A Regulatory Bypass Operation

Tom Miller

Our health insurance choices are burdened by thickening fatty deposits of regulatory sclerosis. We need to open up some new arteries for consumer-driven health care reform. A regulatory bypass operation would insert market-based shunts, grafts, and transplants into health insurance regulation, before the current seeds of comprehensive federal regulation, first planted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), grow deeper roots in the years ahead.

Growing Federal Role in Health Insurance Regulation

We have traveled a long distance from the early days of the McCarran–Ferguson Act in 1945. That legislation, in response to a Supreme Court decision that insurance was interstate commerce, devolved primary regulatory responsibility to the states, as long as state regulation of insurance was consistent with federal purposes (Harrington 2000). With a few minor exceptions, this "reverse preemption" and deference to the states kept federal regulators off the private health insurance playing field for almost three decades. Even federal antitrust laws generally did not apply to the business of insurance—as long as it was sufficiently regulated at the state level.

A different way of describing this policy would be to say that, rather than seek to prevent alleged collusive price fixing by insurers through federal antitrust regulation, the federal preference was to depend upon state regulation to fix prices through political means and then call it "preserving competition."

Beginning in the early 1970s, federal legislation made some limited moves to override certain areas of states' health insurance regulation.

The HMO Act of 1973 not only promoted use of private HMOs; it

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Tom Miller is Director of Health Policy Studies at the Cato Institute.

also overrode various state law restrictions on the corporate practice of medicine and prohibitions on the operation of prepaid group medical practices.

The Employee Retirement and Income Security Act of 1974 (ERISA) established a different layer of "deregulatory" preemption that prohibited state involvement in regulating large, self-insured, employer-sponsored health insurance plans. ERISA protected all employer-plan sponsors from lawsuits based on state tort law. It also exempted self-insured employer plans from state laws regulating health insurance, including mandated benefits. It allowed large, multistate firms in particular the freedom to develop employee benefit plans without the complications of dealing with multiple state laws and regulations.

The Medigap reform legislation included in the Omnibus Budget and Reconciliation Act of 1990 (OBRA) represented the first limited move to regulate the substance of private health insurance benefits at the federal level, but the task of developing ten standardized policies for the private supplemental coverage sold to Medicare beneficiaries was delegated to the National Association of Insurance Commissioners (NAIC) and state regulators. A decade later, we are seeing that one result of this federal/state regulatory effort was to make authorized Medigap coverage for prescription drugs a very poor value and unlikely to be purchased (Medicare Payment Advisory Commission 2000: 27; see also Laschober et al. 2002).

Meanwhile, at the state level throughout the first half of the 1990s, regulators were responding to insolvency problems in other parts of the insurance industry and accompanying calls for federal intervention. They also faced growing affordability and availability problems in small group health insurance markets. This launched a wave of efforts to coordinate the strengthening of state solvency regulation at the NAIC level and also to tighten state regulation of small group health insurance (Nichols and Blumberg 1998: 30).

In the case of HIPAA, the old playbook of expanded state regulation to head off federal regulation did not fully succeed. In addition to establishing a "fuzzy floor" of minimum federal standards for state regulators (Polzer 2001),[1] HIPAA began to narrow the deregulatory

[1]Polzer observes that HIPAA allows states to add requirements for insurers serving group plans, as long as state laws do not weaken federal standards. This provides states some flexibility in conforming to federal standards, allowing more states to maintain primary responsibility for regulating health insurers and to prevent the potential awkwardness and duplication of federal co-regulation. However, by weakening the standardization of rules across states, the "fuzzy floor" model might increase the potential for confusion among consumers, regulated entities, and regulators.

door for self-insured employer plans by imposing new requirements on them as well. It also seemed to whet the congressional appetite for mandating its own assortment of health insurance benefits—mental health benefits parity in 1996, minimum limits for hospital stays by new mothers with maternity benefits, also in 1996, and additional coverage mandates in 1998 for plans providing mastectomy coverage.

Although this federal regulation by "body part" has slowed down in the last few years, that is largely because Congress has focused on passing the kidney stone of much more comprehensive procedural mandates in the perennially "pending" patients' bill of rights (PBOR) legislation. If you look more closely at the most recent Senate version of PBOR (S. 1052) approved on June 29, 2001, it even suggests a new role for federal solvency regulation of health insurers, perhaps because the legislation needs to ensure that their pockets will not be completely empty, at least until they have paid off judgments from the lawsuits that the bill will authorize and encourage (see Schiffbauer 2001: 1132).

To recap, we've seen growing signs of direct federal regulation of health insurance. We can expect regulatory problems with early rounds of federal legislation (like HIPAA) to give rise to further extensions of corrective federal regulation. Even a mixed system of federal and state regulation will not only inevitably drift toward higher and higher federal floor mandates, but also encourage a state race to the bureaucratic bottom instead of the market top.

Schedule This Patient for Bypass Surgery, STAT

HIPAA represented one of the latest layers of incremental regulatory patch jobs applied to problems caused by previous public policy distortions. This article suggests an alternative to the drift toward more centralized health insurance regulation—a comprehensive set of reforms that could bypass the current regulatory dead ends and more effectively achieve HIPAA's objectives (insurance portability and health care access) through market-based means. After highlighting several initial components of a successful regulatory bypass operation (greater consumer-driven decision making and tax parity), this article will concentrate in greater depth on three remaining steps that apply most directly to HIPAA—encouraging voluntary pooling options outside the workplace, removing barriers to innovation, and providing decentralized competition in insurance regulation.

Getting Started

Step one involves diagnosis of the underlying condition. Consumers are not in charge of their health care decisions, primarily because

public policy discourages them from retaining control of their health care dollars and hinders the availability of empowering options in the marketplace. HIPAA reinforced the longstanding bias in federal health policy that ties workers to employer-sponsored group insurance arrangements and third-party payment of most health care expenses. HIPAA's portability rules aimed at keeping employed workers wired into relatively seamless transitions from one job with group health insurance to another one. But they provided little, if any, assistance to consumers who lacked access to continuous employer-sponsored insurance coverage or sought alternatives to it (e.g., individual insurance coverage, greater reliance on self-insurance). HIPAA chose to adopt regulatory shortcuts that eased the insecurities of the mostly "worried well,"[2] rather than to strengthen the ability of individual health care consumers to choose their own mixes of security versus freedom, quality versus cost, and individual decision making versus delegation and deference to third-party agents.

Hence, the next step in a regulatory bypass operation requires moving out of the box of conventional palliative therapy and addressing fundamentals. A necessary, though not sufficient, condition for better health care policy is tax parity—neutralization of the distorting effects of the income tax exclusion that favors employer-financed group insurance. Any tax subsidy for health care spending should be at least proportionately equalized for all consumers and flow directly to them, regardless of where they work or how they choose to purchase health care (Miller 2001: 315; see also Arnett 1999).

Tax parity would provide consumers with real choices in their health care arrangements and decentralize decision making. They would be less likely to turn over key decisions regarding the scope and terms of their health insurance coverage to third parties without first insisting on what values most to them. Current tax subsidies often operate as tax penalties on consumers seeking other types of coverage, whether it is individual insurance, high-deductible policies coupled with personal saving vehicles, or simply different coverage than what their employer offers. At a minimum, any tax benefits for health coverage should be portable at the individual level.

Market-Based Pooling to Protect against Risk Redefinition

Another step requiring a bit more imagination involves developing better vehicles to pool health risks outside of the workplace and

[2]Cutler and Gruber (2001: 37–44) refer to HIPAA as "feeding the middle class" and addressing its concerns about job lock, but not materially impacting the insurance market.

provide longer-term protection against the redefinition of health risks over time. HIPAA's guaranteed issue, guaranteed renewability, and other insurance portability provisions imposed regulatory mandates aimed at protecting consumers who might experience a serious illness or a diagnosis of illness in one time period and then face the likelihood that private insurers would condition the scope and/or price of future coverage to reflect their redefined health risk status. However, the better way to address the risk definition concerns of buyers, particularly those in individual and small-group markets, is not through politically mandated pooling with all risks forced to pay the same premium. Instead, nongovernmental purchasing pools could offer experience-rated, multiperiod contracts to willing buyers, but only if pool sponsors were allowed to establish necessary ground rules (Dowd and Feldman 1992).

Those rules would include:

- Allowing competing health plans to set their own premiums;
- Experience-rating new entrants to the pool at the outset and perhaps for several initial periods, if needed to account for their heterogeneous risk profiles;
- Facilitating entry of new insurers to compete for pool business;
- Providing annual open enrollment periods; and
- Structuring cooperative agreements between pools to allow individuals to transfer among them during such periods.

These kinds of purchasing pools would differ from the early proposed versions of association health plans and health marts, which have been limited to business firm buyers making collective decisions for all their employees (Miller and Conko 1998: 53–54). Membership in "voluntary" purchasing pools should reflect the preferences of individual workers and other health care consumers, not just the interests and conveniences of employers.

Most early experiments with association health plans, health marts, and other health insurance purchasing cooperatives have faltered for two primary reasons. They have failed to attract a critical mass of customers needed for bargaining leverage and scale economies. They also have been plagued by operating rules (community rating, state-level limits on risk classification and rate differentials, curbs on multiyear lock-in commitments) that increase adverse selection. The most likely pool customers have been those most likely to have greater long-term health care claims costs. Low-risk individuals and employer groups are less likely to join, and they are most likely to leave early once they learn of their relative risk status within the pool in any event.

Regarding the lack of success for non-employer-based pooling of health risks thus far, it may be that potential demand for long-term protection against risk redefinition in the individual and small group markets has been exaggerated. But it's more likely that lower-risk consumers' perceived unwillingness to engage in contemporaneous income redistribution through insurance premium subsidies stems from something else—the absence thus far of true multiperiod private contracts offering new tradeoffs, better choices, and higher overall value (Dowd and Feldman 1992).

A fairer market test of voluntary, nongovernmental purchasing pools would allow pool sponsors and members to prespecify a binding set of mutual constraints that provide incentives to remain in the pool on a long-term basis. Exit disincentives might include a second-tier savings component that remains subject to illness-state-contingent "severance payments " for early departure (see Cochrane 1995; Pauly, Nickel, and Kunreuther 1998: 212). Greater use of front-loaded contracts (Hendel and Lizzeri 2000) also would enhance the sustainability of long-term protections and minimize adverse selection incentives. Most of all, actuarially fair prices would be required at the outset, before renewal guarantees kicked in (Dowd and Feldman 1992).

Unless and until voluntary purchasing pools reach sufficient size to achieve competitive clout, they may need to balance risk redefinition protection objectives against desires for a broader menu of health plan choices for pool participants. Benefits standardization and limits on the numbers of eligible plan sponsors reduce the magnitude of adverse selection and the need for risk adjustment, but at the cost of consumer choice and market competition. The only honest answer will come from trial and error entrepreneurial experimentation in a less regulated marketplace. In any case, the combination of expanded purchasing options and long-term risk protection that finds the most buyers will begin to narrow the significant administrative cost differential between larger employer group plans and other insurance purchasing choices.[3]

Will there ever be a sufficient demand in the market for voluntary pooling devices that do not simply aim at propping up the employer–based system? Could a much deeper individual insurance market do most of the job anyway by offering guaranteed renewal options to buyers not wedded to employer plans?

[3]For a more comprehensive analysis of risk pooling, administrative costs, and public policy options in various segments of the health insurance marketplace, see Pauly and Herring (1999: 81–89).

We won't know without tax parity reforms that facilitate individual insurance buying decisions. We won't know without reasonable relief from state-level rating and risk classification restrictions. We won't know without less uncertainty about the likelihood, pace, and scope of future government policy interventions. And we certainly won't know until we scrap the false sense of security offered by HIPAA (see Pauly 2002).

Stop Chilling Health Insurance Innovation

HIPAA not only accelerated the drift toward greater federal regulation of health insurance, it added new barriers to innovative alternatives that could bypass state and federal regulatory constraints. Those innovations represented threats to HIPAA's curbs on risk classification based on health status and its regulatory cross subsidies to high-risk insurance consumers.

Therefore, the next step of a successful regulatory bypass would begin with recognizing the diverse preferences, characteristics, and needs of individual consumers. Operating principles include:

- Respect the decisions that individuals make.
- Enforce private contracts as they are written.
- Instead of prohibiting risk-based pricing, rely on targeted and transparent subsidies if modification of market-based results becomes necessary.

Of course, for several years proposed PBOR legislation has been poised to outlaw or override what remains of the already paltry and unimaginative contractual options available in today's private health insurance market. Regulatory mandates, along with "judge-made insurance" coverage rulings, already discourage most efforts by insurers to stray very far from the medical community's consensus view of what insurers should finance ("medical necessity") and instead more explicitly offer consumers a range of coverage options that vary in quality, access, and pricing (see Morreim 2001, Havighurst 1995, Hall and Anderson 1992).

HIPAA tried to clamp down on risk classification, at least at the individual worker level within employer group plans. But accurate risk assessment promotes efficient behavior by encouraging health insurance purchasers to compare the cost of insurance with the cost of other alternatives that could protect them against health-related losses. Risk rating reduces moral hazard and adverse selection. To be sure, one should not exaggerate the role of risk classification. Risk classes will be refined by insurers only to the degree that the com-

petitive benefits outweigh the costs. But by pricing risks accurately—either at the group or the individual level—insurers can cover bad risks as profitably as good ones (Abraham 1985, Miller and Rustici 1996).

Accurate risk assessment often conflicts with political imperatives to enhance the role of insurance in risk distribution. However, the problems of potential insurance customers with inadequate income or medically uninsurable risks could, and should, be addressed as social problems. Other more targeted means to handle them include safety net subsidies, private charity, community-based clinics, and high-risk pools that do not alter the relative prices of health insurance and medical care services. Rather than put a regulatory eraser on the competitive operation of private insurance markets, it is better to use a subsidy pen to write a more transparent check that redistributes necessary care to the needy.

HIPAA's regulatory debris and its unintended consequences extend well beyond insurance portability requirements. The legislation was sold on the basis of reforms that promised to reassure insured and employed middle-class workers with protection against the risk of preexisting condition restrictions, premium increases, and loss of coverage whenever they decided to change jobs (Twight 1997: 382). One way to offset the costs of the accompanying regulatory burdens was to promise new savings in health care costs through administrative standardization of electronic data gathering and sharing. That naturally gave rise to fears about privacy abuses from centralized databases, electronic health information networks, and easily accessible personal medical information files. So, a few lines were slipped into the HIPAA legislation in the late going that required Congress to legislate privacy protections by a certain date or else the Department of Health and Human Services would provide health privacy regulations (Twight 1997: 388–90, 394–95; see 42 U.S.C. § 1320).

Perhaps it would be too generous to call the administrative simplification program a "good deed," but it certainly did not go unpunished. The ensuing privacy regulations perversely manage to hamper the necessary free flow of health information yet fail to provide essential health privacy protection (Cate 2002). Rather than accept the false choices of full health privacy for everyone or for no one, and between centrally planned government action or simply doing nothing, we should seek better "private" contract solutions that would give individuals the power to choose more privacy or less privacy.

Five years ago, free market advocates hoped that a new federal medical savings account (MSA) program would provide an escape route from HIPAA's regulatory burdens by encouraging greater reliance on out-of-pocket health spending and less emphasis on com-

prehensive insurance coverage. But that path was strewn with eligibility barriers, statutory speed bumps, and benefit design minefields (Bunce 2001). MSAs can help consumers control costs, exercise greater choice in and control of their own health care, improve access to medical care, and increase personal savings. HIPAA thwarted the potential of MSAs by limiting MSA eligibility to employers in the small-group market and the self-employed in the individual market, permitting only a narrow range of insurance deductible levels, and setting a low numerical cap on individuals eligible for a four-year demonstration project.[4]

More recently, regulatory uncertainty under HIPAA has dampened some of the enthusiasm for defined contribution (DC) plans as a consumer-empowering alternative. The danger is that full-fledged DC plans, which would enable workers to choose their own individual insurance coverage with tax-advantaged employer-sponsored contributions, might still be subject to conflicting rules for employer-sponsored group insurance under HIPAA, including those requiring guaranteed issue and prohibiting discrimination based on health status (see, e.g., Scandlen 2000; Cato Institute 2000). The early versions of defined contribution plans might work around this issue by having employers provide a standard version of catastrophic insurance coverage to all their workers and supplement it with the same fixed amount of cash payments into individual health spending accounts (Miller 2002; Martin 2002: 6–7; Wye River Group on Healthcare 2001: 4–5). One other proposed fix—redefining defined contribution plans as not constituting employee welfare benefit plans under ERISA—might solve the insurance regulation problems under HIPAA but then open up challenges to their tax status.[5]

Competitive Federalism and Consumer-Driven Regulatory Competition

Although prospects for enactment of comprehensive managed care insurance regulation (PBOR) have slowed in the last year, we still appear headed toward more federal regulation aimed at patching the growing holes in an unstable structure of already overregulated and

[4]The HIPAA MSA demonstration project originally was scheduled to end on December 31, 2000. On two occasions, Congress has approved limited extensions of HIPAA MSA authority, but it has failed to permanently authorize tax-qualified MSA options, which now are set to end on December 31, 2003.

[5]However, the proposed Health Care Account Act of 2001 (H.R. 2658), introduced on July 26, 2001, tries to cover both bases. It selectively excludes "health care expenditure accounts" from the definitions of group health plans to which HIPAA group health plan requirements would otherwise apply [section 3 (b)], but it also treats eligible defined contributions to those accounts as excluded from gross income for federal tax purposes [section 2 (a)].

oversubsidized employer-based group health insurance. The direction remains clear, only the pace and particulars are in doubt.

Further drift toward greater federal control would tend to lock in a single regulatory framework resistant to competitive pressure. It would be prone to deliver just one answer, of comprehensive scope, likely to be the wrong one, but difficult to reverse.

For the time being, HIPAA left us in an intermediate position. Today's federal requirements establish a floor rather than a ceiling. At a minimum, they have encouraged more uniformity in state regulation, coordinated through the NAIC model law process, as a defensive move to fend off more explicitly intrusive federal regulation. However, even as states retain some administrative responsibility for implementing federal health insurance policy goals, they remain well on their way to becoming mere subcontractors that determine only the means, not the objectives, of regulation.

On the other hand, a return to the past of exclusive state health care regulation based on geography still would fall short of a market-friendly, consumer-empowering environment. The larger problem is monopoly regulation. When insurance consumers are subject to a state government's regulation of insurance products solely by virtue of residing there, they are stuck with the entire bundle of state rules. They may have literal exit rights if they are ready and willing to move out of the state, but they cannot otherwise choose ex ante the type of regulatory regime they might prefer and need as part of the insurance package they purchase.[6]

This brings us to the final step in finding a bypass around the tightening noose of federal health insurance regulation. Revitalized state regulatory competition that could reach across geographic boundary lines—"competitive federalism"—would facilitate diversity, experimentation, and arbitrage in regulatory approaches (Greve 1999). It would slow down the second-guessing of market decisions, discipline the tendency of insurance regulation to promote inefficient wealth transfers, and promote individual choice over collective decisions driven by interest group politics.[7]

Insurers facing market competition across state lines would have strong incentives to disclose and adhere to policies that encouraged consumers to deal with them. Firms would migrate to state regulatory

[6]For a review of the impact of state regulation on the cost and availability of health insurance in the small group and individual markets, see Employment Roundtable (2001: 8–13); Shriver and Arnett (1998); Jensen and Morrisey (1999), Sloan, Conover, and Hall (1999).

[7]Tiebout (1956) pioneered an economic theory of federalism that argued that competition among local jurisdictions allows citizens to match their preferences with particular menus

regimes that did not impose unwanted mandates but instead fit the needs of their customers by offering different "brands" of regulation. State lawmakers would become more sensitive to the potential for insurer exit. At a minimum, interstate regulatory competition would provide an escape valve from arbitrary or discriminatory regulatory policies imposed at either the state or federal level.

The most successful model for such competitive federalism involves corporate law and the business of corporate charters, in which Delaware has specialized and excelled by consistently producing benefits to investors (Romano 1985; Macey 1990).

The key questions in considering whether a similar approach could develop in health insurance regulation involve how it would operate and who would want it. Effective regulatory competition in health insurance will require a number of key design features.[8]

- Only one sovereign (the primary state) can have jurisdiction over a particular set of health insurance transactions, and its law will control the primary regulatory components of the regime governing them.
- Regulatory reciprocity means that other secondary states respect and enforce those legal rules obtained in primary states.
- Insurers can choose their statutory domicile, or otherwise determine the applicable forum and applicable law, and make it part of the purchasing option they present to consumers.
- States must receive some benefits, such as tax revenues, from competing in the production of specific laws and regulations that reduce insurers' business costs and increase the value of insurance products. Conversely, states also feel within their own borders a sufficient amount of any negative consequences of the regulatory regimes they choose to adopt and "export" to consumers in other states.
- Insurers and their consumers can exercise the right of free exit. They can vote with their feet (real or virtual) and their pocketbooks. Insurance companies can choose their domiciles, the markets where they prefer to operate, and the bundle of laws and regulations attached to the products they sell. They can relocate to alternate jurisdictions at relatively low cost. Consumers may

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of local public goods. Qian and Weingast (1997: 85) noted that interjurisdiction competition, along with decentralization of information and authority, can provide credible commitment to secure economic rights and preserve markets.

[8]For a similar analysis of regulatory competition in other lines of insurance, see Greve (2001).

choose not only the state in which they live but also the legal rules attached to the insurance products they buy.

- Competition for the marginally informed consumer operates to protect other consumers who are not aware or informed of the particular regulatory regime.
- Rather than present a single set of contract terms on an all-or-nothing basis, insurers can offer consumers a menu of alternative policies that are priced to reflect different regulatory approaches.
- Solvency regulation remains decentralized and kept at the state level, to avoid federal domination over other regulation in the name of protecting consumers and taxpayers.[9] Regulatory competition for insurance product design, pricing, and pooling can be accommodated within the current state-based guaranty fund system in a manner that limits an individual state's opportunities to impose costs on other jurisdictions.

One shortcut to competition in insurance regulation that is frequently proposed involves a so-called dual chartering option, in which companies could choose between a federal regulator and a state regulator (Wallison 2000, American Council of Life Insurers 2001).[10] However, it remains highly unlikely that state regulators could compete effectively and on relatively level terms with federal ones over the long haul. Even the much-touted example of dual banking regulation eventually led to federally imposed uniform regulations rather than vigorous competition and diversity, due to the combined effects of the threat of federal preemption under the Supremacy clause, the bargaining leverage provided by federal deposit insurance, and state "wild card" statutes that discouraged the provision of diverse legal rules at the state level (Macey and Butler 1988).[11]

The more effective and sustainable path toward vigorous interstate competition in health insurance regulation would involve strategic use of choice of forum clauses, and perhaps choice of law clauses, in

[9]Butler and Macey (1988).

[10]In addition, the American Insurance Association several years ago briefly floated an outline for another hybrid form of regulation called "state-based national chartering" (Brostoff 2000). It would allow states to issue national charters authorizing insurance companies to underwrite property-casualty insurance in any state without rate and form regulation, but those insurers would still be subject to other state regulations (solvency, guaranty fund requirements, premium taxes, market conduct, etc.).

[11]Although Congress eventually approved the Riegle-Neal Interstate Banking and Branching Efficiency Act in 1994 (P.L. 105-24), this development arrived relatively late in the game. Most of the banking regulatory structure had matured to a point where federal regulation was dominant and more vigorous jurisdictional competition in regulation at the state level remained unlikely.

insurance contracts. Insurers would condition sales of a particular policy on a consumer's consent to the designated litigation forum. That forum would be matched to the state whose regulatory law was selected. This choice of forum would need to be adequately disclosed and executed at the beginning of the contractual period, not just at the time of litigation. Insurers could increase the likelihood that the agreement would be enforced and regulatory competition enhanced by linking the designated forum to their company's domicile—rather than the site of the sales transaction (Ribstein and Kobayashi 2001).

Federal law could provide some shortcuts—such as a statute mandating enforcement of choice of forum contracts under the commerce or full faith and credit clauses of the Constitution. Congress also could provide uniform disclosure requirements for choice of forum and the insurer's domicile in insurance contracts.

A more direct federal statutory approach might set an "insurer domicile" rule, in place of a "site of transaction" rule, for determining applicable state law and regulatory authority—at least as a default rule for multistate transactions where the respective parties do not otherwise designate the operative law. For example, Rep. Ernest Fletcher (R-Ky.) recently introduced the "State Cooperative Health Care Access Plan Act of 2002" (H.R. 4170), which would authorize a health insurer offering an insurance policy in one primary state (the primary location for the insurer's business) to offer the same policy type in another secondary state. The product, rate, and form filing laws of the primary state would apply to the same health insurance policy offered in the secondary state (see also Employment Roundtable 2001: 20–21).

Another route to interstate competition in insurance regulation might be built upon decisions by individual states to grant regulatory "due deference" to determinations by out-of-state insurance regulators that a particular insurance company is qualified to conduct such business. Once an insurer submitted evidence of good standing in its domestic jurisdiction and (if different) in the jurisdiction where it conducts the largest share of its health insurance business, it would qualify for licensure in the state granting such regulatory deference.[12]

Involving Congress in structuring interstate regulatory competition

[12]Regulators in secondary states would be most likely to treat proof of licensure and good standing in the primary state as *prima facie* evidence of qualification for licensure in the secondary state, while still requiring additional routine documents and fees and compliance of the primary states' insurance department with broadly accepted accreditation standards, such as those maintained by the NAIC. (For one creative "draft" proposal outlining how regulatory due deference might operate at the state level, see Mirel 2002.) Initially, an individual state's decision to grant regulatory due deference would be similar to a declaration of unilateral free trade in health insurance products. The state would be eliminating

may be necessary to defuse threats of retaliation and exit restrictions by individual state insurance regulators. However, it remains unlikely that Congress would relinquish a great deal of potential federal regulatory authority without asking for something in return. For that reason, the contractual choice of forum approach seems preferable to other more targeted statutory fixes.

Outlining a path toward interstate competition in "deregulation" of health insurance is one thing; building political momentum to set it in motion involves mobilizing political constituencies that would see its benefits and demand them. According to the "franchise theory of federalism" (Macey 1990: 266–68), Congress will choose to delegate to another "firm" of state-based regulators the rights to market the products and services of insurance regulation only when the political support it gains from deferring to the states is greater than the support it obtains from regulating at the federal level.

The most likely future candidates for reinvigorated state regulatory competition might well be large, self-insured, multistate firms. Most versions of proposed PBOR legislation would target them for the greatest liability risks, particularly if those firms administer their own workers' health benefits in-house. If enacted into law, PBOR also would strip away many of the benefits of current ERISA protections against state regulation by imposing a multitude of new federal mandates on self-insured companies. (As of this writing, it remains uncertain whether negotiators may revise the proposed legislation to ease some of the new liability burdens on large self-insured employers by transferring lawsuits against them to federal court.) Multistate, self-insured firms still may seek the uniformity of a single regulator, but getting it at the federal level may not provide a deregulatory haven much longer. If large firms begin to see self-insured status as more of a liability-increasing risk than a regulation-reducing benefit, they may consider the virtues of linking their plans to a single market-friendly regulatory regime at the state level. If state insurance regulatory systems could compete on an interstate basis, the better ones might find a new customer base in multistate firms seeking consolidated regulation of fully insured products at the state level.

Another possible block of customers for competitive federalism–style insurance regulation includes purchasers of individual insurance on the Internet. The current lines of regulatory jurisdiction for Internet sales remain fluid. Congress might consider a special carve-out

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or reducing its own regulatory restrictions on out-of-state insurance, in order to benefit its citizens and to provide a model for other states to emulate.

to minimize the growth of new regulatory burdens on this promising channel of distribution. Matching regulatory jurisdiction to an insurer's state of incorporation would simplify the regulatory branding for Internet insurance products. It also would allow an insurer to offer potential Internet purchasers a more uniform insurance product, regardless of where they reside.

An additional block of potential buyers for competitive federalism–style health insurance could be sponsors of voluntary purchasing coalitions. To gain a firmer foothold in the health insurance marketplace, buyers' groups will need to find state-based regulation that does not overpower them with rating restrictions and pooling requirements. These groups also are likely to operate beyond a single state's boundaries, and they would prefer dealing with a single insurance regulator.

If Congress decides to expand tax benefits to encourage purchase of individual health insurance policies by the uninsured and other workers lacking access to employer-sponsored health plan coverage, it also could consider crafting special regulatory treatment for policies serving this clientele.

But what about the predictable "race to the bottom" warnings and other counterarguments against regulatory competition?

Those who prefer the existing set of choices within the existing health insurance regulatory system can continue to use them. Those consumers who believe there are advantages in new and different regulatory approaches should be allowed to try them.

Reputational concerns would provide both constraints and incentives for the choice of regulatory regimes offered by established insurance firms. There is little to be gained on a long-term basis in contracting for a law and forum that many consumers are likely to know unduly favors insurance sellers over buyers.

Normal competitive pressure would discourage private insurers from repeatedly switching their state insurance regulator on an opportunistic, short-term basis. Insurers would be more likely to issue a credible promise not to remove to another state—in order to reduce doubts about the enforceability of certain provisions of its insurance contracts (Butler and Macey 1988: 715). By voluntarily accepting this restriction, a private insurance company might improve its market value. Insurers also would tend to incorporate in states that had established a tradition of stability in regulation and in states whose economy was more dependent on the insurance industry.

State regulators could coordinate their law enforcement activities to deal with interstate problems. They also could require compliance with the standards of a centralized body to assist necessary uniformity in certain areas. Or Congress could establish a default rule for en-

forcement of certain actions (such as those involving consumer fraud or other improper market conduct) that affect consumers in a secondary state but involve insurance policies regulated by a primary state. The rule would authorize insurance regulators in that secondary state to treat the insurer involved as if it was primarily licensed there (see, e.g., the State Cooperative Health Access Plan Act of 2002: § 101).

Finally, defenders of the current regulatory structure and skeptics of regulatory competition need to answer the "Compared to What?" challenge. They cannot just assume that a hypothetically perfect, well-designed system of more and more federal insurance regulation will materialize in the future. They need to demonstrate its measurable benefits in comparison with a more decentralized system of regulatory competition—a system much more likely to deliver the contractual assurances, services, and features for which buyers are willing to pay.

We have already run a different "race to the bottom" with over-regulation. The losers end up uninsured—because they cannot afford coverage or refuse to overpay for it. The race to the market top needs a full field of state regulators running in each other's markets.

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