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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.

Recommended Sources

Anderson, Alan M. "Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond," 25 *William and Mary Law Review* 81 (1983), http://scholarship.law.wm.edu/wmlr/vol25/iss1/3

Congressional Budget Office. "Letter to Chairman Charles B. Rangel: Preliminary Cost Estimate for H.R. 3962," October 29, 2009, at 4, FN 2, **https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/hr3962rangel0.pdf**

Cowie, Michael G. "Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action," *The Antitrust Source*, December 2009, www.antitrustsource.com

Harrington, Scott E. "An Historical Overview of the Limited Antitrust Exemption for Insurance," Prepared for Harvard Law School Conference "Should Congress Repeal the McCarran-Ferguson Act?" November 2010.

Hyman, David. "Is Repealing McCarran-Ferguson Health Reform," *The Volokh Conspiracy*, February 2, 2010, http://volokh.com/2010/02/26/is-repealing-mccarran-ferguson-health-reform/

Macey, Jonathan R. and Geoffrey P. Miller, "The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role in Insurance Regulation," *Faculty Scholarship Series*. Paper 1605 (1993), http://digitalcommons.law.yale.edu/fss_papers/1605

Rubin, Janice E. and Baird Webel. "Limiting McCarran-Ferguson Act's Antitrust Exemption for the 'Business of Insurance'; Impact on Health Insurers and Issuers of Medical Malpractice Insurance," Congressional Research Service Report for Congress R40968, January 14, 2010.

United States Government Accountability Office. "Legal Principles Defining the Scope of the Federal Antitrust Exemption for Insurance," B-304474, March 4, 2005, http://gao.gov/decisions/other/304474.htm