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David Gamage
Indiana University Maurer School of Law, dgamage@indiana.edu

Darien Shanske
University of California, Davis

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How States Can Respond to the AHCA: Using the McCarran-Ferguson Act

by David Gamage and Darien Shanske

David Gamage is a professor of law at Indiana University’s Maurer School of Law and Darien Shanske is a professor at the University of California Davis School of Law (King Hall).

In this edition of Academic Perspectives on SALT, Gamage and Shanske write that passage of the American Health Care Act as proposed could have serious ramifications for states if enacted. Its reforms, they write, would destabilize the insurance market in each state. They advise states to start thinking creatively about how to bolster their insurance markets to prepare for possible changes.

The House of Representatives has passed the American Health Care Act (AHCA).1 As of this writing, it remains unclear what the Senate will do and whether and in what form the AHCA might become law. Nevertheless, the chance that something similar to the AHCA might become law is substantial enough that state governments should be prepared. Moreover, the Trump administration has been threatening to destabilize state insurance markets on its own, even without congressional action.2 State governments will thus need to start thinking creatively about how to bolster their insurance markets, whatever the fate of the AHCA in the Senate.

As we explained in a prior article, the AHCA would pass state governments a hot potato in that the bill’s reforms would radically destabilize the individual insurance markets within each state, unless each state government promptly responded to the AHCA with countervailing reforms. This conclusion holds even more strongly regarding the new version of the AHCA passed by the House on May 4, as that version of the bill would pose an even greater and more extensive threat to the viability of insurance markets within each state.

The version of the AHCA passed by the House retained most of the features of the original, with a few major additions. Most importantly, federal funding for Medicaid was cut even further, and states were given the option to permit insurers to provide far less generous health insurance options. This article focuses on the implications of the latter change.

That change is important in and of itself, but we focus on it because it poses a new threat to state insurance markets. We will explain how that threat could be countered through a type of state government response that we have not yet

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1 We began writing our first article on the AHCA right after it was introduced, on March 6. By the time we submitted that article to State Tax Notes, the AHCA had been pulled. It was pulled March 24, but we decided to publish the article anyway, thinking the AHCA might return. And indeed, it did return, in a slightly modified form that was passed by the House on May 4.


discussed or seen discussed by others: that is, state governments could levy a discriminatory excise tax on certain insurance providers.

To begin our analysis, remember that the new version of the AHCA would permit state governments to authorize more bare-bones insurance offerings by requiring fewer “essential health benefits.” There are both positive and negative implications of that change.

On the positive side, the change could help to stabilize the individual insurance markets in states that take that option. That is because insurance plans that offer fewer benefits may turn out to be cheap enough for individuals to purchase with their (in many cases, much reduced) premium tax credits. Of course, there is a good question whether one should consider the holders of bare-bones policies as being insured in any meaningful sense. Thus, regardless of whether a state opts for the waiver, states should be ready to face either many more uninsured or many more worse-insured citizens compared with the status quo.

Now consider a negative implication of the AHCA’s new provision. Under current law, the definition of essential health benefits plays a key role in regulating employer-sponsored health insurance plans, as the definition is relevant to determining the scope of the ban on annual and lifetime limits that was established by the Affordable Care Act (and that would be retained by the AHCA). That ban is crucial because it prevents employers and other insurance offerers from designing plans that would primarily benefit healthier insureds while providing incentives for the sickest insureds to seek exchange plans after they exceed the spending limits. Without that ban, insurance offerers outside the exchanges would face very large incentives to design plans that would send their sickest and costliest insureds to the exchanges, which would almost certainly send the exchanges into death spirals.

Consider an insurer facing the ban on lifetime limits. One option it might try would be to offer a plan that simply does not cover many expensive medical situations. That is where the definition of essential health benefits comes into play. So long as the operative definition of essential health benefits is sufficiently broad, an insurer could not attempt an end run around the lifetime limits ban by offering plans with minimal benefits.

Large multistate employer-provided insurance plans are permitted to choose the essential health benefits definitions of any state in which they operate. Thus, if any one state were to choose a skimpier definition of essential health benefits and the law and regulations guiding implementation of the AHCA remain as they are, then any firm that opts to use a waiver-state’s essential health benefits definition would impose a potentially huge cost on the insurance markets of other states.

Put another way, if even a single state selects a skimpier definition for essential health benefits, any multistate employer operating in that state could opt to use that state’s definition for its operations in all states. That would allow the employer to effectively circumvent the annual and lifetime limits, as those limits would apply only to health services covered by the skimpier essential health benefits definition. All health services other than those covered by the skimpier essential health benefits definition could be made subject to annual and lifetime limits.

Through that plan design, multistate employers could provide insurance offerings that would be attractive to their healthy employees while saving enormous costs by forcing their sickest and costliest employees to seek coverage on insurance exchanges, once those employees had exceeded the annual or lifetime limits applicable to their more costly health conditions (to the extent that those conditions would be

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4 Congressional Budget Office, Cost Estimate H.R. 1628, American Health Care Act of 2017 (May 24, 2017) (“A few million people among the uninsured would use tax credits to purchase policies that would not cover major medical risks, CBO and JCT estimate. Those policies would be priced to closely match the size of the credits. Although such policies would provide some benefits, they would not provide enough financial protection in the event of a serious and costly illness to be considered insurance”).


6 For a thorough explanation of this, see Matthew Fiedler, “Allowing States to Define ‘Essential Health Benefits’ Could Weaken ACA Protections Against Catastrophic Costs for People With Employer Coverage Nationwide,” Brookings Institution (May 2, 2017).

7 See 45 Code of Federal Regulations 147.126(c)(1).
exempted from the operative skimpy essential health benefits definition).  

What might state governments do to prevent their individual insurance markets from succumbing to death spirals because of this threat? In our prior article, we explained how a state government could impose its own individual mandate or reinsurance or risk-corridor program.  

Alternatively, a state government might establish its own health insurance option — such as a state-level public option.

Yet none of those efforts would likely be enough if the current version of the AHCA becomes law. In addition to those measures, states would need to somehow counteract the threat posed by multistate employers designing plans around the skimpy essential health benefits definitions of other states.

The best way for state governments to respond to that threat would probably require levying some sort of tax or other charge on insurance providers that avail themselves of the skimpier essential health benefits definition of another state. Could a state government in effect impose an excise tax to discourage that sort of forum shopping? For the reasons discussed below, our tentative answer is yes.

The McCarran-Ferguson Act states that “silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of that business by the several States.” In other words, states can regulate or tax insurance companies in a discriminatory way without running afoul of the dormant commerce clause. This power is not without limits, because any such tax or regulation must pass rational-basis scrutiny under the equal protection clause. But that review is very deferential, so the state power is substantial.

Importantly, the McCarran-Ferguson Act should allow states to regulate insurance in a manner that would otherwise violate the dormant commerce clause. Thus, a state-level excise tax on insurance plans that use the skimpier essential health benefits definitions of other states seems likely to pass muster. The analysis would likely proceed in two steps.

First, a state tax that facially discriminates against an insurance provider because that provider selects another state’s essential health benefits definition would likely be doomed under the dormant commerce clause. Yet, because of the McCarran-Ferguson Act, the dormant commerce clause does not restrict the states regarding the regulation or taxation of insurance. Thus, a state-level excise tax on insurance plans that use the skimpier essential health benefits definitions of other states should pass muster under the dormant commerce clause.

Second, that kind of tax should also pass muster under the equal protection clause because, as we have just explained, the tax would be a rational response with a legitimate purpose. That is, the tax would rationally be aimed at mitigating an externality caused by other states’ adoption of skimpier essential health benefits definitions. By combatting that externality, the tax would advance the state’s legitimate interest in promoting the viability of in-state insurance markets and the consequent health of the state’s citizens.

To be sure, the McCarran-Ferguson Act is in the crosshairs of Republicans in Congress, because it prevents interstate competition that would arguably drive insurance prices down. Leaving aside whether that argument is correct, it is unlikely that Congress will repeal the act.

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9 Supra note 3.

10 15 U.S.C. section 1011. For the interesting history of this act, see Walter Hellerstein and John Swain, State Taxation, section 3.05[3][a] (3rd ed.).

11 Western & Southern Life Insurance Co. v. California State Board of Equalization, 451 U.S. 646, 655 (1981) (“We must therefore reject Western & Southern’s Commerce Clause challenge to the California retaliatory tax: the McCarran-Ferguson Act removes entirely any Commerce Clause restriction upon California’s power to tax the insurance business”).

12 The test, set forth in Western & Southern Life Insurance, 451 U.S. at 668, is that the discriminatory state tax must “bear[] a rational relation to a legitimate state purpose.” In this case, the Court upheld a retaliatory California tax, though note that the Court struck down a discriminatory Alabama tax in Metropolitan Life Insurance Co. v. Ward, 470 U.S. 869 (1985), for failing rational basis review.

13 For a concise discussion of some of the issues, see Michael Ollove, “Interstate Health Insurance: Sounds Good, but Details Are Tricky,” Stateline, the Pew Charitable Trusts, Jan. 18, 2017.
soon. That kind of repeal could not be accomplished through reconciliation, which means that it would require 60 votes in the Senate, assuming, as is very likely, a Democratic filibuster. Leading Republican senators have therefore conceded that repeal of the McCarran-Ferguson Act is unlikely.  

Overall, then, the AHCA would pass state governments a very hot potato. But state governments should be able to handle that hot potato successfully by (a) levying a state-level individual mandate, reinsurance and risk-corridor program, public option, or similar measure, as we explained in our prior article, and (b) levying an excise tax on insurance plans operating within the state that opt to use a skimpier essential health benefits definition of another state. For the reasons discussed previously, enacting the second of those prongs should be within state governments’ power under the McCarran-Ferguson Act.

To foreshadow future directions for analysis, we think there could be other ways in which the freedom provided by the McCarran-Ferguson Act might enable useful state regulatory actions. Moreover, in a follow-up article on how state governments might respond to federal healthcare reform efforts, we plan to explain other options for state governments that would remain viable even if the McCarran-Ferguson Act were to be repealed.

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15 Supra note 3.