further suggests that for the good of consumers and the economy, the business of health insurance should not continue to enjoy an antitrust exemption.

And, finally, repeal of the McCarran-Ferguson antitrust exemption where the business of health insurance is a complement, not an alternative, to the affordable health care act. Some may be think that appealing McCarran-Ferguson alone would be sufficient to help patients and other healthcare consumers obtain affordable health insurance, but we should remember that the House included language almost identical to H.R. 372 in its version of the Affordable Care Act.

This is not an either/or situation. We need both measures to be in place to maximize benefits, improve quality, and lower price for consumers. And so I look forward to the testimony of our witnesses today.

I yield back my time. Thank you, Mr. Chairman.

Mr. FARENTHOLD. Thank you. Without objection, other Members' opening statements will be made part of the record.

Now, we now turn to our first panel of witnesses. Dr. Paul Gosar represents the Fourth District of Arizona and is a sponsor of the legislation that is the subject of this hearing today. Dr. Gosar serves on two Committees, the House Committee on Oversight and Government Reform, and the House Natural Resources Committee. Before being elected to Congress in 2010, Dr. Gosar owned his own

dental practice and was a small business man in Flagstaff for 25 years.

Mr. Austin Scott represents the Eighth District of Georgia. Mr. Scott serves as Chairman of the House Agriculture Committee, Subcommittee on Commodity Exchanges, Energy and Credit. Additionally, he is an active Member on the House Armed Services Committee.

Prior to joining us in Congress in 2010, he spent 14 years in the Georgia State House, and has owned and operated an insurance brokerage firm for nearly 20 years.

Each of the witnesses' written statements will be entered into the record in its entirety. I would ask you to summarize your thoughts within 5 minutes and you understand how the signal system works, so let's get going.

Dr. Gosar.

TESTIMONY OF THE HONORABLE PAUL GOSAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. GOSAR. Thank you, Chairman Farenthold, Ranking Member Cicilline, and the full Chairman Goodlatte, and Ranking Member Conyers. I appreciate it.

I thank you for having this hearing on our bill, the Competitive Health Insurance Reform Act, and for the time you devoted to studying the issue of McCarran-Ferguson, the antitrust exemption for health insurance.

As Congress once again faces the preeminent test of repairing our Nation's healthcare system, first and foremost, we must establish the proper foundation for a competitive and consumer-driven health insurance marketplace. The Competitive Health Insurance Reform Act of 2017 will restore the application of Federal antitrust and competition laws through the health insurance industry. Ending the special interest exemption is the essential first step to broader healthcare reform. Popular cost-reducing reform priority, such as selling insurance across State lines and developing diverse consumer-driven plans, are predicated on the robust competition marketplaces this bill would ensure.

As a healthcare provider for more than 25 years, I understand firsthand the importance of a competitive and dynamic health insurance market. Patients, doctors, and hospitals alike benefit when health insurers compete to provide a variety of quality coverage policies.

As a dentist, I have a unique perspective of the power a truly competitive marketplace could have on price control. Staying far away as possible from government-run health care and utilizing doctor-led insurance practices, industry has been able to deliver care at cost that closely matches inflation, unlike general medicine, whose costs have risen more than 20 times that.

The McCarran-Ferguson Act of 1945 exempted the insurance industry from the Sherman Act and the Clayton Act, acts that have a purpose of ensuring fair competition. This broad exemption was intended to assist the newly developing business of insurance, so that those companies could set sustainable premiums by permitting data sharing between insurance companies. It is important to note that this industry-specific exemption was created and built around

antiquated rudimentary practices for data collection and information processing. The health insurance industry of 1945 was far different than that of today. Today's health industry is concentrated into vertically integrated behemoths, with immense computing power able to access and process more information than the quaint insurers of the 1940s could ever dream of. It seems the only thing that hasn't changed is the special interest antitrust exemption that only this market enjoys.

However, after 70 years, it is apparent that the broad stroke exemption created by Congress in the 1940's was not wise. Over the decades, and expeditiously since the passage of ObamaCare since 2009, the health insurance market has devolved into one of the least transparent and more anticompetitive industries in the United States. These antiquated exemptions are no longer necessary. There is no reason in law, policy, or logic for the insurance industry to have special exemptions that are different from all other businesses in the United States.

The interpretation of antitrust law has narrowed dramatically over the decades. Many of the practices which insurers say they need this exemption to do, such as analyzing historical loss data, have proven to be permissible by the FTC and courts over the decades since McCarran-Ferguson was passed.

This narrowing of the scope has resulted in the zombie law, whose efficacy and usefulness has long since expired; yet, it looks to scare off potential legitimate legal challenges from States, patients, and providers. These entities do not have the tools, money, or manpower to challenge these monopolies in court or head on in the current market. Only the Federal Government with its resources can enforce the laws which rebalance the playing field fairly. Repeal of the specific section of the McCarran-Ferguson Act, which applies only to health insurance, has strong bipartisan support. As we saw in the 2009, 111th Congress, a vote of 406-19 passed the democratically held Congress. In the 112th Congress, it passed by a voice vote. Similar legislation has been introduced by multiple Democratic Members of the House, and attached to my bill has been included in the Republican Study Committee's healthcare reform bill for the last 4. In fact, they even appeared in the Republican Party platform in the convention in Cleveland last year.

As a dentist, I know how important robust competition is to dynamic and effective health insurance. It should protect the patient as well as the healthcare provider.

It should provide uniformly applied associated checks and balances that incentivize competition and prevent monopolies. Today, in the healthcare market, those equally applied antitrust predictions don't exist.

Now, I don't have a crystal ball that will tell you what the future of health care would look like. I don't think anybody knows. But I can tell you that history is an important guide. The 70-year antitrust exemption for the health insurance industry has resulted in a consolidated, anticompetitive, and nontransparent scheme controlled by five mega corporations. That is not what we want for the future. Instead, let's liberate the market by removing this antitrust exemption. Imagine what could exist when we put the patient first

and demand that health insurance companies compete for their business. This market should be patient centric, provide a variety of affordable, quality options, and empower patients' involvement and accountability. I thank everybody for their time today in considering this bill. I look forward to its passage, and thank you for considering it today. Thank you very much.

[The prepared statement of Mr. Gosar follows:]

TESTIMONY OF

Paul A. Gosar, D.D.S.

Member of Congress

House Judiciary Committee – Subcommittee on regulatory Reform, Commercial and Antitrust Law: Hearing on H.R.372, the Competitive Health Insurance Reform Act of 2017

2/16/2017

Good Morning Chairman Marino, Ranking Member Cicilline and members of the Committee. I would like to thank you for having this hearing on my bill, the Competitive Health Insurance Reform Act, and for the time you have devoted to studying the issue of McCarran-Ferguson anti-trust exemptions for health insurance.

As Congress once again faces the preeminent task of repairing our nation's health care system, first and foremost, we must establish the proper foundation for a competitive and consumer-driven health insurance marketplace. The Competitive Health Insurance Reform Act of 2017 will restore the application of federal anti-trust and competition laws to the health insurance industry.

Ending this special-interest exemption is the essential first step to broader healthcare reform. Popular cost-reducing reform priorities – such as selling insurance across state lines and developing diverse consumer-driven plans – are predicated on the robust competitive markets this bill will ensure.

As a healthcare provider for more than 25 years, I understand first-hand the importance of a competitive and dynamic health insurance market. Patients, doctors, and hospitals alike benefit when health insurers compete to provide a variety quality coverage options.

As a dentist, I have a unique perspective of the power a truly competitive marketplace can have on price control. Staying as a far away as possible from government-run healthcare and utilizing doctor-led insurance practices, dentistry has been able to deliver care at a cost that closely matches inflation – unlike general medicine whose costs have risen more than 20 times that.

The McCarran-Ferguson Act of 1945 exempted the insurance industry from the Sherman Act and the Clayton Act – acts that have the purpose of ensuring fair competition. This broad exemption was intended to assist the newly developing business of insurance so that those companies could set sustainable premiums by permitting data sharing between insurance companies.

It is important to note, that this industry-specific exemption was created and built around antiquated rudimentary practices for data collection and information processing. The health insurance industry of 1945 was far different than that of today. Today's health insurance industry is highly concentrated into vertically integrated behemoths, with immense computing power able to access and process more information than the quaint insurers of the 1940's could ever dream of. It seems the only thing that hasn't changed, is the special-interest anti-trust exemption that only this market enjoys.

However, after 70 years, it is apparent that the broad-stroked exemption created by Congress in the 1940's was not wise. Over the decades – and expeditiously since the passage of Obamacare in 2009 – the health insurance market has devolved into one of the least transparent and most anti-competitive industries in the United States. These antiquated exemptions are no longer necessary. There is no reason in law, policy, or logic for the insurance industry to have special exemptions that are different from ***all*** other businesses in the United States.

The interpretation of anti-trust law has narrowed dramatically over the decades. Many of the practices which insurers say they need this exemption to do, such as analyzing historical loss data, have proven to be permissible by the FTC and the courts over the decades since McCarran-Ferguson was passed. This narrowing of scope has resulted in a zombie law whose efficacy and usefulness has long since expired yet it lurks to scare off potential legitimate legal challenges from states, patients, and providers. These entities do not have the tools, money or manpower to challenge these monopolies in court or head-on in the current market. Only the federal government, with its resources, can enforce the laws which rebalance the playing field fairly.

Repeal of this specific section of the McCarran-Ferguson Act, which applies only to health insurance, has strong bipartisan support. A form of this legislation passed the Democratic-controlled House during the 111th Congress by a vote of 406 - 19

and passed the Republican-led House in the 112th Congress by a voice vote. Similar legislation has been introduced by multiple Democratic members of the House and the text of my bill has been included in the Republican Study Committee's healthcare reform bill for the last four congresses in a row. This pro-market reform was even included in the Republican Party Platform adopted at the National Convention in Cleveland last summer.

The continued exemption of the health insurance industry from the full application of federal anti-trust laws has had an unfair impact on consumers; it shows up as artificially higher premiums, unfair insurance restrictions, harmful policy exclusions, and simply no diversity of choice.

As a dentist, I know how important robust competition is to dynamic and effective health insurance. It should protect the patient as well as the health care provider. It should uniformly apply associated checks and balances that incentivize competition and prevent monopolies. Today, in the health care market, those equally applied anti-trust protections don't exist.

I don't have a crystal ball that will tell us what the future of healthcare will look like. I don't think anybody knows. But I can tell you that history is an important guide. The 70-year anti-trust exemption for health insurance has strangled

competition and resulted in a consolidated, anti-competitive, and non-transparent scheme controlled by 5 mega corporations. That's not what we want for the future.

Instead, let's liberate the market by removing this anti-trust exemption. Imagine what could exist when we put the patient first and demand that health insurance companies compete for their business. This market should be patient-centric, provide a variety of affordable, quality options, and empower patient involvement and accountability.

The passage of the Competitive Health Insurance Reform Act into law is an important first step towards increasing competition in health insurance markets, and will assist with setting the foundation for real, competitive, and patient-centered healthcare reform.

I would like to thank the Chairman, Ranking Member and members of the Committee for their time and work on this issue.

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Mr. FARENTHOLD. Thank you.
Mr. Scott, you are recognized for 5 minutes.

TESTIMONY OF THE HONORABLE AUSTIN SCOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. SCOTT. Chairman Farenthold, Ranking Member Cicilline, Chairman Goodlatte, Chairman Conyers, and Members of the Subcommittee, thank you for allowing me to submit my testimony in support of H.R. 372, the "Competitive Health Insurance Reform Act of 2017."

Many of you have law degrees from very distinguished schools, none quite as distinguished as the University of Georgia, where I received my degree in risk management and insurance in the early 1990's. This is when I was first licensed to sell life and health insurance during an internship in the summer of 1991. All in all, I spent approximately 20 years as an employee benefits broker, licensed in multiple States representing approximately 40 carriers. I was designated by the American College as a charter life underwriter, charter financial consultant, registered health underwriter, and a registered employee benefits consultant. I might also mention that my father is a surgeon in a small town, so I have seen this situation from the rural provider's side as well. I have actually read the contracts.

Before I go any further, I want to be clear that I believe there were a number of problems in the health insurance market before the Affordable Care Act passed. I think most brokers would tell you that. I also think that patients, physicians, pharmacists, people who work in the hospitals, would tell you that many of the problems that existed have been made worse by the lack of competition in the health insurance industry today. If I may be so bold as to ask you a few questions.

Do you think that pharmacies should be exempt from the antitrust laws of the country? Do you think that physicians should be exempt from the antitrust laws of the country? What about hospitals? Nobody in this room has or would put forward a bill that exempted any of these people who actually provide health care to patients from the antitrust laws of the country. So why would we allow the health insurance industry, who controls, through their contracts, who our doctor is, who our pharmacist is, which medicine we can get, and which hospital we can go through to being exempt from the antitrust laws of our country?

No doubt, their lawyers will tell you they are exempt because they are regulated by the States. Nothing in this legislation changes the fact that they are regulated by the States.

The groups that I just mentioned are also regulated by the States: Physicians, pharmacists, hospitals, and insurance brokers, all licensed and regulated by the States, not by the Federal Government. None of that changes with this legislation. All of those are subject to the antitrust laws of our country just as they should be.

The only thing that would change is that the health insurance industry would no longer be exempt. I very distinctly remember a renewal letter that a client received with a choice of sign here and accept the new preexisting acceptance clause, and your renewal

will be a certain dollar amount, or don't sign and your renewal would be significantly higher.

The people who argue that the health insurance industry should be exempt from the antitrust laws will also defend this pricing as just good business. This was from one of the biggest of the big carriers, and they are bigger and more controlling today than ever before. They are, in fact, the only carrier available to many of my constituents today.

The dominance of the market that these large carriers enjoy has forced many providers to move, close, merge, or sell to larger regional hospitals. The end results of this is that in the 24 counties that I represent, patients have fewer healthcare providers left. How is the antitrust issue relevant here? By definition, health care and health insurance are not the same thing.

But when one insurance company controls such significant portions of the cash flow of all of the providers in a region, no provider can stay in business without a contract with that carrier. Therefore, the insurance company gets to determine who is and who is not able to provide health care. Sign a contract with the competing carrier, we will cancel your contract. Accept the lower reimbursement, or we will cancel your contract. It is closer to extortion than negotiation.

I don't believe that all of this anticompetitive conduct is technically exempt from the antitrust laws. I have no doubt that in this room, the insurance industry would say the most reprehensible of these conducts is not. But in the courtroom down the street, they know that no provider has the resources to challenge them. The fact is most States don't have the resources to challenge them. The insurance company will simply cancel the provider's contract, and the provider would be broke, and that is the end of the case. A few brief comments to finish. This exemption is not only damaging to the consumer when they purchase health insurance, it damages the healthcare providers and, therefore, further limits access to health care.

I don't think this issue alone solves all of the problems in the health care industry, but I don't think that any of the problems in the insurance market will be solved if this exemption stays in place. Just as Mr. Conyers spoke to, I think it is noteworthy that on February 24th of 2010, the Health Insurance Industry Fair Competition Act passed the House with a vote of 406-19, yet, it was not included in the Affordable Care Act. The sharing of historical loss data primarily benefits small carriers. I think it would be wise to consider specifically allowing historical loss data to be shared to prevent costly, unnecessary litigation.

And I want to thank you for your time and the opportunity to provide testimony this morning. And with that, I yield back the 29 seconds that I don't have.

[The prepared statement of Mr. Scott follows:]

Testimony from Congressman Austin Scott (GA-08)
Subcommittee on Regulatory Reform, Commercial and Antitrust Law
February 16, 2017

- Chairman Marino, Ranking Member Cicilline and Members of the Subcommittee, thank you for allowing me to submit my testimony in support of H.R. 372, the Competitive Health Insurance Reform Act of 2017.

- Many of you have law degrees from very distinguished schools, although none quite as distinguished as the University of Georgia, where I earned my degree in Risk Management and Insurance in the early 90's. This is when I was first licensed as a life and health agent during an internship in the summer of 1991.

- In all I spent approximately 20 years as an employee benefits broker representing approximately 40 carriers. In addition to the BBA, I was designated by the American College as a Chartered Life Underwriter, a Chartered Financial Consultant, a Registered Health Underwriter, and a Registered Employee Benefits Consultant. Just as most of you maintain your bar membership, I still maintain my series seven and several other licenses.

- I might also mention that my father is a surgeon in a small town, so I have seen this issue from the rural provider side as well.

- Before I go any further, I want to be clear that I believe that there were a number of problems in the health insurance market before the Affordable Care Act passed.

- I think most brokers would tell you that, I also think that they as well as patients, physicians, pharmacists, hospital executives, etc. would tell you that many problems that existed have been made worse by the lack of competition in the market.

- As I am limited to 5 minutes, I will stick to the point of the Antitrust.

- If I may be so bold as to ask you a few questions.

- Do you think that pharmacies should be exempt from the antitrust laws of our country?

- Do you think that physicians should be exempt from the antitrust laws?

- What about hospitals?

- Nobody in this room has, or would, put forward a bill that exempted any of the people who actually provide health care to patients from the antitrust laws of our country. It is clearly not in the best interest of patients to do that.

- So why do we allow the health insurance industry who controls through their contracts who our doctor is, who our pharmacist is, which medicine we can get, and which hospital we can go to to be exempt from the antitrust laws of our country?

- No doubt, their lawyer will tell you that they are exempt because they are regulated by the states.

- So are all of the groups that I mentioned before. Physicians, Pharmacists, Hospitals, and even Insurance brokers, all licensed and regulated by the states, not the federal government, and all subject to the antitrust laws of our country just as they should be, just as the health insurance industry should be.

- Because of the conduct of the health insurance industry, this industry, of all industries, does not deserve any exemption.

- I very distinctly remember a renewal letter that a client received with a choice of sign here and accept a new pre-existing conditions clause and your renewal will be a certain dollar amount or don't sign and your renewal will be much higher.

- The people who argue that the health insurance industry should be exempt from the antitrust laws will also defend this pricing scam as just good business.

- This was from one of the biggest of the big carriers, and they are bigger and more controlling today than ever before. They are, in fact, the only carrier available to many of my constituents today.

- The dominance of the market that these large carriers have enjoyed has forced many providers to move, close, merge, or sell to larger regional hospitals.

- The end result of this is that in the 24 counties that I represent, patients have few health care providers left.

- This also drives up the cost of health care to the consumer.
- But how is the antitrust issue relevant here?
- By definition, health care and health insurance are not the same thing, but when one insurance company controls such significant portions of the cash flow of all of the providers in a region, no provider can stay in business without a contract with that carrier. Therefore, the insurance company gets to determine who is, and who is not, able to provide health care.
- Accept the lower reimbursement or we will cancel your contract. It is closer to extortion than negotiation.
- I don't believe that all of this anti competitive conduct is technically exempt from the antitrust laws. I have no doubt that in this room the insurance industry would say the most reprehensible of these conducts is not, but in the court room down the street they know that no provider has the resources to challenge them.
- The insurance company will simply cancel the providers contract and they will be broke before the insurance company is.
- A few brief comments to finish.
- This exemption is not only damaging to the consumer when they purchase health insurance, it damages the health care providers and therefor further limits access to health care.
- I don't think this issue alone solves all of the problems in the health care industry, but I don't think that any of the problems in the insurance market will be solved if this exemption stays in place.

- I also think it noteworthy that on February 24, 2010, the Health Insurance Industry Fair Competition Act passed the House with a vote of 406 to 19. This is only one month prior to the Affordable Care Act being signed into law.

- Much of the debate in 2010 focused on the sharing of historical loss data. The sharing of historical data primarily benefits small carriers, I think it would be wise to consider specifically allowing historical loss data to be shared to prevent unnecessary litigation.

- I thank you all for your time and the opportunity to provide testimony this morning. I yield back the balance of my time.

Mr. FARENTHOLD. And we appreciate your testimony here today on this important issue.

I think this concludes our first panel. Thank you, again, for sharing your insights with us.

I believe Mr. Cicilline——

Mr. CICILLINE. Yes. Mr. Chairman, I would ask unanimous consent that written testimony of the Honorable Tom Perriello, our former colleague from Virginia, be entered into the record. Tom was the lead sponsor of the Health Insurance Industry Fair Competition Act, which passed by a vote of 406–19 in the 111th Congress and has long supported competitive health insurance markets.

Mr. FARENTHOLD. Without objection, so ordered.

[The prepared statement of Mr. Perriello follows:]

Testimony of Hon. Tom Perriello

U.S. House of Representatives Committee on the Judiciary
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Hearing on H.R. 372, the "Competitive Health Insurance Reform Act of 2017"

Thursday, February 16, 2017

Overview[1]

The McCarran-Ferguson antitrust exemption for insurance was never intended to be permanent. Through a legislative aberration, what was originally drafted as a 2-3 year transition for the insurance industry to be treated like most other industries under the antitrust laws became instead a permanent exemption – one that is unnecessary, and, indeed, unfair in the way it protects the business practices of insurance companies from scrutiny.

Insurers will argue that the exemption isn't being used to shield otherwise illicit activity, and if so, they make our argument for us. But there have been numerous instances where the McCarran-Ferguson exemption has been invoked to thwart investigation into potentially illegal collusive activity – activity that harms consumers by keeping their premiums higher and payouts lower than they would be in a truly competitive market.

This question, whether one industry shouldn't have to play by the same rules as others, is part of a larger debate going on this country, namely, who will stand up for the ordinary American? Who will rise to the defense of the individual consumer? The Sherman Act was passed because too many industries were being dominated by a handful of companies. Regulations and antitrust laws should champion the public, not further tip the scales in favor of large corporations. For these reasons, there is simply no justification for continuing to permit this antiquated exemption.

A brief history of antitrust law

When Senator John Sherman (R-OH) introduced the antitrust legislation that now bears his name, he warned of the growing power of corporations, and the cost, both figurative and literal, to the public.

> *These trusts and combinations are great wrongs to the people....They operate with a double-edged sword. They increase beyond reason the cost of the necessaries of life and business....They regulate prices at their will, depress the price of what they buy and increase the price of what they sell.*

[1] The Hon. Thomas Perriello previously served as the U.S. Representative for the 5th District of Virginia in the 111th Congress. He was assisted in the preparation of these remarks by Anant Raut, who most recently served as Counsel to the Assistant Attorney General in the Department of Justice's Antitrust Division, as well as a special advisor on competition to the Office of the Vice President and the President's National Economic Council.

> *They aggregate to themselves great, enormous wealth by extortion which makes the people poor. Then, making this extorted wealth the means of further extortion from their unfortunate victims, the people of the United States, they pursue unmolested, unrestrained by law, their ceaseless round of peculation under the law, till they are fast producing that condition in our people in which the great mass of them are servitors of those who have this aggregated wealth at their command.*[2]

The solution he proposed was new enforcement authority for the federal government, to protect and defend the most economically vulnerable.

> *And it is now for Congress to say, when the devices of able lawyers and the cupidity of powerful corporations have united to spread these combinations over all of the States of the Union, embracing in their folds nearly every necessary of life, whether it is not time to invoke the judicial power conferred upon the courts of the United States to deal with these combinations; when lawful to support them and when unlawful to suppress them.*[3]

For a time, that's exactly what the antitrust laws did, under such legendary enforcers as the Department of Justice's Thurman Arnold.

Over time, however, antitrust moved away from its populist origins. In its place, an economics-heavy school of thought, rooted in the idea that markets, left to themselves, were efficient and self-regulating, pushed for lighter enforcement. Antitrust became less about making consumers better, and more about intervening only to keep things from getting worse.

But this narrative, that the public is best served when markets are deregulated and the enforcement of federal laws is reined in, is belied by observable experience, time, and time again. Ask those people in my district who lost their houses after banks scrambled over each other to push worse and worse mortgages out and sell them back into the market, ask them how well they think that market took care of itself, and whether they think we need more or less bank regulation.

So when we turn to the question of a historically anomalous antitrust exemption, the answer to whether we need stronger or weaker antitrust enforcement should be just as obvious.

Origin of the McCarran-Ferguson exemption

The genesis of the McCarran-Ferguson exemption was a 1944 Supreme Court decision. In *U.S. v South-Eastern Underwriters Association*, 322 U.S. 533 (1944), the United States Supreme Court held that insurance companies were in the business of interstate commerce, and thus subject to federal antitrust enforcement.

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[2] 21 Cong. Rec. 2461 (1890)
[3] 21 Cong. Rec. 2459 (1890)

Prior to that decision, insurance companies had been operating on an understanding that the business of insurance was regulated by the states and did not constitute interstate commerce, based upon a Supreme Court holding, *Paul v Virginia*, 75 U.S. 168 (1869), that predated the Sherman Act. With the *Paul* decision now overturned, the insurance lobby sought a reprieve from Congress, asking for an exemption to legislatively undo *South-Eastern Underwriters Ass'n.* In response, Senators Pat McCarran (D-NV) and Homer Ferguson (R-MI) offered a bipartisan compromise – a grace period from federal antitrust oversight as the insurance industry adjusted to the post-*South-Eastern Underwriters Association* reality.

The version that passed the Senate contained two key amendments that resolved a supposed ambiguity, clarifying that the suspension of the application of the antitrust laws to the insurance industry would only be for a limited duration.[4]

The House passed the version of the bill without those two amendments. But legislative debate at the time indicates that House members agreed that the moratorium was only to last for a limited time, they just thought there was no ambiguity in the legislation about that. So they didn't include the amendments.[5]

It was only when the two bills went into conference that what was understood by both the House and the Senate to be a limited moratorium on antitrust enforcement became permanent. A newly-created proviso added language that indefinitely suspended federal enforcement of the antitrust laws where state law existed.[6]

And in that way, a legislative compromise created to help ease an industry into operating under the antitrust laws led to the very opposite of what it was intended to achieve.

The American public is better off without the exemption

Some proponents of McCarran-Ferguson would say that the exemption is necessary to protect the sharing of historical data that insurance companies can use to more accurately price their products. If the sharing of data is being done in a pro-competitive way, then the insurance

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[4] Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 Wm. & Mary L. Rev. 81, 87 (1983).

[5] *Id.*

[6] The McCarran-Ferguson Act, in relevant part, provides that

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after January 1, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

McCarran-Ferguson Act, Pub. L. No. 79-15, s 2, 59 Stat. 33, 34, (codified at 15 U.S.C. s 1012 (2006)).

industry has nothing to fear. Sharing of historical data among competitors is not in and of itself illegal under the antitrust laws – the federal antitrust agencies would weigh the pro-competitive effects of any such arrangements against the anticompetitive effects, on a case-by-case basis.[7] But if the data exchange is being used to help insurance companies price their products more closely together, at a level higher than would exist in a genuinely competitive market, well, this is exactly the type of price-fixing that the antitrust agencies should be examining. We want insurance companies to compete more, not less.

We also know that the McCarran-Ferguson exemption has been used as a shield to block inquiry into potentially illegal practices by insurance companies, including price fixing and bid rigging.[8] How widespread is this activity? We don't know for sure – but the point is, we can't know, as long as this exemption that this industry gets to enjoy remains in place.

The Perriello-Markey bill

On November 8, 2009, I proudly voted in favor of H.R. 3590[9], the House version of the Affordable Care Act[10], a piece of legislation that has provided health insurance to 20 million previously uninsured Americans; reduced the use of expensive emergency room visits; and given millions of adults with preexisting conditions the security to change jobs, among its many benefits. In Virginia alone, nearly 400,000 people use the exchanges to shop for competing health insurance plans.[11] Nationwide, the percentage of Americans without health insurance has

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[7] The Department of Justice and the Federal Trade Commission have jointly provided guidance, in the 1996 Statements of Antitrust Enforcement Policy in Health Care, *available at* https://www.justice.gov/sites/default/files/atr/legacy/2007/08/15/1791.pdf, and the 2016 Antitrust Guidance for Human Resource Professionals, *available at* https://www.justice.gov/atr/file/903511/download, on factors that make certain types of exchanges of historical data among competitors permissible under the antitrust laws.

[8] *See, e.g.* H. Rep. No. 111-322, at x (2009), citing *Schwartz v Commonwealth Land Title Insurance Co.*, 374 F.Supp. 564 (E.D.Pa. 1974) (in which defendant mutual life insurance companies invoked McCarran-Ferguson to dismiss a price-fixing claim); *Steingart v Equitable Life Assurance Society*, 366 F.Supp. 790 (S.D.N.Y. 1973) (in which defendant mutual life insurance companies employed McCarran-Ferguson to dismiss a price-fixing claim); *et al. See also* United States Cong. Senate Comm. on the Judiciary, *The McCarran-Ferguson Act: Implications of Repealing the Insurers' Antitrust Exemption*. Hearing June 20, 2006. Washington: GPO, 2006 (statement of Ms. Elinor Hoffman, Assistant Attorney General, Office of the Attorney General for the State of New York), citing the use of a McCarran-Ferguson defense in *In re Insurance Brokerage Antitrust Litigation*, 2:04-cv-05184-FSH-PS (D.N.J. filed Oct. 22, 2004) (MDL 1663) to extend for years litigation alleging a bid-rigging conspiracy among nearly two dozen insurance companies and brokers.

[9] Affordable Health Care for America Act, H.R. 3590, 111th Cong. (2010).

[10] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

[11] For the 2017 plan year, 399,084 Virginia residents had signed up for health insurance through the Virginia health exchange as of January 14, 2017. Centers for Medicaid and Medicare Services, *Bi-Weekly Snapshot* (January 18, 2014), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-18.html.

fallen by more than 40 percent; and the uninsured rate among young adults has decreased by more than half.[12]

After the House passed its version of the Affordable Care Act, the Senate passed its own version, identical in many ways, but stripping out a key provision that would have eliminated the McCarran-Ferguson exemption for health insurers, once and for all. I took that language, and, along with Congresswoman Betsy Markey of Colorado, introduced the Health Insurance Industry Fair Competition Act[13]. I sponsored the bill because in my mind, a competitive health insurance market would make the plans available in the framework provided by the ACA even more affordable[14]. For all the talk of how the Affordable Care Act was passed on a partisan basis, I am proud to say that my bill was passed by the House of Representatives in a vote of 406-19, proof that this issue transcends political affiliation.

Conclusion

The health insurance industry is dominated by a handful of national carriers. Cigna, Aetna, and Humana operate in every state in the country and the District of Columbia.[15] It's a vastly more consolidated industry than existed in the late '40s when this exemption, which depends heavily upon state-level enforcement, was passed. As the industry has become national in scope, so should its oversight.

Congressman Gosar and Congressman Conyers have each introduced legislation that take different approaches to repealing the McCarran-Ferguson exemption. Regardless of which direction you take, I commend this subcommittee for taking this important first step in examining this issue, and urge you to continue all the way through. In an era of heightened consolidation, when companies are enjoying record profits, the public needs more protections, not fewer. The Affordable Care Act is one such protection; stronger federal antitrust enforcement is another.

I thank the Committee for its time.

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[12] Centers for Medicaid and Medicare Services, *Strengthening the Marketplace by Covering Young Adults*, Fig. 1 (June 21, 2016), *available at https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-06-21.html*.

[13] Health Insurance Industry Fair Competition Act, H.R. 4626, 111th Cong. (2010).

[14] But the benefits of which would be vastly diminished absent the Affordable Care Act's carrots and sticks.

[15] Department of Justice. (2016). *Justice Department and State Attorneys General Sue to Block Anthem's Acquisition of Cigna, Aetna's Acquisition of Humana* [Press release], *available at https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s*.

Mr. FARENTHOLD. We will take a short break here while they set up. But as soon as they get set up, we are going to get going. We have a busy day in Washington today.

Mr. SWALWELL. Would the gentleman yield just briefly?

Mr. FARENTHOLD. Sure.

Mr. SWALWELL. Thank you. Also, I will also be going between hearings. I was hoping I could enter into the record an American Association of Oral and Maxillofacial Surgeons' letter dated February 16, 2017, from their president, Douglas Fame.

Mr. FARENTHOLD. Without objection, so ordered.

Mr. SWALWELL. Thank you.

Oral and maxillofacial surgeons:
The experts in face, mouth and jaw surgery®

American Association of Oral and Maxillofacial Surgeons

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February 16, 2017

The Honorable Bob Goodlatte
Chairman
House Judiciary Committee
2138 Rayburn HOB
Washington, DC 20515

The Honorable John Conyers, Jr.
Ranking Member
House Judiciary Committee
2138 Rayburn HOB
Washington, DC 20515

Dear Chairman Goodlatte & Ranking Member Conyers:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), I thank you for holding today's hearing on the "Competitive Health Insurance Reform Act of 2017" (H.R. 372). AAOMS is pleased to support this important legislation. Our organization believes that passage of the Competitive Health Insurance Reform Act is an important step toward increasing competition among health care insurers while providing additional protections to consumers.

The health insurance industry's exemption from federal antitrust laws, as provided by the McCarran Ferguson Act in 1945, has helped produce a largely anticompetitive health insurance market in an otherwise competitive economy where almost all other industries are subject to antitrust guidelines. We believe if health insurance companies were required to follow all federal antitrust laws there would very likely be an increase in the number of health plans competing aggressively for purchasers, which would result in policies with lower premiums and more robust benefits.

As oral and maxillofacial surgeons, we think it is essential that consumers enjoy access to the innovative treatments and procedures available in the healthcare marketplace; just as they do in any environment that competes for their business. To this point, AAOMS would ask the Committee to pay particular attention to the inclusive language noted in H.R. 372's definition of "the business of health insurance," as it is the only antitrust-related legislation in Congress that specifies dental insurers as health insurance companies.

AAOMS strongly endorses the Competitive Health Insurance Reform Act of 2017 Act and thanks you for bringing this issue the attention it deserves. We urge the Committee to move forward with a markup of this important legislation. If we can be of assistance to you in any way, please contact Ms. Jeanne Tuerk at the AAOMS Governmental Affairs Department at 800/822-6637 ext. 4321 or jtuerk@aaoms.org.

Sincerely,

Douglas W. Fain, DDS, MD, FACS
President

Mr. FARENTHOLD. I see the usual efficiency of our Judiciary Committee staff as they have gotten you guys ready to go in no time at all. So we will get going on panel two.

We will begin by swearing in our witnesses before I introduce them.

Gentlemen, would you all please rise and raise your right hand.

Do you swear the testimony you are about to give before this Committee is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record reflect that all witnesses answered in the affirmative.

You all may be seated.

Or distinguished panel today includes Mr. Thomas Miller, a resident fellow at the American Enterprise Institute, AEI, where he studies healthcare policy, including health insurance and market based-alternatives to the Affordable Care Act. Prior to joining AEI, Mr. Miller served as a senior health economist for the Joint Economic Committee, JEC, in Congress. He's testified before Congress on issues such as the uninsured healthcare cost, Medicare, prescription drug benefit, health insurance tax and credits, generic information, Social Security, Federal reinsurance of catastrophic events, among others. Mr. Miller also practiced as a trial attorney for the firm of Powell Goldstein Frazer & Murphy in Atlanta, Georgia, where he served as a lead attorney in a lawsuit challenging the State of Georgia's proposed Medicaid regulations. Mr. Miller received his bachelor's degree in political science from New York University, and his JD from Duke University School of Law.

Mr. David Balto is an antitrust attorney with over 15 years of government antitrust experience. Mr. Balto has worked as a trial attorney in the Antitrust Division at the Department of Justice, and several senior level positions in the Federal Trade Commission during the Clinton administration. He received his bachelor's degree from the University of Minnesota and his JD from the Northeastern University School of Law.

Mr. Robert Woody is Vice President for policy at PCI with a primary focus on the development of PCI's policy position on Federal issues. He was deeply involved in the PCT's efforts to educate Congress on the impact of the Dodd-Frank Act, as it was considered in Congress, and continues to be involved in the implementation and reform issues. He is also responsible for reinsurance and guaranteed fund issues at the State and Federal level.

Prior to joining PCI, Mr. Woody practiced law for 16 years at an international law firm. He advised both U.S. and non-U.S. citizens on insurance regulatory matters from the firm's Washington and London office. He was active in lobbying the Congress on the enactment of the Terrorism Risk Insurance Act in 2002, and its subsequent reauthorizations and continues to advise insurance on compliance with what that statute does and its implementing regulations. He is the author of several published articles on various insurance law topics including privacy compliance.

Prior to joining the firm, he was a legislative assistant to Representative Bill Emerson, and previously worked in several capacities in the Virginia General Assembly. He got a bachelor's degree

from James Madison University and a JD from the Catholic University of America.

Mr. George Slover is a senior policy counsel at Consumers Union, where he helps develop and coordinate regulatory comments across a wide range of policy issues, focusing on antitrust and competition issues. Mr. Slover has three decades of Federal Government policy experience with service in all three branches, including 9 years in this Committee, 2 years at the Energy and Commerce Committee, and 11 years at the Justice Department's Antitrust Division. He also serves on the advisory board of the American Antitrust Institute, the Steering Committee of the D.C. Bar's antitrust and consumer law section, and is an elected member of the American Law Institute.

Mr. Slover received his bachelor's degree from Vanderbilt, a master's degree in public affairs from the LBJ School of Public Affairs at the University of Texas, and his JD from the University of Texas Law School. Fellow Longhorn.

All right. So each of your written statements has been provided to us, and will be entered into the record. I would like you to summarize your testimony in 5 minutes. You have got the timer in front of you. I think all of you are familiar with how that works as well. Much like a traffic stoplight, green means go, yellow means hurry up, and red means stop. So we will get going here, and we will start with Mr. Miller.

TESTIMONY OF THOMAS P. MILLER, ESQ., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

Mr. MILLER. Thank you, Vice Chairman Farenthold, Chairman Goodlatte, Ranking Member Conyers, Subcommittee Ranking Member Cicilline, and all the Members of the Subcommittee for the opportunity to testify today on this proposed legislation, and more generally, on competition policy considerations involving limited antitrust exemption for health insurers under the McCarran-Ferguson Act.

Overall, the approach in this bill and similar ones in the recent past does not raise new or pressing issues. It appears to advocate at best the uncertain and limited remedy in search of problems that are hard to find and quantifying empirically, particularly within the health sector of the insurance industry. Many other existing tools already remain in place to police health insurance competition. The likely gains and reciprocal cost of removing the limited antitrust exemption in this sector may appear minor; however, the additional risks of adding new regulatory uncertainty, increasing boundary testing litigation, and distracting policymakers from more important ways to reduce healthcare costs and improve healthcare competition suggested further caution and delay on this front is advisable, at least until the post Affordable Care Act policy path is determined.

Increasing the Federal Government's role in regulating health insurance even more through expanded antitrust enforcement would appear to conflict with proposed reforms to delegate more responsibility to State governments and individual consumers.

The McCarran-Ferguson Act to reaffirm the basic policy against Federal Government regulation of insurance, and more particu-

larly, antitrust regulation, but this rule would apply as long as State governments took on that responsibility.

As interpreted and fleshed out by a long series of court decisions in later years, the Act's protection against Federal antitrust regulation applies only when the conduct of insurers constitutes the business of insurance, is regulated by State law, and does not constitute an agreement to act—an agreement or act to boycott, coerce, or intimidate.

Over the decades, court interpretation of which activities meet a three-factor test for being within the business of insurance have become tighter in accordance with the general rule disfavoring expansive interpretations of exemptions to the Federal antitrust laws.

My written testimony includes a long list of insurer practices that have been ruled to be outside the antitrust exemption. Moreover, the extent of State and Federal regulation of insurers remains broad and deep.

McCarran-Ferguson provides no safe harbors under scrutiny under State antitrust laws, merger enforcement activity over insurers remains at both the State and Federal levels. States also have consumer protection laws and unfair claims practices statutes that further police health insurers' practices. The primary argument over time for establishing retaining—and retaining the antitrust exemption under McCarran-Ferguson has been to facilitate economically efficient sharing of information that helps insurers to evaluate risk and price accurately. However, those cooperative activities always have mattered far more to property casualty insurers than to health insurers. Health insurers have no similar history of utilizing advisory organizations for the joint estimation and projection of medical claims cost.

One can make an argument that many, if not all, the remaining efficiency enhancing and pro-competitive aspects of advisory organization activities today might well pass muster under modern rule of reasoned applications of antitrust enforcement. However, the uncertain risk of litigation challenges and organizational change pressures would produce some offsetting costs. Another less anticipated counter reaction instead might be greater alliance on the State action doctrine, which might not just deflect antitrust concerns but, actually, further enshrine unwise and overaggressive State regulation.

The Competitive Health Insurance Reform Act of 2017 really provides little, if any, evidence of absence of current antitrust and regulatory review of health insurance services, or court decisions allowing anticompetitive conduct under current law, or actual marketplace behavior by health insurers that was enabled by the limited antitrust exemption.

This legislation lacks any real empirical basis for suggesting that health insurers have persistently achieved high, let alone abnormally high profits due to the antitrust exemption. When the congressional Budget Office last examined in 2009, similar legislation to remove the antitrust exemption for health insurers, and also medical liability insurers, it concluded that any effect on insurance premiums is likely to be quite small, because State laws already bar the activities that would be prohibited under the proposed Federal law if enacted.

The larger problem in health policy today is that health care and health insurance is regulated too heavily, not too lightly, particularly after passage of the Affordable Care Act in 2010. In all likelihood, concentrating on this stale issue of the McCarran-Ferguson antitrust exemption, will merely distract our attention from more urgent tasks encouraging and adopting far more important market-oriented reforms that our health system definitely needs. Thank you.

[The prepared statement of Mr. Miller follows:]

AMERICAN ENTERPRISE INSTITUTE

Statement before the House Committee on the Judiciary
Subcommittee on Regulatory Reform, Commercial and Antitrust Law

Competitive Health Insurance Reform Act of 2017

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Summary Points

- The limited antitrust exemption for health insurers under the McCarran-Ferguson Act is neither a new nor particularly pressing issue.
- Efforts to repeal it assume problems that cannot be documented, while they offer little relief from more tangible cost and competition concerns.
- Other current enforcement tools and regulatory policies already address competition issues at the state and federal level.
- The antitrust exemption for most insurers has grown more narrow and less significant over time, and even more so for health insurers.
- The respective gains and costs from removing the exemption are hard to measure and largely offset each other
- The better direction ahead in health policy would be toward more deregulated and decentralized decision making. In such a reformed environment, a modest backup role for pro-competitive antitrust safeguards could be more useful.

Thank you Chairman Goodlatte, Subcommittee Chairman Marino, Subcommittee Ranking Member Cicilline, and Members of the Subcommittee for the opportunity to testify today on the Competitive Health Insurance Reform Act of 2017, and more generally on competition policy considerations involving the limited antitrust exemption for health insurers under the McCarran-Ferguson Act.

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based research organizations.

My remarks will focus on the evolving and current state of the antitrust exemption, the broader context in which competition policy for health insurance is shaped and enforced, and whether elimination of the current exemption would remedy significant problems in health insurance competition, as well as highlight other considerations and tradeoffs in exploring different policy options.

Overall, the approach in the proposed legislation and similar ones of the recent past does not raise new or pressing issues. It appears to advocate, at best, an uncertain and limited remedy in search of problems that are hard to find and quantify empirically – particularly within the health sector of the insurance industry. Many other existing tools already remain in place to police health insurance competition.

The likely gains and reciprocal costs of removing the limited antitrust exemption in this sector may appear limited. However, the additional risks of adding new regulatory uncertainty, increasing boundary-testing litigation, and distracting policymakers from more important ways to reduce health care costs and improve health care competition suggest that further caution and delay on this front is advisable, at least until the post-Affordable Care Act policy path is determined. Increasing the federal government's role in regulating health insurance even more, through expanded antitrust enforcement, would appear to conflict with proposed reforms to delegate more responsibility to state governments.

A more modest case for removing the current antitrust exemption might be made in a future, better-case scenario in which other regulatory barriers to level-playing-field competition already have been reduced or removed. Then, antitrust policy (with appropriate safe harbors for pro-

competitive insurance practices) could be used more effectively as a backstop to support more market-oriented, consumer-driven health care markets.

Background on How We Got Here

The unusual history behind the antitrust exemption generally starts with the Supreme Court decision in 1945 in *U.S. v. South-Eastern Underwriters Association* (322 U.S. 533) that reversed past legal precedent. The Court found that insurance did indeed constitute interstate commerce and fell within the broad jurisdiction of the federal government to regulate it, including through the Sherman, Clayton, and Federal Trade Commission Acts. Congress responded quickly to ensure that state-based regulation and taxation of insurance would remain in place, by passing the McCarran-Ferguson Act of 1945. That law reaffirmed a basic policy against federal government regulation of insurance (as long as state governments took on that responsibility).

The law prescribed that no act of Congress "shall be construed to invalidate, impair, or supersede" any state law enacted for the purpose of regulating or taxing insurance unless Congress specifically so declare and

that the aforementioned federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by state law."

At the time, state rate regulation of collectively developed rates was a common policy (particularly in the property and casualty sector of the insurance industry). It was considered necessary to preserve insurer insolvency and state markets. State government oversight of rating bureau activities, adoption of unfair trade practices legislation, and overall state-level regulation of insurance increased in subsequent years in order to forestall both general insurance regulation and antitrust regulation by the federal government.

Narrowing of Antitrust Exemption over Time

As interpreted and fleshed out by a long series of court decisions in later years, the McCarran-Ferguson Act's protection against federal antitrust regulation applies only when the conduct of insurers meets each of three conditions:

(1) It constitutes the "business of insurance,"

(2) It is "regulated by State law," and

(3) It does not constitute an agreement or act to "boycott, coerce, or intimidate."

The exemption has been narrowed further over the decades as court interpretations of the "business of insurance" have become tighter, in accordance with the general rule disfavoring expansive interpretations of exemptions to the federal antitrust laws. In order for an activity to be exempted as within the "business of insurance," it must meet a three-factor test, including whether the activity (1) transfers or spreads risk for the policyholder, (2) is an integral part of a contract of insurance or relationship between the insurer and insured, or (3) is exclusively limited to insurance industry participants.

The antitrust exemption also will not apply if (1) the State has failed to regulate the activity in question in a sufficiently direct or immediate way, (2) Congress has explicitly overridden state law in the applicable federal statute, or (3) the purported exercise of state regulatory authority violates the U.S. Constitution.

These various judicial screens limit the scope of the McCarran-Ferguson antitrust exemption, predominantly through narrowing what still constitutes the "business of insurance." For example, practices such as provider arrangements, peer review, fixed benefits schedules, UCR (usual, customary, and reasonable) fee schedules, bid rigging, territorial allocation of licensees for marketing and sale of branded health insurance, insurance

reimbursement, claims handling, settlement, and market practices that are not limited to the insurance industry have been ruled to be outside the antitrust exemption.

Extensive Regulation of Health Insurance at State and Federal Levels

Moreover, the extent of state and federal regulation of insurers remains broad and deep. McCarran-Ferguson provides no safe harbors against scrutiny under state antitrust laws. Merger enforcement authority over insurers remains at both the state and federal levels. Most notably, within the last four weeks, the U.S. Department of Justice (DOJ) successfully blocked two proposed mergers between major national health insurers (Aetna-Humana and Anthem-Cigna). In other recent examples of federal antitrust enforcement, DOJ challenged a health insurer's use of most-favored-nation clauses that created disincentives for providers to lower rates in Michigan (the case was settled after the state legislature outlawed use of such clauses in health insurance). On the state enforcement level, the New York Attorney General challenged as flawed and anti-competitive databases operated by a subsidiary of UnitedHealth, which was used by several major insurers in determining reimbursements to out-of-network providers (UnitedHealth settled by agreeing to fund development of an independent database).

State-level regulation of health insurers includes licensure, audits, oversight, filing requirements, network formation and maintenance, and solvency standards, as well as rate and form review. States also have consumer protection laws and unfair claims practices statutes that further police health insurers' practices.

The Limited Antitrust Exemption Matters Less to Health Insurers

The primary argument over time for establishing and retaining the antitrust exemption under McCarran-Ferguson has been to facilitate economically efficient sharing of information that helps insurers to evaluate risk and price accurately. However, those cooperative activities always have mattered far more to property/casualty insurers than to health insurers. In the context of the mid-1940s, insurance rating bureaus had an important role in making historic loss data available in a sufficiently large sample to provide a higher degree of statistical reliability and economies of scale. They were particularly valuable to smaller insurers, or larger insurers with smaller volume in some lines of business and other states. Other cooperative activities that were sheltered to various degrees by the antitrust exemption offered assistance to insurers in development of loss estimation, rate classifications, rating territories, standard policy forms, and joint underwriting of large risks.

As the business of property/casualty insurance, along with antitrust enforcement, evolved in later decades away from focusing on administered pricing, the role of rating bureaus per se declined. They transitioned toward advisory organizations that offered data assistance while stopping well short of providing preliminary price-setting mechanisms.

Meanwhile, health insurers have no similar history of utilizing advisory organizations for the joint estimation and projection of medical claim costs. They rely on their own data and widely available outside statistical sources on mortality and morbidity, augmented in many cases by the assistance of independent actuarial consulting firms. The largest portion of the health insurance market also remains beyond the immediate reach of state-based rate review, either through ERISA self-insurance or experience rating in larger employer groups. In other (smaller) portions of the overall health insurance market, a little less than half the states require prior approval of insurance rates in the individual market or small-group market, although rate review programs were upgraded more recently in line with Affordable Care Act requirements.

One can make an argument that many, if not all, of the remaining efficiency-enhancing and pro-competitive aspects of advisory organization activities today might well pass muster within modern rule of reason

applications of antitrust enforcement. Bona fide information pooling limited to historical loss cost data, development of "optional" common policy forms, joint underwriting pools for residual risks, and well-structured joint ventures in shared research may be likely candidates. However, the uncertain risks of new litigation challenges and organizational change pressures would produce offsetting costs.

Another less-anticipated counter-reaction instead might be greater reliance on the state-action doctrine. The latter's requirements for active supervision by state governments of clearly articulated policies to limit competition might not just deflect antitrust concerns, but actually further enshrine unwise and aggressive state overregulation.

Net Assessment: Little to Gain, Besides Distractions from Real Reform

The Competitive Health Insurance Reform Act of 2017 offers more of a symbolic gesture toward blame-shifting than a tangible path to health policy reform. It provides no evidence of an absence of current antitrust and regulatory review of health insurance services, court decisions allowing anticompetitive conduct under current law, or actual marketplace behavior by health insurers that was enabled by the limited antitrust exemption. This legislative proposal lacks any empirical basis for suggesting that health

insurers have persistently achieved high, let alone abnormally high profits, due to the antitrust exemption.

When the Congressional Budget Office last examined in 2009 similar legislation to remove the antitrust exemption for health insurers (and medical liability insurers), it concluded that any effect on insurance premiums 'is likely to be quite small" because state laws already barred the activities that would be prohibited under the proposed federal law if enacted.

The larger problem in health policy is that health care and health insurance is regulated too heavily, rather than too lightly. After passage of the Affordable Care Act in 2010, state regulation of premium rates in the fully insured small-group and individual markets has grown tighter, along with increased requirements for covered benefits, new mandates on employers to offer approved coverage and individuals to purchase it, adjusted community rating for individual market policies, single pooling, and minimum loss ratio requirements for small-group and individual market insurers. Government policy at the state and federal levels has been tilted much further in favor of greater regulation rather than free-market competition. Yet this move to tighter regulation has been accompanied by further distortion of underlying prices, reduced participation by private

insurers in ACA exchange markets, and rising individual-market premiums in recent years.

This year, a new Congress is considering revising this insurance regulatory mix to delegate more key decisions back to state officials and individual policyholders. Amidst such uncertainty, it seems untimely and out of step to ratchet up the regulatory dials toward greater federal government involvement via new twists on the antitrust knobs. One of the modest benefits of unifying regulatory and antitrust policies at the state level is that they then are less likely to operate at cross purposes. At a minimum, increased federal antitrust scrutiny of health insurance arrangements should be seen as a competition-protecting backstop that only accompanies and facilitates greater *deregulation* of those insurance markets.

In all likelihood, the sky will not fall if the McCarran-Ferguson antitrust exemption is eliminated solely for health insurers. But the sun will not rise and shine through the current haze either if this stale issue further distracts our attention from more urgent tasks: encouraging and adopting far more important market-oriented reforms that our health system needs. Addressing the underlying causes of poor health outcomes and higher health care costs requires a stronger emphasis on improving population health, incentivizing better health behavior, curbing delivery system inefficiencies,

ensuring greater price and cost transparency, reducing barriers to entry, and reducing and retargeting excessive cross-subsidies. Repealing the limited antitrust exemption for health insurers looks like another largely symbolic but empty swing of the enforcement hammer at inconsequential nails.

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Mr. FARENTHOLD. Thank you, Mr. Miller.
Mr. Balto, you are up for 5 minutes.

TESTIMONY OF DAVID BALTO, ESQ., PRINCIPAL, DAVID A. BALTO LAW OFFICES

Mr. BALTO. Thank you, Chairman Farenthold, Ranking Member Cicilline, and the other Members of the Committee. I am David Balto. I am for—used to be the policy director of the Federal Trade Commission. This is actually the 15th time I have testified on healthcare competition issues before Congress, the sixth time before this Committee. I welcome returning to you. I also lead a consumer coalition on healthcare competition issues, the Coalition to Protect Patients' Rights.

The question before you is simple, easy, and clear: Is the McCarran-Ferguson Act necessary—is it necessary to exemptions to the antitrust laws? The answer is clear. It is not. The antitrust modernization committee that this committee helped form says that for there to be an antitrust exemption, there has to be clear case that the conduct in question would subject the actors to antitrust liability, and there is no less restrictive way to solve the problem.

The proponents of keeping the exemption cannot demonstrate a clear case. The law is crystal clear here that the conduct that they would like to engage in would not violate the antitrust laws.

Mr. Miller, in his testimony, actually says they don't even need to engage in this kind of information sharing.

Why are antitrust exemption disfavored? There has not been an industry-wide antitrust exemption passed since this one. That is because the anti—an antitrust exemption replaces the discipline of the free market with private regulation, not government regulation. Even worse, private regulation. Private parties get to determine the terms of competition. That is the worse result for consumers.

Now, the two of us can engage in a debate. You can bring lots of lawyers in front of you debating about how bad the exemption is. But Herb Hovenkamp, Professor Herb Hovenkamp, who is sort of the Tom Brady of antitrust, when the Supreme Court makes a decision on antitrust, they open his treatise first. He says that this distracts a significant toll on competition and on consumers. And, in fact, in the worst ways possible.

Sure, there are exceptions to the Act that the court has tried to form by—in sort of a Swiss-cheese approach, but when you look at a variety of egregious practices, those are permitted by the Act.

Now, what—the proponents of the legislation want you to ask the wrong question. They want you to ask, is there any harm from the exemption? That is not the right question. The right question, according to the Antitrust Modernization Commission, is there an essential benefit that is necessary from this legislation?

Now, they pose three myths, the proponents to the legislation: The first is sort of like, there is only a small pothole. There is a little bit of problem here, but it is, you know, not that big a deal. Well, according to Herb Hovenkamp, it is. And in any case, why do we want to permit potholes in any case? Why do we want to create—give the health insurance industry a get-out-of-jail card? Of

all the industries to give a get-out-of-jail card, the health insurance industry is probably the last one.

Second, they sort of say that there aren't costs imposed, but there are costs imposed. I'll just give the issue of, currently, Blue Cross has agreements that prevent Blue Cross subsidiaries from being able to effectively invade each other's territory. So CareFirst in northern Virginia can't makes its way down to Richmond, and the Blue Cross of Virginia can't make its way up into northern Virginia. That loss of competition costs consumers in higher premiums, and it costs healthcare providers, too.

Third, they say State regulation is enough, but careful studies of State regulation that we cite in our report demonstrate that the vast majority of States do no consumer protection enforcement action. There is zero consumer protection enforcement actions in over 33 States. 80 percent of the actions are done by five States. We went back and searched the websites of all of the insurance commissioners and the NAD. Mr. Miller cites a 2009 case. Great. That was, you know, 8 years ago. There haven't been any cases brought since then. So State regulation isn't enough. There is real harm, and it is no small pothole.

This Committee should go further in its oversight. So illuminating the exemption, the exemption only causes harm. There is no benefit that it causes whatsoever. This Committee should continue, in its oversight function, to make sure that antitrust enforcement continues to be strong in the health insurance industry. That, and smart regulation, work hand-in-glove together to make sure that these markets begin to start to work effectively.

Just to give an example, the Justice Department's challenge of the Aetna-Humana merger, would result in savings of over $500 million a year to American taxpayers and to American consumers, particularly over a million Medicare beneficiaries who would be vulnerable to anticompetitive conduct. This exemption has outlived its usefulness and should be abolished.

[The prepared statement of Mr. Balto follows:]

Statement of David Balto

Before House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law, Hearing on

H.R. 372, the "Competitive Health Insurance Reform Act of 2017"

February 16, 2017

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Chairman Marino, Vice Chairman Farenthold and Ranking Member Cicilline and other members of the committee, I appreciate the opportunity to come before you today and testify about the McCarran-Ferguson Act. I have observed and analyzed health care competition as a government enforcer for over 15 years, as the Policy Director of the Federal Trade Commission, as a consumer advocate, and as counselor to healthcare providers, employers, and unions.[1] Where competition thrives, consumers benefit from numerous choices, low prices, superior service, and innovation. But where competition is absent, consumer pay more for less, have fewer choices, and are at the mercy of market participants with unbridled power. Bringing competition to health insurance markets is essential to achieving meaningful health care reform.

Lack of health insurance competition has led to supra-competitive profits, an epidemic of deceptive and fraudulent conduct, and escalating costs. As the Justice Department demonstrated in successfully challenging the Aetna-Humana and Anthem-Cigna mergers, concentration in health insurance markets is incredible. Today, there are only five national competitors -- UnitedHealth, Anthem, Cigna, Aetna and Humana. Local competition is often worse. For example, a recent Commonwealth Fund analysis found that 97 percent of Medicare Advantage plan markets in U.S. counties are highly concentrated.[2] According to the Kaiser Family Foundation, on average, a state's largest insurer has over a 55 percent market share, and only four insurers within a state have at least a five percent market share.[3] This is true whether you look at individual, small group, or large group markets. Alabama is by far the worst, with Blue Cross Blue Shield of Alabama controlling between 90 and 97 percent of consumers in each of these markets.[4]

Yet the health insurance industry is one of two markets (the other is baseball) that is exempt from federal antitrust laws. The McCarran-Ferguson Act, passed in 1945, effectively grants all insurers an exemption from federal antitrust or consumer protection enforcement. Many legislators, antitrust practitioners and scholars have called for its repeal over years.

H.R. 372, Competitive Health Insurance Reform Act of 2017, will amend the McCarran-Ferguson Act ("MFA") to provide that certain anticompetitive conduct by health insurers and medical malpractice insurers is not immune under the antitrust laws. The bill is a good first step to reforming health insurance markets. The ability for continued health care reform to succeed depends upon all aspects of health care markets to function effectively.

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[1] I am former policy director of the Federal Trade Commission and was actively involved in several health care matters and the revisions of the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care. In my practice I typically represent unions, employers, consumers, and providers in health care competition advocacy. A partial list of my advocacy is in Appendix A. Of greatest relevance I formed and run the Coalition to Protect Patient Choice, an advocacy group for consumers on health care competition and led the consumer opposition to the Aetna-Humana and Anthem-Cigna health insurance mergers. See www.thecppc.com.

[2] Brian Biles, Giselle Casillas, and Stuart Guterman, "Competition Among Medicare's Private Health Plans: Does It Really Exist?" (New York: The Commonwealth Fund, 2015), *available at* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf.

[3] Health Insurance & Managed Care Indicators: Insurance Market Competitiveness, http://kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/.

[4] *Id.*

The question before you today is whether a general antitrust exemption for the health insurance industry is necessary. The answer is simple and clear - absolutely not - and makes the following points:

- **Congress should abolish the McCarran Ferguson Act antitrust exemption. It is an anachronism that is severely out of date with contemporary antitrust law and weakens competition in health insurance markets in which the forces of competition do not function well.**

- **Antitrust exemptions are rarely used and only in very limited conditions. That is sound policy because antitrust exemptions replace the discipline of the market with private regulation.**

- **According to the bipartisan Antitrust Modernization Commission antitrust exemptions can only be justified if there is a clear case that the conduct in question would subject the actors to antitrust liability and no less restrictive way to solve the problem. The MFA exemption cannot meet these standards since antitrust law has evolved to permit the type of conduct (information sharing) that was threatened by the then-state of the law.**

- **The health insurance market is probably the worst type of market to have an antitrust exemption. It is highly concentrated, transactions are complex and opaque, and entry barriers are high. In other words, it is a fertile environment for anticompetitive conduct. That is the worst environment in which to deter the discipline of the antitrust laws and the marketplace.**

- **It would be a mistake to assume the exemption does not impose costs to competition to consumers. Exemptions invariably harm consumers by removing the discipline of the market. The law is uncertain and dominant insurers can use it to justify anticompetitive conduct such as market divisions that lead to higher prices for consumers. Moreover, it is difficult to assess the cost of an exemption since it creates an obstacle to complete antitrust scrutiny.**

- **MFA effectively defers consumer protection enforcement in the health insurance industry to the states. Yet health insurance consumer protection is sporadic at best with less than a handful of states bringing almost all the enforcement actions. This means that the Federal Trade Commission, the federal agency tasked with consumer protection, is not able to provide a high standard of uniform protection in all states. Instead, state insurance commissioners are charged with a wide variety of tasks and do not necessarily have the capacity to fully address the problems that their states' residents are experiencing.**

- **Eliminating the MFA exemption is only a first step in beginning to protect competition and reverse the competitive problems in the health insurance**

marketplace. We need a combination of strong antitrust enforcement and sound regulation to protect and foster competition in these competitively fragile markets. Fortunately, there is much stronger health insurance antitrust enforcement -- that must be continued. The DOJ's successful litigation against the proposed Aetna/Humana merger has been estimated to save consumers and taxpayers $500 million per year. And there are key reforms to the health insurance market in the ACA that Congress should consider retaining in any reform of the Act. Those include the health insurance exchanges, level playing field between insurers and consumers (consumer protections such as banning discrimination on pre-existing conditions and standardizing products), rating rules and review, and medical loss ratio regulation.

I. The McCarran-Ferguson Act is No Longer Necessary; Modern Antitrust Law Recognizes the Procompetitive Activities MFA Was Meant to Protect

There are very few exemptions to the antitrust laws and for good reasons. Antitrust exemptions remove the force of the marketplace and permit firms to replace the discipline of the market with their own decisions. In effect, private regulation replaces competition. In 2007, the bipartisan Antitrust Modernization Commission (AMC) stated that "statutory immunity from the antitrust laws should be disfavored."[5] According to the Antitrust Modernization Commission, free-market competition is the foundation of our economy, and antitrust laws stand as a "bulwark to protect free-market competition."[6] This is the reason why congress has passed exemptions in very few circumstances, and no general exemption – like MFA – since its enactment.

The AMC was "skeptical about the value and basis for many, if not most or all, of these immunities. Many are vestiges of earlier antitrust enforcement policies that were deemed to be insufficiently sensitive to the benefits of certain types of conduct. Others are fairly characterized as special interest legislation that sacrifices general consumer welfare for the benefit of a few."[7]

The AMC set a stiff burden to justify an antitrust exemption:

> Statutory immunities from the antitrust laws should be disfavored. They should be granted rarely, and only where, and for so long as, a clear case has been made that the conduct in question would subject the actors to antitrust liability and is necessary to satisfy a specific societal goal that trumps the benefit of a free market to consumers and the U.S. economy in general.[8]

MFA fails in both of these respects. Indeed, MFA serves the same function as bad regulation in that it shields insurance companies from healthy competition.

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[5] Report and Recommendations, Antitrust Modernization Commission (Apr. 2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.
[6] *Id.*
[7] *Id.*
[8] *Id.*

First, a few words of background. MFA was passed at a time when a large amount of cooperative conduct was declared per se illegal and it was difficult for small firms to collaborate. A Supreme Court decision in *U.S. v. South-Eastern Underwriters Ass'n*, 32 U.S. 533 (1944) effectively prevented information sharing that insurers relied on to engage in rate setting. It was feared at that time that overzealous enforcement would prevent many procompetitive activities that were seen as necessary in the industry. For example, data collection and dissemination, standard setting, and other collaboration that were considered necessary to keep down costs. Congress originally crafted MFA as a temporary moratorium to protect these procompetitive behaviors.[9] It wasn't until the bill reached the joint conference committee that the bill changed from a temporary moratorium to a permanent exemption.[10]

Since MFA was passed, antitrust law has substantially changed to recognize the need for collaboration, especially the type that the MFA was passed to protect. The conduct challenged in Southeast Underwriters would most likely be legal under the current interpretation of the antitrust laws. Horizontal agreements among competitors that may serve procompetitive goals are not automatically condemned. For example, the Supreme Court in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) refused to condemn as *per se* illegal a technical horizontal price fixing agreement, because it created a beneficial new product for the market. Since *Broadcast Music*, the Supreme Court has taken a more nuanced view of the behaviors that Congress wanted to protect with MFA, and activities like information sharing are now understood by courts to be potentially procompetitive and judged under the rule of reason.[11]

Indeed, the well-respected antitrust scholar Herbert Hovenkamp has advocated for repeal of MFA because most of the practices Congress originally intended to grant immunity are no longer violations of the antitrust laws and "to the extent that the insurer's practices are actively supervised by state regulators pursuant to a state policy to substitute regulation for market competition, the insurer would enjoy a 'state action' immunity under the Parker doctrine."[12] This second point is important, because "the presence of even minimal state regulation, even on an issue unrelated to the antitrust suit, is generally sufficient to preserve the immunity."[13]

Our modern antitrust laws have been struggling under the antiquated MFA. Courts have repeatedly been faced with cases of anticompetitive behaviors of the kind that Congress clearly did not intend to protect. When faced with these behaviors, these courts often go through mental gymnastics in their attempts to narrow MFA in order to protect consumer welfare. This has left a law that, unnecessary on its best day, now looks like swiss cheese. It does not take a legal scholar to understand that unclear laws are bad for the

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[9] Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 Wm. & Mary L. Rev. 81, 87-88 (1983), http://scholarship.law.wm.edu/wmlr/vol25/iss1/3.

[10] *Id.*

[11] *See* ABA Section of Antitrust Law § B.3.a., Antitrust Law Developments (7th ed. 2012).

[12] Hovenkamp, Herbert J., The Insurance Industry's Antitrust Immunity (January 23, 2010). U Iowa Legal Studies Research Paper No. 10-03. Available at SSRN: https://ssrn.com/abstract=1489594 or http://dx.doi.org/10.2139/ssrn.1489594.

[13] 1A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219c, at 25 (3d ed. 2006).

marketplace. The MFA that stands today is the worst kind of law - one that does nothing but bring uncertainty and confusion to the market while preventing vigorous competition by deterring enforcement.

The AMC tells us that in determining whether to adopt or keep an exemption Congress should consider "whether the conduct to which the immunity applies, or would apply, could subject actors to antitrust liability." I have practiced antitrust law for over 30 years, including at the highest level of government. I have no doubt that any of the conduct the defenders of the exemption would seek to engage in – such as historical information sharing - would be clearly permissible under current antitrust law. Antitrust scholars agree.[14] Indeed, the DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care make it clear that sharing of historical cost and price information is typically precompetitive, so long as appropriate safeguards are adopted.[15]

The MFA cannot meet the standards set by the Antitrust Modernization Commission and should be abolished.

II. MFA Shields the Wrong Kind of Behavior, Leading to Anticompetitive Conduct and Inadequate Enforcement Thereof

Professor Herbert Hovenkamp has called MFA's application "perverse." MFA insulates horizontal agreements such as price fixing and forms development, where the potential for abuse is high, while discouraging potentially positive vertical agreements such as health insurance/provider agreements, where the threat to competition is low.[16] As former Assistant Attorney General for Antitrust Christine Varney noted, "The most egregious anticompetitive claims, such as naked agreements fixing price or reducing coverage, are virtually always found immune from antitrust prosecution."[17] Thus the DOJ testified that MFA was "very expansive" and recommended its repeal.[18]

Horizontal conduct – agreements among competitors – is a core concern of the antitrust laws. Yet the MFA often immunizes this type of conduct.[19] For example, the Eleventh Circuit found that MFA exempts an alleged agreement among auto insurers to "lower the quality and cost of repairs by specifying the use of non-OEM parts and not passing along the savings to their

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[14] Hovenkamp, *supra* note 12.

[15] U.S. Dep't of Justice & Fed. Trade Comm'n, Statements of Antitrust Policy in Health Care (1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf (For example, Statement 5 states that the provision of factual information about fees charged and amounts, levels, or methods of fees or reimbursements does not necessarily raise antitrust concerns. Statement 6 states that participation in exchanges of price and cost information does not necessarily raise concerns and often has significant benefits to consumers).

[16] Hovenkamp, *supra* note 12.

[17] Statement of Christine A. Varney, Assistant Attorney General of the Antitrust Division of the U.S. Department of Justice at 3, Hearing on Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry (October 14, 2009), https://www.justice.gov/archive/atr/public/testimony/250917.pdf (citing *Id.)*.

[18] *Id.*

[19] Hovenkamp states an "agreement among insurers on the policy price, terms, and conditions is exempt." Hovenkamp, *supra* note 12. This has led to several bad results where harmful activity was found to be exempt.

policyholders through reduced premiums"[20] Additionally, both the Eighth and Eleventh Circuits have found alleged price fixing agreements to set rates of insurance are exempt under MFA.[21]

Moreover, as Hovenkamp has observed, the exemption is often applied too broadly: "The presence of even minimal state regulation, even on an issue unrelated to the antitrust suit, is generally sufficient to preserve the immunity."

Worse, antitrust enforcement may be discouraged even where MFA does not apply. Although MFA has been narrowed, the court-created standard of when MFA immunity is triggered can be hard to apply. This confusion deters enforcers and private plaintiffs from bringing expensive antitrust actions, because there is vast uncertainty about whether they can survive a motion to dismiss based on MFA immunity. For example, the Blue Cross Blue Shield Association ("BCBSA") has often been accused of horizontally allocating markets - something almost always illegal under the antitrust laws - but it was not until just a few years ago that providers and customers actually brought suit. An MFA defense was rejected by the district court, but it was still the first hurdle plaintiffs had to clear before they could proceed.[22] Indeed, scholarship by American Antitrust Institute senior fellow Randy Stutz posited that the availability of MFA immunity was potentially a factor leading to this type of agreement.[23]

Proponents of the exemption may suggest that in many cases, the courts reject the exemption and therefore it does not harm competition. An unnecessary defense, even though it is rejected by the courts, is still harmful. In effect, even where it is rejected, it creates a pothole in the road to effective antitrust enforcement. Antitrust enforcers and private plaintiffs must still attempt to defeat the defense which will also create litigation uncertainty. Ultimately the existence of the defense increases the costs and uncertainty of litigation and thus effectively protects anticompetitive conduct. MFA is like the bad regulations President Trump ran against - serving no purpose other than to increase costs, decrease competition, and create confusion.

III. The Health Insurance Market is Competitively Fragile and is the Last Type of Market That Should Receive an Antitrust Exemption

There are three necessary components of a functioning market: choice, transparency, and a lack of conflicts of interest.[24] Consumers need meaningful alternatives to force competitors to

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[20] *Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004).

[21] *Workers Compensation Insurance*, 867 F.2d 1552 (8th Cir.) cert. denied, 492 U.S. 920 (1989) (finding an alleged price fixing agreement to set the rates of workers' compensation insurance to be exempt); *Uniforce Temporary Personnel, Inc. v. National. Council on Compensation, Inc.*, 892 F. Supp. 1503 (S.D. Fla. 1995), aff'd, 87 F.3d 1296 (11th Cir. 1996) (alleged conspiracy among insurers and rate-making organization to make temporary employee services pay higher workers' compensation rates was exempt business of insurance).

[22] In Re: Blue Cross Blue Shield Antitrust Litigation (MDL No.: 2406), No. 13-20000, Doc. 204 (N.D. Ala. filed June 18, 2014). I am one of the counsels in the provider case.

[23] Stutz, Randy, Market Allocation in the Health Insurance Industry and the McCarran-Ferguson Act (March 8, 2011). Oregon Law Review, Vol. 89, No. 3, 2011. Available at SSRN: https://ssrn.com/abstract=2202470 or http://dx.doi.org/10.2139/ssrn.2202470.

[24] Testimony of David A. Balto, "The Effects of Regulatory Neglect on Health Care Consumers" before the Senate

vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. Only where these three elements are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Any reasonable assessment would conclude that adequate choice and transparency are clearly lacking from today's health insurance markets. Study after study has found that health insurance markets are overly consolidated: A 2016 AMA study found over 70 percent of 388 metropolitan areas, representing all 50 states and the District of Columbia, were "highly concentrated." In 91 percent of markets, one insurer had a commercial share of 30 percent or greater and in 40 percent of the markets one insurer had a share of at least 50 percent.[25] According to the Kaiser Family Foundation, on average, a state's largest insurer has over a 55 percent market share, and only four insurers within a state have at least a five percent market share.[26] A recent Commonwealth Fund analysis found that 97 percent of Medicare Advantage plan markets in U.S. counties are highly concentrated.[27] Concentration has led to substantial premium rate increases, lower premiums paid to providers, and resulting consumer harm from reductions in service and quality of care.

Industry advocates claim that many markets have several competitors. But the reality is these small players are not a competitive constraint on the dominant firms, but simply follow the lead of the price increases of the larger firms. This was clearly demonstrated in the litigation challenging the Anthem-Cigna and Aetna-Humana mergers.

Health insurance is a market that is generally plagued by competition problems, lax antitrust, and insufficient consumer protection enforcement that have led to a poorly functioning health insurance market. Few markets are as concentrated, opaque, contain such high barriers to entry, and are as conducive to deceptive and anticompetitive conduct. Congress has recognized over and over that these markets lack sufficient competition and transparency necessary for a competitive market. As a result, the health insurance market is the worst type of market to have an antitrust exemption.

Uncertain antitrust standards, and the potential to exempt illegal conduct can only worsen competition in the market, drives up costs for consumers, reduces choice, creates barriers to entry, and harms health care providers. That is the worst environment in which

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Committee on Commerce, Science and Transportation, Subcommittee on Consumer Protection, Product Safety and Insurance on Competition in the Health Care Marketplace (July 16, 2009).

[25] Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2016 update, American Medical Association, https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2780009&navAction=push#usage-tab.

[26] Health Insurance & Managed Care Indicators: Insurance Market Competitiveness, http://kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/.

[27] Brian Biles, Giselle Casillas, and Stuart Guterman, "Competition Among Medicare's Private Health Plans: Does It Really Exist?" (New York: The Commonwealth Fund, 2015), *available at* http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf.

to eliminate the discipline of antitrust laws and the market place.

IV. MFA May Prevent Sound Consumer Protection Enforcement by the Federal Trade Commission

The McCarran-Ferguson Act makes the FTC's jurisdiction over health insurers unclear, at least with respect to consumer protection violations. This is especially important when health insurers overcharge or otherwise abuse consumers, as most state laws individuals have no private right of action under the insurance rating law or unfair insurance trade practices act. And state insurance commissioners have very limited resources to investigate consumer protection violations.

Confirming that the FTC has jurisdiction where only state insurance commissioners are now involved would benefit consumers enormously. Amending the MFA, which would make it clear that the FTC can take action against unfair or deceptive trade practices in the health insurance industry and provide strong consumer protection on the federal level is needed.

V. State Enforcement is Insufficient to Substitute for Effective Federal and Private Enforcement

Congress may have envisioned upon enacting MFA that states would be fully capable of protecting consumers from competitive harm and providing adequate consumer protection. Indeed, all states have insurance commissioners and there is also a National Association of Insurance Commissioners. But there are many reasons a system of state enforcement alone may be inadequate to effectively protect consumers from anticompetitive or deceptive practices. First, insurance commission offices have extremely limited resources. A study by the Center for American Progress found that the vast majority of enforcement actions against health insurers for consumer protection violations were taken by only five states.[28] Thirty-three states brought zero consumer protection actions. Other than that handful of states, there is sporadic enforcement action at best.

The situation on the antitrust side is no better. As this Committee knows well, antitrust cases are extremely complex, costly, and time-consuming. In the recent Anthem-Cigna and Aetna-Humana mergers, very few state insurance commissioners engaged in a careful hearings process to evaluate the merger. Less than a handful of states issued decisions evaluating the antitrust issues in the mergers. Some states, such as Florida, approved the Aetna merger, despite the DOJ and the district court finding substantial competitive problems in that state.

Moreover, according to the state insurance commission and the National Association of Attorneys General websites, there have not been any health insurance antitrust enforcement actions brought solely by state insurance commissioners or state AGs without taking the lead

[28] David Balto and Stephanie Gross, *Don't Leave It to the States*, Center for American Progress (Oct. 22, 2009), https://www.americanprogress.org/issues/healthcare/news/2009/10/22/6800/dont-leave-it-to-the-states/.

from federal enforcers in quite some time.[29]

State antitrust and consumer protection enforcement are insufficient to make up for the impediments for enforcement caused by the MFA. Indeed, the State of New York has supported repeal of MFA in the past, arguing that "[t]he exemption has interfered with the ability of public and private enforcers to readily use the full panoply of federal antitrust remedies to correct, deter and obtain compensation for abuses in the insurance sector."[30]

VI. The "Costs" of the Exemption Compel Repeal

Proponents of the exemption suggest that the sponsors of the legislation must demonstrate there are substantial costs being imposed by the exemptions. They are asking the wrong question. According to the Antitrust Modernization Commission, it is the ***proponents*** of an exemption who must demonstrate that there is market failure and that the exemption is necessary to achieve some overarching procompetitive goals. Furthermore, proponents should have to show that there is no less restrictive alternative method of achieving these procompetitive goals.[31] Since none of the conduct that the exemption proponents seek to engage in faces antitrust risk, they cannot meet that standard.

Moreover, by suggesting that the sponsors of the legislation must demonstrate the cost of the exemption, the proponents set an impossible standard. Because an antitrust exemption dampens enforcement and antitrust scrutiny, and weakens consumer protection, one typically will not know what the costs of the exemption are. Industries that are exempt are not subject to appropriate scrutiny and therefore one cannot know the cost of lost competition.

As former FTC Policy Director and Heritage Foundation Senior Fellow, Alden Abbott has explained it is often impossible to demonstrate the "but for" world – the costs of an antitrust exemption. In his testimony to the Antitrust Modernization Commission he said "[i]n attempting to assess the magnitude of harm caused by antitrust exemptions, we cannot directly examine the 'but for' world that would exist in the absence of such exemptions. Nevertheless, it is instructive to look at the positive welfare effects of deregulation in certain industries, because antitrust exemptions are like economic regulation in the sense that they, too, produce a more constrained form of competition. For example, the positive welfare effects of transportation deregulation (trucking, airlines), well documented by economists, may be a sort of 'natural experiment' that highlights the benefits that flow from introducing more vigorous competition when it previously existed in a much more constrained form."[32] A Cato Institute policy brief explains that

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[29] A search of the NAAG Antitrust Committee website, as well as state insurance commission websites did not return any results for recent enforcement actions not involving federal enforcers.

[30] Comments of the Office of the Attorney General of New York State In Response to the Request for Public Comments on Immunities and Exemptions, http://govinfo.library.unt.edu/amc/public_studies_fr28902/immunities_exemptions_pdf/Office_of_NY_AG_revd.pdf.

[31] Report and Recommendations, *supra* note 5 at 354.

[32] Alden F. Abbott, Prepared Statement Before the Antitrust Modernization Commission (Dec. 1, 2005), https://www.ftc.gov/sites/default/files/documents/public_statements/ftc-staff-testimony-antitrust-modernization-

deregulation of airlines led to more competitors, lower prices, and higher percentage of seats filled.[33]

Abbott further observed "[m]any exemptions (albeit in different ways, depending upon the statute) allow firms to agree to limit the terms of competition among themselves and impose restrictions on entry into the affected sector. To put it more bluntly, such exemptions foster legal cartels. From an antitrust perspective, such agreements – 'horizontal restraints' – generally present the greatest risk of competitive harm. Unless the restraint is reasonably necessary to the generation of countervailing efficiencies, consumers."

Recognizing the problematic results of certain antitrust exemptions, Congress has eliminated antitrust exemptions in the past, even where there was not clear evidence of competitive harm.[34] We do know from some examples that where antitrust immunities or exemptions were eliminated, there were substantial consumer savings.

Even in the limited facts before us, there can be some compelling evidence that MFA leads to continuing ongoing harm. For example, Blue Cross has a national licensing scheme that prevents Blue Cross plans from competing with each other. For example, subscribers in Ranking Member Cicilline's district who wish to choose between "Blue plans" only have the alternative of BC of Rhode Island -- BC of Massachusetts or Connecticut dare not invade Rhode Island and risk running afoul of association rules. Or in Chairman Goodlatte's district, consumers' only Blue plan option is Blue Cross of Virginia. The BC subsidiary in Northern Virginia, Carefirst, cannot invade Richmond or vice versa. The harm caused by geographically segmenting the market could be hundreds of millions of dollars, since that type of competition can significantly lower premiums for consumers (or improve reimbursement for providers).

In private litigation, a district court has held that MFA does not immunize the conduct, however, Blue Cross is still able to use MFA as a defense in appealing the decision. We do not know what the appellate court will decide, but it's safe to say that MFA continues to be an arrow in Blue Cross's quiver which emboldens them to fight this battle. Antitrust exemptions encourage firms to "play it close to the legal line." Therefore, there may be attendant harm even if the conduct has not blossomed into a full-blown antitrust violation.

Additionally, under previous MFA rulings it appears that insurance companies could agree to fix prices, or worse – they could agree to lower the quality of care a patient receives in order to save on costs.[35] These types of activities would be disastrous for consumers and yet

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commission-concerning-statutory-immunities-and/051202statutory.pdf.

[33] Thomas Gale Moore, Cato Institute Policy Analysis: Deregulation and Re-Regulation of Transportation, Cato Institute (Jul. 8, 1982), https://www.cato.org/publications/policy-analysis/deregulation-reregulation-transportation.

[34] See, e.g., Congressional reform to antitrust immunity enjoyed by the rail transportation industry: Railroad Revitalization and Regulatory Reform Act, Pub. L. No. 94-210, 90 Stat. 31 (1976); Staggers Rail Act, Pub. L. No. 96-448, 94 Stat. 1895 (1980); Interstate Commerce Commission Termination Act, Pub. L. No. 104-88, 109 Stat. 803 (1995).

[35] *See Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004); *Workers Compensation Insurance*, 867 F.2d 1552 (8th Cir.) cert. denied, 492 U.S. 920 (1989) (finding an alleged price fixing agreement to set the rates of workers' compensation insurance to be exempt); *Uniforce Temporary Personnel, Inc. v. National.*

would likely go unpunished.

VII. Eliminating MFA is Not Strong Enough Alone to "Fix" Health Insurance Markets

While repeal of the McCarran-Ferguson Act is an important part of fostering real competition in the health insurance marketplace, it cannot do this work alone. The important lesson of the past decade of scrutiny of health insurance markets is that neither antitrust enforcement nor regulation alone can solve the chronic problems in health insurance markets. Rather, the market needs continued vigorous antitrust enforcement combined with smart regulations to protect consumers from the exercise of market power and attempt to overcome the chronic weaknesses in health insurance markets. In these efforts, I would urge this Congress to keep some important provisions of the Affordable Care Act that protect consumers and make health insurance markets more responsive to consumer demand. These provisions will fit hand in glove with a repeal of McCarran-Ferguson to restore health insurance markets through healthy competition. In addition, the Trump administration must continue Obama Administration's record of strong antitrust enforcement.

The importance of an overall policy to promote competition cannot be understated, as seen in the past month when two judges rejected the mega-health insurance mergers of Anthem-Cigna and Aetna-Humana, citing competitive concerns. In a climate where market power is present and only a handful of large companies dominate, these mergers would have reduced the number of major insurers from 5 to 3. For several weeks in two separate courtrooms, the public heard first hand how concentration and these mergers lead to higher premiums, less innovation and less service.

In that same vein, it must be recognized that the ACA includes essential and hard won provisions that worth preserving to promote and facilitate competition. Obviously the ACA is controversial and will receive careful scrutiny in this Congress. But let's note the successes.

The Affordable Care Act was successful in its goal of providing Americans greater access to health insurance. Over 20 million Americans have health insurance today because of the ACA and the the uninsured population has been reduced to 28.5 million.[36] 52 million cannot be denied coverage due to a pre-existing condition. People with complex or chronic conditions no longer live in fear of hitting a lifetime cap on what their health plan will pay. Women are no longer forced to pay more than men for coverage. We have also successfully bent the cost curve. The Congressional Budget Office recently adjusted its projected spending on Medicare over the next 10 years by $2 trillion over what it had projected for the same time period in 2009.[37] U.S.

Council on Compensation, Inc., 892 F. Supp. 1503 (S.D. Fla. 1995), aff'd, 87 F.3d 1296 (11th Cir. 1996) (alleged conspiracy among insurers and rate-making organization to make temporary employee services pay higher workers' compensation rates was exempt business of insurance).

[36] Key Facts about the Uninsured Population, Kaiser Family Foundation (Sep. 29, 2016), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[37] Harry Stein and Laura Pontari, The Medicare Cost Curve Bent During the Obama Administration, Center for American Progress (Aug. 9, 2016).

healthcare spending projections "are $2.6 trillion lower than the original post-ACA baseline forecast through 2020 — a reduction in projected spending of almost 13%."[38] Income and wealth inequality, a topic that has appeared in numerous policy debates since the Great Recession, is exacerbated by differences in access to a much lesser degree as a direct result of the ACA.

Review of the ACA is essential. In many counties, too few insurers compete. Many counties have only a single insurer. Navigating choices between highly complex products remains difficult for consumers, leading to less robust benefits of competition. Perhaps most importantly, premiums are increasing rapidly and are still unaffordable for many Americans and high deductibles leave people underinsured and vulnerable to sudden, large expenses.

Reforms should build on existing successes to improve competition, consumer choice, transparency, and value. Amending the McCarran-Ferguson Act to eliminate the health insurance antitrust exemption is an important step toward this goal, but its scope is limited. In order to improve healthcare markets and make coverage more affordable, Congress must recognize the critical, common-sense provisions of the Affordable Care Act and how they improve competition and preserve or strengthen many of those provisions.

Several ACA provisions do not regulate prices but rather encourage "(1) Competitive bargaining between payers and providers and (2) Rivalry within each sector to drive price and quality to levels that best serve the public." It is important to keep these provisions because they create a level playing field on which plans can compete and a "floor" that consumers can depend on as a minimum level of protection. Free market advocates and consumer advocates alike know that a level playing field is necessary for markets to function in the best interests of consumers. Industries should be able to adapt to a reasonable regulatory framework, as long as competitors are held to equal standards.

The provisions in the ACA that help protect consumers and level the playing field are reduced variation, rate review, a ban on discriminatory plan designs, and MLR (medical loss ratio).

a. ACA Provisions are Necessary to Make Health Insurance Markets Work and Protect Consumers

For consumers to exercise their power in the health insurance marketplace, regulators need to level the playing field vis-a-vis health plans. It is challenging for consumers to assess and understand health insurance products and and excessive product variation and too many choices can make consumers worse off, not better. The ACA introduced several provisions to address these concerns.

A manageable number of "good" choices better than many choices. Consumers Union

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https://www.americanprogress.org/issues/healthcare/news/2016/08/09/142386/the-medicare-cost-curve-bent-during-the-obama-administration/.

[38] Michael Hiltzik, Obamacare update: Still succeeding, repeal fading, Los Angeles Times (June 21, 2016 9:36 AM), http://www.latimes.com/business/hiltzik/la-fi-hiltzik-obamacare-succeeding-20160621-snap-story.html.

published a report showing that more choice is not better when it comes to shopping for health insurance. The best thing for the market is to allow shoppers to choose from a manageable number of products that meet a minimum quality standard.

Standardizing the scope of covered benefits to a comprehensive level helps reduce the number of plan attributes that can vary and gives consumers the peace of mind that they will not find surprise coverage gaps in their plan. Removal of annual and lifetime limits also reduces the plan attributes that can vary and helps spread the expenses of the sickest consumers across a broad pool.

Actuarial value tiers, known as "bronze, silver, gold, and platinum" plans,[39] correspond to the percentage of expenses the health plan will pay, and are easily understood by consumers as representing understandable levels of plan generosity. Consumer testing in Massachusetts and California suggest that standardizing cost-sharing into a limited number of consumer friendly designs would provide even more help to shoppers.

i. Rating Rules and Review help prevent anticompetitive conduct

Consumers want premiums to be fair. The rating rules and efforts to strengthen state review processes established by the ACA is a major source of consumer protection. It bans medical underwriting, a practice that made it difficult for consumers to get coverage and huge costs into the premium before the ACA was passed. Today, instead of buying individually underwritten plans, individuals consumers enter a risk pool which "guarantees issue and renewability and allows rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange."[40] The ACA grants more resources to the states to enforce a federal "floor" of protections through rate review and banning discriminatory plan designs. As of April 2016, forty-six states have effective rate review programs in both the individual and small group markets. In the four states which do not (AL, MO, TX, WY), federal rate review will be conducted until the state can provide effective rate review.[41] According to CMS, "Improved rate review has reduced total premiums in the individual and small group markets by approximately $1 billion in 2013 and $1.2 billion in 2012."[42]

ii. Medical Loss Ratio deters the exercise of market power

In a highly concentrated market firms can exercise market power. To address this issue the ACA established Medical Loss Ratio standards (MLR) to ensure that a certain amount of health care premiums result in direct benefits to consumers (and not administrative costs or

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[39] What the Actuarial Values in the Affordable Care Act Mean, Kaiser Family Foundation (Apr. 2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf.

[40] Summary of the Affordable Care Act, Kaiser Family Foundation, http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act.

[41] State Effective Rate Review Programs, CMS, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/rate_review_fact_sheet.html.

[42] *Id.*

profits). MLR regulations "require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets."[43] Health insurance companies were required to pay $469 million in rebates to about 5.5 million people in 2014;[44] the total over four years was more than $2.4 billion. This is a consumer protection that does not work on its own, however. In the absence of competition or regulation, insurers will simply expand the "pie" (enrollee premiums) and take their bigger - yet still compliant - slice.[45]

iii. The ACA strengthens State Protections

Critics of the ACA argue that states are adequate, if not better, at regulating insurance and protecting consumers than the Federal government. While it is true that states are closer to the front lines, they are also almost certainly under-resourced. Evidence shows a general inability to resolve issues faced in this industry on the state level.

Hence, the ACA protected consumers with a federally mandated "floor" of protections, as described above, but States can guarantee more protections to consumers if they so choose. The ACA also provided for flexibility via waivers, as long as consumers were not worse off nor the federal deficit increased. Finally, the ACA provided grants to help increase state capacity to meet the needs of their residents. For example, in all states, consumers can guarantee they will not be subjected to discriminatory plan design, such as structuring a plan so all HIV/AIDS patients pay out-of-pocket for all HIV/AIDS-related treatment.

iv. Exchanges provide an invaluable marketplace fostering competition

Exchanges provide an infrastructure and a forum for supply and demand to meet, where buyers are in a better position to demand value due to regulation and transparency. Indeed, the Exchanges are one of the most overtly "pro-competition" aspects of the Affordable Care Act, described by Congressman Johnson of Georgia as "explicitly designed to facilitate competition among insurers."[46]

Early studies show the structure of the exchanges encouraged new entry; HHS reported that 88% of enrollees lived in counties with at least three insurers in 2016, up from 70% in 2014.[47] Recent

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[43] Summary of the Affordable Care Act, *supra* note 40.

[44] Consumers Get Rebates, More Premium Value and Stability Protection in 2014, CMS, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014_Medical_Loss_Ratio_Report.pdf.

[45] Testimony of Leemore Dafny, Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?, Senate Committee on the Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights, http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf.

[46] *Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the H. Judiciary Comm.*, 114th Cong. 114-47 (2015).

[47] Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace, ASPE (Oct. 30, 2016), https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace.

exits by insurers from the exchanges are disappointing. However, a judge found that Aetna's exit in some territories appeared to be a strategic move to avoid antitrust scrutiny, rather than an outright rejection of the exchange model.[48] Further legislation and reform could help exchanges become more robustly competitive in the future, potentially using California as a model.

Active Purchaser exchanges, such as in California, have been particularly successful because they employ an overarching entity to oversee the "playing field," keeping it as level and fair to consumers as possible. A Brookings Institution study found that California had the "healthiest" Obamacare exchange, with its "uninsured rate [down] from 17.2 percent to 8.1 over four years… The report attributed that to several factors: Covered California's ability to 'somewhat aggressively' negotiate premiums with insurers; its insistence on consistent benefit offerings among all insurers; a large and stable number of insurers – 11 – offering plans; and a large network of 'navigators' (community groups and individuals who helped enrollees sign up)."[49] Rather than offering consumers plans as long as they comply with the ACA, California's exchanges represent a higher standard due to these proactive efforts by the state.

b. Vigorous Antitrust Enforcement is Essential to Making the Market Work

Repeal of MFA will do nothing without a tough antitrust cop on the beat. In 2009, when I was last here to discuss MFA, competition was in a sorry state. Regardless of any statutory antitrust exemption the DOJ had provided a de facto antitrust exemption. It brought no cases against anticompetitive conduct by health insurers. There were over 400 health insurance mergers and the DOJ did not challenge a single one. The abysmal enforcement record under the earlier Administration had greatly cost consumers. Permitted mergers, like the 2008 Nevada merger of Sierra Health and UnitedHealth, had a tremendous impact on prices. A study of small-group premiums in two Nevada markets found that premiums increased by 13.7 percent the year following the merger.[50] The result of this enforcement celibacy -- ten of the largest health insurers saw their profits balloon 428 percent, from $2.4 billion in 2000 to $13 billion in 2007.[51]

Today, we are in a far better position. The Obama antitrust authorities significantly revived health insurance antitrust enforcement. We now have the opportunity to build on the strong recent enforcement record of the DOJ, especially with the passage of H.R. 372.

Here are examples of some of the recent actions that have revived health insurance antitrust enforcement.

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[48] U.S. v. Aetna Inc., No. 16-1494 (D.D.C. filed Jan. 23, 2017).

[49] Claudia Buck, California gets high marks on running state's Obamacare exchange, The Sacramento Bee (Feb. 9, 2017), http://www.sacbee.com/news/local/article131852734.html.

[50] J. R. Guardado, D. W. Emmons, and C. K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra," Health Management, Policy and Innovation, June 2013 1(3):16–35.

[51] Mark Gendernalik, "Domestic Policy Subcommittee Oversight and Government Reform Committee," Statement before the Domestic Policy Subcommittee, House Committee on Oversight and Government Reform, September 16, 2009, available at http://groc.edgeboss.net/download/groc/domesticpolicy/prepared.testimony.of.mr.mark.gendernalik.pdf.

i. The DOJ and State of Michigan's Suit Against BCBS of MI Use of Most Favored Nations Clauses Sent a Clear Signal to the Market

In 2010, the DOJ, along with the state of Michigan, filed suit against BCBS of MI for its alleged anticompetitive use of most favored nations clauses ("MFNs") in its contracts with hospitals to disadvantage rivals. These MFNs required a hospital either to charge BCBS of MI no more than it charges BCBS of MI's competitors, or to charge the competitors a specified percentage more than it charges BCBSM, in some cases between 30 and 40 percent. The MFNs caused some hospitals to demand prices too high to allow competitors to compete, effectively barring them from the market. The DOJ's complaint also alleged that BCBS of MI agreed to raise the prices that it pays certain hospitals to obtain the MFNs, thus buying protection from competition by increasing its own costs.

The facts of this case caused the state legislature to sit up and take notice. Thanks to this case, the state of Michigan enacted legislation on March 18, 2013 that, among other reforms, prohibits health insurers, including BCBSM, from including or using MFNs in provider contracts. This was a substantial victory for consumers and competition that would not have been possible without strong enforcement from the DOJ.

ii. The DOJ's Recent Victories Blocking the Proposed Anthem/Cigna and Aetna/Humana Mergers Greatly Benefited Consumers

In July 2015, four of the largest health insurance companies in the market announced two mega-mergers -- Aetna's merger with Humana, and Anthem's acquisition of Cigna.[52] Aetna proposed the purchase of Humana for $37 billion. The merger would have resulted in a combined entity servicing 33 million beneficiaries. Anthem attempted to acquire Cigna for $54 billion, and a combined firm would serve 53 million members. Even more substantial, collectively Anthem and other Blue Cross or Blue Shield plans control 105 million lives. The addition of Cigna would have added 14.7 million more, representing a 14 percent increase in the lives controlled by Blue plans across the U.S.[53] The total would have been equivalent to roughly one-third of the U.S. population.

Five insurers dominate the U.S. market for health insurance (Aetna, Humana, Anthem, Cigna and UnitedHealth). The mega-mergers would have resulted in three national health insurers remaining in the market. Following approximately year-long investigations, in July 2016 the DOJ filed two suit to enjoin the two mergers. Then U.S. Attorney General Loretta Lynch

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[52] This committee held a hearing to discuss health insurance mega-mergers in September, 2015. Members and a diverse panel of experts contributed testimony and data about health insurance markets that has proven highly valuable as Congress considers health insurance market reforms. *Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the H. Judiciary Comm.*, 114th Cong. 114-47 (2015).

[53] Letter by the American Hospital Association to the Department of Justice commenting on the Anthem-Cigna merger (Feb. 29, 2016).

stated "These mergers would restrict competition for health insurance products sold in markets across the country and would give tremendous power over the nation's health insurance industry to just three large companies. Our actions seek to preserve competition that keep premiums down and drives insurers to collaborate with doctors and hospitals to provide better healthcare for all Americans."[54]

Aetna-Humana

On July 21, 2016 the DOJ, eight states and the District of Columbia sued to enjoin the Aetna-Humana merger.[55] The complaint alleged that the merger would greatly reduce Medicare Advantage competition in over 250 counties across 21 states, impacting over 1.5 million Medicare Advantage members. Additionally, the complaint alleged the deal would harm competition to sell commercial health insurance to individual and families on the public exchanges in Florida, Georgia and Missouri, hurting over 700,000 individuals.

Judge John Bates held a 14-day bench trial before deciding to enjoin the merger, during which he heard from approximately 30 witnesses from both sides. Much of the DOJ's focus was on the competition between the insurers for Medicare beneficiaries. The insurers attempted to argue that Medicare Advantage and Traditional Medicare are in the same market, meaning the market for Medicare services is vastly broader than a market specific to Medicare Advantage. However, Judge Bates did not by the insurers' market definition and ruled that the merger would substantially reduce competition for Medicare Advantage plans in 364 counties. He held that the evidence presented by the DOJ suggested significant head-to-head competition, which drives improvements to plan cost and quality, and that if the merger were consummated, that competition would be lost, resulting in deterioration in the Medicare Advantage products offered.

The trial was also tainted by Aetna's withdrawal from ACA individual market exchanges. Aetna withdrew from all 17 exchanges alleged to be problematic shortly after the DOJ's complaint was filed, including exchange where their presence was profitable. While suspected by DOJ that Aetna's withdraw was an attempt to thwart antitrust scrutiny, Judge Bates round that the withdraw was done solely to improve its litigation position. However, Judge Bates only identified three counties in Florida where Aetna was likely to compete after 2007. Nonetheless he ruled that the merger would substantially lessen competition in those three counties. As of February 14, Aetna and Humana have abandoned the attempted merger.

Anthem-Cigna

On July 21, 2016 the DOJ, eleven states and the District of Columbia sued to block Anthem's takeover of Cigna. The suit against Anthem and Cigna alleged that the merger would reduce competition for millions of consumers who receive coverage through their large-group employers in at least 45 metropolitan areas, and from public exchanges in St. Louis and

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[54] Press Release, Justice Department and State Attorneys General Sue to Block Anthem's Acquisition of Cigna, Aetna's Acquisition of Humana, DOJ (July 21, 2016). https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s.

[55] Complaint, U.S. v. Aetna, No. 16-1494 (D.D.C. filed July 21, 2016).

Delaware. It was also alleged that the acquisition of Cigna threatened competition among commercial insurers for the purchase of healthcare services from providers.

The merger trial was overseen by Judge Amy Berman Jackson, which lasted 20 days and saw 27 witnesses. Judge Jackson ultimately ruled in favor of the DOJ blocking the merger finding that the merger is likely to harm competition.[56] The DOJ argued against the merger from two-sides of the market – one that the merger will increase costs for consumers, and two that it will decrease reimbursement costs for providers in the markets at issue. Judge Jackson agreed and recognized that Anthem was asking the court for significant leeway and "go beyond what any court has done before: to bless this merger because customer may end up paying less to healthcare providers for the services that the providers deliver even though the same customers are also likely to end up paying more for what the defendants sell…" In her findings Judge Jackson wholly refuted the insurers' argument that efficiencies would be pro-consumer and a counter-weight to potential competitive problems.

Also telling in Judge Jackson's decision to block the merger was the highly abnormal relationship between two merging parties – Cigna seemingly actively worked against the merger. Judge Jackson noted that the DOJ was not the only party raising questions about Anthem's characterization of the outcome of the merger. "Cigna officials provided compelling testimony undermining the projections of future savings, and the disagreement runs so deep that Cigna cross-examined the defendants' own expert and refused to sign Anthem's Findings of Facts and Conclusions of Law on the grounds that they 'reflect Anthem's perspective' and that some of the findings 'are inconsistent with the testimony of Cigna witnesses.'"

Economic theory underlying horizontal merger enforcement shows that without sufficient competition, companies do not have incentives for passing savings through to consumers. In rejecting both mergers, the courts affirmed that the health insurance market's high concentration level warrants close scrutiny of any action that would increase firms' market power. The mergers were wins for millions of consumers who will not suffer increased premiums and decreased healthcare services due to undue concentration.

Conclusion

Health insurance is at a crossroads and trying to enhance competition in these competitively fragile markets is an important national priority. Antitrust exemptions typically impose costs on competition and consumers and as the Antitrust Modernization Commission has observed are disfavored and face a very difficult task to be justified. The MFA cannot meet the standards suggested by the AMC that is why this Committee should endorse H.R. 372, Competitive Health Insurance Reform Act of 2017.

This Committee should go further to protect health insurance competition. Strong, vigorous antitrust enforcement is essential to making the market function. This Committee should use its oversight function to ensure that the progress in health insurance antitrust

[56] U.S. v. Anthem, Inc., No. 16-1493 (D.D.C. filed Feb. 8, 2017).

enforcement is not weakened. Competition, regulation, and robust antitrust enforcement must all come together to make health insurance markets function properly and deliver high quality products at a reasonable price to consumers. As Congress plans its next steps and the fate of the Affordable Care Act, it must take into consideration how vital these protections and regulations have been for the health of the market as well as protecting tens of millions of people from harm. Without these key provisions, health insurance markets will become highly unstable and consumers, patients, and families will pay the price.

Appendix

Healthcare Advocacy of David Balto

- Formed the Coalition to Protect Patient Choice, a consumer-supported organization to oppose the Aetna-Humana and Anthem-Cigna mergers. (See www.TheCPPC.com). Submitted comments in opposition to the mergers in 12 states: California, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Missouri, New York, Ohio, Virginia and Wisconsin. Testified in opposition to the mergers in 6 states: California, Delaware, Missouri, New York, Virginia and Wisconsin. Testified before the national Association of Insurance Commissioners. Presentations to the DOJ and over state attorneys generals offices.

- Provided expert testimony on health care competition before Congress 14 times.
  - Testimony on Pharmacy Benefit Management Competition, Before the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law, November 17, 2015.
  - Testimony on the ACA, Consolidation and the Impact on Competition in Health Care, Before the House Judiciary Committee, Subcommittee on Regulatory Reform, Commercial and Antitrust Law. September 19, 2013.
  - Testimony on the Express Scripts-Medco PBM Merger, Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy, and Consumer Rights. December 6, 2011.
  - Testimony on Health Industry Consolidation, Before the House Committee on Ways and Means, Subcommittee on Health. September 9, 2011.
  - "The Need for a New Antitrust Paradigm in Health Care," Testimony Before the House Judiciary Committee, Subcommittee on Courts and Competition Policy on Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients. December 1, 2010.
  - "Antitrust Enforcement Agencies Face Unprecedented Challenges," Testimony Before the House Judiciary Committee, Subcommittee on Courts and Competition Policy. July 27, 2010.
  - "Oversight of the Enforcement of the Antitrust Laws," Testimony Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Protection. June 9, 2010.
  - "Protecting Consumers and Promoting Health Insurance Competition," Testimony Before the House Judiciary Committee, Subcommittee on Courts and Competition Policy. October 8, 2009.
  - "The Effects of Regulatory Neglect on Health Care Consumers," Testimony Before the Senate Committee on Commerce, Science and Education. July 16, 2009
  - "A Progressive Agenda for Antitrust Enforcement at the Antitrust Division," Testimony Before the Senate Judiciary Committee. March 10, 2009.
  - "A Progressive Vision for Antitrust Enforcement to Protect the Opportunities for Small Businesses and to Protect Consumers," Testimony Before the House Small Business Committee. September 25, 2008.
  - Testimony on the Proposed Recommendations for Consideration on the Proposed Merger of Highmark and Independence Blue Cross, Before the Senate Banking and Insurance Committee. September 23, 2008.

- "Consumers Suffer as Health Insurers Consolidate," Testimony Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy, and Consumer Rights. July 31, 2008.
- "The Impact of our Antitrust Laws on Community Pharmacies and Their Patients," Testimony Before the House Judiciary Committee, Antitrust Task Force. October 18, 2007.

- Led consumer advocacy in favor of pay-for-delay legislation designed to ensure increased generic drug entry into the U.S. market.

- Led consumer advocacy in opposition to the Teva Pharmaceutical takeover of Mylan.

- Led consumer advocacy in opposition to the CVS Health-Omnicare merger.

- Led consumer advocacy against Partners Healthcare acquisition of South Shore Hospital in the Boston, Massachusetts area.

- Provided expert testimony to the Department of Labor, ERISA Advisory Council concerning the necessity of pharmacy benefit management compensation and fee disclosure to welfare benefit plans.

- Led consumer, payor and provider opposition to the pharmacy benefit manager merger of Express Scripts and Medco.

- Provided expert testimony on the UPMC-Highmark dispute in the Pittsburgh, Pennsylvania area before the Pennsylvania State Senate Committee on Banking and Insurance.

- Provided expert testimony in opposition to the Highmark/Independence Blue Cross merger in Pennsylvania, which was ultimately disbanded by the Pennsylvania State Senate Committee on Banking and Insurance.

- Led consumer and provider opposition to the UnitedHealth-Sierra merger affecting the state of Nevada.

- Served as an expert witness for the state of Maine in *Pharmaceutical Care Management Ass'n v. Maine Atty. Gen.*, 1:03-cv-00153 (D. Me. 2003) brought by the association representing pharmacy benefit managers challenging a statute designed to regulate pharmacy benefit managers in the state.

Mr. FARENTHOLD. Thank you very much, Mr. Balto.
Mr. Woody, you are recognized for 5 minutes.

TESTIMONY OF ROBERT W. WOODY, ESQ., VICE PRESIDENT, POLICY PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA (PCI)

Mr. WOODY. Thank you, Chairman Farenthold, Ranking Member Cicilline, and Chairman Goodlatte, and Ranking Member Conyers. I am Robert Woody, the vice president for Policy and Property Casualty Insurers Association of America. PCI is composed of nearly 1,000-member companies representing the broadest cross-section of insurers of any national insurance trade association.

PCI appreciates that the sponsors of H.R. 372 are genuinely concerned about the availability and affordability of health insurance, the consumers, and we share that concern.

We also appreciate that the bill does not include property casualty insurers in the proposed repeal of the limited antitrust provisions of the McCarran-Ferguson Act. As such, PCI has no formal position on the bill. But I am here today because PCI is extremely concerned that supporters of this bill have misidentified McCarran as the source of the problems in the health insurance industry, and that misperception of how and why McCarran-Ferguson works as it does could ultimately cause significant harm to our industry and, more importantly, to our consumers and your constituents were the repeal ever expanded to cover the PC industry.

The bill appears to be premised on the mistaken perception of McCarran's antitrust provisions leave insurers unfettered by antitrust laws, and free to engage in what would otherwise be illegal and anticompetitive activity, but this is not the case. The decision Congress made in enacting McCarran was not to excuse the industry from antitrust compliance completely, but, instead, to assign to the States the power to enforce certain limited antitrust functions with respect to the business of insurance.

In particular, they recognize that some joint insurer activity is actually pro-competitive, and, thus, good for consumers. For example, small and medium-sized insurers don't have a base of loss experience large enough to be statistically significant. And, so, they must rely on historical loss costs, and industry loss costs data to be able to look into the future and to project loss costs and then price their products responsibly. If they can't do that, they are effectively driven from the market, leaving it only to their largest competitors.

Those are all things that are part of the insurance pricing process. And so the Congress said, in 1945, why shouldn't the entire regulation process be overseen by the same regulators? And the result has been that the State insurance regulatory system has performed remarkably well, I think, especially as compared to the Federal regulators in other financial services sectors.

I want to highlight several particular misperceptions about McCarran as it relates to health insurance. First, McCarran is being cited as a barrier to the ability of the health insurers to sell insurance across State lines. Now, PCI takes no position on that health industry issue, but it arises because of differences from

State to State in the regulation of health insurance products, not from antitrust concerns.

There is no connection between that issue and the antitrust provisions of McCarran. Moreover, when the Congress reserved to the States the right to regulate the business of insurance, it was also very careful, to preserve for itself, the right to preempt State regulation whenever it sees the need. All Congress must do is to be clear that the legislation it passes expressly applies to insurance. Congress has done that many times without seeing the need to amend McCarran.

But some has suggested that McCarran is also responsible for the high level of market concentration in the health industry, which can result in a lack of competition. But McCarran also applies to the property casualty insurance industry, and yet, the PC industry is extremely competitive, has very low market concentration. If McCarran caused higher levels of concentration in the health insurance market, wouldn't it also be expected to have the same effect in the property casualty market? Clearly, it does not.

Moreover, just this week, we have seen the power of the Federal Government at work to block not just one, but two major proposed mergers in the health insurance industry. The Department of Justice and the courts are actively blocking M&A activity in that industry. Again, McCarran-Ferguson has not stood in the way.

And, finally, the Congressional Research Service has said that repealing McCarran could spur further consolidation in insurance markets. The Congressional Budget Office has said that repeal is not likely to reduce the cost of health insurance for consumers, and the National Association of Insurance Commissioners, our regulators, said that this bill could "hinder competition, harm consumers, and weaken the health insurance market."

So listen to the nonpartisan organizations that serve Congress and listen to those who regulate insurers and protect consumers, your constituents. PCI urges the Subcommittee to investigate the true causes of the problems in the health insurance market and to recognize that the McCarran-Ferguson Act is not one of those causes.

Thank you, again, for the opportunity to testify today.

[The prepared statement of Mr. Woody follows:]

Testimony of

Robert W. Woody
Vice President, Policy
Property Casualty Insurers Association of America (PCI)

H.R. 372, the "Competitive Health Insurance Reform Act of 2017"

Subcommittee on Regulatory Reform, Commercial and Antitrust Law
Committee on the Judiciary
United States House of Representatives
February 16, 2017

The Property Casualty Insurers Association of America (PCI) is pleased to offer testimony on the impact of H.R. 372, the Competitive Health Insurance Reform Act of 2017, which would repeal certain antitrust provisions of the McCarran-Ferguson Act as they apply to health insurers. PCI is the leading property-casualty trade association representing nearly 1,000 insurers, the broadest cross-section of insurers of any national trade association. Our members are leading providers of home, auto and business insurance.

PCI appreciates that the sponsor and cosponsors of H.R. 372 are genuinely concerned about the availability and affordability of health insurance for consumers, and we share their concern. This is an issue that policymakers have been debating for decades. Now that we have a few years' experience with the Affordable Care Act under our belt, it is indeed an appropriate time for Congress and the Administration to take a fresh look at how it has worked and consider whether improvements or other approaches to the problem are in order.

PCI also appreciates that the sponsor of H.R. 372 has taken care to draft the bill to apply to the health insurance industry only and not to the property casualty industry. It is for that reason that PCI has taken no formal position on the bill. Nevertheless, PCI is extremely concerned that enactment of this bill might establish a precedent that could ultimately lead to future consideration of broader legislation that *would* apply to the property casualty industry. The McCarran-Ferguson Act serves a *pro-competitive* and not an anti-competitive purpose, and this is especially true as it applies in the property casualty industry. Thus, *any* proposals to repeal those provisions are worrisome. PCI therefore believes it is critical that the Committee carefully consider the anti-competitive impacts that proposals to repeal the antitrust provisions of McCarran could have on insurance markets and consumers generally, including in both the health and property casualty sectors.

PCI has two broad concerns about H.R. 372. First, while the bill's proponents argue that it is a cure to the availability and affordability problems they see in the health insurance industry, they have mistakenly identified McCarran-Ferguson as a source of those problems. We discuss in more detail below some of those problems and the mistaken connection made to McCarran.

Second, PCI believes that the bill is premised on a misunderstanding of the reason Congress enacted the McCarran-Ferguson Act. While the Act does provide a limited exemption from Federal antitrust laws, insurers are not entirely exempt from the application of Federal antitrust laws, it is not a wholesale exemption. More importantly, insurers are subject to state antitrust laws. Indeed, the intent of Congress in passing McCarran-Ferguson was not to give insurers free reign to engage in anticompetitive activities, but instead to delegate to the states the power to regulate certain competitive issues via state rather than federal antitrust laws along with the power to regulate the business of insurance generally. In so doing, Congress recognized, that state antitrust enforcement is complementary to state insurance regulatory authority. The result is that abuses are not permitted under state insurance law. All states have laws governing rates and insurance conduct, generally prohibiting any rates that are excessive, inadequate, or unfairly discriminatory. In addition, anticompetitive price fixing, bid rigging, and market allocations are generally illegal under state antitrust laws. In the rare event that state regulators should become aware of an insurer engaging in inappropriate activity, they have the power they need under their own antitrust and insurance regulatory authority to deal effectively with such situations. It is for that reason that there is little evidence of such activity in the industry.

Just as Congress intended when it passed McCarran, the state insurance regulatory system has, on balance, performed extremely well and has avoided industry-wide meltdowns such as those that occurred in the savings and loan industry in the 1980s and more recently in the banking industry in the 2008 financial crisis. Indeed, the insurance sector remained strong and well-capitalized throughout the 2008 crisis. PCI

therefore questions the wisdom of reversing this delegation of power to the states and transferring power to federal regulators whose record is much less impressive.

McCarran-Ferguson Purpose and Background

The McCarran-Ferguson Act was enacted by Congress in 1945 in response to a Supreme Court decision that preempted state control and governance of insurance. McCarran provides that:

> "No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance" (15 U.S.C. 1012(b), 1013(b) (1976)).

A separate provision of the statute then limits certain provisions of the Sherman Act, the Clayton Act, and the Federal Trade Commission Act to the "business of insurance." Thus, McCarran does not give insurers a blanket exemption from antitrust laws – some Federal antitrust jurisdiction remains applicable to insurers. Rather, Congress passed McCarran recognizing that insurance is a local issue with very different regional risks and tort laws, and that the states are better equipped to respond to local competitive needs than the federal government. In addition to state antitrust and insurance law, federal antitrust laws apply to insurers unless:

(1) The activity is the business of insurance,

(2) The activity is regulated by state law, and

(3) The activity does not involve boycott, coercion or intimidation.

Congress had a very good reason for enacting this limited insurer exemption from federal antitrust laws. Insurers must price their products before they know the costs of providing them. One of the many factors that goes into pricing risks is the historical "loss costs" associated with similar risks. Insurers must have a reliable way of projecting those loss costs in order to price their products in a sound manner. McCarran-Ferguson, with its delegation of antitrust supervision of insurers to the states, was enacted to permit the pooling of aggregated historical loss cost data necessary for sound underwriting, residual market mechanisms, risk pools, forms uniformity, and a

number of other activities that Congress and the states have agreed *promote* competition and are beneficial to consumers.

Without state-governed loss pooling, smaller insurers, as well as new market entrants of any size, would have too little data to develop actuarially reliable rates, would have to charge consumers an extra risk premium, and would be more prone to insolvency. Research by the Wharton School of the University of Pennsylvania confirmed that repeal of McCarran Ferguson would likely reduce competition, increase the cost of insurance and reduce availability for some high-risk coverages, because the threat of antitrust litigation would make insurers unwilling to engage in efficiency-enhancing cooperative activities.[1]

Many larger insurers, including some PCI members, do not rely heavily on aggregate historical loss costs to support the underwriting of their products because they write enough business to have a statistically significant base of information without need to use industry-wide data. Many of the larger insurers in the health sector may be among them, and we therefore believe that enactment of the bill would not have the impact on health insurance markets that the bill's sponsors are seeking to achieve. However, start-ups and many medium and smaller insurers need such information on an ongoing basis. Even large insurers of any size seeking to enter new states, markets, classes of business, or product lines depend upon industry wide data that is available to them only because of the McCarran limited antitrust exemption. Repealing the McCarran antitrust delegation could affect the marketplace only by imposing a massive barrier to entry for new competition and smaller insurers, raising costs and further reducing choices for consumers. Thus, while PCI believes that the sponsors of H.R. 372 are genuinely seeking to promote competition in the health insurance industry, repealing the antitrust provisions of McCarran could have exactly the opposite effect.

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[1] Patricia M. Danzon, the Wharton School of the University of Pennsylvania, *The McCarran Ferguson Act Anticompetitive or Procompetitive?*, Regulation - The Cato Review of Business and Government, 1991.

Misunderstandings About the Impact of McCarran-Ferguson

Proponents of this bill have made a number of statements about the impact of McCarran-Ferguson on insurance markets and insurance consumers that appear to reflect a misunderstanding about why Congress enacted McCarran and how it works.

First, they have suggested that the enactment of McCarran was an "historical error" that has resulted in an "unbridled" antitrust exemption being applied to insurers. On the contrary, Congress made a very deliberate and purposeful decision to delegate to the states the authority to regulate the business of insurance, but that delegation was in no way "unbridled." It applies only to activities that constitute the "business of insurance" and not to any other activities in which insurers engage. That wise decision has worked out just as Congress intended and the result today is a strong, robust and effective state regulatory system that has protected the interests of insurance consumers much more effectively than has too often been the case with federal financial regulators with respect to other parts of the financial services sector.

Second, proponents have suggested that the McCarran antitrust delegation is a barrier to the ability of health insurers to sell insurance across state lines. However, PCI sees no connection between the antitrust delegation in McCarran and the issue of selling health insurance across state lines. Moreover, provisions of McCarran that delegate general regulatory (in addition to some antitrust enforcement) authority to the states are not without limits. In enacting McCarran, Congress reserved the right to apply Federal laws to the business of insurance whenever it wants to. All that is required is that the Congress make it clear that the Federal law applies to insurers. Indeed, Congress has done this many times. For example, Congress expressly applied the Affordable Care Act, the Terrorism Risk Insurance Act, the Dodd-Frank Act and many other federal statutes to insurers. PCI takes no position on whether Federal legislation is necessary to address the issues of selling health insurance across state lines. However, in the event that the Congress determines that it is, McCarran is no obstacle. Congress has the full power to enact whatever legislation it thinks is necessary to address that issue and it can do so without any amendment to McCarran-Ferguson.

Third, proponents have noted that there is a high level of concentration, and thus less competition than there might be, in the health insurance industry. They are not alone in expressing that concern. However, they then suggest that the McCarran antitrust provision is the cause and that repealing it will cure the problem and increase competition. PCI knows of no support for this proposition.

The commonly accepted measure of market concentration is the Herfindahl-Hirschman Index (HHI), which is utilized by the Justice Department and the Federal Trade Commission. Markets in which the HHI is between 1000 and 1800 points are considered to be moderately concentrated and those exceeding 1800 are highly concentrated. For 2015, the HHI for the property casualty industry calculated on an individual company basis was 75.2. When calculated on a group basis it was 290.8. By either measure, the level of concentration in the property casualty sector of the industry is extremely low and the sector is highly competitive. While PCI does not have data on HHI concentration measures in the health industry, the dominance of large major companies in the sector would appear to suggest higher concentration levels than in the property casualty industry. However, the McCarran antitrust provision applies to *all* sectors of the insurance industry. So if McCarran were the cause of concentration in the health insurance industry, we would expect it to have the same effect in all other sectors as well. Clearly it does not, which demonstrates that, whatever the causes of higher concentration levels in the health insurance industry may be, McCarran is not one of them.

It is also worth noting that McCarran provides no obstacle to federal review of proposed mergers and acquisitions in the insurance industry. Indeed, just last year, the Department of Justice filed suit to block the proposed merger of Aetna and Humana, last month a Federal court sided with DOJ, and earlier this week the parties called the transaction off. States also review these transactions under their own antitrust laws. While reasonable people may disagree on the outcome of the antitrust review of any particular merger or acquisition, there is no evidence that McCarran-Ferguson poses

any impediment to such reviews at either the Federal or state level. To the extent concentration in the health insurance industry is a concern, Congress cannot effectively address that concern if it misidentifies the cause.

Fourth, proponents have suggested that the limited McCarran antitrust exemption as applied to insurers results in vastly different rules being applied to insurers than to all other businesses. In fact, the practical effect of the exemption is not at all different from the way in which the courts have applied Federal antitrust laws to other industries. With respect to other industries, courts have sometimes ruled that certain activities that might otherwise be found to violate Federal antitrust laws can nevertheless be permissible if they have pro-competitive effects. The McCarran antitrust provision is unusual only in that the decision to protect pro-competitive activities was made by Congress rather than the courts. Some have suggested that, if the limited McCarran exemption from Federal antitrust laws were repealed, courts might follow the example they have set in some other industries and fashion safe harbors to accomplish the same pro-competitive objective the Congress did in enacting McCarran. While this is possible in theory, it would take many years of expensive litigation for the law in this area to settle, and with no guarantee that the courts would ultimately get it right. In the meantime, the pro-competitive activities made possible by McCarran would become prohibited, forcing smaller players to leave the market and increasing market concentration – just the problem the bill's proponents say they are trying to solve.

Conclusion

The Congress is justifiably concerned about the cost of health care and health insurance, and we share that concern. However, repealing any provision of the McCarran-Ferguson Act in a way that could threaten pro-competitive activities and serve as a barrier to new entrants in the market would not solve problems of availability, affordability, and consumer choice. We therefore ask that Congress take care not to mis-identity the McCarran-Ferguson Act as the cause of current problems in the health insurance market, and in particular, to recognize the competitive benefits that McCarran has particularly in the property casualty market.

Mr. FARENTHOLD. Thank you very much, Mr. Woody.
Mr. Slover, 5 minutes is yours.

TESTIMONY OF GEORGE SLOVER, ESQ.,
SENIOR POLICY COUNSEL, CONSUMER UNION

Mr. SLOVER. Thank you. Consumers Union supports this bill. We have long supported removing this antitrust exemption, so the rules of competition can apply as they do in the rest of the American free market economy. The antitrust laws help the free market work for consumers, and the insurance industry should not be left out.

This antitrust exemption was created by accident. It was supposed to be a 3-year breathing spell so insurers could adjust to a Supreme Court decision. That was 70 years ago. We hope that, for health insurance, the stars have aligned. A similar bill passed the House with over 400 votes a few years ago, and there is bipartisan support in this Committee now.

Since our founding more than 80 years ago, we have worked to make health care available and affordable for all Americans. We are strong supporters of the Affordable Care Act, which has significantly improved health care availability and affordability for many millions of Americans, including millions who previously had no health insurance.

We would be very concerned by any move to repeal it without having an effective new plan already figured out and in place that maintains comparable coverages in consumer choices and protections.

The healthcare marketplace is complex in how it operates, and an effective regulatory framework is needed to shape that complex environment to help safeguard consumers and keep costs under control, and make a full range of healthcare services widely available.

Our country's long experience shows you can't expect a healthcare system to function effectively on competition alone. For example, making sure preexisting conditions are not excluded required a rule. The free market simply wasn't going to give us that key protection.

But while the regulatory framework sets important requirements and safeguards, competition within—the bounds of that framework—adds a market-driven business incentive to improve service while holding down prices and providing better value. Regulation and competition both work best when they can work hand in hand. For these reasons, we support the bill the Subcommittee is considering today. The rest of the healthcare supply chain is already operating under the antitrust laws, and we would like to see health insurers join in.

As the healthcare marketplace evolves, we want health insurers motivated to continue improving the way coverage is provided to consumers with higher quality, better choice, and more affordability. A key part of that motivation is knowing that if they don't, others likely will, and they could be left behind.

But an antitrust exemption dampens that motivation, inviting insurers to make a pact to delay making improvements until everyone is ready to agree that no one will get out in front of the others

and offer consumers a better deal. That harms consumers, and it blocks progress.

For example, consumers like to have a choice about which doctors they can see, and which hospitals they can go to. But some insurers have been moving to narrower provider networks as a cost-cutting measure. If there is effective competition and transparency, consumers who don't like the narrower network can switch. But if insurers can make a pact that they will all move to narrower networks, consumers don't have the power of choice. Regulation can address the too-narrow-network problem by setting some minimum baselines for what qualifies as an adequate network. But we don't want health insurers all just doing the bare minimum, agreeing among themselves to treat the regulatory floor as also their ceiling. Competitive incentives can and should augment whatever minimum that regulation sets.

Just to be clear, having a health insurance activity subject to the antitrust laws is not the same as automatically outlawing that activity. Passing this bill won't warp the antitrust laws into a straitjacket that keeps health insurers from engaging in activities that benefit consumers. To violate the antitrust laws, the activity would have to significantly harm competition and consumers, like a price-fixing conspiracy would, or the improvement stalling pact I just described, or restrictive deals to lock up providers blocking other insurers from getting fair access so they can offer consumers better choices.

This bill won't be the cure-all for everything that ails health insurance, but it is a constructive step that is going to help give insurers better choices, and, as a result, help promote better value.

Health insurers play a key role in our healthcare system. Adding a dose of competition would help focus their incentives in line with benefiting consumers. Healthcare markets, for all their complexities and special characteristics, are no exception to this economic fact of life. Thank you.

[The prepared statement of Mr. Slover follows:]

ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

STATEMENT OF GEORGE SLOVER
SENIOR POLICY COUNSEL
CONSUMERS UNION

BEFORE THE

SUBCOMMITTEE ON REGULATORY REFORM, COMMERCIAL AND ANTITRUST LAW

HOUSE COMMITTEE ON THE JUDICIARY

ON

H.R. 372, THE "COMPETITIVE HEALTH INSURANCE REFORM ACT OF 2017"

February 16, 2017

Chairman Marino, Ranking Member Cicilline, Subcommittee Members, thank you for the opportunity to be here today, to discuss the proposal to remove the antitrust exemption in the McCarran-Ferguson Act as it applies to health insurance.

Consumers Union has long supported the removal of this antitrust exemption, to enable insurance markets to function under the rules of competition that apply throughout the American free market economy. The antitrust laws are a key to making sure that the free market works for consumers, and the insurance industry should not be left out.

Congress created this exemption in the midst of the Second World War, when attentions were rightly directed elsewhere, in the wake of a Supreme Court decision clarifying that the antitrust laws did apply to insurance. It started out to be a temporary three-year breathing spell, to allow insurers to familiarize themselves with the antitrust laws and adjust their practices to the accepted rules of competition. Instead, it has become an obstinate and persistent single-industry exemption from those rules.

This Committee has been re-examining this exemption over several decades, as a series of expert bodies has called for removing it or significantly scaling it back. The Antitrust Modernization Commission, established in 2002 by legislation authored in this Committee, singled out this exemption for particular skepticism as to any justification for it.[1]

The consensus that consumers and the economy would be better off without the exemption is now particularly strong with respect to health insurance, as demonstrated by passage of legislation to repeal the exemption as to health insurance, on the House floor seven years ago, by a roll call vote of 410-19. We are hopeful that, with bills now sponsored from both sides of the aisle, the stars may finally be aligned to take care of this.

Consumers Union is the public policy and mobilization arm of Consumer Reports. Our mission is to work for a fair, just, and safe marketplace for all

[1] Antitrust Modernization Commission, Report and Recommendations (April 2007) at 351, http://govinfo.library.unt.edu/amc/report_recommendation/toc.htm.

consumers, and to empower consumers to protect themselves. And one key to empowering consumers to protect themselves is working to ensure meaningful consumer choice, through effective competition.

By meaningful choice, we mean easy for consumers to understand and compare, and sensitive to what's important to consumers. When consumers have meaningful choice, businesses are motivated to provide more affordability, better quality, and new thinking.

From our founding more than 80 years ago, one of our top priorities has been to make health care available and affordable for all Americans. We continue to be actively engaged at the federal and state level in working for policies to better ensure that consumers have good health care and health insurance options, and that those options are understandable and affordable.

We are strong supporters of the Affordable Care Act, which has significantly improved the availability and affordability of health care for many millions of Americans, including millions who previously had *no* health insurance.

We would be very concerned by any move to repeal it without having an effective new plan already figured out and in place that maintains comparable coverages and comparable consumer choices and protections. Such a move would be a grave threat to the financial and health security of American families, and to the very stability of our nation's health care system overall.

As we know, the health care marketplace is complex in how it operates and how it motivates providers, insurers, and consumers. An effective regulatory framework is needed to shape that complex environment, to help safeguard consumers, help keep costs under control, and help make a full range of health care services available. Our country's long experience shows you can't expect a health care system to run effectively on competition alone.

As just one example, we needed to legally prohibit insurance companies from limiting their obligations and lowering their costs by excluding coverage for pre-existing conditions, or jacking up rates for covering them. This is a key consumer

protection that the free market has shown it will not take care of on its own. In this and numerous other ways, effective regulation can promote improved health care delivery and improved cost control, by ensuring that all insurance companies are required to follow certain basic consumer-friendly "rules of the road."

But while our regulatory framework sets important requirements and safeguards, and it standardizes plan and benefit descriptions for easier comparison, consumers benefit from also having effective competition, at all levels in the supply chain. Even the best regulatory framework works better where competition, within the bounds of that framework, gives businesses a market-driven incentive to want to improve service while holding down prices and providing better value.

Regulation and competition both work best when they can work hand in hand.

For these reasons, we support the legislation the Subcommittee is considering today. The other levels of the health care supply chain are already subject to the antitrust laws, and it will be beneficial to the health care marketplace, and to consumers, if the insurance level joins them.

As the health care marketplace evolves, there will continue to be opportunities for health insurers to improve the way health insurance coverage is provided to consumers, with higher quality, better choice, and more affordability. The question is: *will* they? If a health insurer can increase its income by declining to make those improvements, or by delaying them, or even by taking things in a backwards direction, there would be a natural temptation to do so.

If there is competition, the insurer won't be able to confidently get away with that. Other insurers will see making those improvements as a way to attract consumers away. But if the one insurer could get the others to agree to also hold back, then it wouldn't have to worry about being undercut by the others offering consumers a better deal.

And that's where the antitrust laws come in to protect consumer choice. It's a violation of those laws for competing companies to cheat the market by banding

together and agreeing to withhold benefits from consumers, or to slow-walk them, for the purpose of protecting everyone's profits.

Just to pick one possible example, consumers like to have a choice about which doctors they can see, and which hospitals they can go to. Some insurers have been moving in the direction of narrower provider networks in their plans, as a cost-cutting measure. If there's effective competition, along with effective transparency, consumers (and employers acting for their employees) who don't want a narrow network can switch to a plan that offers more providers. But if the health insurers can band together and agree that they will all move to narrow networks, consumers no longer have a choice.

Regulation can address that problem by setting a minimum baseline for what qualifies as an adequate network. But we don't want health insurers agreeing among themselves that they will treat the regulatory floor as also the ceiling. Here is an instance where competitive incentives can augment whatever regulation may require.

The McCarran-Ferguson antitrust exemption applies to the "business of insurance." The courts have made clear that that does not cover every business activity an insurance company might engage in, even as part of its insurance operations. The exemption doesn't cover insurance company mergers, for example, has we have recently seen with the Justice Department's successful antitrust challenges to the Aetna-Humana and Anthem-Cigna mergers.

The antitrust exemption also doesn't cover arrangements between an insurance company and a provider, unless the arrangement has an impact on consumers, and some relation to the spreading of risk. Many kinds of arrangements, such as if insurers were to require providers to restrict the quality of care they offer consumers, or to impose higher cost-sharing, in order to participate in a network, could be covered. But arrangements that are not covered are already subject to the antitrust laws.

And just to be clear, making an activity subject to the antitrust laws is not the same as automatically outlawing it. Passing this bill won't suddenly warp the antitrust laws into a straitjacket that stops insurers from engaging in activities that

benefit consumers. To violate the antitrust laws, the activity has to significantly *harm* competition and consumers.

Like price fixing, for example.

Or the kinds of innovation-stalling agreements I described a minute ago.

Or agreeing to freeze out providers who won't cut corners on essential quality of care.

Or making restrictive deals with providers that keep new insurance companies from getting the access they need to come in and offer consumers other choices.

This bill won't be the cure-all for everything that ails the health insurance marketplace. But it is a constructive step toward bringing the beneficial forces of market competition more into play, and that's going to help give consumers better choices, and as a result, help promote better value.

Health insurers play a key role in our health care system. And better competition will help more strongly focus insurer incentives in line with benefiting consumers.

As the Justice Department has explained, where there is effective competition, coupled with transparency, in a consumer-friendly regulatory framework, insurers will compete against each other by offering plans with lower premiums, reducing copayments, lowering or eliminating deductibles, lowering annual out-of-pocket maximum costs, managing care, improving drug coverage, offering desirable benefits, and making their provider networks more attractive to potential members.[2]

We want those motivations to be strong. Providing those kinds of benefits costs insurers more than not providing them. What makes it in their interest to provide them anyway is that doing so attracts customers who might otherwise go

[2] *See, e.g.*, Competitive Impact Statement, United States v. Humana, United States v. Humana Inc. and Arcadian Management Services, Inc., No. 12-cv-464 (D.D.C., March 27, 2012), at 8, www.justice.gov/atr/case/us-v-humana-inc-and-arcadian-management-services-inc.

elsewhere. For that to work, there needs to be an elsewhere for customers realistically to go and hope to obtain those benefits. Health care markets, for all their complexities and special characteristics, are no exception to this fundamental economic fact.

Ultimately, we hope the McCarran-Ferguson antitrust exemption is removed for all insurance, not just health insurance. We'd like the antitrust laws to apply across the economy. But that discussion is for another day. We support your proposal to remove the exemption now for health insurance.

And if the focus is to limit this to health insurance, the exclusions you set out would appear to make sense, except that we're not sure why you would exclude hospital indemnity insurance.[3] We would urge you to take another look at that.

Thank you again for the opportunity to testify on this important issue for consumers.

[3] 26 USC 9832(c) (3)(B).

Mr. FARENTHOLD. Thank you very much.

And we will get started with questions. And I will recognize myself for 5 minutes.

Mr. Miller, I am a big fan of AEI. I tend to agree with them on most issues, but this one kind of issue I struggle with. By definition, antitrust laws were designed to promote competition. And by exempting them, the natural occurrence in, somebody who is not an expert in the field's mind is, if we exempt them from antitrust laws, you are going to get anticompetitive behavior. And that is what antitrust laws were designed to protect against.

I understand the devolving things to this date. I know it is something AEI supports devolving as much as possible to the States. But one of the key features of the debate on the replacement of ObamaCare is creating competition across State lines. So all of a sudden, some of these regulations are going to be preempted just out of necessity by whatever provisions we choose to enact to enable sale across State lines.

So I guess my question is, what is so special about the insurance industry when we create a more traditional market for it that would require this exemption to continue?

Mr. MILLER. Well, I am trying to put this in a little bit of a larger context to suggest you just might want to curb your enthusiasm on this. There is more than one school of antitrust thought and practice, and there is a mixed history as to what antitrust means beyond the pro-competitive wrapper. So we need to have the same skepticism about antitrust regulation, which is not uniform and always good, and from Administration to Administration, you will see how it changes,

In the same way, we need to have some skepticism about the proclaimed virtues of independent, politically driven regulation. It is somewhat like, if you will, Forest Gump opening up a box of chocolates. You don't always know what you are going to get in antitrust regulation.

Now, on the McCarran-Ferguson—or on the across-State-lines issue, you are talking to someone who probably wrote the first academic article in favor of that about 15 years ago. First, that issue has changed. There is less space to really do much on that front, but in this particular context, Congress can, at any time, write a new law that deals with that issue.

McCarran-Ferguson is just a, you know, initial place setting, which Congress periodically changes in terms of—you mandated various benefits in health insurance, and have done other types of Federal moves into the healthcare space. So it is not an end-all/be-all. Also, there are interstate compacts which get around that issue as well. The magnitude, though, is a little bit exaggerated as to how much savings you get from——

Mr. FARENTHOLD. I want to talk to Mr. Woody about across State lines and State regulatory issue as well. It would seem to me that, as just a cost of compliance, having to deal with 50 different State regulations for an insurance company would be more expensive than trying to deal with just one Federal standard. Again, that—I am kind of loathe to say that, because I am opposed to Federal regulation, but we have got a real crisis right now on how to deal with the cost of health care. So what is your take on that?

Mr. WOODY. Mr. Chairman, PCI has over 1,000 members, and many of them are small- to medium-sized companies that don't do business on a 50-State basis. So to them, State regulators are closer to them, closer to their markets and closer to their consumers. I can certainly understand why an insurer who does business nationally might say, well, it might be more efficient to have one regulator instead of 50. And, indeed, over the years, we have seen some discussion within the industry, and in Congress, about an optional Federal charter. Even from those who, at one time, supported an optional Federal charter, we don't hear much talk about that now. And I think one of the main reasons is there is concern about the regulatory environment at the Federal level that they see with respect to other sectors of the financial services industry, and I think even those insurers are now saying, at least for the time being, we are happier at the State level than at the Federal level on balance.

Mr. FARENTHOLD. Finally, I just want to talk for a second about barriers to entry. One of the arguments for the exception was to make data more available.

I will give Mr. Miller and Mr. Slover a chance to just give me about 15 seconds on this, since I am almost out of time.

How do we effectively remove barriers of entry to bring more competition? I will give Mr. Balto 15 seconds, too.

Mr. Miller?

Mr. MILLER. I will be simple. It is a different context in health insurance, since it is mostly actuarial consulting firms. Although, you never can tell where you may go with antitrust once you open them up to challenge, I suppose, they may have a lot of lawsuits.

But the barriers, to answer you, are more a matter of lightening the load so that less conventional insurers or other people approaching this space can get in. We have made it so dense and difficult, only the largest operators can basically comply with the burden of regulation. We keep loading on, plus what we add from the ACA.

Mr. FARENTHOLD. I know, Mr. Balto, you wanted to weigh in on this. And I know I am running out of time.

Mr. BALTO. The simple message for this Committee is that McCarran-Ferguson could conceivably facilitate dominant insurers to engage in anticompetitive practices that would keep other insurance companies from entering.

Example, in Michigan, Blue Cross of Michigan had a most-favored-nations provision that kept other insurers out. Aetna sued, and successfully challenged that provision. Aetna, not a small competitor——

Mr. FARENTHOLD. Again, I apologize. I will give you an extra minute, Mr. Cicilline.

But, Mr. Slover, did you want to weigh in on that real quick?

Mr. SLOVER. Yes, just briefly.

Briefly, from an antitrust perspective, the—removing the exemption will make it harder for insurance companies to create barriers to entry across the board.

Mr. FARENTHOLD. Thank you very much.

Mr. Cicilline.

Mr. CICILLINE. Thank you, Mr. Chairman.

I want to start with Mr. Miller. I want to be sure I understand your argument. In your written testimony, and you repeated it again today, you say the primary argument over time for establishing and retaining the antitrust exception under McCarran-Ferguson has been to facilitate economically efficient sharing of information that helps insurers to evaluate risk and price accurately.

You go on to argue in your written testimony that that really doesn't apply in the health insurance market. And that really——

Mr. MILLER [continuing]. A component of the historical background to this.

Mr. CICILLINE. Yeah. "Meanwhile, health insurers have no similar history of utilizing advisory organizations for the joint estimation and projection of medical claim costs."

So it seems like you argue against your own position. You say, "The primary reason for this is a sharing of information, which is much more present in the property casualty insurance market," to Mr. Woody's point, but you acknowledge it actually doesn't implicate the health insurance market. So the primary argument that's advanced is actually an argument that you don't think is credible.

Mr. MILLER. There's a larger argument involved in the overall testimony.

Mr. CICILLINE. No, I understand. Your other argument——

Mr. MILLER. That's one slice of it.

Mr. CICILLINE. Okay. But that's the primary, and you say it's not a good one. And then you say——

Mr. MILLER. Historically, that's been the primary argument. That's correct.

Mr. CICILLINE [continuing]. It's disruptive and you think the Committee and Congress should look at other things. That's the, sort of, gist of the argument.

Mr. MILLER. We are in the midst of re-sorting how we are approaching regulation in health care and health insurance. I would not change one thing in isolation without looking at the larger context.

We have just gone through over the last 5 years a massive increase in regulation of health insurance. I could tick them off in my testimony.

Mr. CICILLINE. No, no.

Mr. MILLER. What could possibly have gone wrong?

Mr. CICILLINE. That's a different——

Mr. MILLER. Maybe lack of insurers in markets? Rising prices and problems in concentration?

Mr. CICILLINE. Right. That's a different question——

Mr. MILLER. We need to rethink it in a larger context.

Mr. CICILLINE.—Mr. Miller. That's a different question. What I'm asking you is——

Mr. MILLER. It's a more important question.

Mr. CICILLINE. No, what I'm asking you, though, is, if the presumption is—and I think the organization you work for has advanced this presumption many times over—that competition is advantageous to consumers, to choice, to spurring innovation, that this is an exemption which exists in this industry and no other, that there ought to be a justification. And fear of what it might

bring, it seems to me—and we'll disagree—is not sufficient justification.

But I'll turn now to Mr. Slover.

Professor Herbert Hovenkamp, who is widely regarded as the dean of American antitrust law, has written that under the McCarran-Ferguson Act the presence of even minimal State regulation, even on an issue unrelated to the antitrust law, is generally sufficient to preserve the immunity.

Can you respond to that?

Mr. SLOVER. Yes, that's how the language has been interpreted. About the same time as the McCarran-Ferguson Act was enacted, the Supreme Court was deciding *Parker v. Brown* and establishing how State regulation and the antitrust laws work hand-in-hand. And there was a looking at the State regulation. This was later fleshed out, that there had to be a clear State regulation and there had to be active supervision in order to displace the antitrust laws.

What you have, unfortunately, under the McCarran-Ferguson Act is a minimal requirement, where there doesn't have to be any State regulation; there just has to be the sense of regulation. And so it doesn't have to pass any grade. And so you have a situation in which there isn't a natural incentive to make State regulation effective, and you don't have either one.

Mr. CICILLINE. So there's been a lot of discussion, both in this hearing already but throughout the country, about this notion of allowing competition across State lines. There is nothing that prohibits that today in the ACA. In fact, it is expressly authorized, is it not?

Mr. SLOVER. That's correct; it is expressly authorized in interstate compacts. It is also perfectly legal for an insurance company to sell in any State it wants to, as long as it abides by the rules of that State.

The distinction here I think that's important is not can they, but will they? And there are natural impediments to the insurance companies wanting, having the incentive to enter into each other's territory that this would help fix.

Mr. CICILLINE. I think that's a very important point, because there's been a lot of discussion of, if only we would allow this to happen, this will solve the problem. There is nothing that prohibits this from happening, and I think you're exactly right.

And I'd ask unanimous consent to introduce an article dated October 13 entitled "Insurers Not Interested in Selling ObamaCare Across State Lines," which recounts that for the last 12 months States have been legally allowed to let insurers sell plans outside their borders. Despite the idea's enduring popularity, no States have signaled an interest in the policy.

And I think this is really the question of whether or not insurance companies are interested in doing that, but there is no legal prohibition. And so we just sort of should view this issue in the context of the facts. And I'd ask unanimous consent that be included in the record.

Mr. FARENTHOLD. Without objection, so ordered.

[The information referred to follows:]

THE HILL

Insurers not interested in sellin ObamaCare across state lines

BY SARAH FERRIS - 10/13/16 06:00 AM EDT

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Donald Trump had one response when asked about how he would replace ObamaCare at this week's presidential debate: He'll allow companies to sell insurance across state lines.

The GOP's decade-old talking point has gained momentum since the healthcare law passed six years ago. But Republicans rarely — if ever — acknowledge that the crux of what they want is already allowed under ObamaCare.

For the last 10 months, states have been legally allowed to let insurers sell plans outside their borders.
Despite the idea's enduring popularity, no states have signaled interest in the policy, insurance experts and regulators say. And the federal government never even finished writing the rules for how it would work.

"Insurers aren't interested at this point," Linda Blumberg, a senior fellow on health policy at the Urban Institute, said in an interview. "It's kind of a lot of effort for no necessary return."

ObamaCare's little-known provision that allows insurers to sell plans across state lines was tucked inside the 1,000-page law at the time of its

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passage, though it didn't go into effect until January 2016.

Under the law, two or more states can band together into what's called a "healthcare choice compact." That means people can buy health coverage from another state that wouldn't be subjected to the rules of their home state, as long as those states agree.

States would have to explicitly pass legislation to empower insurers to enter into these agreements.

Thirteen states have tried to pass these laws since ObamaCare was signed in 2010, in part because of a push by the powerful conservative group American Legislative Exchange Council.

Only three states have approved those laws — Kentucky, Georgia and Maine — although none have actually made deals with other states to sell their plans, according to the National Conference of State Legislatures.

Conservatives say the provision that's already in the law is far from what Republicans have in mind when they're touting the idea on the campaign trail.

"It's like a fake-out, and it's not even a very convincing fake-out," said Tom Miller, a health policy expert at the conservative American Enterprise Institute.

Insurance companies in these special agreements under ObamaCare would still have to follow the law's minimum standards, which requires all health plans to cover certain types of providers and services in each network. The biggest change is that companies could skirt rules that are stricter than ObamaCare's.

"All that's saying is, you get to do something different as long as you do the same thing you're doing before," Miller added.

In the GOP's ideal world, companies would be selling insurance across state lines without the mandatory coverage requirements of ObamaCare.

Candidates like Trump have vowed to entirely repeal the healthcare law. States would again set their own regulations, leaving GOP-controlled statehouses to set low regulatory bars with hopes of driving down the costs of health plans.

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"We have to get rid of the lines around the state, artificial lines, where we stop insurance companies from coming in and competing," Trump said at Sunday's debate, condemning what he described as insurance "monopolies" in states. "We want competition."

But healthcare experts have long been skeptical about the plan, because they say there's been no evidence that it would actually spur competition among insurers.

In the two years before ObamaCare, 14 states tried to pass bills that would make it legal to sell multi-state plans. But no insurer ever tried to sell their plans out-of-state.

Rhode Island was the first to approve legislation on the issue back in 2008. It allowed for the start of a New England-based health insurance market and called for a study into bringing out-of-state insurers into Rhode Island without additional licensing.

That study was never completed, and any hopes for the idea have since faded, according to Rhode Island Health Insurance Commissioner Dr. Kathleen Hittner.

"We personally, at this time, do not believe this is a good idea," Hittner said in an interview.

She said the idea was floated recently as a way to entice a specific insurer into the state marketplace, but it was "fought vigorously" by existing Rhode Island insurers.

The biggest problem with the idea is a practical one, Hitter said.

Any insurer entering a new marketplace has to sign contracts with providers and hospitals in that state to offer those services. It's difficult work already but far tougher when a company doesn't have a footprint in that state.

"Creating the network is not such a simple thing," she said. "You have to really worry about network adequacy."

Insurance experts say there's still a lot unknown about the ObamaCare provision on cross-state plans.

Few details were included in the initial legislation, and the Obama administration was charged to work with the National Association of Insurance Commissioners to write the rest of the rules by 2013.

But one staff member with the group representing commissioners said this week that they were never contacted. And they don't even support it.

"Not a single state carrier has ever asked to do this," said the staff member, who requested anonymity because they were not authorized to speak on behalf of the group.

Without the federal government's regulations, state insurance officials who decide to get on board with the policy would be left to figure out much of the logistics.

That's particularly hard for insurance regulators when they're weighed down by existing struggles with ObamaCare, such as double-digit premium hikes and insurance companies deciding to leave their states.

"It's a talking point. But we know it's been discussed and discussed and discussed," the member said. "At the end of the day, it's just not going to work."

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Mr. CICILLINE. And I yield back.

Mr. FARENTHOLD. Thank you very much.

We'll now recognize the Chairman of the full Committee, the gentleman from Virginia, Mr. Bob Goodlatte.

Mr. GOODLATTE. Well, Mr. Chairman, thank you. And thank you for holding this hearing.

And I want to commend all the witnesses. This has been an excellent discussion. I think it's very helpful.

A couple of things that I think are a reality here that we all ought to focus on. One is that similar legislation passed a few years ago by 406 to 19. So the odds are we're going to pass it again. The question is what should it look like, so I'd like to get some of you to focus on that.

But before I do that, I'd like to pick up where the Chairman left off, on the issue of what is causing this problem in terms of regulation.

I happen to believe that competition is good. That's our objective. It will help to hold down costs. And McCarran-Ferguson may be an impediment to some of that competition. I will say that I think the largest problem here we have with choice and healthcare costs is related to overregulation by, first, the States—and this problem existed prior to the Affordable Care Act coming into being—and then, to some extent, the Federal Government stepped in and expanded upon that by dictating to virtually every insurance company in America what should be in every health insurance plan in America.

So that's, in my opinion, why there's not a lot of competition across State lines, because there isn't any incentive to have that competition. If have you to go in and comply with the States' regulations and you have a homogenized Federal regulation, the net effect of that is that only the big guys are going to be able to succeed and continue in the marketplace.

But here's my question for you, Mr. Woody. I think Mr. Balto gave an example for Virginia about Blue Cross Blue Shield, which I was very interested in since I represent Virginia. I don't represent the parts of Virginia that are affected here, so I feel very comfortable asking the question.

But he said that Blue Shield Blue Shield has an agreement that they don't compete with each other, separate Blue Cross entities don't compete with each other. So the Blue Cross in Richmond doesn't do business in northern Virginia; the one in northern Virginia doesn't do business in Richmond.

Wouldn't the elimination of McCarran-Ferguson enable State and Federal Governments to step in and say, why aren't you competing in these two separate marketplaces and providing at least some more choice for consumers?

Mr. WOODY. Well, I have a disadvantage over Mr. Balto in that I'm not an antitrust lawyer, and I'm certainly not an expert in the blues. But I'll tell you what I do think I know about it, and that is that the antitrust law has developed such that market allocation cases, instances where defendants have tried to assert a McCarran-Ferguson defense have generally not been very successful. And I understand that even in a recent case involving Blue Cross it wasn't successful.

I saw a Law Review article just the other day that said that——

Mr. GOODLATTE. So do you think it's just Virginia's choice that they're not going to try to encourage this competition within their State?

Mr. WOODY. I don't know what Virginia's choice is, but what I do know is that McCarran-Ferguson does not, I think, present a barrier to going after these market allocation issues.

Mr. GOODLATTE. Let me ask Mr. Balto to respond.

Mr. BALTO. Well, you know, we could have a lengthy discussion of, you know, the nature——

Mr. GOODLATTE. Not too lengthy, because I've only got a minute and a half left.

Mr. BALTO. Yeah. So, no, the defense has applied in certain circumstances. The fact that there are some district court decisions that have narrowed the defense just shows the problem of the defense. Courts work actively to try to narrow it, whereas it should just be eliminated because it's not serving any purpose. There is, as my testimony documents, harmful conduct that does come about because——

Mr. GOODLATTE. Okay. Let's see what we can agree upon in terms of what we should preserve. If we are going to do this, we've talked about keeping the ability for loss histories to be preserved. Are we all in agreement that we should allow insurance companies to have that, or should it just be smaller insurance companies? If you're above a certain size, should you not be able to share that information, or should everybody share that information?

Mr. BALTO. The caselaw and the statements of the antitrust enforcement agencies are crystal-clear on this. That conduct is legal so long as it's properly structured. There is no antitrust risk from that kind of conduct.

Mr. MILLER. There's a line between the assembly of the historical loss data and then you get into trending and beginning to move toward signaling rates. And that's where I think there's a little bit of a barrier to it.

Mr. GOODLATTE. So build on that, Mr. Miller. And let me ask Mr. Woody, as well. Assuming we are going to take action here, what kind of things should be looked for to make sure we have in this measure that changes or repeals McCarran-Ferguson?

Mr. MILLER. Well, I'm not a fanatic about this in terms of the exemption is so wonderful you have to keep it. I'm saying—and you're only a Subcommittee of particular jurisdiction, but you need to see this in the larger context. Not all antitrust regulation is procompetitive. It depends on the eye of the beholder and who's there. And so you're opening up a toolbox which could be used for other purposes as well.

Mr. GOODLATTE. I get that. But what kind of—you may want to write to us afterwards, but what kind of things—what kind of precautionary——

Mr. MILLER. I'm generally comfortable with the type of safe harbors—there's elements beyond historical loss data. There are some elements of building common forms, if they are not coercive, where they're put as options out on the table, where coordinated activity, whether it's advisory organizations, has some validity as well.

Mr. GOODLATTE. All right.

Mr. MILLER. There could be joint underwriting activities for high risks, which are a valid—and that's generally accepted under rule of reason. If you want to legislate it, you can do it, although the courts have handled that fairly well thus far.

Mr. GOODLATTE. Mr. Chairman, my time has expired. I just want to make one last point.

And I think that when we talk about the difference between the disparate effect of McCarran-Ferguson that I think Mr. Woody pointed to in property and casualty insurance and in health insurance, I would say that the biggest explanation there is again going back to the regulations. While States do regulate property and casualty insurance, they don't get into the minute details of telling insurance companies what they have to cover and under what circumstances they have to cover. And I think that has both driven up cost and driven down competition and driven down choice for consumers, and we've got to find a way around that.

I'm very interested in anything you submit to us following this in terms of how to frame this legislation as the Committee considers it.

Mr. FARENTHOLD. Thanks, Chairman Goodlatte.

We'll now recognize the Ranking Member of the full Committee.

Mr. CONYERS. Thank you so much.

George Slover, Consumers Union. Your testimony, to me, captured what I think is key here, and I've got a couple questions for you.

Mr. Miller's testified that current enforcement tools and regulatory policies already address competition issues at the State and Federal level. How do you respond to that?

Mr. SLOVER. Well, the health insurance marketplace is very complex, and there is a regulatory framework that has developed over many years to try to deal with some of that. It's developed in the absence of the antitrust laws being applicable. And there are parts of it that seek to set baselines to protect consumers. There are also some States who choose to enforce their competition laws, even though the Federal antitrust enforcement agencies can't do that.

But there is no substitute for having the Federal antitrust laws apply, and for the industry and the people in the industry to take heed of that when they're making decisions about how they're going to structure their relationships with their competitors.

Mr. CONYERS. So we need a Federal involvement in this whole consideration?

Mr. SLOVER. I believe that would be very helpful, yes, sir.

Mr. CONYERS. Uh-huh.

Now, what about the suggestion that State insurance commissioners are in the best position to promote competition and other issues in the health insurance costs? How do you feel about that?

Mr. SLOVER. Well, they are regulators; they are not competition enforcers. And they just come from a different background and have different goals. And I think you want to put the competition policy enforcers in charge of enforcing competition policy.

Mr. CONYERS. So you don't agree with this position.

Mr. SLOVER. I think State regulation definitely has a role to play, and they can play that role alongside Federal antitrust enforcement.

Mr. CONYERS. Uh-huh.

Now, do you think that McCarran-Ferguson's exemption no longer serves a legitimate purpose? I mean, that was back in 1945. Have things developed since then that don't make this as important a consideration as it once was?

Mr. SLOVER. I don't think it was really needed, even back in 1945. I think the practices that the insurance industry wanted to engage in that were legitimate, and didn't harm competition, they would've been able to engage anyway. I also think State regulatory authority was going to be fine. I think that's become clearer as the antitrust laws have evolved and the caselaw has evolved over the 70 years since then. But I don't think it was necessary then, and I certainly don't think it's necessary now.

Mr. CONYERS. Uh-huh. Well, thank you very much for your position as a leader in Consumers Union.

And I yield back my time if there's any left.

Mr. FARENTHOLD. Thank you very much.

We'll now recognize the gentleman from Georgia, Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

I think one of the more telling points here—and I think it was a good point—is a concern here, but also from the Chairman just a few moments ago, that, you know, this is an idea that has seen in this Congress a very, I guess, positive vote, depending on which way you're going to look at it. And so the question is a little bit more of how do we make sure that this is, you know, properly done if this is the way we're continuing.

So one of the questions I have—and just a few questions here. Because I think what we have seen—and I'm going to bring this up again in a moment. But I think one of the things we have seen in the healthcare market, especially in the pharmacy benefit manager perspective, is we have seen how monopolistic, terroristic kind of organizations can do to an independent community healthcare field.

So, Mr. Miller, let me just—just a couple of quick things. With the exception of per se violations, would you agree that the Sherman Act only prohibits anticompetitive conduct that unreasonably restrains trade?

Mr. MILLER. That's how it's written. That's not always how it's enforced. Give me a period of time, and I'll give you different versions of antitrust.

Mr. COLLINS. We'll give you who's interpreting on the Court. Great. I love that.

Would you agree that the FTC Act only bans that and not all methods? It only bans that quote part but not all methods of competition, correct?

Mr. MILLER. All right, all right. I'll play along. Yeah.

Mr. COLLINS. You'll play along with that one? Okay. Then why, then, would health insurers need to be able to engage in unreasonable restraints on trade or unfair competition?

Mr. MILLER. I'm not in favor of them doing that. We have other tools to handle that.

Look, part of this argument, if you really want to boil it down politically, is a disagreement over whether—you know, different States may have different views as to the type of competition and

type of regulation they want. There's an impulse to say, let's do it all at the Federal level and let's make it uniform, and let's go hunting for things and we'll figure out kind of what it is.

So the question is whether there might be different political preferences and different degrees of regulation in different States. That goes back to the interstate proposal. It's not to enshrine the Affordable Care Act's menu in every State in the same way under a different wrapper. In a world in which you might have different brands of State insurance regulation, consumers could choose which regulation they want as part of their insurance package. We can't do that today because the marketplace has changed. That's the original concept and——

Mr. COLLINS. And, you know, reclaiming my time, I think that's a great argument to have at another hearing, and I think that's a——

Mr. MILLER. Well, it came up at this hearing.

Mr. COLLINS. And I agree with you. But I think that is one of the problems that we are dealing with. You're very right in that regard. I'm not—this, I think, is one of the—just before I move on, real quick, will the sky fall down if McCarran-Ferguson is repealed?

Mr. MILLER. I think I said in my written testimony the sky wouldn't fall down, but the sun, when it rises, is going to be clouded by a lot of other problems.

Mr. COLLINS. Oh, okay. We can go on that.

Mr. Balto, there is clearly a lack of competition in health insurance markets throughout the country. We're seeing that right now. One-third is basically represented by one or less, actually. Would eliminating this exemption make that worse?

Mr. BALTO. No. In fact, it would potentially lead to improvements here. Right now, dominant insurance companies can engage in anticompetitive practices to keep new entrants from the market, and they can claim that that's protected by the McCarran-Ferguson Act——

Mr. COLLINS. Okay.

Mr. BALTO [continuing]. Or they can deliver inferior services to consumers.

Mr. COLLINS. Well, and one of the things—and, again, not necessarily projected by the McCarran-Ferguson Act—is I think—and it's what I mentioned here just a minute ago—I think we're seeing how a monopolistic look at a health care—from a regulation standpoint or unregulated, however we look at it. And we're particularly dealing in the pharmacy benefit manager perspective—which is, you know, doing nothing but terroristic raids on independent community pharmacists. They're hijacking the price setup. They're trying to claim, you know, rebates and passing on the savings to others, which has been proved false on many occasions.

And right now I do realize that there is a large generated money machine ready to try to rebuke everything that I've said over the past 2-1/2 years on this issue. The problem is you can, you know, smear all the makeup you want on that pig but it ain't going to look good.

And so I think this is an area where we need to continue to look at, and I appreciate your concern on this.

Mr. BALTO. Yeah. If I could just reply to that, there is a fundamental problem in lax regulation of payors, such as PBMs and insurance companies. And the people who are on the front lines—the doctors, hospitals, and pharmacists—are being given take-it-or-leave-it reimbursement terms that ultimately result in poor health care for consumers.

Mr. COLLINS. Exactly. And I think—and that's the one part of that. It's why I bring it up here, but I think that's one of the issues that we do need to address. But it shows what happens in this kind of a constricted market.

So, again, with that, Mr. Chairman, I thank you, and I yield back.

Mr. FARENTHOLD. Thank you very much.

And we'll stay with the great State of Georgia and recognize Mr. Johnson for 5 minutes.

Mr. JOHNSON. Thank you, sir.

Mr. Miller, would you agree that the insurance marketplace should be left free of government regulation?

Mr. MILLER. No. That's a little extreme. Left free of regulation? I mean, I like the First Amendment that says there should be no law, but we do go beyond that and suggest that maybe occasionally we should have a few other things—enforce fraud and property rights, steady rule of law. There's plenty of role for government regulation. It's not a, you know, absolutist, night watchman alternative.

Mr. JOHNSON. But, basically, you would want the laws of the free market economy, so in other words supply and demand, to be able to dictate prices within the insurance marketplace.

Mr. MILLER. Well, generally, the role of government is to say it's our job to restrain competition rather than private parties to do it. And it's done a pretty good job of it in the healthcare space.

Mr. JOHNSON. Yeah, but you would agree, though, that the health insurance marketplace should largely be free of government regulations so that the law of supply and demand is what determines prices.

Mr. MILLER. That's a simple construct and a starting point. Obviously, it's much more complicated than that alone.

Mr. JOHNSON. I understand. Well, do you agree that monopolistic behavior distorts the free market force of supply and demand?

Mr. MILLER. There are practices that move toward monopoly which need to be policed.

Mr. JOHNSON. Well, let me ask you——

Mr. MILLER. There are also monopolies that arise because someone else does a better job.

Mr. JOHNSON. Let me ask you the question this way and ask you for a yes-or-no answer. Do you agree that monopolistic behavior distorts the free market force of supply and demand, yes or no?

Mr. MILLER. Yes, in those simple terms.

Mr. JOHNSON. Now, would you agree that the antitrust laws protect against monopolistic behavior?

Mr. MILLER. I think they are written to do that. They have not always done that in practice.

Mr. JOHNSON. Well, if we did not have any antitrust laws, do you believe that monopolistic behavior would go away, or would it predominate?

Mr. MILLER. We've had lots of monopolies supported by government policy. That's the historical record.

Mr. JOHNSON. Well, are you saying that we don't need antimonopolistic legislation?

Mr. MILLER. We need better antitrust policy. Just enacting a law isn't the same as carrying it out in a market-competitive manner.

Mr. JOHNSON. Well, let me ask you this. Is it your position that applying antitrust laws to the health insurance marketplace will result in higher insurance costs to consumers?

Mr. MILLER. It's an open question.

Mr. JOHNSON. Well, shouldn't we try—after 70 years of exemptions from antimonopolistic conduct, shouldn't we try at this point to bring a little less monopolistic behavior into the healthcare marketplace?

Mr. MILLER. My testimony has indicated that we've already been applying a lot of antitrust and procompetitive——

Mr. JOHNSON. How?

Mr. MILLER [continuing]. Policies.

Mr. JOHNSON. How?

Mr. MILLER. States have a wide latitude to apply all of this. Merger enforcement activity goes on. There are a range of activities which are not within this exemption whatsoever——

Mr. JOHNSON. Well, let me ask you this.

Mr. MILLER [continuing]. And they've been doing enforcement actions as a result of it.

Mr. JOHNSON. Isn't it a fact that States have not done any antitrust enforcement solely on their own, without taking the lead from Federal enforcers over the years?

Mr. MILLER. Well, that's what Mr. Balto's testimony wants you to believe. I think that's a judgment from time to time depending on who the personnel are in place. They allocate the resources. There are different views as to what a particular State, you know, should or should not do. That's part of the diversity across 50 States, rather than saying, here's one single policy.

Mr. JOHNSON. Well, let me ask you this question, Mr. Miller. The American Medical Association has studied the health insurance marketplace for the past 15 years, and they have found that there is "a near-total collapse of competition among health insurers." Do you——

Mr. MILLER. I think that's overstated. Their methodology has been criticized by some people, including myself. There are ways in which you can draw lines. They have their particular point of view, and they want to magnify that. It's not that stark a situation.

There are problems in doing statewide levels. Now, there are different ways to break it up in terms of metropolitan areas, but you can play a lot of games with statistics on that.

Mr. JOHNSON. Gosh, Mr. Balto, you've got 6 seconds to respond to anything that has come before you.

Mr. BALTO. I disagree with everything Tom says.

But, look, just on the higher cost issue, years ago we eliminated antitrust exemptions like in the airline industry and railroads, and

there were tremendous cost savings. But the question here, is do you want to have private regulation, you know, private parties, competitors determining the terms of competition, or do you want to have the forces of the free market.

Thurgood Marshall said that the antitrust laws are the Magna Carta of our free market system. Why should we cut them short when it comes to health insurance?

Mr. JOHNSON. Thank you.

Mr. Slover, it's good to see you.

Thank you for coming, Mr. Woody.

And, with that, I yield back.

Mr. FARENTHOLD. Thank you very much, Mr. Johnson.

We'll now recognize the gentleman from Florida for 5 minutes.

Mr. GAETZ. Thank you, Mr. Chairman.

My question is a simple one, Mr. Balto. And as I've spoken with a number of my Republican colleagues, they answer the question in almost diametrically different ways.

Today, under current law, are health insurers allowed to functionally collude on price?

Mr. BALTO. That technically would not be exempt under—the exemption would not apply to that.

Mr. GAETZ. When you say "technically," so does that mean that the type of information that health insurers are allowed to share with one another facilitates outcomes that walk and quack like collusion?

Mr. BALTO. No. First of all, if they engaged in naked price fixing, that would be illegal under the Act. If they want to engage in the kinds of things that, you know, Mr. Woody is talking about, the black letter law at this point is that sharing information is legal under the law.

Mr. GAETZ. So does the consequence of the sharing of that information result in monopolistic tendencies in the price space?

Mr. BALTO. No, I think everybody—in terms of sharing historical information, I think everybody sees that as being procompetitive. But Mr. Miller says that they don't even need to do that and they don't really do that in the health insurance industry.

Mr. GAETZ. I guess my next question relates to the extent to which——

Mr. MILLER. Well, they do it in different ways. And the question would be whether——

Mr. GAETZ. Right. I'm on to a different question.

Mr. MILLER. Okay.

Mr. GAETZ. So, as we look at a potential for ACA reforms and replacement that would allow people to purchase insurance across State lines, in the absence of dealing with this McCarran-Ferguson question, would we see the choice impact of those reforms impaired?

Mr. BALTO. You might not, because the exemption provides a dominant insurance company to engage in anticompetitive conduct to keep new rivals from entering their markets. So the goals of ACA reform might be stifled if you permit this exemption to continue.

Mr. GAETZ. Mr. Miller, would you agree that the goals of those reforms to enhance consumer choice would be stifled in that context?

Mr. MILLER. It's not going to have much of an effect, this particular reform. There's a lot of other reforms that would.

Just in terms of the interstate thing, one of the biggest barriers to having interstate competition is individual State insurance commissioners who believe that their approach to regulation is perfect——

Mr. GAETZ. Well, sure, but we're contemplating——

Mr. MILLER [continuing]. Anyone else.

Mr. GAETZ. Right. I think it's pretty out there that we're contemplating some functional preemption of that, where we would not allow States to be able to bar people from being able to cross State lines for the purpose of purchasing insurance.

The question is, if we do not enact reforms that Mr. Gosar and Mr. Scott were advocating this morning, do we limit the effect of those choice protocols?

Mr. MILLER. You can legislate right around it. Look, there's older bills, and you know a number of them, which have set up a template of primary State insurer and the secondary State, domicile-based choice by the insurer as to where they're going to be regulated. There are models for doing that which don't in any way get to the particulars of the antitrust exemption.

Mr. GAETZ. Mr. Balto, I served in the Florida legislature, and, you know, I saw the interaction that we had between health insurers in our State.

Do you have a fear that there are circumstances around the country where States have sort of wrapped their legislative apparatus around the business models of various health insurers, leading to anticompetitive outcomes?

Mr. BALTO. Yes. Oftentimes, there are relationships between the legislatures and the insurance commissioners and insurance commissioners doesn't effectively police the market.

In your State, unfortunately, for example, in the Aetna-Humana merger, the insurance commissioner did a very cursory review of the merger. Ultimately, the Justice Department sued and blocked the merger because of the substantial harm to Florida consumers.

Mr. GAETZ. Thank you, Mr. Chairman. I yield back.

Mr. FARENTHOLD. Thank you very much.

We'll now recognize the gentlewoman from Washington, Ms. Jayapal.

Ms. JAYAPAL. Thank you very much, Mr. Chair.

Thank you for your testimony.

And, Mr. Slover, thank you for all of your work at Consumers Union.

I come from the State of Washington, and I want to direct a few questions to you so I can understand what the impacts of this would be on a State that, frankly, has embraced the Affordable Care Act, and has put in place a relatively strong insurance commissioner. We do have a fairly robust insurance set of plans and insurers in the State. And we also have had, I think, decent oversight on many of our plans to make sure that we have small insurers that are able to participate.

Part of our success also is that we, in our strong market, is that we moved very early to expand access to the State's Apple Health Care Medicaid program and chose to run our own State exchange.

At the same time, our premiums are still too high. They are much lower than they are for the midlevel plans compared to the Federal increases and premiums, but we have had two insurers drop out and two more that potentially might drop out in 2017. I'm trying to understand how a repeal would affect a State like Washington, where we've actually embraced regulation at the State level in a way that benefits consumers.

Could you speak a little bit to those issues of a repeal and how we put in place protections so that we don't have a race to the bottom as we open up the marketplace but we actually protect the strong regulation that we already have in place in the State and strengthen it further?

Mr. SLOVER. Sure. Well, we are supporters of the Affordable Care Act, and whatever happens in the future, there are a lot of specific protections that are in that Act that we think are very important.

What this legislation that's before us does is to add a dose of competition to the mix, that's lacking right now. We don't want everything that we want an insurance company to do to have to be regulated, to have to be a regulatory requirement. We would like the free market incentives of competition to also come into play, so that whatever a State decides is a minimum floor that needs to be set for some protection doesn't become the ceiling because the insurance companies all agree, "Well, we've got to follow whatever the State's telling us to do, but that's all we're going to do, right, guys? We're not going to see if we can cut consumers a better deal. We're going to stick together on this so the consumers don't take advantage of us."

We don't want businesses with that instinct. We want businesses with the instinct to say, "Okay, we've got this requirement. What else can we do? We have a certain market share now. We'd like to get more consumers buying from us, so we're going to look for ways to make our service better."

Ms. JAYAPAL. If we did repeal this, are there particular protections that you would want to see put in place in the manner in which we repeal it?

Mr. SLOVER. I don't think allowing competition to be added to the current mix is going to create any uncertainties or dangers that would need to be separately addressed. I think those still need to be considered, as they have been. And whatever those decisions are, they will be augmented, the benefits to consumers will be augmented by having competition.

Ms. JAYAPAL. I did have a question for Mr. Miller.

Mr. Slover had stated that regulation and competition both work best when they can work hand-in-hand. What is your response to that?

Mr. MILLER. I think if we had less health insurance regulation we might be able to accommodate more antitrust regulation as a backup move. And I signaled that in my testimony. I'd like to see that mix put on the table.

Ms. JAYAPAL. So you would support strong regulation in conjunction with——

Mr. MILLER. A balanced regulation.

Ms. JAYAPAL. And what does that——

Mr. MILLER. It's a matter of degree. What I'm saying we are regulating this space so heavily through so many tools that adding more on top of it is piling more on, not just redundancy, but actually adding to it.

If instead you had freer competition at the baseline level in other areas of regulation of health insurance, then there is an argument that could be made, as a backup policing move, that the normal operations of better versions of antitrust may be more appropriate in that regard.

Ms. JAYAPAL. I have just 20 seconds left, but can I push you a little bit on that? Just tell me, what balanced regulation would you support?

Mr. MILLER. Well, depends which Administration you're talking about. We improved antitrust regulation quite a bit in the late 1970's and the 1980's. It slipped backwards over the last decade in general.

Ms. JAYAPAL. So no specific—go ahead.

Mr. MILLER. I can elaborate in some followup testimony. You asked for a quick answer.

Ms. JAYAPAL. Go ahead. You've got a couple more seconds.

Mr. BALTO. Yeah, I can't think of anything worse than suggesting that we slip backwards in antitrust enforcement. In the Bush administration, there were over 400 health insurance mergers; they didn't challenge any. When they've gone back and done econometric studies, they found that consumers are paying a lot more for their health insurance. The Obama administration reversed that, and I hope those gains are retained in the new Administration.

Ms. JAYAPAL. Thank you.

I yield back.

Mr. FARENTHOLD. Thank you very much.

We'll now recognize my colleague from Texas, Mr. Ratcliffe.

Mr. RATCLIFFE. Thank you, Mr. Chairman.

Mr. Woody, I want to start with you because you've staked out kind of an interesting middle ground, it seems to me, as a property casualty insurer.

The group that you represent doesn't appear to be directly impacted by the current legislation. I guess, first of all, am I correct with respect to that? And if that's the case, do you have a concern regarding the repeal of McCarran-Ferguson?

Mr. WOODY. It is correct that the bill as it's currently drafted does not apply to property casualty insurers. Our concern is that we rely on the McCarran exemption, though, I think, much more than the health insurance industry does. So we're looking down the road and saying, well, if they repeal it for the health industry, we might very well be next. And I think we have a bigger stake in it, actually, than the health insurers do.

Mr. RATCLIFFE. Okay.

Well, so let me ask you a followup question. Data sharing is one of the key activities that insurers cite for maintaining McCarran-Ferguson. But one criticism of the exemption is that it doesn't distinguish between procompetitive and anticompetitive data sharing.

Do you think that's a valid criticism?

Mr. WOODY. I don't. I actually think that the data sharing that goes on in the industry is largely procompetitive. And I think there may be some agreement on the panel about that. I think it's working fairly well, the State system is working fairly well to police activity, anticompetitive activity that shouldn't be allowed, and yet allow the procompetitive activities that are good for consumers.

Mr. RATCLIFFE. Well, I'm guessing maybe Mr. Miller agrees with that.

Mr. MILLER. Sure. I mean, that's pretty well-established.

There's a little bit of an odd contradiction in some of the arguments here, which is that all these things antitrust currently would say is okay, that's why it's so vital that it be restored in order to police these things, which is already waving it ahead and saying is all right.

Mr. RATCLIFFE. I noted in your written testimony you said that we've seen a shift in tighter Federal regulation following the passage of ObamaCare. What impact has that increased regulation had on the current marketplace with respect to competition, pricing, product offerings?

Mr. MILLER. If you're asking me, a more narrow range of policies that people can choose from. That's why a number of people are upset in the outside market that they had to either change provider networks or the policies they previously had—well, there's been some grandmothering to paper that over.

In addition, we've had in many areas—it's done more on a county basis than a population basis, that's a different measure, in terms of a single insurer in a lot of the marketplace exchanges, as the early rush in has been followed by an exit out as insurers find out it's not a good business to keep losing money based upon the prescribed formulas in which they have to operate.

Mr. RATCLIFFE. So how would repealing McCarran-Ferguson impact that further?

Mr. MILLER. No, what I've said is that it's not really an issue of repealing McCarran-Ferguson really helping it or not. It's reconsidering those policies as part of the broader regulatory mix.

Mr. RATCLIFFE. Okay.

Mr. Balto, I want to give you an opportunity here. Your position was very clearly stated when you said you think that McCarran-Ferguson does nothing but bring uncertainty and confusion to the market.

You've said that State insurance commissioners don't necessarily have the capacity to fully understand or to fully address the problems that their State residents are experiencing. But the National Association of Insurance Commissioners has submitted a letter, in this case, opposing repeal. So where do you see the lack of capacity playing out?

Mr. BALTO. So when we've studied this issue—and we went back and studied it again and will continue to study it—you've seen very sporadic actions by State insurance commissioners. And if you were to contrast that, Congressman, with other industries where we have a Federal consumer protection enforcer, the Federal Trade Commission, it's dramatically different. You have one enforcer

which has sophistication, the resources to bring the kinds of nationwide cases we're looking for.

By the way, going to a point you were making before, this whole debate about the regulations to protect consumers, one way McCarran causes harm is it keeps the FTC out of the game. And because we don't really have an effective Federal enforcer, we have to look more toward Federal regulation to protect consumers, whereas if you eliminate McCarran and the FTC becomes the Federal consumer protection enforcer here, you might not have to rely on regulations quite as much.

Mr. RATCLIFFE. I want to thank all the witnesses for being here. Mr. Slover, I'm sorry, my time's expired, but I appreciate you all being here.

I yield back, Mr. Chairman.

Mr. FARENTHOLD. Thank you, Mr. Ratcliffe.

We'll now recognize the gentleman from Illinois for 5 minutes.

Mr. SCHNEIDER. Thank you, Mr. Chairman.

And I want to also thank the witnesses for being here, for sharing your perspectives on a debate that, as you have all touched on, has been going on since McCarran-Ferguson was introduced, let alone passed.

I'd like to start with Mr. Slover, please.

One school of thought holds that repeal of McCarran-Ferguson won't necessarily achieve the desired objectives of providing affordable, accessible, high-quality health care. How would you respond to that? And why do you get a sense that they're arguing it won't move the needle?

Mr. SLOVER. Well, I think competition is always a good thing. I think this marketplace also needs regulation. And they work in tandem, or that's how they ought to work, is in tandem, and that competition will spur businesses to want to—the insurance companies here, the health insurance companies—to find a way to give consumers a better deal because their business will thrive as a result of that.

So in all kinds of ways the whole principle behind antitrust is that you don't want competitors getting together and saying, you know, "We're feeling a lot of pressure from competition now. If we all sit down and talk together, we can figure out a way to take some of this pressure off so that consumers won't be taking such advantage of us, and we'll be able to get a better deal for ourselves in the marketplace."

You don't want that kind of an instinct to develop as a way of doing business. And, in general, having the antitrust laws there, you don't have to bring an enforcement action every day. Just the fact that they're there is going to change business instincts for the better.

Mr. SCHNEIDER. Mr. Balto, do you want to expand on that?

Mr. BALTO. That was a great answer. I can't do better than that.

Mr. SCHNEIDER. Fair enough.

One of the debates happening in Congress right now is whether or not to repeal the Affordable Care Act, whether we repeal the Affordable Care Act without a replacement.

What impact would a repeal of McCarran-Ferguson, repeal of the Affordable Care Act without replacement, what sense would you have that would have on the marketplace?

Mr. Balto?

Mr. BALTO. First, at the end of our testimony, it builds on George's point that you need a mix of antitrust enforcement and smart regulation to make these markets work effectively. And I think it's worth everybody taking a look at it to sort of see how regulation does really improve the nature of competition.

I think eliminating this just provides greater opportunity for competition to fully break out, and that's something that's necessary to make health insurance markets work. And if that happens, then, you know, we may need to rely somewhat less on regulation as we go forward.

Mr. SCHNEIDER. Mr. Miller?

Mr. MILLER. Well, what I usually hear is the addition key and not the subtraction key or the balancing key—more, more, more. If there's a window to think about a better balance, that's a more promising avenue in which to follow.

Mr. SCHNEIDER. But is it a fair question—you look at the Affordable Care Act that has tried to increase competition. Overall, I think the assessment is, over the last number of years, the rate of increase in healthcare costs have come down, but we're seeing that health insurance costs and the competition in States like Illinois isn't what we had hoped it would be.

How would repeal of McCarran-Ferguson address——

Mr. MILLER. I think it's really somewhat to the side of it, and that's the reason why you had the Congressional Budget Office view in 2009 on similar legislation that it really wouldn't have much impact in either direction.

However, we have to be careful of what we call competition. What the Affordable Care Act wanted was a particular type of highly managed, highly regulated "competition" in quotation marks, which was to achieve certain results. They haven't worked out as materialized, but it was not the same thing as a consumer-directed level of procompetitive activity.

Mr. SCHNEIDER. And Mr. Balto?

Mr. BALTO. And my testimony directly addresses that and shows that there have been savings because of some of those regulatory provisions. But just to give one concrete example, when you talk about the market division in Virginia affecting Mr. Goodlatte's constituents, there's clearly added costs that might come about because of the McCarran-Ferguson Act. It dampens the type of competition that would otherwise occur.

Mr. SCHNEIDER. Okay.

Again, I'll thank the witnesses for your testimony and your input and thank the Chairman for calling this hearing. Thank you very much. I yield back.

Mr. FARENTHOLD. Thank you.

We'll now recognize the gentleman from California for 5 minutes.

Mr. SWALWELL. Thank you, Chair.

Mr. Slover, you've expressed your support for the Affordable Care Act and its important provisions that have extended health insurance coverage to millions of Americans. This landmark legislation

has even saved the lives of people like Terri, one of my constituents from Dublin, California.

Before the Affordable Care Act, Terri did not have access to proper medical care. After the Affordable Care Act was passed, Terri got covered and was able to get preventive care. During a well-woman exam, it was revealed that Terri had early-stage breast cancer. By catching her cancer early, she was able to undergo surgery and is now cancer-free. Without the Affordable Care Act, Terri tells us she would never have received the preventive care that she credits for saving her life.

While I've heard countless stories like Terri's, House Republicans are looking to dismantle the hard-fought protections of the Affordable Care Act. How do you think Congress should be working to strengthen the Affordable Care Act and ensure people like Terri from Dublin, California, can keep their coverage?

Mr. SLOVER. Well, we're strong supporters of the Act, and we want to see whatever is changed to continue the essential protections that are in the Affordable Care Act, to build on those, rather than to undermine them.

And I could take some time to tell you some of the key things that we think are benefits of the Affordable Care Act that we think need to be preserved.

It should cover as many or more Americans as currently—not just make coverage "available" in some sense, but actually be as affordable or more affordable to those who are now covered.

Preexisting conditions should not be excluded or charged at a higher rate. Families are now protected against being frozen into keeping the same insurance company, or keeping the same job because that's where they get their insurance, or being devastated when circumstances force them to switch insurance companies or jobs.

A family should all be able to stay on the same health plan until the kids are grown and out of the house and have their own jobs.

A basic package of health benefits should be as good or better than what's available now.

There should be no caps on coverage, not annual and not lifetime. They would've probably affected your constituent that you're talking about. We don't want consumers to be hit with devastating illness and then find that they don't have insurance any longer to cover that.

There should be strong, clear provider network standards.

The choices of available plans must be clear and understandable.

And then there's a lot in the Affordable Care Act that doesn't make the headlines but that has been critically important for bringing down the cost of providing health care while also improving patient safety and quality of care, and those programs should continue.

And that's just a short list. You know, we could spend all day talking about what the benefits are. Our point is just there's a lot of good stuff there, and we want to see it kept.

Mr. SWALWELL. Mr. Slover, I was talking to a small-business owner in the East Bay area of California over the weekend, and he told me something that I don't think gets enough attention. He said, look, I'm a small-business owner. I'm exempted from the Af-

fordable Care Act because I have 50 or fewer employees, so I don't have to provide healthcare coverage to my employees.

But he said, what I appreciate about the Affordable Care Act is that, each year, before the Affordable Care Act, my team, management team, would have to sit down and look at how astronomically high the coverage costs have been, and then we'd have to figure out how to cover the difference, and sometimes that meant, you know, increasing the deductible amounts so that our employees could afford it.

And he said, what I've noticed since the Affordable Care Act is that we don't have to have those pressure-point decisions anymore, meaning that he hasn't seen the costs of health care go up as much or at the same rate that it was going up before the Affordable Care Act went in place.

So what he is saying is he doesn't even fall under the Affordable Care Act as far as now having coverage and didn't have coverage before, but because so many other people have coverage, he's noticed that the cost of healthcare coverage for his company and providing for his employees has gone down. Have you seen that?

Mr. SLOVER. Yes. I think a rising tide lifts all boats. And California has been particularly good in implementing the Affordable Care Act. One of our offices is in San Francisco, so we're very well aware of how things have improved in California, and we hope that will stay.

Mr. SWALWELL. Great. Thank you.

Mr. Chair, I yield back.

Mr. FARENTHOLD. Thank you very much.

Seeing as we have no other Members with questions, I want to take this opportunity to once again thank our panel of witnesses and welcome Mr. Cicilline. This is his first day as the Ranking Member of the Committee. I'm the Vice-Chairman of this Subcommittee. You will usually see Mr. Marino sitting up here.

But I hope I made your first day a pleasant one.

Mr. CICILLINE. You did. You did.

Mr. FARENTHOLD. And I would also remind our panelists that the Chairman of the full Committee, Mr. Goodlatte, did indicate that the political climate is such that the repeal of McCarran-Ferguson is likely, and if you all have concerns about how it's done, now is the time to let the Committee know about it. And we would welcome any followup you have in writing.

So thank you all again very much.

And, with that, this Subcommittee is adjourned.

[Whereupon, at 11:59 a.m., the Subcommittee was adjourned.]

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