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The Case for Interstate Insurance Choice

Why Creating National Markets for Property and Casualty Insurance and Health Insurance Will Help Insurers and Consumers

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In an ideal world, the function of insurance is to make policyholders' losses equal to or less than the losses they would reasonably expect to suffer when assessing at a risk situation from the outset. Policyholders pay premiums equivalent to the likelihood of loss times the payout they will receive in the event of that loss, plus anything they are willing to pay as profit in exchange for the certainty of knowing what their losses will be and the ability to plan accordingly—the "peace of mind" touted by insurance advertisers. When possible, insurers increase returns on premiums—for instance, by investing them—and reduce their own risk—through diversification of the types of risks they assume—in order to make a profit while charging premiums of an amount *lower* than the losses policyholders could expect to suffer without insurance.

Ours is not an ideal world, however, and the distortions from which it suffers include coverage mandates and laws requiring insurers to participate in residual markets. Though promoted as a way to make sure that people at high risk can buy insurance, coverage mandates also force consumers to buy insurance, often at above-market rates or for risks they do not face. When states make insurers participate in residual markets, insurers must usually cover high-risk policyholders at insufficient rates and pass on the resulting losses to other policyholders.

Fortunately, there is a feasible solution to the market distortions and high costs that these requirements impose on both insurers and consumers: Interstate insurance choice.

How do coverage mandates work? Most state insurance regulators wield significant control over both the sets of risks that insurers can cover—the policies they issue—and the rates they charge for this coverage. The majority of states either forbid insurers to issue policies and

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set rates without the regulator's prior approval or, under a system known as "file and use" or flex rating, allow the regulator to disapprove policies and rates within a given time window, during which time companies can change rates without any specific approval.[1]

There are two basic types of coverage mandates. The first and most common type requires that all policies in a given broad category—such as property and casualty or health insurance—cover risks of a given nature, such as a given hazard or health condition. The other common type requires that all policies covering a given risk reimburse policyholders for specific measures they take to mitigate risks or remedy damages arising from that risk.

Coverage mandates of this type allow insurers to take individuals' risk levels into account when determining premiums. Yet they distort the market because some individuals are at especially high risk for particular conditions. People whose actuarially adequate rate *vis-à-vis* a given risk exceeds that risk's share of the regulator-approved rate must still buy a policy covering that risk, creating a loss that must be spread among the other policyholders subject to that coverage mandate. Customers whose actuarially adequate premium falls within the permitted range must therefore pay that premium *plus* some share of the insurance company's expected loss from persons whose actuarially adequate premium is higher than the law allows.

Mandates of a second, more stringent type include "community rating" rules, which establish that all persons are to be charged the same rate for a given risk except for specific reasons enumerated in those rules. These mandates not only make people pay too much but inflate the set of people paying premiums on a given risk beyond those for whom it is rational to insure against that risk at all.

As limits on risk-based pricing increase, so does the number of high-risk people whom insurers cannot cover profitably—or even break even on—under the pricing strictures imposed. When coverage mandates are accompanied by restrictions on risk-based pricing, low-risk customers are forced to subsidize not only individuals whose risk is too high for permitted rates but those who are currently affected by the condition in question. Additionally, in some cases, a customer may not be prone at all to a risk for which coverage is mandated, but rating rules may forbid insurers to account for that fact when setting rates, so the portion of the customer's overall rate devoted to covering that risk amounts to pure subsidy. For example, both male and female consumers may be forced to purchase health policies covering tests for reproductive cancers specific to one sex at the same time that laws require spreading the cost of each test among policyholders of both sexes.

Coverage mandates' distortion of the insurance market harms low-risk customers in two ways. First, these mandates redistribute wealth from low-risk individuals to high-risk ones: Low-risk individuals will pay premiums that exceed the value of the benefits they can expect to recoup, while those at high risk can expect to receive more in benefits than they will pay in premiums.

Second, coverage mandates increase premiums because they create artificial demand, forcing customers to insure against particular risks they would rather bear on their own. They also make some types of coverage unaffordable by disallowing offerings that would be aimed at different

types of consumers in a free market. In some cases, customers who could afford to insure against a smaller set of risks selected *a la carte* may be unable to afford a mandated, one-size-fits-all package deal.

This phenomenon has two consequences. First, the low-risk customer in question is priced out of the market and cannot obtain coverage for himself. As the Center for Affordable Health Insurance puts it, "Mandating benefits is like saying to someone in the market for a new car, 'If you can't afford a Lexus loaded with options, you have to walk.'"[2]

Second, as each low-risk customer exits the market, the costs imposed by high-risk customers are spread among fewer people, making matters worse for each low-risk customer who remains. Low-risk customers then have increased incentive to leave the market, creating a vicious cycle.

How do state-mandated residual risk pools work? Residual risk pools are nonprofit entities that provide insurance to customers who pose such high risks that insurers cannot legally charge them an adequate rate, meaning that the customers cannot obtain policies in the for-profit market. Some residual risk pools are directly chartered by state governments. Others are established by insurers, usually because state laws require them to do so.

Residual risk pools usually operate at deficits. The deficits of state-chartered pools are covered by taxpayers. In most cases, insurers must cover the deficits run by the pools they operate, and in order to stay in business they must pass those deficits on to other customers—with the result, similar to the effect of coverage mandates, that low-risk clients pay artificially inflated premiums to subsidize high-risk individuals. The combination of caps on approved rates, the nonprofit status of residual pools, and the requirement that taxpayers or policyholders cover most pools' deficits enables these pools to charge inadequate premiums and "crowd out" for-profit insurers from the high-risk insurance market.

Differences in the regulation of specific health and P&C coverage provisions. Most states have fewer coverage mandates for property and casualty insurance, especially for real property, than for health insurance. (Thus, coverage mandates add less to the typical P&C premium than to the typical health premium.)

One reason for this difference is that market forces encourage insurers to include many types of coverage in all real estate policies regardless of government requirements. Most real estate transactions are financed by mortgages, and virtually all mortgage lenders require borrowers to insure against fire, wind, and floods on the property they are financing. Because virtually all real property owners need to buy such insurance, virtually all policies include it.

A second reason is that the availability of health insurance has become a politically sensitive topic. Since persons prone to a given condition form a well-defined constituency, mandates that insurers cover specific conditions are more frequently a hot political issue.[3]

Differences in state involvement in health and P&C markets. Government plays a greater role in the health insurance market than it does in the property and casualty market. At

the federal level, its involvement with health care is wider in scope, and at the level of most states, the role it plays in health care is more direct.

In addition to the federally administered Medicare and Veterans Health Administration programs, the federal government partners with state governments through Medicaid and the State Children's Health Insurance Program (SCHIP). While states play an active role in providing health care to low-income individuals under these programs, few if any states offer comparable income-based assistance with homeowners' policies.[4]

Although most states attempt to ensure that high-risk individuals can obtain both P&C and health insurance, their means of ensuring access are different for non-automotive P&C insurance than for health insurance. States that assist high-risk individuals with health insurance require *taxpayers* to foot the bill, whereas most states that mandate assistance with homeowner's insurance require *other policyholders* to foot the bill.

As of FY 2007, 33 states had high-risk health insurance pools operated directly by state governments[5], with the effect that taxpayers subsidize their deficits.[6] In most years, these subsidies come from state budgets, but Congress has in the past supplemented them with federal funding.[7]

In contrast, in the non-liability P&C market, most states require—or have procedures through which their insurance commissioners can require—*insurers* to participate in residual risk pools,[8] with the effect that the insurers' other customers cover their deficits. Some states, such as Vermont,[9] expect these risk pools to be self-sustaining and enforce that expectation by holding the risk pools' clients responsible for any deficits. Others do not have such expectations. For example, Maine's non-automotive residual statute expressly anticipates that its pool may operate at a deficit and provides for the apportioning of that deficit (or the cost of reinsuring against it) among insurers participating in the pool.[10]

Three major exceptions to this generalization are Florida and Louisiana, which directly operate state agencies that sell full-fledged homeowners insurance purportedly residual in nature, and North Carolina, which maintains a massive state auto insurance pool. Deficits in these risk pools, like other state-operated pools, are absorbed by taxpayers. The taxpayer burden is especially heavy in Florida, where legislation effectively guarantees many participants rates that are far below market and actuarially inadequate, compounding the problem by crowding out private insurers.

Opportunity for P&C insurance reform. One recommendation gaining favor among analysts and legislators in recent years is to allow consumers to buy policies issued by insurers in other states and regulated under other states' laws. A Property and Casualty Coverage Choice Act (PCCCA) would enable consumers to realize substantial savings by allowing them to switch from states with burdensome residual risk-pooling requirements to states with fewer or no such requirements. Customers who live in states that mandate insurer-subsidized residual pools for a given risk could cover that risk with policies regulated by a state with no pool, a voluntary pool, or a pool that is mandatory but self-sustaining—thus reducing their premiums by the amount that

would have subsidized their home states' residual pools under their old policies.

This freedom would encourage long-term improvements in regulatory environments to permit a better correspondence between the premiums customers pay and the risks they impose. As one jurisdiction repeals inefficient laws and regulations, its insurance sector would become more attractive to customers in states saddled with burdensome regulations—which would in turn be pressured to make their own laws equally favorable in order to keep business in their state.

As low-risk customers in high-regulation states exit their home states' markets in search of more affordable coverage, the subsidy which each remaining low-risk customer would have to provide would increase, raising the incentive for the remaining low-risk customers to take their business elsewhere. The departure of customers would shrink these states' insurance sectors and associated tax revenues, inspiring state legislative efforts to keep remaining customers and regain customers who had left. To make their home states' markets attractive again, state legislators could implement either a voluntary risk pool regime or a mandatory but self-sustaining one. The ultimate result would be an across-the-board improvement in regulatory environments, to the benefit of consumers in all jurisdictions.

A PCCCA would also benefit insurers who did business in a confined geographic area prior to the Act's enactment. The freedom to issue policies in more distant locations would help them diversify financial risks, especially those related to natural disasters. As the geographic area for which an insurer issues policies increases, the number of disasters to which it is exposed may increase, but each of those disasters is likely to affect a smaller fraction of the properties it insures, meaning that the volatility of its payouts will likely decrease. [11]

Diversification also helps policyholders in two ways. First, a reduction in the significance of any individual disaster will lower premiums because investors facing lower risk will demand less return in exchange. Second, diversification will reduce the likelihood that any individual disaster will bankrupt an insurer and render it unable to pay claims.

A PCCCA would promote policy innovation in the property and casualty insurance sector. There is plenty of room for improvement—P&C insurers have not developed policies covering substantially new sets of risks since homeowner's first became available in *1950*.[12]

From the insurer's perspective, a PCCCA would both reduce the costs of regulatory compliance and increase the potential revenue from each new product developed. If an insurer can issue a policy nationwide upon its approval by only one state's regulatory authority, the insurer will have to jump through only one state's set of regulatory compliance hoops, instead of having to repeat the process for every jurisdiction in which it hopes to issue the policy. And by expanding the base of potential customers for each product, the PCCCA will increase the possible return on an insurer's investment in developing that product.

From the consumer's perspective, a PCCCA would increase the variety of policies to choose from. When the costs of developing each new policy are reduced and the potential benefits of doing so are increased, insurers will be more responsive to consumers' demands for a wide array

of policies suited to different needs and risk profiles.

In addition to these benefits, a PCCCA would have two side effects. First, it would encourage a move toward risk-based pricing. The overlap between the set of people posing risks to insurers and the set of people paying insurers to bear those risks will increase, as will the correspondence between each policyholder's premium and the loss the insurance company can expect to bear on his or her behalf—an effect that market-oriented critics view as an increase in fairness. Second, when state law permits more risk-based pricing rules, some high-risk individuals will be unable to afford premiums corresponding to the risks they impose, and for that reason they will not purchase insurance.

An existing model—the Health Care Choice Act. The past three sessions of Congress have seen the introduction of a Health Care Choice Act (HCCA),[13] which would allow health insurance policies substantively regulated by one state to be sold in other states—thereby enabling consumers to "opt out" of their home states' coverage mandates—as long as the issuing insurer meets certain federal solvency requirements. Proponents claim that its adoption would result in three major benefits.

The first goal is the one most desired by voters and most emphasized by the politicians who appeal to them: HCCA would reduce the burdens on consumers who live in high-regulation states and are willing to assume some level of risk. If coverage of a particular health risk or treatment is mandated by a consumer's home state but not by another state, the consumer can purchase a policy regulated by the other state, forgo the mandated coverage item in question, and reduce his premium by the corresponding amount.[14]

Second, consumers' increased freedom of choice will give jurisdictions an incentive to attract business from customers in other states and to keep the business of their own residents. To do so, jurisdictions will compete to create the most efficient regulatory environment, benefiting consumers in all jurisdictions for the reasons discussed above.

Third, it would encourage the development of new insurance products and improvement of existing products. Because the health-insurance market is not as stagnant as the P&C market, the increase in innovation might not be as dramatic as that inspired by a PCCCA, but qualitatively similar improvement in the market is likely.

Considered on its own, HCCA would have side effects similar to those of a PCCCA, but its interaction with other laws governing the health-insurance sector would create unique complications.

Like a PCCCA, an HCCA-type law would encourage a move toward risk-based pricing. In the short term, most of that progress would come on the low-risk end as consumers move to states with few coverage mandates and less restrictive rating rules. Progress on the high-risk end would follow: As insurers in more heavily regulated states lose business, they would pressure their legislatures to loosen restrictions on the rates they can charge and requirements as to whom they must cover. Following the delays inherent in the legislative process, they would likely become

able to charge higher rates and reject more high-risk applicants not insurable within whatever pricing restrictions remain.

Some critics of the HCCA cite this result as an argument against its adoption, pointing out that under other entitlement programs, taxpayers will remain ultimately responsible for many costs these high-risk individuals impose: As insurers increase the premiums of high-risk applicants and reject more of those they cannot afford to cover, many applicants will become unable to obtain insurance in the private market. They will then enroll in Medicaid or (for children) SCHIP, join state-subsidized high-risk pools, resort to emergency room care that they cannot afford but that virtually all hospitals must provide, or engage in a combination of these.[15]

This concern is legitimate, but misplaced. Entitlement programs, rather than the HCCA, are responsible for taxpayers being on the hook. As long as these programs remain in place, taxpayers will remain burdened whether the HCCA is enacted or not. If one wishes to reduce taxpayer responsibility for high-risk individuals' health-care costs, one should argue not against the HCCA but in favor of entitlement reform.[16]

Conclusion. A consumer-choice law covering property and casualty insurance would benefit consumers and markets for the same reason as would the Health Care Choice Act. Some of its benefits would go beyond those of the HCCA: Geographic diversification would enable P&C insurers, particularly small ones, to reduce the volatility of their cash flows, and taxpayers would be less burdened by the combined effects of such a law and existing entitlement programs. If the HCCA proves controversial and has difficulty meeting with public approval, an application of its principles in the property and casualty market could be an even better place to start.

Notes

[1] Insurance Association, "State Rate and Form Law Guide" (2007 ed.), Washington, D.C.: AIA Law Publications. One of these two regimes govern auto insurance rates in 40 states (not including Massachusetts, which is currently transitioning away from a system that directly prescribes rates) and homeowner's insurance rates in 41 states. Most other states follow a "use and file" system that requires insurers to inform the government of the rates they have set, and one state, Illinois, does not require rate filings.

[2] Victoria Craig Bunce, J.P. Wieske, and Larry Siedlick, "Health Insurance Mandates in the States" (2007 ed.), Alexandria, Va.: Council for Affordable Health Insurance (2005 edition available at http://www.cahi.org/cahi_contents/resources/pdf/MandatePubDec2004.pdf). "All-or-nothing" affordability problems could arise even if low-risk individuals were not forced to bear the costs of uninsurable individuals. Even if every individual pays a premium reflecting an actuarially sound calculation of the bundle of risks he imposes on an insurance company, some individuals may be unable to pay the grand total of premiums covering every risk in the bundle.

[3] In some states with large amounts of disaster-prone land, occupants of that land form a similar constituency and win similar concessions. For example, they have pressured the legislatures of Florida and Louisiana to involve their governments in the homeowner's insurance market to the point of directly sponsoring and subsidizing insurance plans.

[4] 15 U.S.C. § 6701, as amended by 110th H.R. 2761; *see also* "S&P: TRIPRA's Passage Keeps U.S. Commercial Lines Outlook Stable," *Insurance Journal*, January 8, 2008, http://www.insurancejournal.com/news/national/2008/01/08/86223.htm (last visited January 31, 2008). In the field of property and casualty insurance, federal assistance is largely limited to the specific risks of floods and terrorism. Coverage under the National Flood Insurance Program is available to residents—both rich and poor—of localities that have adopted risk-mitigating regulatory ordinances. The federal Terrorism Risk Insurance Program, last reauthorized on December 27, 20007,

imposes a nationwide mandate that insurers "make available" property and casualty insurance against certain terrorism-related risks to commercial property. It accompanies this mandate with a "backstop" reimbursing each insurer for its share of the sector's losses due to terrorism above the first $100 million and a deductible equivalent to 20 percent of its annual premiums.

[5] Comments to the House Appropriations Subcommittee on Labor, Health & Human Services, Education and Related Agencies, April 7, 2006, http://www.cahi.org/cahi_contents/resources/pdf/ HouseAppropFY07Funding.pdf (last visited February 7, 2008).

[6] Communicating for Agriculture, "Comprehensive Health Insurance for High Risk Individuals" (1999), cited in Heritage Foundation, "Lessons from Tennessee's Failed Health Care Reform" (2000), http://www.heritage.org/ Research/HealthCare/BG1357.cfm.

[7] *See*, *e.g.*, the State High Risk Pool Funding Extension Act of 2006, 109th H.R. 4519, S. 288, signed into law as P.L. 109-172, 120 Stat. 185, on February 10, 2006.

[8] *See* "State Rate and Form Law Guide" (2007 ed.), n. 1 *supra*.

[9] *See* 8 Vt. Code §§ 4982, 4986.

[10] 24A Me. Code § 2325-B(6)(E).

[11] Insurers, in particular smaller insurers, might be unfamiliar with the level of risk in the locations a PCCCA would make newly available to them. Their lesser familiarity with those risks might make them less willing to issue policies covering those locations. However, the growing accessibility of information reduces the practical impact of this concern. For example, the LOCATION® database published by the Insurance Services Office quantifies a wide variety of risks with a high degree of geographical precision, such that one can look up the level of each of these risks simply by entering a property's address, http://www.iso.com/index.php?option=com_content&task=view &id=1188&Itemid=510 (last visited January 31, 2008).

[12] American Association of Insurance Services, "The Homeowners Class Plan: How It Has Become Folklore" (monograph), Wheaton, Ill., 2003.

[13] 110th (current) H.R. 4460, S. 1019; 109th H.R. 2355, S. 1015; 108th H.R. 4662. The Act's provisions were also included in 109th H.R. 4845, which died in committee under the primary title Innovation and Competitiveness Act, http://www.govtrack.us/ congress/bill.xpd?bill=h109-2355, and http://www.govtrack.us/congress/bill.xpd? bill=h109-4845 (last visited January 17, 2008).

[14] The way consumers would save under such a law is thus slightly different from the way they would save under a PCCCA. In the P&C market, private lenders will keep most consumers from forgoing many specific coverage provisions, since maintaining insurance against certain risks is a near-universal condition of financing and most real property is purchased via mortgages. On the other hand, in most states, policy premiums subsidize residual P&C markets but not residual health insurance markets. Comparing the two laws side by side, consumers would realize similar savings for different reasons: For health policies, they would save by opting out of mandated coverage provisions, and for P&C policies, they would save by choosing not to subsidize residual markets.

[15] Hospitals accepting Medicare funding must treat all emergency room patients, regardless of ability to pay, under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd.

[16] The property and casualty sector—except in Florida and Louisiana—generally lacks taxpayer-funded programs comparable to these entitlements, so the complications they create and the corresponding objections they inspire would be mostly inapplicable to a PCCCA.