

Healthy Competition

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On Nov 7, 2009, the House of Representatives approved a health care bill, the Affordable Health Care for America Act, by a vote of 220-215. On Dec 24, 2009, the Senate passed a different health care bill, The Patient Protection and Affordable Care Act¹, by a supermajority of 60-39. On March 21, 2010, the Senate bill was passed by the House by a vote of 219–212 and was signed into law by President Obama on March 23, 2010. However, the House added amendments to the Senate bill via the Health Care and Education Reconciliation Act of 2010. These amendments relate largely to funding and tax provisions. The Senate passed the amendments with some revisions by a simple majority using the reconciliation process. The House then passed the Reconciliation Act with the Senate’s changes. The Reconciliation Act was signed into law by President Obama on March 23, 2010. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 together comprise the current health care reform legislation.

This note will compare the Patient Protection and Affordable Care Act (‘Senate bill’), now Pub. L. No. 111-148, and the Affordable Health Care for America Act (‘House bill’), which did not pass into law.² The two bills share significant features. Notably, they both require most Americans to have health insurance coverage, they create insurance exchanges, government regulated market places where individuals and businesses can buy coverage, and they institute consumer protective measures including government review of rate hikes and a ban on insurance denial for individuals with preexisting conditions.³

The current health care legislation will improve consumer protection in the healthcare and insurance markets. However, a comparison of the House and Senate bills remains relevant to identify the shortcomings of the Senate bill. The Senate and the House bills differ in many

¹ Amended title: An Act Entitled The Patient Protection and Affordable Care Act.

² Affordable Health Care for America Act, H.R. 3962, 111th Cong. (as passed by House, Nov 9, 2009)[hereinafter H.R. 3962]; The Patient Protection and Affordable Care Act, S. 3590, 111th Cong. (enacted) [hereinafter S. 3590].

³ S. 3590 § 1501, 1311, 1101; H.R. 3962 § 411, 301, 101.

material respects. This note will discuss only those provisions relating to competition, consumer protection and antitrust.

Both the House and the Senate bills create an insurance pooling mechanism.⁴ The Senate plan creates state-based American Health Benefit Exchanges and Small Business Health Option Program Exchanges.⁵ Individuals and small businesses will be able to buy insurance through these exchanges immediately. Larger employers, however, those with more than 200 employees, will have to wait until 2017 to buy insurance on the Exchange.⁶ In contrast, the House plan creates a more centralized National Health Insurance Exchange where health insurance would be immediately available for sale to businesses and individuals.⁷

The rationale behind the Exchange is to create more transparency in the market. Both plans create four plan-benefit categories offered through the Exchange.⁸ In theory, this allows consumers to more easily compare plans. Such comparison promotes a market in which companies compete for consumer loyalty by offering better, cheaper services. In practice, however, the Senate bill might not achieve these goals. First, the Senate bill's default is to separate the small business and the individual health insurance markets.⁹ This heightens uncertainty. Many consumers will have a choice to purchase insurance through their employer or to buy it individually on the Exchange. Separating the two markets makes comparison more difficult and serves no pressing need. While the initial purchasers differ—employer versus employee—the product, health insurance, and the end user, the individual employee, are the same. In fact, the Senate bill gives the states the power to merge the two markets into one exchange.¹⁰ The House bill, on the other hand, consolidates all insurance sales into one national exchange affirming the belief that separate markets for individual and small business markets are not necessary.¹¹

⁴ H.R. 3962 § 301; S. 3590 § 1311.

⁵ S. 3590 § 1311(b)1.

⁶ Id. at § 1312(f)(2)(B).

⁷ H.R. 3962 § 301.

⁸ S. 3590 § 1302(d); H.R. 3962 § 303(c)(1)(A).

⁹ S. 3590 § 1311(b)(1)(B).

¹⁰ Id. at § 1311(b)(2), (a)(3).

¹¹ Under the House bill, states however do retain the option to create their own insurance exchanges. H.R. 3972 § 308.

Next, the Senate bill's attempt to create more transparency is undermined by additional provisions in the bill itself. Unlike the House bill, the Senate bill allows insurance purchased outside the Exchange to qualify as acceptable coverage for the purposes of the individual mandate.¹² Such an exception defeats the purpose of an insurance exchange that groups all available plans in one place for easy comparison.

The most important difference between the two bills is that the Senate bill does not provide a public option while the House bill does.¹³ The chief argument from insurance companies and conservative politicians against a public option is that it would be so attractive to consumers that private insurers would be unable to compete. Similar arguments used by defendants in antitrust cases to justify anti-competitive behavior have failed to garner support from the courts. *NCAA v. Board of Regents* 468 U.S. 85, 87 (1984) ("Seeking to insulate live ticket sales from the full spectrum of competition because of its assumption that the product itself is insufficiently attractive to draw live attendance when faced with competition from televised games...is inconsistent with the Sherman Act's basic policy.") In fact, the court rejects even those arguments that allege competition is harmful to public welfare. *National Society of Prof. Engineers v. United States*, 435 U.S. 679, 696 (1978) (Agreement which prohibited competitive bidding of engineers was held illegal even though defendants argued competition on price contravened public welfare since engineers should be chosen based on quality and experience, not price.) Similarly, such arguments should only confirm the benefits of a public option.

Though a public option would undoubtedly provide healthy competition, the House bill tempers its pro-competitive effects through other bill provisions. For instance, the public health insurance option would be required to negotiate rates with providers just like private insurance companies.¹⁴ In addition, the bill provides that the negotiated rates could be no lower than those of Medicare.¹⁵ In effect, this institutes a self-imposed floor on rates, raising the minimum price the government could charge for services and consequently providing weaker price competition to the private insurance companies.

¹² S. 3590 § 1312(d)(3)(C), (a)(1).

¹³ H.R. 3962 § 100(a)(3)(B).

¹⁴ Id. at § 304(a)(2)(B).

¹⁵ Id. at § 304(a)(2), (a)(3).

Though the Senate bill does not offer a public option, it creates an alternative to plans offered by conventional insurance companies. The bill requires that each Exchange have at least one multi-state plan that is offered by a non-profit entity.¹⁶ The bill fosters the creation of these entities through the Consumer Operated and Oriented Plan (CO-OP) program.¹⁷ The entities created under this program will be qualified to receive federal funds if they meet certain criteria.¹⁸ First, they must not be an existing health insurer.¹⁹ In other words, existing insurance companies cannot establish subsidiaries that will function in a “non-profit” capacity. Second, the entity must be governed by the vote of a majority of its members.²⁰ Third, profits must be used to reduce premiums and improve benefits.²¹ Finally, the entities must have a strong consumer focus.²² Since insurance services offered by these new entities and those offered by traditional insurance companies must meet the same requirements for sale on the Exchange, these entities, if successful, have the potential to chip away private insurance companies’ hold on the market.

Nevertheless, these new co-ops face difficulties. Most notably, a co-op must establish a network and must negotiate contracts with health providers. However, most providers are already contracted with the dominant insurance firms. In addition, the co-ops will have far less bargaining power than either established insurance companies or the federal government under its own public plan. While the co-ops could conceivably rent a network from an established insurance company, such an arrangement creates an economic disadvantage not conducive to establishing a lower-cost option for consumers. In addition, the new co-ops lack brand identity. Brand identity is expensive to create and foster, particularly in a market dominated by multi-billion dollar companies with virtually unlimited advertising capital. In short, the Senate plan attempts to build new competition from the ground up instead of taking advantage of the already established powerful federal brand with its Medicare networks.

The weakness of new competition from co-ops illustrates the need for stronger enforcement of antitrust laws. The House bill accomplishes this goal by repealing the

¹⁶ S. 3590 § 1334(a).

¹⁷ Id. at § 1322(a)(1). The House bill provides for similar co-ops. H.R. 3962 § 310.

¹⁸ S. 3590 § 1322(c).

¹⁹ Id. at § 1322(c)(2)(A).

²⁰ Id. at § 1322(c)(3)(A).

²¹ Id. at § 1322(c)(4).

²² Id. at § 1322(c)(3)(C).

McCarran-Fergusson Act federal antitrust exemption for insurance companies.²³ The repeal of the antitrust exemption would allow the Justice Department to punish and deter behavior that is the root cause of unreasonable monopoly prices. Unfortunately, the Senate bill does not contain this repeal. The McCarran-Fergusson Act provides that Federal anti-trust laws will not apply to the "business of insurance" as long as the state regulates in that area.²⁴ Even if co-ops were able to establish competitive and expansive networks, it is unlikely that they would be able to do so fast enough to effect swift change in health insurance prices.

Market-based evidence suggests that waiting for co-ops to evolve into a formidable competitive force to temper the insurance oligopoly will not solve the current pressing problem of excessive prices. Goldman-Sachs recently advised investors to buy shares of UnitedHealth Group and Cigna because rates increased sharply and competition is down.²⁵ An industry expert noted that employers in particular are finding it difficult to buy insurance because carriers would rather abandon customers than sacrifice profits.²⁶ The insurance market requires a present, not just a future, viable threat to the current oligopoly.

While the Senate bill attempts to address high insurance prices in other ways, the bill's solution is weak compared to the House bill's repeal of the antitrust exemption. The Senate bill merely establishes a process to review rate increases and requires insurers to justify them.²⁷ Such review is resource- and time-consuming because it requires review and justification from each company for each rate hike. Second, it does not address the cause of such rate increases, an oligopolistic system that facilitates collusion.²⁸ Third, it traps the government into continually verifying costs and evaluating necessary expenditures in a specialized field—a task for which it has no experience and little expertise. Finally, the Senate bill's solution does not address the inadequate state antitrust enforcement system. Karen Pollitz, a professor at the Georgetown University Health Policy Institute, noted that, "state regulators necessarily focus primarily on

²³ H.R. 3962 § 262.

²⁴ McCarran-Ferguson Act, 15 USCA § 1012(b).

²⁵ David M. Herszenhorn, *Obama Wields Analysis of Insurers in Health Battle*, N.Y. Times, March 6, 2010.

²⁶ *Id.*

²⁷ S. 3590 § 3209(a)(1)(2).

²⁸ Robert Pear, *Loss of Competition Is Seen in Health Insurance Industry*, N.Y. Times, Apr 30, 2006.

licensing and solvency. Dedicated staff to oversee consumer protections in health insurance...are limited.”²⁹ Consequently, state antitrust enforcement against insurance companies is weak.

Detractors of the House bill’s repeal of antitrust exemption argue that coordination among insurance companies is necessary for determining and allocating risk. The House bill is mindful of this special need. It makes exceptions for insurance activities such as (1) collecting, compiling, classifying, or disseminating historical loss data; (2) determining a loss development factor applicable to historical loss data and (3) performing actuarial services as long as doing so does not restrain trade.³⁰

In conclusion, the Senate bill does not regulate or restructure the insurance market as well as the House bill does. Nevertheless, it prohibits denial of coverage for preexisting conditions, requires review of rate hikes, requires rebates to consumers when insurance company spending on services is less than 80% in the individual or small group market and consequently provides long over-due protection for consumers.

²⁹ Karen Pollitz, Hearing on the Tri-Committee Draft Proposal for Health Care Reform, June 23, 2009.

³⁰ H.R. 3962 § 262(c)(2).