Selling insurance across state lines: Intended and unintended consequences

Susan Philip, MPP

Milliman

Health insurance in the United States has long been priced, regulated, and sold separately for each state. Recent policy proposals may potentially change this approach by allowing insurance to be sold across state lines. There are some critical intended and unintended consequences resulting from this change, and these depend greatly on policy intent and design.

This paper explores these potential consequences broadly and does not contemplate the impact of any specific policy proposal.

The McCarran-Ferguson Act of 1945 gave states the authority to regulate the "business of insurance" to a limited extent. State legislatures, state insurance commissioners, and other state regulatory bodies exercise this authority by enacting and enforcing laws related to financial solvency, network adequacy, consumer protections, rate development and approvals, and other market conduct rules.

State and federal proposals to allow sale of health insurance policies across state lines are not new. For example, a decade ago in California, Senate Bill (SB) 365 would have allowed an insurer domiciled in another state to sell health insurance in California without a license from the Department of Managed Health Care or without a certificate of authority from the insurance commissioner.[1] Most recently, there has been discussion of related federal policy proposals, although no specific provisions have been included in recent proposals to repeal and replace the Patient Protection and Affordable Care Act (ACA).[2]

Broadly speaking, by allowing insurers to sell insurance across states without being subject to state-specific regulations, these proposals intend to increase competition and lower the cost of health insurance. The question as to whether these proposals have the potential to meet their intended policy goals can be informed by prior state and federal efforts and research to date.

It should be noted that large employers who self-insure or self-fund their health insurance coverage are subject to ERISA, which is administered by the U.S. Department of Labor. As such, they are exempt from state-specific health insurance regulations. In the privately insured market, this leaves the fully insured employer, small group, and individual markets that could be affected by efforts to allow purchasing across state lines.

Prior efforts to allow purchasing across state lines

In the last decade, 21 states have considered legislation related to purchasing across state lines, although only Rhode Island passed a related law prior to the ACA (in 2008). Rhode Island's law directed the commissioner to study existing laws and regulations to determine steps needed to establish a regional health insurance market and to allow insurers from Massachusetts and Connecticut to obtain reciprocal licensure in Rhode Island. The study was not completed due to little interest from insurers or other stakeholders.[3,4]

Interestingly, the ACA allows for insurance sales across state lines under Section 1333. Section 1333(a) allows for two or more states to establish healthcare choice compacts and then allows insurers to sell qualified health plans in the individual markets within states participating in the compact. Specific ACA requirements would still apply, such as the requirement to cover essential health benefits. In addition, any insurer would still be required to be "licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State."[5]

1 The full Senate Bill 365 is available at **http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=200720080SB365**.

2 Armour, S. & Wilde Mathews, A. (December 3, 2016). **Crossing state lines is no easy jaunt for insurers and local regulators**. *Wall Street Journal*. Retrieved September 27, 2017, from **https://www.wsj.com/articles/crossing-state-lines-is-no-easy-jaunt-for-insurers-and-local-regulators-1480933801**.

3 The full text of the Rhode Island bill is available at **http://webserver.rilin.state.ri.us/BillText/BillText08/SenateText08/S2286.pdf**.

4 Corlette, S., Monahan, C., Keith, K., & Lucia, K. (2012). **Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage**. Washington, D.C.: The Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

5 Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010), Sec. 1333. Retrieved September 27, 2017, from **https://sites.google.com/site/healthreformnavigator/ppaca-sec-1333**.

A less talked about provision of the ACA is Section 1333(b), which allows insurers to develop a "nationwide qualified health plan" that can be sold in the individual and small group markets. Some important restrictions apply: The insurer would still be required to be "licensed in each State in which it offers the plan," and to offer "a benefits package that is uniform in each State" and is compliant with the essential health benefits requirements. However, this provision allows a nationwide qualified health plan to be exempted from certain state requirements that are inconsistent with ACA requirements. To date, despite there already being the potential framework to have sales across state lines, there is no evidence of an ACA-compliant nationwide qualified health plan in the individual and small group markets.

Section 1333 raises many questions that were to be addressed in regulations to be promulgated in coordination with the National Association of Insurance Commissioners (NAIC) by January 1, 2013. However, such regulations have not been developed to date.[6]

Following the passage of the ACA, several states considered establishing healthcare choice compacts or multistate compacts, but only five passed related laws: Georgia (2011), Kentucky (2012), Maine (2011), Oklahoma (2017), and Wyoming (2010).[7] In May 2017, Oklahoma passed the Health Care Choice Act, allowing insurers domiciled in other states but not licensed in Oklahoma to issue health insurance in-state.[8,9] None of these five states have out-of-state insurers selling insurance in their state.[10,11]

Why have these prior efforts not spurred purchasing across state lines?

There are several reasons why prior efforts have not driven purchasing across state lines.

State authority: Allowing an out-of-state carrier to sell insurance domestically—with no federal floor and no explicit agreement among states—could undermine the domestic state's authority. The domestic state's ability to enforce laws related to financial solvency, network adequacy, consumer protections, rate review and approvals, and other market conduct rules could be undercut. It is also unlikely that the domestic state will concede its authority to another state (assuming that the out-of-state carrier is still subject to the laws and regulations of the state in which it is domiciled).

Regulatory complexity: Under the current available structure, even if states are willing to consider establishing compacts with other states, regulatory complexity could be a barrier. State regulatory agencies would need to engage in a careful and labor-intensive process to review and compare all applicable licensing rules, as well as applicable rules governing the business of insurance and healthcare. Each state would have to decide which rules it would consider waiving and for which market segment(s), e.g., fully insured employer, small group, and/or individual. Working with stakeholders and the industry to obtain input and buy-in, promulgate rules, and educate the public would be another substantial hurdle.

Fear of "race to the bottom": The ACA enacted several provisions to implement consumer protections, increase oversight of health insurance premium rates for the small group and individual markets, establish minimum loss ratio requirements, and establish a benefit floor. If some or all of these provisions were to be repealed, then state laws and practices would prevail. In the pre-ACA world, there was variation in state laws especially related to underwriting, guaranteed issue, and mandated benefits. State regulators see a potential for a "race to the bottom" if purchasing across state lines were permitted because insurers would likely seek to be domiciled in a state with minimum requirements in order to sell the most competitively priced policies. For example, if one state had fewer benefits mandated to be covered by policies regulated in that state, those policies could then be sold in other states less expensively than the policies regulated in those states, which cover more benefits. Large multistate insurers would be at an advantage when compared with smaller regional insurers because they could theoretically reduce marginal costs by choosing to be domiciled in states in which they already have a presence and with the least burdensome requirements. They could also reduce marginal costs associated with filing in multiple states.

Establishing local provider networks: One of the most substantial barriers to entry for an out-of-state insurer is the ability to develop advantageously priced contracts with providers. Insurers licensed and already doing business within a state typically have better relationships with in-state providers than out-of-state providers. These preexisting relationships give in-state providers an advantage when it comes time to develop networks and negotiate provider contracts. It would be a greater challenge for an insurer wishing to offer a "high value" network or managed care product that leverages a closed network model. For example, a local hospital system in California may be unwilling to enter into contract with an out-of-state carrier

6 National Federation of Independent Business (2017). **Comments Regarding the Request for Information on Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients**. Nashville, Tenn.: NFIB.

7 Cauchi, R. (August 1, 2017). Allowing Purchases of Out-of-State Health Insurance. National Conference of State Legislatures. Retrieved September 27, 2017, from **http://www.ncsl.org/research/health/out-of-state-health-insurance-purchases.aspx**.

8 The Health Care Choice Act does have specific limitations. For example, out-of-state insurers must be domiciled in a state with which Oklahoma has a compact. In addition, the insurer must be approved to sell insurance in-state by the Oklahoma insurance commissioner and must also meet other requirements.

9 The full Oklahoma Health Care Choice Act is available at **http://webserver1.lsb.state.ok.us/cf_pdf/2017-18%20ENR/SB/SB478%20ENR.PDF**.

10 Corlette, S., et al., ibid.

11 Jenson, J. & Riley, T. (2017). **Selling Health Insurance Across State Lines: Lessons for States and Questions for Policymakers**. Portland, Maine: National Academy for State Health Policy.

if it had to go to another state's regulator to obtain approvals, submit reports, or file complaints. Large multistate insurers with a domestic presence would be at an advantage, especially if they could leverage their existing local provider networks.

Ability to set competitive premiums: The notion that an individual in a high-premium market can suddenly buy the same health insurance product for a lesser price because it is now offered by an out-of-state carrier is not realistic. For example, an insurer will not price a health insurance product for an urban community in Southern California based on the experience of a community in rural Idaho. Premiums are set based on historical data, which shed light on the underlying unit costs of services, drugs, and devices; utilization; demographics; risk mix; and trends. Entering into a new market without historical experience data is challenging. Large insurers with substantial capital reserves and ability to absorb losses would be more likely to manage such market entry risk.

Impacts on competition: Large multistate insurers would likely be at an advantage to reap the rewards of purchasing across state lines for the aforementioned reasons. In addition, they could develop products with fewer mandated benefits to achieve lower premiums than the domestic insurers subject to the domestic state's laws. Domestic regional insurers in states that require pure community rating (i.e., premiums cannot be differentiated based on age) would likely lose young people to out-of-state insurers. The domestic insurer, now facing adverse selection, would likely have to increase premiums, exit the market, or move its domicile to a state with more lax requirements. Thus, an unintended consequence may be to reduce competition—especially with smaller insurers. Depending on the jurisdiction's rating rules, older populations may also face increasing costs.[12]

Future considerations

There are current state and federal proposals that seek to allow some version of multistate or cross-state purchasing for the individual and small group markets. For example, H.R. 1101 would allow professional and trade associations to offer health insurance to their members. These association health plans would be subject to federal certifications but exempt from state regulations.[13] S. 1546 introduced in July 2017 seeks to bolster Section 1333 of the ACA by requiring the secretary of the U.S. Department of Health and Human Services (HHS) to request NAIC to develop a report detailing how states can develop interstate compacts and develop related model legislation to support states interested in doing so.[14] A bipartisan group of congressional members called the Problem Solvers Caucus encourages HHS to issue regulations for Section 1333 of the ACA. The Caucus hopes that clear guidelines on healthcare choice compacts will encourage state participation and ultimately bring innovation, choice, and competition to the market while protecting consumers.[15]

An assessment of the impact of any state or federal proposals to allow for purchasing across state lines must consider whether there are any explicit agreements about financial solvency, consumer protections, rate development and reviews, or market conduct rules among participating states. Knowing the rules could help address uncertainty for insurers considering new market entry.

12 Mitchell, L. (2017). **Selling Health Insurance Across State Lines**, pp. 14-16. Society of Actuaries.

13 The full H.R. 1101, Small Business Health Fairness Act of 2017, is available at **https://www.govtrack.us/congress/bills/115/hr1101/details**.

14 The full S. 1546, Commonsense Competition and Access to Health Insurance Act, is available at **https://www.govtrack.us/congress/bills/115/s1546**.

15 Problem Solvers Caucus. **Bipartisan Problem Solvers Caucus Proposal to Stabilize the Individual Market**. Washington, D.C.: Problem Solvers Caucus.

CONTACT

Susan Philip
susan.philip@milliman.com

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