Primer: Interstate Sale of Health Insurance

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The interstate sale of health insurance is an idea that has been gaining momentum among health insurance reform advocates for decades. Though there are obstacles that would have to be overcome, allowing individuals to purchase their health insurance from other states could ultimately help to increase competition and affordability.

History

Until 1945, the sale of health insurance was not considered 'commerce' and so was constitutionally outside the scope of federal regulation. In 1944 a Supreme Court ruling in US v. South Eastern Underwriters Association held that the purchase of health insurance is participation in 'commerce' and therefore under congressional control.[1] To avoid major upheavals in the market, in 1945 Congress passed the McCarran-Ferguson Act giving states the power to regulate insurance as long as Congress does not *explicitly* state the federal legislation is intended to affect the regulation of insurance.

In 1974 Congress passed the Employee Retirement Income Security Act (ERISA) and, without serious debate or consideration, included employer self-insurance under its provisions.[2] The inclusion of health insurance in ERISA removed insurance plans run by employers from state control. The effect was to create a dichotomy among health insurance regulations – small employers are subject to different, and often more expensive regulations than self-insured employers, which puts fully insured employers and individuals at a competitive disadvantage in purchasing insurance.

A Cost-Benefit Analysis

As health care and health insurance have grown and changed over the last 70 years, state regulations have diverged greatly from one another, creating vastly different regulatory environments, and insurance companies have adapted to suit each state's regulatory framework. While state laws have become more polarized, developments in technology have decreased the importance of local versus national markets and made cross-country sales of everyday items and services commonplace.[3] Americans

have easy access to information about health insurance in other states, but they continue to be unable to purchase it. This has led to more and more discussion of the sale of health insurance across state lines.

There are many benefits to a world in which health insurance could be sold across state lines, as well as some potential drawbacks.

Pros

If insurance was sold across state lines, consumers would have more options; this means that they would be more likely to find the plan best suited to their personal needs. For example benefits that are mandated in some states, such as drug rehab or acupuncture may raise the cost of plans by 30-50 percent, and are controversial. Consumers in states where these are mandatory may not want to pay for these unwanted benefits, while consumers in neighboring states may be unable to obtain these benefits at all.[4] By allowing greater freedom of choice, individuals can signal to insurers and states what benefits they actually find valuable through market rather than political pressure. As Tom Miller of the American Enterprise Institute has said, "You shouldn't limit people to products in the states where they live, or make them move to get the insurance they want."[5] By allowing insurance to be sold across state lines, consumers would be enabled to get the products they want without moving.

There is also a strong argument to be made for competition in the health insurance market. By allowing the sale of insurance across state lines the increased competition created would make premiums more affordable. The Congressional Budget Office has speculated that 50 true 'Across State Lines' laws—where the holders' state's fraud and abuse laws are applied but consumers could purchase from any state—would lead to about one million people leaving the employer sponsored insurance market in favor of cheaper or more comprehensive out of state plans. There would likely be additional migration among consumers in the individual market,[6] which would exert downward pressure on premiums. A drawback of this is that it would likely take several years for out-of-state insurers to create large enough networks and gain enough market share to affect average premiums within a state.[7]

Another great advantage to allowing sale of insurance across state lines is that, like individuals, small employers would have more options.[8] This

would help to lessen the inequalities between small and large employers who provide insurance to their employees by making it more affordable for fully insured companies.

While some of these benefits might have limitations, 'Across State Lines' laws would be most effective in states with dense populations or major cities near their borders, such as MD, DC, and VA, or NY, NJ, and PA, where the effect of opening the insurance market could cause a 22-49 percent increase in health coverage (over 2012 numbers) based on these benefits alone.[9]

Cons

On the other side of the debate there are also some legitimate concerns. First among them is the concern that there will be a race to the bottom among states trying to attract business. The fear is that some states will continue to roll back mandated benefits beyond ancillary benefits and will begin to drop basic consumer protections.[10] If, for example, one state decided it wanted to draw a larger market share it might eliminate drug rehab from mandatory benefits. This would cause an adverse selection effect where people with low risk of needing those benefits will be drawn to that state, and those most interested in this benefit would still be able to get it from insurers who continued to offer it within the state or by purchasing insurance from another state. The aggregate effect of this could lead to more generous plans increasing in cost.[11]

Another iteration of the adverse selection effect that some worry about is whether community rating would be able to survive in a truly competitive market.[12] Although it is possible that there may be market forces working against community rating, there are other forces that could help mitigate any problems caused by it—specifically the addition of more people to the individual marketplace, and the downward force on premiums would help to make even underwritten plans more affordable.

In Practice

Many people believe 'Across State Lines' laws are a good idea in theory, but the disagreement arises over how to implement this idea without sacrificing too many consumer benefits mandated by some state laws. There are generally three options put forward: give the states control, give

the federal government more control, or give the federal government total control.

Where States Have Control

Before the passage of the Affordable Care Act (ACA), a handful of states enacted versions of 'Across State Lines' laws that called for either the study or implementation of such policies.[13] Six states succeeded in passing these laws, where many others fell short of this goal. Kentucky, Washington state, and Rhode Island passed laws that called for the study of whether and how to create laws that allow for interstate sale of insurance.[14] All three studies resulted in evidence that there would be significant hurdles to implementing this type of law, and so they ultimately did not allow for the sale or purchase of insurance outside their borders.

Georgia and Maine went a little further and allowed insurers who were already licensed in those states to offer residents plans that insurer offered in other states.[15] This was a small step forward, since there are generally few differences among plans offered by the same insurer among the different states and new insurers were not allowed to enter the market, but it was made even smaller by Maine, where permissible out-of-state plans were limited to those sold in Connecticut, Massachusetts, New Hampshire, and Rhode Island—states with some of the most burdensome consumer protection laws.

Wyoming went the farthest towards creating a true free market in health insurance by allowing out-of-state insurers to offer their plans in the state if the state the insurer is licensed in has insurance regulations that are consistent with those of Wyoming.[16] The law also expresses the hope of the state legislature that a multi-state insurance agreement would develop.[17]

Unfortunately neither the multi-state agreement nor the exercise of this law ever materialized, likely because it was passed in 2010 and it was unclear to states and insurers what effect the ACA would have on the health insurance landscape. In fact, no insurer in any of these states has taken advantage of the laws. Beyond the uncertainty that arose as a result of the passage of the ACA, there are other obstacles to overcome for states that allow interstate sale of insurance and the insurers in those states.[18]

The practical barriers to expansion of insurance plans are the biggest problem, but also likely the easiest to solve. The first hurdle for insurers

moving into new states will be developing networks within those states.[19] It is difficult to create a network out of whole cloth, and it will take insurers time to determine which providers should be included, and how to keep costs low within the network. Keeping costs low will be particularly difficult in states where established insurers dominate the market; new insurers will have difficulty negotiating with providers because they will likely not have as much volume of consumers to bargain with. However, it would not take long for an insurer with other competitive advantages to make up for this disadvantage and overcome these obstacles by attracting more customers.[20]

Another obstacle to the success of interstate sale of insurance will be the fact that not even a perfect free market will eliminate regional variations in the cost of care—plans (and prices) in one state may be entirely inappropriate in another state, making it difficult if not actuarially impossible to perfectly replicate the same plan in multiple states.[21]

The concept of multi-state compacts could help overcome problems from regional variation, particularly if they manage to create a minimalist regulatory system.[22] These compacts may well develop over time, but in the short term it can be expensive and time consuming to understand and implement them, and then to deal with the inevitable conflicts that will develop when actors in one state are ruled by the laws of another state. There could also be trouble for the courts if what are today state-law questions began finding their way into federal courts based on the diversity of citizenship between insurers and their customers.[23] In this scenario, the fewer the laws and the freer the market, the sooner insurers and consumers will be able to adapt and the less costly the transition will be.

Where the Federal Government Has More Control

Another possible way to allow the interstate sale of health insurance would be to create Multi-State Plans (MSPs) approved by a federal agency.[24]

The ACA has attempted its own version of these plans, but allows them to be sold only through the ACA health care Exchanges. The ACA's MSPs are heavily regulated by the federal government—they are designed after the Federal Employees Health Benefits Plan (FEHBP) and are run by the Office of Personnel Management, which also manages FEHBP.[25] MSPs are required to operate in at least 30 states in 2014, and must expand to all 50

states by 2018, though they are not required to serve all regions in a state.[26] These plans are subject to federal and not state regulations because while the McCarran-Ferguson Act prevents state regulations from field preemption, a federal statute directly taking control of a sector of the health insurance market will preempt state laws.

Blue Cross/Blue Shield was the only insurer to submit an application to participate in the MSP program.[27] This lack of competition in the multi-state market confirms fears that under this type of federally run system, insurers will not enter new markets, but the largest insurers will simply expand and consolidate their market share. Even though states still had control of their individual markets, the national multi-state plan seems to have all the risks of interstate sales, with none of the benefits.[28]

Where the Federal Government Has Total Control

The final option for opening state borders for the sale of insurance would be to repeal McCarran-Ferguson and legislate mandatory participation in interstate sales of insurance. In this scenario Congress could create minimum consumer protections and even fraud and abuse regulations. This heavy-handed approach seems to avoid some of the parade of horribles opponents of free markets predict, but it would also have the effect of not allowing insurers and consumers to take advantage of different opportunities in the market, but of forcing consolidation into one national health care market.

This type of reform was explicitly considered and rejected during the 2009 debates over the ACA.[29] There the Senate insisted on state-based exchanges rather than on federal exchange with the ability to mandate minimum standards for participation. Still, the idea of a nationally regulated health insurance market holds sway with some groups, such as Families USA, who are afraid that allowing competition among states would lead to the deterioration of things like community rating.[30] Others rejoin by stating that moving away from centralized control would “improve conditions in states that have ruined their markets by rigidly regulating policies” (JP Wieske),[31] and allow Americans to choose the type of plans and protections they want without having to move to another state.

Conclusion

Though there are some obstacles in the way, they are easily overcome and the benefits of expanding the sale of health insurance across state lines could be significant. By freeing individuals of the constraints of regulation a state can give its citizens their best opportunity to find the insurance plan that best fits their needs. It will be important though for state legislatures to remember that the point of insurance reforms should be to give citizens more choice, not to increase the appearance of choice while really creating a market where only the insurers that are already dominant can survive.

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[1] US v. South Easter Underwriters Assn, 322 U.S. 533 (1944).
[2] ERISA, 29 U.S.C. §1001-1461.
[3] National Federation of Independent Businesses Research Foundation, Healthcare Solutions: Interstate Insurance Markets, nfib.com, accessed Aug. 27, 2014; http://www.nfib.com/Portals/0/PDF/AllUsers/research/cribsheets/interstate-insurance-markets-cribsheet.pdf.
[4] Avik Roy, Will Buying Health Insurance Across State Lines Reduce Costs?, Forbes.com (May 11, 2012); http://www.forbes.com/sites/theapothecary/2012/05/11/will-buying-health-insurance-across-state-lines-reduce-costs/.
[5] Phil Galewitz & Lexie Verdon, FAQ: Selling health insurance across state lines, Kaiserhealthnews.org (Jan. 25, 2011); http://www.kaiserhealthnews.org/stories/2010/september/30/selling-insurance-across-state-lines.aspx.
[6] CBO, Cost Estimate H.R. 2355 Health Care Choice Act of 2005 (Sept. 12, 2005); http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/66xx/doc6639/hr2355.pdf.
[7] Roy, *supra* note 5.
[8] NFIB, *supra* note 4.
[9] Id.
[10] Richard Cauchi, Out-Of-State Health Insurance – Allowing purchases (State Implementation Report), National Conference of State Legislatures (May 2014); Sam Baker, Parties Clash Over Selling Insurance Across State Lines, The Hill (May 25, 2011); http://thehill.com/policy/healthcare/163297-parties-clash-over-selling-insurance-across-state-lines.
[11] Baker, *supra* note 11.
[12] Roy, *supra* note 5.
[13] Cauchi, *supra* note 11.
[14] Id.
[15] Id.
[16] Id.
[17] Not to be confused with the national-level Interstate Healthcare Compact formed in 2011. This Compact is a full healthcare reform proposal with limited language affecting health insurance specifically, and is therefore outside the scope of this paper
[18] Sabrina Corlette, Christine Monahan, Katie Keith & Kevin Lucia, Selling Health Insurance Across State Lines: An assessment of state laws and implications for improving choice and affordability of coverage, Georgetown University Health Policy Institute Center on Health Insurance Reforms (October 2012); http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401409.
[19] Roy, *supra* note 5.
[20] Id.
[21] Jordan Rau, IOM Finds Differences In Regional Health Spending are Linked to Post-Hospital Care and Provider Prices, Kaiser Health News (Jul. 24, 2013);

http://www.kaiserhealthnews.org/stories/2013/july/24/iom-report-on-geographic-variations-in-health-care-spending.aspx.
[22] Corlette et al., *supra* note 18.
[23] Id.
[24] Sarah Goodell, The Multi-State Plan Program, Health Affairs Health Policy Briefs (May 29, 2014); http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=116.
[25] Id.
[26] Id.
[27] Id.
[28] Id.
[29] Galewitz & Verdon, *supra* note 6.
[30] Id.
[31] Id.