An Uncertain Future: Examining Two Proposals for Health Care Reform

By Hayden S. Wool and Gregory R. Smith, Garfunkel Wild PC, and Susan F. Zinder, The Law Office of Susan F. Zinder

Not even seven years has elapsed since the adoption of the Patient Protection and Affordable Care Act (ACA, colloquially known as "Obamacare"), and the implementation of the associated regulations that triggered numerous changes for insurers, providers, and patients across the health care landscape. Donald Trump's election as America's 45th President, accompanied with the election of Republican majorities in the House and Senate, could upend the business of health care for the second time in a decade.

Convinced that the regulatory requirements on health care insurers and providers are overly burdensome and inhibit competition, Republicans have long put forward an agenda that focuses on increasing competition in the health care business community. Although written before any ACA replacement legislation has been agreed upon, this article discusses the potential impact of two proposals that are expected to be included in any final replacement legislation, namely allowing health insurers to compete across state lines and promoting greater provider pricing transparency.

Selling Health Insurance Across State Lines

President Donald Trump and newly confirmed Department of Health and Human Services (HHS) Secretary Tom Price have previously proposed creating a national health insurance market by modifying "existing law that inhibits the sale of health insurance across state lines."[1] For example, before the election, Trump's campaign website stated "[a]s long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up."[2]

The idea behind the proposal is that by avoiding the expense of complying with each state's regulatory framework, competing insurers would be able to pass on cost savings to consumers. Currently, patients in states where only a few payers dominate the health insurance market (and are tightly connected to state regulators) experience a lack of choice among insurers and products from which to choose. An expanded pool of insurers within the state would, in theory, diminish the market and regula-

tory power of the existing payers for the benefit of consumers. Moreover, people (particularly young people) who have chosen not to pay the cost of ACA policies would enter the market with an expanded choice of presumably cheaper, less comprehensive, insurance policies (which would not have to meet the current ACA minimum standards).

Critics, however, are skeptical that the proposal will have the impact that its proponents envision. In fact, some have argued that allowing the sale of health insurance across state lines will not only fail to reduce health care costs, but also could harm consumers by removing existing state regulatory protections. The development of a national insurance market also may be undermined by existing market realities.

First, more than half of all Americans are covered by their employers' self-insured or self-funded plans.[3] These plans are already exempt from state regulations, and thus would not be impacted by a replacement of the ACA. Second, out-of-state insurers are currently allowed to sell across state lines through interstate "health care choice compacts."[4] Specifically, the ACA permits two or more states to enter into compacts under which one or more insurance plans may be offered in the compacting states, subject to the laws and regulations of the state in which the compact was written.[5] The insurer would remain subject to the market conduct, unfair trade practices, network adequacy, consumer protection, and dispute resolution standards of any state in which the insurance was sold, be licensed in each state, and notify consumers that it was not otherwise subject to the laws of the selling state. Approval from HHS would be required for interstate insurance sales, certifying that the coverage would be as least as comprehensive as that sold through the Health Insurance Marketplace (or health insurance "exchange"), provide coverage and cost-sharing protections at least as affordable, cover at least as many residents as coverage under Title I of the ACA, and not increase the federal deficit.

Georgia, Maine, and Wyoming have all enacted laws allowing health care choice compacts. However, insurers have not yet taken advantage of them due, at least in part, to the fact that the insurers remain subject to certain minimum state and ACA requirements. Under a repeal of the ACA, insurers would theoretically be able to sell across state lines without the ACA's (and possibly even the state's) mandatory coverage requirements, assuming that such requirements are not included in any replacement legislation.

Even so, insurers seeking to enter a new state will still need to attract a connected network of providers to participate in their plan, which will require favorable rates to compete against established insurers. Unless they are well capitalized, new insurers may not have the leverage necessary to negotiate rates to attract physicians to their networks during the initial ramp-up period. To gain market share, insurers will also have to attract a customer base seeking competitively priced premiums. The proposal assumes that the market will be flooded as insurers rush to compete in other states simply because they can, and that doing so will be economically desirable. Yet during the first few years, costs will be high with no guarantee of success, which could discourage entrants other than highly capitalized entities with a long-term time horizon.

The idea behind the proposal is that by avoiding the expense of complying with each state's regulatory framework, competing insurers would be able to pass on cost savings to consumers.

Critics of the proposal also raise concerns that allowing insurers to sell insurance across state lines could create a harmful "race to the bottom" as insurers relocate their business domiciles to the states with the weakest regulatory protections. A similar situation occurred in 1978, when the U.S. Supreme Court ruled that state anti-usury laws regulating interest rates could not be enforced against nationally chartered banks based in other states.[6] The Court held that nationally chartered banks would be subject only to federal regulation by the Comptroller of Currency and the laws of the state in which they were chartered.[7] The result was that credit card companies established operations in states that had the weakest usury laws, such as Delaware and South Dakota. Over the next decade, many other states accelerated the repealing or relaxing of their anti-usury laws, allowing state-chartered banks to compete on a more level playing field with national banks. As a result, the use of credit cards vastly increased, and since the mortgage industry soon followed suit, the issuance of subprime mortgages also increased dramatically, contributing to the housing bubble that led to the 2008 housing crisis.[8]

The National Association of Insurance Commissioners (NAIC) issued a briefing in which it argued that "interstate sales of insurance will allow insurers to choose their regulator, the very dynamic that led to the financial collapse that has left millions of Americans without jobs. It would also make insurance less available, make insurers less accountable, and prevent regulators from assisting consumers in their states."[9] To avoid this result, out-of-state insurers could be required to comply with in-state requirements, although this would arguably undermine the main goal of generating cost savings by removing state regulatory barriers for out-of-state insurers.

Even assuming these issues could be addressed and that insurers embraced the idea, it is uncertain that selling insurance across state lines would decrease health care insurance costs. As noted above, the repeal of the ACA would not affect the large segment of the health care insurance market that focuses on employers' self-insured and self-funded plans, as well as Medicare and Medicaid. Moreover, health insurance premiums generally consist of two components, the claims expense and an administrative charge. Approximately 85% of insurance costs are typically attributable to claims expenses, with the balance of approximately 15% attributable to administrative costs. Permitting competition is unlikely to significantly impact the claims expense, which reflects the cost of paying for care and is relatively static. Any material cost reduction would have to come from the administrative charge, which may

[F]or transparency to have the desired effect, patients must be able to discern value by comparison shopping (i.e., by choosing not only lower-priced but high-quality providers).

have a negative impact on customer service. It is also unclear that administrative savings, if any, would be passed on to consumers as insurers seek to maintain executive compensation and profits in the face of increasing competition. The elimination of mandated benefits may create some additional savings, although mandated benefits add, at most, approximately 5% to the cost of a policy, according to the NAIC.[10] To achieve success, insurers also likely would need to engage in significant marketing campaigns targeted at consumers along the lines of campaigns engaged in by automobile and property insurers, highlighting their cost, coverage, and network differentials.

While the proposal to create a national insurance market by allowing insurers to compete across state lines is aimed at increasing competition, lowering costs, and improving health care for consumers, some of the issues discussed above could complicate that effort or potentially negatively impact care and the health insurance market.

Price Transparency in Health Care

Republican proposals to replace the ACA also focus on increasing transparency regarding the costs of health care. To this end, replacement proposals include requiring price transparency from all health care providers, especially doctors, clinics, and hospitals. While the exact parameters of such a proposal are unclear, President Trump has stated that "individuals should be able to shop to find the best prices for procedures, exams or any other medical-related procedure."[11] Similar to encouraging the sale of health insurance across state lines, the stated goal of greater price transparency is to increase competition and respond to rising out-of-pocket costs for consumers.

A more complete and transparent understanding of one's own health care costs may be an important part of reducing overall health care costs. According to an article in *Health Affairs*,

> When faced with paying the excessive rates charged by high-priced providers, most consumers shift towards lower-priced providers. These changes in consumer choices result in reductions in prices and payments. Some high-priced providers reduce their prices so as to mitigate the threatened loss of volume. Payments by employers and insurers decline as consumers shift to providers that charge lower prices.[12]

However, for transparency to have the desired effect, patients must be able to discern value by comparison shopping (i.e., by choosing not only lower-priced but high-quality providers). Unfortunately, not all health care services are "shoppable." For a health care service to be "shoppable," it must be non-emergent and something that patients have the time and ability to research ahead of time. In addition, there must be enough providers of a given service available in a market, and sufficient transparency about the pricing and, most importantly, quality of services in a format that is searchable. According to one study, only about one-third of total health care spending in a given year is on services that are considered shoppable.[13] Another study has estimated that approximately 43% of total health care spending is spent on shoppable services.[14]

According to a 2013 study published by the *Journal of the American Medical Association* (JAMA), as of 2012 there were 62 patient-oriented, state-based health care price websites.[15] Half of these sites were initiated since 2006, and most were provided by a state agency or a hospital association. Most of the sites reported prices of inpatient care for medical conditions or surgeries, whereas prices of outpatient services such as diagnostic or screening procedures, radiology studies, prescription drugs, or laboratory tests were reported less often.[16] Most prices reflected billed charges, and where a full episode of care was billed (i.e., both the technical and professional components of the claim), most price estimates included only the technical fees.[17] Few price estimates incorporated patient insurance status or specific health plans. Quality information was rarely included with pricing information.[18] The study concluded that there are opportunities to improve publicly reported health care price information by focusing information on services that are predictable, non-urgent, and subject to deductibles (e.g., routine outpatient care for chronic diseases), rather than services that are unpredictable, emergent, or would exceed most deductibles (e.g., hospitalization or life-threatening conditions).[19]

A more recent JAMA study from 2016 investigated the effects of the "Truven Treatment Cost Calculator," a price transparency tool offered to employees of two large companies represented in multiple markets nationwide.[20] One employer introduced the tool on April 1, 2011, and the other on January 1, 2012. The tool provided users with information about what they would pay out-of-pocket for services from different physicians, hospitals, and other clinical sites. Outpatient spending among employees who were offered the tool was compared with spending among employees from other companies that were not offered the tool, in the year before and after it was introduced. According to the study, offering a price transparency tool was not associated with lower health care spending, as the tool was used by only a small percentage of eligible employees—approximately 10%. The study noted that low usage rates have also been reported for other price transparency tools, and that low utilization is the most commonly reported challenge to price transparency initiatives by insurers who offer such tools.[21]

Health care is a unique service, driven by a myriad of factors and considerations that are inherently personal. Price is only one aspect of why a patient chooses one provider over another, and often, not the most important aspect. Quality, reputation, and trust all play a crucial role in the decision-making process. Even a patient who is comparison shopping for a new physician and who is interested in pricing information may not limit her comparison to price or even to another measurable metric. For example, a woman seeking a new gynecologist may be looking for a new physician based on the comments section of popular comparison sites such as Yelp, or based on information

received from a friend about the physician's interpersonal skills that will not show up as a publishable metric.

Moreover, it is physicians who typically drive referrals, and patients' trust in their physicians is an integral part of the service model. In this context, transparency and comparative data doesn't necessarily lead to better or more efficient decisions or outcomes, or lower overall costs. That said, for certain types of health care services, as discussed above, increased price transparency may offer an opportunity to lower costs and improve quality.

Conclusion

President Trump and the Republican Congress have made replacing the ACA a top priority. Although the specifics are unclear as of this writing, Republicans believe an alternative plan could enhance the quality of the country's health care system, reduce some of the regulatory constraints on the health care insurance marketplace, and enable provider competition around comparative pricing.

The country's health care system is complex, however, and even carefully thought out, and well-intentioned, proposals may have effects that undermine the shared goals of increasing access to high quality, low cost medical care. The country's seven-year experience with the ACA suggests that achieving these goals will not be a straight line.

About the Authors

Hayden S. Wool (hwool@garfunkelwild.com) is a Partner/Director of Garfunkel Wild PC, which he joined in 1992. Mr. Wool advises clients on a variety of business, regulatory, and transactional issues, with a particular expertise in the application of the Federal and New York State self-referral (Stark) laws and Anti-Kickback laws. Mr. Wool received his BS in Healthcare Administration and Management, With Honors, from Alfred University in 1982, and his JD, With Honors, from Albany Law School of Union University in 1985.

Gregory R. Smith (gsmith@garfunkelwild.com) is a Partner at Garfunkel Wild PC, which he joined in 2002. Mr. Smith advises clients on a wide range of compliance matters, including Medicare and Medicaid audits, application of the Federal and New York State self-referral (Stark) laws, Anti-Kickback laws, and other fraud and abuse issues. Mr. Smith received his JD, With Distinction, from the Hofstra University School of Law in 1999, and his BA from the State University of New York at Plattsburgh in 1993.

Susan F. Zinder (szinder@zinderlaw.com) is the Principal of her own New York City based law practice. For over 25 years (serving as both in-house and outside counsel) she has helped health care and not-for-profit clients successfully address their legal, regulatory, and operational challenges. Susan holds a JD from Fordham Law School and an AB, *cum laude* with High Honors in Politics from Brandeis University. She is currently serving as Vice Chair/Publications for the Business Law and Governance Practice Group of the American Health Lawyers Association.

Thanks go out to the leaders of the Business Law and Governance Practice Group for sponsoring this feature article: **Jay A. Martus**, Advantia Health, Washington, DC (Chair); **Jeffrey L. Kapp**, Jones Day, Cleveland, OH (Vice Chair—Research & Website); **Susan F. Zinder**, The Law Office of Susan F. Zinder, New York, NY (Vice Chair—Publications); **Glenn P. Prives**, McElroy Deutsch Mulvaney & Carpenter LLP, Morristown, NJ (Vice Chair—Membership); **Carolyn Victoria Metnick**, Akerman LLP, Chicago, IL (Vice Chair—Educational Programs); **Lisa D. Taylor**, Inglesino Wyciskala & Taylor LLC, Parsippany, NJ (Vice Chair—Strategic Planning and Special Projects); and **Reema Sultan**, Northwell Health, New Hyde Park, NY (Social Media Coordinator). For more information about the Business Law and Governance Practice Group, visit www.healthlawyers.org/PGs or follow them on Twitter at @ AHLA_BLG.

Endnotes

1 *See* https://assets.donaldjtrump.com/HCReformPaper.pdf.
2 *Id.*
3 Self-insured plans are subject to the Employee Retirement Income Security Act, administered by the U.S. Department of Labor. 29 U.S.C. 1164 et seq. (2012).
4 Insurance firms in each state are protected from interstate competition by the federal McCarran-Ferguson Act (1945), which grants states the right to regulate health plans within their borders. 15 U.S.C. § 1011 et. seq. (2012).
5 *See* § 1333 of the ACA.
6 *See Marquette Nat. Bank of Minneapolis v. First of Omaha Serv. Corp.*, 439 U.S. 299 (1978).
7 *Id.*
8 *See* Elizabeth Warren and Amelia Warren Tyagi, The Two-Income Trap (2003), at pp. 128–129.
9 *See* www.naic.org/documents/topics_interstate_sales_myths.pdf.
10 *Id.*
11 *See* https://assets.donaldjtrump.com/HCReformPaper.pdf.
12 Ann Boynton & James C. Robinson, *Appropriate Use of Reference Pricing Can Increase Value*, Health Affairs, *available at* http://healthaffairs.org/blog/2015/07/07/appropriate-use-of-reference-pricing-can-increase-value/.
13 *See Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*, National Institute for Health Care Reform, NIHCR Research Brief Number 18 (Oct. 2014).
14 *See Spending on Shoppable Services in Health Care*, Health Care Cost Institute, Issue Brief #11 (Mar. 2016).
15 *See* Jeffrey T. Kullgren, MD, MS, MPH; Katia A. Duey, MPH, Rachel M. Werner, MD, PhD, *A Census of State Health Care Price Transparency Websites*, JAMA, vol. 309, no. 23 (June 19, 2013).
16 *Id.*
17 *Id.*
18 *Id.*
19 *Id.*
20 *See* Sunita Desai, PhD, Laura A. Hatfield, PhD, Andrew L. Hicks, MS, Michael E. Chernew, PhD, Ateev Mehrotra, MD, MPH, *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, JAMA, vol. 315, no. 17 (May 3, 2016).
21 *Id.* at p. 1879.