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The Health Care Choice Act: The Individual Insurance Market and the Politics of 'Choice'

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THE HEALTH CARE CHOICE ACT: THE INDIVIDUAL INSURANCE MARKET AND THE POLITICS OF "CHOICE"

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INTRODUCTION

Our health care system is in crisis. Although we spent nearly $1.9 trillion on health care in 2004,[1] a figure expected to rise to $3.1 trillion by 2012,[2] this appears to be the result of higher prices, rather than increased access to or usage of health care.[3] At the same time, health insurance is increasingly hard to get, keep, and afford. As a result, a growing number of Americans are uninsured—46 million people in 2004, an increase of 6 million since 2000.[4]

Traditionally, employer-sponsored group insurance plans have been the backbone of health insurance coverage in the United States. While it is still true that most Americans get their health insurance through em-

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1. THE HENRY J. KAISER FAMILY FOUND., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE, *available at* http://www.kff.org/insurance/7031 (follow the "Section 1" hyperlink) [hereinafter TRENDS AND INDICATORS] (last visited Mar. 22, 2007) ("Expenditures in the United States on health care were nearly $1.9 trillion in 2004, more than two and a half times the $717 billion spent in 1990, and more than seven times the $255 billion spent in 1980.").

2. Stephen Heffler et al., *Health Spending Projections for 2002-2012*, HEALTH AFF., Feb. 7, 2003, at W3-54, W3-54, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.54v1.pdf.

3. Gerard Anderson et al., *It's the Prices, Stupid: Why the United States is So Different from Other Countries*, HEALTH AFF., May-June 2003, at 89, 90, *available at* http://content.healthaffairs.org/cgi/reprint/22/3/89. According to testimony before the Senate, "we pay higher prices for the same services, have higher administrative costs, and perform more complex specialized procedures" than other countries. KAREN DAVIS & BARBARA S. COOPER, THE COMMONWEALTH FUND, AMERICAN HEALTH CARE: WHY SO COSTLY? 3 (2003), *available at* http://www.cmwf.org/usr_doc/davis_senatecommitteetestimony_654.pdf.

4. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, GAPS IN HEALTH INSURANCE: AN ALL-AMERICAN PROBLEM 1 (2006), *available at* http://www.cmwf.org/usr_doc/collins_gapshltins_920.pdf.

ployment,[5] the erosion of employer-sponsored coverage has increased the ranks of the uninsured.[6] It has also pushed more workers, retirees, and their families into the individual insurance market—a small but important part of the broader health insurance market.

Despite its relatively small size—9.1 percent of the population, or nearly 27 million people, turned to individual policies for health insurance coverage in 2005[7]—the individual market is increasingly important.[8] States have been active in regulating the individual market, and there now appears to be increased federal interest in connection with proposed tax credits for the purchase of individual health insurance.[9]

5. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 16 (2005), *available at* http://www.census.gov/prod/2005pubs/p60-229.pdf ("The percentage of people covered by employment-based health insurance decreased to 59.8 percent in 2004, from 60.4 percent in 2003."); *see also* KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE IN AMERICA: 2004 DATA UPDATE 10 fig.2 (2005), *available at* http://www.kff.org/uninsured/upload/health-coverage-in-america-2004-data-update-report.pdf [hereinafter 2004 DATA UPDATE] (61 percent of nonelderly covered by employer-sponsored health insurance); GARY CLAXTON ET AL., THE HENRY J. KAISER FAMILY FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS SURVEY: 2005 ANNUAL SURVEY 39-49 (2005), *available at* http://www.kff.org/insurance/7315/upload/7315.pdf (60 percent of nonelderly covered by employer-sponsored health insurance in 2005).

6. For an overview of the uninsured and access to care, see Elizabeth A. Pendo, *Images of Health Insurance in Popular Film: The Dissolving Critique*, 37 J. HEALTH L. 267, 284-87 (2004) [hereinafter Pendo, *Images of Health Insurance in Popular Film*].

7. U.S. Census Bureau, Historical Health Insurance Tables, Table HI-1: Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin, 1987 to 2005, http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html (last visited Mar. 22, 2007); *see also* DENAVAS-WALT ET AL., *supra* note 5, at 19 fig.6 (stating that in 2004, 9.3 percent of the population had individual coverage; in 2003, 9.2 percent); 2004 DATA UPDATE, *supra* note 5, at tbl.1 (stating that in 2004, 5.4 percent of the population under age 65, or nearly 14 million people, had individual coverage); BETH C. FUCHS, THE ROBERT WOOD JOHNSON FOUND., HEALTH POLICY ALTERNATIVES, INC., EXPANDING THE INDIVIDUAL HEALTH INSURANCE MARKET: LESSONS FROM THE STATE REFORMS OF THE 1990S, at 3, 18 n.4 (2004), *available at* http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no4_synthesisreport.pdf (stating that in 2002, only about 7 percent of Americans under the age of 65, or approximately 17 million people, had individual health insurance coverage).

8. Jon Gabel et al., *Individual Insurance: How Much Financial Protection Does it Provide?*, HEALTH AFF., Apr. 17, 2002, at W172 [hereinafter Gabel et al., *Individual Insurance*], *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.172v1.pdf (quoting Deborah L. Rogal & Anne K. Gauthier, *The Evolution of the Individual Insurance Market*, 25 J. HEALTH POL. POL'Y & L. 3 (2000)) ("The long-term decline of employer-based insurance has thrust individual insurance, long viewed by the insurance industry as the 'residual market' onto center stage.").

9. *See, e.g.*, FUCHS, *supra* note 7 (examining state reforms of the insurance market); Press Release, The White House, Making Health Care More Affordable and Accessible for All Americans (May 1, 2006), *available at*

Unfortunately, this market has not worked well for consumers, because individual policies usually cost more and cover less than those obtained through an employer, and even those consumers who can afford it may not have access.

The Health Care Choice Act of 2005 (HCCA)[10] aims to reform perceived problems in the individual market, and is touted as part of the solution to the problem of the uninsured. It purports to allow individuals who are not eligible for or cannot afford group coverage to purchase an individual policy in and from any state. If passed, the HCCA would allow health insurers to offer individual policies of insurance from any state without being required to comply with the laws of the insured's own state. Its proponents claim that it would lower the cost of individual health insurance by bypassing state laws such as those mandating benefits, and offer consumers more choice.

The HCCA has not received a lot of attention, perhaps because it was overshadowed by another bill, the Health Insurance Marketplace Modernization and Affordability Act (Enzi Bill), aimed at the small-group market.[11] But the HCCA is worth examining because it represents a bad choice for the individual market. It does not appear that the HCCA would lower costs for most purchasers, increase meaningful choices, or reduce the overall number of uninsured. Moreover, the HCCA would permit health insurers to sell policies from the states with the fewest consumer protections, and to market and sell those policies to consumers in all other states. This would erode important consumer protections under state law and undercut the role of the states in regulating health insurance products and protecting their citizens.

Worse, the HCCA could increase the existing problem of fragmen-

http://www.whitehouse.gov/news/releases/2006/05/20060501-8.html [hereinafter "Making Health Care More Affordable and Accessible for All Americans"] (outlining President George W. Bush's health care agenda, including a refundable tax credit to help low-income Americans purchase health coverage on the individual market). The *Journal of Health Politics, Policy and Law* also devoted an entire issue to policy initiatives in the individual market. 25 J. HEALTH POL. POL'Y & L. 3 (2000).

10. The Health Care Choice Act of 2005, H.R. 2355, 109th Cong. (2005); S. 1015, 109th Cong. (2005).

11. Health Insurance Marketplace Modernization and Affordability Act (Enzi Bill), S. 1955, 109th Cong. (2005). The Enzi Bill, named in recognition of its sponsor, Senator Michael Enzi, would have permitted small businesses and trade association to join together to form association health plans across state lines, and to offer coverage in a state without complying with its mandated benefit laws. 152 CONG. REC. S4459 (daily ed. May 11, 2006) (statement of Sen. Enzi). The bill was effectively blocked in the Senate on May 11, 2006, by a failure of a motion to close debate. U.S. Senate, U.S. Senate Roll Call Votes 109th Congress—2nd Session (reporting that the cloture motion was rejected on S. 1955); 152 CONG. REC. S4459-60 (daily ed. May 11, 2006).

tation in the individual and broader insurance markets and divert attention away from systemic issues such as the increasingly high cost of health care, and the growing crisis of un- and under-insurance. Indeed, the HCCA can be seen as an example of the larger political approach to health care policy, one focused on individual, market-based solutions that undermine the concept of health insurance as an expression of social solidarity and collective responsibility.

I. OVERVIEW OF THE INDIVIDUAL INSURANCE MARKET

Although the individual market covers a relatively small percentage of the population, it provides a critical source of coverage for people without access to group coverage. As noted by one author,

> Anyone can find himself or herself in need of individual insurance. Common circumstances that lead people to seek coverage in the individual market include "aging off" a parent's coverage, getting a job without health benefits, self-employment, working part time or taking extended leave, becoming divorced or widowed, and retiring before the age of 65, when Medicare coverage begins. Thus, people who are used to having employment-based or public coverage may still need individual health insurance at some point during their lifetime.[12]

The role of the individual market as a "safety net" for those without access to a group policy on a short- or long-term basis may become even more important as employer-based health coverage continues to erode, and the number of uninsured continues to rise.[13] Unfortunately, the individual insurance market has not worked well for consumers.

A. *Cost*

Individual policies usually cost more and cover less than those obtained through an employer.[14] Unlike employer-based coverage, in

12. KAREN POLLITZ ET AL., THE HENRY J. KAISER FAMILY FOUND., HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-THAN-PERFECT HEALTH? 1 (2001), *available at* http://www.kff.org/insurance/20010620a-index.cfm (follow the "Report" hyperlink). Workers who have exhausted their eligibility for continuation health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986), may also find themselves in the individual market. *See generally* LISA DUCHON ET AL., COMMONWEALTH FUND, SECURITY MATTERS: HOW INSTABILITY IN HEALTH INSURANCE PUTS U.S. WORKERS AT RISK 24-25 (2001), *available at* http://www.cmwf.org/usr_doc/duchon_securitymatters_512.pdf.

13. Gabel et al., *Individual Insurance*, *supra* note 8, at W172 ("The long-term decline of employer-based insurance has thrust individual insurance, long viewed by the insurance industry as the 'residual market' onto center stage.").

14. *See, e.g.*, *id.* at W176, W177, W178 exhibit 3 (comparing the costs and available

many states the health and claims history of applicants for individual policies may be examined prior to an offer of coverage, and premiums may vary according to the applicant's health status, age, and sex.[15] Moreover, in an unregulated market, there are generally no limits on the premiums the insurer can charge.[16] Although reliable data is difficult to find,[17] according to a 2004 survey of policies actually purchased, the average annual premium for an individual policy was $2,268 for an individual, and $4,424 for a family.[18] Other studies have looked at a smaller number of purchases, or at premiums offered but not adjusted for medical underwriting. For example, a 2001 study by eHealthInsurance reported annual premiums averaging $1,200 to $1,500 for individual policies,[19] and a 2002 study by the Health Insurance Association of America reported average single premiums of $2,070 and family premiums of $4,009.[20] These figures reflect the first premium offered or accepted,

benefits of individual and group health insurance plans).

15. *See id.* at W173 (describing the process of medical underwriting); POLLITZ ET AL., *supra* note 12, at 1 (describing a study that constructed seven hypothetical applicants and asked nineteen insurance companies and managed care organizations in eight markets how they would respond to an application for coverage); NANCY C. TURNBULL & NANCY M. KANE, HARVARD SCH. OF PUB. HEALTH, INSURING THE HEALTHY OR INSURING THE SICK? THE DILEMMA OF REGULATING THE INDIVIDUAL HEALTH INSURANCE MARKET 17 fig.3 (2005), *available at* http://www.cmwf.org/usr_doc/771_turnbull_insuring_healthy_or_sick_findings.pdf (comparison of predicted premiums by family characteristics).

16. Federal law does not regulate premium rates in the individual market. *See* DENISE HARRIS & KATHLEEN STOLL, FAMILIES USA, PROTECTING CONSUMERS FROM UNFAIR RATE HIKES: THE NEED FOR REGULATION OF HEALTH INSURANCE RENEWAL PREMIUM INCREASES 7 n.1 (2003), *available at* http://www.familiesusa.org/assets/pdfs/Rate_Hikes_Revised_Feb_2003ca7a.pdf.

17. *See* FUCHS, *supra* note 7, at 3 (noting that reliable premium comparisons are difficult because advertised premiums do not reflect increases due to medical underwriting; premiums vary according to factors such as age, sex, health status, and state; policies are not standardized; and premiums may be higher upon renewal).

18. THOMAS F. WILDSMITH, CTR. FOR POL'Y & RESEARCH, AM. HEALTH INS. PLANS, INDIVIDUAL HEALTH INSURANCE: A COMPREHENSIVE SURVEY OF AFFORDABILITY, ACCESS, AND BENEFITS 5 tbl.1 (2005), *available at* http://www.ahipresearch.org/pdfs/individual_insurance_survey_report8-26-2005.pdf (discussing a survey based on actual purchases of "just under 1.9 million policies, covering approximately 3.2 million [people]"). The survey is "the most extensive industry survey of individual coverage undertaken to date." *Id.* at 1.

19. VIP PATEL, EHEALTHINSURANCE, ANALYSIS OF NATIONAL SALES DATA OF INDIVIDUAL AND FAMILY HEALTH INSURANCE: IMPLICATIONS FOR POLICYMAKERS AND THE EFFECTIVENESS OF HEALTH INSURANCE TAX CREDITS 2 (2001), *available at* http://www.ehealthinsurance.com/ehealthinsurance/eHealth2.pdf (discussing survey based on 20,000 actual sales by eHealthInsurance).

20. THOMAS D. MUSCO, HEALTH INS. ASS'N OF AM., HIAA SURVEY: INDIVIDUAL MEDICAL EXPENSE INSURANCE: AFFORDABLE, SERVES YOUNG AND OLD 1 tbl.1 (2002), *available at* http://www.ahipresearch.org/PDFs/19_HIAAIndividualMarketPremiums.pdf.

not the actual or entire cost of individual coverage. For example, once the policy has been issued, rates can generally be increased upon renewal.[21] In addition, cost sharing features such as deductibles and coinsurance are often higher with individual plans,[22] and premiums paid for individual coverage do not receive the same preferential tax treatment as employer-sponsored plans.[23]

Although premiums for individual coverage can vary widely, it is clear that cost is a major barrier to the individual market. The majority of uninsured adults reported cost as the reason they lacked coverage.[24] The majority of people who have considered purchasing an individual health plan in recent years have found it unaffordable, and only a minority of those who looked into an individual policy ended up purchasing coverage.[25]

B. *Access*

Even those who can afford individual coverage may not have access. In most states, health insurers offering individual policies have no legal obligation to offer or provide coverage.[26] In an unregulated market, insurers can exclude from or impose waiting periods for coverage of

21. In general, federal law does not regulate premium rates in the individual market. *See* HARRIS & STOLL, *supra* note 16, at 3. Although the Health Insurance Portability and Accessibility Act (HIPAA) provides that an individual leaving group coverage can purchase an individual policy that is guaranteed to be renewable, 42 U.S.C. §§ 300gg-41 to -42 (2006), it does not limit the premium that the offering insurer may charge, 42 U.S.C. § 300gg-41(f)(1). In 2002, a federal bill was introduced that would limit the practice of medical re-underwriting as a basis for increasing premiums for an individual insured at the time of renewal, but to date, it has not passed. Health Insurance Fairness Act, S. 3119, 107th Cong. (2002); H.R. 5682, 107th Cong. (2002).

22. *See, e.g.*, Gabel et al., *Individual Insurance*, *supra* note 8, at 176-77.

23. CONGRESSIONAL BUDGET OFF., CONGRESSIONAL BUDGET OFFICE COST ESTIMATE, H.R. 2355 HEALTH CARE CHOICE ACT OF 2005, at 5 (2005) [hereinafter CBO COST ESTIMATE] (as ordered reported by the House Committee on Energy and Commerce on July 20, 2005), *available at* http://www.cbo.gov/ftpdocs/66xx/doc6639/hr2355.pdf. For an overview of the tax treatment of health care plans, see Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 782-86 (2006).

24. JOHN A. GRAVES & SHARON K. LONG, THE URBAN INST., WHY DO PEOPLE LACK HEALTH INSURANCE? 4 fig.1 (2006), *available at* http://www.urban.org/UploadedPDF/411317_lack_health_ins.pdf (54 percent of uninsured adults under age 65 reported high cost as the reason they were uninsured).

25. DUCHON ET AL., *supra* note 12, at 24-25.

26. HIPAA provides the right to buy an individual policy for individuals leaving group coverage, and in the small group market, but federal law does not ensure access for those previously uninsured or covered by a different individual policy. *See* 42 U.S.C. § 300gg-42. Only a few states have enacted guaranteed issue laws that ensure the right of people to purchase in the individual market. *See* FUCHS, *supra* note 7, at 7 fig.6 (stating that, as of 2000, twelve states had enacted guaranteed issue laws).

applicants with pre-existing conditions.[27] For example, a study by the Kaiser Family Foundation looking at seven applicants of varying age, gender, and life circumstances and with seven different pre-existing conditions—including hay fever, a surgically repaired knee, asthma and recurrent ear infections, breast cancer, depression, high blood pressure, and HIV+ status—found that overall the applicants were rejected 37 percent of the time.[28] When offers of coverage were made, only 10 percent of the offers were at the standard rate, and most contained benefit restrictions, surcharges, or both.[29] In an unregulated market, individuals in less-than-perfect health may be offered coverage at prohibitively high rates or denied coverage altogether.[30]

C. *Adequacy*

The quality or adequacy of coverage available on the individual market is also an issue. Individual policies usually cover less than those obtained through an employer. For instance, individual policies typically offer lower levels of reimbursement. One study reported that individual insurance covers, on average, 63 percent of medical bills, while group insurance covers 75 percent.[31] Consumers also may have a difficult time finding coverage for what many consider to be basic benefits, such as "maternity benefits, mental health care, and prescription medications [which] tends to be limited, especially in comparison to what is typically offered under group health plans."[32] As stated above, in the absence of state regulation, insurers can also exclude coverage of pre-existing conditions and impose significant waiting periods.

27. *See* FUCHS, *supra* note 7, at 7 fig.6 (stating that, as of 2000, thirty-one states had enacted laws limiting exclusions for pre-existing conditions).

28. POLLITZ ET AL., *supra* note 12, at ii, 17 chart 6, 20.

29. *Id.* at 20. The average annual premium offered was $3,996, a significant increase from the standard average annual rate of $2,988. *Id.* at 21.

30. *See* ALLIANCE FOR HEALTH REFORM, HEALTH CARE COVERAGE IN AMERICA: UNDERSTANDING THE ISSUES AND PROPOSED SOLUTIONS 10 (2006), *available at* http://www.allhealth.org/publications/pub_7.pdf. HIPAA prohibits insurers from excluding or medically underwriting individuals in group health plans, but offers no such protection for individuals seeking individual policies. *See id.*

31. Gabel et al., *Individual Insurance*, *supra* note 8, at W172.

32. POLLITZ ET AL., *supra* note 12, at 31; *see* SARA R. COLLINS ET AL., COMMONWEALTH FUND, PAYING MORE FOR LESS: OLDER ADULTS IN THE INDIVIDUAL INSURANCE MARKET 1-2 (2005) (citations omitted), *available at* http://www.cmwf.org/usr_doc/841_Collins_older_adults_ib.pdf ("[A]dults ages 50 to 70 who rely on individual market insurance pay much higher premiums than their counterparts with employer coverage or Medicare. . . . Yet, . . . older adults with individual coverage . . . have far less comprehensive coverage and are more likely to face insurance restrictions and administrative complications," poorer access to care, and higher out-of-pocket expenses.).

It is well known that less comprehensive health plans can subject people to tremendous health and financial risks.[33] According to one study, "[over half] the underinsured (54%) and uninsured (59%) went without at least one of four needed medical services—double the rate of those with adequate insurance."[34] Moreover, "rates of medical bill stress among the underinsured were equal to those reported by the uninsured."[35] It is not surprising, then, that people with individual policies are less likely to say that they feel "well protected" by their insurance than people with group policies, and the majority of them are at least somewhat worried that their health plan will not pay for their health care needs.[36]

D. *State Regulation*

In response to problems such as these, states have used their traditional regulatory powers under the McCarran-Ferguson Act[37] to enact various reforms to the individual market. In general, these reforms attempt to make coverage more accessible and affordable, and to spread risk across a large number of people.[38] Common types of state regulation include: guaranteed issue laws; guaranteed renewal laws; limitations of exclusions for pre-existing conditions; rating reforms aimed at limiting the extent to which premiums can vary by age, sex, or health status, such as rating bands or community rating; and reforms designed to spread risk across insurers.[39]

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33. *See generally* SHERRY GLIED ET AL., THE COMMONWEALTH FUND, BARE-BONES HEALTH PLANS: ARE THEY WORTH THE MONEY? (2002), *available at* http://www.cmwf.org/usr_doc/glied_barebones_518.pdf; Laura Tollen & Robert M. Crane, *A Temporary Fix? Implications of the Move Away from Comprehensive Health Benefits*, EMP. BENEFIT RES. INST., Apr. 2002, at 1, *available at* http://www.ebri.org/pdf/briefspdf/0402ib.pdf.

34. Cathy Schoen et al., Commonwealth Fund, *Insured but Not Protected: How Many Adults are Underinsured?*, HEALTH AFF., June 14, 2005, at W5-289.

35. *Id.*; *see also* FUCHS, *supra* note 7, at 4; ALLIANCE FOR HEALTH REFORM, *supra* note 30, at 5.

36. *Assessment of Current Plan*, HEALTH POLL REPORT (The Henry J. Kaiser Family Found.), Sept.-Oct. 2004, at 4, *available at* http://www.kff.org/healthpollreport/Oct_2004/upload/healthpoll_oct04.pdf ("People who purchase their own insurance are less likely to say they feel well protected by their insurance (43%) than people who are insured through their employers (58%). Nearly six in ten (57%) self-purchasers are at least somewhat worried that their health plan will not pay for their health care needs (including 11% who say their insurance is inadequate and they feel very worried).").

37. 15 U.S.C. §§ 1011-1015 (2000).

38. FUCHS, *supra* note 7, at 7-9.

39. *See generally id.* (defining and summarizing types of reforms); TURNBULL & KANE, *supra* note 15, at 2-3 (same). For case studies of regulations in individual states, see Mark A.

Another key area of state regulation is aimed at the adequacy of coverage, addressed through mandated benefit laws that require insurers to offer or cover a specific provider, procedure, or benefit.[40] For example, Massachusetts law requires that all health insurance policies that provide coverage for pregnancy-related benefits must provide the same extent of "coverage for medically necessary expenses of diagnosis and treatment of infertility."[41] About one-third of the states have enacted some type of mandated benefit law requiring insurers to offer or to cover certain infertility treatments.[42] According to the Kaiser Family Foundation, "Over the last few years, an increasing number of states have enacted mandated benefits and consumer protection laws, and the scope of these laws has expanded."[43]

State efforts to reform the individual market to increase access and affordability have met with mixed results.[44] Many who turn to the individual market for coverage still find themselves unable to get, keep, or afford coverage. According to one survey, more than half of those polled said that it was "difficult or impossible to find a[n individual policy] to fit their health needs," and two-thirds said that it was "difficult or

Hall, *An Evaluation of New York's Reform Law*, 25 J. HEALTH POL. POL'Y & L. 71 (2000); Mark A. Hall, *An Evaluation of Vermont's Reform Law*, 25 J. HEALTH POL. POL'Y & L. 101 (2000); Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. HEALTH POL. POL'Y & L. 133 (2000); Katherine Swartz & Deborah W. Garnick, *Lessons from New Jersey*, 25 J. HEALTH POL. POL'Y & L. 45 (2000).

40. There are a few federal mandates. For example, ERISA has been amended to require that health care benefit plans include coverage for post-delivery hospital stays, 29 U.S.C. § 1185(a) (2000), and to require coverage for certain post-mastectomy treatment and care, including reconstruction, 29 U.S.C. § 1185b(a).

41. MASS. GEN. LAWS ch. 175, § 47H (2004). The Massachusetts Health Care Reform plan currently includes all presently mandated benefits, although there is a moratorium on new mandated benefits until January 1, 2008, when the State will complete a study of the cost and necessity of existing mandates. 2006 Mass. Legis. Serv. 121 (West).

42. A summary of state infertility insurance coverage laws can be found at the webpage of the National Conference of State Legislatures. Nat'l Conference of State Legislatures, 50 State Summary of State Laws Related to Insurance Coverage for Infertility Therapy, http://www.ncsl.org/programs/health/50infert.htm (last visited Mar. 22, 2007). Of course, employers may choose to include infertility treatment in their health plans absent a state mandate. *See* Mercer Health & Benefits, Employer Experience with, and Attitudes Toward, Coverage of Infertility Treatment (May 31, 2006) (copy on file with author) (finding that of those surveyed, approximately 50 percent of employers covered evaluation of infertility, 37 percent covered drug therapies, and 20 percent covered "in vivo" or "in vitro" fertilization. Moreover, more than two-thirds have been providing infertility coverage at their current level for more than five years).

43. TRENDS AND INDICATORS, *supra* note 1, § 4 exhibit 4.12.

44. *See, e.g.*, FUCHS, *supra* note 7, at 9-14 (discussing findings based on a review of the literature); TURNBULL & KANE, *supra* note 15, at vi-viii (summarizing findings based on an assessment of reforms in seven states that adopted different approaches).

impossible to find an affordable" individual policy.[45] As a result, less than one third of those who considered individual coverage actually purchased a policy.[46]

II. PROPOSED SOLUTION: THE HEALTH CARE CHOICE ACT

The Health Care Choice Act of 2005 claims to address barriers to the individual market by increasing access and affordability. Under current law, health insurance is regulated by each state, so individuals must buy health insurance coverage in the state in which they live.[47] If passed, the HCCA would allow health insurers to offer individual policies of insurance from any state without being required to comply with the laws of the insured's home state.

The insurer could file an individual heath insurance policy in a state of its choosing,[48] the "primary state," and then sell that coverage in other states, the "secondary states."[49] In general, the laws of the primary state would apply to individual health insurance coverage offered in the primary state or in any secondary state.[50] Insurers would be exempt from laws in the secondary states such as guaranteed issue laws, guaranteed renewal laws, rating reforms, and, significantly, mandated benefit laws.[51] However, insurers would not be exempt from laws of the secondary states regarding taxes, registration, financial examination, compliance with certain court orders, participation in high-risk pools, and fraud, abuse, and unfair claims practices.[52]

45. DUCHON ET AL., *supra* note 12, at 24; *see also* POLLITZ ET AL., *supra* note 12 (examining the application process of seven hypothetical consumers in the individual insurance market).

46. DUCHON ET AL., *supra* note 12, at 24 (reporting that "[o]nly 28 percent purchased a[n individual health] plan").

47. Under the McCarran-Ferguson Act, regulation of insurance is reserved to the individual states. 15 U.S.C. § 1012(b) (2000) ("No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.").

48. Health Care Choice Act of 2005, H.R. 2355, sec. 4(a), Pt. D., § 2795(1), 109th Cong. (2005). There are certain minimum requirements: the primary state must use a risk-based capital formula for solvency, and have an independent external review law or rules, unless the insurer's independent review process is the functional equivalent of the National Association of Insurance Commissioners' model act. H.R. 2355, sec. 4(a), Pt. D., § 2797.

49. H.R. 2355, sec. 4(a), Pt. D., § 2796(a)(1) (defining "primary state" and "secondary state"). Any coverage offered in a secondary state must also be offered in the insurer's primary state. H.R. 2355, sec. 4(a), Pt. D., § 2796(e).

50. H.R. 2355, sec. 4(a), Pt. D., § 2796(a).

51. H.R. 2355, sec. 4(a), Pt. D., § 2796(b). The HCCA does prohibit the insurer from reclassifying an insured based on health-status factors at renewal, or increasing premiums based on health status or claims history. H.R. 2355, sec. 4(a), Pt. D., § 2796(d).

52. H.R. 2355, sec. 4(a), Pt. D., § 2796(b).

Accordingly, individuals would be free to purchase policies filed in states other than their own. Policies and renewal policies sold in secondary states would be required to include a "clear and conspicuous disclosure" that the policy is governed by the law of the primary state.[53] Insurers would be permitted to change designation of the primary state upon renewal, but would be required to provide notice of such change to the insurance commissioners of the primary and secondary state.[54]

Finally, the primary state would have sole jurisdiction to enforce its applicable laws.[55] The secondary state may enforce only those laws from which the insurer is exempt, and may notify the applicable authorities of the primary state of any suspected violation of the primary state's laws.[56]

III. A BAD CHOICE?

The HCCA has received little attention, perhaps because the individual insurance market is small, and because the HCCA was overshad-

53. H.R. 2355, sec. 4(a), Pt. D, § 2796(c). Policies must provide the following notice:

> This policy is issued by ____ and is governed by the laws and relations of the State of ____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of ____, including coverage of some services or benefits mandated by the law of the State of ____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of ____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.

Id.

54. H.R. 2355, sec. 4(a), Pt. D, § 2796(g). Subsection (g) requires, inter alia:

> Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—(1) to the insurance commissioner of each State in which it intends to offer such coverage . . . a copy of the plan of operation or feasibility study . . . written notice of any change in its designation of its primary State; and . . . written notice from the issuer of the issuer's compliance with all the laws of the primary State.

Id.

55. H.R. 2355, sec. 4(a), Pt. D, § 2798(a).

56. H.R. 2355, sec. 4(a), Pt. D., § 2798(d). Some opponents of the HCCA have raised concerns regarding the effectiveness of enforcement under this section. *See, e.g.*, FAMILIES USA, H.R. 2355: THE WRONG PRESCRIPTION FOR AMERICA'S HEALTH CARE NEEDS 2 (2006), *available at* http://www.familiesusa.org/assets/pdfs/bad-ideas-shadegg-hr-2355.pdf. This is of concern in light of previous findings regarding fraud in the individual market. *See, e.g.*, *Health Insurance Challenges: Buyer Beware: Hearing Before the S. Comm. on Finance*, 108th Cong. 40 (2004) (statement of Robert J. Cramer, Managing Dir., Off. of Special Investigations, U.S. Gen. Accounting Off.) ("At least 15,000 employers purchased coverage from unauthorized entities, affecting more than 200,000 policyholders from 2000 through 2002.").

owed by the Enzi Bill, which was aimed at the small-group market.[57] But it is worth examining because it represents a bad choice for the individual market. It does not appear that the HCCA would lower costs for most purchasers, increase meaningful choices, or reduce the overall number of uninsured. Instead, it may further erode protections under state law, and undercut the role of the states in regulating health insurance products and protecting their citizens.

A. *Cost*

Supporters of the HCCA[58] claim that the cost of individual health insurance would be lowered by offering consumers choices across state lines. As explained by Senator Jim DeMint:

> Consumers can choose the policy that best suits their needs, and their budget, without regard to State boundaries. Individuals looking for basic health insurance coverage can opt for a policy with few benefit mandates, and such a policy will be more affordable. On the other hand, consumers who have an interest in a particular benefit, such as infertility treatments, will be able to purchase a policy which in-

57. Health Insurance Marketplace Modernization and Affordability Act of 2005 (Enzi), S. 1955, 109th Cong. (2005).

58. Supporters of the HCCA include: Alliance for Affordable Services; Americans for Tax Reform; Chamber of Commerce of the United States; Council for Affordable Health Insurance; eBay; Latino Coalition; The Maine Heritage Policy Center; National Association for the Self-Employed; National Association of Insurance Commissioners; National Center for Policy Analysis; National Federation of Independent Business; National Taxpayers Union; Small Business & Entrepreneurship Council; and Steve Forbes. *See, e.g.*, Letter from Angela M. Hunter, Council for Affordable Health Ins., Dir. of Fed. Affairs, to Rep. John Shadegg (May 12, 2005), *available at* http://www.cahi.org/cahi_contents/issues/HR2355supportltr.pdf; Letter from William Callaghan, President, Alliance for Affordable Servs., to Rep. John Shadegg (May 5, 2005) (on file with the author); Letter from Paul J. Gessing, Nat'l Tax Payers Union, Dir. of Gov't Affairs, to Rep. John Shadegg (May 12, 2005), *available at* http://www.cahi.org/cahi_contents/issues/NTUltr05-11-05ShadeggHealthCare.pdf; Press Release, Me. Heritage Pol'y Ctr., Free-Market Health Insurance Reform Introduced to John Shadegg (May 12, 2005), *available at* http://www.cahi.org/cahi_contents/issues/MaineHeritagePolicyPR05.12.pdf; Letter from Grover G. Norquist, President, Am. for Tax Reform, to Sen. Jim DeMint (May 17, 2005) (on file with the author); Letter from Dan Danner, Executive Vice President, Public Pol'y & Pol., Nat'l Fed'n of Indep. Bus., to Rep. John Shadegg (May 11, 2005), *available at* http://www.cahi.org/cahi_contents/issues/NFIBsupportltr05.pdf; Letter from Tod H. Cohen, Vice President, Global Gov't Relations, eBay, to Rep. John Shadegg (May 10, 2005), *available at* http://www.cahi.org/cahi_contents/issues/latinocoalitionsupportltr05.pdf; Letter from Robert G. de Posada, President, Latino Coalition, to Rep. John Shadegg (May 10, 2005), *available at* http://www.cahi.org/cahi_contents/issues/latinocoalitionsupportltr05.pdf; Letter from Robert Hughes, President, Nat'l Assoc'n for the Self-Employed, to Rep. John Shadegg (June 20, 2005), *available at* http://www.cahi.org/cahi_contents/issues/NASEsupportltr0705.pdf.

cludes that benefit.[59]

The argument is that state laws, and mandated benefit laws in particular, make health insurance more expensive.[60] For example, insurance industry advocacy groups such as the Council for Affordable Health Insurance (CAHI)[61] have stated that "in certain states, mandated benefits have increased the cost of individual health insurance by as much as 45%."[62] Another study, by the Cato Institute, claims that state mandated benefit laws have a net cost of $13.5 billion.[63] Therefore, supporters of the HCCA argue, if consumers were able to purchase individual health insurance policies from other states—presumably states with fewer mandated benefits and protections—their coverage would cost less.

The claim that state mandated benefit laws dramatically increase the cost of individual coverage is "the traditional defense by the insurance industry against coverage mandates of all sorts."[64] Although the impact of mandated coverage on health care premiums is an issue, the core assumption that state mandated benefit laws dramatically increase

59. 151 CONG. REC. S5073 (daily ed. May 12, 2005) (statement of Sen. DeMint), *available at* http://www.senate.gov/~finance/hearings/testimony/2005test/040606jdtest.pdf.

60. In the words of Senator DeMint, "The cost of insurance is often increased by excessive State regulations. These State mandates raise the cost of insurance which, in turn, increases the number of Americans who are priced out of the health insurance market." *Id.* Conservative and industry advocacy groups also criticize guaranteed issue and community rating laws. *See, e.g.*, CONRAD F. MEIER, DESTROYING INSURANCE MARKETS: HOW GUARANTEED ISSUE AND COMMUNITY RATING DESTROYED THE INDIVIDUAL INSURANCE MARKET IN EIGHT STATES (2005), *available at* http://www.cahi.org/cahi_contents/resources/pdf/destroyinginsmrkts05.pdf. The first finding in the text of the HCCA appears to adopt this argument: "The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable health insurance coverage, thereby impeding commerce in individual health insurance coverage." H.R. 2355, sec. 3(1).

61. According to its webpage, the Council for Affordable Health Insurance is "a nonprofit research and advocacy association whose mission is to develop and promote free market solutions to America's health care challenges." Press Release, Council for Affordable Health Ins., CAHI Applauds Florida's HSA for State Employees (Oct. 11, 2006), *available at* http://www.cahi.org/article.asp?id=697.

62. COUNCIL FOR AFFORDABLE HEALTH INS., 2006 STATE LEGISLATORS' GUIDE TO HEALTH INSURANCE SOLUTIONS 23-25 (2006) [hereinafter 2006 STATE LEGISLATORS' GUIDE TO HEALTH INSURANCE SOLUTIONS], *available at* http://www.cahi.org/cahi_contents/resources/pdf/2006StateLeg.pdf (reporting that "as many as one in four individuals who are without coverage are uninsured because of the cost of state health benefits mandates").

63. Christopher J. Conover, *Health Care Regulation: A $169 Billion Hidden Tax*, CATO INST., Oct. 4, 2004, at 13, *available at* http://www.cato.org/pubs/pas/pa527.pdf.

64. Adam Sonfield, *Drive for Insurance Coverage of Infertility Treatment Raises Questions of Equity, Cost*, THE GUTTMACHER REP., Oct. 1999, at 4, 5, *available at* http://www.guttmacher.org/pubs/tgr/02/5/gr020504.pdf.

the cost of individual insurance bears close scrutiny. Indeed, according to the report of the Congressional Budget Office generated in connection with the HCCA, "[even if] only those benefit mandates imposed by the states with the lowest-cost mandates were in effect in all states, the price of individual health insurance would be reduced by about 5 percent, on average."[65]

Consider state mandates requiring coverage of infertility treatment, frequently singled out as an example of expensive and optional treatment,[66] including in the HCCA's legislative history.[67] Opponents of state laws mandating equitable coverage of infertility treatment, such as the law in Massachusetts, would argue that increased coverage of treatments for infertility, in particular in vitro fertilization,[68] would dramatically increase the cost of coverage. However, this argument is unconvincing because there is evidence that the cost of including comprehensive coverage of infertility treatment is overstated.[69] Past studies have reported estimated cost increases from $20 to $175 per year.[70] One recent study of more than 900 employers found that 91 percent of employers who provided infertility coverage for their employees did not experience an increase in their medical costs as a result of providing coverage for infertility treatment, including employers offering coverage of in vitro fertilization.[71] Of course, cost data from the group

65. CBO COST ESTIMATE, *supra* note 23, at 4.

66. Sonfield, *supra* note 64, at 5 (stating that "'infertility treatment is sometimes lumped together with cosmetic surgery as a life-style type procedure, rather than considered serious medicine'" (internal quotation marks omitted) (quoting Deborah Wachenheim of RESOLVE)); *see also* Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 343 (2004) [hereinafter Pendo, *The Politics of Infertility*].

67. 151 CONG. REC. S5073 (daily ed. May 12, 2005) (statement of Sen. DeMint), *available at* http://www.senate.gov/~finance/hearings/testimony/2005test/040606jdtest.pdf.

68. "In vitro" fertilization is a process in which the ova are removed from the woman's body by laproscopy, fertilized with semen from her partner or a donor, incubated in a laboratory dish until an embryo develops, and then transferred to the woman's uterus. RESOLVE, RESOLVING INFERTILITY: UNDERSTANDING THE OPTIONS AND CHOOSING SOLUTIONS WHEN YOU WANT TO HAVE A BABY 176-77, 179-83 (Diane Aronson, ed., 1999).

69. *See* Pendo, *The Politics of Infertility*, *supra* note 66, at 340-42 (discussing costs of comprehensive treatment of infertility).

70. Jane Gross, *The Fight to Cover Infertility: Suit Says Employer's Refusal to Pay is Form of Bias*, N.Y. TIMES, Dec. 7, 1998, at B1, *available at* 1998 WLNR 2965792 (Westlaw) ("A study in Massachusetts, based on actual experience, found that the additional cost of such coverage was $1.71 a month per member. Other studies, based on projections, put the cost at about $3 a year."); Shorge Sato, Note, *A Little Bit Disabled: Infertility and the Americans with Disabilities Act*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 189, 197-200 (2001) (stating that the National Center for Policy Analysis "alleged a much higher premium increase . . . raising the cost of a policy from $105 to $175 per year").

71. There is also evidence that comprehensive coverage of infertility treatment could

market is not readily transferable to the individual market due to decreased risk pooling, but it does suggest that cost arguments against state mandates should be scrutinized.

While evidence that the HCCA would significantly reduce the cost of individual policies overall is far from convincing, it does appear likely that allowing people to purchase less comprehensive policies across state lines would reduce the cost of such policies for some. As noted by the Congressional Budget Office, the HCCA 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."[72] This creates the risk of adverse selection, a process by which people who have higher health care costs seek health insurance at a disproportionate rate to people who have (or think they have) relatively lower health care costs.[73] Similarly, under the HCCA, individuals with relatively low health care costs could choose cheaper out-of-state policies, thus increasing the proportion of people with higher health care costs and ultimately eroding the availability of more comprehensive coverage in the home state. This causes the pool of people to lose its healthier members and costs to increase, a process called the "death spiral."[74] Indeed, studies of state reforms suggest that if insurers organized in weaker-regulation states, as permitted under the HCCA, older and less-healthy consumers could have difficulty getting coverage.[75]

achieve cost savings, at least in the group market. Sato, *supra* note 70, at 198-99; *see also* Pendo, *The Politics of Infertility*, *supra* note 66, at 342-43.

72. CBO COST ESTIMATE, *supra* note 23, at 13.

73. Professor Mary Crossley made a similar argument with respect to health savings accounts. Mary Crossely, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 136-37 (2005).

74. *See* CLAUDIA H. WILLIAMS & BETH C. FUCHS, THE ROBERT WOOD JOHNSON FOUND., POLICY BRIEF NO. 4, at 2 (2004), *available at* http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no4_policybrief.pdf (discussing "adverse selection"); NANCY C. TURNBULL ET AL., INSURING THE HEALTHY OR INSURING THE SICK? THE DILEMMA OF REGULATING THE INDIVIDUAL HEALTH INSURANCE MARKET: SHORT CASE STUDIES OF SIX STATES 20 (2005), *available at* http://www.cmwf.org/usr_doc/790_turnbull_insuring_healthy_or_sick_case_studies.pdf (discussing "adverse selection spiral").

75. *See* TURNBULL & KANE, *supra* note 15, at vii ("In the four states with weaker regulations a significant percentage of applicants—as many as 30 percent to 40 percent for some carriers—is rejected for coverage, leaving these people with no option except high-risk pools with very expensive premiums.").

B. *Access*

Opponents of the HCCA[76] also note that without decreasing costs and increasing choice, it appears unlikely that the HCCA would significantly reduce the number of uninsured. Indeed, the Congressional Budget Office predicted that the HCCA would not lead to a significant net increase in the number of people with insurance,[77] although there could be a shift of approximately one million people from employer-sponsored coverage to the individual market.[78] In light of the problems with individual coverage outlined above, simply shifting one million people from employer-sponsored coverage to the individual market not only fails to solve the problem, but also appears to make it worse.[79]

76. Opponents of the HCCA include: AFL-CIO; Alliance for Advancing Nonprofit Health Care; Alliance for Children & Families; American Academy of Child & Adolescent Psychiatry; American Academy of HIV Medicine; American Academy of Physician Assistants; American Association for Geriatric Psychiatry; American Association for Marriage and Family Therapy; American Association of People with Disabilities; American Chiropractic Association; American College of Nurse-Midwives; American Counseling Association; American Federation of State, County and Municipal Employees; American Group Psychotherapy Association; American Nurses Association; American Occupational Therapy Association; American Podiatric Medical Association; American Psychological Association; American Psychotherapy Association; American Society of Pediatric Nephrology; Anxiety Disorders Association of America; Association for the Advancement of Psychology; Association of University Centers on Disabilities; Clinical Social Work Guild 49, OPEIU; Commission on Social Action of Reform Judaism; Committee of Ten Thousand; Communications Workers of America; Consumers Union; Delta Dental Plans Association; Depression and Bipolar Support Alliance; Eating Disorders Coalition for Research, Policy and Action; Family USA; Foundation for Taxpayer and Consumer Rights; HIP Health Plan of New York; Hemophilia Federation of America; International Brotherhood of Electric Workers; NAADAC, Association for Addiction Professionals; NETWORK, a National Catholic Social Justice Lobby; National Association of Anorexia Nervosa and Associated Disorders; National Association of Social Workers; National Council for Community Behavioral Healthcare; National Council of Jewish Women; National Disability Rights Network; National Health Law Program; National Hemophilia Foundation; National Mental Health Association; National Multiple Sclerosis Society; National Partnership for Women and Families; National Women's Law Center; Public Citizen; Service Employees International Union; Suicide Prevention Action Network USA; The Arc of the United States; U.S. PIRG; United Cerebral Palsy. *See* Letter from Nat'l Partnership for Women & Families, to J. Dennis Hastert, Speaker of the House, U.S. H. of Reps. (June 20, 2006), *available at* http://www.aapd-dc.org/policies/so060622hr2355.htm.

77. CBO COST ESTIMATE, *supra* note 23, at 7 ("CBO estimates that enacting H.R. 2355 would not have a substantial effect on the number of people who have health insurance coverage: compared to current law, there could be a small increase or decrease in the number of uninsured individuals.").

78. *Id.* at 5 ("CBO estimates that H.R. 2355 ultimately would reduce annual spending on employer-sponsored health insurance by $5 billion in 2006 dollars."); *see also id.* at 1 ("The increase in revenues would result largely from a reduction in the number of people who receive health insurance through employer-sponsored plans. That would reduce the share of compensation that is tax-advantaged . . . and increase the share that is taxable . . . .").

79. Nor is there strong evidence that bypassing state law mandates and consumer protections would increase consumer choice, as several studies have shown that a few insurers

C. *Adequacy*

Those who are able to access and afford individual coverage may find themselves underinsured, particularly if they choose a less comprehensive policy.[80] In addition, the HCCA would do little to reduce cost sharing such as deductibles and co-insurance, or administrative costs, all of which are higher with individual plans.[81]

D. *Eroding State Mandates*

As described above, the HCCA would permit health insurers to sell policies from the states with the fewest consumer protections, and to market and sell those policies to consumers in all other states. As noted above, several states have begun to require equitable coverage of infertility treatment. Under the HCCA, an insurer from outside these states would be permitted to sell a policy of insurance to citizens of these states without these protections. In this respect, the HCCA may do to the individual insurance market what preemption under the Employee Retirement Income Security Act of 1974[82] (ERISA) has done to self-funded group plans.

It is well-known that state law mandates requiring coverage of certain conditions or treatments are unlikely to lead to uniform results be-

dominate the individual insurance market. TURNBULL & KANE, *supra* note 15, at viii (emphasis omitted) ("A few carriers in each state dominate the individual health insurance market, a trend that has strengthened over time."); THE HENRY J. KAISER FAMILY FOUND., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE—SECTION 5: TRENDS IN THE STRUCTURE OF THE HEALTH CARE MARKETPLACE exhibit 5.12, *available at* http://www.kff.org/insurance/7031 (follow the "Section 5" hyperlink) (last visited Mar. 22, 2007); FUCHS, *supra* note 7, at 3 (citation omitted) ("While hundreds of insurance companies and health plans still sell in the individual market, only a few insurers account for 50 percent or more of the market in any state.").

80. "Underinsured" is generally understood as "[h]aving coverage that is inadequate, either because it includes high copayments and deductibles or because important costs are not covered." NAT'L CONFERENCE OF STATE LEGISLATURES, FORUM FOR STATE HEALTH POLICY LEADERSHIP, FREQUENTLY ASKED QUESTIONS, ACCESS AND THE UNINSURED 13, *available at* http://www.ncsl.org/programs/health/forum/faqaccess.pdf.

81. *See* ALLIANCE FOR HEALTH REFORM, *supra* note 30, at 5; Gabel et al., *Individual Insurance*, *supra* note 8, at W173 (citation omitted) ("Fees paid to insurance agents often constitute 10-15 percent of the premium dollar. Whereas administrative expenses consume about 25-40 percent of each premium dollar for individual insurance, they account for about 10 percent of each premium dollar among large employer groups and 15-25 percent in the small-group market."); Mark V. Pauly & Allison M. Percy, *Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets*, 25 J. HEALTH POL. POL'Y & L. 9, 18 (2000) (stating that administrative loading on individual policies is one-third to one-half of premiums, in excess of the 5 to 30 percent for group policies).

82. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (2000)).

cause of the structure of the preemption provisions of ERISA.[83] ERISA, which regulates employer-sponsored welfare benefit plans including health benefit plans,[84] "contains a broad preemption clause that preempts state law insofar as it 'relates to' employee benefit plans, and ERISA provides the exclusive remedial scheme for ERISA benefits claims."[85] ERISA preemption has three parts. First, the "preemption clause" provides that ERISA supersedes any and all state laws that relate to any employee benefit plan.[86] Second, the "savings clause" exempts specific state laws regulating insurance, banking, and securities law from preemption.[87] Third, under the "deemer clause," self-funded[88] employee welfare plans cannot be deemed insurance plans, and therefore will not be subject to specific state regulation.[89]

Because self-funded plans cannot be deemed insurance plans, state laws directed at insurance are not saved with respect to self-funded plans, and self-funded plans have not been considered subject to specific state regulation.[90] In the context of state laws mandating coverage of a certain treatment or condition, it is well accepted that the structure of ERISA preemption leads to dramatically different results because such laws apply to insured plans, but not to self-funded plans.[91] For example, state laws mandating coverage, such as the Massachusetts law mandating equitable coverage of infertility treatment, apply to most non-ERISA plans, such as individual policies, and to ERISA plans that are insured, but not to self-funded plans. The HCCA could do to the individual market what ERISA has done in the employer-based system—introduce an increasingly inequitable pattern of protection for people with individual

83. *See, e.g.*, Pendo, *The Politics of Infertility*, *supra* note 66, at 302; 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, 491-92 (1998); John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 352-61 (1997).

84. ERISA § 3(1), 29 U.S.C. § 1002.

85. Pendo, *The Politics of Infertility*, *supra* note 66, at 309.

86. ERISA § 514(a), 29 U.S.C. § 1144(a).

87. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

88. "A self-funded plan is one in which the plan sponsor, rather than a health insurer, assumes the risk of covering the costs of the health care benefits provided by the terms of the plan." Colleen E. Medill et al., *Coverage of Reproductive Technologies under Employer-Sponsored Health Care Plans*, 8 EMP. RTS. & EMP. POL'Y J. 523, 541 (2004).

89. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).

90. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B); FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (interpreting the deemer clause broadly to exempt self-funded, ERISA-regulated plans from state regulation and state law claims).

91. *See* Pendo, *The Politics of Infertility*, *supra* note 66, at 312 n.101 (discussing deemer clause exemptions of self-funded plans from other state laws, and the regulation of self-insured plans generally).

coverage, even within the same state.

IV. THE POLITICS OF "CHOICE"

The HCCA is an example of the current political approach to our health care crisis. Although it is aimed at one small part of the overall health insurance market and although it may not pass,[92] it is representative of the larger political approach to health care policy, focused on individual, market-based solutions to the health care crisis. With respect to the individual market, the current administration is proposing tax-credits for the purchase of individual policies,[93] and supporters of the HCCA are also urging similar reforms to the individual market, including an optional federal charter, allowing insurers to file plans with the federal government and then sell insurance in any state, and an interstate compact permitting multi-state association.[94] In the insurance market generally, the administration is promoting the use of health savings accounts in connection with a high-deductible policy, a combination referred to as a consumer-driven health plan.[95]

As Deborah Stone stated in her influential article, *The Struggle for the Soul of Health Insurance*, "The politics of American health insurance is a struggle over which vision of distributive justice should govern: the solidarity principle or the logic of actuarial fairness."[96] In Stone's view, the solidarity principle recognizes that insurance is a form of mutual aid

92. As reported by Hewitt Associates, "It is unclear if Congress will address [the HCCA] this year. House leaders are reluctant to bring H.R. 2355 to the floor since it may not have enough votes for approval." HEWITT ASSOCS., HEWITT FEDERAL LEGISLATION QUICK GUIDE, PENDING LEGISLATION—HEALTH AND WELFARE PLANS 12 (2006), *available at* http://www.hewittassociates.com/_MetaBasicCMAssetCache_/Assets/Legislative%20Updates/Quick%20Guide/hc_080806.pdf.

93. *See* Making Health Care More Affordable and Accessible for All Americans, *supra* note 9.

94. 2006 STATE LEGISLATORS' GUIDE TO HEALTH INSURANCE SOLUTIONS, *supra* note 62, at 35.

95. *See* Pendo, *Images of Health Insurance in Popular Film*, *supra* note 6, at 291-93 (discussing the shift toward consumer-directed health plans). The Medicare Prescription Drug Improvement and Modernization Act of 2003 amended the Internal Revenue Code to authorize the use of tax-favored health savings accounts in connection with a high-deductible health insurance policy. Pub. L. No. 108-173, § 1201, 117 Stat. 2066, 2469 (2003). The combination is referred to as the consumer-driven health plan. *See* Pendo, *Images of Health Insurance in Popular Film*, *supra* note 6, at 291-93.

96. Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 287 (1993) [hereinafter Stone, *The Struggle for the Soul of Health Insurance*] ("Redistribution from the healthy to the sick is built into insurance. Payouts are made on the basis of need (or loss incurred) not on the basis of contribution to the scheme. . . . [S]ubsidy from the vast majority of policyholders to a small minority is precisely what is supposed to happen in insurance.").

and collective responsibility, and that redistribution from the healthy to the sick is a necessary part of health insurance.[97] Indeed, Stone describes broad-based, inclusive systems of insurance as a social good:

> To participate in a risk-pooling scheme is to agree to tax yourself not only for your own benefit should you incur a loss, but also for the benefit of others who might suffer from loss when you do not. Insurance thus creates what might be called a "moral opportunity," the opportunity to cooperate with and help others.[98]

Despite the powerful influence of a conservative free-market ideology, "health insurance in the United States began as a social enterprise, and the concept of health insurance as a collective concern continues to resonate with the public."[99]

In the context of the individual insurance market, state reforms which have attempted to make coverage more accessible and affordable (particularly to those who need it most), and to pool risk across a larger number of people, have exemplified the social solidarity point.[100] For example, according to a survey of the literature, comprehensive state reforms to the individual market made coverage more expensive on average, although it did increase affordability and access to coverage for those who needed it most.[101]

In contrast, the principle of actuarial fairness, which Stone defines as "each person paying for his own risk," rejects redistribution from the healthy to the sick.[102] Instead, it seeks to divide and categorize people into small, discrete groups based on individually assessed risks.[103] As such, it is highly individualistic, and aligned with the interests of private insurers in a competitive market: "Public policy has, for over a century, both permitted and exhorted insurers to compete in the market, on the theory that competition would breed innovation, efficiency, and ultimately public welfare."[104]

The HCCA and similar proposals follow the logic of actuarial fair-

97. *Id.* at 292.

98. Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 14 (1999).

99. Pendo, *Images of Health Insurance in Popular Film*, *supra* note 6, at 293 (citing Victor R. Fuchs, *What's Ahead for Health Insurance in the United States?*, 346 NEW ENG. J. MED. 1822, 1822 (2002)).

100. Thomas R. Oliver, *Dynamics Without Change: The New Generation*, 25 J. HEALTH POL. POL'Y & L. 225, 226 (2000) (referring to the work of Len M. Nichols).

101. FUCHS, *supra* note 7, at 12.

102. *See* Crossley, *supra* note 73, at 77.

103. Stone, *The Struggle for the Soul of Health Insurance*, *supra* note 96, at 290.

104. *Id.* at 313.

ness by touting individual choice and freedom as the solution to a variety of problems with the individual market.[105] People in need of insurance are seen as autonomous, individual consumers, free to make choices in the market.[106] As Stone explains,

> In the competitive market, customers would shop around for the best deals to suit their budgets and their risk preferences. Those who know (or think) they have a low risk for particular diseases would buy just the policies tailored to their own risk profiles. Through self-selection and pursuit of the almighty bargain, individuals would sort themselves into homogenous risk classes, albeit perhaps not as refined as the classes achieved though underwriting. The market could accomplish for insurers what government forbids them to do themselves.[107]

This is echoed in the words of Senator DeMint:

> The Health Care Choice Act will allow consumers to shop for health insurance the same way they do for other insurance products—online, by mail, over the phone, or in consultation with an insurance agent in their hometown. The Act empowers consumers by giving them the ability to purchase an affordable health insurance policy with a range of options.[108]

"'[C]hoice' also includes individual responsibility to make the right choices in terms of price and quality and the individual obligation to bear the consequences of such choices."[109] As scholars of neo-liberalism in health care policy have noted, current health care policy is "increasingly requiring that individuals take personal responsibility for their own future and purchase goods and services which are designed to meet their personal requirements."[110] Moreover, failure to make the right choices is seen as a personal failure, rather than a failure of the system to provide adequate options.[111] Not surprisingly, scholars looking at

105. I have written previously about this conception of "choice" in the context of consumer-driven health plans. *See* Pendo, *Images of Health Insurance in Popular Film*, *supra* note 6, at 291-93.

106. Alan Peterson, *Risk, Governance and the New Public Health*, *in* FOUCAULT, HEALTH AND MEDICINE 189, 194 (Alan R. Petersen & Robin Bunton, eds., 1997) (citation omitted) ("[N]eo-liberal rationality emphasises [sic] the entrepreneurial individual, endowed with freedom and autonomy, and the capacity to properly care for him- or herself.").

107. Stone, *The Struggle for the Soul of Health Insurance*, *supra* note 96, at 314.

108. 151 CONG. REC. S5073 (daily ed. May 12, 2005) (statement of Sen. DeMint), *available at* http://www.senate.gov/~finance/hearings/testimony/2005test/040606jdtest.pdf.

109. Pendo, *Images of Health Insurance in Popular Film*, *supra* note 6, at 293.

110. Sarah Nettleton, *Governing the Risky Self: How to Become Healthy, Wealthy and Wise*, *in* FOUCAULT, HEALTH AND MEDICINE, *supra* note 106, at 208.

111. This is a strain of neo-liberal theory that some scholars have applied to health care

reforms to the individual market have raised "fundamental questions about the role of competitive markets in promoting access to health care."[112] As one author has noted, "Are all the choices in benefits, cost-sharing, premiums, and market entry and exit really that valuable, though, for most customers? To argue that one can get a good price if one is 'aggressive, informed, interested, and lucky' is not comforting."[113]

CONCLUSION

The increasingly high cost of health care and the growing number of Americans without insurance are again making health care reform a prominent national issue. Lack of insurance hurts the health and finances of people without insurance[114] and people with insurance, who bear the burden of increased premiums.[115] It also damages the national economy, costing $65 to $130 billion according to one estimate.[116] Public support for health care reform is also high.[117] A recent survey

policy. *See, e.g.*, Monica Greco, *Psychosomatic Subjects and the 'Duty to be Well': Personal Agency Within Medical Rationality*, 22 ECON. & SOC'Y 357, 361 (1993) ("If the regulation of life-style, the modification of risky behaviour and the transformation of unhealthy attitudes prove impossible though sheer strength of will, this constitutes, at least in part, *a failure of the self to take care of itself*—a form of irrationality, or simply a lack of *skillfulness* . . . ."); Peterson, *supra* note 106, at 194 ("[S]ince the mid-1970s, there has been a clear ideological shift away from the notion that the state should protect the health of individuals to the idea that individuals should take responsibility to protect themselves from risk.").

112. Robert B. Hackey, *The Politics of Reform*, 25 J. HEALTH POL. POL'Y & L. 211, 211 (2000).

113. Oliver, *supra* note 100, at 227-28.

114. For an overview of the uninsured and access to care, see Pendo, *Images of Health Insurance in Popular Film*, *supra* note 6, at 280-82.

115. *See, e.g.*, FAMILIES USA, PAYING A PREMIUM: THE ADDED COST OF CARE FOR THE UNINSURED 1 (2005), *available at* http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf ("In 2005, premium costs for family health insurance coverage provided by private employers will include an extra $922 in premiums due to the cost of care for the uninsured; premiums for individual coverage will cost an extra $341.").

116. Paul Fronstin & Ray Werntz, *The "Business Case" for Investing in Employee Health: A Review of the Literature and Employer Self-Assessments*, EMP. BENEFIT RES. INST., Mar. 2004, at 7, 8, *available at* http://www.ebri.org/pdf/briefspdf/0304ib.pdf.

117. THE HENRY J. KAISER FAMILY FOUND., THE PUBLIC, MANAGED CARE, AND CONSUMER PROTECTIONS, KAISER PUBLIC OPINION UPDATE 2 (2001), *available at* http://www.kaisernetwork.org/health_cast/uploaded_files/PublicOpinionUpdate1.pdf (stating that "at least three out of four Americans support[] such laws over time"); *Attitudes Toward the United States' Health Care System: Long-Term Trends*, HEALTH CARE NEWS, Aug. 21, 2002, at 1, 1-5 *available at* http://www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2002Vol2_Iss17.pdf (discussing a 2002 poll, which showed that the prior-documented gaps between the views of the public, physicians, employers, hospital managers, and health plan managers have

showed that most people felt that our health care system needs either "fundamental change" or "complete rebuilding," and that expanding coverage and controlling costs should be top priorities for federal action.[118] Despite the claims of its proponents, the HCCA is unlikely to solve the problems of affordability and access that it claims to address, and it may in fact exacerbate them.

On a political level, the continued focus on individual "choice" and market-based solutions as a response to our deepening health care crisis is counterproductive. Individualistic, market-based solutions like the HCCA will not address systemic issues such as the increasingly high cost of health care or the growing crisis of un- and under-insurance. Instead, these proposed solutions may disproportionately disadvantage those in less-than-perfect health by further fragmenting the market.

narrowed, with the level of support for "radical change" similar across these groups); *see also* Humphrey Taylor, *Attitudes to Government Regulation Vary Greatly for Different Industries*, Harris Poll No. 19 (Apr. 2, 2003), http://www.harrisinteractive.com/harris_poll/index.asp?PID=367 (discussing a 2003 poll, in which two of the top four industries most often characterized as needing more regulation were the managed care industry and the health insurance industry, ranking just in front of the pharmaceutical and oil industries).

118. CATHY SCHOEN ET AL., THE COMMONWEALTH FUND, PUBLIC VIEWS ON SHAPING THE FUTURE OF THE U.S. HEALTH SYSTEM 3, 11 (2006), *available at* http://www.cmwf.org/usr_doc/Schoen_publicviewsfuturehltsystem_948.pdf.