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36. 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

- repeal the Patient Protection and Affordable Care Act;
- 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, millions of Americans walk or are carried into hospitals. Many are ill. Others are injured. 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 is that for decades, millions of these and other patients had their medical bills paid, voluntarily, *by complete strangers*. The benefactors did not know the patients. They did not know their illnesses. They may not have practiced the same religion or even spoken the same language. Had they met the patients, they might not have even liked them. And yet, without anyone pressuring or forcing them to do so, these strangers repeatedly purchased lifesaving medical care for others. Indeed, they played a role every bit as important as the doctors and hospitals. By some marvel, this wonderful phenomenon occurred every day in the United States without central direction or compulsion.

That marvel is voluntary health insurance. When individuals choose to purchase health insurance, they agree to pay 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 when she is sick or injured. Yet that only makes voluntary health insurance markets all the more marvelous: it harnesses the self-interest of millions of strangers to produce an unquestionably compassionate result.

As discussed in Chapter 39, that sort of generosity invites opportunistic behavior. If somebody else 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 who bear the cost are just strangers.) Likewise, health care providers will try to sell those patients more medical care than they need. If individuals can tap this generosity whenever they choose, many will not contribute to the pool until they become sick. At that point, what they draw from the pool could well exceed their premium contributions. If enough people join the pool too late, then premiums will spiral out of control, and then no one will want to participate. For these reasons, members of the insurance pool hire someone to protect themselves and their generosity from opportunistic behavior. Those intermediaries are private health insurance carriers.

Health insurance companies prevent this unquestionably compassionate arrangement from unraveling. As intermediaries between members of the insurance pool, insurance carriers charge higher premiums to enrollees who purchase more extensive coverage because those members will draw more money from the pool. Charging more for more coverage also encourages people to purchase only the coverage they truly value. In addition, insurance companies require members to pay part of the cost of their own medical care. Deductibles, reverse deductibles, coinsurance, and copayments discourage wasteful medical care and help ensure that members aren't careless with other members' money. In many cases, they look over physicians' shoulders. Managed-care tools like capitated payments, preauthorization, and utilization review help ensure physicians are being careful with their members' money and health.

Risk-Based Premiums Protect Consumers

In a market system, insurance carriers further protect their members by charging higher premiums to new enrollees who have a higher risk of needing medical care and lower premiums to enrollees with a lower risk. 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 therefore both preserve the stability of the insurance pool and promote compassionate behavior. If individuals could wait until they got

sick to join the pool, few would contribute to the pool while healthy. In that event, premiums would climb until the pool collapsed. When insurers set premiums according to risk, they prevent individuals from taking advantage of the generosity of other members of the insurance pool. They are also promoting compassionate behavior. Risk-based premiums encourage individuals to contribute to the pool while they are still healthy and their premiums are low, so their premiums can help save the lives of strangers. Thanks to an innovation called "renewal guarantees," 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 39.

Do Health Insurance Markets Fail?

Critics lodge several complaints against voluntary insurance markets. They argue that unregulated insurance markets do not provide secure access to medical care. They claim that risk-based premiums are unfair. They say that insurance companies drop people when they get sick. They complain that markets will not provide health insurance to everyone. Finally, they argue that government must create compulsory pooling arrangements to correct these alleged market failures.

Evaluating the performance of unregulated health insurance markets is difficult. Since 2014, all health insurance in the United States has involved some form of compulsion. Even before then, the vast majority of Americans with health insurance obtained it through compulsory arrangements. For example:

- Nearly all seniors obtain health insurance from the government through the federal Medicare program (see Chapter 38).
- Even before the Patient Protection and Affordable Care Act (ACA) took effect in 2014, federal and state tax laws imposed large penalties on workers whose employers do not offer coverage or who turn down the health insurance their employer offers (see Chapter 37). As a result, more than 80 percent of Americans who have private health insurance get it through an employer. Since 2014, the ACA has threatened nearly all Americans with penalties if they do not purchase health insurance.
- Prior to the ACA, Congress already prohibited employer-based health plans from protecting their members by charging risk-based premiums.

Many states imposed such price controls (and other costly regulations) on the individual market. With the ACA, Congress has banned this consumer protection from all forms of insurance.

The evidence we have about how voluntary, unregulated health insurance markets perform comes from the individual market prior to the ACA. Even then, this market made for an imperfect test case. Numerous government interventions left the individual market with fewer consumers and higher administrative costs.

Markets Provide Secure Access to Health Care

Researchers examining these badly hampered markets nevertheless have found considerable evidence that unregulated markets provide consumers with reliable long-term protection from the cost of illness. University of Pennsylvania economist Mark Pauly and his colleagues found the following:

- "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 allow enrollees who develop expensive illnesses to keep purchasing coverage at standard premium rates, "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* the federal government mandated it in 1996.
- Unregulated markets provide sick enrollees coverage that is more secure than employer-sponsored coverage. High-cost individuals who enroll in coverage through small employers are nearly twice as likely to end up uninsured as high-cost individuals with individual-market coverage.
- "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."

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

- 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."
- "Purchasers derive value from having the range of choices that the individual market offers."
- "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."

Do Carriers Drop Coverage Because Enrollees Get Sick?

Critics counter that without regulation, insurance companies could and did cancel coverage, often retrospectively, when enrollees fell ill and began filing expensive claims. It is indeed true that insurance companies sometimes rescind coverage—often with good reason.

Another type of opportunistic behavior, in which individuals attempt to take advantage of other members of the insurance pool, is fraud. A person who waits until she is sick to purchase coverage, then lies to the insurance company about her need for medical care, is not contributing to the pool while she is healthy. She is only drawing from the pool when she is sick. She is therefore taking advantage of others in the pool. By only joining the pool once she is sick, she is also making the pool sicker on average. This makes health insurance less available to others by driving up its cost. Rescinding coverage from people who commit fraud is a consumer protection. Such rescissions make health insurance more widely available and protect members of the insurance pool from individuals who would take advantage of them.

Insurers could indeed rescind coverage for misrepresentations that were not fraudulent. Whether a misrepresentation was intentional and material, or just a clerical error, is often a judgment call, and there is no obvious place to strike the balance between protecting members of the insurance pool from fraud and forgiving those who made innocent mistakes on their

applications. A market system has ways of punishing insurers who are too aggressive with rescissions. Prior to the ACA, media scrutiny of rescissions led California insurers to reinstate coverage for many enrollees. Media scrutiny and insurers' concern for the reputation of their brand are market mechanisms. Insurers can also spell out rescission policies in insurance contracts, and victims of overzealous rescissions can take insurers to court. Each of these types of consumer protection can spur insurers to change their behavior.

Critics also allege insurers will cancel entire health plans to avoid covering enrollees with expensive conditions. Pauly and colleagues found 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." All told, free markets provide considerably better and more secure health coverage than critics suggest.

Should Markets Provide Universal Coverage?

Critics correctly note that voluntary insurance will not provide health insurance to everyone. Nor should it. Exclusions for preexisting conditions are essential for creating a stable system of subsidies for people who develop expensive conditions, and for reducing the number of people with preexisting conditions who lack secure coverage. Allowing exclusions for preexisting conditions does not preclude other options for subsidizing the needy, a topic discussed in Chapter 39.

Even when insurers can charge premiums that reflect risk, voluntary insurance pools often will decline to cover medical conditions that are known to exist at the time an individual applies for coverage. Exclusions for preexisting conditions do not indicate a lack of compassion by insurance companies or consumers. They are the market's way of telling us that *consumers* do not want to subsidize people with preexisting conditions *through insurance*.

If voluntary insurance pools offered coverage for preexisting conditions, few individuals would purchase insurance until they had an expensive medical condition, as already discussed. Insurance pools would unravel. Exclusions for preexisting conditions are therefore essential to preserve the stable system of subsidies that voluntary insurance pools create for those who developexpensive conditions. Exclusions for preexisting conditions also reduce the number of people with expensive illnesses who lack

coverage. They encourage individuals to purchase coverage before they develop an expensive condition, so that they will then have access to that stable system of subsidies if they develop such a condition.

That still leaves a problem. Risk-based premiums and rescissions for fraud 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, these individuals require *subsidies*—not *insurance*. Insurance is merely one way—and in reality, a very expensive and ultimately harmful way—of subsidizing preexisting conditions. Insurance resembles a blank check. Charities and other compassionate people tend not to give blank checks to strangers. Strangers are difficult to monitor and (encouraged by their health care providers) may take more than they need. Other ways of subsidizing people with preexisting conditions include limited amounts of cash, vouchers, or in-kind subsidies from providers, private charities, or the government. Exclusions for preexisting conditions are the market's way of telling us that—relative to these alternatives—the added costs of subsidizing preexisting conditions through insurance far outweigh the added benefits.

Regulation Blocks Secure Health Insurance

The United States no longer has a voluntary health insurance market. As noted earlier, federal and state governments divert the vast majority of consumers into job-based insurance by penalizing them if they do not enroll in their employer's coverage. Federal and state governments also impose countless regulations on insurance markets. They restrict insurance pools' ability to limit or refuse coverage and to vary premiums according to risk. They dictate what coverage insurers must offer, limiting consumers' freedom to purchase only the coverage they wish. States limit the ability of insurers to negotiate price discounts from providers. Finally, states prohibit their residents from purchasing insurance from states with more consumer-friendly regulation.

The most disastrous health insurance regulations are requirements known as "guaranteed issue" and "community rating" that create a scheme of government price controls. Guaranteed-issue mandates attempt to *expand access to health insurance* for people with preexisting conditions by requiring insurers to offer coverage to all applicants. This regulation therefore allows people to take advantage of strangers by removing the insurance

pool's ability to protect itself from opportunistic behavior. It 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. Guaranteed-issue requirements leave insurance pools smaller and sicker, which puts upward pressure on premiums.

Insurance pools could still protect themselves somewhat by charging higher premiums to individuals who wait until they are sick to join the pool. But because many people with preexisting conditions cannot afford those risk-based premiums, and since the purpose of guaranteed-issue requirements is to give those individuals access to health insurance, the government also limits 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, regardless of their health risk. The Patient Protection and Affordable Care Act imposes a guaranteed-issue requirement and community-rating price controls on the entire individual market. Insurers must charge all enrollees of a given age the same premium, regardless of health status. Insurers may charge their oldest enrollees no more than three times their youngest enrollees, even though the oldest enrollees typically cost six or seven times as much to insure.

Even before the ACA was enacted, several states and the federal government imposed various restrictions on the ability of insurance pools to deny coverage for or to vary premiums on the basis of preexisting conditions. In some states' individual markets, and in employment-based coverage, these requirements are even stricter than under the ACA.

Community-rating laws try to force insurance pools to *provide greater subsidies* to people with preexisting conditions. They do so by forcing healthy people to pay higher premiums than otherwise, so that less healthy people can pay lower premiums. Put differently, these laws prevent insurers from responsibly managing the relationships between members of a 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 see their premiums rise to subsidize sicker members of the pool, who are generally older and (ironically) tend to have higher incomes. Many drop out of the pool, safe in the knowledge that if they get sick, the government will require insurers to sell them coverage at the same premium they charge healthy people. Their departure makes the pool sicker on average, which further increases premiums. This causes additional healthy members to drop out of the pool. Economists and actuaries call this vicious cycle an "adverse selection death spiral." To prevent a death spiral, the ACA imposes an individual mandate that penalizes Americans if they do not purchase health insurance, and spends $1 trillion over 10 years to hide the full premium from consumers in the individual market.
- Fewer enrollees engage in healthy behaviors or avoid unhealthy behaviors, because doing so no longer reduces their health insurance premiums. This adversely affects health and increases claims and premiums.
- Community-rating price controls create a race to the bottom on quality. 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. Any insurer who becomes known for providing the best coverage for the sick risks bankruptcy. Insurers therefore compete to provide coverage that is attractive to healthy individuals and unattractive to the sick. Insurers may also make enrollment difficult for sicker people, or curtail services that sick people value, hoping that sicker members will choose another carrier. Insurance-company greed cannot explain the race to the bottom. Community-rating price controls reward insurers for offering coverage that is unattractive to the sick if insurers do so unintentionally.
- Community rating requires even more regulation and government intervention. Supporters are aware of the perverse incentives that community-rating price controls create. In an attempt to prevent a race to the bottom, the ACA further regulates the content and marketing of health insurance plans. These requirements increase the cost of coverage and require consumers to buy coverage they do not want and may find morally objectionable (e.g., coverage for contraceptives). These provisions appear not to be working. Insurers participating in the ACA's health insurance "exchanges" have curtailed provider networks, increased cost sharing on specialty drugs, and taken other steps to avoid providing coverage attractive to the sick.

For all the damage they cause, guaranteed-issue and community-rating laws appear to offer little benefit in terms of expanding coverage to the sick. On the basis of their pre-ACA studies of unregulated markets and markets with community rating, Pauly and his colleagues reach the following conclusion:

> 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.

Community Rating Blocks Innovative, Secure Coverage

Finally, guaranteed-issue and community-rating laws have destroyed innovative insurance products and prevent the development of further innovations that provide more secure coverage to people who develop expensive conditions. As previously noted, guaranteed-renewable health insurance is an innovation that allows consumers who develop expensive conditions to keep purchasing coverage at standard premiums. Insurers build up reserves to cover those costs. When Congress tried to solve the problem of preexisting conditions with the ACA's guaranteed-issue and community-rating provisions, it made guaranteed-renewable health insurance impossible. Blue Cross Blue Shield of North Carolina used its $156 million guaranteed-renewability reserve fund to issue all of its policyholders refunds averaging $725 each. Market forces had led insurers to set that money aside for the sick. The ACA led insurers to give it away to healthy people.

The ACA destroyed another innovative and promising insurance product that markets had just begun to introduce. In 2008 and 2009, insurance regulators in 25 states approved the sale of "preexisting conditions insurance." These products allow *uninsured* enrollees who develop expensive conditions to purchase health insurance at standard rates. UnitedHealthcare Group offered this revolutionary product for 20 percent of the cost of the underlying health insurance policy, a savings of thousands of dollars per year.

Like a renewal guarantee, preexisting conditions insurance protects consumers against the risk that their premiums will rise after they get an expensive, long-term medical condition. The ACA's community-rating price controls destroyed the market for these innovations by imposing a government-dictated approach to pooling those risks.

Finally, the ACA is preventing markets from developing further innovations. Two examples illustrate the possibilities. Law professors Tom Baker and Peter Siegelman explain how insurers could make health insurance more attractive to so-called "young invincibles," and thus induce them to purchase it voluntarily, by offering cash back to people who don't file claims. Economist John Cochrane explains how markets could offer health insurance with a total satisfaction guarantee: health insurance contracts could allow sick enrollees who grow dissatisfied with their coverage to fire their insurance company, receive a large cash payout, and then choose from among other carriers who would compete to cover rather than avoid them.

Markets can make health care more secure by protecting sick patients from the incentives insurers face to renege on their commitment to provide secure coverage. At the same time the ACA increases incentives for insurers to renege on those commitments, it blocks the market's ability to solve that problem and to make health care more secure for the sick.

State Regulations Harm Patients

States have enacted further health insurance regulations that harm patients. For example, more than half of states 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 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 Morrisey. "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." The result is that consumers pay more for medical care and for health insurance.

Like the federal government, all states increase the cost of health insurance by requiring consumers to purchase certain types of coverage, whether or not they want it. Many states require consumers to purchase coverage for services that many consider quackery, such as acupuncture (12 states),

chiropractors (44 states), and naturopathy (4 states). Thirty-three states require consumers to purchase at least 40 types of mandated coverage. States have also required consumers to purchase coverage for medical treatments that later proved *harmful* to health, such as hormone replacement therapy (4 states) and high-dose chemotherapy with autologous bone marrow transplant for breast cancer (at least 1 state, Minnesota).

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 13 percent. States prevent individuals (and employers) from avoiding unwanted regulatory costs by prohibiting them from purchasing health insurance from states with more consumer-friendly regulations.

To Stop the Bleeding, Repeal the ACA

Congress should repeal the ACA and replace it with reforms that allow better, more affordable, and more secure health care. The ACA's insurance regulations are sending health insurance into a downward spiral of low-quality coverage and higher premiums. If Congress repeals the Act, premiums would fall for millions of Americans who would no longer have to buy coverage they do not want or pay the hidden taxes that further increase their premiums. Consumers could once again purchase coverage that is more secure than either ACA coverage or employer-sponsored insurance. They would have the option to purchase preexisting conditions insurance, which would provide protection from the financial costs of long-term illness at a fraction of the cost of a standard health insurance plan. Consumers could look forward to the day when health insurance comes with a total-satisfaction guarantee and patients don't have to worry about their coverage—because it just works.

Merely repealing the ACA is not enough to improve quality and expand access for everyone currently receiving subsidies under its auspices. Federal and state policymakers must take additional steps outlined in this chapter and in Chapters 4, 14, 35, 37, 38, and 39. As Congress takes these steps to transition the U.S. health care sector from a government-run system to a market system, political necessity may require Congress to offer transitional assistance to the relatively small number who receive coverage under the ACA but would not see their premiums fall after repeal. Targeted assistance, perhaps in the form of a federally funded high-risk pool, could

be one of the purposes for which Congress allows the block grants recommended in Chapter 39.

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. It is the insurance-licensing laws that make those regulations possible. Each state uses insurance-licensing laws to require every insurance policy sold to its residents to comply with all that state's regulations. Those laws prohibit individual insurance purchasers from joining insurance pools with residents of other states. And they prohibit residents from purchasing out-of-state insurance products that come with a different set of regulatory protections. As a result, they erect barriers to trade between the states and prevent individuals from shopping for consumer 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 consumer protections. Those regulators then behave the way all monopolists do. They provide a low-quality product at an excessively high cost.

The best solution is for states to repeal insurance-licensing laws. Full liberalization would eliminate government's ability to use insurance regulations to redistribute income, or to shower rents on favored special interests. Government enforcement of contracts and competition would continue to provide the financial solvency protections and other safeguards that insurance purchasers demand.

If repealing insurance-licensing laws is politically infeasible, preliminary steps could provide nearly as much benefit to consumers. Under one approach, the federal or state governments would allow individuals and employers to purchase health insurance licensed by other states. 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. Economist Stephen Parente and colleagues estimate that

- letting individuals and employers purchase health insurance 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; and

- when combined with tax reforms (see Chapter 37), 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 and prepayment), and delivery systems (integrated, nonintegrated, and everything in between). (See Chapter 35.) Insurance pools would be more stable, and consumers would have more freedom to obtain coverage that fits their needs.

Perhaps most important, regulatory federalism would force insurance *regulators* to compete with 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. One or a handful of states would likely emerge as the dominant regulators in a national marketplace, just as Delaware has created a niche for itself by offering a hospitable regulatory environment for corporate chartering.

Critics of this proposal do not want greater competition. Insurance regulators enjoy being monopoly providers. They would oppose threats to their monopoly position. The insurance industry would oppose regulatory federalism because it would subject them to greater competition as well. What regulator or 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?

Competition benefits consumers. But regulators and insurers would paint this form of competition as a threat to consumers. Some critics claim that letting individuals and employers purchase coverage licensed by other states would lead to a race to the bottom. Others claim that some states would be so eager to attract premium tax revenue that they would 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 would avoid states whose regulations prove inadequate, and ultimately, so would insurers. The first people to be harmed by inadequate regulatory protections would likely be residents

of that state, who would then demand that their legislators enact better consumer protections. The result would not be zero regulation or a race to the bottom, but a race to equilibrium or multiple equilibriums—between too much and too little regulation—as consumers revealed their preferences.

Opponents of regulatory federalism also claim that consumers would have to travel to another state to have those protections enforced. On the contrary, those protections could be enforced in the consumer's state of residence. Not only could state courts enforce other states' laws, when appropriate, but another state's regulations could 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 they are ultimately controlled by extensively developed legal doctrine and case precedents. Insurance regulators could 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 licensed by any other 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.

Though far from ideal, states could also give their residents a more limited right to purchase coverage out of state. They could allow residents to purchase insurance from select states, or they could enter into reciprocal compacts with other states. These approaches, however, would unnecessarily limit competition among insurers and regulators, as well as consumer choice. Reciprocal compacts would oddly 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 a free-trade zone. Article I, Section 8, of the Constitution grants Congress the power to regulate commerce among the states, largely so that Congress can 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 would (re)emerge as a monopoly provider of regulatory protections. Consumers would be even worse off than they are today. As they do under the ACA, rent-seeking special interests would storm Capitol Hill with demands for additional regulation. Federal regulations would be even further removed from the people than state regulations, and much more difficult to dislodge.

Any federal law aimed at regulatory federalism must 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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—Prepared by Michael F. Cannon