



Cato Handbook for Policymakers

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16. Health Insurance Regulation

State legislators should

- eliminate licensing of health insurance or, as a preliminary step, recognize insurance products licensed by other states.

Congress should

- eliminate states' ability to use licensing laws as a barrier to trade with out-of-state insurers, and
- relinquish any role as an insurance regulator.

Every year in the United States, thousands upon thousands of Americans walk or are carried into hospitals. Some are in extreme pain. Some are close to death. Using the tools of modern medicine, doctors routinely heal their pain and save their lives. No less marvelous, however, is the fact that the bill is often paid, voluntarily, *by complete strangers*. These benefactors do not know the patient. They do not know her illness. They may not practice the same religion or speak the same language. Were they to meet the patient, they might not even like her. And yet, without anyone pressuring or forcing them to do so, these people repeatedly purchase life-saving medical care for complete strangers. Indeed, they play a role every bit as important as the doctors and hospitals. By some marvel, this wonderful phenomenon occurs every day in the United States.

That marvel is health insurance. When individuals choose to purchase health insurance, they make an agreement to pay for the medical expenses of those in the insurance pool who become sick or injured. They uphold that agreement by paying a periodic premium to an insurance company. To be sure, it is not compassion for others but self-interest that motivates most insurance purchasers: each wants to have her own medical bills paid

in the event of a catastrophe. Yet that only makes health insurance all the more marvelous. Health insurance harnesses the self-interest of millions of strangers to produce an unquestionably compassionate result.

As discussed in Chapter 13 (“Medicaid and the State Children’s Health Insurance Program”), that sort of generosity invites opportunistic behavior. If the insurance pool is paying for all their medical care, some patients will consume more medical care than they need. (And why not? Those other people in the pool are just strangers.) Likewise, health care providers will try to sell those patients more medical care than they need. If individuals can tap that generosity whenever they choose, many will not contribute to the pool until they become sick. By the time they join the pool, their medical expenses would well exceed their contributions. Before long, the premiums would spiral out of control, and no one would want to participate. For these reasons, members of the insurance pool hire someone to protect the members’ generosity from opportunistic behavior.

Health insurance companies are essentially intermediaries between members of the pool. They charge higher premiums to enrollees who purchase more extensive coverage, because those members will draw more money from the pool. They require members to pay part of the cost of their own medical care (through deductibles, coinsurance, and copayments) to ensure that members aren’t careless with other members’ money. They look over physicians’ shoulders (with managed-care tools like capitation payment, preauthorization, and utilization review) to ensure physicians are being careful with their members’ money. They also calibrate each new member’s premium to her expected claims. If an individual waits until she is sick to join the pool, her premiums will therefore be much higher than if she joined while healthy. Risk-based premiums thus *promote* compassionate behavior, because they encourage individuals to contribute to the pool while they are still healthy—so their premiums can help save the lives of strangers. Once in the pool, however, insurers don’t increase members’ premiums when they become ill.

Insurers compete to see who can best manage these features, and provide members the protection they desire at the lowest possible premium. That competition is the market’s way of navigating the Samaritan’s dilemma, discussed in Chapter 13 (“Medicaid and the State Children’s Health Insurance Program”).

Do Health Insurance Markets Fail?

Critics claim that unregulated insurance markets do not provide secure access to medical care; that risk-based premiums are unfair; that insurance

companies drop people when they get sick; that markets will not provide health insurance to everyone; and that government must create pooling arrangements that correct these alleged market failures.

Evaluating the performance of unregulated health insurance markets is complicated by the fact that most Americans obtain health insurance in markets heavily regulated or distorted by government. For example:

- Nearly all seniors obtain health insurance from government through the federal Medicare program (see Chapter 12).
- Due to large tax preferences for employer-sponsored insurance (see Chapter 14, “The Tax Treatment of Health Care”), about 90 percent of nonelderly Americans with health insurance obtain it through an employer.
- Only 10 percent of the nonelderly insured (about 18 million people) obtain insurance directly from an insurance company, i.e., through the “individual” market.

In addition, many states impose significant regulations on their individual health insurance markets. Even if a state does not, administrative costs and premiums in that market will be higher than necessary because government diverts most consumers into the employment-based market.

Researchers examining America’s badly hampered individual health insurance markets nevertheless have found considerable evidence that unregulated markets provide consumers with reliable long-term protection from the cost of illness. For example, University of Pennsylvania economist Mark Pauly and colleagues find as follows:

- “Actual premiums paid for individual insurance are much less than proportional to risk, and risk levels have a small effect on obtaining coverage.”
- “Premiums do rise with risk, but the increase in premiums is only about 15 percent of the increase in risk. Premiums for individual insurance vary widely, but that variation is not very strongly related to the level of risk.”
- “Guaranteed renewable” policies, which are intended to protect against premium increases if the enrollee becomes sick, “appear to be effective in providing protection against reclassification risks in individual health insurance markets.”
- The vast majority of insurance products (75 percent) provided guaranteed renewability *before* they were required to do so by government.

- High-cost individuals who are covered by small employers are nearly twice as likely to end up uninsured as high-cost individuals covered in the individual market.
- “On average, guaranteed renewability works in practice as it should in theory and provides a substantial amount of protection against high premiums to those high-risk individuals who bought insurance before their risk levels changed. The implication is that, although there are some anecdotes about individual insurers trying to avoid covering people who become high risk (for example, by canceling coverage for a whole class of purchasers), the data on actual premium-risk relationships strongly suggest that such attempts to limit risk pooling are the exception rather than the rule.”

Similarly, RAND economist Susan Marquis and colleagues find that the individual market protects enrollees with expensive conditions and that risk-based premiums are not as harsh as critics imply:

- “Purchasers derive value from having the range of choices that the individual market offers.”
- In the individual market, “a large number of people with health problems do obtain coverage.”
- “We also find that there is substantial pooling in the individual market and that it increases over time because people who become sick can continue coverage without new underwriting.”
- Regarding enrollees who purchase insurance and later become sick, “in practice they are not placed in a new underwriting class.”
- “Our analysis confirms earlier studies’ findings that there is considerable risk pooling in the individual market and that high risks are not charged premiums that fully reflect their higher risk.”

Recent experience in California shows that insurance companies will sometimes rescind coverage when enrollees provide inaccurate information about preexisting conditions—and perhaps even when enrollees have not done so. California insurers have since reinstated coverage for many enrollees. That episode demonstrates that media scrutiny is an important market mechanism; that government enforcement of insurance contracts can prevent individuals from defrauding strangers and prevent insurers from breaching their contracts; and that both types of consumer protection can spur insurers to change their behavior. All told, free markets provide considerably better health coverage than critics suggest.

Should Markets Provide Universal Coverage?

Critics are correct that markets will not provide health insurance to everyone. Voluntary insurance pools often will not cover medical conditions that are known to exist at the time an individual enrolls.

Health insurance markets are completely justified in not covering preexisting conditions. If they did, few would purchase insurance until they had an expensive medical condition, and the pool would unravel. Thus, there is a very good reason why markets will not deliver universal coverage.

That still leaves a problem. Risk-based premiums will encourage most people to purchase insurance before they become ill. Yet there will always be some people who either did not join a pool while they were still healthy or never had the opportunity because their high-cost condition has been with them since birth.

Assuming they cannot afford medical care, individuals with expensive preexisting conditions require *subsidies*, which is not to say they need *insurance*. Insurance is merely one way—and a very expensive way—of subsidizing preexisting conditions. More than other types of subsidies, insurance resembles a blank check. In general, strangers do not voluntarily give blank checks to other strangers, again with good reason: strangers are difficult to monitor, and the beneficiaries (encouraged by their health care providers) may take more than they need. Other ways of subsidizing the needy include limited amounts of cash, vouchers, or in-kind subsidies from providers, private charities, or government. Compared with the alternatives, the added costs of subsidizing preexisting conditions with insurance outweigh the added benefits.

Exclusions for preexisting conditions do not indicate a lack of compassion by insurance companies or consumers. They are the insurance market's way of telling us that consumers do not want to subsidize people with preexisting conditions *through insurance*. They do not preclude other options for subsidizing the needy, a topic discussed in Chapter 13 (“Medicaid and the State Children’s Health Insurance Program”).

State Regulation of “Individual” Health Insurance Markets

As a result of the damage it has sustained from federal and state governments, however, the individual market performs well below its potential. As noted earlier, the federal government diverts the vast majority of insurance purchasers into job-based insurance. Moreover, state governments impose countless regulations on their insurance markets. Those

regulations include restrictions on insurance pools' ability to limit or refuse coverage, to vary premiums according to risk, and to negotiate price discounts from providers. States also limit enrollees' freedom to purchase only the coverage they wish. Finally, states prohibit their residents from purchasing insurance from states with more consumer-friendly regulation.

The most disastrous state health insurance regulations are known as "guaranteed issue" and "community rating." Guaranteed issue requires insurers to offer coverage to all comers. Supporters claim that requiring insurers to offer coverage to all individuals will increase access to coverage for those with preexisting conditions. States with guaranteed-issue requirements include Idaho, Maine, Massachusetts, New Jersey, New York, Ohio, Rhode Island, and Vermont. Similarly, 31 states and the federal government restrict, to a lesser extent, insurance pools' ability to deny coverage for preexisting conditions.

Guaranteed issue allows individuals to avoid contributing to an insurance pool until they have a high-cost condition, which is akin to letting drivers who cause an accident purchase retroactive auto insurance. Such laws allow people to take advantage of strangers by removing the insurance pool's ability to protect itself from opportunistic behavior. They leave insurance pools smaller and sicker, which puts upward pressure on premiums.

Despite guaranteed-issue requirements, insurance pools can protect themselves somewhat by charging higher premiums to individuals who wait until they are sick to join the pool. As one might expect, many people with preexisting conditions cannot afford those risk-based premiums. Since the very purpose of guaranteed-issue laws is to give those individuals access to health insurance, many states also limit the extent to which insurance pools can price coverage according to risk. In its purest form, "community rating" requires insurance pools to charge the same premium to all members. States with the strictest community-rating laws include Maine, Massachusetts, New Jersey, New York, North Dakota, Oregon, Vermont, and Washington. Some 10 additional states impose lesser limits on insurance pools' ability to adjust premiums according to new enrollees' age and health status.

Community-rating laws try to force insurance pools to provide greater subsidies to people with preexisting conditions. In effect, community rating forces healthy people to pay higher premiums so that irresponsible people can wait until they are sick to purchase insurance. Put differently, community rating prevents insurers from responsibly managing the relationships

between members of the pool. When community rating requires insurers to charge healthy 18-year-olds the same premium as 50-year-olds with multiple chronic conditions, it encourages all parties to behave in ways that are harmful to the pool and to society:

- Individuals with preexisting conditions see their premiums fall, and therefore purchase more coverage. That increases claims made against the pool, which increases the community-rated premium.
- Healthy individuals are essentially asked to subsidize sicker members of the pool, who are generally older and (ironically) have higher incomes. As the healthy members see their premiums rise, many will drop out of the pool, safe in the knowledge that they can always return and pay a community-rated (i.e., average) premium. Their departure makes the pool sicker on average, which further increases the community-rated premium. As that premium rises, additional healthy members drop out of the pool, and the cycle repeats itself. Economists and actuaries call that process an “adverse selection death spiral.”
- All individuals find that they can no longer reduce their health insurance premiums by engaging in healthy behaviors or avoiding unhealthy behaviors. Thus, fewer individuals will do so, which reduces health and increases claims and premiums.
- Insurers compete to enroll healthy individuals and avoid the sick. Since all enrollees must pay the same premium regardless of their expected claims, healthy members become a gold mine and sick enrollees become a liability. Insurers therefore market their products with benefits (e.g., gym memberships) and advertising (e.g., featuring healthy-looking families) designed to appeal only to healthy people. They may also make enrollment difficult for sicker people, or curtail services that sick people value, hoping that sicker members will choose another insurer.

Community rating contributes to the large number of uninsured. It is one reason why residents of New York and New Jersey face some of the most expensive health insurance premiums in the nation.

For all the damage they cause, community-rating laws appear to offer little benefit. On the basis of his studies of unregulated markets and markets with community rating, Pauly concludes:

We find that regulation modestly tempers the (already-small) relationship of premium to risk, and leads to a slight increase in the *relative* probability

that high-risk people will obtain individual coverage. However, we also find that the increase in overall premiums from community rating slightly reduces the total number of people buying insurance. All of the effects of regulation are quite small, though. We conjecture that the reason for the minimal impact is that guaranteed renewability already accomplishes a large part of effective risk averaging (without the regulatory burden), so additional regulation has little left to change.

Some 21 states also increase the cost of health insurance with “any-willing-provider” laws. Health insurers frequently negotiate discounts from providers. In exchange, those “preferred” providers receive a greater volume of business as insurers steer enrollees toward them. Any-willing-provider laws, however, require insurers to offer the same payment levels and contract terms to any provider who agrees to those terms. “Any-willing-provider legislation removes the incentive to compete aggressively on a price basis,” writes health economist Michael Morrissey. “No one has an incentive to offer much of a discount since discounts will result only in lower prices with little or no expanded volume,” he adds. The result is that enrollees pay more for medical care and health insurance.

All states increase the cost of health insurance by requiring consumers to purchase certain types of coverage, whether or not they want the particular coverage. As a result of these “mandated coverage” laws:

- Teetotalers must purchase coverage for alcoholism treatment (45 states).
- Nonsmokers must purchase coverage for smoking-cessation programs (2 states).
- Non-drug users must purchase coverage for drug-abuse treatment (34 states).
- Many consumers must purchase coverage for services they consider quackery, such as acupuncture (11 states), chiropractic (44 states), and naturopathy (4 states).
- Consumers are required to purchase coverage for services that may be more economical to purchase directly, such as various screening exams (mammograms, 50 states; cervical cancer and/or human papillomavirus, 29 states; colorectal cancer, 28 states; newborn hearing, 17 states; ovarian cancer, 3 states; and prostate cancer, 33 states), as well as uncomplicated deliveries (21 states) and well-child care (31 states).
- Ten states require residents to purchase coverage for hairpieces.

- Many consumers must purchase insurance that covers services or people in relationships that they find morally offensive, such as coverage for contraceptives (31 states), human papillomavirus vaccine (16 states), in vitro fertilization (13 states), and domestic partners (13 states).
- States have also required consumers to purchase coverage for medical treatments that later proved *harmful* to health, such as hormone replacement therapy (2 states) and high-dose chemotherapy with autologous bone marrow transplant for breast cancer (at least 1 state, Minnesota).

Eleven states require consumers to purchase 50 or more types of mandated coverage: California (50), Connecticut (51), Maine (53), Maryland (63), Minnesota (64), Nevada (52), New Mexico (51), New York (55), Texas (54), Virginia (55), and Washington (53). Another dozen states require at least 40 types of mandated coverage. State legislatures have enacted a total of 1,961 mandated coverage laws.

Mandated coverage laws are not sought by broad coalitions of consumers. Legislatures impose these requirements on consumers in response to pressure from special-interest groups, such as chiropractors, acupuncturists, massage therapists (four states), and other providers who want to expand the market for their services. Mandated coverage laws are special-interest legislation that harms consumers by reducing choice and increasing both the cost of health insurance and the number of Americans who cannot afford coverage.

States impose many additional regulations on insurance pools, from premium taxes to rules limiting insurers' ability to manage utilization. The Congressional Budget Office estimates that, on average, state regulations increase the cost of health insurance by 15 percent. Moreover, states prohibit individuals (and employers) from avoiding those laws by purchasing health insurance from states with more consumer-friendly regulations.

The Cure: Force Regulators to Compete

The original sin of health insurance regulation is not guaranteed issue, community rating, any-willing-provider laws, or mandated coverage laws. The original sin of health insurance regulation is insurance-licensing laws. Each state uses insurance-licensing laws to require every insurance policy sold to their residents to comply with all other insurance regulations. Insurance-licensing laws prohibit individual insurance purchasers from

joining insurance pools with residents of other states. Put differently, they prohibit residents from purchasing out-of-state insurance products that come with a different set of regulatory protections. As a result, insurance-licensing laws erect barriers to trade between the states and prevent individuals from shopping for regulatory protections the same way they shop for other insurance features. In effect, insurance-licensing laws give each state's insurance regulators a monopoly over providing regulatory protections. Those regulators then behave the way all monopolists do: they provide a low-quality product at an excessively high cost.

The best solution would be for states to repeal insurance-licensing laws. Doing so would eliminate government's ability to use regulation to redistribute income, or to shower rents on favored special interests. Government enforcement of contracts would continue to provide the financial solvency protections and other safeguards that insurance purchasers demand. If that is infeasible politically, preliminary steps could provide nearly as much benefit to consumers.

With an approach known as "regulatory federalism" the federal or state governments would leave most health insurance regulations intact but would allow individuals and employers to purchase health insurance from other states, regulated by that second state. If a purchaser is content with her own state's regulations, she could continue to purchase a policy regulated at home. But if her state imposes too many mandates, or prevents the insurance pool from protecting itself from irresponsible and opportunistic behavior, then the purchaser could choose an insurance plan with more consumer-friendly regulations. A recent study by economist Stephen Parente and colleagues estimated the following:

- Letting individuals and employers purchase health insurance from out of state could reduce the number of uninsured Americans by as many as 17 million, or one-third of the most-cited estimate of the number of uninsured.
- When combined with tax reforms (see Chapter 14), this approach could cover as many as 24 million uninsured Americans.

Regulatory federalism would increase competition in health insurance markets. Insurers would face lower barriers to introducing products into new states. As a result, consumers would have much greater choice among cost-saving features (e.g., cost sharing and care management), provider financial incentives (fee-for-service, prepayment, and combinations thereof), and delivery systems (integrated, nonintegrated, and everything

in between). Insurance pools would be more stable, and consumers would have much more freedom to obtain coverage that fits their needs.

Perhaps most important, regulatory federalism would force *insurance regulators* to compete against one another to provide the optimal level of regulation. States that impose unwanted regulatory costs on insurance purchasers would see their residents' business—and their premium tax revenue—go elsewhere. The desire to retain premium tax revenue would drive states to eliminate unwanted, costly regulations and retain only those regulations that consumers value. It is likely that one or a handful of states would emerge as the dominant regulators in a national marketplace. Regulatory federalism already exists for corporate chartering, where Delaware has created a niche for itself by offering a hospitable regulatory environment.

Many people, of course, will not want greater competition. Insurance regulators enjoy being monopoly providers. They will oppose threats to their monopoly position, even at the cost of harming consumers. The insurance industry will oppose regulatory federalism, which would subject them to greater competition as well. What insurance company wants to have to look over its shoulder to see if someone else might be doing a better job of managing insurance pools? Those are the very competitive pressures that benefit consumers, yet regulators and insurers will paint competition as a *threat* to consumers.

For example, opponents will claim that regulatory federalism will lead to a “race to the bottom,” with some states so eager to attract premium tax revenue that they will eliminate all regulatory protections or skimp on enforcement. In reality, both market and political forces would prevent a race to the bottom. As producers of regulatory protections, states are unlikely to attract or retain customers—insurers, employers, or individual purchasers—by offering an inferior product. Purchasers will avoid states whose regulations prove inadequate, and ultimately, so will insurers. Moreover, the first people to be harmed by inadequate regulatory protections will likely be residents of that state, who will demand that their legislators remedy the problem. The resulting level of regulation would *not* be zero regulation. Rather than a race to the bottom, regulatory federalism would spur a race to equilibrium—or multiple equilibria—between too much and too little regulation. That balance would be struck by consumers' revealing their preferences.

Opponents of regulatory federalism will also claim that consumers would have to travel to another state to have those protections enforced.

On the contrary, those protections can be enforced in the consumer's state of residence. Not only will state courts enforce other states' laws, when appropriate, but another state's regulations can be incorporated into an insurance contract and enforced in the purchaser's home state. Such "choice-of-law" decisions are complicated and often disputed, but are ultimately controlled by extensively developed legal doctrine and case precedents. Insurance regulators can even play a role in policing and enforcing other states' regulatory protections. There is no reason not to allow consumers to choose where they purchase their health insurance.

There are several options for implementing regulatory federalism. Ideally, each state would unilaterally give its residents the right to purchase insurance from out of state. All a legislature need do is deem as licensed in its state any health insurance policy licensed by any of the other 49 states or the District of Columbia.

States could also give their residents a more limited right to purchase coverage out of state. For example, they could allow residents to purchase insurance from select states, or they could enter into reciprocal compacts with other states. These approaches, however, would be less desirable. They would unnecessarily limit competition among insurers and regulators, as well as limit consumer choice. The latter option would condition each consumer's access to affordable health insurance on whether the legislature *of another state* is willing to do the right thing. Lowering this trade barrier unilaterally and completely is the more consumer-friendly option.

The best way to eliminate those trade barriers might be for Congress to do so. The Framers intended the United States to be one large free-trade zone. Article I, section 8, of the Constitution grants Congress the power to regulate commerce among the states, largely so that Congress could prevent states from erecting trade barriers that keep out products from other states. Insurance-licensing laws are a clear example of such trade barriers and a perfect target for congressional elimination. As with state-level reform, Congress need not alter any state's health insurance regulations. All that is necessary is for Congress to require each state to recognize the insurance licenses issued by the other states.

The Constitution, however, does not grant Congress the power to regulate health insurance. Thus, in the same legislation, Congress should relinquish any role as an insurance regulator. Were Congress to do otherwise, the federal government itself would soon emerge as a monopoly provider of regulatory protections, and consumers would be even worse off than they are today. Over time, rent-seeking special interests would storm

Capitol Hill with demands for additional regulation. Once those federal regulations were enacted, they would be even further removed from the people than state regulations, and much more difficult to dislodge. It is crucial, therefore, that any federal law aimed at regulatory federalism do nothing more than allow consumers to purchase health insurance regulated by another state and ensure that those are the only regulations that govern. If Congress uses the opportunity to regulate health insurance itself, reform will not have been worth the effort.

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