



## A National Market for Individual Health Insurance

University of Minnesota  
Division of Health Policy and Management  
Minneapolis, MN

### BACKGROUND

Health insurance markets are regulated by the states under the McCarran-Ferguson Act (15 U.S.C. 1011) of 1945. The ‘purpose clause’ of the Act states that regulation and taxation of the business of insurance by the states is in the public interest. As a result of McCarran-Ferguson, every health insurer must be licensed in the policyholder’s state of residence. The states have responded with a complex patchwork of mandates and laws that vary widely across the country. As a result, people who buy health insurance in the individual insurance market (i.e. they pay the premium themselves, without an employer or union contribution) pay wildly different premiums depending on where they happen to live. A 49-year old man in Trenton, NJ can enroll in a popular Health Maintenance Organization (HMO) for \$409 per month. If he lived across the Delaware River in Morrisville, PA, the premium for an HMO with the same coverage would cost just \$250 per month. He would also find many more choices in Pennsylvania – 97, compared with 19 in New Jersey. These differences in premiums and choices are not caused by differences in prices or the doctors and hospitals in each community. Our Garden Stater might get his medical care at excellent hospitals in Philadelphia, and the Pennsylvanian could drive over the river to excellent hospitals in New Jersey.

What distinguishes our two customers is that New Jersey is one of the most heavily regulated states in the U.S. It requires that all individual

---

The Roe Better Government Network researches and distributes public policy solutions for the benefit of the New England states. The Roe Papers are selected from among the most intriguing and original submissions to Pioneer Institute’s annual Better Government Competition. Pioneer works with each submission’s author to develop their ideas into detailed, actionable policy proposals.

**We are appreciative of the Roe Foundation’s generous support for this initiative.** Their sustained funding has enabled Pioneer to vet these ideas with policy makers and experts as well as legislators and executive officials.

Please visit [www.pioneerinstitute.org](http://www.pioneerinstitute.org) for more information.

insurance policies be community rated, meaning that insurers are not allowed to recognize differences in risk that cause healthcare costs to be higher for some people than for others. Because community rating requires low-risk policyholders (often young and less wealthy) to subsidize high-risk policyholders, many people have dropped coverage and those who remain insured pay higher premiums. New Jersey also requires insurers to sell insurance to all potential customers regardless of health or pre-existing conditions, and it has 30 insurance mandates that require insurers to cover particular services or providers.

The economic law of demand says that high prices will drive customers away, and that is exactly what has happened in New Jersey's individual health insurance market. In 2008, we estimate there were only 20,328 individual policyholders in the entire state; in contrast, Pennsylvania, a state with about 40% more people, had 644,614 individual policyholders. The problem of excessive regulation plays out across the country, where we observe that heavily-regulated states have higher premiums and stunted individual insurance markets, while less-regulated states have lower premiums and more vibrant markets. Until we solve this problem, the individual insurance market will never develop adequately to meet the needs of the self-employed and workers whose employers do not offer health insurance.

### **SOLUTION**

Today, most large employers that offer health insurance are exempt from McCarran-Ferguson through another federal law, the Employee Retirement Income Security Act (ERISA) (Pub.L. 93-406, 88 Stat. 829), which states that firms that provide insurance as an employee benefit without the assistance of a risk-bearing insurer are not subject to state regulation. Self-insured firms can buy insurance anywhere, from any carrier that meets their needs. Only individuals and small employer groups are regulated by the states and must buy insurance from an in-state carrier, if at all.

Federal lawmakers are interested in changing the law that prohibits individual health insurance from being sold across state lines.<sup>1</sup> Advocates of this reform argue that state-level regulations distort prices and that permitting national competition for such insurance has the potential to increase demand for individual health insurance policies.

To fix the problem identified above, we propose to allow people to shop across state lines for individual health insurance. Under our proposal, individuals could buy insurance licensed in another state. We conducted a simulation analysis of three specific alternatives for the state of purchase: the least-regulated large state; the least-regulated state in each of four geographic regions; and the least-regulated of all states. The simulations showed that our proposal has the potential to increase significantly the take-up of individual health insurance in the U.S.

### **POSITIVE OUTCOMES**

Literature was reviewed to characterize the state-specific individual insurance markets with respect to state regulations and to identify the effect of those regulations on health insurance premiums. We used empirical data to develop premium estimates that reflect state-specific differences in health care markets and we used a revised version of the 2005 Medical Expenditure Panel Survey (MEPS) to complete a set of simulations to identify the impact of three scenarios for development of a national market. The three scenarios are:

- Scenario 1: Only the five largest states, by population, are eligible for the national market. The idea is that insurance departments in large states have the critical skills to take on additional regulatory responsibilities for new out-of-state customers. The five largest states in the United States are California, Texas, New York, Florida, and Illinois. Of these, Texas has the least-regulated health insurance environment and is the national shopping state in the simulation.

- Scenario 2: The national market is divided into Northeast, South, Midwest, and West. Residents in each region can buy insurance from the state in their region with the most favorable premium due to decreased regulation. This scenario was based on the regional Medicare Part D (drug coverage) and TriCare (armed services) contracts with insurance carriers. The Northeast state with the least regulated environment was New Hampshire; the Midwest, Nebraska; the West, Arizona; and the South, Alabama.
- Scenario 3: For this scenario, the state with the least regulation is identified as Alabama. All interstate consumers are assumed to switch policies to Alabama unless they already are residents of Alabama. This could be the most extreme outcome of legislation similar to that proposed by Rep. Shadegg.

Each scenario was run on a set of minimum, moderate and maximum impacts of state-specific regulations derived from the literature. The impact of each scenario was calculated by multiplying a given person's original premium by a state-specific adjustment factor to predict the premium for that person in the national market. If the consumer faces a lower premium as a result of the proposed policy change, the consumer will choose the better price. If the new premium is not a better deal than in the home state, they will choose the home state in the simulation.

Under the moderate impact assumption, competition among the five largest states would increase insurance coverage by 4.7 million individuals from a base of 47 million uninsured. Under the scenario of competition within four regions, we find greater insurance take-up with a moderate impact estimate of 7.8 million newly insured. Allowing for a national market where anyone can shop for health insurance in the least-regulated state yields the largest gain of 8.5 million previously uninsured who now have coverage.

We also analyzed the impact of our proposal across different income groups. Selecting household income of \$45,000 as the cutoff because this is roughly the mean U.S. household income, we found a greater percentage increase in insurance occurring among the population with less than \$45,000 income (44%), compared with those with more than \$45,000 income (37%).

## **COSTS**

Development of a national market requires no additional federal resources other than support for legislation to permit the development of such a change. However, under any scenario for interstate shopping, there will be significant implementation issues. Rep. Shadegg's 'Health Care Choice Act of 2005' exempted the policy from coverage laws in the policyholder's state of residence, but left the insurer with some obligations to that state, such as premium taxes and compliance with state fraud and abuse laws. These proposals might form the basis for legislated or contractual agreements to divide regulatory powers between the states of issue and residence. Adequate disclosure to consumers of the states' obligations will be paramount for this plan to work.

## **CONCLUSION**

The Massachusetts plan received a great deal of interest and renewed interest in health insurance reform at the national level. The Commonwealth Health Insurance Connector, where over 350,000 people have signed up for coverage, could play an important role in a national market by allowing people from other states to shop for insurance plans that have the Connector's 'seal of approval.' However, the subsidized insurance program that is at the heart of the state's initiative has suffered from high costs, and employers are finding that the minimum coverage standards for 2009 are making insurance more expensive than they can afford.

A national market could be combined with tax credits for purchasing health insurance, as proposed by

then-presidential candidate Senator John McCain (R-AZ), or with a health insurance exchange model, as proposed by President Obama. Others, including Senator Ron Wyden (D-OR), have argued for an individual mandate to buy insurance that is not tied to the workplace. A national market for individual insurance would make the cost of that mandate more affordable.

**ENDNOTES**

1. Representative John Shadegg's (R-AZ) and Senator Jim DeMint's (R-SC) 'Health Care Choice Act of 2005' (H.R. 2355 and S.1015) would amend the Public Health Service Act (Title 42 U.S.C.) to allow for interstate commerce in health insurance while preserving the states' primary responsibility for regulation of health insurance.



85 Devonshire Street, 8th Floor, Boston, MA 02109 |  
T: 617.723.2277 F: 617.723.1880 |  
[www.pioneerinstitute.org](http://www.pioneerinstitute.org)