Medical Industry Leadership Institute

Carlson School of Management

# Insurance Regulation
# Is Increased Competition in the Health Insurance Industry Desirable?

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## *Abstract*

*The Affordable Health Care for America Act was passed by the United States House of Representatives on November 7, 2009. This Act removes the exemption from antitrust laws for health insurance providers and creates a National Health Insurance Exchange to increase competition and access for consumers to insurance coverage. This paper evaluates whether competition in the health insurance industry will be beneficial to consumers. Subsequent to this paper being written, the United States Senate passed the Patient Protection and Affordable Care Act on December 24, 2009, which will be discussed briefly in the appendix.*

## I. Introduction

The House passed the Affordable Health Care for America Act (AHCAA) on November 7, 2009. It is now being debated by the Senate. This bill proposes significant changes for the health insurance industry. The insurance industry has always been regulated at the state level and not at the federal level. The current health care reform targets health insurance as a way to increase access and reduce the cost of healthcare provided to patients. As this paper will discuss, the AHCAA contains provisions that further some rationales for insurance regulation, but also have the potential to cause damage. Within the health insurance industry, competition can be contrary to public health and wellbeing, may harm consumers, and may increase the risk of insolvency of insurance providers.

The interaction between the health insurance industry and the medical provider industry is important in analyzing the merits of competition and antitrust enforcement. As recognized by the Supreme Court, the business of insurance is closely related to the public interest.[1] This is because people invest substantial amounts of money and rely on insurance providers to pay for their medical treatment. Randall, Susan. *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*. 26 Fla. St. U. L. Rev. 625, 627 (Spring 1999). In 2007, the United States spent over $2 trillion on health care. *National Health Expenditures, Forecast summary and selected tables*. Office of the Actuary in the Centers for Medicare & Medicaid Services, Issued 2008. The need for reform in the healthcare system is evident by the fact that 45.7 million Americans were without health insurance in 2007. *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. U.S. Census Bureau.

[1] *See German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 411-15 (1914)

Issued August 2008. The AHCAA attempts to improve the healthcare system by mandating health insurance coverage for all individuals, increasing competition among health insurance providers, and establishing a self-funded public health insurance option. H.R. 3962.

There are two opposing views as to whether medical service is a regular good that consumers choose to purchase and choose how to finance the purchase. One view is that consumers should have the freedom of choice whether or not to mitigate the financial risk of their own health care. The other view is that everyone should have access to a certain level of medical services and society should assist consumers in managing their financial exposure health care costs. Our society must decide who bears the risks associated with the cost of health care, individuals or shared by society as a whole. This paper will not evaluate the arguments around this question, but will attempt to show how the current version of the AHCAA causes changes in the insurance industry that do not achieve either goal.

## II. Rationales for Regulation of Insurance

Various rationales are given to justify the regulation of insurance because free market competition may have consequences contrary to public objectives. The basic insurance transaction involves a consumer paying the company in exchange for the company agreeing to pay for future medical claims. Randall at 627. Regulation either affects the first interaction by imposing fair trade practices when entering the contract or the second interaction by ensuring insurer solvency. The rationales in favor of regulation generally protect against excessive competition, counteract the disproportionate bargaining power between insurance companies and consumers, or further socially desirable objectives.

Excessive competition will lead to lower premiums and may then lead to insurer insolvency, resulting from the inability to pay for the claims made by policyholders. Robert Jerry, Douglas Richmond. *Understanding Insurance Law*, 3rd Ed. (2007) §20 at 61. The argument is that multiple insurers competing to acquire policyholders will compete on prices because, assuming similar policies, there are few other areas where insurers can differentiate themselves. A basic tenant of perfect competition is inefficient firms will fail and go out of business because they will be unprofitable, thereby allowing the market to adjust to equilibrium. Insolvency in the insurance industry is, in some views, contrary to the public good because it will lead to inefficient insurers going out of business. Because many people rely on their insurance providers to reimburse their health care, insurer insolvency would cause widespread hardship for its policyholders. Most states regulate the rates that insurers may offer to consumers to reduce the risk of insolvency. *Id.*

A second rationale is the inability for consumers to access reliable information and the disproportionate bargaining power between insurers and consumers. *Id*. at 62. Consumers have difficulties comparing quality of service between insurers before purchasing the policy because payment of claims involves future transactions. Insurance policies are also complex. Many consumers lack the necessary understanding to make rational decisions. Finally, because transferring information about insurers is difficult, there are few reliable sources of knowledge. Consumers are generally unable to bargain with insurers and are usually price takers in the marketplace because of asymmetric information and a large number of consumers buying policies from a few insurers. *Id.*

A final rationale is to further social objectives or paternalism. *Id.* at 63. One argument is that consumers should be forced to purchase insurance even if they would not otherwise in a free market because it is in their best interest to do so. One reason consumers may not purchase insurance is they do not understand the risks posed to them. For example, an individual may not know what the risk is of having a heart attack and, because of the lack of information, may choose not to insure even if a policy makes economic sense. Alternatively, a consumer could understand the risk profile and choose not to purchase an insurance policy because they prefer to either pay out of pocket or expect to receive subsidized care. See EMTALA[2]. Regulation may also further social objectives, such as prohibiting certain types of discrimination. Robert at 63. However, this can pose problems for correctly underwriting policies. Truly balancing risk means discrimination based on all known health factors. For example, discrimination based on race should clearly not be permitted for social reasons, but medical conditions may affect races differently. Therefore, prohibiting discrimination limits the insurer's ability to properly underwrite the risk of the policy being issued. This is good from a public policy perspective, but creates higher costs for insurers. Many states mandate a certain form of coverage or require a standardized contract. This has the benefit of providing coverage to individuals with defined diseases, but also forces purchasers of the policy to pay for coverage of the defined diseases regardless of whether they would if given the choice. *Id.*

The rationales for regulating the insurance industry have counter arguments. One is that the insurance industry is no different than other industries and market forces will reach equilibrium if unregulated. *Id.* This may be true from an economic standpoint. However, the

[2] Emergency Medical Treatment and Labor Act. 42 U.S.C. § 1395dd (1986). This act requires hospitals to provide emergency healthcare regardless of the ability to pay.

more important policy question is whether the consequences of perfect competition will achieve public policy goals. Perfect competition will reach equilibrium by increasing the parties in the market when prices are above marginal costs and decreasing the number of parties in the market by allowing firms to fail when prices are below marginal costs. Because the insurance transaction involves paying premiums now for the payment of claims in the future, low premiums determined by competitive forces increase the risk of firm failure if firms do not retain sufficient capital to remain solvent and pay the claims. The business of health insurance involves balancing current premiums against the costs of future medical events. This is an empirical question, not answered here, but poses one of the risks of increasing competition among insurers.

## III. Historical Background of Insurance Regulation

Beginning in the 1770's, states regulated insurance companies through the corporate charter process. Robert at 64. When an insurance company applied for a charter, the state would impose certain restrictions on the corporation as a condition to approving the charter. *Id.* With the enactment of general incorporation acts, the ability to regulate insurance companies individually was no longer available. *Id.* Statutes were enacted that require reporting financial status to state officials and maintaining a certain level of reserves to ensure solvency when paying out claims. *Id.* at 65. This created a system of separate state regulations and, at that time, insurance companies sought uniformity among states to reduce the cost of doing business across state lines. *Id.*

### a. Developments between 1869 and 1945

A significant decision in the history of insurance regulation was *Paul v. Virginia*, 75 U.S. (1 Wall.) 168 (1869). Insurers found individual state regulations burdensome and wanted Congress to adopt national standards. Robert at 65. Insurance companies brought a claim under federal jurisdiction where an agent of a New York insurance company was doing business in Virginia without obtaining the state license requirements. *Id.* The Supreme Court found that insurance regulation was not delegated under the Constitution to the federal government because "issuing a policy of insurance is not a transaction of commerce". *Id.* (citing *Paul,* 75 U.S. 168). This decision prevented the federal government from regulating insurance because interstate commerce was not present. After *Paul v. Virginia*, the insurance industry began to prefer state regulation because it was relatively lenient to insurers. *Id.* Over time, state regulation increased significantly in most areas, except for ratemaking. *Id.* The regulatory landscape was uneven and the degree of enforcement varied among states. *Id.* Between the 1900s and 1940s, states gave more authority to the regulatory commissions, but both regulation and enforcement were relatively ineffective. In 1944, the Attorney General from Missouri brought a case that challenged. *Id.* at 67; see *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944). In *South-Eastern Underwriters Association*, the Supreme Court overruled *Paul v. Virginia* and held that insurance transactions were subject to federal regulation under the commerce clause. *Id.*

### b. McCarran-Ferguson Act

The insurance industry was concerned that antitrust laws would prohibit pooling actuarial data thereby inhibiting the ability to determine appropriate rates. *Id.* at 67.

Immediately after the *South-Eastern Underwriters* case, Congress enacted the McCarran-Ferguson Act (MFA)[3]. *Id.* The MFA, among other things, provided that federal antitrust laws shall not cover the "business of insurance", to the extent the conduct is "regulated by State law", provided that it does not amount to an agreement to "boycott, coerce, or intimidate." Carlson, Larry D. *The Insurance Exemption from the Antitrust Laws*. 57 Tex. L. Rev. 1127, 112. (Oct. 1979). The definition of the "business of insurance" was later developed through the *Drug-Pireno* test: 1) whether the practice has the effect of transferring or spreading a policyholder's risk; 2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and 3) whether the practice is limited to entities within the insurance industry. *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982) (citing *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979)). The business of insurance also includes performing the contracts and payment of the claims, which is integral to the insurance business. *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969) ("without performance of the terms of the insurance policy, there is no risk transfer at all").

c. **Current Regulation**

In the 1900s, states have regulated insurance primarily in three areas: ratemaking, access, and covered benefits. These areas concentrate primarily on the initial transaction when a consumer purchases the policy. Solvency is still controlled through mandatory reporting to state regulatory agencies and capital requirements. However, states must maintain a balance of regulation between the initial transaction, where consumers are provided fair terms, and the secondary transaction, where insurance companies must pay for claims.

[3] 15 U.S.C. §§ 1011-1015 (2006).

Ratemaking is regulated in order to assure sufficient capital so that the insurance company will be solvent when paying claims. Harrington, Scott E. *Insurance Rate Regulation in the 20th Century*. Journal of Insurance Regulation. Vol. 19, No. 2. 204, 207 (Winter 2000). Increases in the cost of claims during the 1970s caused a number of states to increase rate regulation in an attempt to limit premium increases. *Id.* at 208. During the 1990s, the increasing burdens of compliance with multiple state regulations led to the view that uniform federal regulation might reduce compliance costs. This led to some relaxation in state regulations, but the burden of multi-state regulation remains today. *Id.* Currently, most states prohibit or restrict high premiums based on the status or the risk of medical claims through two types of restriction: rate bands and community ratings. Kofman, Mila, Pollitz, Karen. *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change.* Health Policy Institute, Georgetown University. (April 2006) at 3.

Rate bands limit the amount insurers can charge for premiums to a certain range. The range is based on the health and claims of the policyholder. *Id.* at 3. Since the 1990s, the National Association of Insurance Commissioners (NAIC) model acts permitted variation of up to 200 percent based on health claims with further variation limited to 15 percent based on age, gender, industry, group size, geography, and family composition. *Id.* Previously, the NAIC model act allowed price differentials of 26 to 1. *Id.* An individual could pay $100 per month or $2,600 per month depending on the risk factors present. *Id.*

Community rating requires set prices for policies based on collective claims from the same policy level within a given community. Kofman at 3. Insurers are generally not allowed to vary premiums based on the customer, but can adjust based on geography and sometimes age.

*Id.* Also, customers with historic claims may not be charged higher rates than others with the same policy. *Id.* The current NAIC model act limits surcharges based on age to 200 percent and prohibits variance in premiums based on gender or employer size. *Id*. Community rating spreads and redistributes the risk among policyholders. *Id.* Without rate regulations and partly because of the lack of price information, policy prices can be drastically different for people with the same risk criteria. One study of rating practices in unregulated markets found rate variation of 9:1 for the same policy based on age and health status. *Id.* at 4 (citing Pollitz, Karen, et al., "How Accessible is Individual Health Insurance for Consumers in Less than Perfect Health?" Kaiser Family Foundation. June 2001).

The enactment of HIPAA[4] in 1996 established a national minimum standard for health insurance products. Kofman at 1. During the 1990s, many states enacted laws requiring insurers to offer policies to small businesses regardless of employee medical conditions. HIPAA also included a guaranteed issue provision requiring all insurers to sell small group policies regardless of whether the contract was profitable for the insurance company. *Id.* at 2. Furthermore, HIPAA requires renewal and prohibits cancellation of coverage of individuals based on medical claims or diagnoses. *Id.* States can attempt to prevent the circumvention of these requirements by requiring insurers to actively market to small businesses. *Id.*

States have enacted mandated benefit requirements where insurance policies must provide coverage for certain disease states or conditions and insurers must reimburse certain types of medical providers or services. Kofman at 4. Mandates are one way to shift the cost of managing these diseases as insurers will spread the cost over all policyholders. *Id.* It also

[4] Health Insurance Portability and Accountability Act. (1996) Public Law 104-191.

prevents adverse selection. Those who do not have the condition would not choose to purchase the insurance coverage for the condition and would self-segregate based on their health status. *Id.*

In all states, insurance companies and agents must be licensed to conduct business in the state of domicile and can apply for licenses in other states as foreign insurers. Robert at 67. The lack of a federal regulatory system is burdensome for insurers because the variety of state regulations is complex and costly. Because many insurers do business in multiple states, there is a desire in the industry to nationalize the regulatory system.

## IV. Antitrust and Competition

Antitrust laws are premised on the principle that society is generally better off if markets behave competitively. Sullivan, E. Thomas, Harrison, Jeffrey, *Understanding Antitrust and Its Economic Implications*, 5th Ed. 2009 §1.01. One of the main areas of antitrust[5] relevant to the insurance industry is the prohibition against price fixing. *Id*. at 361. The Robinson-Patman Act makes it illegal to discriminate in price among customers. *Id.* Charging different prices to different customers must reflect differences in the marginal cost of providing the services. *Id.*

### a. Current Antitrust Regulation

When contracting with providers, health insurers have been somewhat excused from restriction of price and non-price discrimination on the grounds that they act as aggressive purchasing agents for the consumers they represent. Hammer, Peter; Sage, William, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L. J. No. 3 (2004) 949-988, 949; See *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984).

[5] A detailed overview of antitrust law will not be conducted in this paper.

*Kartell* held that the insurer's ban on balance billing by participating physicians did not violate antitrust laws because of the assumption that the contractual restrictions would reduce health care costs for policyholders. *Id.* at 2. With rising physician fees, the insurance company did not increase policy premiums due to public pressure and the result was that the company's reserves reduced from $26 million to less than $1 million. *Id.* The only available option was to reduce reimbursement to physicians. *Id*. The suit claimed violation of antitrust laws for price fixing, among other claims. Blue Cross asserted that it was exempt because state law mandated the practices. *Id.* The court reasoned that the insurance company packaged physician services and insurance which it sold to consumers in exchange for premiums. *Id.* It was found that Blue Cross bought medical services for the account of others and that no law forbids a company from buying the "goods or services needed to make the customer whole." This meant the conduct was lawful even though Blue Cross possessed significant market power which was used to obtain lower than competitive prices. *Id.* at 956 (citing *Kartell*, 749 F.2d at 929-30)). After *Kartell*, courts have given strong deference to insurers to negotiate lower reimbursement rates. *Id.* Because of the exemption from federal antitrust laws and case history, insurance companies have great freedom in negotiating reimbursement rate with physicians.

**b. Competitive Markets**

The question of whether antitrust laws should apply to the insurance industry depends on what benefits competition would bring to consumers. The main indicator of a perfectly competitive market is that firms are price-takers, meaning they sell their product or service at a

given market price. Sullivan §2.02.[6] The service offered by firms is completely homogenous, meaning there is no difference in the quality or form of service offered among the firms. *Id.* In addition to homogeneity, there must be full information such that the quality of services and the prices offered in the market are well known to suppliers and consumers. Generally, there must be sufficient supply and demand to reach market equilibrium. *Id*. Theoretically, there must be an infinite number of suppliers of the service and an infinite number of customers that wish to purchase the service. This also means that suppliers and customers do not have significant costs or barriers when entering or exiting the market. Finally, parties always attempt to maximize their profits. *Id.* If a party's cost is above the market equilibrium price, the party will exit the market by either going out of business or choosing not to purchase the service. If parties in the market have surplus profit, new suppliers will enter the market causing the supply curve to adjust, driving the prices down to equilibrium, or new customers will enter the market increasing the number of services demanded. *Id.*

Under economic theory, perfect competition will reach an equilibrium, but competition also has consequences for the parties involved, whether suppliers (insurance companies) customers (consumers). The merits of competition in health insurance and health care should be evaluated using two questions. The first question is whether these requirements exist inherently in health care or whether perfect competition would be contrary to the industry norms. Even if perfect competition may exist naturally, the second question is whether promotion of the competitive model will be beneficial to consumers or society from a public health or public welfare perspective.

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[6] See also Pepall, Lynne, et al., Industrial Organization: Contemporary Theory & Practice. 2nd Ed. 2002. Ch. 2; Varian, Hal., Intermediate Microeconomics: A Modern Approach. 5th E. 1999.

The United States economy generally prefers market competition. *Improving Health Care: A Dose of Competition*. Report by the Federal Trade Commission and the Department of Justice. Issued July 2004. Ch. 1. The government usually does not decide which prices or services are offered by firms and a functioning market will reach equilibrium based on individuals making their own decisions. *Id.* at 4. Price competition can reduce prices and non-price competition can increase quality and innovation under certain conditions. *Id.*

**c. Competition in the Provider Industry**

Many people consider healthcare a special good. Because of ethical obligations, healthcare professionals often provide service to customers even if they are unable to pay. *Improving Health Care: A Dose of Competition*. Ch. 1 at 41. Integration seems to reduce costs overall by lowering administrative and transaction costs, increasing economies of scale, and by allowing payors to efficiently contract with the networks. *Id*. Ch. 2 at 4. If groups create price agreements and attempt to seek increased reimbursement from payors, they may be liable under antitrust laws. *Id.* Licensure requirements for physicians and laws limiting the scope of practice restrict entry into the market. *Id*. at 25. One rationale for licensure requirements is that patients have limited information about health care and there is a high cost of obtaining such information. *Id*. at 27. Licensure also creates an incentive for physicians to invest in training and education because they will be able to recoup full returns and not face competition from lower quality substitutes. *Id.* State requirements and licensure also limit mobility for practicing physicians making it difficult for the market to adjust. *Id.*

In the past few decades, hospitals have consolidated into multi-hospital systems allowing them to compete more effectively by improving quality of care and reducing

administration costs. *Id.* Ch. 3 at 10-11. Systems compete on a geographic basis and create capacity in "must have" hospitals. This is a hospitals that health care plans believe they must offer to attract customers. *Id.* at 15. Patients tend to prefer hospitals close to their home choosing to receive care in local hospitals despite higher mortality rates and less experience with specific procedures. *Id.* Ch. 4 at 19. Because of scope of practice limitations and the differences between hospitals and physician practices, there is little competition between outpatient providers and inpatient providers as they are distinct service markets. *Id.* at 21-2.

Differences in scope of practice, expertise, and access to technology mean that medical services are far from homogenous in quality and category. Many of the regulations regarding physicians are specifically meant to prevent competition and entry into the market. This allows them the ability to recover the cost of education. Because of licensing requirements and the difficulties of changing jurisdictions, there are steep barriers preventing easy entry by new firms into the market. Even if these factors were not contrary to a fully functioning competitive marketplace, competition may yield lower quality services or increase the cost by creating unneeded capacity.

**d. Competition in the Insurance Industry**

There are various aspects of competition in the insurance industry which conflict with the rationales for regulation discussed above. Competition has been shown to lower premium rates. Dicken, John. GAO-09-864R. *Competition in Health Insurance Markets*. July 31, 2009. Several studies also found that less competition is associated with cost savings for insurers and more competition with lower profits. *Id.* at 6. In addition, risk-based premiums for health insurance are sometimes perceived as unfair and against ethical norms because those with a

high risk of future medical costs will pay higher premiums. *Improving Health Care: A Dose of Competition* Ch 1. at 41. Mandated coverage also prohibits discrimination based on health status when underwriting a policy. Therefore, regulation and public policy make it difficult for insurers to determine policy prices. The policies are relatively homogenous because of mandates and standards imposed by state regulation.

Customers have significant barriers to exit the industry or to choose their insurer. Roughly 61% of the population has employment-based insurance through either self-insured plans or the employer purchasing from insurance companies. *Improving Health Care: A Dose of Competition*. Ch. 5 at 7. Most employers who offer insurance through a commercial insurer bargain on behalf of their employees. *Id.* Even if the employer offers multiple commercial carriers, employees have little choice and the cost of switching insurance providers is high. In other words, an employee either purchases a policy negotiated by their employer or negotiates individually with the insurance company. The later is generally more expensive because there is no spreading of the underwriting risk for individuals. *Id.* at 13. Insurance companies also have barriers to entry including regulations, economies of scale, and firm reputation. *Id.* Ch 6 at 8. There are significant costs associated with creating a provider network and with developing a reputation within a new community. *Id.* at 9. Also, insurance pools require large patient enrollment in order to gain economies of scale and effectively spread the risk. *Id.* at 10-11.

Competition could lead to lower premiums, but could also lead to insolvency for insurance companies. Increasing competition and mandating coverage also limit insurers' ability to compete effectively. Because of employer-based insurance coverage, consumers of insurance policies are not able to exit the market efficiently. Finally, insurers have large

barriers to entering the market because of the necessary scope and capital requirements. Many factors of the insurance industry demonstrate that competition is not necessarily beneficial for consumers.

**e. Interaction between provider and insurance industries**

The health insurance industry is intertwined with the medical provider industry. Any benefits to consumers will depend on the amount of competitive forces within both industries as well as the interaction between the two industries. If the goal is to provide the greatest benefit to consumers, legislators should be conscious of how market structures affect consumers and not merely promote competition in industries where it may harm consumers.

Studies regarding competition in the HMO industry and reimbursement rates for providers have mixed results. Dicken at 4. One study[7] found that market concentration was not associated with physician rates while a different study[8] found that greater market concentration was associated with a reduction in hospital rates. *Id.* However, research has shown that greater competition may be associated with decreased use of inpatient services. Its effect on outpatient services was unclear. *Id.* Though there was little consensus, some studies found that greater competition was associated with a lower quality of care and customer satisfaction. *Id.* A higher concentration at the state level was positively associated with greater efficiency for hospitals, possibly because the insurers have the ability to promote cost savings

[7] See Schneider, J.E., et al. "The Effect of Physician and Health Plan Market Concentration on Prices in Commercial Health Insurance Markets," *International Journal of Health Care Finance and Economics,* vol. 8, no.1 (March 2008) 13-26.

[8] Feldman, R., Wholey, D., "Do HMOs Have Monopsony Power?" *International Journal of Health Care Finance and Economics*, vol. 1, no. 1 (March 2001), 7-22.

by exerting their market power[9]. *Id.* at 6. Physicians have lobbied for an exemption from antitrust laws in order to collectively bargain with insurance companies with a few states passing legislation that exempts self-employed physicians from antitrust laws. *Improving Health Care: A Dose of Competition*. Ch. 2. at 17-9. Physicians argue that they need the market power to counter the "take-it-or-leave-it" contracts from insurers. *Id.* at 20.

In evaluating both provider and insurer industries and competition in health care, competition may not improve and could actually decrease in customer satisfaction and quality. Concentration of insurers may allow exertion of their market power to force improvements on providers. Also, bargaining with strong market share by insurers may keep the costs of healthcare down by imposing financial restrictions on providers.

## V. Federal Insurance Legislation

With a national insurance industry regulated by a network of individual states, many proponents have attempted to federalize regulation of insurance. Health insurance has been seen as a way to reform the health care industry, perhaps with the desire that by controlling premium payments and reimbursement, that the insurance companies will influence health care professionals to improve efficiency.

### a. Previous Attempts

In 2005, in an attempt to improve competition, insurance companies licensed in one state, primary state, would be allowed to do business in other states, secondary states, without complying with the laws of the secondary state. Kofman at 7 (citing Health Care Choice Act of 2005 H.R. 2355). Also, after the Graham-Leach-Bliley Act of 1999, insurers considered

[9] See Baes, L.J., Mukherjee, K., Santerre, R.E., "Market Structure and Technical Efficiency in the Hospital Services Industry: A DEA Approach," *Medical Care Research and Review*, vol. 63, no. 4 (August 2004), 499-524.

themselves at a competitive disadvantage in the financial regulatory structure and argued for an optional federal charter. Webel, Baird. CRS Report for Congress. *Insurance Regulation: Issues, Background, and Legislation in the 111th Congress.* August 19, 2009. Until that time, proposals to increase federal involvement would result in state reform efforts forestalling federal involvement. *Id.* Insurance insolvencies, such as Executive Life and Monarch Life, prompted questions as to whether state regulation could sufficiently oversee the industry. *Id.* The proposed National Insurance Act of 2007 H.R.3200 attempted to create an optional federal charter and regulatory structure for property/casualty and life insurance, but not health insurance, which would continue to be regulated by the states. *Id.* Though health insurance companies were not covered within the proposed bill, the move in recent years has been towards federal regulation of insurance.

**b. Affordable Health Care for America Act**

The current version of the Affordable Health Care for America Act (AHCAA, the Act), passed by the House on November 7, 2009 and currently being debated in the Senate, provides a number of provisions to increase access by consumers to insurance policies and to increase competition among insurance companies. H.R. 3962. This paper examines selected provisions from the bill. The stated purpose of the Act is to "provide affordable, quality health care for all Americans and reduce the growth in health care spending." *Id.* at 3-4.

The most pertinent provision to this paper is the removal of the antitrust exemption for insurance companies by amending the McCarran-Ferguson Act. *Id.* at 150 et seq. Insurers would be liable under antitrust laws with respect to price fixing, market allocation, or monopolization. *Id.* at 151. Insurers would still be able to collect, compile, classify, and

disseminate historical loss data; determine a loss development factor; perform actuarial services; and set rates by an authorized state regulatory entity. *Id.* at 151.

In order to expand access, the Act establishes a Health Insurance Exchange (Exchange), effective January 1, 2013, where individuals and employers may purchase health coverage from multiple suppliers. *Id.* at 155 et seq. The Exchange will provide a variety of "affordable, quality health insurance coverage, including a public health insurance option." *Id*. at 155. The Exchange will also provide information and assistance to individuals and small employers in a comparative manner including information on "benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction". *Id.* at 187.

The Secretary of HHS will establish standards for the health plans with different levels of benefits. *Id*. at 155-6. The benefits will be standardized into three levels: a basic plan covering 70% of the actual value of benefits, an enhanced plan covering 85% of the value, a premium plan covering 95% of the value. An optional premium-plus plan covers additional benefits, such as oral health and vision. *Id.* at 168. The Act also requires employers to offer coverage or pay into a trust fund to subsidize purchase. *Id.* at 268 et seq. The Act requires all individuals to have "acceptable coverage" by imposing a tax on individuals who do not have coverage under a qualified health benefits plan or other acceptable coverage plans. *Id.* at 301-2. In order to allow insurers to provide policies in multiple states, it adopts the previously proposed idea of having insurance companies subject to primary state regulations and some regulations by the secondary state. *Id*. at 203-4.

The Act also creates a public health insurance option offered through the Exchange that will meet the same requirements and provide the same benefits as private plans. *Id.* at 211 et seq.

The Secretary will negotiate reimbursement rates not lower than Medicare rates and not higher than average qualified health benefits plans. *Id.* at 212. The Act authorizes the Secretary to establish premium rates for the public plan at a level to finance the costs of health benefits and administrative costs. *Id.* at 214. An account will be established in the Treasury to include start-up funding to be repaid over a ten year period, but specifically provides that "in no case shall the public health insurance option receive any Federal funds for purposes of insolvency" similar to the Troubled Assets Relief Program. *Id.* at 215-6.

**c. Analysis of the proposed AHCAA**

Overall, the Act has the effect of increasing competition in the insurance industry as well as mandating consumers to purchase coverage and providing a public health insurance option. The Act introduces factors that arguably weigh against the traditional rationales for regulation of insurance, but at the same time introduces factors that coincide with the rationales. Increasing competition is meant to decrease the cost of premiums for consumers and to increase access to the millions of individuals currently without health insurance coverage. Forcing consumers to purchase coverage also furthers the paternalistic view that consumers, given the choice, will not choose to mitigate their financial risk. The public option provides the otherwise uninsurable individuals with the means to be covered through a public pool.

The American Bar Association (ABA) has advocated a repeal of the exemption to antitrust laws for the insurance industry since 1989. Gotts, Ilene Knable, Chair, ABA Section of Antitrust Law. *Statement on Behalf of the American Bar Association, Before the Judiciary Committee of the U.S. House of Representatives,* Concerning H.R. 3596, The Health Insurance Industry Antitrust Enforcement Act of 2009 at 2. The ABA argues that insurers should be authorized to

engage in safe harbor activities not shown to restrain competition, rather than a blanket exemption from antitrust laws. *Id*. The argument is that repealing the antitrust exemption while creating safe harbors would better protect pro-competitive behavior while not allowing anticompetitive behavior. *Id*. at 4. The ABA feels that there is no justification for providing the insurance industry with exemption from antitrust laws. *Id.* The ABA suggests insurance companies engage in anticompetitive behaviors, such as price collusion, forcing consumers to purchase coverage they do not desire in order to obtain coverage they do desire, and market allocations reducing the number of competitors. *Id.* at 6. There are some practices recognized as helping consumers and are included within the safe harbors: collecting and disseminating past loss data, standard forms to simplify consumer understanding, joint-underwriting and cooperation in making rates, residual market cooperation, and other collective activities that do not unreasonably restrain competition. *Id.* 4-5.

The anticompetitive behaviors suggested by the ABA do exist in the insurance industry, but they are behaviors caused partially by regulation and further the rationales for regulation discussed above. Rates and prices are regulated to be held within certain bands to provide consumers with fair prices while allowing insurance companies to maintain sufficient reserves. Historic insolvencies led to ratemaking regulation in order to ensure insurance companies held enough capital thereby protecting consumers. Harrington at 206. Insurance insolvencies harm consumers immensely as thousands of policyholders may be left without insurance coverage if an insurer goes out of business, unless the plan is otherwise protected through a guaranty fund or reinsurance.

There are arguments that increasing competition in the insurance industry would yield greater efficiency and increase the public good. Regulating solvency requirements separately from ratemaking may be adequate protection and competition is seen as a way to increase access to coverage by encouraging price competition. Harrington at 207-8. Also, the argument is that competition creates incentives for insurance companies to accurately forecast and underwrite policies accordingly, so that they will not become insolvent. *Id.* at 211. However, competition also creates an incentive to minimize the sum of claim costs. *Id.* at 212. Some people may see this as positive because it will reduce the costs of the health care system. However, there may be much more efficient and direct ways of reducing costs.

Because of asymmetrical information and the desire to prohibit unfair trade practices, state regulators have also regulated rates in order to ensure fair trade practices with consumers. Because consumers do not have access to historic loss data and, even if they did, they would most likely not be able to comprehend the complexities of underwriting an insurance policy. Because of this, states have created the bands to protect consumers against excessive premiums by insurance companies. Given the interaction between low premiums and insolvency and the desire to protect consumers from excessively high premiums, a delicate balance must be found in order to ensure solvency while protecting consumers.

In the AHCAA, the balance between freedom of choice and paternalism may be in conflict because the Act increases competition while requiring all Americans to purchase insurance. States mandate coverage for many conditions because of the paternalistic view that consumers will not choose what is in their best interests. The rationale of paternalism does in fact conflict with the standard notion of perfect competition where consumers should be allowed freedom

of choice in their purchasing decisions. However, because health insurance is seen as important for access to health care, the Act forces all individuals to purchase coverage. This creates an inherent conflict between the ideals of competition, encompassing freedom of choice, and paternalism mandating coverage. Forcing individuals into the demand side of the market and promoting competition on the supply side of the market will not yield a perfectly competitive equilibrium.

One of the requirements for a competitive market is the ability to enter and exit the market without significant barriers. Under the AHCAA, all individuals in the United States are forced to purchase health insurance policies and the policies offered on the Exchange are standardized. This combination is contrary to the fundamental idea of perfect competition and to the rationale for eliminating the antitrust exemption. Perfect competition should allow consumers to choose whether or not to purchase coverage and which type of coverage they desire. In a competitive healthcare marketplace, a consumer should be able to choose not to purchase insurance coverage and be expected to pay for their own health care out of pocket. In other words, for perfect competition to function and reach equilibrium, a consumer who chooses not to transfer the risk of their health care costs through insurance must bear the costs and not receive medical care if they are unable to afford treatment.

Our society has values that people should receive medical care, at least in certain circumstances, such as emergencies through EMTALA. Furthermore, the purpose of the AHCAA is to "provide affordable, quality health care for all Americans and reduce the growth in health care spending." H.R. 3962 at 4. Therefore, the purpose of the Act does not coincide with increasing competition in the insurance industry. In other words, because the Act requires all

individuals to purchase coverage, it eliminates one of the forces that enable a functioning perfectly competitive marketplace to reach equilibrium.

Controlling and limiting the number of competitors furthers the desire to maintain adequate capital and solvency for insurance companies. Competition will reduce the prices paid for premiums, which means that insurers have less cash per policyholder going into their reserves. This results in a higher risk of insurer insolvency because the reserves of the company have less cash than they would under regulated rates. The rationale may be similar to *Kartell* where insurance companies will reduce the cost of healthcare by using their bargaining power with health care providers and lower reimbursement rates for hospitals and physicians.

The introduction of the public health insurance option is beneficial to our society in that it will provide health insurance coverage to millions of people who would otherwise not be able to purchase coverage on the free market. However, the public option undermines the reasoning behind increasing competition. A public risk pool could distort the market for private insurers. People with significant health risks will purchase the public option and generally healthy people will purchase lower coverage private alternative policies. This adverse selection will overburden the public option and increase the risk of insolvency or increase costs for the government. Risk pooling functions when risk is spread over multiple individuals, healthy and sick, and the Exchange will create pools of healthy people separate from pools of sick people.

The concern with doing business in multiple states, similar to concern expressed after H.R.2355, is that market de-stabilization will occur. Kofman at 9. Insurers in states with high coverage mandates would be at a disadvantage against insurers in states without mandates. *Id.* This could lead to a race to the bottom by insurers where companies choose the states with the

least amount of mandated coverage. This would then adversely impact consumers who need the comprehensive coverage. *Id.* This could potentially leave people with high risk factors no choice but to choose the public health insurance option from the Exchange. Because of the differences in mandated benefits among states and the increased availability of information by the Exchange, consumers will choose the state based on their current health status and medical needs. This will lead to cause a disruption in rate setting as people with a given health condition or of higher risk will purchase policies from insurance companies whose primary state of regulation mandates coverage of that condition.

## VI. Conclusion and overall analysis

In the AHCAA, all individuals are required to purchase qualified health coverage, but the high risk individuals will not be pooled with low risk individuals, which will not sufficiently shift the costs of the high risk individuals. Again, the ultimate question is whether society shares medical risks and costs or whether individuals should pay for whatever diseases or conditions they are unfortunate to have. Perfect competition, if truly left to market forces, will reach equilibrium where insurance companies that do not manage their capital will go out of business and where consumers who do not prudently mitigate their medical risks go bankrupt or do not receive the medical treatment they need. However, neither of these results is beneficial to the public good and welfare.

The health care industry needs reform and the AHCAA attempts to resolve the problems in health care through reforming the health insurance industry. Legislators should be cautious about causing disruptions in market structure that could potentially harm individual consumers as well as insurers. Under competitive structures, the market will reach equilibrium. However,

within the health insurance industry, the forces that will lead to competitive equilibrium are contrary to the public good and may harm consumers. Also, because so many individuals in our economy rely on the health insurance industry to manage their medical costs and risks, increasing competition among insurers will test the stability of an already weakened financial system. Legislators should rethink the AHCAA and determine whether the proposed changes in the insurance industry lead to better consumer protection and public welfare.

**Appendix: Patient Protection and Affordable Care Act**

The United States Senate passed the Patient Protection and Affordable Care Act (PPACA) on December 24, 2009. Similar to the AHCAA (the House version), the PPACA also requires individuals to maintain minimum essential coverage. H.R.3590 at 321 et seq. The PPACA would create American Health Benefit Exchanges. *Id.* at 130 et seq. The Senate version of an exchange is state based, rather than a national exchange proposed by the House. Each state would establish an exchange, either a government agency or a non-profit entity, to facilitate the purchase of qualified health plans and establish Small Business Health Options Programs. *Id.* The exchange would include four benefit categories and a catastrophic plan, similar to the benefit categories in the House version. *Id.*

The PPACA does not remove the antitrust exemption for insurance companies nor does it include a public health insurance option. The Senate version does promote competition in the health insurance industry by establishing state exchanges. However, it does not seem to pose the same risks of market distortion as the House version. Leaving the antitrust exemption in place provides better assurances of health insurer solvency. Also, a state exchange without a public option may operate more efficiently. However, mandating health insurance coverage without providing a public option might also cause distortions in the market. The state of health care reform is unclear at best. There is the possibility that no act will pass in the near future. The AHCAA and PPACA may be starting points for healthcare reform or they could become merely another failed attempt. Only time will tell.