FEDERALISM, FEDERAL REGULATION, OR FREE MARKET? AN EXAMINATION OF MANDATED HEALTH BENEFIT REFORM

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Every state regulates the substance of health insurance contracts issued to its residents, requiring the coverage of certain treatments, services, and providers. These state mandated health benefit laws apply only to insured health plans, while self-insured plans (typically sponsored by a large employer) are exempt. The disparate application of state mandated benefit laws is criticized as contributing to an unjust and expensive system of health care in the United States. As a result, state mandated benefit laws are under attack and the subject of numerous federal reform efforts. This article explores three possible approaches to mandated benefit reform: (1) exclusive state regulation of mandated benefits, (2) deregulation of mandated benefits, and (3) positive federal regulation of mandated benefits. The article concludes that there are compelling arguments against both exclusive state regulation and deregulation. While federal regulation is far from perfect, it has significant advantages over the status quo and represents the best way forward for mandated benefit reform. Current and proposed mandated benefit reforms are analyzed in light of these conclusions. The article exposes these reform efforts as coordinated movements toward deregulation, an option that, while respecting individual rights, will harm the sick while improving the position of the healthy.

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INTRODUCTION

Health care coverage and financing in the United States is a perplexing, complex mix of government and private funding and federal and state regulation that fails to produce superior health outcomes. The United States spends more than any other country on health care, yet over forty-six million Americans lack health insurance of any kind,[1] and we lag behind other countries in key health outcomes such as life expectancy and infant mortality.[2]

The United States' system of regulation and financing is partly to blame. Approximately sixty percent of the nonelderly population receives health coverage voluntarily offered by an employer, while the remaining population either receives government-sponsored coverage, purchases individual coverage, or is uninsured.[3] While the federal government regulates nearly all employer-provided health coverage, states retain the power to regulate insurance contracts issued to their residents.[4] As a result, employers who purchase insurance to cover their health plan benefits are subject to both federal and state regulation, while employers who self-insure plan benefits are exempt from all state insurance regulation and subject to only minimal federal regulation. Employers who self-insure (most often large employers) enjoy nearly complete freedom to structure their health plans, while those who purchase insurance (most often small firms and individual purchasers) are often heavily regulated by their state. This disparity in regulation is hard to justify, particularly given that it provides those who are most likely to provide health coverage with the lowest regulatory burden, while imposing a more significant regulatory burden on those who are already least likely to provide health coverage to employees or to purchase it for themselves.

Given these disparities and the justified criticism of our current regulatory system, this article explores how we might improve the manner in which we regulate health insurance. Rather than exploring unrealistic options that require the complete overhaul of health care in the United States, discussion in this article is intentionally limited to currently salient and politically feasible health insurance reform options.

1. KEN MCDONNELL ET AL., EBRI DATABOOK ON EMPLOYEE BENEFITS tbl.26.3 (2006), *available at* http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2026.pdf (reporting that as of 2006, 46.1 million Americans lacked health insurance coverage). The United States spends more on health care than any other country both on a per capita basis and as a share of national income. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH, UNITED STATES, 2004, tbl.116 (2004), *available at* http://www.cdc.gov/nchs/data/hus/hus04trend.pdf#116.

2. *See* UNICEF, The State of the World's Children 2006, http://www.unicef.org/sowc06/pdfs/sowc06_table1.pdf (last visited Mar. 13, 2007).

3. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER 1 (2006) (stating that 61% of the nonelderly population receives employer-based coverage, 16% receives government-sponsored coverage, 5% purchases individual insurance, and 18% are uninsured).

4. McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015 (2000)).

Specifically, this article examines a current focus of federal health care reform: state mandated health insurance benefits. Every state currently mandates that coverage for certain procedures, treatments, and providers be included in every health insurance policy issued to state residents.[5] These mandated benefit laws, which do not apply to self-insured health plans, are criticized by many as contributing to an expensive and unjust health care system that leaves many without health coverage.

The issue of state mandated health insurance benefits involves several of the core debates regarding our system of health coverage: dual federal and state regulation, the proper role of the Employee Retirement Income Security Act of 1974 (ERISA),[6] the proper role of the market, and the benefits of federalism. Part I of this article examines the current status of state mandated benefit laws, discussing both the policy justifications for such mandates, as well as the complicating factor of ERISA preemption. Part II examines three possible end-point approaches to mandated benefits reform: (1) exclusive state regulation of mandated benefits; (2) total federal preemption of state law, combined with complete deregulation of mandated benefits; and (3) total federal preemption of state law, combined with new federal-level regulation of mandated benefits. After analyzing the three possible approaches from both an efficiency-based and normative perspective, this article concludes that there are compelling arguments against both exclusive state regulation and deregulation. While federal regulation is far from perfect, it is the best available reform option. Federal regulation of mandated benefits would end the current disparity between insured and self-insured plans, eliminate the pressures of jurisdictional competition on the legislative process, and perhaps make it more difficult for interest groups to secure economic rents. Unfortunately, as Part III concludes, the current federal legislation and legislative proposals targeting state mandated benefits consistently move in the direction of deregulation, a reform option that respects individual rights but, in the process, systematically favors the healthy over the sick.

I. CURRENT REGULATION OF HEALTH COVERAGE

Unlike nearly every other major component of the national economy, the federal government has left to the states the ability to regulate insurance.[7] Each state regulates the business of insurance, including the substance of health insurance contracts issued to its residents.[8] These substantive insurance contract requirements, which typically require cov-

5. U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-96-161, HEALTH INSURANCE REGULATION: VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE 9 (1996) (stating that on average, states have enacted laws mandating about eighteen specific benefits).

6. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26, 29 U.S.C.).

7. *See* 15 U.S.C. §§ 1011–1015.

8. *See id.*

erage for certain procedures, treatments, and providers, are referred to as "mandated benefit laws."[9] States average eighteen health insurance mandates, ranging from a low of two mandates in Idaho to a high of thirty-five mandates in California.[10] This Part will provide a brief background on state authority to regulate health insurance and an overview of the policy justifications for mandated benefit laws. It will then examine the impact ERISA has on the ability of states to regulate health insurance.

A. State Mandated Health Benefits

1. State Authority

The states have been granted explicit authority to regulate the business of insurance by Congress, but such authority remains subject to Congressional override. Initially, the Supreme Court held that the business of insurance did not involve interstate commerce and, therefore, the federal government was unable to regulate it.[11] But in 1944, the Supreme Court reversed its decision and held that interstate commerce was implicated in the business of insurance.[12] Less than one year later, the McCarran-Ferguson Act[13] was passed, providing that, in the absence of specific congressional action, states would retain the ability to regulate the business of insurance.[14] However, section 1012(b) of the Act specifically provides that Congress may preempt state insurance law by specifically stating that federal legislation is intended to apply to the business of insurance.[15] Congress therefore retains the ability to regulate insurance so long as it makes its intentions explicit.

9. As used in this article, the term "mandated benefit laws" refers to state laws that provide for the mandatory inclusion of particular providers, services, or subscribers in the insurance contract. *See* NAT'L ASS'N. OF INS. COMM'RS, COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS, II-HB-10-1 (2004).

10. *See id*. at II-HB-10-3 to II-HB-20-16. Author used cited data to calculate the average.

11. Paul v. Virginia, 75 U.S. 168, 183 (1869) (holding that "[i]ssuing a policy of insurance is not a transaction of commerce").

12. United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 552–53 (1944).

13. Pub. L. No. 79-15, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015 (2000)).

14. 15 U.S.C. § 1011 (2000). While the act was billed as a protection for states' rights, it was "the product of the Association of Insurance Commissioners, which drafted a statute and presented it to Congress." Jonathan R. Macey, *Federal Deference to Local Regulators and the Economic Theory of Regulation: Toward a Public-Choice Explanation of Federalism*, 76 VA. L. REV. 265, 281 (1990). The first significant incursion on the state's franchise to regulate the insurance industry came in the area of product liability, by way of the Product Liability Risk Retention Act of 1981. *Id*. That act permits product manufacturers to purchase insurance on a group basis in order to reduce the problem of the rising cost of product liability insurance. *Id*.

15. 15 U.S.C. § 1012.

2. Mandated Benefits Policy

Using the authority granted by the McCarran-Ferguson Act, the states have actively regulated the health insurance industry, not only by regulating the business of insurance companies,[16] but also in requiring health insurance contracts to contain certain substantive coverage provisions in the form of mandated benefit laws. The prevalence of state mandated health benefits has grown dramatically since the 1960s.[17] States typically enact mandated health benefit laws in order to spread the risk of certain medical expenses across the entire state-insured population in an effort to avoid adverse selection and its related problems.[18]

To illustrate the problem of adverse selection, assume that one percent of the state population suffers from diabetes. Further assume that those who have diabetes and those who are at increased risk for developing diabetes know of their condition or increased risk. Assume also that the treatment of diabetes is expensive, and insurance companies would like to avoid those costs. It is likely that insurance companies will exclude diabetes coverage from their standard health insurance policies in order to control such costs. In the absence of a state mandate that requires insurance companies to include treatment of diabetes in its health insurance policies, individuals seeking insurance coverage for diabetes will be forced to request a "diabetes rider" to the standard insurance policy. Insurance companies will conclude that applicants who request a diabetes rider have reason to believe that they will utilize the benefits offered by such a rider. As a result, when the insurance company determines how to price the rider, it should set a price that is close to the actual cost of expected treatment for diabetes provided by the rider.[19] To the applicant seeking the diabetes rider, if the price of the rider is close to the expected benefit, the applicant may decide to forgo the coverage. This decision is rational, because as the cost of the rider nears or equals

16. For example, states typically regulate the amount of financial reserves an insurance company must maintain. Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL'Y L. & ETHICS 89, 95 (2001).

17. Jonathan Gruber, *State Mandated Benefits and Employer Provided Health Insurance* (Nat'l Bureau of Econ. Research, Working Paper No. 4239, 1992); *see also* U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 9 (stating that, on average, states have enacted laws mandating about eighteen specific benefits).

18. *See* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 731 (1985); Gruber, *supra* note 17, at 5–6; *see also* TEX. DEP'T OF INS., HEALTH INSURANCE REGULATION IN TEXAS: THE IMPACT OF MANDATED HEALTH BENEFITS 14–17 (1998) (discussing additional reasons why mandated benefits are thought to be necessary).

19. The pricing function is a bit more complex than this simplified explanation. The insurance company will use data that it has regarding the extent to which individuals who request diabetes riders make use of the benefit (presumably a use rate of less than 100%, because not everyone who is at risk for the disease will develop the disease or need treatment). On its own, this would result in a price somewhat lower than the value of the benefits themselves. However, the administrative costs associated with the insurance will drive the price somewhat higher. In the end, the price for a diabetes rider will likely be somewhat lower than the value of the benefits, but it should not deviate too significantly.

the expected cost of the benefits to be provided, the rider ceases to function as insurance and functions only as the prepayment of expenses.[20]

States seek to remedy the problem just described by requiring that treatment for certain conditions be covered by all health insurance policies issued to state residents. With a state benefit mandate in place, the health insurance applicant who knows or has reason to suspect that he or she will need treatment for diabetes does not need to request a special rider to cover the treatment. And insurance companies, instead of pricing individual riders for the treatment, spread the cost of treating diabetes among the entire insured population of the state. As a result, those without diabetes pay slightly more for their health insurance, but those with diabetes do not find themselves priced out of effective health insurance. State benefit mandates effectively force low-risk individuals into the risk pool, allowing insurers to price the insurance at an average market rate (taking into account the population-wide risk) rather than based on the individual's expected risk.[21] States may enact such laws based on the presumption that health risks should be shared within the community or that state public health costs may rise in the absence of a mandate (or a combination of the two).[22]

In addition to addressing adverse selection, benefit mandates are thought to produce other gains as well. For example, given an individual's propensity to underestimate the probability of certain illnesses, he or she may choose not to insure against those illnesses in the free market, "which may lead to suboptimal levels of coverage."[23] For example, I may falsely believe that I am at low risk of developing breast cancer. When I seek to purchase an insurance policy, I am not likely to seek a rider to cover annual mammography at increased cost. In the absence of a mammography-coverage mandate, my cognitive bias may result in my purchasing a suboptimal level of insurance coverage. Mandating coverage for certain benefits prevents individuals from making such mistakes. And this coverage benefits society in that certain diseases, in this case

20. *See* 43 AM. JUR. 2D *Insurance* § 478 (2003) (noting insurance can cover "almost any contingent or unknown event"); *id.* § 479 (noting insurance is not available for "a loss that the insured either knows of, planned, intended, or is aware is substantially certain to occur").

21. Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1230–31 (2004). The exact pricing method will vary based on state law. Some states have community rating requirements, which require insurance companies to set premiums based solely on community-level risk, while others allow states to take into account an individual's estimated risk. Even in states that allow individual risk rating, mandated benefit laws still help to spread the risk associated with the disease or treatment. Asymmetrical information is widely acknowledged in the insurance purchasing context, meaning that the insured typically has more information about his or her risks than the insurance company. *See id*. at 1241. Without mandated benefit laws, the insured signals risk to the insurer when he or she requests a rider to cover a specified condition. When a mandate is in place, that information signaling is unavailable and the insurance company must independently determine risk, which, due to information asymmetries, will result in a certain degree of risk spreading. *See* Swartz, *supra* note 16, at 94, 97.

22. *See* TEX. DEP'T OF INS., *supra* note 18, at 14–18.

23. Gruber, *supra* note 17, at 6.

breast cancer, will not go undetected and untreated. In turn, societal costs associated with such diseases should decrease.[24] Of course, mandating benefits on this justification only makes sense if the mandate is based on good evidence of systematic cognitive error (that is, that individuals do, in fact, consistently underestimate their risk of certain illness, and coverage for those illnesses is then mandated). There is little evidence that states actually undertake this type of sophisticated analysis as part of the legislative process.[25]

Mandated health benefits can also address problems related to externalities. Even where individuals correctly assess their risk of certain illnesses, externalities may prevent individuals from purchasing a level of coverage that is optimal from a societal perspective.[26] The positive externalities associated with immunization are a common example of externalities resulting in a suboptimal level of insurance.[27] If an individual determines that her risk of contracting infectious diseases is low and weighs that risk against the cost of adding coverage for immunizations to her health insurance policy, she may rationally decide to forgo such coverage. However, her decision fails to take into account the benefit to society that results from her immunization. Mandated benefits can help address these externalities by requiring coverage in all health insurance contracts.

The primary argument against state mandated health benefits is that these mandates increase insurance costs for the entire insured population, and therefore lead to a lower overall level of health insurance coverage.[28] While benefit mandates should increase coverage levels for indi-

24. Societal costs in this situation may take the form of increased medical costs (when individuals are uninsured and cannot afford coverage, the cost of their care is generally passed along to the state or its citizens), or they may take noneconomic forms such as an unproductive population. Whether mandates are effective in reducing societal costs is not always clear. *See, e.g.*, Jonathan Klick & Sara Markowitz, *Are Mental Health Insurance Mandates Effective?: Evidence from Suicides* (Nat'l Bureau of Econ. Research, Working Paper No. 9994, 2003).

25. *See* TEX. DEP'T OF INS., *supra* note 18, at 68–80 (discussing states' legislative review processes, most of which focus on cost-benefit analysis).

26. *See* Gruber, *supra* note 17, at 6.

27. *See* Andre Hampton, *Markets, Myths, and a Man on the Moon: Aiding and Abetting America's Flight from Health Insurance*, 52 RUTGERS L. REV. 987, 999–1000 (2000).

28. Various studies have suggested that the cost of mandated benefits averages about twenty percent of premium costs. *See* Gruber, *supra* note 17, at 5; *see also* TEX. DEP'T OF INS., *supra* note 18, at 25–28 (discussing the difficulty of accurately assessing the impact of mandated benefits on health insurance premiums). However, the one study that has measured the marginal cost of mandates found that state mandates raised health insurance premiums by four to thirteen percent compared to the cost of policies without the mandated benefits. Gail A. Jensen & Michael A. Morrisey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 MILBANK Q. 425, 444–45 (1999) (citing Acs et al., *Employers' Payroll and Insurance Costs: Implications for Play or Pay Employer Mandates*, *in* HEALTH BENEFITS AND THE WORKFORCE (1992)). Despite the fact that mandated benefits increase costs and therefore decrease coverage, at least one commentator has suggested that mandating benefits is more efficient than public provision of the same benefits. *See* Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177, 178–81 (1989). However, the flip side to the argument is that mandated benefits benefit only those with state-regulated health insurance. *See id*. at 181.

viduals affected by, or at risk for, the medical conditions that are the subject of benefit mandates, the resulting increased cost borne by low-risk individuals may increase their rate of uninsurance. One study has suggested that as much as one-quarter of noninsurance in the United States is due to state regulation of insurance.[29] Unfortunately, there is a distinct lack of agreement among researchers and commentators on the extent to which state benefit mandates increase health insurance premiums and the extent to which any such premium increase decreases the take-up rate[30] of insurance.[31] At least one study has found that mandated benefits have little impact on the propensity of small firms to offer health insurance.[32] This finding is significant, given that those employed by small employers are the least likely to be offered health insurance.[33]

What we do know about uninsurance is that as of 2005, 46.1 million Americans, or nearly 18% of the population, lacked health insurance.[34] Those with family incomes below 200% of the poverty level were more likely to be uninsured than those with higher income levels.[35] Nearly 70% of the uninsured were in households with at least one full-time worker.[36] Those employed in small businesses, service industries, and blue-collar jobs were more likely to be uninsured than those employed in

29. *See* PRESIDENT'S COUNCIL OF ECON. ADVISORS, ECONOMIC REPORT OF THE PRESIDENT 141 (1991), *available at* http://fraser.stlouisfed.org/publications/ERP/issue/1515/download/5812/ERP_1991.pdf.

30. "Take-up rate" refers to the rate at which individuals who are offered coverage elect to take advantage of such coverage.

31. *See* TEX. DEP'T OF INS., *supra* note 18, at 25–37 ("For example, a recent news article quotes one large Texas insurer as saying mandates raise the price of insurance by as much as 20%. In the same article, another large insurer estimates the cost to be only about 2%."); *see also* U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 8–9; Renate M. Nellich, *Executive Partnerships in Reinsurance*, NAT'L UNDERWRITER LIFE & HEALTH/FIN. SERVS. EDITION, Apr. 20, 1998, at 10 ("Since 1975 U.S. benefits have grown from 30 percent of payroll to 41.9 percent of payroll today. Nearly half of the increase is due to the expansion of mandated benefits.").

32. *See* Gruber, *supra* note 17, at 3. The study finds that at least part of the reason that mandated benefits do not appear to effect small firms' decision to offer health insurance is that most firms offer the benefits even when they are not mandated to do so. *Id*.; *cf.* Paul Fronstin et al., *Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey*, EBRI ISSUE BRIEF, No. 253, Jan. 2003, at 6, 14 (reporting that 45% of small employers surveyed believed that "government regulations" were a "major reason" for increasing health care costs, and 63% of small employers surveyed cited "the business cannot afford it" as a major reason for not offering a health plan).

33. While 98% of firms with 200 or more employees offer health insurance, only 59% of small firms (those with less than 200 employees) do so. KAISER FAMILY FOUND., HEALTH BENEFITS OFFER RATES § 2, 32 (2005).

34. KAISER FAMILY FOUND., *supra* note 3, at 1; MCDONNELL ET AL., *supra* note 1, at tbl.26.3.

35. KAISER FAMILY FOUND., THE UNINSURED AND THEIR ACCESS TO HEALTH CARE (2005), http://www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-Fact-Sheet-6.pdf (stating that the number of uninsured has been rising since 2000, when there were 39.6 million uninsured Americans).

36. *Id*.

other sectors.[37] Affordability is the most common reason cited for turning down employer-offered health insurance.[38]

The effects of uninsured status are thought to be significant in several areas. Some researchers estimate that a reduction in mortality of five to fifteen percent could be achieved if the uninsured were to gain continuous health coverage.[39] Another estimate is that "at least 18,000 Americans die prematurely each year solely because they lack health coverage."[40] In addition, the medical costs of uninsured individuals often get passed on to those with insurance in the form of higher costs for medical care and, consequently, higher insurance premiums.[41] While the exact impact that state mandated benefits have on levels of insurance coverage is unclear, it is clear that the problem of uninsurance in the United States is a significant one that needs to be addressed.

Mandated benefits can also be critiqued on the grounds that they increase the moral hazard associated with insurance coverage.[42] Moral hazard refers to the phenomenon that occurs when individuals with insurance coverage become more likely to experience a loss because of the insurance coverage itself.[43] For example, in the automobile insurance context, a driver who has generous insurance coverage may be more likely to engage in risky behavior (such as parking in an unsafe location) than a driver without coverage. This in turn makes it more likely that the driver with generous insurance will experience a loss and make an insurance claim. The same may be true with health insurance. If a state has mandated coverage for diabetes, those with health insurance coverage may be less likely to make lifestyle changes recommended by their doctor to avoid the onset of diabetes than they would be if they did not have diabetes coverage. Moral hazard is only a concern, however, for those diseases or conditions over which the individual has some degree of control. Mandated benefits for many diseases, such as those not linked to lifestyle factors, should not lead to any increase in moral hazard. Even for those diseases linked to lifestyle, the case for moral hazard may be difficult to make, given the many nonmonetary costs associated with illness.[44]

37. *Id*.

38. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey*, EBRI ISSUE BRIEF NO. 287, Nov. 2005, at 15, *available at* http://www.ebri.org/pdf/EBRI_IB_11-2005.pdf; *see also* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 26 (2001).

39. KAISER FAMILY FOUND., *supra* note 3, at 2.

40. *Id*.

41. Stephen Blakely, *The Economic Costs of the Uninsured*, EBRI NOTES, Aug. 2000, at 1.

42. Gruber, *supra* note 17, at 6–7.

43. THOMAS RICE, THE ECONOMICS OF HEALTH RECONSIDERED 82 (1998). The term "moral hazard" was originally used in the fire insurance context, where it was recognized that an individual with fire insurance might be more likely to incur a loss (i.e., set a fire) or be less diligent in preventing fire. *Id.*

44. *See* Raisa B. Deber, *Canadian Medicare: Can It Work in the United States? Will It Survive in Canada?*, 19 AM. J.L. & MED. 75, 87 (1993) (arguing that moral hazard may affect the propensity to

Of course, many object to mandated benefit laws based on the belief that such laws represent rent seeking by special interest groups rather than good public policy.[45] Mandated benefit laws appear to be the type of provisions susceptible to such rent seeking, in that they typically involve a small group that exclusively benefits from the law.[46] Provider mandates, such as those that require medically necessary services provided by a chiropractor to be covered by all health insurance policies, are often viewed as rent seeking.[47] After all, chiropractors are a small group with high stakes in passing such a provider mandate. If passed, their business may increase exponentially. And while the public may in fact benefit from the law, the potential benefit is the greatest for the chiropractors.

The same argument can be made for treatment mandates. When those who suffer from a given illness join together to seek treatment mandates, we again have a small group with high stakes in the legislative outcome. And while every state resident has the potential to benefit from the mandate, those with the illness have much more to gain. If benefit mandates are influenced significantly by such rent seeking and not by underlying health policy goals, it is hard to justify mandated benefit laws.

Another argument against state mandated health benefits is that the greater the state regulation of health insurance benefits, the more likely employers are to self-insure.[48] A health plan is self-insured when the plan sponsor (generally an employer) funds the plan benefits itself and retains the risk of loss, rather than shifting the risk of loss to a third party by purchasing an insurance contract.[49] In an insured plan, the insurance company is directly liable to plan beneficiaries; in a self-insured plan, the plan sponsor retains all benefit liabilities.[50] Self-insurance is perfectly legal and, as discussed below, allows employers to avoid all state mandated benefit laws. The objection to incentivizing employers to self-insure is twofold. First, self-insured plans do not pay premium tax to the state,

purchase insurance, but that it likely does not affect lifestyle choices due to the nonmonetary costs of illness).

45. Rent seeking has been defined as "the attempt to obtain economic rents . . . through government intervention in the market." Jonathan R. Macey, *Promoting Public-Regarding Legislation Through Statutory Interpretation: An Interest Group Model*, 86 COLUM. L. REV. 223, 224 n.6 (1986). In other words, rent seeking occurs when interest groups lobby the government to secure legislation that provides an economic benefit to the group that they would not otherwise enjoy in the absence of legislative intervention in the market.

46. *See* MANCUR OLSON, JR., THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS 143–44 (1965); Robert D. Tollison, *Rent Seeking*, *in* PERSPECTIVES ON PUBLIC CHOICE: A HANDBOOK (Dennis C. Mueller ed., 1997).

47. *See, e.g.*, Al Knight, *Medical Mandates: Government Puts Squeeze on Employers*, DENV. POST, May 18, 1997, at F1.

48. Gruber, *supra* note 17, at 7. *But see* Christina H. Park, *Prevalence of Employer Self-Insured Health Benefits: National and State Variation*, 57 MED. CARE RES. AND REV. 340, 343 (2000) (finding that state benefit mandates have no significant role in the propensity to self-insure).

49. *See* Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 364 (4th Cir. 1997).

50. For a further discussion of self-insured plans, see *infra* Part I.B.

shrinking the state tax base.[51] Second, because of the distortion that the costs associated with state mandated benefit laws have on the decision to insure versus self-insure, companies may choose an inefficiently high level of self-insurance given the increased risk associated with self-insurance.[52]

Overall, mandated benefits are a useful policy tool. They can help spread risk, eliminate adverse selection, and address problems such as externalities and cognitive biases. There is, however, potential for abuse. If state legislatures give in to rent seeking by interest groups or fail to require well-reasoned justifications for new laws, mandates may contribute to the high cost of health insurance, thereby increasing the number of Americans unable to afford health coverage. The next subpart examines how ERISA complicates the analysis of state mandated benefit laws.

B. The Role of ERISA

State mandated benefits do not end up affecting the health insurance coverage of many Americans, due to the peculiarities of the preemption provisions of ERISA. ERISA is a federal law that governs nearly all employer-sponsored benefit plans, including group health plans.[53] At the time it was enacted in 1974, ERISA's substantive provisions were focused exclusively on pension plans.[54] While ERISA created disclosure requirements, fiduciary standards, and remedies for all types of employee benefit plans, ERISA did not dictate what benefits a group health plan was required to provide.[55] Only recently has ERISA been amended to include substantive requirements for group health plans, similar to state mandated benefit laws, and to date they have been relatively limited.[56] The current requirements include minimum hospital stays following the birth of a child,[57] limits on the preexisting condition exclusions that plans may impose,[58] and mental-health parity requirements.[59]

One of ERISA's policy goals was to provide a single regulatory scheme for employers who operate in multiple states.[60] In order to achieve such uniformity, ERISA provides that state laws that "relate to"

51. Gruber, *supra* note 17, at 7.

52. *Id*.

53. *See* Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26, 29 U.S.C.).

54. *See* Colleen E. Medill, *HIPAA and its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 487–88 (1998).

55. *Id*.

56. Particularly when compared with an average of eighteen benefit mandates per state. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 5; *supra* text accompanying note 5.

57. Newborns' and Mothers' Health Protection Act of 1996, 42 U.S.C. § 300gg-4 (2000).

58. 26 U.S.C. § 9801 (2000); 29 U.S.C. § 1181 (2000); 42 U.S.C. § 300gg.

59. Mental Health Parity Act of 1996, 29 U.S.C. § 1185a (2000); *id.* at 42 U.S.C. § 300gg-5 (2000).

60. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987).

any employee benefit plan are preempted.[61] Although ERISA "saves" from preemption state laws that regulate insurance,[62] the Act provides that a self-insured employee benefit plan shall not be deemed to be an insurance company or to be engaged in the business of insurance for purposes of any state law purporting to regulate insurance companies or insurance contracts.[63] Functionally, what the "deemer clause" provides is that states may not regulate self-insured employee benefit plans. This system of preemption protects the ability of states to regulate insurance, while at the same time exempting self-insured plans from such rules.[64]

The effect of this preemption scheme on employer-sponsored group health plans is that plans that are self-insured are subject only to the limited substantive requirements of ERISA, while plans that are funded through insurance contracts are subject to state insurance laws (including mandated benefit provisions), as well as any substantive requirements of ERISA that require greater benefits than applicable state law.[65] While insured plans therefore must comply with many substantive requirements, self-insured plans operate rather happily in a "regulatory void."[66] This is true even if the self-insured plan purchases stop-loss insurance.[67]

Many plan sponsors who self-insure health plans protect against the risk of loss that they have retained by purchasing a stop-loss insurance policy.[68] A stop-loss policy reimburses a plan sponsor for losses incurred by the health plan once those losses exceed a given level, generally determined either on an individual basis or a planwide basis.[69] The point at which a stop-loss policy begins to reimburse a plan sponsor is referred to as the policy's "attachment point."[70] From both the plan sponsor's and employee's perspective there may be very little difference between an insured and self-insured plan. Both types of plans are typically administered by a third-party health insurance company that processes claims

61. 29 U.S.C. § 1144(a) (2000).

62. *Id*. § 1144(b)(2)(A) (commonly referred to as the "savings clause").

63. *Id*. § 1144(b)(2)(B) (commonly referred to as the "deemer clause"). A self-insured plan is one that does not transfer the risk of loss through the purchase of an insurance contract to cover benefit payments. *See* Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 364 (4th Cir. 1997). Instead, the plan sponsor funds the benefits itself and retains the ultimate risk of loss. *Id*.

64. Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another*," 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 105 (2005).

65. For example, a state insurance law requiring a minimum hospital stay of thirty-six hours following childbirth would be superseded by the federal Newborns' and Mothers' Health Protection Act of 1996, which requires a minimum hospital stay of forty-eight hours following childbirth. *See* 42 U.S.C. § 300g-4 (2000).

66. *See* Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 239 (1997).

67. *See*, *e.g*., Bill Gray Enters. Inc. Employee Health & Welfare Plan v. Gourley, 248 F.3d 206, 214 (3d Cir. 2001); *Am. Med. Sec., Inc.*, 111 F.3d at 364; United Food & Commercial Workers v. Pacyga, 801 F.2d 1157, 1161–62 (9th Cir. 1986).

68. Paredes, *supra* note 66, at 249.

69. *See id.* at 249–50.

70. *See* Medill, *supra* note 54, at 492–93.

and negotiates provider networks and charges.[71] The only difference is that the source of the money used to pay benefits due under a self-insured plan is the employer rather than an insurance company.[72] To further confuse matters, a self-insured plan that has purchased stop-loss coverage with a low attachment point effectively has insured against the risk of loss just as an insured plan has, but as a technical matter the plan with stop-loss coverage is still considered to be self-insured and therefore not subject to any state laws that "relate to" an employee benefit plan.[73]

One reason that many commentators criticize, or are puzzled by, ERISA's preemption scheme is that it regulates health plans that appear to be identical in vastly different ways.[74] Not only are there legitimate equity concerns, but the regulatory system also effectively impedes state mandated benefit laws from having a significant impact on risk pooling and other policy goals. While it is difficult to determine exactly how prevalent self-insured health plans are, one recent study reports that fifty-four percent of workers covered by employer-sponsored health plans were in self-insured plans.[75] Such data suggest that self-insurance significantly reduces the number of individuals included in the risk pools that state mandated benefit laws attempt to create.[76]

The likelihood of an employer self-insuring increases with employer size.[77] As a result, those most likely to be subject to state insurance regulation, and therefore mandated benefit requirements, are small employer plans and individuals. This is particularly significant, given that individuals employed by small employers and those who are unemployed are most likely to be uninsured. If mandated benefits negatively affect insurance coverage levels due to increased cost, they are likely to do so with respect to the population most at risk of lacking health insurance coverage. Given these perceived problems with our system of health in-

71. In both types of plans, the insurance company typically processes all initial claims. However, employers often have the ultimate authority to decide a claim on appeal from a self-insured plan, whereas the insurance company will decide all levels of an appealed claim in an insured plan.

72. This difference generally is not apparent to a plan participant. The only way for a plan participant to determine the funding status of his or her health plan is to consult the plan's summary plan description, a plain English summary of plan terms that is required to be provided pursuant to ERISA § 101(a). *See* 29 U.S.C. § 1021(a) (2000). One of the required items to be included in a summary plan description is the funding source for the plan. 29 C.F.R. § 2520.102-3(q) (2006).

73. *See* Am. Med. Sec., Inc. v. Barlett, 111 F.3d 358, 364 (4th Cir. 1997).

74. *See, e.g.*, Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985); Jeffrey G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615 (1995); Paredes, *supra* note 66.

75. KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 109 exhibit 10.1, *available at* http://www.kff.org/insurance/7315/upload/7315.pdf.

76. Sixty-six percent of nonelderly Americans are covered by nongovernmental health insurance and therefore potentially subject to state mandated benefit laws. *See* KAISER FAMILY FOUND., *supra* note 3, at 2 (reporting that 61% are covered by employer-sponsored plans and 5% are covered by individual insurance policies). Of this number, approximately half (or 33% of all nonelderly Americans) are exempt from state mandated benefit laws because their employer self-insures its benefit plan.

77. *See* Park, *supra* note 48, at 348.

surance regulation, the next Part examines three possible end-point approaches to mandated benefits reform.

II. POSSIBLE APPROACHES TO MANDATED BENEFITS REFORM

As stated in the Introduction, this article will not engage the "what if we started over" debate, but instead will explore possible reform options in our second-best world—our existing and firmly entrenched health care system. Specifically, this Part will explore three different end-point approaches to addressing the perceived problems with state mandated benefit laws. The first possibility is to repeal ERISA preemption as it applies to self-insured health plans, in order to give the states the exclusive ability to mandate health benefits. The second possibility is to take the power to mandate health benefits away from the states, but not replace it with any federal regulation—in other words, complete deregulation of the substance of health insurance contracts. Finally, a third possibility is to take the power to mandate health benefits away from the states and instead mandate benefits at the federal level.[78] Each of these possibilities is discussed in turn, from both an efficiency-based and normative perspective.

There are several possible conclusions one might reach after analyzing the reform options. While there may be compelling arguments for the reform option, or compelling arguments against it, it is also possible that there is an absence of compelling arguments either for or against the reform. In this latter case, such reform option should be compared to the status quo to determine whether the reform offers a significant improvement over the status quo and is therefore worthy of pursuit.

This Part concludes that there are compelling arguments against both exclusive state regulation and deregulation. State regulation would create significant economic inefficiency, while deregulation would further disadvantage high-risk individuals. Federal regulation, on the other hand, does not have compelling arguments either for or against it. As a result, this Part concludes by comparing the possibility of federal regulation against our current regulatory system, finding that federal regulation addresses the inequities present in our current system, while retaining the important policy tools that mandated benefits provide and not causing undue inefficiencies. Thus, federal regulation provides significant advantages over our current system and is a reform option worth pursuing.

78. One might argue that there is a fourth approach, a hybrid approach of the type found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936. Under that approach, federal law sets minimum standards that states are free to exceed by passing their own laws. I omit such an approach from my discussion because it appears to offer all of the burdens of two distinct levels of regulation, without offering benefits that cannot be achieved by either exclusive state regulation or exclusive federal regulation.

A. Exclusive State Regulation

One possible end-point for the reform of mandated benefits laws is to provide the states with exclusive authority in this area and repeal ERISA preemption as it applies to self-insured health plans.[79] Instead of lessening the impact of state mandated benefit laws, as deregulation would do, this reform would strengthen state mandated benefit laws by bringing self-insured plans within their reach. This section concludes that although there are strong normative arguments in favor of state regulation, efficiency considerations make such an end-point undesirable.

1. Efficiency-Based Arguments in Favor of State Regulation

There is not a strong case to be made in favor of state regulation from an efficiency perspective. State regulation would result in the risk associated with mandated benefits being spread more broadly than under our current system of regulation, but only to a limited extent. Such increased risk spreading would result from (1) self-insured plans covering mandated benefits for the first time and (2) employers who switch from a self-insured plan to an insured option in the face of state laws that apply equally, regardless of funding.[80] In the case of self-insured plans that offer mandated benefits for the first time, the risk would be spread only within that plan. This nonetheless represents an improvement in risk spreading compared with the status quo where such risk was not even spread among the plan's population.

Additionally, exclusive state regulation would prevent any distortions in an employer's decision whether to insure or self-insure its health plan.[81] While these changes are indeed positive, they are not very significant, and the inefficiencies that result from such a regulatory system are much more substantial.

2. Efficiency-Based Arguments Against State Regulation

For all health insurance purchasers, but particularly for multistate employers, state-level regulation impedes economic efficiency. One of the most valued benefits of ERISA preemption for employers, provided they choose to self-insure, is that it allows them to be subject to only one level of regulation for all of its employees. Having to comply with up to fifty different sets of health plan regulations is significantly less efficient.

79. Specifically, this end-point would require repealing ERISA's "deemer" clause. For purposes of this article, I will assume that the deemer clause is repealed only as it applies to the substance of self-insured health plans. I will not consider or discuss whether self-insured health plans should be subject to broader state insurance regulation, such as requirements for financial reserves.

80. If risk pooling is a top priority, only a single payor system would provide an adequate solution. Our third party payor system will always segment risk to a certain degree.

81. *See supra* notes 48–52 and accompanying text.

If ERISA preemption were repealed, multistate employers would have to either (1) purchase a separate group health insurance contract in each state in which it has employees, or (2) hire a third-party administrator to administer a self-insured health plan that complies with each relevant state's laws. Either option will certainly cost more than the nearly complete freedom that self-insurance currently provides, in which only minimal federal-level regulation applies.[82]

From an efficiency-based perspective, the case against exclusive state regulation is strong. While state regulation would improve risk spreading and eliminate distortions in employer funding decisions, it would raise compliance costs.

3. Normative Arguments in Favor of State Regulation

Repealing ERISA preemption as it applies to self-insured health plans would provide each state with the power to legislate health policy for *all* of its residents with health coverage, not just those whose employers chose to purchase a contract of insurance and those who buy individual insurance contracts. With the power to regulate both insured and self-insured health plans, state legislation would have a much broader reach and an increased ability to affect health policy. Specifically, it would give to the states the power to ensure that each state resident with health coverage would have access to certain mandated benefits.

Giving states the exclusive authority to mandate health benefits respects the traditional role of the states as innovators in health policy.[83] States have distinct populations with (perhaps) distinct health care needs, and allowing the state government to respond to those needs may produce a better outcome than one-size-fits-all federal legislation. After all, a state with a large immigrant population may have very different health policy goals than a state with a more homogenous population. Giving states both the power and freedom to respond to their populations and to experiment on a state level could be very helpful in reaching a solution to American's health care problems.[84]

82. Even if we compared exclusive state regulation to a system of positive federal regulation of mandated benefits, the state-based system would still have significantly higher compliance costs. Instead of having to satisfy one level of national regulation, health insurance purchasers would have to comply with as many as fifty different sets of state laws.

83. *See* Carol S. Weissert, *Promise and Perils of State-Based Road to Universal Health Insurance in the U.S.*, 7 J. HEALTH CARE L. & POL'Y 42, 42 (2004).

84. As discussed in this article, states would be limited to reform efforts centering on legislation that concerned the substance of health coverage. It would not open up self-insured plans to other types of state regulation, and therefore what states could accomplish would remain somewhat limited. For example, as part of the recently passed Massachusetts health care reform, employers who do not offer their employees health insurance might have to pay a fee to the state to help cover the health care costs of uninsured workers. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, KEY FACTS, MASSACHUSETTS HEALTH CARE REFORM PLAN 1 (2006), http://www.kff.org/uninsured/upload/7494.pdf. Under our current system of ERISA preemption, it is unclear to what extent these reforms will apply to employers and employer plans. The result would not change under the assump-

Exclusive state regulation also addresses one of the fundamental criticisms of ERISA, namely that it regulates health plans that are in all relevant respects the same in vastly different ways.[85] No longer would it matter whether the employer purchases a contract of insurance to pay plan benefits or whether it self-insures the plan and purchases stop-loss insurance to protect itself from loss. All employer plans, regardless of funding source, would have to cover those benefits mandated by the state. One important side effect of state regulation is that small employers would face the same regulatory burdens as other health coverage providers.[86] However, while the regulatory playing field would be leveled, large employers would still have a health insurance purchasing advantage due to economies of scale and their larger risk pools.

4. Normative Arguments Against State Regulation

One could make a normative argument against state-level regulation for all health plans on the basis of such regulation's effect on the economy. If one believes that a strong economy is a moral good (for example, because a strong economy creates more, better, and more secure jobs), then one should avoid regulatory systems that damage the economy. Because state-level regulation could impede the national economy by putting in place a cumbersome fifty-state regulatory scheme that burdens large employers, an argument can be made that such a reform option should be avoided on moral grounds.

5. Conclusion

The normative arguments in favor of state regulation are very appealing. We would strengthen the ability of states, long innovators in health policy, to produce real change in the health care arena; we would also address the regulatory inequity in our current system between insured and self-insured plans. However, the price exacted in the form of decreased efficiency in our health care system (and increased costs to many health care purchasers) provides a compelling argument against this reform option.

tions of this article, where ERISA preemption is repealed only to the extent it applies to the substance of self-insured health plans.

85. The other two end-points discussed, federal regulation and federal deregulation, also address the disparity between insured and self-insured plans that currently exists under ERISA.

86. Because small employers are least likely to self-insure their health plans, eliminating the preference for self-insurance would make small employers subject to the same regulations as all other employers. *See* KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, *supra* note 75. Again, federal regulation and federal deregulation would also level the regulatory playing field between small and large employers by making all employers subject to the same regulation, regardless of funding decisions.

B. Federal Deregulation

Another possible end-point for mandated benefits reform would be for the federal government to completely preempt all state mandated benefit laws, but with no new federal-level regulation. In other words, the second possible end-point is for the federal government to deregulate the substance of health insurance contracts.[87] This section concludes that there are compelling arguments against deregulation from both an efficiency-based and normative perspective, such that deregulation should not be considered a viable reform option for mandated benefit laws.

1. Efficiency-Based Arguments in Favor of Deregulation

There are several strong efficiency-based arguments to be made in favor of deregulation. If the substance of health insurance contracts is deregulated, health insurance purchasers would have access to coverage that could be better tailored to the purchaser's precise preferences. Employers would enjoy simplified and more efficient health care purchasing, and small employers would have access to lower-cost coverage.

a. Preference Satisfaction

If we deregulate the substantive content of health insurance policies, a health insurance purchaser would be free to select the policy that best fits his or her personal preferences. For example, a healthy woman in her thirties might decide that she has a very strong preference for maternity coverage, but no desire for substance abuse coverage. Similarly, an employer could buy a group insurance policy with any mix of benefits it desires. In a deregulated market, the purchaser is provided with the opportunity to maximize her utility by being free to select that mix of coverages that is most valuable to her. All purchasers would be given the freedom to take into account their unique preferences and, given their limited resources, how best to satisfy those preferences.

b. Simplified Administration

While all purchasers are likely to experience utility and efficiency gains under a deregulated system, employers (particularly multistate employers) are in a unique position to benefit. Under a deregulated system, an employer would be able to choose the exact mix of benefits it wants to provide to its employees (regardless of their location), while still receiving the protection of an insurance contract if desired. Under our current system, if an employer wants to offer an insured health plan to its em-

87. I am not suggesting that the business of insurance be entirely deregulated, just that the federal government take away the power of the states to mandate substantive provisions of health insurance contracts.

ployees, it must purchase a separate insurance contract in each state that it has employees, and each such contract must comply with the insurance regulations, including mandated benefit laws, of that state.[88] If the employer does not want to offer different benefits to employees in different states, it must self-insure and retain the risk of loss associated with the health coverage.[89] Deregulation would change this calculus and allow employers to select their desired mix of benefits for their entire employee population, while causing no distortion in the decision to insure or self-insure.[90]

c. Lower Costs for Small Employers

Rates of self-insurance vary inversely with employer size.[91] While a majority of large employers self-insure their health plans, relatively few small employers do so.[92] Small employers are also the least likely to offer health insurance to their employees.[93] Data suggests that one of the drivers of low offer rates by small employers is that small employers face larger health care costs than their larger counterparts, due in part to the effect of state mandated benefit laws.[94] Effectively eliminating mandated benefit laws through deregulation should help lower health insurance costs for small employers, possibly increasing the likelihood that such employers will offer coverage to their employees.[95]

d. Summary

The efficiency-based case to be made for deregulation appears fairly compelling at this point. Purchasers would be free to maximize their utility by selecting an insurance policy that matches their preferences. Fur-

88. While insurance companies are likely to bear the brunt of the burden of technical compliance with individual state laws, having separate insurance contracts in different states does raise costs for multistate employers. For example, pursuant to ERISA an employer is required to furnish a summary plan description for each group health plan that it sponsors. *See* 29 U.S.C. § 1021(a) (2000). Multistate employers who offer insured health plan options will in most cases have to produce a separate summary plan description for each insured plan that it offers in a different state, in order to accurately communicate the mandated benefits required by each state.

89. Employers may purchase stop-loss insurance to protect themselves against the risk of loss associated with a self-insured health plans. *See* Paredes, *supra* note 66, at 248. While stop-loss coverage does provide the employer with some protection, the employer remains directly liable to plan participants for promised plan benefits. *Id*. at 250. If the stop-loss insurer becomes insolvent, the employer would remain liable for benefits. *See id*.

90. See *supra* notes 44–58 and accompanying text for a discussion of how the current system of mandated benefit regulation distorts the decision to insure or self-insure a plan.

91. *See* KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, *supra* note 75.

92. *Id*.

93. *Id*. at 35 exhibit 2.2.

94. It is clear that cost is a principal driver of the decision by small employers whether to offer health insurance. *See id*. at 37 exhibit 2.6. What is less clear is the extent to which mandated benefit laws affect either the cost of coverage to small employers or their decision to offer health insurance. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 15.

95. *See* Fronstin et al., *supra* note 32, at 15.

thermore, employers would find it easier and more efficient to purchase health insurance contracts for their employees without having to satisfy multiple sets of state laws, and small employers particularly would benefit from lower health insurance costs.

2. Efficiency-Based Arguments Against Deregulation

While the efficiency-based arguments in favor of deregulation appear strong, the efficiency-based arguments against such a system are more persuasive. First and foremost, deregulation would reintroduce adverse selection problems in health insurance, one of the main problems state mandated benefits laws are meant to address. In addition, it may prevent certain high-risk individuals from being able to afford health insurance coverage, and it raises problems associated with purchasers' capacity for accurate risk assessment. Finally, it is not clear that deregulating would increase coverage rates.

a. Adverse Selection

While deregulation may result in decreased cost and increased choice, it would also undermine the risk pooling function of mandated benefits. For example, if I am a young and healthy person (with perhaps an unrealistic view of my health risks), in a deregulated market I might select a "bare bones" health policy. If I have a family history of diabetes, or am myself a diabetic, I will likely want to purchase a policy that covers diabetes treatment and supplies. Similarly, to the extent employers are trying to satisfy the preferences of their employee group, they will seek out policies that provide those benefits that their employees are likely to value and utilize.[96] In other words, health care purchasers would act in their own best interest.

The result should be obvious. Those who are healthy enough to select bare bones policies will benefit from lower insurance costs, while those who elect additional coverage will pay significantly more, since

96. Employers are not always motivated principally by low premium costs. The interests of employers who purchase insurance are not always identical or even similar to the interests of the employees who are covered by such insurance. *See* Hyman & Hall, *supra* note 38, at 26–27. If price is an employer's sole motivator (or if the employer believes that price is the most important factor to its employees), the employer would likely seek to purchase a bare bones policy. However, employee demand (or market pressure) may lead employers to offer more generous coverage than that provided by the lowest cost policy. At least one study has shown that most employers who self-insure their health plans offer all of the benefits mandated by their state of residence, even though they are under no legal obligation to do so. U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 15. One might use this fact to argue that deregulation would not create negative results, since employers tend to offer the mandated benefits even when they are not legally obligated to do so. However, it is not clear that employers would continue to offer the benefits under a deregulated system. It is possible, after all, that self-insured plans offer mandated benefits because of market pressures created by the mandated benefit laws (i.e., employers with self-insured plans offer the benefits because they must compete against employers with insured plans that are required to include the benefits).

those purchasing decisions will signal to insurance companies the type of risk that the purchaser likely represents.[97] The adverse selection problem that was being solved by state benefit mandates would return.

b. Risk Pooling Undermined

As explained earlier, state mandates are often enacted in order to spread the risk of a particular condition across the state insured population.[98] This risk spreading may raise the insurance cost for those who are low risk, but allow those who are high risk to have access to insurance that covers the condition at a price that is not prohibitive. Allowing health insurance purchasers to opt out of this risk spreading by allowing them complete freedom in selecting those benefits they want to include in a health insurance policy undermines the ability of states to achieve one of the primary policy goals behind mandated benefits.[99]

c. Problems of Risk Assessment

Deregulation would take away the paternalistic function of mandated benefit laws. No longer would the state require the inclusion of certain benefits in every health insurance contract, regardless of the preferences of the purchaser. Instead, the purchaser would have both the freedom and responsibility to select those benefits that satisfy his or her preferences and adequately protect him or her from risk. In the health insurance context there are two distinct purchasers, employers and individuals, each with their own distinct issues. Because most decision-making studies focus on individuals, rather than on employer-level decision making,[100] this section will focus primarily on problems of indi-

97. Some argue that propitious selection reduces or eliminates the problem of adverse selection. The theory of propitious selection posits that high-risk individuals are precisely those who do not want to buy insurance; "the same attitudes that lead them to take risks in the first place give them little reason to insure against such risks." Siegelman, *supra* note 21, at 1266. "[I]nsurance is most attractive to the most risk-averse individuals among those eligible to buy it, not those with the highest tolerance for risk." *Id*. The same attitudes that lead these individuals to be risk averse in other behaviors is thought to lead them to value insurance highly. While this theory may hold true in certain insurance markets, it likely has little impact in the health insurance context, because many conditions that qualify an individual as high risk from a health insurance perspective are completely unrelated to risky behavior generally.

98. *See supra* Part I.A.2.

99. For a wonderful example of how purchasing decisions would be made under a deregulated system, and why such decisions would undermine risk pooling, see David R. Henderson, *Terminator-care*, WALL ST. J., Jan. 10, 2007, at A17. In advocating for deregulation, Mr. Henderson states, "[w]ere I in the market for individual insurance and given the choice, I would not bother paying for coverage for alcohol or drug abuse."

100. While there do not appear to be any studies of employer decision making in this context, my personal experience as counsel to employers of varying size in designing employee medical plans is that their decision-making processes vary tremendously, and with it the possibility of having decisions affected by cognitive biases. The largest employers tended to engage sophisticated human resources consultants who analyzed the employer's health care claims in detail and provided cost-benefit analyses of various coverages. Such efforts would seem to counteract any of the cognitive biases discussed

vidual risk assessment and conclude that there is reason to doubt whether individuals adequately assess their own risks and insurance needs.

If an individual incorrectly assesses her own risk for poor health at too high of a level, she will purchase "too much" insurance and pay an inefficiently high premium. If she assesses her risk for poor health at too low a level, she will purchase insufficient health insurance and potentially face large out-of-pocket costs.[101] In addition, if risk is assessed at too low a level and the individual develops a health condition that is not covered by the insurance purchased, she may be priced out of the market if she seeks a new health insurance policy to cover the newly discovered health condition.

There is very little good evidence of how well individuals judge their own risk.[102] Some studies have been done to see how well people can predict outcomes in their own lives, but the results have been somewhat contradictory.[103] In studies examining the way in which people make probabilistic judgments, the strong suggestion is that individuals are "unlikely to be able to turn that information into an accurate assessment of how much more or less risky than average they actually are."[104] In the health insurance context, this suggests that individuals may fail to purchase an optimal level of insurance. In a deregulated system, individuals are being asked to adequately assess their risk for a number of different conditions and would be particularly unlikely to elect optimal insurance coverage. In the following subsections, particular hurdles that individuals face in making purchasing decisions will be discussed.

i. Optimism Bias

Optimism bias refers to the propensity of individuals to consistently underestimate personal risk in the decision-making context.[105] Such bias may cause an individual to fail to purchase health insurance coverage that adequately covers future risk. Optimism bias is most likely to occur

below. However, the smallest employers tended to either (1) trust the insurance company to advise them on what to cover or not cover or (2) rely on an in-house human resources professional to make such determinations without any special training or data analyses. These employers would seem to be the most susceptible to cognitive biases.

101. Of course, right now there is great potential for inefficiency because there is no choice. Mandated benefits may prevent an individual from selecting an efficient level of insurance by failing to allow the individual to satisfy her preferences for coverage.

102. Siegelman, *supra* note 21, at 1243.

103. *Id*. at 1244. One study found that individuals were reasonably good at predicting how long they would live. *Id*. However, a more recent study found that there was a rather weak relationship between self-perceived and actual risk of death. *Id*.

104. *Id*. at 1245. For example, an individual may know that he is overweight and has high blood pressure, but may be unable to translate that knowledge accurately into an assessment of his risk for developing heart disease.

105. JUDITH H. HIBBARD ET AL., DECISION MAKING IN CONSUMER-DIRECTED HEALTH PLANS 5 (2003), *available at* http://assets.aarp.org/rgcenter/health/2003_05_cdp.pdf.

when "hazards are perceived as low in probability, [particularly] when individuals have had little personal experience with the risk, or when the risk is judged to be controllable by personal action."[106] As a result, it seems probable that some individuals will suffer from optimism bias when purchasing health insurance. For example, when weighing two different policies, one that covers substance abuse and one that does not, the individual may underestimate her risk of developing a substance abuse problem and select the plan without such coverage.[107] In the end, an individual who is given a wide range of choice in selecting health insurance benefits may optimistically end up with a policy that does not adequately protect against risk.

A deregulated system appears vulnerable to the problem of optimism bias in the individual market, potentially resulting in suboptimal insurance purchases. Employers, however, seem unlikely to suffer from such bias. While there are no reported studies addressing this issue, it seems likely that employers, in aggregating employer and employee preferences, would be unlikely to factor individual experience and perceived personal control into plan selection.

ii. Availability Heuristic

We also know that, in the face of complex decision making, individuals are often influenced by the availability heuristic.[108] When determining the probability of some future event, individuals will judge that events with which they are familiar are more likely to occur than events with which they are not familiar.[109] In many cases, availability is an appropriate proxy for frequency, because frequently occurring events are often easier to recall than rare events.[110] However, availability is also affected by factors unrelated to frequency of occurrence, such as memorability, and this can lead to predictable biases.[111] For example, studies have shown that, when judging the frequency of lethal events, individuals overestimate the frequency of dramatic and sensational causes of death

106. *Id*.

107. One study has found that adults disproportionately reported that their personal risk of developing drug addition was "below average." Neil D. Weinstein, *Optimistic Biases About Personal Risks*, 246 SCIENCE 1232, 1232 (1989). The same study also found that adults disproportionately reported that their personal risk of developing asthma, food poisoning, influenza, lung cancer and pneumonia was similarly "below average." This is consistent with the theory of optimism bias, in that substance abuse is judged to be controllable by personal action.

108. *See, e.g.*, Paul Slovic et al., *Facts Versus Fears: Understanding Perceived Risk*, *in* JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES 463, 465–72 (Daniel Kahneman et al. eds., 1982).

109. Amos Tversky & Daniel Kahneman, *Availability: A Heuristic for Judging Frequency and Probability*, *in* JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES, *supra* note 108, at 163, 164 ("A person is said to employ the availability heuristic whenever he estimates frequency or probability by the ease with which instances or associations could be brought to mind.").

110. Paul Slovic et al., *supra* note 108, at 465.

111. *Id*.; *see also* Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, *in* JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES, *supra* note 108, at 3, 11.

(which receive more publicity), and underestimate the frequency of more common, unspectacular causes of death.[112] This translates into individuals overestimating the frequency of death resulting from all types of cancer, but underestimating the frequency of diabetes-related deaths.[113] In the health insurance purchasing context, this suggests that individuals and employers might overinsure for certain diseases that they incorrectly judge to occur with a relatively high frequency and underinsure for those diseases they incorrectly judge to occur with low frequency.[114]

d. Failure to Increase Coverage Rates

One final, and not insignificant, argument against deregulation is that it is not clear that eliminating substantive health insurance requirements will in fact decrease the cost of coverage sufficiently to affect rates of uninsurance. Since the success of deregulation from an efficiency perspective depends on increasing coverage rates by decreasing cost, this has the potential to be a devastating objection. As was noted earlier, there is little agreement with respect to the magnitude of the effect that mandated benefits have on health insurance premiums.[115] Many of the cost estimates that are available measure the fraction of health insurance *claims costs* attributable to mandated benefits, rather than the incremental *premium cost* associated with adding the coverage.[116] The only study measuring the marginal cost of mandates found that state mandates raised health insurance premiums by four to thirteen percent.[117] And none of these estimates accounts for any long-term savings to insurers that may result from mandated benefits (such as benefits aimed at identifying illnesses earlier).[118] Further, while one economic model predicted that state benefit mandates could explain as much as twenty-five percent of the level of noninsurance,[119] a more recent study found that mandates do not affect the propensity of small firms to offer insurance.[120]

A cost decrease could increase insurance coverage by either (1) increasing the number of employers who offer health insurance to their employees or (2) increasing the percentage of employees who elect employer-provided health coverage or purchase individual contracts. With

112. Paul Slovic et al., *supra* note 108, at 466–67.

113. *Id*.

114. To complicate matters further, it is likely that insurance companies will have data on those benefits that individuals irrationally overconsume, and perhaps prices those benefits accordingly.

115. *See supra* note 28.

116. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 14.

117. Gail A. Jensen & Michael A. Morrisey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 MILBANK Q. 425, 444–45 (1999) (citing Acs et al., *Employers' Payroll and Insurance Costs: Implications for Play or Pay Employer Mandates*, *in* HEALTH BENEFITS AND THE WORKFORCE (1992)).

118. *See* TEX. DEP'T OF INS., *supra* note 18, at 16.

119. JOHN C. GOODMAN & GERALD L. MUSGRAVE, FREEDOM OF CHOICE IN HEALTH INSURANCE 20 (Nat'l Center for Policy Analysis 1988).

120. Gruber, *supra* note 17, at 27.

respect to the latter, data suggest that in order to increase coverage rates, premium decreases would need to be significant; even then, only modest increases in coverage are predicted to result.[121] Marginal reductions in substantial premium costs appear to have relatively small effect on health insurance take-up rates.[122] With respect to employer offer rates, a survey of small employers reported that only ten percent of companies stated that they were "much more likely" to seriously consider offering a health insurance plan if insurance costs fell by ten percent.[123] Deregulation, then, does not appear very promising from an efficiency perspective. Even if we assume that mandated benefits have a significant effect on health insurance premiums, it is unlikely that the marginal decrease in price will have a substantial effect on coverage rates.

3. Normative Arguments for Deregulation

The primary normative argument in favor of deregulation of the substance of health insurance is that deregulation would decrease the cost of health insurance and therefore increase the number of Americans that have access to affordable health insurance. In a society that values health care as a genuine good (perhaps a primary good), this is a desirable outcome.

In addition, a deregulated health insurance system respects individual rights by allowing purchasers the freedom to choose insurance contract terms, rather than allowing the government to dictate such terms. This is a basic libertarian argument that individuals are morally entitled to not be used as sacrifices for the good of others:

> [N]o moral balancing act can take place among us; there is no moral outweighing of one of our lives by others so as to lead to a greater overall *social* good. There is no justified sacrifice of some of us for others. . . . [T]here are different individuals with separate lives and so no one may be sacrificed for others . . . .[124]

Mandated benefits violate this principle of individual rights. By requiring the inclusion of certain provisions in a health insurance contract, we are requiring some individuals to sacrifice their good for the benefit of others. Take our common example of a benefit mandate that covers dia-

121. Michael Chernew et al., *The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?*, 32 HEALTH SERVICES RES. 453, 453 (1997). In a study of low-income workers at small firms with no other source of health insurance coverage, premium subsidies of 75% only increased participation rates from 89% to 92.6%. *Id*. at 464. The authors note, "[a]lthough the overwhelming majority of individuals participate in their employer's plan, there appears to be a subset who do not, even at prices heavily distorted by the employer. For this group of workers, it is unlikely that a further subsidy would alter participation dramatically." *Id*.

122. *Id*. at 461.

123. Fronstin et al., *supra* note 32, at 15. The survey reported that 34% of employers not currently offering health insurance were "somewhat more likely" to seriously consider offering a plan if costs fell ten percent, while 55% were "no more likely" to seriously consider offering a plan. *Id*.

124. ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA 33 (1974).

betes treatment, testing, and supplies. By requiring such coverage in a health insurance contract, we are infringing on the ability of an individual to receive more affordable health insurance without such coverage. By forcing these monetary sacrifices so that an individual with diabetes is able to receive affordable health insurance coverage, we are requiring a sacrifice of individual good for a social good, without the individual's consent. Moreover, this sacrifice could be quite substantial; under a mandated benefits system, it is possible that an individual will be unable to afford health insurance due to benefit mandates.[125] We might be forcing such an individual to make an enormous sacrifice for the benefit of others, given the financial ruin that can result in the absence of health insurance and the expense of purchasing it.[126]

This problem is compounded by the fact that only certain diseases and treatments are the subject of benefit mandates.[127] We require the sacrifice of some for others when it comes to coverage for certain diseases or treatments, but not others. So individual A may have to subsidize diabetes coverage for individual B due to the operation of a state mandate, but individual B may not be required to share in the cost of individual A's substance abuse treatment. If we are going to require individual sacrifice for the social good, it arguably should be for all "medically necessary" services and supplies. Fairness seems to require that, if medical risks are appropriate to be shared, they should be shared uniformly.

Historically the United States has favored the resulting social good over the individual sacrifice in the mandated benefits arena. If we deregulate health insurance such that the individual good is favored, we will be allowing individuals to be free from the burdens of other individuals' health risks and remove the inequality of only mandating benefits for legislatively favored benefits.[128]

125. While it is true that studies suggest that health insurance costs would need to decrease substantially in order for take-up rates to increase (i.e., decrease much more than the savings that would be achieved by eliminating mandated benefits), there will be a certain number of individuals at the margin for whom mandated benefits means the difference between being able to afford health insurance or going without coverage.

126. The fact that an individual does not know what his or her future health care needs will be is irrelevant. The argument about individual sacrifice has to do with the freedom to enter into a contract that protects against only those risks the individual selects. That is, an individual should be free to choose which unknown risks to insure against. As David Hyman has observed, "[a]fter illness strikes . . . behavior would have been different 'had they only known'—including their willingness to have paid higher premiums to secure coverage. Ex ante, willingness to pay is not nearly so apparent." David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 235 (2000).

127. *See, e.g.*, David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N.C. L. REV. 5, 13 (1999) ("Legislative mandates can reallocate resources within the common pool, but new or enhanced services are covered at the expense of other services, increased premiums, or both. In short, you don't get something for nothing . . . .").

128. This would almost certainly be true in the individual insurance market. Those who receive coverage through their employer would still be faced with the pooling of health risks. However, given the subsidies that employers typically provide to employees for the purchase of health insurance, it is

4. Normative Arguments Against Deregulation

As noted above, deregulation of health insurance would respect individual sovereignty over required risk pooling. While individual rights would be respected, we would be moving away from "a vision of health insurance as mutual assistance" and toward a model of individual accountability that is undesirable in the health insurance context.[129] In other words, deregulation would change the very nature of insurance.

Changing the nature of insurance to decrease, if not eliminate, social risk pooling raises efficiency concerns, as previously discussed, but it raises normative issues as well. As Professor Jacobi has pointed out, "[h]ealth insurance is premised, in part, on notions of mutual aid and social pooling—the common effort to ameliorate each person's risk of catastrophic medical expense."[130] Deregulation would undermine the social good that risk pooling in health insurance currently provides. While mandated risk pooling does require some sacrifice of individual rights, in this country we have historically found the sacrifice worthwhile, in part because we have not viewed sickness as blameworthy. Traditionally, sickness has been thought to be the result of randomness or "bad luck," rather than due to any individual shortcoming or bad action on the part of the affected individual, and therefore the associated risk was considered appropriate to be shared.[131]

Preventing states from mandating coverage and risk pooling for certain conditions allows the relatively healthy to have access to less expensive health insurance, but it puts sick individuals (or those who become sick) at risk. No longer are health risks appropriate to be shared throughout a community, but are the responsibility of the individual involved. And sick individuals' risks should not be allowed to "harm" or "disadvantage" those who are healthy. Opponents of deregulation disagree, arguing that it is more important to keep the social risk pooling function of health insurance, even at the expense of low risk individuals who are forced to pay more than their individual risk level and preferences would dictate.

While the sacrifice involved in requiring individuals to receive coverages they do not desire (at a higher premium than they would other-

likely that individuals still come out ahead (the increased cost of risk pooling for low risk individuals is likely less than the amount of the employer subsidy for coverage).

129. *See* John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 313–14 (1997) (stating that the passage of the Health Insurance Portability and Accountability Act of 1996 had swung the balance "toward a vision of health insurance as mutual assistance, and away from individual accountability").

130. *Id*. at 312. Professor Jacobi goes on to point out that, "in the United States [health insurance] has also come to mean 'a person's self-centered calculations to protect himself against loss.'" *Id*. (citing WILLIAM A. GLASER, HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS 14 (1991)). This model of health insurance appears to be the one being pursued by advocates of deregulation.

131. *See* David A. Super, *The New Moralizers: Transforming the Conservative Legal Agenda*, 104 COLUM. L. REV. 2032, 2063 (2004).

wise face) is a serious one, it does not provide a compelling justification for pursuing deregulation of the substance of health insurance contracts. Individuals should, in almost all circumstances, be held responsible for their actions. But most health outcomes are not directly caused by individual action. Some individuals are born with predispositions to develop certain diseases, while many diseases are thought to simply develop through no action or fault of the individual. It is true that certain illnesses are caused by, or contributed to through, individual action. While that may justify avoiding benefit mandates for such "blameworthy" conditions, the vast majority of illness is not caused by individual action or inaction. The negative effect that deregulation would have on the ability of high-risk individuals to obtain effective health coverage provides a compelling argument against deregulation.[132]

5. Conclusion

There are compelling efficiency-based and normative arguments against deregulating the substance of health insurance. While deregulation may result in greater preference satisfaction, decreased cost, and respect for individual rights, these benefits do not outweigh the significant downsides to deregulation. Deregulation would undermine risk pooling and reintroduce adverse selection problems, while systematically favoring the healthy over the sick.

C. Positive Federal Regulation

The federal government regulates nearly every major category of social spending.[133] To date, however, regulating the business of health insurance, which has tremendous public policy implications, has been left largely to the states. Given the perceived problems caused by state mandated health benefits, one possible avenue for reform is to shift the regulation of the substance of health insurance contracts to the federal level.[134]

132. While federal laws such as the American with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA) help protect high-risk insurance purchasers, these protections do not address fundamental areas of concern that would be present in the absence of mandated benefits, such as adverse selection and plan design that omits certain benefits. See COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE 316–25, 338–41 (2004), for a general discussion of HIPAA and ADA provisions as they apply to group health insurance.

133. Kirk J. Stark, *Fiscal Federalism and Tax Progressivity: Should the Federal Income Tax Encourage State and Local Redistribution?*, 51 UCLA L. REV. 1389, 1390 (2004).

134. To date, no one has seriously proposed increasing the role of the federal government in this manner. Even when national health insurance was being seriously considered during the Clinton administration, reform proposals all relied on significant state government involvement. *See* Candice Hoke, *Constitutional Impediments to National Health Reform: Tenth Amendment and Spending Clause Hurdles*, 21 HASTINGS CONST. L.Q. 489, 500 (1994).

Before discussing the arguments for and against the federalization of mandated benefits, I will set forth an important assumption upon which the following discussion is based. The Supreme Court held in *United States v. South-Eastern Underwriters*[135] that the business of insurance involved interstate commerce, leaving the federal government free to regulate such matters.[136] However, an act of Congress, the McCarran-Ferguson Act, specifically reserved for the states the ability to regulate the business of insurance, with the caveat that Congress may preempt state insurance law by specifically stating that legislation was intended to apply to the business of insurance.[137] Because of the undesirability of two possible levels of regulation, this section will assume when discussing the federal regulation of health insurance that Congress would specifically act to preempt states' authority to regulate the substance of health insurance contracts. Given this assumption, this section will explore both the efficiency-based and normative arguments for and against exclusive federal regulation of mandated health insurance benefits, concluding that neither normative nor efficiency-based arguments provide a compelling justification for pursuing, or not pursuing, this avenue of reform. While there is a lack of compelling justification for or against federal regulation of mandated benefits, Part II.D below concludes that federal regulation is nevertheless superior to our current regulatory system and therefore the one reform option that appears to be worth pursuing.

1. Efficiency-Based Arguments in Favor of Federal Regulation

The primary efficiency-based arguments in favor of federal regulation of mandated benefits are (1) that, because of ERISA preemption of state laws, and the geographical limitations on state legislation, benefits mandated at the federal level are the only way to achieve universal inclusion of benefit mandates in health insurance coverage; (2) that federal legislation would eliminate the pressures of jurisdictional competition that currently face state legislatures; and (3) that legislating at the federal level is more efficient than legislating at fifty different state levels.

a. Universal Inclusion of Benefit Mandates

Assuming that one of the ends of benefit mandates is to ensure that individuals with health insurance receive coverage for certain health conditions, federalizing benefit mandates would be more effective than current state legislation. State benefit mandates are limited in what they can achieve by both ERISA preemption and the geographical limitations of state boundaries. As discussed earlier, ERISA prevents self-insured

135. 322 U.S. 533 (1944).
136. *Id.* at 552–53.
137. 15 U.S.C. § 1011 (2000).

plans from being subject to state mandated benefit laws and, given the large percentage of employer-sponsored plans that self-insure, this insulates from state benefit mandates a large percentage of the population with health coverage.[138] As a result, states only have the power to regulate those employer-sponsored plans that purchase insurance contracts (which small employers have the greatest tendency to do).[139] In addition, states are necessarily limited by their borders, so that the coverage mandated benefits seek to achieve can only be accomplished on a limited scale. As a result, federal legislation offers the possibility of reform on a scale that states are unable to achieve.[140] If the coverages currently being mandated by the states are critical to ensuring adequate health insurance, federal legislation would be far more effective in providing such coverage.

b. Eliminate Pressures of Jurisdictional Competition

Our current system of state mandated benefit laws involves, at least to a certain degree, jurisdictional competition that may hamper state health policy efforts. When states structure their mix of taxes and public goods, they compete for "mobile individuals and resources."[141] Because of exit rights (an individual's ability to exit the jurisdiction), there is a powerful check on "state governments' powers to tax and regulate."[142] In the mandated benefits context, this pressure on state governments may result in a state failing to mandate needed benefits because (1) they are not perceived as valuable by the voting public, (2) they attract an unwanted population to the state,[143] or (3) they fail to attract businesses, particularly small businesses, to the state. Perhaps the best example of this pressure is provided by state mandates for infertility treatment. Infertility treatment is expensive,[144] making insurance coverage highly de-

138. Approximately fifty-four percent of those with employer-provided coverage are covered by self-insured plans. *See supra* note 75 and accompanying text.

139. KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, *supra* note 75 (finding only 13% of workers in small firms (3–199 workers) were covered by a self-insured plan, compared with 53% in midsize firms, 78% in large firms, and 82% in jumbo firms).

140. As Professor Medill has pointed out, "ERISA is the most obvious and most convenient mechanism for Congress to enact future federal health care reforms." Medill, *supra* note 54, at 508. Enacting reform through ERISA would ensure that every employer-sponsored group health plan would be affected, which would cover the vast majority of the privately insured population. However, stand-alone federal legislation could also be passed in order to cover individually purchased insurance contracts.

141. Larry E. Ribstein & Bruce Kobayashi, *The Economics of Federalism*, *in* ECONOMIC APPROACHES TO THE LAW (Larry E. Ribstein & Bruce Kobayashi eds., forthcoming) (manuscript at 3).

142. *Id*. at 4.

143. Indeed, states may be particularly hesitant to enact mandates that would be attractive to "sick" individuals, particularly if neighboring states do not have such mandates in place.

144. One cycle of in vitro fertilization costs between $10,000 and $15,000. The cost per live birth is significantly higher. One study found that the cost per live birth with the use of assisted reproductive technology in 1993 was nearly $60,000. Martha Griffin & William F. Panak, *The Economic Cost of*

sirable for affected individuals. Infertility mandates are, therefore, likely to attract individuals (particularly from neighboring states), who are in need of coverage. For example, Massachusetts mandates coverage for infertility services, but New Hampshire does not. Infertile couples who live in New Hampshire (particularly those who already live close to the Massachusetts border), will have a strong incentive to either relocate to Massachusetts or to seek employment with a Massachusetts employer. The result is that Massachusetts is likely to attract a more-infertile-than-average population, leading to higher insurance costs. For a state considering such a mandate, the effects of jurisdictional competition are likely to weigh heavily in the legislative decision-making process. By moving the ability to mandate benefits to the federal level, jurisdictional competition would be largely removed, allowing legislators a greater ability to focus on health policy concerns.[145]

c. More Efficient Legislative Process

In addition to allowing for a broader reach to mandated benefit legislation and for a legislative process not threatened by jurisdictional competition, there also may be efficiency gains to be realized from moving legislation to the federal level. From the perspective of interest groups, lobbying at the federal level should be more efficient than lobbying fifty individual state governments.[146] Admittedly, it may be a more complex process, but there should be efficiency gains to having a single level at which to lobby.[147] In addition to potentially lowering costs by consolidating lobbying efforts, the fact that resulting mandates would be included in nearly every health insurance policy in the country, with no exception for self-insured plans, gives interests groups more bang for their lobbying bucks.

Infertility-Related Services: An Examination of the Massachusetts Infertility Insurance Mandate, 70 FERTILITY & STERILITY 22, 26 (1998).

145. One could argue that while the federal government does not face the same jurisdictional competition pressures that the states do, benefits at the federal level may cause employers to consider moving U.S. jobs overseas. If benefits are mandated at the federal level, such that all employers must include such mandates in their health plans, and such mandates raise the price of coverage, employers may consider whether it is economically more attractive to move jobs overseas. I am unpersuaded by such an argument. First, even if one assumes that benefit mandates significantly raise the cost of health coverage, the decision of an employer to offer health insurance to its employees remains voluntary. An employer could choose not to offer such coverage if the mandates become too burdensome. In addition, employers are free to pass some or all of the cost of coverage along to their workers.

146. *See* Katherine M. Jones, *Law, Politics, and the Political Safeguards of Federalism: The Case of Insurance Regulation and the Commerce Clause, 1938–1948*, 11 CONN. INS. L.J. 345, 393 (2005).

147. For example, the American Diabetes Association has been active in lobbying forty-six state governments to pass diabetes coverage mandates and is still actively working to secure such legislation in the four states that do not have such mandates. *See The Health Care Choice Act: Hearing on H.R. 2355 Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 109th Cong. 35–36 (2005) (statement of L. Hunter Limbaugh). Allowing such groups to focus their lobbying at a single, national level should reduce lobbying costs. However, the state legislative process usually draws less media attention and enjoys lower visibility than the federal counterpart. This lowered scrutiny of the state legislative process may make it quicker or cheaper to lobby at the state level.

d. Summary

While there are not compelling efficiency-based arguments in favor of federal regulation, there do appear to be several potential, although relatively minor, benefits. Insured and self-insured plans issued in every state would be subject equally to such regulation, allowing mandated benefit provisions to have a much farther reach than they currently enjoy. The federal government would not face the jurisdictional competition pressures felt by state governments and would potentially be able to accomplish more than states are currently politically able to do. Finally, interest groups should find that lobbying at a single level is more efficient than state-by-state lobbying.

2. Efficiency-Based Arguments Against Federal Regulation

While mandating benefits at the federal level may help to achieve some of the policy goals associated with such benefits, it leaves many unaddressed. In particular, (1) mandating benefits at the federal level will have limited effect on risk pooling, (2) political support for federally mandated benefits may be lacking, (3) rent seeking may be increased, (4) the historic role of states as innovators in health policy would be ignored, and (5) increased distortions in preference aggregation would result.

a. Limited Improvement in Risk Pooling

Recall that one of the functions of mandated benefits is to spread risk across the insured population. Because the benefit is included automatically in every insurance policy, purchasers do not need to "signal" their risk to the insurance company by requesting a special rider to cover the benefit. Without the signal of a specific coverage request, insurers will have incomplete information about the purchaser's risk. In addition, because every policy must include the mandated benefits, each policy carries with it at least some risk of loss. In the face of this incomplete information and universal potential for loss, insurers will spread the risk of loss associated with the mandated benefits across the insured population.[148]

Mandating benefits at the federal level would spread the risk of loss across a greater population than such risk is spread under our current system. However, the risk pools created under a system of exclusive federal regulation would be fragmented.[149] Assuming that self-insured plans

148. As previously mentioned, it is not necessarily true that individuals will bear the same cost for the mandated benefit, since state laws differ in the extent to which insurers can take into account an individual's likely risk. However, mandated benefit laws nevertheless encourage risk spreading by taking away from the insurance company an important source of information regarding individual risk (the request for a benefit-specific rider).

149. This argument assumes that the only state insurance regulation that is being superseded is state regulation of the mandated health benefit laws. It assumes that states retain the general ability to

remain self-insured under a system of federally mandated benefits, such plans will have to cover mandated benefits, but the risk associated with such benefits will only be spread among participants in a given plan, not added to the insured pool that exists in the state or used to create any sort of federal risk pool.[150] If a primary goal of state mandated benefits is to require the spreading of risk for certain expenses, federally mandating benefits will help, but will not achieve the maximum amount of risk spreading possible.[151] If maximum risk spreading is a top priority, federalizing mandated benefits may not be an ideal reform option.[152]

b. Weakened Political Support

There are other reasons to believe that regulating health insurance benefits at the federal level offers little advantage over our existing system of state regulation. For example, Mark Pauly's work suggests that we value income gains of those who live in close proximity to us more highly than those who live further away.[153] Pauly provides two justifications for his theory, one based on altruism and the other based on external benefits.[154] Pauly argues that altruistic motives for income redistribution are affected by frequency of contact with the "problem," which helps motivate local redistribution more strongly than widespread redistribution.[155] In addition, local problems can be more easily understood; individuals are in a better position to understand the local economic conditions that lead to poverty, rather than simply blaming poverty on laziness or lack of motivation, and are therefore more inclined to favor redistribution to solve such problems.[156] Externalities can also favor local redistribution. For example, there may be externalities associated with

regulate the business of insurance. Because each state would still license insurers and impose regulatory restrictions on insurers (such as pricing controls, guaranteed issue requirements, etc.), risk pools would still be formed at the state level. The result could be changed, however, if *all* state insurance law was preempted by federal-level regulation. In that case, a federal-level risk pool could be achieved.

150. It may nonetheless increase risk spreading to the extent that a plan now covers a mandated benefit for the first time. For example, if a self-insured plan that did not offer diabetes benefits now does so, the diabetes risk will now be spread among participants in that plan.

151. It is possible that mandating benefits at the federal level will lead to fewer employers choosing to self-insure their health plans, since it would take away one of the primary benefits of self-insurance. If employers move away from self-insurance in sufficient numbers and begin to insure their health plans, risk pools could very well widen. This outcome is, of course, purely speculative at this point.

152. To maximize risk spreading, a federal-level risk pool would need to be created by using a single payor system. In our existing third-party payor system, risk pooling will never be maximized, regardless of how mandated benefits are regulated.

153. *See* Mark V. Pauly, *Income Redistribution as a Local Public Good*, 2 J. PUB. ECON. 35, 37 (1973).

154. *Id*. at 37–38.

155. *Id*. at 37.

156. Lior Jacob Strahilevitz, *The Uneasy Case for Devolution of the Individual Income Tax*, 85 IOWA L. REV. 907, 957 (2000).

redistributing wealth to address poverty, such as reducing crimes of poverty in the local area.[157]

Pauly's theory may have important implications for the federalization of health benefit mandates. The political support for mandates at the federal level may be significantly less than that at the state level because the utility increase individuals experience from federal mandates may not be as great as that which they would experience from the same mandate at the state level, due to the (perceived) lack of proximity to the individuals benefiting.[158] For example, individuals in state Y may perceive that disease X infrequently affects the citizens of state Y, while individuals in state Z believe disease X often affects citizens in state Z. As a result, individuals in state Y (and states with similar perceptions) are unlikely to support a federal mandate that covers disease X. With a system of state mandates, such geographic differences in preferences are not as problematic, and state Z could likely pass a mandate for disease X. As a result, it may be significantly more difficult to pass mandated benefit legislation at the federal level than at the state level, resulting perhaps in less protection for individuals through fewer mandates.

It is perhaps helpful to keep in mind when evaluating the desirability of federal regulation of health benefits that under our current system Congress is free to enact mandated benefits that apply to every group health plan governed by ERISA, yet it has done so only on very limited occasions.[159] It is difficult to know precisely why we have seen so little federal regulation of health care. Some posit that Americans tend to find expanding the role of the federal government in health care particularly unappealing.[160] It could also be that it is too difficult to get national support for certain mandates[161] or that Congress is reluctant to enter into an area that the states have traditionally controlled. Regardless, it may not be wise to advocate for a greater federal role in health insurance regulation if, for whatever reason, Congress is hesitant to act in the area.[162] If political inaction results, a system that was intended to federalize mandated benefits may in reality function as a deregulated system.

157. Pauly, *supra* note 153, at 37–38.

158. *See*, *e.g.*, Jacques LeBoeuf, *The Economics of Federalism and the Proper Scope of the Federal Commerce Power*, 31 SAN DIEGO L. REV. 555, 580 (1994) (stating that "benefits derived from redistribution decrease as the geographic area over which the redistribution is affected increases").

159. *See supra* notes 56–59 and accompanying text.

160. *See* Weissert, *supra* note 83, at 66.

161. Support might be difficult because of the spatial component of utility interdependence previously mentioned or because Congress and the states currently have overlapping jurisdiction in the area.

162. Not everyone would view this as an undesired result. Many commentators believe that states have been too quick to mandate benefits and that they do so without sufficient reflection. A regulatory system that makes it more difficult to pass mandated benefits may therefore be desired.

c. Greater Incentive to Rent-Seek

While the lobbying process may be more efficient for interest groups at the federal versus the state level, this also creates greater incentive for such groups to engage in rent seeking. In large part this increased incentive would be caused by the tremendous potential rents available through federally mandated benefits. After all, not only would the benefit be mandated on a nationwide basis, it would also include both insured and self-insured plans. The economic rents to be obtained from federally mandated benefits far outweigh the current rents available through state mandated benefits, significantly increasing the incentive for interest groups to seek out such rents.

However, while there is likely to be much greater incentive to rent-seek under a system of federal regulation, it remains possible that it will be more difficult for interest groups to secure the rents they seek. State legislative processes often enjoy a lower level of scrutiny than the federal counterparts, perhaps making it easier to push through the desired legislation. So while the stakes may be higher under a federal system, rents may be more difficult to obtain than under our current state system.

An additional factor in the rent seeking debate is the role that jurisdictional competition plays. Rent seeking at the state level is constrained, in part, by jurisdictional competition and exit rights.[163] States do not want to allow rent seeking that will compromise their ability to compete for mobile individuals and resources. Federal-level regulation does not face this same competitive pressure and is therefore more susceptible to rent seeking.[164] Even if we assume that there is lower scrutiny of the legislative process at the state level, it is likely that rent seeking will be increased under a system of federal regulation due to the increased incentives and lack of jurisdictional competition constraints.

d. No Role for State Innovation

Federal regulation of health policy would also ignore the long-standing role that states have had as the leading innovators in health policy.[165] States have a variety of advantages over the federal government when it comes to shaping and implementing health policy. For example, states have the mechanism of direct democracy and are able to respond more directly to their distinct population with its distinct preferences.[166]

163. *See* William J. Carney, *The Production of Corporate Law*, 71 S. CAL. L. REV. 715, 757 (1998).

164. *See* Daniel C. Esty, *Revitalizing Environmental Federalism*, 95 MICH. L. REV. 570, 611 (1996) (arguing that decentralization counters rent seeking).

165. *See* Weissert, *supra* note 83, at 42. For example, it was states that first developed that idea of mandated health insurance benefits to address perceived shortcomings in the health insurance market.

166. *Id*. at 46. In approximately half of all states, citizens can propose legislation or constitutional amendments. *Id*. at 48. And in nearly half of all states citizens are offered the popular voter referendum where citizens can vote to accept or reject legislation already passed. *Id*. In terms of preferences, the citizens of a given state have more homogeneous preferences than the nation as a whole. *Id*. at 49.

States may be more willing and able to act on issues that are divisive at the national level.[167] In addition, to the extent that states make "mistakes" in their legislation of mandated benefits, it is a simpler task to reverse the legislation than it would be to repeal federal legislation, resulting in an arguably greater capacity for states to be innovators and risk-takers.[168]

e. Increased Distortions in Preference Aggregation

Individuals obviously have unique preferences for health care coverage. When governments legislate mandated benefits, they do so presumably on the basis of preference aggregation.[169] The larger the group whose preferences are being aggregated, the greater the distortion that results from aggregating such preferences (i.e., the larger the group, the less representative the preference aggregation is of the group as a whole).[170] As a result, distortions resulting from preference aggregation will be greatest under a system of federal regulation.[171] In other words, more individuals will have their preferences ignored under a system of federal regulation than would be the case under state regulation, which requires the aggregation of a smaller pool of preferences. The result is that benefits mandated at the federal level may not be able to satisfy individual preferences as well as state-level regulation.

f. Summary

There are a fair number of efficiency-based arguments to be made against federal regulation. Federalizing mandated benefits would not significantly increase the risk-spreading function of mandated benefits and would provide greater incentives for interest groups to seek rents. Political support for federal benefit mandates may be difficult to come by, and the regulatory system would likely result in less innovation than under our current state-based regime. Federalization would also suffer from distortions in preference aggregation. In the end, however, these

A uniform federal policy is more likely to make a "significant number of persons with differing tastes in different states unhappy." *Id*. While some believe that individuals have a greater impact on local political action than on federal legislation (where individual votes are more diluted), others question whether individuals acting as such have much political impact. *Compare* Eric J. Gouvin, *Radical Tax Reform, Municipal Finance, and the Conservative Agenda*, 56 RUTGERS L. REV. 409, 458 (2004) (citing Gerald E. Frug, *Empowering Cities in a Federal System*, 19 URBAN LAW. 553 (1987)), *with* Elizabeth Garrett, *Money, Agenda Setting, and Direct Democracy*, 77 TEX. L. REV. 1845, 1863 (1999) ("Any political process is largely the domain of organizations; politics is not an environment where individuals acting alone often can have much impact.").

167. *See* Weissert, *supra* note 83, at 49–50.
168. *Id.* at 47.
169. *See* Hyman, *supra* note 126, at 245–46.
170. *Id*. at 246.
171. *Id*.

efficiency-based arguments against federal regulation fail to make a compelling case either for or against federalizing mandated benefits.

3. Normative Arguments in Favor of Federal Regulation

While the efficiency-based arguments in favor of federal regulation do not appear to be compelling, two primary normative arguments may provide support for such a regulatory regime. The first argument is that federal regulation would end morally impermissible arbitrary distinctions between insured and self-insured plans, while the second argument posits that federal regulation would eliminate one piece of the competitive advantage granted to large employers under our current system.

Insured and self-insured plans are functionally equivalent to one another, differing only in their funding mechanism.[172] Health plans can be administered by the same insurance company, yet one employer purchases a contract of insurance to cover benefits, while the other retains direct liability for benefits and purchases stop-loss insurance; this difference in funding determines whether employers must comply with state mandated benefit laws. As a result, under our current system individuals have different health care rights based on their employer's choice of funding for its health plan.[173] Few would disagree that this distinction is arbitrary, and it is widely accepted that such arbitrary distinctions are morally impermissible.[174] In this case, the outcomes of our current system of health insurance regulation turn on a morally arbitrary distinction—a distinction based solely on how a health plan is funded. Individuals with health insurance have different rights even though they receive coverage that is "in all *relevant* respects the same."[175] Federal

172. Comparing an insured plan with a self-insured plan that purchases stop-loss insurance, even the difference in funding mechanism is very slight. While an insured plan purchases insurance to pay benefits directly to plan participants, a self-insured plan with stop-loss coverage purchases insurance that reimburses the plan sponsor for the benefits it pays to plan participants.

173. Of course, individuals also have different health care rights based on their state of residence. This section will not address this inequality because we seem willing to accept such jurisdictional differences in the law given that those differences are affected by the "bargain" struck between state residents and their representatives on a wide variety of topics (for example, residents of state X may have fewer mandated benefits than state Y, but also lower taxes than state Y).

174. *See, e.g.*, JAMES RACHELS, THE ELEMENTS OF MORAL PHILOSOPHY (MCGRAW-HILL 4th ed. 2003) (stating that an ethical theory based on a morally arbitrary distinction is unacceptable); Anthony Flew, *Three Concepts of Racism*, LXXV ENCOUNTER 63, 63 (1990) (arguing that racism is unjust because it treats differently persons who "are *in all relevant respects* the same").

175. Flew, *supra* note 174, at 63 (emphasis added). One might argue that the individual with lesser coverage paid a premium that reflected the lesser coverage and, therefore, the individuals are not in all relevant respects the same. However, while the individuals may have been treated fairly from an economic perspective, they have not been treated fairly in terms of access to coverage. The individual whose employer chooses to insure health plan benefits gets not only access to the mandated benefit, but also the risk-spreading associated with that coverage. While the individual whose employer self-insures might pay a lower price for coverage because certain mandated benefits are not included, that individual may not have the ability to use that cost savings to purchase the desired supplemental coverage on the individual market because the risk spreading aspect of mandated benefits

regulation would end this arbitrary distinction by imposing equal regulatory requirements on all health plans.

Federal regulation of mandated benefits would also effectively address the regulatory inequity between large and small employers caused by our current system of regulation. Small employers are less likely than large employers to be able to (1) internally retain the risk of loss associated with the firm's self-insured health plan or (2) purchase stop-loss insurance to cover the risk of loss associated with a self-insured health plan. As a result, small employers are much less likely to self-insure than their larger counterparts.[176] On the other hard, the largest employers almost always self-insure their health plans.[177] Because of the significant regulatory advantages associated with self-insured status and the relative ease with which large employers can self-insure, our current system provides a morally unjustifiable competitive advantage to large employers. Federal regulation would end this unjustifiable advantage by requiring all employers, regardless of size, to comply with mandated benefit laws.[178]

We can debate the extent to which individuals have a right to health care, but most would agree that the distribution of health care is at least morally important, such that we should strive toward a just health care system. Providing for federal regulation of substantive health insurance provisions would address, at least in part, the current inequities that result from our state-based and ERISA-preempted system of mandated benefits.[179]

4. Normative Arguments Against Federal Regulation

It is difficult to make an effective normative argument against federal regulation, because doing so requires justifying the current distinctions between insured and self-insured plans. One might argue, for example, that our current system is not unfair because individuals who are not covered by state mandated benefit laws because of their employer's decision to self-insure have the opportunity to gain coverage for the mandated benefits through other means. The individual could decline the employer's coverage and instead purchase an individual health insurance policy that would be governed by state law. Alternatively, the individual could take the employer coverage and purchase supplemental coverage on the individual market that covers the desired benefit, or the

will not apply, causing the price for individual supplemental coverage to be much higher than inclusion in a group policy through the application of state law.

176. *See* KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, *supra* note 75.

177. *See id*. (stating that eighty-two percent of the largest firms self-insured their health plans in 2005).

178. This is, of course, only one of many advantages enjoyed by large employers in the health care context. Small employers would still face higher relative costs because of their smaller risk pools and limited bargaining power.

179. The qualifier "at least in part" is used because federally mandated benefits would not address all of the inequality or unfairness present in our nonuniversal health care system.

individual could lobby the employer for voluntary inclusion of the desired benefit in the employer's group policy. All of this is true—the affected individuals do have other coverage options. However, the existence of other options does not justify the existing disparity in our regulatory system, but provides only a method of ameliorating its disparate effects.[180]

One might also argue that the federal regulation of mandated benefits can be opposed on normative grounds because it increases regulatory burdens in the absence of a compelling reason to do so. Again, however, this argument fails to justify the disparity present in our current system. If one is opposed to imposing regulatory burdens without justification, one could make a normative argument in favor of deregulation, but such an argument fails to justify disparate regulatory burdens.

5. Conclusion

The normative arguments in favor of federal regulation are compelling (just as they are in the case of state regulation and federal deregulation) in that federal regulation would effectively address the unjustifiable disparity present in our current system. Unlike state regulation and deregulation, however, there are no competing, compelling arguments against federal regulation that make it an untenable reform option. But aside from the normative argument in its favor, the case for federalization of mandated benefits is not overwhelming. As a result, the section below analyzes whether federal regulation has sufficient advantages over our current system such that it is worth pursuing as an avenue for reform.

D. Which Approach to Pursue?

This Part has thus far examined three possible end-points to mandated benefits reform in an effort to identify which approach is the best avenue of reform to pursue. Unfortunately, none of the possible approaches appears to be a perfect solution. All three approaches have the advantage over our current regulatory system of eliminating the disparity between insured and self-insured plans, while none succeeds in significantly enhancing the risk spreading aspect of mandated benefits. Two of the possible end-points can be eliminated as desirable reform options based on the compelling arguments to be made against them. A system of exclusive state regulation would create inefficiencies that are difficult to justify, while deregulation would create adverse selection problems and further disadvantage high-risk individuals. We are left with federal

180. None of the options would, however, put the individuals in the same position they would have been in had their employers been subject to the state mandated benefit laws. While individuals could purchase individual health insurance policies, they would have to do so without the benefit of the generous tax subsidy provided to employer-sponsored coverage.

regulation as a possible reform option—an option which lacks compelling arguments either for or against its adoption.

In the absence of compelling arguments for or against federal regulation, we must compare it to our current regulatory system in order to determine if it is a reform option worth pursing. Our current regulation of mandated benefits is far from perfect. It results in disparate treatment of insured versus self-insured plans, which is of particular concern given the effect the disparity has on small employers. In addition, while the risk associated with the mandated benefits is spread among the state insured population, the risk spreading is limited due to the exemption that self-insured plans enjoy. The state-level political process may make it easy for interest groups to secure rents, due to the relatively low public scrutiny of state legislation. And jurisdictional competition among the states may hamper serious health policy efforts.

The positive aspects of the current regulatory system include allowing states to respond to their distinct populations, rather than imposing a national one-size-fits-all solution. Because they are responding to a limited population, mandates at the state level should be politically easier to enact. While the mandates have a limited reach because of state boundaries and ERISA preemption, there is also less incentive for interest groups to rent-seek as a result.[181] Finally, our current system of regulation provides a lower regulatory burden than a system of federal regulation would provide, exactly because it allows health plan sponsors to effectively opt out of regulation by self-insuring.

In comparison, federal regulation has stronger arguments in its favor and weaker arguments against it. While federal regulation would not significantly expand risk spreading, it would increase it slightly. And while it may be more difficult to garner political support for mandates at the federal level, this is not necessarily a bad outcome. Because mandates tend to increase premium costs and cause a certain level of inefficiency, we may want a system that discourages the "easy" passage of such mandates. Mandates are an important policy tool that can be vital to ensuring adequate health coverage for individuals, but only if they are the result of informed policy deliberations. Rent seeking is certainly a concern under a system of federal regulation, but perhaps no more so than under our existing system. There will be greater incentive to rent-seek at the federal level because the stakes are higher for the interest groups. However, it should also be harder for those groups to secure rents given the increased public scrutiny of the federal legislative process and competition from rent seekers with other objectives. Furthermore, although federal regulation would ignore the historic role of the states as innovators in health policy, given the impotent role states currently play due to

181. As stated earlier, it may be easier for interest groups to *secure* rents at the state level, but there is less incentive to *seek* such rents in the first place, due to the limited reach of state laws. *See* discussion *supra* Part II.C.2.c.

ERISA preemption, this does not represent a significant loss. Federal regulation would result in a greater regulatory burden than our current system because it would prevent purchasers from being able to opt out of the system by self-insuring. However, a regulatory system that applies equally and fairly is a better system than one that allows the biggest players to opt out, even if it does potentially increase the regulatory burden on those who previously enjoyed special treatment.[182]

While far from perfect, federal regulation would accomplish more than our current regulatory system. Benefit mandates would have nearly universal reach, thereby almost entirely eliminating adverse selection problems for the benefits mandated. All health insurance purchasers would have to play by the same rules, and distortions to funding decisions would be eliminated. With the playing field leveled, small employers would no longer face larger regulatory burdens than large firms.[183] And because exit from the federal system is limited, the federal government would not be hampered by the pressures of jurisdictional competition when crafting mandated benefits policy.

Having concluded that positive federal regulation represents the best way forward in the mandated benefit reform movement, the next Part examines current legislative reform efforts, analyzing whether such efforts move mandated benefits reform in a positive direction.

III. CURRENT LEGISLATIVE PROPOSALS

This Part examines three different mandated benefit reform efforts: (1) health savings accounts, (2) association health plans, and (3) interstate sale of health insurance. Health savings accounts have already been made law and are currently affecting state mandated benefit laws, while association health plans and the interstate sale of health insurance are current proposals under consideration in Congress. Although they all use different mechanisms, each represents a move toward the deregulation of the substance of health insurance contracts—an undesired path for health insurance reform.

A. The Impact of Health Savings Account Legislation

The Medicare Prescription Drug, Improvements, and Modernization Act of 2003 added section 223 to the Internal Revenue Code, au-

182. A counter argument could be made that this is not a preferable outcome if it results in lower coverage rates due to increased cost. I agree that such an outcome would be cause for significant concern. However, under a regulatory system that applies equally to all, there should be greater incentive for both Congress and large employers to lobby for change (that is, if federal mandates are adversely affecting coverage rates, the big players should be incentivized to take political action to lessen the regulatory burden). Under our current system, the most powerful players (large employers) have no reason to engage in the state mandated benefit debate.

183. Of course, small employers in many states would still face less favorable premiums than larger employers, but unequal regulation would no longer contribute to the price differential.

thorizing the creation of health savings accounts.[184] The goal of health savings accounts is to reduce health care costs by incentivizing individuals to spend their medical dollars wisely (as they presumably would for any other consumer purchase).[185] By reducing health care costs, insurance costs should decrease and coverage levels should increase, thereby addressing the problem of the uninsured. The philosophy behind these accounts is consistent with the current theme of federal health care reform: decreasing health care and health insurance costs, while increasing individual rights and responsibilities. This is the same theme championed by mandated benefit opponents, as discussed later in this article. We shall see presently that health savings accounts and mandated benefit laws collide.

The addition of health savings accounts to the federal tax code raised a novel problem for certain states. In order to establish a health savings account, an individual must be covered by a "high deductible health plan," as that term is defined in section 223 of the Code.[186] High-deductible health plans need to have deductibles of at least $1000 for individual coverage or $2000 for family coverage, and out-of-pocket maximums that do not exceed $5000 for individual coverage and $10,000 for family coverage.[187] The only services that are permitted to have "first-dollar" coverage (i.e., coverage not subject to the deductible) are preventive services.[188] The Treasury Department provided a specific definition of "preventive services" with no deference to existing state insurance laws.[189] As of January 2004, when the health savings account legislation became effective, twelve states had health insurance laws that did not permit a health insurance policy that met the requirements of section 223 of the Code to be issued to state residents. For example, several states required that certain types of benefits be covered without imposing a deductible, or with a maximum deductible below that required for a high-deductible health plan.[190]

The Treasury Department issued guidance relating to these conflicting state laws that were in effect as of January 1, 2004, stating that such laws would not be treated as disqualifying a high-deductible health plan, *provided* that the state amended the problematic laws by January 1, 2006.[191] All states that had conflicting laws have since passed legislation removing any conflict with the requirements for a high deductible health

184. Pub. L. No. 108-173, § 1201, 117 Stat. 2066, 2469 (2003) (codified as I.R.C. § 223).

185. *See* Cato Inst., *The Ownership Society and Health Care*, http://www.cato.org/cgi-bin/scripts/printtech.cgi/special/ownership_society/healthcare.html (last visited Feb. 27, 2007).

186. I.R.C. § 223(c) (West Supp. 2006).

187. *Id.* § 223(c)(2). These amounts are indexed for inflation. For 2006, the minimum deductibles are $1050 for individual coverage and $2100 for family coverage, with respective out-of-pocket maximums of $5250 and $10,500. Rev. Proc. 2005-70, 2005-47 I.R.B. 979.

188. I.R.C. § 223(c)(2)(C).

189. *See* I.R.S. Notice 2004-43, 2004-27 I.R.B. 10.

190. *See id.*

191. *Id*.

plan contained in section 223 of the Code.[192] Below is a table that briefly summarizes the changes made by each state applicable to high deductible health plans that are offered in conjunction with a health savings account pursuant to section 223 of the Code:

State	*Action Taken*
Arizona	Law specifies that a plan qualifying as a high-deductible health plan may still require the application of deductibles to benefits provided under the plan.[193]
Connecticut	Law amended to exempt high-deductible health plans from deductible and coinsurance limitations that otherwise apply to home health care benefits.[194]
Florida	Law that prohibits insurers from charging insurance deductibles or copayments to victims of violent crime does not apply to high deductible health plans.[195]
Kansas	Law amended to exempt high-deductible health plans from existing coverage mandates for outpatient alcoholism, drug abuse, or nervous or mental condition treatment.[196]
Maryland	Amended law prohibiting application of a deductible for certain home health visits for recently delivered mothers and newborns.[197]
New Jersey	Amended law prohibiting application of a deductible for treatment of lead poisoning.[198] In addition, health plans that qualify as high-deductible health plans are required to provide all medically necessary preventive services without imposing a deductible, to the extent allowed by federal law.[199]
North Dakota	Exempted high-deductible health plans from existing mandated benefit requirements for substance abuse and mental disorder treatment.[200]

(*Continued on next page*)

192. New York allows high-deductible health plans to be offered to group purchasers, but state law continues to prohibit such plans from being offered on the individual market. Individual plans are required to include a maximum deductible of $1000 per individual and $2000 per family, a twenty percent coinsurance amount, no deductible for home health care services, and an out-of-pocket maximum of $3000 per individual and $5000 per family. N.Y. INS. LAW §§ 3216, 4304 (McKinney 2006); *see also id*. § 4322.

193. ARIZ. REV. STAT. ANN. § 20-826.02 (Supp. 2006).

194. CONN. GEN. STAT. ANN. §§ 38a-493(f), 38a-520(f) (West Supp. 2006) (requiring that for other insurance policies, home health care may not be subjected to a deductible greater than $50 per person covered and may not have a coinsurance level less than 75% of the reasonable charges).

195. FLA. STAT. ANN. § 627.413 (West Supp. 2006) (amending FLA. STAT. ANN. § 624.128).

196. KAN. STAT. ANN. § 40-2,105 (2000) (as amended by H.B. 2545). Current law requires all other health insurance policies to provide outpatient treatment of alcoholism, drug abuse and nervous or mental conditions at levels not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1640 in any year and limited to not less than $7,500 in such person's lifetime. *Id.*

197. MD. CODE ANN., INS. § 15-812(g)(2) (LexisNexis 2006).

198. N.J. STAT. ANN. § 17:48E-35.27 (West 2006).

199. *Id*. § 17:48E-35.28.

200. N.D. CENT. CODE §§ 26.1-36-08(2)(d), 26.1-36-09(f)(4) (2005). Prior law prohibited requiring a deductible or copayment for the first five substance abuse treatments in a calendar year, and prohibited a copayment greater than 20% for remaining visits. Similarly, insurance companies were not permitted to establish a deductible or copayment for the first five hours of mental disorder treatment, nor impose a copayment of greater than 20% for remaining hours.

TABLE—*Continued*

State	*Action Taken*
Ohio	Existing law regarding deductibles amended to specifically allow the necessary deductibles for high-deductible health plans.[201]
Oklahoma	New law exempts high-deductible health plans from all state mandated health benefits.[202]
Pennsylvania	New law exempts high-deductible health plans from any state mandated benefits that restrict or limit deductibles for mandated-minimum health insurance benefits or reimbursements, except to the extent such provisions mandate benefits for preventive care, as determined by the standards set forth by the IRS.[203]
Rhode Island	Amends existing insurance laws to exempt health plans from state mandated benefit laws that require any deductible or other cost-sharing provisions that may conflict with the requirements of section 223.[204] Applies to both existing and future mandated benefit laws, although the law change is currently set to expire as of July 1, 2010.[205]
Virginia	Amends law to specifically provide that "any health carrier . . . authorized to conduct business in the Commonwealth may offer a high deductible health plan that would qualify for and may be offered in conjunction with a health savings account pursuant to § 223 of the Internal Revenue Code."[206]

Given the presumably important public policy goals these mandated benefit laws were intended to achieve, it is perhaps surprising that states so quickly (and almost uniformly) repealed mandated benefit laws in order to provide tax-favored health savings accounts to its residents. Professors Jost and Hall interviewed several state regulators regarding these changes and found that

> [t]he states saw it as their responsibility to fix problems of nonconformity so that they would not be a barrier to marketplace innovations spurred by the federal initiative. Without any specific federal requirement or threatened penalty, most were willing to set aside the particular public health or provider protection considerations that caused them to enact various benefits mandates in order to facilitate the federally led consumer-driven market initiative.[207]

201. OHIO REV. CODE ANN. § 1751.12 (LexisNexis 2005).

202. OKLA. STAT. ANN. tit. 36, §§ 7002–7003 (West Supp. 2007).

203. 72 PA. STAT. ANN. § 3402b.5 (West Supp. 2007). Among other things, this law change eliminates the requirement that insurers provide coverage for at least one home health visit for new mothers who are discharged from the hospital less than 48 hours following a normal delivery or 96 hours after a Caesarean delivery. It also changes required coverage of medical foods for the treatment of several health conditions.

204. R.I. GEN. LAWS 27-69-3 (Supp. 2006) (as amended by HB 5228).

205. *Id*.

206. VA. CODE ANN. § 38.2-5602.1 (Supp. 2006).

207. Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 404 (2005). "The few states that have refused so far to jump on the bandwagon have principled reservations about consumer-directed health care that are appropriately respected by this more passive federal approach. Thus in the end, the MMA seems a very promising model of incentive-based federalism in health insurance regulation." *Id*. at 416. At the time the article

In terms of its effect on mandated benefit reform, the health savings account legislation can perhaps best be described as incentive-based deregulation. While not requiring states to amend their mandated benefit laws, it does create a significant incentive to do so.[208] Such incentive-based deregulation is certainly preferable to outright deregulation. With the voluntary nature of the deregulation, states are able to weigh the value of offering their residents health savings accounts against the value of the conflicting mandated benefit laws. In this case, each affected state decided that offering health savings accounts was the more valuable of the two options. The health savings account legislation should, however, be recognized for what it is—part of a growing federal effort to undermine state mandated benefit laws and move toward deregulation. The next two reform proposals discussed represent even bolder moves in this direction.

B. Association Health Plans

Several federal reform proposals have advocated the creation of "association health plans" (AHPs).[209] AHPs allow small businesses the opportunity to cooperatively purchase health insurance through trade and professional associations.[210] Under current law, employers are free to join together to purchase insurance, but such a decision could subject them to state regulation. ERISA provides that a health plan that covers the employees of multiple, unrelated employers is considered a "multiple employer welfare association" (MEWA), unless established pursuant to a bona fide collective bargaining agreement.[211] MEWAs are subject to state insurance laws in each state where plan participants are located, regardless of whether the plan benefits are insured or self-funded.[212]

by Professors Jost and Hall was written, New Jersey had not yet amended its laws to allow high-deductible health plans to be offered. They found that New Jersey had failed to amend its laws due, at least in part, to political opposition to federal health policy. *Id*. at 405. New Jersey has obviously overcome this opposition, although its legislative response did include a requirement that high-deductible health plans cover all medically necessary preventive services without imposing a deductible.

208. There is obviously only an incentive to the extent that state mandated benefit laws conflict with the offering of a high deductible health plan. Many state mandated benefit laws do not conflict with high deductible health plans because such mandates do not prevent a deductible from being applied to the benefit.

209. *See, e.g.*, Patients' Health Care Reform Act, H.R. 2203, 109th Cong. § 801 (2005); Promoting Health Care Purchasing Cooperative Act, S. 820, 109th Cong. (2005); Small Business Health Fairness Act of 2005, S. 406, 109th Cong. § 801 (2005).

210. U.S. DEP'T OF LABOR, ASSOCIATION HEALTH PLANS: IMPROVING ACCESS TO AFFORDABLE QUALITY HEALTH CARE FOR SMALL BUSINESS 2 (2002).

211. 29 U.S.C.A. § 1002(40)(A) (West 2006).

212. *Id*. § 1144(b)(6). MEWAs must comply with, among other things, state mandated benefit laws and premium pricing requirements. CONG. BUDGET OFFICE, INCREASING SMALL-FIRM HEALTH INSURANCE COVERAGE THROUGH ASSOCIATION HEALTH PLANS AND HEALTHMARTS 9 (2000), *available at* http://www.cbo.gov/ftpdocs/18xx/doc1815/healthins.pdf.

MEWA provisions were added to ERISA after several self-funded MEWAs became seriously underfunded.[213]

Under current proposals, AHPs would be exempt from state insurance laws and would instead be regulated at the federal level.[214] The goals of AHPs are to "help small businesses lower their administrative costs and receive more favorable treatment from insurers."[215] In addition, "by operating under federal law, AHPs *can avoid the cost of state benefit mandates*."[216] Just like self-insured single-employer plans, the only mandated benefit laws such associations would have to comply with would be federal mandates, of which there are currently very few. In order to protect participants, the legislation would require self-funded AHPs to meet cash reserve requirements, maintain stop-loss insurance, maintain indemnification insurance, charge sufficient premiums as determined by a qualified actuary and pay an assessment to an AHP fund to help protect plan participants against potential insolvency.[217]

AHPs are promoted based on the claim that removing the burden of state insurance regulation, and state mandated benefits in particular, will result in lower health insurance costs and a corresponding increase in coverage rates.[218] Because AHPs are targeted toward small employers who otherwise have little leverage when negotiating health insurance contracts for their employees, and because employer size is correlated to the propensity to offer health insurance, AHPs are thought to be particularly promising when it comes to expanding health care coverage.[219] Normatively, AHPs would eliminate some of the disadvantage that small employers face under our current regulatory regime.

At first glance, AHPs look like positive federal regulation. After all, they would take regulatory power away from the states and replace it with new, federal-level regulation. However, the new federal regulation would be limited to solvency-related issues, not the substance of health insurance coverage. Instead, AHPs are quite explicitly exempt from state mandated benefit laws, with no federal-level mandates to replace them.[220] AHPs therefore represent yet another effort to move toward the deregulation of the substance of health insurance contracts, albeit limited to purchasing groups who meet the requirements of AHPs. As with health savings account legislation, the result is somewhat better than

213. U.S. GEN. ACCOUNTING OFFICE, GAO/HRD-92-40, EMPLOYEE BENEFITS: STATES NEED LABOR'S HELP REGULATING MULTIPLE EMPLOYER WELFARE ARRANGEMENTS 2 (1992), *available at* http://archive.gao.gov/t2pbat6/146055.pdf.

214. *See* Small Business Health Fairness Act of 2005, H.R. 525, 109th Cong. (2005).

215. U.S. DEP'T OF LABOR, *supra* note 210, at 2.

216. *Id*. (emphasis added).

217. *Id*. at 8.

218. *Id*. at 1.

219. *Id*. at 9.

220. Indeed, AHPs depend on the absence of mandates, and the ability to offer bare bones coverage, for a significant part of the cost savings they provide. *See* CONG. BUDGET OFFICE, *supra* note 213, at 17.

pure deregulation. In this case, the deregulation allows small groups to use the opt-out from state regulation that large employers currently enjoy. In that sense, it helps to level the regulatory playing field. Nonetheless, it moves mandated benefit reform in the wrong direction—toward a deregulated system that benefits low-risk purchasers.[221] Given the modest increase in coverage that is expected to result from the introduction of AHPs, this reform seems difficult to justify.[222] The next reform proposal, the interstate sale of health insurance, moves even further toward deregulation.

C. Interstate Sale of Health Insurance

Under current law, an individual may only purchase an insurance policy licensed under the laws of his or her state of residence.[223] Such a policy must comply with all of the state's laws regarding the substance of the insurance contract, pricing, and renewability. Individuals do not have the ability to purchase an insurance policy governed by a different state's laws, even if they find the other state's laws more appealing. Bills have recently been introduced in both the House and Senate which would change that outcome. The Health Care Choice Act, introduced in May 2005, would allow insurance companies authorized to sell health insurance policies in one state to make such policies available to out-of-state residents.[224] According to congressional findings, "[t]he application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage."[225] Under the proposed legislation, insurance policies offered in the nonresident state would be exempt from the resident state's laws, including consumer protection and mandated benefit laws, as well as laws affecting the availability, pricing, and renewal of insurance

221. *See id*. at 13 (stating that AHPs would give low-cost firms access to lower premiums, while causing some high-cost firms to face higher premiums).

222. In 2000, the Congressional Budget Office estimated that the introduction of AHPs and HealthMarts together would result in premiums that were on average 13% lower than those in the existing small group market. *Id*. at 16. The exemption from benefit mandates and the efficiency of group purchasing accounted for a 5% decrease, while an 8% decrease was attributed to the better-than-average risk profile of the purchasers and the avoidance of state premium controls. *Id*. at 17. However, even with these assumed cost savings, only 330,000 individuals were expected to gain coverage as a result, and such figure represents new coverage resulting from both AHPs and HealthMarts. *Id*. at 14.

223. The current regulation of health insurance has been characterized as federal deference to state legislation. Jost & Hall, *supra* note 207, at 398. As discussed earlier, ERISA's preemption scheme also shows deference to the ability of states to regulation the business of insurance. *See id*. at 398.

224. Health Care Choice Act of 2005, H.R. 2355, 109th Cong. (2005).

225. *Id*.

policies.[226] Instead, all of the nonresident state's laws would govern the contract.

Many of the arguments made in favor of allowing the interstate sale of health insurance are similar to those made in favor of deregulation. Like deregulation, allowing the interstate sale of health insurance should decrease costs and thereby increase coverage. Purchasers would have the freedom to select a health insurance policy that more closely matches their preferences than is often possible under our current system, and multistate employers would find health insurance purchasing simplified. While multistate employers who chose to insure would still have to comply with state law, allowing interstate sale of health insurance would allow such employers to comply with only a single state's laws, instead of complying with the state laws in each state where the employer has employees.

In the case of interstate sale of health insurance, the cost decrease would come from having the ability to select a health insurance policy issued by a low-mandate state.[227] No longer would individuals in high-mandate states be forced to pay for coverage they do not want. An extreme form of jurisdictional competition would arise. Citizens who are unhappy with their resident state's insurance laws could elect a different state's laws without the usual burden of having to physically change residence.[228] As a result, states would be forced to compete nationally for health insurance purchasers and such competition should help to decrease price, at least for that segment of the population that insurance companies seek to attract.

Perhaps the most oft-cited argument in favor of the interstate sale of health insurance is that it provides increased freedom and individual choice.[229] The individual-choice arguments for interstate sale as a solution to health care problems are similar to those used in the retirement savings context.[230] Retirement savings in the United States is in many ways similar to health care in the United States. Both rely primarily on

226. CONG. BUDGET OFFICE, COST ESTIMATE, H.R. 2355: HEALTH CARE CHOICE ACT OF 2005, at 3 (2005).

227. There would also be cost decreases available to certain individuals as a result of being able to avoid unwanted state insurance pricing regulations. Nevertheless, this article is intentionally limited to a discussion of mandated benefit laws.

228. It also potentially allows individuals to get their preferred mix of mandated benefits and health insurance premium costs without changing employers (i.e., an individual could elect to forgo a plan offered by her employer and purchase an individual policy closely tailored to her needs). However, this argument fails to take into account the generous tax subsidies (and often employer subsidies) that are provided for employer-sponsored plans. *See* Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 782–86 (2006). As a result, it is unlikely that an individual would forgo employer-sponsored coverage in order to purchase unsubsidized insurance in a freer market.

229. This freedom and choice is often presented as a good in its own right. *See, e.g.*, *The Health Care Choice Act: Hearing on H.R. 2355 Before the Subcomm. on Health of the H. Committee on Energy and Commerce*, *supra* note 147, at 2, 53, 58.

230. *See generally* Super, *supra* note 131, at 2050; Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451 (2004).

employers to voluntarily offer such benefits, and the likelihood of an individual having access to such benefits varies based on employer size, type of employment, and similar factors.[231] Unlike health care, however, private retirement benefits in the United States were (and are) heavily regulated by both ERISA and the tax code and were quite paternalistically structured.[232] The retirement plan landscape has changed dramatically in the last twenty-five years to embrace an individual-choice model, as seen in the popular 401(k) plan.[233] Proponents argue that these individual-choice models put incentives in their proper place and allow individuals to make choices that will increase welfare compared to paternalistic systems.[234] Opponents argue that individual-choice models put individuals at risk and allow society to avoid providing a social safety net.[235] Opponents of this individual-choice movement essentially argue that the rhetoric of individual empowerment is a distraction from the real goal of decreasing social welfare spending.[236]

A shift similar to that which has taken place in the retirement savings context can be seen in recent federal health care reform efforts, such as health savings accounts and interstate health insurance sales, both of which embrace greater individual choice and decreased government regulation.[237] As in the retirement context, as soon as we provide greater choice, we also incorporate greater personal responsibility for outcome. If an individual who participates in a health savings account fails to save sufficient amounts to pay for necessary medical treatment, the individual bears the responsibility for the bad outcome.[238] Similarly, take an individual who believes that she is not at risk for developing diabetes. Assuming that interstate health insurance sales are permitted, she would be able to purchase a health insurance policy from a low-cost state that does not have a diabetes coverage mandate. If the individual subsequently

231. *See* KAISER FAMILY FOUND., *supra* note 35; KEN MCDONNELL ET AL., EBRI DATABOOK ON EMPLOYEE BENEFITS, tbl.10.6 (2005), *available at* http://www.ebri.org/pdf/publications/databook/DB.Chapter%2010.pdf.

232. For much of the 20th century, defined-benefit plans (what are commonly referred to as traditional pension plans) were the dominant means of private retirement savings. These plans were (and are) heavily regulated and place the risk of loss on the plan sponsor, rather than the individual participant. *See* Amy B. Monahan, *Addressing the Problem of Impatients, Impulsives and Other Imperfect Actors in 401(k) Plans*, 23 VA. TAX REV. 471, 475–76 (2004).

233. *See id.* at 476–79. There have also been efforts to move the social security system in the same direction, allowing for individual 401(k)-style savings accounts in lieu of at least part of the currently guaranteed government benefit.

234. *See id*. at 473.

235. *See* Super, *supra* note 131, at 2062.

236. *See id*.

237. While association health plan proposals do not explicitly embrace individual choice, they do allow health care purchasers to avoid state insurance law at their discretion.

238. *See* John V. Jacobi, *Consumer-Directed Health Care and The Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 577 (2005) (stating that requiring the chronically ill "to go through the exercise each year of spending through their deductible amount is nothing more than a tax on the sick—a transfer of cost from sponsors and the general insured pool to the chronically ill").

develops diabetes, she has only herself to blame for not purchasing adequate coverage.[239]

Of course, where there is risk there is also the possibility of reward. While it is true that individual-choice models in both retirement savings and health care create individual responsibility for bad choices, individual-choice models also give individuals the opportunity to maximize their welfare by tailoring their retirement savings or health care to their individual preferences. In the retirement savings context, individuals are able to choose how much to save for retirement, where to invest such amounts, and when to begin spending such amounts, choices not available to participants in a paternalistic defined-benefit plan. Similarly, in health care, an individual who can choose from among a broad menu of coverage options has the opportunity to purchase health insurance that both has a lower cost and better fits her health needs. But a unique feature of choice in the health care context is that it often works to the advantage only of those who represent a below-average risk. Low-risk individuals are most likely to benefit from health savings accounts,[240] just as they are most likely to benefit from the interstate sale of health insurance, as discussed in more detail below.

Many of the arguments deployed against deregulation can be made against interstate sale of health insurance. First and foremost, allowing interstate sales will result in adverse selection problems. In addition, it may prevent certain high-risk individuals from being able to afford health insurance coverage, and also raises problems associated with individuals' capacity for accurate risk assessment. Finally, it is unlikely that allowing interstate sale will actually increase coverage rates.

While proponents of interstate sale focus on the decreased cost and increased choice that may result, what they seem to ignore is the effect such regulatory change would have on the risk pooling function of mandated benefits. Mandated benefit laws rely on market restriction in order to function. In a world of interstate health insurance sales, an individual of any state may purchase a health insurance policy offered under the laws of any other state. As proponents correctly point out, this allows individuals to select the set of laws and regulations that best matches their preferences. Allowing individuals to opt out of this risk spreading by purchasing insurance in a state without such mandates fundamentally undermines the ability of states to achieve one of the primary policy goals behind mandated benefits.

The result should be obvious. The state with the fewest mandates will tend to attract an insured population that is healthier than average, while states with generous mandates will attract insured populations that

239. As David Super points out, "The moral argument presenting uninsuredness as blameworthy is far easier to digest" than arguments about market conditions that make healthcare coverage less available to low-income people and those with serious illnesses. Super, *supra* note 131, at 2065.

240. *See* Monahan, *supra* note 228, at 814–18.

are sicker than average.[241] Premium costs in the low-mandate state will fall as a result of the better than average risk pool, while costs in the high mandate states will rise as a result of the worse than average risk pool. States would no longer be able to spread the risk of certain conditions across insured populations, since individuals would be free to opt out of risk pools that do not include their personal risks.

A related concern is that states will engage in a race to the bottom, decreasing their consumer protections in order to decrease the cost of issuing health insurance in the state, thereby attracting a greater number of insurance companies to the state.[242] The result may be that insurers cease doing business in high-mandate states and only issue policies in the states with the least amount of regulation.[243] If this results, high-risk individuals may be left without effective health coverage.[244]

If interstate sale is permitted, state legislatures would not necessarily be marketing health insurance packages to their citizens, but to citizens of all states. This fundamentally changes the nature of the state legislative exercise. Under our current system, where citizens of one state may only purchase health insurance contracts that are licensed under the laws of their state of residence, state legislators evaluate proposed benefit mandates taking into account the health policy concerns of their constituents. Typically, this involves analyzing whether the cost of the proposed benefit mandate justifies the resulting benefit, or whether there is some other overriding health policy justification for including the mandate, such as fairness or justice. Some states even require that benefit

241. The Congressional Budget Office cost estimate for the Health Care Choice Act predicts as much:

> For most people in a secondary state, the price of individual health insurance coverage offered by an insurer licensed in a primary state would be lower than the price under current law of individual coverage offered by an insurer licensed by their state. Conversely, individual health insurance coverage from out-of-state insurers either would not be offered to people expected to have relatively high health care costs, or it would be offered at a price that is higher than the price under current law of individual coverage offered by an insurer licensed by their state. The shift of individuals expected to have relatively low health care costs to out-of-state insurance coverage would increase the price of coverage offered by insurers licensed in-state, and could lead to erosion of the availability of such coverage by insurers located in secondary states.

CONG. BUDGET OFFICE, *supra* note 226, at 4. It is also possible that low-mandate states will attract individuals with a range of risk profiles, due to individuals' problems with accurate risk assessment.

242. Other examples of state competition, such as among state usury laws, may provide a helpful analogy. After the Supreme Court held in *Marquette National Bank v. First of Omaha Service Corp.*, 439 U.S. 299 (1978), that a national bank could charge credit card interest according to the state's laws where the bank is located (rather than the customer's state of residence), there was a rapid move by banks to states with very high or no interest rate ceilings. Todd J. Zywicki, *The Economics of Credit Cards*, 3 CHAP. L. REV. 79, 146 (2000).

243. *See* CONG. BUDGET OFFICE, *supra* note 226, at 4.

244. While they may be able to purchase the necessary coverage by paying a premium commensurate with their risk, it is likely due to adverse selection issues previously discussed that they would find such coverage unaffordable. *See id.* at 7 ("H.R. 2355 would reduce the price of individual health insurance coverage for people expected to have relatively low health care costs, while increasing the price of coverage for those expected to have high health care costs. Therefore, CBO expects . . . a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage.").

mandates be reviewed periodically to ensure that they remain justifiable from a policy perspective.[245]

In a system that permits the interstate sale of health insurance, state legislators will be made powerless in the health policy arena. Because they can no longer mandate risk pooling or combat adverse selection, they will presumably evaluate proposed benefit mandates in terms of the effect such mandates will have on the state's revenue stream. Rather than evaluating the health policy interests of state citizens, legislators will evaluate whether the mandate will help or hurt the business of insurance. States will no longer be in the health policy business, but rather the insurance business. The result seems to deprive citizens of effective health policy legislation, since states will be *unable* to legislate on such a basis, even if they (and their citizens) desire such legislation.

Imagine a state that has a preference for a substance abuse benefit mandate. If the interstate sale of health insurance is permitted, the state would gain nothing, and perhaps suffer economic losses, if it were to legislate such a mandate. For if the state mandates substance abuse treatment, it will disproportionately attract individuals who value that benefit highly, and any insurers who issue policies under that state's laws will price the coverage accordingly or exit the market.[246] As a result, the benefit mandates will become useless, and the power of citizens to effect health policy, particularly when it comes to risk pooling, will be effectively taken away.

As with deregulation, there is a legitimate question as to whether interstate sale will lower costs to the degree required to raise coverage rates. The Congressional Budget Office (CBO) estimate prepared for the Health Care Choice Act suggests that it will not. The CBO estimate assumes that the premium reduction associated with moving from coverage in a high-mandate state to a low-mandate state will average five percent.[247] The CBO further estimates that about one million individuals would lose employer-sponsored coverage once the Health Care Choice Act is fully implemented because of the improved individual market.[248] However, in terms of the net effect on coverage, the CBO estimates that the Health Care Choice Act "would not have a substantial effect" on the

245. TEX. DEP'T OF INS., *supra* note 18, at 14.

246. In a state without pricing controls, the benefit would be priced based on the theory of adverse selection—that those who seek out a policy in a state with a substance abuse mandate have reason to believe that they will utilize such benefits. If the state has pricing controls that make it difficult for insurers to operate profitably in the face of adverse selection, insurers will simply exit the market and cease offering policies in that state.

247. CONG. BUDGET OFFICE, *supra* note 226, at 4.

248. The CBO assumes that some employers (particularly smaller ones) would stop offering employee health coverage due to the improvements in the individual market. *Id.* at 5. In addition, some individuals who currently receive employer-sponsored coverage will choose instead to purchase individual health insurance coverage through an out-of-state insurer. *Id.* That would increase the per capita cost of the employer's health plan, and is therefore expected to result in additional employers dropping coverage. *Id.*

number of people with health coverage.[249] While one million people are expected to lose employer-sponsored coverage, the CBO estimates that many of those will purchase individual coverage, as will many individuals who are currently uninsured, resulting in little effect on overall coverage rates.[250]

The CBO cost estimate states simply, "H.R. 2355 would reduce the price of individual health insurance coverage for people expected to have relatively low health care costs, while increasing the price of coverage for those expected to have relatively high health care costs. Therefore, CBO expects that there would be an increase in the number of relatively healthy individuals, and a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage."[251] This conclusion is consistent with the issues discussed above regarding adverse selection, risk pooling, a race to the bottom, and state legislative impotency. In the end, then, one must justify the interstate sale of health insurance solely on the basis of normative arguments regarding individual rights. And as was discussed in the context of deregulation, the individual rights arguments cannot overcome the negative effects such a system would have on high-risk individuals.

D. Where to from Here?

The U.S. health care system has widely acknowledged problems, prominent among them the number of Americans who are uninsured. We have a unique and piecemeal system of regulating health insurance. Most Americans receive health insurance through their employers, and such plans are governed by ERISA, a federal law that imposes very few substantive requirements on such plans. Employers who choose to purchase insurance to fund health plans for their employees are subject to additional regulation at the state level, which typically involves a fair number of substantive mandates. Employers who self-insure their health plans are exempt from state regulation. Individuals who do not receive coverage through their employers may purchase individual coverage regulated by their state of residence, but may not purchase insurance regulated by another state. The result is that employers who self-insure are in the best position to offer affordable health care coverage to their workers, while small employers and individuals who must purchase their own coverage are likely to face the highest costs.

In an effort to address the increased costs faced by those who purchase insurance rather than self-insure, there are several efforts underway at the federal level to reduce the ability of states to require health insurance contracts to include coverage for mandated benefits. While

249. *Id*. at 7.
250. *Id.*
251. *Id.*

much effort has gone into these reform proposals, it is unclear that the proposed reforms will have their desired effect: improving our system of health care regulation and decreasing the number of uninsured Americans.

Let us begin by accepting that a proper goal of health insurance reform is to reduce the number of uninsured Americans. Let us also assume that many Americans lack insurance due to the high cost of coverage. Given these assumptions, lowering the cost of health insurance should help us reach our goal of increasing coverage rates.[252] Despite the lack of reliable data, let us even assume that effectively eliminating state mandated benefits will in general decrease the costs of health insurance premiums sufficiently to increase coverage rates.

But the story does not end there. The reduction in cost would come at a price—perhaps not an easily ascertainable dollar amount, but a price nonetheless. The reduction in health premiums under a system that lacked mandated benefits would be available only for those who are not affected by, or at risk for, the medical conditions to which the benefit mandates relate. While a healthy individual with no known risk factors may well enjoy lower health insurance premiums, those with existing medical conditions or known health risks may very well be subject to *higher* insurance premiums than under our current system. And so the question becomes whether reforms that favor individual rights at the expense of high-risk individuals are worth pursuing.

If the answer is yes, we must find a way to provide medical coverage for individuals who will lose under the system. This could take many forms, from state-subsidized high-risk insurance pools to direct government grants to individuals who suffer from certain conditions that make them unattractive to insurers.[253] It is beyond the scope of this article to address this issue, but it must be acknowledged as we contemplate current health reform efforts. If we move to an individualistic model of insurance, we must somehow account for those who will be left behind.

This article argues that we do not want to embrace an individualistic model of health insurance, that health risks are, at least in part, unblameworthy and appropriate to be shared within a community. This conclusion necessitates that we abandon the current reform efforts aimed at deregulating the substance of health insurance contracts. In their

252. Some have expressed skepticism that merely reducing costs will be sufficient to materially increase rates of coverage, because for many Americans the cost of health insurance would have to drop dramatically for the purchase of insurance to become either attractive or possible. *See, e.g.*, Jacobi, *supra* note 129, at 402–03 (suggesting that positive funding would be necessary to increase coverage rates, given the high-cost coverage).

253. There are plenty of examples of governmental programs to deal with high-risk insurance purchasers, such as existing state health insurance high-risk pools and the federal flood insurance program.

place, we should seek reform that makes the federal government solely responsible for regulating the substance of health insurance contracts.[254]

Although federalizing mandated benefits will address the regulatory inequities of our current system while retaining an important policy tool, it does not directly address the problem of uninsurance. The large number of Americans who lack health insurance is not an easy problem to resolve, and it may involve fundamentally changing the way health insurance is taxed in this country or creating either a refundable tax credit for the purchase of health insurance or some other means of making coverage more affordable.[255]

Regardless of how we answer the fundamental question regarding the ends of health insurance, we must at least be willing to have an open and honest debate about the matter. We cannot examine the current reform proposals without acknowledging how they change the ends of health insurance, and what that means from both an efficiency-based and normative perspective. Only in doing so can we move the health reform debate forward.

IV. CONCLUSION

Critics are right to see serious flaws in our current system of health care regulation, particularly with respect to state mandated benefit laws. The disparate treatment of insured versus self-insured plans is difficult, if not impossible, to justify, particularly given the disadvantageous position in which it puts small employers and individual purchasers. The answer, however, does not lie in deregulation. There are very good reasons for the government to mandate that health insurance policies include certain benefits. Without benefit mandates, individuals with certain conditions may be unable to receive effective health insurance coverage. We may be disappointed with how states currently legislate these benefits, but the truth remains that benefit mandates can serve very important purposes. As a result, Part II of this article argues that the best reform option for mandated benefit laws is for the federal government to (1) preempt the ability of the states to regulate the content of health insurance policies and (2) enact appropriate federal-level benefit mandates. Not only would this reform preserve the policy functions that mandated benefits serve, but it would also eliminate the preferential treatment that self-insured plans currently enjoy.

254. I leave to a future article a discussion of the specifics of the legislative process that should be involved in mandating benefits at the federal level, what types of evidence should be sufficient to support a mandate, and what benefits (if any) might meet such requirements.

255. President Bush has proposed eliminating the exclusion of employer-provided health insurance from taxable income and in its place offering a standard deduction for health insurance. *See* Press Release, White House Office of the Press Secretary, Fact Sheet: Affordable, Accessible, and Flexible Health Coverage (Jan. 22, 2007), *available at* http://www.whitehouse.gov/news/releases/2007/01/20070122-3.html.

Unfortunately, as discussed in Part III, current reform efforts are not aimed at federalizing mandated benefits, but rather at pursuing deregulation (even if such aim is not explicitly acknowledged). Such efforts must be recognized for what they are—a push toward a system that values individual rights above all. It is a system that would reward the healthy and punish the sick. Given the significant problems our health care system faces, we deserve reform efforts that will benefit all Americans.