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O'Neill Institute
for National and Global Health Law

Legal Solutions in Health Reform

The Purchase of Insurance Across State Lines in the Individual Market

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O'Neill Institute

for National and Global Health Law

THE LINDA D. AND TIMOTHY J. O'NEILL INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW AT GEORGETOWN LAW

The O'Neill Institute for National and Global Health Law at Georgetown University is the premier center for health law, scholarship and policy. Housed at Georgetown University Law Center, in the heart of the nation's capital, the Institute has the mission to provide innovative solutions for the leading health problems in America and globally—from infectious and chronic diseases to health care financing and health systems. The Institute, a joint project of the Law Center and School of Nursing and Health Studies, also draws upon the University's considerable intellectual resources, including the School of Medicine, the Public Policy Institute, and the Kennedy Institute of Ethics.

The essential vision for the O'Neill Institute rests upon the proposition that the law has been, and will remain, a fundamental tool for solving critical health problems in our global, national, and local communities. By contributing to a more powerful and deeper understanding of the multiple ways in which law can be used to improve health, the O'Neill Institute hopes to advance scholarship, research, and teaching that will encourage key decision-makers in the public, private, and civil society sectors to employ the law as a positive tool for enabling more people in the United States and throughout the world to lead healthier lives.

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- *Reflective Problem-Solving.* For select high-priority issues, the O'Neill Institute organizes reflective problem-solving initiatives in which the Institute seeks to bridge the gap between key policymakers in the public, private, and civil society sectors and the intellectual talent and knowledge that resides in academia.

OVERVIEW
LEGAL SOLUTIONS IN HEALTH REFORM

The American public has increasingly identified health care as a key issue of concern. In order to address the multiple problems relating to the access and affordability of health care, President Obama and federal lawmakers across the political spectrum continue to call for major health reform. In any debate on health reform, a predictable set of complex policy, management, economic, and legal issues is likely to be raised. Due to the diverse interests involved, these issues could lead to a series of high-stakes policy debates. Therefore, **it is critical that advocates of reform strategies anticipate such issues in order to decrease the likelihood that legally resolvable questions become barriers to substantive health reform**. In an effort to frame and study legal challenges and solutions in advance of the heat of political debate, the O'Neill Institute for National and Global Health Law at Georgetown University and the Robert Wood Johnson Foundation have crafted the "Legal Solutions in Health Reform" project.

This project aims to identify practical, workable solutions to the kinds of *legal issues* that may arise in any upcoming federal health reform debate. While other academic and research organizations are exploring important policy, management, and economic questions relating to health reform, the O'Neill Institute has focused solely on the critical legal issues relating to federal health reform. The target audience includes elected officials and their staff, attorneys who work in key executive and legislative branch agencies, private industry lawyers, academic institutions, and other key players. This project attempts to pave the road towards improved health care for the nation by providing stakeholders a concise analysis of the complex legal issues relating to health reform, and a clear articulation of the range of solutions available.

LEGAL ISSUES V. POLICY ISSUES

Among the major issues in federal health reform, there are recurring questions that are policy-based and those that are legally-based. Many times questions of policy and of law overlap and cannot be considered in isolation. However, for the purpose of this project, we draw the distinction between law and policy based on the presence of clear legal permission or prohibition.

Under this distinction, policy issues include larger-scale questions such as what basic model of health reform to use, as well as more technical questions such as what threshold to use for poverty level subsidies and cost-sharing for preventive services. In contrast, legal issues are those involving constitutional, statutory, or regulatory questions such as whether the Constitution allows a certain congressional action or whether particular laws run parallel or conflict.

Based on this dividing line of clear permission or prohibition, policy questions can be framed as those beginning with, "*Should we…?"*, and legal questions can be framed as those beginning with, "*Can we…?"* The focus of this paper will be the latter, broken into three particular categories: 1) "Under the Constitution, *can we ever…?*"; 2) "Under current statutes and regulations, *can we now…?";* 3) " Under the current regulatory scheme, *how do we…?"* This final set of questions tends to be mixed questions of policy, law, and good legislative drafting.

PURPOSE AND LAYOUT OF THE PROJECT

This project is an effort to frame and study legal challenges and solutions in advance of the heat of political debate. This effort is undertaken with the optimistic view that all legal problems addressed are either soluble or avoidable. Rather than setting up roadblocks, this project is a constructive activity, attempting to pave the road towards improved health care for the nation. Consequently, it does not attempt to create consensus solutions for the identified problems nor is it an attempt to provide a unified field theory of how to provide health insurance in America. Furthermore, this project does not attempt to choose among the currently competing proposals or make recommendations among them. Instead, it is a comprehensive project written to provide policy makers, attorneys, and other key stakeholders with a concise analysis of the complex legal issues relating to health reform and a clear articulation of the range of solutions available for resolving those questions.

LEGAL ISSUES

Based on surveys of current health policy meetings and agendas, popular and professional press, and current health reform proposals, our team formulated a list of legal issues relating to federal health reform. After much research, discussion, and expert advice and review, our initial list of over 50 legal issues was narrowed to ten. An initial framing paper was drafted which identified these ten legal issues and briefly outlined the main components of each. In May of 2008, a bipartisan consultation session was convened to provide concrete feedback on the choice and framing of the legal issues. The attendees of the consultation session included congressional staff, executive branch officials, advocates, attorneys, employers, and representatives of a wide range of interests affected by health reform. Feedback and analysis from this session further narrowed the ten issues to eight key legal issues which warranted in depth analysis of the current law.

These eight pertinent issues are truly legal in nature and must be addressed in any significant reform proposal to avoid needless debate or pitfalls as policy decisions are made. There are multiple other legal issues that will arise as the discussion evolves and, if a federal policy is adopted, the system changes. In this project, however, we have targeted the issues essential for an immediate discussion of federal health reform.

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LEGAL SOLUTIONS IN HEALTH REFORM PROJECT

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Ms. Kanwit has been in private law practice and government service in Chicago and Washington, D.C. for over thirty-eight years. Formerly General Counsel and Senior Vice President of Public Policy and Research at the American Association of Health Plans (AAHP), she also was a Partner at the law firm, Epstein Becker & Green, P.C. in Washington, D.C., where she focused on health litigation and counseling in the managed care industry. Until 1996, she served as Vice President of Health Litigation for Aetna's health businesses, responsible for managing Aetna's litigation involving antitrust, provider network issues, Medicare and ERISA issues, health care fraud and abuse in the private and governmental sectors, adverse medical outcomes, and life and long-term disability insurance.

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EXECUTIVE SUMMARY
Prepared by the O'Neill Institute

INTRODUCTION:

Proposals to allow the purchase of insurance across state lines (PASL) have gained some support in recent years. Health insurers have traditionally been allowed to sell a policy only within the state that approved and regulates that particular policy. PASL would allow insurers to sell a policy approved in one state to people residing in any state.

Any federal legislation to enact PASL in an individual insurance market would have to address two main legal considerations: 1) the McCarran-Ferguson Act, which allows the states to retain their regulatory authority over insurance, and 2) a constitutional prohibition against the commandeering of state officials by the federal government. This paper outlines these obstacles and potential solutions, and concludes that as long as the legislation is thoughtfully drafted (see below), there is no significant legal or Constitutional barrier to enacting PASL. Additionally, the concepts discussed here may be relevant to any federal health reform legislation involving regulation of health insurance or the use of state officials.

POTENTIAL SOLUTIONS:

- **Congressional Authority under the McCarran-Ferguson Act**: The federal McCarran-Ferguson Act delineates the respective roles of the federal and state governments in regulating health insurance. While states retain the primary role in regulating health insurance, the federal government can preempt state laws in this area if it does so explicitly and clearly, or if a federal law specifically relates to the business of insurance. PASL legislation is most likely to survive a potential court challenge to Congress' authority if it includes both of the following two steps:

  - **Clearly state that Congress is using its Commerce Clause power**: Courts have historically been very deferential to Congress when it is legislating under its Commerce Clause authority, increasing the chance that the legislation would be upheld. A clear statement of Commerce Clause jurisdiction in legislation would make this authority clear to the Court.

  - **Ensure that the legislation meets the legal preemption standard:** The legislation could expressly state that the law preempts state laws on the subject. Alternatively, Congress could include clear language ensuring that the legislation specifically relates to the business of insurance, which would meet the Supreme Court test for preemption under the McCarran-Ferguson Act.

- **Commandeering of State Officials:** The federal government is prohibited under the Constitution from requiring state officials to implement or enforce federal law, or "commandeering" those state officials. However, the Supreme Court has ruled that the federal government can regulate interstate commerce, so long as state officials are not required to alter their actions as a result. Congress can also attach conditions or requirements to federal money it grants to the states.

For a PASL proposal, concerns about commandeering challenges can be minimized by Congress' taking the following steps:

- **Impose No New Duties**: Congress should make the strongest case possible that any responsibilities modified by the PASL legislation do not impose new duties on state officials. Additionally, Congress could characterize the participation of states as "primary states" in PASL as voluntary.

- **Use Congress's Spending Power**: If Congress provides new funding to states to incentivize them to participate in a PASL program, it can rely on its Constitutional spending power and can attach requirements on the states' participation. Use of the relatively broad spending power can minimize any commandeering concerns.

LEGAL ISSUES & APPLICABLE LAW:

- **McCarran-Ferguson Act:** Ordinarily, where a state and federal law conflict, the federal law preempts (takes priority over) the state law. The federal McCarran-Ferguson Act, by contrast, re-affirms the role of the states as the primary regulators of the insurance industry while preserving federal authority to regulate insurance if it acts specifically to do so. If Congress wishes to preempt state health insurance law, it can explicitly declare that a particular piece of legislation preempts state law, or draft the legislation to fit under the exception provided by the Act for legislation specifically relating to the business of insurance.

- **Commandeering of State Officials:** The Tenth Amendment and the principle of state sovereignty in the Constitution prohibit the federal government from commanding the states to implement federal law or policies that would interfere with state sovereignty. This is referred to as the "anti-commandeering" principle. A PASL bill could minimize this constitutional concern by characterizing duties of state officials as consistent with existing duties and by providing incentives to states through funding, as opposed to requiring state participation.

CONCLUSION:

PASL legislation can be implemented, if it addresses key legal issues using the solutions outlined above. McCarran-Ferguson concerns can be addressed by carefully crafting the legislation with explicit references to the insurance industry, or by including a specific statement of preemption. Concerns about the commandeering of state officials can be curtailed by drafting the legislation so that state officials are not given additional duties, and by providing financial incentives to the states to enforce the federal law. Policymakers should keep in mind that the solutions above, in addition to being relevant to PASL proposals, may also be relevant to any federal legislation involving the federal regulation of health insurance or that requires specific action by state officials.

Legal Solutions in Health Reform:
The Purchase of Insurance Across State Lines in the Individual Market

Stephanie Kanwit[1]

Introduction

This paper analyzes the legal issues associated with the leading and much-debated proposals that aim to revitalize state regulatory competition and allow individuals to purchase insurance across state lines (PASL). These proposals seek to reverse decades-old principles of state preeminence in the regulation of individual health insurance and instead create "jurisdictional competition" in the individual market by allowing an insurer to choose the state under whose law it wishes to be regulated, subject to certain consumer protections. Advocates say this type of jurisdictional competition would reform perceived problems in the individual market and lower the costs of individual health insurance by imposing the regulatory authority of only the insurer's selected "home" state.

Supporters of PASL legislation cite the perceived advantages of greater competition, a reduction in the costs of regulation, and additional consumer choice. For example, the health care reform program of the former Republican presidential nominee, Senator John McCain (R-AZ) featured a PASL proposal along with modifications to the tax treatment of employer sponsored coverage, tax credits, and funding of guaranteed access plans.[2] In fact, legislation authorizing PASL was introduced in both the 109th and 110th Congresses by Representative Shadegg (R-AZ)[3], allowing insurers to select a "primary" state to govern the policy, but also giving a "secondary" state authority to enforce certain consumer protections as well as collect premium taxes.[4]

In accordance with the ground rules for the Legal Solutions in Health Reform project, this paper does not take a position on the merits of PASL as a component of health care reform. As we discovered over the course of the Presidential campaign season, the various supporters and opponents of PASL have articulated these views in some detail, and we anticipate further discussion of this approach.[5] Instead, this paper explores the legal as well as practical legislative issues associated with potential federal legislation to allow PASL. Note that for space limitations, this paper focuses on the individual market for health insurance as opposed to insured group markets, although many of the same fundamental legal issues would apply.

Part I summarizes the issues that PASL legislation seeks to address and discusses the current regulatory framework of health insurance to provide background as to how PASL could alter the regulatory environment. Part II outlines these leading federal proposals, as well as touches briefly on analogous state efforts. Whether these proposals can be implemented is addressed in the second half of the paper, with Part III discussing two basic legal issues that may arise from PASL proposals: how to draft any legislative language to both (1) avoid running afoul of the federal McCarran-Ferguson Act[6], and (2) avoid improperly requiring state insurance departments to enforce new federal standards and thus possibly violating the Tenth Amendment to the Constitution, as well as solutions for minimizing these possible legal problems.

I. Current Regulatory Environment

Today, more than 230 million Americans access health care coverage through their employers or through government programs such as Medicare and Medicaid. Most non-elderly individuals receive private health coverage through health and welfare benefit plans sponsored by employers; in 2006, about 158 million non-elderly people were insured through employer-sponsored insurance. A significant number, however, purchase insurance on their own in the individual market: one estimate puts the number at over 17 million in 2007.[7] The number of individuals who are currently uninsured is estimated at over 45 million.[8] The true intended audience of a PASL proposal will likely vary, however, depending on how and whether the proposal is linked with the offer of incentives or disincentives for employer-based coverage. For example, some proposals – such as those offered by Senator McCain eliminating the favorable tax treatment of health insurance benefits provided to workers when coupled with a PASL proposal – could have the effect of increasing coverage in the individual market but only at the expense of diminishing employer-based coverage.[9]

Proposals to allow PASL are based on the assumption that state mandated benefits, state rating rules, and state regulatory regimes distort pricing and result in decreased uptake of insurance by price-sensitive consumers in the individual market. Under current law, companies may only sell policies to individuals who reside or work in the state in which the company is licensed (although large insurers license products in every state). So, for example, a New Jersey resident has no choice but to purchase a policy from a carrier licensed in that state and that carrier can only sell that resident a policy compliant with all the state's mandates as well as its guaranteed issue and community rating requirements. But because of the variation in state requirements regarding guaranteed issue, mandates, and rating rules, as well as state demographics, there is a tremendously wide price variation in individual policies. According to a recent nationwide survey, annual premiums averaged $5,326 for single coverage in New Jersey in the 2006-2007 period, but only $1,254 in Wisconsin.[10] Contrast the cost of a New Jersey individual policy – $5,326 – with that of a Connecticut policy, where the average cost would be much lower, $3,326. The national average cost of such a policy was $2,613.[11]

A particular New Jersey consumer, however, looking to purchase insurance in the individual market might feel that the state's extensive regulation was "worth it," especially if he or she has medical issues, since no one can be turned down for coverage in the individual market, and the particular mandates for certain "high-cost" benefits will cause the cost to be spread out across a large community-rated pool. In contrast, the relatively younger New Jersey resident without health conditions might prefer a cheaper product rated for his or her individual risk as it would be in other states. Supporters of PASL proposals argue a solution to this problem is to create a national market for individual health insurance to allow for greater competition by insurers, a greater choice in the types of plans available to individuals, and consequentially lower prices as a result of decreased mandates, less-expensive rating rules, and a more favorable regulatory environment.[12] Supporters point to historical analogies such as Delaware corporate chartering, dual banking charters, regional compacts for banking, the Risk Retention Act, regulation of surplus lines insurance, and association health plans.[13]

Consumer advocates, on the other hand, are concerned lest PASL proposals have the effect of circumventing state consumer protections by producing a regulatory "race to the bottom," with insurers selecting the least regulated state with the fewest mandates as their primary state.

Opponents further note the adverse consumer impact, in that insurers remaining in states with more mandates will necessarily be forced to increase costs as a result of individuals requiring those mandated benefits remaining in the secondary state's pool.

The dissenting Democrats summarized their concerns with the Choice Act at the hearing before the House Subcommittee on Health in 2005 – namely, that the legislation would erode consumer protections, since "[s]tates would be powerless to stop out-of-State insurance companies from selling coverage in their State which did not meet important State consumer and benefit protections."[14] The protections cited included access to emergency care and specialty care, mandated benefits such as maternity coverage, and enforcement of state fraud and abuse laws. Others have reiterated that restrictions on state authority would probably create a greater risk of fraud and abuse, requiring a state (for example) to turn to the courts to shut down an insurance company regulated by another "primary" state rather than use the current more expedited administrative process.[15] There is also the problem created by a primary state's regulators' having to provide assistance to consumers living in a (much-smaller) secondary state, such as the difficulties that might await a California consumer who buys a policy from a company licensed in Delaware and is then forced to seek protection from "a regulator some 3,000 miles away and staffed to regulate insurance markets on a much smaller population scale."[16]

The witnesses testifying in favor of the Choice Act, conversely, emphasized that the bill was indeed "pro-consumer" in that it provided an option for those who cannot "afford all the services and 'protections' prescribed by their state," in the form of mandates and community rating, for example.[17] These pro-PASL witnesses assured the Committee that the bill contained adequate consumer protections, including requirements regarding disclosure, requirements relating to the insurer's financial stability, and the availability of an independent review mechanism.[18] The testimony also noted the current reality of a mobile and decentralized workforce, made possible by the Internet and other communication tools, rendering state-based insurance regulation an anachronism in some cases.[19]

Additionally, the Congressional Budget Office has weighed in since the Choice Act hearing in the House with a cautionary note: that the very virtue of any PASL proposal – its goal of increasing access to the individual market – may turn out to be its Achilles heel if it is not carefully designed. The increase in individual market uptake may reduce the number of people who are covered by employer-sponsored coverage, the CBO notes in its assessment of the Choice Act, since: (1) some employers (especially smaller employers) would stop offering coverage because individual market coverage would become less expensive; and (2) some employees with low health care costs might opt to purchase this less expensive coverage in the individual market. Thus, the resulting increase in the per-person cost of the remaining employees in the group might cause employers to drop coverage.[20]

In order to understand the state "patchwork" of insurance law that PASL supporters are seeking to address, it is necessary to understand the historical framework of insurance regulation.

A. State Insurance Regulation under the McCarran-Ferguson Act

States have historically had the primary role in regulation of insurance products. This role was reaffirmed by the McCarran-Ferguson Act of 1945 (McCarran-Ferguson Act),[21] enacted in response to the Supreme Court decision in *United States v. South-Eastern Underwriters Ass'n*,

holding that insurance activity which crossed state lines was interstate commerce and subject to the federal antitrust laws.[22] Faced with the prospect of federal antitrust penalties for commonplace and arguably pro-competitive insurer activities, the insurance industry joined with the National Association of Insurance Commissioners (NAIC) to obtain passage of McCarran-Ferguson.

The Act had two aims: (1) to re-affirm the role of the states as the primary regulators of the insurance industry while preserving federal authority to regulate insurance through "specific" enactments; and (2) to provide limited federal antitrust immunity for the insurance industry.[23] The relevant statutory language is as follows:

> **(a) State regulation**
> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> **(b) Federal regulation**
> 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, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, that . . . . the Sherman Act, . . . the Clayton Act, and the . . . Federal Trade Commission Act, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.[24]

While the Act specifies that "***silence*** on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of [the business of insurance] by the several states," explicit wording in a federal statute could still allow federal law to trump a state's authority to act.[25]

In response to the McCarran-Ferguson Act, states have developed comprehensive regulation of the "business of insurance," including licensing, market conduct, financial solvency, policy language, underwriting standards, agent licensing, receivership, and (in some cases) pricing of coverage. States have also used the limited antitrust immunity under the Act to develop various forms of rate regulation, often in the form of model laws developed by the NAIC. To protect consumers, all states have also adopted unfair trade practices laws to regulate not only insurer but also producer marketing and advertising activities.

B. State Regulation: Rating, Mandated Benefits, Regulatory Regimes

The states' authority to regulate health plans and health insurers is limited by federal law under the Employee Retirement Income Security Act of 1974 (ERISA),[26] which specifically preempts any state regulation of employer self-funded group products and provides for uniformity in certain areas for group plans insured through state-regulated insurers. ERISA does, however, allow the states to regulate the "business of insurance" and hence health insurance policies purchased by employers.[27] In addition to ERISA, the states' authority is also limited by other federal reforms – most notably, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) – which created certain minimum insurance protections for both federally-regulated

and traditionally state-regulated coverage.[28] Two of its provisions are especially relevant: (1) *guaranteed renewal*, requiring that all health coverage (individual and group) be renewable upon expiration of the policy term;[29] and (2) *group-to-individual portability*, guaranteeing eligible individuals losing group coverage access to coverage through individually-purchased insurance or alternatives, such as state-sponsored high-risk pools.[30]

But at the same time it imposed a "floor" of federal protections in certain areas on states, HIPAA also gave the states substantial flexibility in determining the mechanism for making coverage available to those eligible and for enforcing the insurance-related portions of that federal statute for both the group and individual markets. Thus, states could opt to apply the "federal fallback" approach or develop an alternative mechanism that: (1) offers a choice of guaranteed access coverage to all eligible individuals; (2) imposes no preexisting condition exclusions; and (3) adopts one of several approaches relating to risk spreading, including a standard high-risk pool approach (which includes a 200% premium cap) and any other approach that provides for risk adjustment, risk spreading, or a financial subsidy to eligible individuals.[31] In most states, eligible individuals are guaranteed access to coverage in the state's high-risk pool.

That substantial flexibility left to the states by HIPAA – consistent with the primacy of state regulation of insurance – has left, and in some areas even increased, considerable state-by-state variation in, for example, how those risk pools work and how effective guaranteed renewability is when coverage may be unaffordable. The key driver to PASL proposals is to minimize that widely varying state regulation in the individual market, on the assumption that the divergence of state regulatory regimes imposes considerable additional costs for those purchasing in the individual market. State regulation often involves more than one entity in the same state, as well as laws and regulations that are at significant variance with each other. Supporters of state regulation, however, argue that such costs for state oversight – including market conduct examinations, corrective actions for insurers, and establishing state guaranty funds in case of insurer insolvency – are valuable, since they assure that individuals are best protected by local regulators and responsive elected officials.

Under the various PASL proposals, health insurance issuers could offer individual policies of insurance from any state regardless of the residence state of the individual purchaser, subject to the primary state's mandated benefit laws, rating laws (including community rating, for example), guaranteed issue, and guaranteed renewal laws. The mandated benefits requirements and rules affecting the extent to which insurers may charge different prices for coverage offered to individuals are anticipated to have the greatest effect on the price of individual health coverage – assuming that the cost of care is constant across all geographic areas.

The following is a short description of three key areas of state regulatory variation identified by supporters of PASL proposals: 1) Community rating and guaranteed issue; 2) Mandated benefits; and 3) General regulatory regimes.

1. Community Rating and Guaranteed Issue

A minority of states have attempted to make health coverage more accessible in the individual market by enacting "guaranteed issue" and "community rating" reforms, which forbid age-based premiums differentials and medical underwriting for new policies. Under community rating, insurers generally are not allowed to vary rates based on the health or claims of a business or

person, although adjusted or modified community rating can permit adjustments for such factors as geographic location and age.[32] "Guaranteed issue" requirements prohibit insurers from denying coverage to individuals based on health status, and currently five states require all insurers to sell coverage to all applicants in the individual market on a guaranteed issue basis.[33] As a result of the passage of HIPAA in 1996, all insurers are required to sell their small group policies on a guaranteed issue basis, but in the individual market, when not linked with an individual mandate, such laws may encourage healthy individuals to remain uninsured until health care coverage is needed.

These reforms tend to create subsidies for older and/or less healthy individuals while resulting in higher premiums for younger/healthier individuals. States with either guaranteed issue or community rating rules tend to have higher than average premiums because younger and healthier people are incentivized to avoid purchasing insurance until they become ill, allowing the insurance pools to be disproportionately represented by higher cost individuals. Supporters of these reforms contend that this subsidy is necessary to ensure accessible coverage to all regardless of health or age.

In most states, premiums for individual coverage are allowed to vary by age, which can encourage younger people to purchase coverage, as well as by gender. Likewise, most states allow insurers to medically underwrite new applications for coverage, which involves a process to assess risks and classify them according to degrees of insurability so that appropriate rates may be assigned to discernable categories of risk. Underwriting can discourage individuals from waiting until they are ill to purchase insurance, thereby assuring the pool of insured individuals within each discernable category has a mix of those who are more healthy and less healthy, which serves to spread the risk of claims across the entire population, and assure more level premiums.

2. Mandated benefits and access

There are very few federal mandates on health policies in the individual market.[34] States, however, have enacted a wide variety of laws mandating which categories of individuals must be covered by an insurer, which benefits must be covered, and which practitioners must be allowed to deliver medical treatment and services. The Council for Affordable Health Insurance (CAHI) issued a report in 2008 listing over 1900 state mandates applicable to individual and small group policies.[35] These mandates can include: (1) *provider mandates* such as inclusion of chiropractors and acupuncturists; (2) *benefit mandates* such as the inclusion of prescription drugs, well-child care, infertility services, and hearing aids; and (3) *covered classes of insureds*, such as dependent students and grandchildren.

Many forces drive the push to introduce and enact mandates, including guaranteed third-party reimbursement for providers and additional coverage for individuals with a particular disease or condition.[36] Estimates of costs imposed by such mandates vary greatly. CAHI has developed estimate ranges for each of the state mandates, ranging from less than 1% to between 5-10% of additional cost. While the costs of a specific mandate may be low, the accumulation of 40 or 50 mandates in a state may price certain individuals out of the market. Critics of mandates note that mandates ultimately harm consumer health by imposing static clinical procedures, despite the dynamic nature of changing clinical "best practices," and by raising the cost of health insurance and thus contributing to the number of uninsured Americans.[37]

A growing number of states, recognizing that mandates are not cost-free, are requiring systematic review of either state mandates or of proposed mandate legislation. The Massachusetts Division of Health Care Finance and Policy, for example, estimated the total spending on the state's 26 mandated benefits at $1.32 billion, or 12% of premiums for the one-year study period (July 1, 2004 through June 30, 2005). The true *net* cost impact of mandated benefits, however, was estimated to be significantly lower (in the range of 3-4% of premiums) because of federal mandate laws and the likely behavior of insurers and employers in the absence of state mandates.[38]

3. Regulatory regimes for insurers

States also vary in terms of the regulatory regimes they choose to impose on insurers in the individual market. One area in which there is significant variation is in the area of external review – also known as independent medical review. External review laws provide a mechanism for resolving health care coverage disputes between consumers and their health insurance plans by providing a formal process that allows an appeal of coverage determinations to a third party. Currently, 44 states and the District of Columbia have external review programs that apply to private health insurance plans, usually in both the group[39] and individual markets.[40]

From an administrative standpoint, however, the scope of these state external review laws differs widely. Some apply to medical necessity determinations[41], while others, for example, have external review laws that are broader and cover determinations involving experimental services or treatments, or even payment denials for providers.[42] Other states, such as Arizona and Washington, apply external review to any adverse determination affecting coverage.[43] Process requirements also vary widely in terms of time frames, the nature of the review, the qualifications of the reviewer(s), and whether an adverse decision is binding on the insurer.

II. Leading Federal PASL Proposals

PASL proposals attempt to solve the administrative complexities and inefficiencies that can arise in state-by-state regulation and help correct what proponents see as resulting distortions in pricing which may discourage younger and healthier consumers from purchasing individual insurance. The leading federal PASL proposal is the Choice Act, introduced by Representative Shadegg in the last two Congresses.[44] Companion bills were introduced by Senator Jim DeMint (R-SC) in the Senate.[45]

In brief, the various versions of the Choice Act would amend the federal Public Health Service Act to provide that the laws of the state designated by a health insurance issuer (the "primary" state) would apply to individual insurance coverage offered by that issuer in the primary state and in any other state ("secondary" state), so long as the coverage and the issuer comply with the provisions of the Act. The Act's provisions would specify which types of state laws apply, thus requiring that the primary state's law would apply to mandated benefit laws, rating laws (including community rating, for example), guaranteed issue, and guaranteed renewal laws. To avoid duplication, the Act would give sole jurisdiction to the primary state to enforce its covered laws in the primary state as well as in any secondary state.

The secondary state, however, would retain authority in certain specific areas: (a) levying nondiscriminatory premium and other taxes, (b) requiring compliance with lawful orders in relation to delinquency proceedings in the case of financial impairment, (c) requiring compliance with injunctions issued by the secondary state's courts based on a petition that the issuer is in a hazardous financial condition, (d) allowing financial examinations according to NAIC standards if the primary state's insurance commissioner had not done so, (e) requiring non-discriminatory participation in an insurance insolvency guaranty association, (f) requiring adherence to the secondary state's law relating to fraud and abuse and unfair claims settlement practices, and (g) enforcing countersignature requirements by secondary state agents or brokers.

The Choice Act also requires that there be a process in place for external review in both the secondary state and the primary state. If both states do not have relevant underlying laws or regulations, then the issuer must provide an independent review mechanism substantially identical to that of the NAIC's Health Carrier External Review Model Act for all individuals who purchase insurance coverage under the Choice Act, except that the reviewer or panel of reviewers must meet requirements set out in the Act.[46]

Senator McCain's campaign proposal for the private market emphasized individual choice in the purchase of health insurance coverage. Although the plan lacks detail, this author assumes it would have had substantial similarities to the Choice Act. The McCain proposal sought to harness competition to improve the quality of health insurance with greater variety to match people's needs, lower prices, and portability and allow families to be able to purchase health insurance nationwide, across state lines. Individuals who are not able to purchase insurance in this new regulatory environment or who face much higher premiums would be able (under Senator McCain's proposal) to obtain coverage through a guaranteed access plan with a limitation on premiums and subsidies for individuals with lower incomes.[47]

We should note that many *non-federal* approaches to the same issue of incenting individual choice of insurance product have been considered by state legislators.[48] Rhode Island, for example, enacted a study bill this term that requires the Commissioner of Insurance to review the laws and regulations of the state and its New England neighbors to: identify the changes necessary to enable insurers licensed in other states to do business in Rhode Island without a separate specific license; analyze the advantages and disadvantages of creating a regional health insurance marketplace; examine the extent to which obtaining a license is a barrier for new insurers to enter the market; and develop a proposed plan to implement a regional health insurance marketplace.[49] Interstate Compacts may also provide a similar innovative approach, by which states band together either in particular regions (such as Northeast, South, Midwest, and West) or nationally. One example of this approach in another insurance context is the Interstate Insurance Product Regulation Commission. Thirty-three states have adopted compact legislation to establish the Commission which develops uniform national product standards and serves as a central point of electronic filing for certain insurance products, including life insurance, annuities, long-term care, and disability insurance.[50]

III. Constitutional Issues

For purposes of this discussion, the proposals that would alter the law to allow individual health insurance policies to be sold across state lines all effectively preserve the states' primary authority for the regulation of health insurance while allowing Congress to set standards that

modify that authority. Those federal standards would have a formidable impact, as noted above, on almost every aspect of state-regulated insurance markets, including mandates, guaranteed issue laws, and community rating requirements.

As Congress sifts alternatives and attempts to craft health insurance reform, any PASL proposals (such as the Choice Act and Senator McCain's) present two overriding constitutional issues:

- Whether the federal government has the authority to regulate insurance so as to limit the scope of the McCarran-Ferguson Act.

- Whether legislation allowing purchase of insurance across state lines could result in impermissible commandeering of state regulatory and enforcement bodies in violation of the constitutional prohibitions against commandeering.

This paper discusses each of these two issues in turn, as well as suggests possible solutions for minimizing constitutional challenges.

A. Issue #1: Whether the federal government has the authority to regulate insurance so as to limit the scope of the McCarran-Ferguson Act.

As noted above, the McCarran-Ferguson Act reaffirmed the power of the states to regulate and tax insurers but allows federal law to trump state enactments if the law "specifically relates to the business of insurance":

> "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, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance."[51] (emphasis added)

Some have questioned whether Congress can curtail the states' ability to regulate in their respective individual insurance markets by enacting a PASL proposal. This author notes that a review of the legislative history of HIPAA, which introduced significant federal regulation in areas previously regulated solely by the states, reveals that the Congressional drafters did not feel the need to amend McCarran-Ferguson before imposing federal rules on the individual market.

1. Supreme Court Test

Barnett Bank of Marion County, N.A. v. Nelson sets out distinct guidelines for assessing whether a federal statute overrides McCarran-Ferguson's anti-preemption rule.[52] In *Barnett*, the Supreme Court evaluated whether a 1916 federal law permitting national banks to sell insurance in small towns preempted a 1974 Florida statute prohibiting such banks from selling most types of insurance.

In a unanimous opinion delivered by Justice Stephen Breyer, the Court engaged in a two-stage analysis to determine whether the federal statute preempted the state statute. First, it looked to see whether under ordinary legal principles of preemption, the federal statute would preempt the state statute. Finding no "express preemption"[53] and no "field preemption"[54], the Court

discussed whether federal and state statutes are in "irreconcilable conflict" based on the language and purpose of the McCarran-Ferguson Act taken together.

It found that the federal and state statutes were not in irreconcilable conflict – as they would be if the federal statute said "you must sell insurance" and the state statute said "you may not sell insurance." Rather, a federal statute authorized national banks to engage in activities that the state statute expressly forbade. Florida maintained that the federal statute was intended to allow the bank to sell insurance "only to the extent that state law also grants permission to do so." Rejecting that approach, the Court noted that "where Congress has not expressly conditioned the grant of 'power' upon a grant of state permission, the Court has ordinarily found that no such condition applies," and concluded that under ordinary principles of preemption, the federal law preempts the state's prohibitory statute.

The Court went onto to evaluate whether the McCarran-Ferguson special anti-preemption rule governed, and formulated a three part test to examine whether a federal statute "specifically relates to the business of insurance." First, it examined whether the law "relates" to the business of insurance, based on its historically broad interpretation of the term "relates" (giving as an example the "relates" to language in the ERISA preemption clause as analyzed in *Pilot Life Ins. Co. v. Dedeaux*[55]) and concluded that "[i]n ordinary English, a statute that says that banks may act as insurance agents, and that the Comptroller of the Currency may regulate their insurance-related activities, '*relates'* to the insurance business."[56]

Second**,** the Court looked at the more "important" issue of whether the statute "specifically" relates to the insurance business. In a plain language analysis, the Court distinguished between "implicit" and "explicit" references and contrasted the general term "business activity" with an explicit reference to "finance, banking, and insurance."

The third element of its analysis concerned whether the statute specifically relates to the "business of insurance," with the Court noting that the statute not only focused on industry-specific selling practices, but also "affects the relation of insured to insurer and the spreading of risk – matters that this Court in other contexts, has placed at the core of the McCarran-Ferguson Act's concern." (preceding cites omitted).

In sum, the court in *Barnett* confirmed that there is no need for there to be express statutory language in a federal statute to allow it to trump state law "regulating the business of insurance" additionally noted that this analysis does not require specific language such as "state law is preempted" or the like to fall within the McCarran-Ferguson Act exception.

2. Solutions for Minimizing McCarran-Ferguson Challenges

In the event that PASL proposal or a variation is considered by Congress, its sponsors could minimize concerns about a challenge to the federal government's authority to enact such a proposal by taking the following two steps:

a) State clearly that the Congress intends to regulate interstate commerce through the legislation. The drafters should clearly invoke interstate commerce jurisdiction, as courts traditionally have been very deferential to the Congress when evaluating whether the federal government has interstate commerce jurisdiction.

The very reason for the enactment of the McCarran-Ferguson Act was the Supreme Court's expansive holding, in *United States v. South-Eastern Underwriters Assn.,* that "[n]o commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance."[57]

While the specific lines of the Commerce Clause have shifted over the years, there appears little doubt of Congress's power to regulate insurance, even if certain insurance activities were viewed as solely intrastate.[58] Any judicial review of a statute would be subject to only "rational basis" analysis.[59]

The Health Care Choice Act of 2007 included a specification of constitutional authority under the Commerce Clause: "This Act is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution." Additionally, the Act included a findings section delineating the case for interstate commerce jurisdiction in order to set forth a basis for finding a "rational" basis for the linkage.[60] The proposed legislation provided a "roadmap" finding section, noting that (a) state law variations impact the ability of insurers to offer and individuals to obtain affordable individual health coverage, thus impeding interstate commerce; (b) the channels for offering coverage (Internet and mail) are part of interstate commerce; (c) the appropriateness of increasing efficiency through a collaborative approach of states; and (d) risk-retention groups as a successful model for sale of insurance across state lines. This level of specification in federal legislation should prove sufficient to satisfy court scrutiny.

b) Ensuring that the legislation meets the standards of ordinary legal preemption in one of three ways: (1) express preemption (stating that the law expressly preempts state laws on the subject); (2) regulating the area so pervasively, that the law achieves "field preemption;" or (3) establishing the type of conflict between federal and state laws so as to establish a basis for "conflict preemption."

In the case of a PASL proposal, the drafters can achieve the intended result through either express preemption language or following the blueprint laid out by the court in *Barnett Bank.* Any language should thus ensure that the legislation clearly (1) specifically; (2) relates; (3) to the business of insurance. It does not appear that this test would be problematic for the Health Care Choice Act of 2007 or the very similar McCain proposal. So long as the proposal explicitly relates to "finance, banking, and insurance," it will almost certainly satisfy the test. The Health Care Choice Act of 2007 recognizes this and provides such specificity, for example, in the findings section reproduced above. Likewise, the McCain proposal has an explicit statement: "An important part of [the] plan is to use competition to improve the quality of health insurance with greater variety to match people's needs, lower prices, and portability. Families should be able to purchase health insurance nationwide, across state lines."[61]

Second, because the term "relates to" is interpreted so broadly by the Court, any common-sense link to insurance in the legislation will likely be satisfactory. Finally, the "business of insurance" prong of the test is likely to be satisfied on its face by the current wording of either the Health Care Choice Act of 2007 or a proposal by Senator McCain.

B. Issue #2: Whether a purchase of insurance across state lines proposal would result in impermissible commandeering of state regulatory and enforcement bodies in violation of constitutional prohibitions against commandeering.

A second legal issue with PASL proposals such as the Choice Act is whether they improperly require state insurance departments to enforce new federal standards. Some have argued that state legislatures would specifically need to adopt these federal standards[62] to make them enforceable under the Tenth Amendment to the Constitution, since the Supreme Court has held that "Congress cannot compel the States to enact or enforce a federal regulatory program."[63]

The Tenth Amendment's anti-commandeering language provides: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."[64] That language raises the following questions:

- Although PASL proposals "at first glance" appear to retain regulatory authority and responsibility with the primary state's insurance commissioner and not compel new functions, would the primary state's insurance commissioner be considered to be "commandeered" because the commissioner would now have the added duty of enforcing standards for state licensed insurers issuing policies to insureds residing in other states?[65]

- Would a secondary state's insurance commissioner be considered to be "commandeered" by virtue of being required to monitor the financial conditions of out-of-state insurers selling insurance to the secondary state's residents?[66]

- Would recordkeeping imposed by such proposals – such as requiring the completion of federal forms certifying compliance with state law – be interpreted by a court as commandeering?[67]

1. Supreme Court's Anti-Commandeering Doctrine

The leading case on "commandeering" is *Printz v. United States*.[68] There, chief law enforcement officers for counties in Montana and Arizona challenged the constitutionality of interim provisions of the federal Brady Handgun Violence Prevention Act that directed state law enforcement officers to participate in the administration of a federally-enacted regulatory scheme. The legislation required the chief law enforcement officer of each local jurisdiction to conduct background checks of handgun purchasers until such time as a national system was in place.

Ultimately, the Supreme Court overturned that requirement in a 5-4 decision with an opinion delivered by Justice Scalia:

> We held in *New York*[69] that Congress cannot compel the States to enact or enforce a federal regulatory program. Today we hold that Congress cannot circumvent that prohibition by conscripting the States' officers directly. The Federal Government may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program. It matters not whether policymaking is involved, and no case by case weighing of the burdens or benefits is necessary; such commands are fundamentally incompatible with our constitutional system of dual sovereignty. Accordingly, the judgment of the Court of Appeals for the Ninth Circuit is reversed.[70]

The door does not seem to be shut, on the other hand, for a reading that "voluntary compliance" by states or use of the spending power to urge state participation may pass muster. Justice O'Connor's concurrence supports that view, especially coupled with the four dissenters' analysis that the Brady Act provisions were constitutional:

> Our holding, of course, does not spell the end of the objectives of the Brady Act. States and chief law enforcement officers may voluntarily continue to participate in the federal program. Moreover, the directives to the States are merely interim provisions scheduled to terminate November 30, 1998. Congress is also free to amend the interim program to provide for its continuance on a contractual basis with the States if it wishes, as it does with a number of other federal programs.[71] (citations omitted)

Another Supreme Court case may shed some additional light on how courts could evaluate a PASL proposal, if elements of a bill were deemed to regulate state activities as opposed to the actions of private parties. In *Reno v. Condon*, South Carolina and its attorney general challenged the constitutionality of the federal Driver's Privacy Protection Act (DPPA), which limits the ability of states to release a driver's personal information without the driver's consent.[72] The Supreme Court held that the Act was a proper exercise of the authority of Congress to regulate interstate commerce under the Commerce Clause. Additionally, the Court distinguished *Printz* because the DPPA did not require state officials to enforce federal law in violation of the Tenth Amendment, but instead regulated the state as an owner of a database rather than attempting to control or influence the manner in which states regulated private parties.

2. Strategies for Minimizing Anti-Commandeering Challenges

In the event that a PASL bill is considered by Congress, its sponsors could minimize concerns about an anti-commandeering challenge to the Federal government's authority to enact this proposal by taking the following steps:

a) **Make the best case possible that any responsibilities modified as the result of the legislation do not impose "new" duties on state officials.** The drafters could characterize the choice of law rule as an exercise of federal preemption power under the Supremacy Clause. Drafters could be mindful of characterizing the duties of primary and secondary

state officials as consistent with already-existing duties of the official. Any additional actions could thus be characterized as not constituting direct compulsion of the state officials.[73] Another approach might be to characterize the participation of states as "primary states" in the program as a voluntary effort.[74]

b) **Provide new funding to the states from the federal government to establish spending power authority to incentivize states to participate in the program**. One option to consider would be to provide the states with federal dollars or incentives to participate in the program. Congress' spending power is broad, but not unlimited. It is subject to the following restrictions: (1) the exercise of the spending power must be in pursuit of "the general welfare;" (2) if Congress desires to condition the states' receipt of federal funds, it must do so unambiguously so that the states can exercise their choice knowingly; (3) there must be a relationship "to the federal interest in particular national projects or programs"; and (4) no other constitutional provisions may provide an independent bar to the conditional grant of federal funds.[75]

Conclusion

The various proposals to allow individuals to purchase and insurers to sell insurance across state lines are motivated by the laudatory goals of making health insurance more affordable by increasing competition among health insurers, giving consumers more choices of products and companies, and minimizing costs of duplicative or unnecessary regulation by 51 different regulators with varying rules. The constitutional difficulties appear to be surmountable if legislation is drafted properly. But the practical difficulties of such an approach are legion.

Fundamentally, by overturning the traditional paradigm of solely state-regulated insurance products, PASL proposals of all stripes create difficulties in determining what was heretofore a simple question: "Where does the policy live?" The shift will necessarily impact all kinds of state assessments on insurers. For example, over 30 states have implemented high-risk health pools, which are nonprofit organizations created by state law to offer health insurance to individuals who otherwise would be unable to secure coverage. Because the premiums collected from participants in these pools fund only about 58% of costs, however, the vast majority assess health insurers for at least a portion of the pools' funding, with formulas based on revenue generated in the state or on market share in the state.[76] Yet those funding mechanisms may be difficult to sustain in a state where consumers choose to "vote with their feet" and purchase policies issued in another state.

There are additional practical problems about how PASL proposals would impact the myriad areas of extensive state-based regulation of not only insurers but also others working with them in the chain, such as state rules relating to licensing of brokers and/or agents, prompt pay requirements for providers, and provider adequacy and network requirements. Thus, how can Maryland require a Colorado-based insurer to comply with Maryland network adequacy rules? Should state prompt-pay requirements be enforced based on the residence of the consumer or based on where the provider service is rendered? Any federal PASL proposal would need to contemplate how to address these difficult issues, and many papers have been published arguing the pros and cons of allowing consumers to buy insurance from outside their domicile state, and proposing variations on PASL proposals.[77]

This paper has outlined a variety of other legal and practical issues that arise from a federal PASL proposal, many of which have been raised and vigorously discussed by consumer advocates, insurance commissioners, and academics. Perhaps the overriding issue is how PASL proposals –which impact only the individual market – would fit within what seems to be a broader national effort to reform the health care system in terms of both access and affordability. PASL proposals in essence attempt to simplify only one element of the health insurance regulation, by eliminating comprehensive (and often duplicative and variable) state-by-state regulation, while leaving in its place arguably less comprehensive regulation that may also be less protective of individuals from the "primary state." As the CBO has noted, these proposals may drive healthy individuals currently insured by employer-based coverage to opt for individual, less expensive coverage purchased from another state, leaving sicker and more expensive workers in the group coverage.[78] Broader efforts at reform that address all markets – individual, group, and government-regulated – may be the better approach to reform.

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[2] See Health08.org, Kaiser Family Foundation, 2008 Presidential Candidate Health Care Proposals: Side-by-Side Summary, *available at* http://pdf.kff.org/health08/compare_5.pdf (last visited January 9, 2009).
[3] Health Care Choice Act of 2005, H.R. 2355, 109th Cong. (2005); Health Care Choice Act of 2007, H.R. 4460, 110th Cong. (2007). Hereafter both bills are referred to as "the Choice Act". The bills were also introduced in companion form by Senator DeMint (R-SC) as S. 1015, 109th Cong. (2005); and S. 2477, 110th Cong. (2007).
[4] Other proposed regulatory ideas include the concept of Optional Federal Chartering (OFC), which would keep state regulation in place but allow an insurer to choose to be regulated under a single federal charter instead of on a state-by-state basis. An example is the National Insurance Act of 2007, S. 40, 110th Cong. (2007), introduced by Sens. Sununu (R-NH) and Johnson (D-SD). The bill was also introduced in companion form H.R.3200, 110th Cong. (2007) by Reps. Bean (D-IL) and Royce (R-CA). To date, the major OFC proposals have not included medical insurance.
[5] See e.g., M. Matthews, Opinion, "McCain Is Right On Interstate Health Insurance", *Wall Street Journal*, Oct. 1, 2008, *available at* http://online.wsj.com/article/SB122282743245193057.html (last visited January 9, 2009); B. Herbert, "McCain's Radical Agenda", *New York Times*, September 16, 2008, at A29, *available at* http://www.nytimes.com/2008/09/16/opinion/16herbert.html (last visited January 9, 2009); see also, The Health Care Choice Act: Hearing on H.R. 2335 Before the Subcommittee on Health of the House Committee on Energy and Commerce, 109th Cong. (2005) (witness testimony), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_house_hearings&docid=f:22986.pdf (last visited x y, z)..
[6] 15 U.S.C. §§ 1011-1015 (2008).
[7] See Survey, *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2007*, Annual Social and Economic Supplement, Current Population Survey, U.S. Census Bureau (2008), *available at* http://pubdb3.census.gov/macro/032008/health/h01_001.htm (last visited x y, z).
[8] See U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (August 2008), at 19, *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf (last visited x y, z)..
[9] Congressional Budget Office Cost Estimate, *H.R. 2355, Health Care Choice Act of 2005* (September 12, 2005), *available at* http://www.cbo.gov/ftpdocs/66xx/doc6639/hr2355.pdf (last visited x y, z).
[10] See Survey, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," America's Health Insurance Plans Center for Policy and Research (December 2007), at 8-9, *available at* www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf (last visited x y, z).
[11] It should be noted that average premiums in the individual market are normally lower than in the group market, probably as a result of higher cost-sharing provisions in individual policies. See e.g., The Kaiser Family Foundation & Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey" (2007), at 1, *available at* http://www.kff.org/insurance/7672/upload/76723.pdf (reporting the average annual total premium cost for individual coverage in an employer-sponsored plan as $4,479) (last visited x y, z).
[12] See, e.g., Matthews, *supra* note 5.
[13] See T. Miller, "Geographic Monopolies vs. Choice and Competition in Health Insurance Regulation: Starting a Market Driven Race to the Top," presentation at American Enterprise Institute for Public Policy Research, July 31, 2008, *available at* http://www.aei.org/docLib/20080731_MillerPresentation.pdf (last visited January 12, 2009).
[14] *Health Care Choice Act of 2005: Hearing on H.R. 2355 before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 109th Cong. (2005).
[15] M. Kofman and K. Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Health Policy Institute, Georgetown University (April 2006), at 9, *available at* http://www.pbs.org/now/politics/Healthinsurancereportfinalkofmanpollitz.pdf (last visited January 29, 2009).
[16] *Id.*
[17] See e.g., *H.R. 2355, the Health Care Choice Act, Hearing Before Subcomm. on Health of the H. Comm. on Energy and Commerce*, 109th Cong. (June 25, 2008) (statement of Merrill Matthews, Director, Council for Affordable Health Insurance, *supra* note 72, at 27, *available at* http://archives.energycommerce.house.gov/reparchives/108/Hearings/06282005hearing1564/Matthews.pdf (last visited x y, z).
[18] *Id*. at 17-18.
[19] *Id*. at 26.

[20] See Congressional Budget Office Cost Estimate, *supra* note 9, at 5.
[21] 15 U.S.C. §§ 1011-1015 (2008).
[22] 322 U.S. 533 (1944).
[23] Property and casualty insurers (P/C insurers) have traditionally employed this antitrust exception to pool information through rating bureaus in order to forecast claims trend and market analysis, with the goal of reducing administrative costs and promoting a more competitive insurance market. These bureaus are sanctioned under state law to comply with state antitrust laws in all states in which they operate.
[24] 15 U.S.C. § 1012 (2008).
[25] 15 U.S.C. § 1011 (2008) (emphasis added); see, e.g., *Ophthalmic Mut. Ins. Co. v. Musser*, 143 F.3d 1062 (7th Cir. 1998).
[26] 29 U.S.C. §§ 1001 *et seq* (2008).
[27] As a result, specific state laws, even if they have a connection with or reference to an ERISA welfare benefit plan have been held to avoid preemption, including:

- State laws mandating minimum health benefits; See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).
- State laws requiring independent physician review of medical necessity disputes; See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).
- State "any willing provider" laws requiring health plans to admit "any willing provider" (physicians, hospitals, and/or pharmacists) willing to accept the health plan's terms and conditions; See *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003).

[28] See K. Pollitz, et al., "Early Experience with 'New Federalism' in Health Insurance Regulation," *Health Affairs*, 19 (July/August 2000): 7-22, at 8, calling the passage of HIPAA "a new era of federal/state partnership" which "created certain minimum protections for consumers in federally and state-regulated health plans, including self-funded employer plans, while maintaining states' ability to enforce their laws that exceed federal protections."
[29] HIPAA requires guaranteed renewability of coverage in the individual market of the same policy with the same insurers, unless there is fraud, nonpayment of premiums, and other specific events. Thus, an insurer must renew an individual's policy regardless of health status unless the individual chooses to drop it. 42 U.S.C. § 300gg-42 (2008).
[30] 42 U.S.C. § 300gg-41 (2008).
[31] United State General Accounting Office, Health, Education and Human Services Division, *Letter to the Hon. Nancy L. Johnson, Chairman, Committee on Ways and Means, House and Representatives, Implementation of HIPAA: State-Designed Mechanisms for Group-to-Individual Portability, Alternative Mechanisms Under HIPPA*, GAO/HEHS-98-161R (May 20, 1998), *available at* http://archive.gao.gov/paprpdf2/160522.pdf (last visited x y, z).
[32] See Small Employer and Individual Health Insurance Availability Model Act (National Association of Insurance Commissioners 2001).
[33] The five states are Maine, Massachusetts, New Jersey, New York and Vermont. See Me. Rev. Stat. Tit. 24A, § 2736-C; Mass. Gen Laws Ch. 176J, § 4; N.J. Stat. Ann. § 17B:27A-4; N.Y. Ins. Law §§ 3231 and 4317; Vt. Stat. Ann. Tit. 8, § 4080b(d). All of these statutes need to include a year.
[34] Federal mandates include the following: minimum post-delivery hospital stays; certain post-mastectomy treatment and care, including reconstruction, and mental health parity requirements. See Employee Retirement and Income Security Act, 29 U.S.C. §§ 1185, 1185a, 1185b (2008); Public Health Service Act, 42 U.S.C. §§ 300gg-4, 300gg-5, and 300gg-6 (2008).
[35] V. C. Bunce and J.P. Wieske, Council for Affordable Health Insurance, "Health Insurance Mandates in the States 2008," *available at* http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf (last visited January 13, 2009).
[36] America's Health Insurance Plans, Coverage Mandates, *available at* http://www.ahip.org/content/default.aspx?bc=39|341|315 (last visited January 13, 2009).
[37] Board of Directors, America's Health Insurance Plans, A Commitment to Improve Health Care Quality, Access, and Affordability, March 2004, *available at* http://www.ahip.org/content/default.aspx?docid=428 (last visited x y, z).
[38] See Commonwealth of Massachusetts, Division of Health Care Finance and Policy, *Comprehensive Review of Mandated Benefits in Massachusetts*, Report to the Legislature, July 7, 2008, *available at* http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf (last visited x y, z).
[39] The Supreme Court in *Rush Prudential v. Moran*, 536 U.S. 355 (2002), held that state external review laws were "saved" from preemption and could apply to ERISA plans without supplementing or supplanting ERISA's exclusive civil enforcement scheme if they allowed the independent reviewer power to construe terms such as "medical necessity" only, rather than free-ranging power to construe contract terms, on an analogy to a medical second-opinion.

[40] America's Health Insurance Plans Center for Policy and Research, An Update on State External Review Programs, 2006, (July 2008), at 3, *available at* http://www.ahipresearch.org/PDFs/StateExternalReviewReport.pdf (last visited January 15, 2009).
[41] States where external review laws apply to medical necessity determinations include: Illinois, Iowa, Louisiana, Maryland, Minnesota, Missouri, Montana, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, Utah, and the District of Columbia. *Id.*
[42] These states include: Alaska, Arkansas, California, Connecticut, Florida, Kansas, Kentucky, Maine, Maryland, Massachusetts, Nevada, New York, North Carolina, Oregon, South Carolina, Tennessee, Vermont, Virginia, West Virginia, and Wisconsin. *Id.*
[43] *Id.* at 5.
[44] The Health Care Choice Act of 2005, H.R. 2355, 109th Cong. (2005); and The Health Care Choice Act of 2007, H.R. 4460, 110th Cong. (2007).
[45] S.1015, 109th Congress (2005); and S. 2477, 110th Congress (2007).
[46] The Choice Act was ultimately reported favorably out of Committee, but received no further action in the full House.
[47] See R.E. Moffit and N. Owcharenko, The Heritage Foundation, "The McCain Health Care Plan: More Power to Families," *Backgrounder*, no. 2198 (October 15, 2008), *available at* http://www.heritage.org/Research/Healthcare/upload/bg_2198.pd (last visited January 15, 2009), for a discussion of the McCain health care proposal.
[48] State PASL legislation has been building momentum. See e.g., H.B. 1327, 66th Gen. Assem., 2d Reg. Sess. (Colo. 2008) (allowing a carrier that is not subject to Colorado law to sell a policy to a Colorado resident if the policy is lawfully sold in another state; the out-of-state policy would be subject to Colorado's prompt pay law and the state's claim denial and internal appeals requirements); S.B. 1190, 190th Gen. Assem. (Pa. 2007) (providing that a state resident has the right to purchase health insurance from a foreign insurer, regardless of whether the foreign insurer is licensed or in compliance with state laws); H.B. 214, 2007-2008 Legis. Sess. (Vt. 2007) (allowing Vermont residents to purchase health insurance policies sold in other states, provided certain financial and consumer protection requirements of Vermont law are met, such as surplus and reserve requirements, disclosure and reporting requirements, and grievance procedures).
[49] H.B. 7493, Gen. Assem., 2008 Legis. Sess. (R.I. 2008); and S.B. 2286, Gen. Assem., 2008 Legis. Sess. (R.I. 2008).
[50] See e.g., Interstate Insurance Product Compact website (currently limited in scope to life insurance, annuities, long-term care, and disability insurance), *available at* http://www.insurancecompact.org (last visited January 29, 2009).
[51] 15 U.S.C. § 1012(b) (2009).
[52] 517 U.S. 25 (1995).
[53] "Express preemption" exists when the statute contains explicit congressional intent to preempt state law. See *Boggs v. Boggs*, 520 U.S. 833, 841 (1997) (Employee Retirement Income Security Act of 1974 § 514, 29 U.S.C. § 1144(a) (2006), as express preemption clause).
[54] "Field preemption" exists when the statute contains a schema of federal regulation "so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).
[55] 479 U.S. 806 (1986).
[56] See *Barnett Bank*, *supra* note 52, at 38.
[57] 322 U.S. 533, at 552 (1944); see also *U.S. v. International Business Machines Corp.*, 517 U.S. 843, 877 (1996) (noting that the Court "abandoned long ago the notion that insurance is not commerce and so beyond the power of Congress to regulate.")
[58] See, e.g., *Gonzales v. Raich*, 545 U.S. 1 (2005) (holding that Commerce Clause authority includes the power to prohibit the local cultivation and use of marijuana in compliance with California law); *Perez v. United States*, 402 U.S. 146 (1971) (holding that Supreme Court "case law firmly establishes Congress' power to regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce.")
[59] See, e.g., *Raich*, *supra* note 58, at 22 ("In assessing the scope of Congress' authority under the Commerce Clause, we stress that the task before us is a modest one. We need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding.")
[60] See Health Care Choice Act of 2007, *supra* note 3, at § 3.
[61] Quote from Senator McCain on "The Official Website of John McCain's 2008 Campaign for President," site is currently inactive.

[62] M. Kofman and K. Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Health Policy Institute, Georgetown University (April 2006), at 9, *available at* http://www.pbs.org/now/politics/Healthinsurancereportfinalkofmanpollitz.pdf (last visited January 29, 2009).
[63] *Printz v. United States*, 521 U.S. 898, 935 (1997).
[64] U.S. Const. Am. 10.
[65] T. Westmoreland, et. al, The Law of Health Reform: Ten Legal Issues, O'Neill Institute for National and Global Health Law (May 30, 2008), *available at* http://www.law.georgetown.edu/oneillinstitute/documents/reform_top10.pdf (last visited Dec. 31, 2008).
[66] *Id*.
[67] *Id*.
[68] *Supra* note 63.
[69] *New York v. United States*, 505 U.S. 144 (1992).
[70] See *Printz*, *supra* note 63, at 935.
[71] *Id*. at 936.
[72] 528 U.S. 141, 150 (2000).
[73] See *Minnesota ex rel. Hatch v. U.S.*, 102 F. Supp. 2d 1115, 1120-22 (D. Minn. 2000).
[74] See e.g., *Printz*, *supra* note 63, at 935 (O'Connor, J., concurring).
[75] *South Dakota v. Dole*, 483 U.S. 203 (1987). See e.g., *Printz*, *supra* note 64, at 935 (O'Connor, J., concurring); *Kansas v. U.S.*, 214 F.3d 1196, 1202-03 (10th Cir. 2000) (distinguishing state requirements resulting from acceptance of federal welfare funds from the situation described in *Printz*).
[76] National Association of State Comprehensive Health Insurance Plans, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, (22d ed. 2007/2008): at 11.
[77] See e.g., T. Miller, "A Regulatory Bypass Operation," *Cato Journal* 22, no. 1 (Spring/Summer 2002), 85-102; D. Hyman, "Health Insurance: Market Failure or Government Failure," Illinois *Law and Economics Research Papers Series*, Research Paper No. LE08-003 (2008), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1087830 (last visited x y, z); S. Parente, R. Feldman, J. Abraham, and Y. Xu, Consumer Response to a National Marketplace for Individual Insurance, Final Report, Carlson School of Management, University of Minnesota (June 28, 2008), accessed at www.aei.org/docLib/20080730_National_Marketpla.pdf (last visited x y, z).
[78] See Congressional Budget Office Cost Estimate, *supra* note 9, at 5.