



# Sales of Insurance across State Lines

## ACA Protections and the Substantial Risks of Eliminating Them

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## Introduction

Allowing insurance to be sold across state lines is an extremely popular policy among the 2016 Republican presidential candidates, including Marco Rubio, Ted Cruz, and Donald Trump,<sup>1</sup> and it was included in both the McCain and the Romney presidential campaigns. Supporters argue that sales across state lines would increase both competition in insurance markets and the choice of insurance products offered to consumers. However, the candidates' advocacy for such a policy has not acknowledged that a related policy was implemented as one component of the Affordable Care Act (ACA).<sup>2</sup>

As the Urban Institute noted in 2010, the ACA's approach differs from that of advocates of such a policy in two fundamental ways: (1) it limits sales across state lines to states that have entered into an interstate compact, basically an explicit agreement over the rules; and (2) sales across state lines are permitted only within the broad consumer protections implemented in 2014 to provide a national regulatory floor for nongroup and small-group insurance (Blumberg 2010). Absent these two differences, permitting sales of insurance across state lines could undermine state regulations and undercut insurers' ability to provide comprehensive insurance coverage in nongroup markets. Even with the ACA in place, sales of coverage across state lines raise difficult questions of state regulatory authority and enforcement. Moreover, insurers face the challenge of offering competitive premiums in markets where they have not previously negotiated provider payment rates and established a network. No states have taken advantage of this option to date.

Advocates of unrestricted sales of health insurance across state lines consistently couple the policy with deregulation of the small-group and nongroup insurance markets, eliminating the national regulatory floor established by the ACA. The pre-ACA environment was characterized by substantial

state-by-state regulatory variation in the small-group and nongroup insurance markets, with the latter being the least regulated.

Policies that would increase segmentation of health care risks, such as sales across state lines outside the regulatory floor the ACA provides, could adversely affect those without access to employer-sponsored insurance and those who have health problems. Sales across state lines would reduce premiums for those who are healthy at a given time while increasing premiums and reducing access to coverage for those with current or past health problems. Insurers would also be reluctant to offer comprehensive insurance policies in the nongroup market. The approach seriously underestimates the value of access to adequate, affordable coverage over time as individuals' health care needs change.

## Background

Self-insured health plans, those most frequently provided by large employers, are not regulated by states and as such are not relevant to a discussion of sales across state lines. Neither are fully insured products sold to employers of 50 or more; these are subject to state regulation but are not of significant concern for this policy debate. All states allow insurers to set premiums for such fully insured health plans based upon the group's characteristics and health services use. Fully insured small-group plans are subject, under the ACA, to many of the same insurance regulations as nongroup insurance, yet the discussion of sales across state lines has not focused on this market. Nongroup insurance (that is, insurance sold outside the employment context) is the central market at issue here. Because individuals can make purchasing decisions based on their own knowledge and expectations of their health care needs, the nongroup market is the one in which the potential for adverse selection is the greatest.

Before 2014 and implementation of the main ACA coverage provisions, most states allowed insurers to deny coverage to applicants in the nongroup insurance market; a few states (such as Massachusetts and New York) required guaranteed issue. (The Health Insurance Portability and Accountability Act of 1996 required guaranteed issue in the small-group market.) Some states gave insurers broad license to vary premiums based on customers' health status or history, gender, age, industry of employment, and a range of other factors. (Many had no limits on nongroup insurers' rating decisions or the factors used.) Other states put narrower limits on the permitted pricing variation. At one extreme, for example, New York had pure community rating in both the small-group and nongroup insurance markets before the ACA, as it does today (Kaiser Family Foundation 2012). Some states permitted insurers to permanently exclude coverage for particular diagnoses or body systems based on a customer's health history (also known as benefit riders) while others prohibited these permanent benefit exclusions. Because a consumer's preference for comprehensive insurance was considered a signal that he or she would be a significant user of medical care, insurance offerings tended to be parsimonious, often excluding or significantly limiting coverage for maternity care, prescription drugs, and mental health care, while including large cost-sharing requirements.

# The Risks Associated with Sales of Insurance across State Lines outside the Context of the ACA

Pre-ACA proposals to permit sales of insurance across state lines would have allowed insurers to take advantage of the regulatory variation across states. The same is true for current proposals to permit such sales while simultaneously repealing all or most of the ACA. Under such a policy scenario, insurers would have powerful financial incentives to domicile firms in states that have little regulation of nongroup insurance markets, such as those without guaranteed issue, those with no limits on premium rating, those permitting liberal use of benefit riders, and so on. Insurers doing so could then selectively sell insurance to just the healthiest, lowest-risk individuals living in states that regulate their markets more strictly. Healthier individuals living in states that require more sharing of health care risk between the healthy and the sick would have a strong financial incentive to buy coverage from these out-of-state insurers, who could charge them low premiums based on their particular characteristics and health experience.

Consequently, average health care costs would increase significantly for those enrolled in a product meeting the standards of a high-regulation state, making premiums unaffordable for those trying to buy more comprehensive coverage. Premiums would go up not just for sick people but also for relatively healthy people who prefer the more generous coverage in the more regulated market, that is, healthy older adults or families. The eventual outcome of such a dynamic could feasibly be a regulatory “race to the bottom,” in which policymakers realize that nongroup insurance markets are not sustainable in states that impose more sharing of health care risk and better consumer protections. A state’s policy intentions and preferences could therefore be undermined by decisions made in other states.

In addition to increasing costs and reducing access to insurance for those with current or prior health problems, such an environment would make it difficult for insurers to offer comprehensive coverage, even to those in seemingly excellent health. With limited sharing of health care risk remaining in the market, insurers would likely perceive purchasers’ interest in comprehensive coverage as a signal that they are aware of significant future health care service needs that insurers could not predict. As such, insurers would price plans with broader benefits or lower cost sharing considerably higher than more-limited options, as they did before the ACA. More-comprehensive plans would thus become more unattractive to the healthy and likely financially unsustainable over time, leaving consumers with only limited benefit plans from which to choose. Combined, these dynamics counter the expectations that sales across state lines would increase the health insurance options available to consumers, healthy or not.

Aside from the issues related to health care risk, health insurance sales across state lines raise the question of who would enforce the regulations of the state from which coverage is sold. Individuals may not even be aware that they are buying a policy not subject to the laws of their own state. Say an insurer violated the laws or regulations of the state of sale. Insurance regulators in the purchaser’s state would undoubtedly find it difficult, if not impossible, to enforce their laws on an insurer that may not even be licensed to sell coverage in their state. Regulators in the state in which the insurer is domiciled might

have insufficient resources and insufficient incentives to protect the residents of another state. Consequently, it is unclear how consumers would have a path for redress if necessary.

## Current Law on Selling Insurance across State Lines

Section 1333 of the ACA details the circumstances under which nongroup insurance plans may be offered in more than one state.<sup>3</sup> Insurers domiciled in one state may sell coverage to individuals residing in another state when those states have entered into a health care choice compact. Health care choice compacts are agreements in which one or more qualified health plans can be sold in the participating states; the plan is subject to the laws and regulations of the state in which it was written or issued, as opposed to the state in which the purchaser resides. However, under the ACA, the plans sold must still comply with some of the laws of the purchaser's state, including those on market conduct, unfair trade practices, network adequacy, and consumer protection (such as rules related to premium rating). Compacts are permitted as of January 2016, and state laws permitting them are required under the ACA to be enacted after the date of the ACA's enactment, March 23, 2010. However, no compact has yet been attempted, even in states that had previously enacted some form of legislation regarding sales across state lines.

The purchaser's state would also be responsible for addressing disputes about the performance of the insurance contract. Insurers are required to be licensed in each state in which they offer coverage, and they must clearly alert purchasers that the plan may not be subject to all the laws and regulations of the purchaser's state. In addition, the Secretary of the Department of Health and Human Services has the power to approve these interstate compacts and can prevent them if they are likely to reduce the generosity of coverage, decrease the number of people insured, increase the federal deficit, or weaken enforcement of laws and regulations in any of the participating states.

These conditions placed around interstate sales of nongroup insurance are intended to prevent the adverse consequences likely to occur if insurance could be sold across state lines without agreement by all the states involved and without a specified regulatory floor, like that included in the ACA, that applies to all states. If sales are only permitted with agreement from all the states involved, and if insurers must comply with the premium-rating rules in the purchaser's resident state, then one state's policy decisions cannot undermine the decisions of another without consent. And given the compact approval power of the Secretary of the Department of Health and Human Services, consumers are more likely to be protected from mutual state policy decisions that may well undermine ACA protections.

## No State Has Taken Advantage of the Option for Sales across State Lines

No state has yet taken advantage of the option offered in Section 1333. Thus far, five states—Georgia, Kentucky, Maine, Rhode Island, and Wyoming—have enacted legislation related to sales of insurance across state lines.<sup>4</sup> However, Rhode Island and Wyoming passed their laws before enactment of the

ACA; as such, they would have to enact new laws to comply with the ACA's requirements. Kentucky's law authorizes the state to explore the feasibility of an interstate agreement with contiguous states but does not specifically permit such sales. Georgia and Maine passed laws following the ACA's enactment, but neither contemplates meeting the ACA requirement of applying to the US Department of Health and Human Services for approval of a compact. Georgia's law permits insurers to sell individual health insurance policies that have been approved for issuance in other states. Maine's law permits the sales of individual health insurance policies that have been authorized for sale in Connecticut, Massachusetts, New Hampshire, or Rhode Island. Thus, states have shown extremely limited interest in the ACA's option for sales across state lines, and no state has taken all the steps necessary to put it in place (Corlette et al. 2012).

With strong and effective insurance regulation (as opposed to insurers competing for customers who have the lowest health risks, as they did before the ACA), opening markets to competition from out-of-state plans is not likely to lead to increased price competition. Out-of-state insurers face major barriers to entering new markets because of the difficulty in building provider networks whose payment rates allow them to compete with established insurers. In-state insurers have for years negotiated with doctors and hospitals and, with many covered lives in a given market area, can get significant rate concessions. Out-of-state plans have no market share and thus no bargaining power. The net result would be higher premiums than existing competitors, not lower.

## Discussion

Allowing insurers to sell plans in any state they choose, and allowing consumers to purchase coverage from an insurer based in any state, sounds straightforward and seems a common-sense proposal. But, like much of health care policy, simple descriptions can easily disguise serious adverse consequences. Why is health care so different than other products? The complexity stems from large variations in individuals' health care risks across the population.<sup>5</sup> The great bulk of health care spending is attributable to a small share of the population. Policy approaches that lead to the availability of narrower, lower-cost insurance products for the healthy will, in general, increase costs and reduce access to insurance and medical care for those who are less healthy. And, although most people are healthy most of the time, an individual's good health can change without notice. Further, everyone's health care needs tend to increase with age, meaning even the currently healthy will find value in guaranteed access to adequate, affordable health care throughout life.

The ACA allows states to enter into health insurance compacts that are based on mutually agreed-upon conditions. Proposals that would permit sales across state lines without the other states' permission and without the consumer protections provided by the ACA's insurance regulatory minimums would allow insurers to undermine state regulations and profit from enrolling healthier individuals and excluding those at risk for health care needs. The consequences would be extreme for those who are less healthy, and over the course of a lifetime, the increased costs for those with health problems and the reduced choice in plans could affect a broad swath of the population.

## Notes

1. Kimberly Leonard, “An Obamacare Provision Even Republicans Can Love,” *US News and World Report*, January 6, 2016, <http://www.usnews.com/news/articles/2016/01/06/an-obamacare-provision-even-republicans-can-love>; Marco Rubio, “My Plan to Fix Health Care,” Members Only, *Politico*, August 17, 2015, <http://www.politico.com/magazine/story/2015/08/marco-rubio-plan-to-fix-health-care-121453>.
2. Patient Protection and Affordable Care Act, 42 U.S.C., § 1333 (2010).
3. The US Department of Health and Human Services has not yet issued regulations on Section 1333 (Leonard, “Obamacare Provision”).
4. Richard Cauchi, “Out-of-State Health Insurance—Allowing Purchases (State Implementation Report),” National Conference of State Legislatures, December 2015, <http://www.ncsl.org/research/health/out-of-state-health-insurance-purchases.aspx>.
5. Linda Blumberg and John Holahan, “Don’t Let the Talking Points Fool You: It’s All about the Risk Pool,” *Health Affairs* (blog), March 15, 2016, <http://healthaffairs.org/blog/2016/03/15/dont-let-the-talking-points-fool-you-its-all-about-the-risk-pool/>.

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**Linda J. Blumberg** is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the ACA; in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in select states and nationally. Examples of other research include analyses of the implications of the *King v. Burwell* and *House v. Burwell* Supreme Court cases; studies of competition in nongroup insurance marketplaces; assessing the implications of self-insurance among small employers; and comparing the importance of employer and individual mandates in reaching ACA objectives. She also

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Blumberg is frequently asked to testify before Congress and is quoted in major media outlets on health reform topics. She serves on the Cancer Policy Institute’s Advisory Board and has served on the *Health Affairs* editorial board. From 1993 through 1994 she was a health policy advisor to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy.

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