



# Making Health Care Competition Work

## How to Ensure Health Insurance Reform Is Transparent and Effective

David Balto June 2010

If one fact is clear after over a year of comprehensive examination of the country's health care system, it is that health insurance markets are simply not functional. The essential elements of a competitive market are choice and transparency, and both of these are lacking in private, non-group health insurance markets.

Most consumers have no meaningful choice in their insurance coverage. Study after study has found that health insurance markets are overly consolidated and consumers in the private- or small-group markets have few options. A report by Health Care for America Now found that two firms control at least 50 percent of the market in 39 states, and a single firm controls at least 75 percent of the market in nine others.<sup>1</sup> A 2009 American Medical Association study found that almost 99 percent of all markets are highly concentrated.<sup>2</sup> Industry advocates may claim that some markets have several competitors; but the reality is that these small players are not a competitive constraint on the dominant insurers—they just follow the lead on larger firms' price increases.

The transparency necessary for a well functioning market is also lacking. Insurance policies are inordinately complex and not standardized. Consumers simply do not have access to the information they need to make well-informed decisions, giving insurers the ability to mislead or deceive them. Consumers who testified before Congress detailed egregious, misleading, and deceptive conduct by health insurers. Health insurers would search for loopholes and novel policy interpretations to deny coverage for medically necessary treatments.

Former insurance executive Wendell Potter testified to this lack of transparency before Congress, saying, "Insurers make promises they have no intention of keeping, they flout regulations designed to protect consumers, and they make

it nearly impossible to understand—or even to obtain—information we need.”<sup>3</sup> Consumers simply cannot make an informed buying decision without transparency and adequate information about a plan’s coverage, terms, and conditions. Insurers are meanwhile protected by complexity and opaque arrangements, and can avoid real competition in price, quality, and service.

This lack of choice and transparency caused the market for health insurance to simply stop working for American consumers. The number of uninsured skyrocketed: more than 47 million Americans are uninsured, and according to Consumer Reports, as many as 70 million more have insurance that doesn’t really protect them. Health insurance premiums have increased by more than 87 percent during the past six years alone, rising four times faster than the average American’s wages. Just this year, a WellPoint plan in California tried to raise members’ premiums by fully 39 percent from the previous year. Health care costs are a substantial cause of three out of five personal bankruptcies. Yet the 10 largest publicly traded health insurance companies at the same time increased their annual profits 428 percent, from \$2.4 billion in 2000 to \$12.9 billion in 2007.

Part of the reason for the dismal state of competition is a stark history of regulatory neglect. The Bush administration took no federal enforcement actions against either anticompetitive or deceptive and fraudulent conduct by health insurers. Almost all of the health care resources of the Antitrust Division of the Justice Department and the Federal Trade Commission were spent pursuing either alleged cartels of physicians or sham health care products. The health insurance industry went untouched.

The Ingenix scheme, uncovered by New York Attorney General Andrew Cuomo in 2009, provides a clear example of an unregulated insurance industry engaged in deceptive conduct to defraud consumers. Various insurers submitted usual and customary rates to the Ingenix database, a wholly owned subsidiary of United Health Care, so that insurers could determine reasonable reimbursement rates for out-of-network coverage. These insurers lowballed rates for years to artificially depress reimbursement rates, and as a result, systemically underpaid consumers millions of dollars over the years. The New York Attorney General’s office secured about \$100 million, and a class action suit by the American Medical Association settled for \$400 million.<sup>4</sup>

There were over 400 health insurance mergers during the Bush administration’s tenure. None were challenged, and the Department of Justice only required mod-

est restructuring in two cases. There is little evidence that the wave of consolidation over the past decade led to significant efficiencies, lower costs, or other benefits. Indeed, the fact that insurance premiums continued to rapidly increase suggests that the companies simply pocketed any efficiencies rather than lowering premiums or creating other consumer benefits.

The total lack of antitrust enforcement during the Bush administration resulted in rapidly increasing premiums, increasing profits, greater numbers of uninsured, and noncompetitive market structures in all but a handful of markets.

The story of regulatory neglect was not significantly better at the state level. Health insurance regulation is primarily perceived as a state affair. But state enforcement is inadequate because those charged with policing the health insurance industry—state insurance commissioners—simply do not have the resources to fully address their anticompetitive conduct and consumer protection violations. Litigating against insurance giants, which have massive resources, is a daunting task.

A Center for American Progress study of 33 states' Department of Insurance's enforcement activity involving health insurers over the past five years found that there were no significant state antitrust actions. The vast majority of consumer protection actions were from just five states. Over a third of states examined took *no* significant consumer protection actions, and in six of the seven most concentrated markets for health insurance, the state insurance commissioner had taken no significant consumer protection actions. The most competitive markets for health insurance—California and Florida—also had the most active regulators. State enforcement of these violations is erratic at best, and a patchwork of state laws cannot consistently control the activity of the national giants. A federal enforcer should instead be charged with regulating health insurers.

The Patient Protection and Affordable Care Act takes great strides to restore competition in health insurance markets and to protect consumers from faulty and ineffective products. This report will describe some of the tools PPACA has created to protect consumers and promote competition, and then suggest how the Federal Trade Commission and Department of Justice can work with the Department of Health and Human Services to supplement those efforts and reverse the history of regulatory neglect.

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## The health reform law provides the tools to restore competition and consumer protection in health insurance markets

Three critical elements of PPACA serve to enhance competition in health care markets: the creation of state health insurance exchanges, requirements for clear and standardized information about plans, and standardized processes for reviewing rate increases.

### Health exchanges to spur competition

Purchasing health insurance in the individual or small group market is a daunting task. Consumers have to navigate inconsistent, unclear, and downright misleading information about their options—and they usually have just a narrow set of options to begin with. Even the most educated Americans have difficulty understanding the terms and conditions of their plans, and a loophole or hidden condition could lead to high costs or a complete loss of coverage when it is most needed. Passage of PPACA should soon begin to fix all of this.

The state health insurance exchanges established by PPACA will serve as marketplaces for individual and small-group health insurance plans. It will be a clearinghouse for the consumer who wants to directly compare plans and understand what they are buying and at what cost. The web portal will provide tools for individuals and small businesses to determine what benefits or subsidies should apply to them, which should give consumers a full understanding of their ability to afford a particular plan. Transparency in turn will enhance competition. Health insurers in this environment will be forced to compete directly on price and quality, and consumers will be able to make meaningful comparisons between various products rather than having to guess which might be the best option.

### Clear, standardized information for health care consumers

PPACA also sets in place a number of requirements for private insurers to advertise and represent their individual and small-group plans in a clear and consistent fashion such that consumers can better understand the product they are purchasing. This information will be available online and make the process of identifying an appropriate and affordable plan far simpler for consumers.

The creation of a simple web portal will enable consumers to determine the key information in choosing the insurance plan with the best combination of price and service. Making certain information transparent—including the proportion of policies that the insurer rescinds, percent of claims denied, and number and result of appeals—will add to consumers’ understanding of the actual quality of a particular plan. Establishing standardized requirements for representing benefits, coverage, and costs to consumers will help individuals make direct comparisons between health insurance products and, like the establishment of online portals, force insurers to compete directly on price and quality.

### Reining in unreasonable rate increases

Standards for rate review similarly create greater consistency in the private market and provide the public with an opportunity to scrutinize rising premiums. Only a handful of states currently require insurers to submit premium increases for approval, and consumers do not necessarily learn that their premiums are about to rise until they receive notification from their insurer. PPACA requires the Department of Health and Human Services to set standards for states to screen premium increases. The new law also requires insurers to post justification for premium increases on their websites in advance and gives federal regulators the ability to ban insurers that have excessively increased premiums from participating in the exchanges.

It is important that HHS and state entities pair any enforcement capabilities they take against unreasonable rate increases available under state laws and PPACA with strong public disclosure requirements, which give consumers the ability to make more informed decisions about health insurance products. US PIRG, a national consumer interest group, emphasizes in comments submitted to HHS the importance of making these disclosures publicly available in a consumer-friendly fashion. Their comments describe the importance of making the information clear and accessible so that consumers can make simple comparisons and make more informed purchasing decisions.

HHS and the states must enforce the law strongly and consistently in order to effectively protect consumers from unreasonable rate increases and to maintain consistency in the market. A recent CAP study by Scot Paltrow found that the states, unfortunately, do not necessarily have the resources to be proactive on this front, and many have little experience dealing with rate review: 23 states do not have the ability to block rate increases for individual health plans before

they go into effect, and nine of these states have no regulatory authority over rate increases at all. Strong leadership on the federal level is thus important.<sup>5</sup> And further guidance by HHS on the standards for rate review is essential.

The National Association of Insurance Commissioners recommended in comments submitted in May of this year that HHS clearly define an unreasonable rate increase and formulate a standard that is both specific and objective. NAIC's comments emphasize how complicated and difficult it is to engage in effective rate review, and they include a list of 11 broad categories of factors that might affect whether or not an increase is unreasonable. These include whether the rate reflects benefit changes, exceeds a predetermined portion of the total original rate, and includes provisions for excessive administrative expenses or profit. Many of these factors are difficult to identify and ultimately balance.<sup>6</sup>

The Obama administration has already grappled with how to stop unreasonable rate hikes, and HHS Secretary Kathleen Sebelius has made it clear that this is a crucial element of making reform effective. When a WellPoint affiliate in California attempted to raise premiums 39 percent, Sebelius asked the plan to publicly justify the increase. When the insurer had no reasonable justifications to offer the public, they simply withdrew the proposed increase. This example may seem extreme, but a recent study by the Kaiser Family Foundation found that, in the individual insurance market, premiums rose an average of 20 percent in the most recent round of premium increases.<sup>7</sup> Indeed, public disclosure requirements and increased transparency are important tools to prevent excessive rate increases and protect consumers who might otherwise find their coverage all of a sudden unaffordable.

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## The missing piece: federal antitrust and consumer protection enforcement

Now that PPACA has set in place requirements to make health insurance markets far more competitive and consumer-friendly, it is critical for the Obama administration to reverse the history of regulatory neglect. Indeed, it is more important than ever that the DOJ and FTC make full use of antitrust and consumer protection laws to make reform effective. Anticompetitive, deceptive, and egregious practices by health insurers have the potential to undermine Congress' efforts to create choice and transparency in health insurance markets, and the FTC and DOJ should be our first line of defense.

PPACA takes excellent measures to promote competition, but the antitrust laws must serve as an effective guard against some of health insurers' old tactics. Practices, such as most favored nations provisions, all-products clauses, territorial allocations, and silent networks—which limit providers' ability to enter into arrangements with rival insurers, increase the power of the insurer at the expense of the health care provider, and ultimately, the consumer, and limit the ability of rival insurers to enter and expand in the market. For example, a most favored nations provision prevents providers from entering into more attractive arrangements with new entrants into the insurance market. Other provisions, such as gag clauses, may prevent physicians from making consumers aware of better coverage when insurers deny medically necessary treatments.

One simple step could do scores to enhance the FTC and DOJ's ability to reverse their record of regulatory neglect toward the health insurance market. For over 60 years, health insurers have lived under an antitrust exemption—the McCarran-Ferguson Act—that is outdated and unnecessary. Supporters of the act claim that it has not had a deleterious effect, but how would we know when the FTC and DOJ have brought so few enforcement actions? Repeal of the act is particularly critical to restoring health insurance competition. If the act is not repealed, the new health insurance exchanges could become environments for tacit collusion or coordination.<sup>8</sup>

Repeal is also critical to restore effective consumer protection enforcement, since McCarran appears to limit the FTC's jurisdiction in this area. The FTC has been remarkably effective at protecting consumers from deceptive and fraudulent activity in practically every other market, but health insurance enforcement has been nonexistent. We need strong federal consumer protection enforcement in order for the PPACA reforms to be fully effective. If the health care debate has accomplished nothing in the past year, it certainly has taught us that the health insurance market is ridden with consumer neglect and deception. McCarran-Ferguson repeal is necessary so that the FTC can focus instead on health insurers in order to protect consumers and promote competition where it is sorely needed.

The FTC and DOJ should play their part in restoring a competitive health insurance market and supporting the efforts of health reform to create competition and protect consumers with the following actions:

## Marshal competition enforcement resources to focus on insurers' anticompetitive and deceptive conduct

Health insurance markets are extremely concentrated, and the complexity of insurance products and the opaque nature of their insurance practices provide a fertile medium for anticompetitive and deceptive conduct. The government's considerable health care enforcement resources should be redeployed to focus on health insurance.

## Create a vigorous health insurance consumer protection enforcement program at the FTC

The FTC's health care consumer protection enforcement currently focuses on companies that market clearly sham and deceptive products. This is unfortunate. In many other areas, such as financial services, the FTC uses a broad range of powers to better inform marketplace participants of how to properly abide by the law, including studies, workshops, policy hearings, legislative testimony, and industry conferences. The FTC should adjust its health care consumer protection enforcement to focus on health insurers. These efforts should focus both on enforcement to prevent egregious and fraudulent practices, and to assure that there is a sufficient amount of information and choice so that consumers can make fully informed decisions. Because of the importance of these issues, especially in controlling health care costs, the FTC should establish a new division for health insurance consumer protection.

## Work with HHS, the states, and the exchanges to ensure that insurers provide enough information to buyers so that consumers can make fully informed decisions

The DOJ and FTC can draw on their consumer protection expertise to ensure that a variety of health care reforms are carried out in the most effective manner possible. The agencies should work directly with the new Office of Consumer Information and Insurance Oversight at HHS to ensure that consumers in the exchanges have adequate information about their alternatives and can act as informed buyers in health insurance marketplaces. HHS, with the guidance of the antitrust agencies, can make the exchanges and web portal environments that facilitate and encourage comparison shopping by all consumers. A model of effec-



tive cooperation across federal agencies already exists in the DOJ's current effort to work with the U.S. Department of Agriculture to better understand competitive issues in various agriculture markets. The antitrust agencies should partner with HHS in a similar fashion.

### Reinvigorate enforcement against anticompetitive conduct

Both the DOJ and FTC need to reinvigorate enforcement against health insurers' anticompetitive conduct. Some of the practices that should be addressed are those that increase entry barriers, such as most favored nations provisions, or the long-standing territorial divisions among Blue Cross plans. The FTC can also play a critical role since it enforces Section 5 of the FTC Act, which allows the agency to attack practices that are not technical violations of the traditional, more narrow antitrust laws—the Sherman and Clayton Acts—but that are still harmful to consumers.

### Strengthen health insurance merger enforcement

There has been massive consolidation in the health insurance marketplace over the past eight years. The Obama administration has taken solid initial steps to reverse the previous lack of enforcement. Earlier this year its threatened challenge to Blue Cross Blue Shield of Michigan's proposed plan to purchase the Physicians Health Plan of Mid-Michigan led to the abandonment of the merger. The merger would have created an insurance behemoth with about 90 percent of the market in Lansing. We hope this is an example of far more aggressive scrutiny of health insurance mergers in the future.

### Conduct a retrospective study of health insurer mergers

A study of consummated health insurer mergers is critical to restoring merger enforcement. The Bush-era FTC conducted a retrospective study of consummated hospital mergers. This study led to an important enforcement action in Evanston, Illinois, which helped to clarify the legal standards and economic analytical tools for addressing hospital mergers. A similar study of consummated health insurance mergers would help to clarify the appropriate legal standards for health insurance mergers and identify mergers that have harmed competition.<sup>9</sup>

## Recognize that the insurer does not represent the consumer

Insurers do help to control costs, but they are not the consumer. The consumer is the individual who ultimately receives benefits from the plan. It is becoming increasingly clear that insurers do not act in the interest of the ultimate beneficiary. They are not the proxy for the consumer interest, but rather exploit the lack of competition, transparency, and opportunity for deception in order to maximize profits.<sup>10</sup> This principle should guide the DOJ and FTC's enforcement priorities, since their mission is to protect consumers.

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## Conclusion

The promise of health care reform is to restore competition and consumer-friendly health insurance markets. This is a crucial time to make sure the proposed reforms are as effective as possible. Restoring competition in these broken markets is a daunting task. And a recommitment to health insurance enforcement by the FTC and DOJ will be essential to these efforts.

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## Endnotes

- 1 Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses" (2009), available at [http://hcfan.3cdn.net/dadd15782e627e5b75\\_g9m6isl1.pdf](http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isl1.pdf)
- 2 American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2009 Update," (2009).
- 3 Wendell Potter. Statement before the U.S. Senate Committee on Commerce, Science & Transportation Hearing: "Consumer Choices and Transparency In the Health Insurance Industry." June 24, 2009. Accessed at [http://commerce.senate.gov/public/?a=Files.Serve&File\\_id=6bbaf0e4-b8f2-497d-8a54-88f5be8c4cae](http://commerce.senate.gov/public/?a=Files.Serve&File_id=6bbaf0e4-b8f2-497d-8a54-88f5be8c4cae).
- 4 Bob Cook, "Final health plan reaches settlement over Ingenix database." *American Medical News*, July 6, 2009, available at <http://www.ama-assn.org/amednews/2009/06/29/bisc0629.htm>
- 5 Scot J. Paltrow. "The Case for a Stronger Federal Role in Insurance Regulation" (Washington: Center for American Progress, 2010).
- 6 National Association of Insurance Commissioners. "NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act," (2010), available at [http://www.naic.org/documents/committees\\_e\\_hrsi\\_hhs\\_response\\_rr\\_adopted.pdf](http://www.naic.org/documents/committees_e_hrsi_hhs_response_rr_adopted.pdf)
- 7 Kaiser Family Foundation. "Survey of People Who Purchase Their Own Insurance" (2010), available at <http://www.kff.org/kaiserpolls/upload/8077-R.pdf>
- 8 David Balto, McCarran-Ferguson Antitrust Reform 101" (Washington: Center for American Progress, 2010), available at [http://www.americanprogress.org/issues/2010/02/health\\_antitrust101.html](http://www.americanprogress.org/issues/2010/02/health_antitrust101.html)
- 9 It should be noted that that FTC is not prevented from doing this under the FTC Improvements Act of 1980, which orders the commission not to conduct any investigation of the business of insurance unless authorized by a vote by either the Senate or the House Commerce Committee. Mergers are clearly outside the scope of the "business of insurance."
- 10 I explored this distinction in testimony, David Balto, "A Progressive Agenda for Antitrust Enforcement at the Antitrust Division," Testimony before the Senate Judiciary Hearing, March 10, 2009, available at [http://www.americanprogressaction.org/issues/2009/03/balto\\_antitrust.html](http://www.americanprogressaction.org/issues/2009/03/balto_antitrust.html). See, in particular, page 10.