

Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage

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Executive Summary

Proposals to authorize the sale of private health insurance “across state lines” are often promoted to address the challenges of high health insurance costs and a lack of choice among insurers and have been a core component of alternative health reform proposals since the mid-2000s. Critics, however, argue that across state lines proposals would lead to deregulation and a “race to the bottom” where health insurers relocate to the states with the least burdensome regulations.

Despite the often forceful arguments for and against across state lines proposals, there has been little opportunity to assess how they work in practice. To understand the impact of across state lines proposals on the availability of health insurance and the competitiveness of state health insurance markets, we analyzed legislation that has been enacted in six states—Georgia, Kentucky, Maine, Rhode Island, Washington and Wyoming—to require, encourage or study the feasibility of allowing the sale of health insurance across state lines or the formation of interstate health insurance compacts. To gain a more in-depth understanding of the laws’ impact, we also reviewed related materials such as regulations, studies and reports and conducted interviews with government officials and insurers.

We find that while across state lines proposals cite many important goals—such as enhancing consumer choice, increasing competition and making insurance more affordable—the across state lines proposals as currently enacted in six states do not address the true drivers of health insurance costs nor do they adequately take into account the complexity of how insurance products are sold and regulated. The proposals also underestimate the administrative hurdles necessary for full implementation. As a result, none of the across state lines laws resulted in a single insurer entering a new market or the sale of a single new insurance product.

Key Findings

- **To date, although all states have long had the authority to do so, only six have enacted across state lines legislation.** Georgia, Maine and Wyoming enacted legislation allowing the sale of insurance across state lines. In addition, Maine and Wyoming encourage the formation of interstate compacts. After failed attempts to pass across state lines legislation, Kentucky, Rhode Island and Washington enacted legislation requiring their insurance departments (DOIs) to research and evaluate the feasibility of allowing the sale of policies across state lines or forming interstate compacts.
- **The stated purpose of laws permitting the sale of health insurance across state lines and the formation**

of interstate compacts were largely similar across the states. The purpose of these laws was generally to increase the availability and affordability of health insurance coverage by allowing consumers to purchase products approved in other states. In interviews, state officials and insurers also noted goals such as 1) exempting coverage from state benefit mandates, often perceived to be a driver of premium increases; and 2) securing the same “deal” on insurance that a neighboring state gets. Respondents in some states noted that across state lines proponents were frequently looking for an “alternative” to the Patient Protection and Affordable Care Act (ACA) and similar state efforts to expand coverage to the uninsured.

- **Across state lines proposals have been unsuccessful at meeting their stated goals.** Of the three states requiring feasibility studies, only two states completed such studies. Officials in both states—Kentucky and Washington—concluded that there were significant roadblocks to implementation. Regulators took no further action and neither legislature enacted subsequent across state lines legislation. The two states that have implemented across state lines laws, Georgia and Wyoming, reported similar challenges. No out-of-state insurers have entered either of these markets or indicated their intent to do so as a result of the states’ across state lines legislation. Maine officials reported that no out-of-state insurers have yet indicated their intent to enter the market under Maine’s new across state lines law.
- **Across state lines legislation was largely unsuccessful because of the localized nature of how health care is delivered.** Respondents universally reported the enormous difficulty that out-of-state insurers face in building a network of local providers, and insurers identified doing so as a significant barrier to market entry that far surpasses concerns about a state’s regulatory environment or benefit mandates. State officials and insurers also noted that across state lines legislation ignores the primary cause of high prices—the cost of delivering care—and fails to account for often dramatic differences in the cost of care between states and regions.
- **Practical barriers and administrative obstacles also hinder success.** Many state regulators are reluctant

to relinquish some or all authority to enforce state standards by taking the risk of allowing another state to establish and enforce consumer protections that affect their residents. Respondents in five states reported difficulties in implementation because other states have little incentive to establish across state lines partnerships. In addition, officials and insurers in all six states noted the complexity of health insurance as a practical barrier to across state lines proposals and that establishing the rules under which an interstate health insurance compact would operate would likely demand more time and resources than states are willing to commit.

- **Once enacted, these laws appear to lack any organized champion.** Although some of the administrative obstacles to regional sales or compacts may have been surmounted if supporters advocated for the laws to be fully implemented, not one state official reported any advocacy from any stakeholder, including the consumers and insurance companies the laws were designed to benefit. Respondents reported little insurer interest in using the laws as vehicles for entering a new market or selling new products. Across state lines legislation moved through state legislatures largely because of the efforts of well-positioned legislators, think tanks and, in some states, small business trade groups who did not push for full implementation of the law after it was passed.

Although our findings are limited to the context of state-based across state lines legislation, the concerns raised are likely the same if across state lines legislation is enacted at the federal level. Indeed, federal across state lines legislation has the potential to preempt many more state consumer protections, lead to a regulatory “race to the bottom,” and reduce access to coverage for people with pre-existing conditions. It poses these risks while failing to address market barriers identified by respondents—such as the cost of building a network of local providers and the cost of delivering care in different states and regions.

While it is certainly the case that many consumers and small businesses lack meaningful choices among insurers and struggle to find affordable coverage, our findings suggest that across state lines legislation does not appear to be the “silver bullet” that proponents are searching for.

Introduction

Historically, private health insurance has been regulated at the state level, resulting in significant variation across the country in the rules and consumer protections that apply to insurance companies and the products they sell. While certain standards appear to be consistent across states, such as financial solvency requirements, other requirements, such as benefit mandates, rating rules and requirements to offer or continue coverage, vary widely.¹

In many ways, this variation has led to the creation of distinct regulatory regimes across the 50 states and, some argue, hinders the competitiveness of health insurance markets and limits access to affordable health insurance for consumers. To address such challenges, some policymakers have called for the sale of private health insurance “across state lines.”² Allowing insurers to do so would authorize an out-of-state health insurer to sell products in multiple states without complying with all of the different insurance laws in each of those states.

States have long been able to authorize the sale of insurance across states lines. This remains true even as new federal laws established a more active role for the federal government in the regulation of health insurance. These laws include the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Protection Act of 1996 (HIPAA) and, most recently, the Patient Protection and Affordable Care Act of 2010 (ACA). While such laws set minimum national standards for group and individual health insurance, states continue their role as the primary regulators of health insurance, and have significant flexibility in how they implement and enforce the federal standards.

A Brief History of Across States Lines Proposals

Proposals to facilitate the sale of private health insurance across state lines have been considered at both the federal and state level. The concept of across state lines policies was first introduced at the federal level by Representative John Shadegg and Senator Jim DeMint in the Health Care Choice Act of 2005.³ Shadegg and DeMint’s proposal would allow insurers to be governed by the rules of the state

in which they are domiciled, referred to as the “primary state,” rather than the rules of the state in which they are selling a product, referred to as the “secondary state.” The Health Care Choice Act did not pass and Congress has yet to pass federal across state lines legislation.

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With or without changes to federal law, states already have full authority to decide whether or not to allow sales across state lines and, if so, under what circumstances. For example, a state may allow the sale of policies from insurers in any other state or choose to allow out-of-state insurers on a more limited basis, such as from neighboring states. In addition, states have the ability to determine which regulatory and enforcement functions remain under their jurisdiction. Across state lines proposals are consistently popular among state legislators: for example, at least 17 states considered some version of such legislation during the 2012 legislative session.⁴

In addition to these traditional across state lines proposals, states and the federal government have enacted interstate compact legislation. Under such proposals, compacting states establish a standard set of rules and processes to govern the sale of health insurance within the boundaries of the compact. Compacting states would choose to adopt the standards of a given state or mutually develop and adopt a new set of uniform standards.

Although federal legislation is not necessary for states to enter into compacts, the ACA includes a provision authorizing states to enter into “health care choice compacts” subject to approval by the Secretary of the U.S. Department of Health and Human Services (HHS) beginning January 1, 2016.⁵ Under the ACA, “health care choice compacts” must meet a number of criteria that include, for example, subjecting insurers to certain standards of the state in which the purchaser of a

policy resides. These standards include market conduct, unfair trade practices, network adequacy and consumer protections such as rating restrictions, among others. In addition, the Secretary of HHS may only approve a compact if she determines that it, among other things, will not weaken the enforcement of laws and regulations in any member state.

Nonetheless, states are not barred from entering into compacts that do not meet the federal standards nor does the ACA include any incentive for states, such as grant funding, to opt for its version of a compact. Although states already have this authority, no states have entered into an “interstate compact” for health insurance.

In contrast, forty-one states currently participate in the Interstate Insurance Product Regulation Commission (IIPRC), a compact founded in 2006 that provides a uniform electronic filing platform and national standards for life insurance, disability income, long-term care insurance and annuities.⁶ The IIPRC was established in response to widespread concerns about the impact of variation in state standards as well as filing and review processes for life insurance. Although considered successful for these lines of insurance, the IIPRC specifically excluded health insurance (as well as automobile and homeowners insurance) in recognition of these products’ sensitivity to local costs and conditions.⁷

Arguments For and Against Across State Lines Proposals

Proposals to facilitate the sale of private health insurance across state lines generate significant debate and are often controversial. Exhibit 1 briefly summarizes common

arguments for and against allowing health insurers to sell health insurance across state lines.

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Proponents of selling across state lines policies argue that allowing health insurers to do so creates national or regional markets for health insurance, in which insurers can bypass costly and burdensome state regulatory processes, administrative costs and mandates. They argue that this would give consumers access to more affordable products that may be more tailored to their needs. For example, proponents argue that a 30-year-old man should be able to buy an insurance product that does not include his state’s maternity benefit mandate. By allowing insurers to offer policies across state lines, proponents argue that consumers would have more options available to meet their needs at more affordable prices.⁸ In addition, some proponents note that the creation of a regional market for insurance would help consumers, employers and insurers in regional job markets, where large numbers of people live in one state and commute to work in another state.⁹

Critics, however, argue that across state lines policies lead to deregulation and a “race to the bottom” where health insurers choose as the primary state the state with the least burdensome regulations. If required to offer more comprehensive benefit packages, guaranteed

Exhibit 1: Common Arguments For and Against Across State Lines Proposals for Health Insurance

Arguments For Across State Lines Proposals	Arguments Against Across State Lines Proposals
<ul style="list-style-type: none"> Creates national or regional markets for health insurance Allows insurers to bypass burdensome state regulatory processes and costly state mandates Gives consumers access to more affordable products Provides consumers with products that may be more tailored to their needs 	<ul style="list-style-type: none"> Leads to a “race to the bottom” where health insurers adopt standards from the states with the least burdensome regulations and fewest consumer protections Increases premiums for individuals and families with pre-existing conditions Segments the risk pool rather than encouraging competition or efficiency Disadvantages insurers offering more comprehensive coverage and consumer protections

issue or community-rated policies, insurers operating under the rules of more protective states would attract a disproportionately unhealthy risk pool and thus face higher costs and be unable to compete against insurers operating under the rules of states with fewer regulatory requirements. While critics acknowledge that allowing the sale of across state lines policies could increase the availability of lower premium plans for some, they argue that this is true only for the healthiest customers who may be able to access lower-cost plans while premiums would increase significantly for individuals with pre-existing conditions or families who need more comprehensive coverage.^{10,11}

While critics acknowledge that allowing the sale of across state lines policies could increase the availability of lower premium plans for some, they argue that this is true only for the healthiest customers who may be able to access lower-cost plans while premiums would increase significantly for individuals with pre-existing conditions or families who need more comprehensive coverage.

Researchers have identified parallels between across state lines proposals and the market for health insurance sold through associations.^{12,13} Already, many states exempt health insurance that is sold through an out-of-state, or national, association from some or all standards that apply to their traditional health insurance markets.¹⁴ Researchers have found that such exemptions can negatively impact markets and undermine consumer protections.¹⁵ For instance, by allowing national association plans to bypass state rate and form filings (and, instead, simply certify that they are in compliance), regulators often only learn of noncompliance after problems have occurred through consumer complaints or market conduct investigations. In addition, some regulators have reported barriers to assistance for consumers covered by a national association due to jurisdictional issues and resource constraints.¹⁶ Critics argue that across state lines legislation could have the same deleterious effects on state markets.

Others have noted both constitutional and practical limitations of across state lines legislation, particularly in the context of federal across state lines proposals.¹⁷ With full implementation of the insurance provisions of the ACA, under which a significantly more robust

federal floor of insurance regulation will be in place, the deregulatory impact of across state lines proposals is likely to be tempered.¹⁸ Nonetheless, states' ability to adopt or maintain stronger rules than those required by federal law could be preempted if a federal across state lines law were enacted.^{19,20}

About This Study

Despite the often forceful arguments for and against across state lines proposals, there has been little opportunity to assess how they would work in practice. To understand the impact of across state lines proposals on the availability of health insurance and the competitiveness of state health insurance markets, we reviewed state legislative proposals that promote the sale of insurance across state lines, as well as proposals to encourage the formation of interstate health insurance compacts. We identified a total of six states that have enacted an across state lines or compacting law: Georgia, Kentucky, Maine, Rhode Island, Washington and Wyoming. We analyzed these laws as well as administrative materials such as regulations, studies and reports generated as a result of these laws. To gain a more in-depth understanding of the laws' impact, we also conducted interviews with government officials and insurers.

This study does not include all legislative activity regarding across state lines proposals. Instead, the analysis is limited to fully enacted legislation that encourages the sale of across state lines policies or requires an evaluation of such proposals. Thus, we did not address legislative resolutions (which may not be binding in all states) on across state lines proposals²¹ or legislation regarding the role of health insurance exchanges in facilitating across state lines sales.²²

This study also does not address state "Health Care Compact" bills designed to nullify the ACA and allow states to circumvent federal requirements on all federal health care programs (including Medicare and Medicaid). This type of legislation is broader than the health insurance compacting laws discussed below, which are focused solely on the regulation of private health insurance, and is outside the scope of this paper.

The findings in this paper are the authors' alone and should not be attributed to any individuals or groups with whom we consulted.

Findings

To date, only six states—Georgia, Kentucky, Maine, Rhode Island, Washington and Wyoming—have enacted laws to require, encourage or study the feasibility of allowing the sale of health insurance across state lines or the formation of interstate compacts.

To date, only six states—Georgia, Kentucky, Maine, Rhode Island, Washington and Wyoming—have enacted laws to require, encourage or study the feasibility of allowing the sale of health insurance across state lines or the formation of interstate compacts. Kentucky, Rhode Island and Washington enacted legislation requiring their insurance departments (DOIs) to research and evaluate the feasibility of allowing the sale of policies across state lines or forming interstate compacts. None of these three states took additional action—such as passing further across state lines legislation—following their study and analysis. In contrast, Georgia, Maine and Wyoming enacted legislation allowing the sale of insurance across state lines with Maine and Wyoming additionally encouraging the formation of interstate compacts.

Of these three states, Georgia and Wyoming's laws are currently in effect; Maine's law becomes effective January 1, 2014. Officials in all six states reported that no health insurers have entered the market or expressed an interest in entering the market in response to the passage of across state lines or interstate compact legislation.

The Evolution of Across State Lines Laws in Six States

The stated purpose and goals of laws to encourage the sale of health insurance across state lines and the formation of interstate compacts were largely similar in Georgia, Kentucky, Maine, Rhode Island, Washington and Wyoming (Exhibit 2). In interviews, state officials and insurers also noted goals such as 1) exempting coverage from state benefit mandates, often perceived to be a driver of premium increases; and 2) securing the same “deal” on insurance that a neighboring state gets. For example, one Maine respondent noted, “everything is cheaper in New Hampshire, so it's natural for people to ask, ‘why can't we buy our insurance in New Hampshire?’”²³

Exhibit 2: Summary of Across State Lines Laws in Six States, September 2012

State	Purpose	Scope	Year Enacted
Georgia	To increase the availability of health insurance coverage by allowing insurers licensed in Georgia to sell products that have been approved in other states.	Individual health insurance products	2011 (effective Jul. 1, 2011)
Kentucky	To promote and protect the interest of consumers and improve coordination among DOIs regarding uniform minimum standards while ensuring that Kentucky's laws are “maintained and protected.”	Explore feasibility	2006 (included annually in state budget bill)
Maine	Not identified in legislation.	Individual health insurance products	2011 (effective Jan. 1, 2014)
Rhode Island	To encourage the development of a regional market for health insurance and encourage more insurers to enter the Rhode Island market.	Study and report	2008
Washington	To provide affordable health insurance coverage for persons purchasing individual health coverage.	Study, report, and model state legislation	2008
Wyoming	To increase the “competitive availability” of health insurance coverage and, by creating a multi-state consortium, attract insurers to “develop and rapidly introduce lower cost effective products” to the residents of Wyoming.	Individual health insurance products	2010

Sources: Authors' review of state legislation.

State officials and insurers reported that laws to encourage the sale of health insurance across state lines and the formation of interstate compacts were largely supported by advocates seeking a “silver bullet” to address the challenges of high costs and a lack of choice among insurers.²⁴ Insurers indicated that they remained largely neutral on the efforts to pass across state lines legislation, noting that the bills were typically promoted by think tanks and legislators that often act as their “friends” on other issues.²⁵

Respondents in some states noted that across state lines proponents were frequently looking for an “alternative” to the ACA and similar state efforts to expand coverage to the uninsured. At the same time, with the exception of Washington, respondents reported that across state lines bills moved forward largely without much organized backing from business groups, the insurance industry, or other health care stakeholders in the states. As one state official put it, “this [bill] was an effort by lawmakers to say, ‘yes, we’re doing something’ [about the cost of health insurance].”²⁶ An industry observer noted, “[the bill] became part of the Rotary Club speeches in which legislators pointed to their accomplishments.”²⁷ In Washington, a state business association was the major proponent of the across state lines law.²⁸

Respondents in some states noted that across state lines proponents were frequently looking for an “alternative” to the ACA and similar state efforts to expand coverage to the uninsured.

In Rhode Island, Washington and Kentucky, failed attempts to pass across state lines legislation evolved into laws requiring the insurance departments to study the issue. This evolution may have resulted from a lack of political support for bills that would have exempted insurers from regulatory oversight; opposition from state DOIs reluctant to cede regulatory authority; and concerns raised by consumer groups about maintaining existing consumer protections.

Across State Lines Laws: Are They Working? Reports from Six States

Interviews with officials in the six states suggest that across state lines proposals have been unsuccessful at

meeting their stated goals. First, of the three states requiring feasibility studies, only two states completed such studies. Regulators in both states—Kentucky and Washington—concluded that there were significant roadblocks to implementation and neither the regulators nor the legislature took further action. Second, the two states that implemented across state lines laws (Georgia and Wyoming) report similar implementation challenges. No out-of-state insurers have entered either of these markets or indicated their intent to do so as a result of the states’ across state lines legislation.

Interviews with officials in the six states suggest that across state lines proposals have been unsuccessful at meeting their stated goals.

Study States. Of the three states requiring studies on the feasibility of across state lines proposals and the formation of interstate compacts (Exhibit 3), only Rhode Island’s study has not been completed. Rhode Island officials indicated that the study likely would have been completed if stakeholders had shown more interest in the study’s conclusions, but noted that they have not been contacted about the issue since the law’s passage.²⁹ There has been similar disinterest from insurers: a regional health insurer based in Massachusetts indicated only minimal interest in the legislation, noting that Rhode Island’s regulatory requirements are a comparatively low priority in deciding whether to enter the market.³⁰

In contrast, Kentucky’s legislation did not require the DOI to conduct a study, but simply expresses the intent to “explore the feasibility” of entering into an “Interstate Reciprocal Health Benefit Plan Compact” with contiguous states.³¹ The insurance commissioner subsequently sent letters to the insurance commissioners of Kentucky’s seven contiguous states (Missouri, Illinois, Indiana, Ohio, West Virginia, Virginia and Tennessee), asking if they had interest in joining in such a compact. Kentucky regulators reported engaging in a number of discussions with regulators in these states, but ultimately concluded that there were significant roadblocks to the implementation of a compact. Among other challenges, regulators pointed to open questions such as how each state’s benefit mandates and consumer protections would be treated as well as which state would enforce legal

Exhibit 3: State Requirements for Studying Across State Lines Proposals, September 2012

State	Requirements
Kentucky	Explore an Interstate Compact. The provision expresses the intent of the Commonwealth of Kentucky to “explore the feasibility of an Interstate Reciprocal Health Benefit Plan Compact (IRHBPC) with contiguous states” to allow residents of the compacting states to buy health plan coverage among the participating states.
Rhode Island	Study and Report. By March 1, 2009, the Health Insurance Commissioner was required to review the laws of New England states; consider whether the Rhode Island licensing process is a barrier to entry for out-of-state insurance companies; and submit a report to the General Assembly on what steps would be necessary to allow insurers based in other New England states to do business in Rhode Island without a Rhode Island license.
Washington	Study and Report. By December 1, 2008, the DOI was required to study the feasibility of a multi-state health insurance plan compact and propose model state legislation that each participating state would enact prior to entering into the compact.

Sources: Authors’ review of state legislation.

protections if a consumer had a problem with a policy. State officials noted that, six years after the legislation was passed, they have not received any inquiries or interest from insurers or other stakeholders regarding a compact.³²

Kentucky regulators reported engaging in a number of discussions with regulators in these states, but ultimately concluded that there were significant roadblocks to the implementation of a compact.

Washington was also required to complete a feasibility study, which the Office of the Insurance Commissioner submitted to the legislature in December of 2008.³³ The study concludes that a multi-state compact for the regulation of health insurance is not currently viable, nor is it a solution to the lack of affordable health insurance. Specifically, the study notes that:

- Compacts require consensus and champions to be successful, and they must be adopted by multiple states on a word-for-word basis. The authors conclude there is not sufficient consensus among states to make a health insurance compact feasible, particularly given the widely varying approaches to regulating health insurance.
- For the compact to achieve its goals, it would require leveling the wide diversity in costs of health care goods and services that exist from state to state and market to market. Because the costs of health care are based on local issues like the availability of providers and

population demographics, the report concludes that a compact could not effectuate the necessary leveling of prices.

The Washington report further concludes that the administrative costs needed to create a compact outweigh the potential benefits.³⁴

Across State Lines States. Of the three states that enacted across state lines legislation (Exhibit 4), Wyoming’s law was enacted first and has two main requirements. First, the insurance commissioner is directed to identify five states with health insurance laws that are consistent with Wyoming’s laws and approve policies from these states for sale in Wyoming. Second, the insurance commissioner must explore the creation of a consortium with other insurance commissioners of “like-minded” states to develop a reciprocity agreement.³⁵

The Wyoming insurance commissioner reached out to surrounding states shortly after the legislation was passed in 2010. However, the commissioner was unable to find a state interested or willing to create a consortium as envisioned under the law.

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Exhibit 4: State Requirements for Across State Lines Laws, September 2012

State	Requirements
Georgia	<ul style="list-style-type: none"> • Regulatory Oversight. The DOI must approve individual health insurance products if they are approved for sale in another state, so long as the insurance company is licensed in Georgia. Domestic insurers must also be permitted to sell products equivalent to those out-of-state products. All products, even those approved for sale in another state, must be filed with the DOI. • Consumer Disclosure. The products must include a notice to consumers that the benefits of the policy “may primarily be governed by the laws of a state other than Georgia,” and the marketing materials must include a side-by-side chart comparing the benefits covered by the policy with the benefits required to be covered under Georgia law.
Maine	<ul style="list-style-type: none"> • Regulatory Oversight. Individual health insurance policies marketed by a “regional” insurer can be sold in Maine without a “Certificate of Authority” (or license) from the state. To be a regional insurer, a company must be licensed to sell individual policies in Massachusetts, New Hampshire, Connecticut or Rhode Island. Although exempt from many of Maine’s insurance rules (such as benefit mandates), insurers must comply with certain Maine laws, including: consumer disclosure requirements about benefits and exclusions; network adequacy; grievance procedures; and rating rules. In addition, insurers licensed in Maine are allowed to sell products duplicating those offered in other regional states by their affiliates, or those offered in Maine by regional insurers. • Consumer Disclosure. Applications and policies must disclose to consumers that the policy is “governed by the laws and rules of (regional insurer’s or health maintenance organization’s state of domicile). This policy may not be subject to all the insurance laws and rules of the State of Maine,” including coverage of certain benefit mandates. Consumers are advised to review the policy’s terms and conditions of coverage.
Wyoming	<ul style="list-style-type: none"> • Identify Similar States for Policy Approval. The insurance commissioner must identify five states with health insurance laws that are consistent with Wyoming’s laws and approve insurance policies for sale in Wyoming if approved for sale in the identified states. • Regulatory Oversight. Insurers must hold a license in Wyoming and meet actuarial and solvency standards established by the National Association of Insurance Commissioners (NAIC). The commissioner may subject out-of-state carriers to certain specified requirements such as the payment of premium taxes and high risk pool assessments; registration for service of process; submission to financial examinations; and compliance with fraud and abuse laws, unfair claims settlement practices, external review requirements and laws regarding timely payment of claims. The commissioner may suspend or revoke the sale of out-of-state policies, if the laws of the state in which the sponsoring company is domiciled are determined to “egregiously harm” Wyoming residents. • Explore an Interstate Compact. The insurance commissioner is required to explore the creation of a consortium with other insurance commissioners of “like-minded” states. Once reciprocity is established, insurance companies would be authorized to choose a state in the consortium to be the “primary” state for regulation purposes. The insurer must be licensed and approved for doing business in the primary state before it can sell products in the other member states (“secondary” states). The laws of the primary state would govern the marketing and sale of those products in the secondary states.

Sources: Authors’ review of state legislation and regulation.

as envisioned under the law. State officials speculated that the lack of response may have been due to the fact that Wyoming has relatively few consumer protections compared to its neighbors: as one official put it, “We probably have the fewest mandates, so if insurers pick a primary state, it will probably be Wyoming.”³⁶ Officials further noted that neighboring states may have been reluctant to allow Wyoming’s “mandate-lite” policies to be sold in their states and were too busy with implementation of the ACA to devote the time necessary to negotiating the consortium rules envisioned under Wyoming’s law. Wyoming officials also reported a lack of interest from insurers with no insurer inquiries about across state lines policies since the law’s passage.³⁷

Slightly over a year later, however, regulators reported that no insurer has entered the Georgia market to offer out-of-state policies. One insurer remarked: “Not one plan has gone through [the process of selling an out-of-state policy] and I don’t think any plan will.”

Georgia enacted its across state lines legislation in 2011. As noted above, the law requires the DOI to approve individual health policies for sale in Georgia if they have been approved in other states, so long as the insurer selling the policy is licensed in Georgia.³⁸ The DOI subsequently promulgated a regulation to implement the law, providing insurers with operational guidance and filing requirements.³⁹ Slightly over a year later, however, regulators reported that no insurer has entered the Georgia market to offer out-of-state policies. One insurer remarked: “Not one plan has gone through [the process of selling an out-of-state policy] and I don’t think any plan will.”⁴⁰

State officials attributed the lack of insurer interest in part to a lack of consumer demand, noting: “Insurance companies are pretty informed about what their customers want and there just hasn’t been the groundswell of consumer demand that perhaps the proponents envisioned.” Officials also acknowledged that the law’s requirement that insurers maintain a Georgia license could be a barrier for some out-of-state insurers. In most states, the licensing process can be costly and require an extensive review of a company’s solvency, business plan, governance and financials.⁴¹ However, officials noted

that the licensing requirement is an essential consumer protection to prevent “fly-by-night” companies from coming into the state and failing to honor claims.⁴² Although domestic insurers maintain licensure in Georgia and, thus, could conceivably offer products that they make available to consumers in other states, state officials suggested that domestic insurers have little interest in “cannibalizing” their own, established products with cheaper alternatives from other states. As a result, domestic insurers are thought to be as unlikely as out-of-state insurers to offer out-of-state policies in Georgia.

In contrast to the laws in Wyoming and Georgia, Maine’s across state lines law expressly exempts certain insurers from the state’s licensing process. These insurers must, however, be licensed to sell individual market health insurance in Massachusetts, New Hampshire, Connecticut or Rhode Island. Maine’s law directs state regulators to enter into some kind of agreement or memorandum of understanding (MOU) with these states, and they have begun reaching out to their counterparts to do so. A state official explained that such MOUs are expected to be necessary because Maine will be ceding their licensing and product approval authority to these other states, adding that the MOUs must address significant and complex jurisdictional issues, and that the other states do not have reciprocal laws in place.⁴³ It is unclear what incentive these states would have to enter into the negotiations necessary for drafting such MOUs.

For example, a regional insurer, based in Massachusetts, reported that the company is “always looking at expansion opportunities” in New England, but is not considering Maine because of difficulties in establishing a provider network in the state, which was referred to as a “very challenging environment.”

Although passed in 2011, Maine’s law does not become effective until January 1, 2014. Because of this delay in implementation, state officials reported that they have not yet issued regulations or guidance to insurers, and no insurance company has indicated its intent to enter the Maine market or inquired about the state’s progress on implementing the new law.⁴⁴ This could indicate either disinterest on the part of insurers or be because the law

will not go into effect for more than 12 months. There are indications that Maine could be facing the same lack of interest other states have experienced. For example, a regional insurer, based in Massachusetts, reported that the company is “always looking at expansion opportunities” in New England, but is not considering Maine because

of difficulties in establishing a provider network in the state, which was referred to as a “very challenging environment.” According to the insurer, the main challenge is that “the delivery system is locked up and [we] can’t make a deal [on provider reimbursement].”⁴⁶

Challenges to Implementing Successful Across State Lines Policies

Respondents reported similar implementation challenges in each of the six states that passed across state lines legislation. The first challenge is that across state lines laws do little to address the most significant barriers to market competition and affordable coverage. The second challenge is that across state lines laws cannot be fully implemented without significant effort from state regulators and insurers to address legal and practical hurdles.

Out-of-State Insurers and In-State Care: “It’s the Network, Stupid”

Officials and insurers in all six states reported that their across state lines legislation was largely unsuccessful because of the localized nature of how health care is delivered, rather than the state’s regulatory requirements. As Wyoming officials noted, their residents generally do not want to leave the state to see an in-network provider.⁴⁵ Indeed, to compete with domestic insurers, out-of-state insurers must build a network of local providers and negotiate competitive reimbursement rates. Out-of-state insurers thus face a chicken-and-egg dilemma: they must build a sufficient membership to negotiate competitive rates with providers, but, to garner that membership, they must show customers they have an adequate network of providers and charge a premium that is comparable to their competitors.

Respondents universally reported the enormous difficulty that out-of-state insurers face in building a network

of local providers, and insurers identified doing so as a significant barrier to market entry that far surpasses concerns about a state’s regulatory environment or benefit mandates. This difficulty is compounded in states like Maine, Washington, Wyoming and Georgia, which face provider shortages in rural areas. As one insurer put it, a bill allowing insurers to gain exemptions from benefit mandates or other requirements may “pique interest, but it doesn’t change things like the delivery network.”⁴⁷ A Washington state official suggested that, for western states in particular, building a provider network is such a barrier that, in all likelihood, only old-fashioned indemnity (i.e., not network-based) plans would be viable.⁴⁸

State officials and insurers also noted that across state lines legislation ignores the primary cause of high prices—the cost of delivering care—and fails to account for the dramatic differences in the cost of care between states and regions and, in some cases, within a single state. Thus, while the cost of an individual health plan may be less expensive in a neighboring state, those rates are typically lower because of the prices charged by providers rather than the state’s regulatory environment. Thus, insurers seeking to expand from a low-cost state to a high-cost state may find that premium differentials disappear once the cost of care is taken into account. As one insurer put it: “You can go out and purchase something that looks cheaper in south Alabama but when you actually deliver the health care in Atlanta, Georgia, it’s much more expensive.”⁴⁹

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Practical Barriers: Who’s in Charge?

Even if out-of-state insurers are able to build a local network in a secondary state, regulators and insurers in all six states identified additional challenges that states would face in regulating across state lines policies. First,

many state regulators are reluctant to relinquish some or all authority to enforce state standards by taking the risk of allowing another state to establish and enforce consumer protections that affect their residents. For example, officials in three of the states questioned how to implement a compact or across state lines policy that allows the secondary state to enforce the laws of the primary state and vice versa.

Even if authority is clearly determined, some questioned whether a primary state would have the capacity to enforce its regulations and provide protection to consumers in other states. This concern has been echoed in other states as well. Although not one of the states studied here, Louisiana regulators reported to the Senate Committee on Insurance that the sale of health insurance across state lines “would provide minimal consumer protections and minimize our state’s oversight” in part because regulators’ “attempts to remedy a Louisiana resident’s insurance complaint would be hindered when the product was purchased in another state.”⁵⁰

Second, respondents in five states reported difficulties in implementation because other states have little incentive to establish across state lines partnerships. For example, efforts to approach other states by regulators in Kentucky and Wyoming were largely unsuccessful. In each case, the regulators’ overtures were met with resistance or indifference from other states for reasons that range from being too busy with ACA implementation to a lack of resources to concerns about the treatment of state mandates and assigning jurisdiction in the case of consumer complaints.

Finally, officials and insurers in all six states noted the complexity of health insurance as a practical barrier to across state lines proposals.

Finally, officials and insurers in all six states noted the complexity of health insurance as a practical barrier to across state lines proposals. Other lines of insurance, such as life insurance and long-term care coverage, are far simpler: state officials noted that these other lines of insurance are fairly standardized in the products sold and the regulatory structure under which they operate and do not tend to be network-based. In contrast, respondents noted that health insurance is a far more complex product, delivered through highly localized networks and subject to diverse state standards. This complexity is one reason that efforts to explore interstate health insurance compacts have foundered in Kentucky, Rhode Island, Washington and Wyoming. Respondents also noted that establishing the rules under which an interstate health insurance compact would operate would likely demand more time and resources than states are willing to commit.

Although the administrative obstacles to regional sales or compacts may be surmounted if health insurers, consumers, employers or other health care stakeholders were advocating for the laws to be fully implemented, not one state official reported advocacy from any stakeholder, including insurance companies. Insurers reported little interest in using the laws as vehicles for entering a new market or selling new products. To a large extent, the bills moved through state legislatures thanks to the efforts of well-positioned legislators, think tanks and, in some states, small business trade groups.⁵¹ They advanced often in spite of opposition from consumer and patient advocacy groups. But once enacted, these laws appear to lack any organized champion.

Conclusion

Our findings suggest that while proponents of across state lines proposals cite important goals—such as enhancing consumer choice, increasing competition and making insurance more affordable—the across state lines proposals currently enacted in six states have been unsuccessful in meeting these goals. Our findings further suggest that such proposals do not address the true drivers of health insurance costs nor do they adequately take into account the complexity of how insurance products are sold and regulated. The proposals also underestimate the administrative hurdles necessary for full implementation. As a result, none of the across state lines laws resulted in a single insurer entering the market or the sale of a single new insurance product. Such findings suggest a cautionary tale for overestimating the ability of across state lines proposals to improve access to affordable health insurance coverage. Although the ACA establishes a significantly more robust federal minimum standard of insurance regulation that could temper the deregulatory impact of across state lines proposals, our findings suggest that such proposals

include many unforeseen administrative complexities and that state officials do not necessarily want to cede their regulatory authority to other states. Although our findings are limited to the context of state-based across state lines legislation, the concerns raised are likely the same if across state lines legislation is enacted at the federal level. Indeed, federal across state lines legislation has the potential to preempt many more state consumer protections, lead to a regulatory “race to the bottom” and reduce access to coverage for people with pre-existing conditions. It poses these risks while failing to address true market barriers identified by respondents—such as the cost of building a network of local providers and the cost of delivering care in different states and regions.

While it is certainly the case that many consumers and small businesses lack meaningful choices among insurers and struggle to find affordable coverage, our findings suggest that across state lines legislation does not appear to be the “silver bullet” that proponents are searching for.

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Endnotes

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- ³ John Shadegg, (Jan. 14, 2010) (quoted in Tom Bevan, *Shadegg Retires*, (Jan. 14, 2010), <http://realclearpolitics.blogs.time.com/2010/01/14/shadegg-retires/>).

- ⁴ In addition to the 17 bills that would authorize across-state-line sales, two states considered, but did not pass, legislation suggesting general support for the policy. Legislators in California considered a resolution that would have supported the sale of health insurance “across state lines” while legislators in Hawaii considered a bill that would have directed state regulators to solicit proposals from insurers outside the state. Cal. Assembly Joint Res. 36 (2012); Haw. S.B. No. 2676 (2012).
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- “What type of insurance policies would the Compact cover?” <http://www.insurancecompact.org/faq.htm>.
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 - 17 Stephanie W. Kanwit, *The Purchase of Insurance Across States Lines in the Individual Insurance Market*, O’Neill Institute for National and Global Health Law (2009).
 - 18 Linda J. Blumberg, *Does the Patient Protection and Affordable Care Act Permit the Purchase of Health Insurance Across State Lines?* (Aug. 2010), <http://www.rwjf.org/content/dam/web-assets/2010/08/does-the-patient-protection-and-affordable-care-act-permit-the-p>.
 - 19 *Id.*
 - 20 *Supra* n. 12.
 - 21 For example, such resolutions include those issued by Louisiana and Montana in 2010 and 2011, respectively. 2010 La. S.C.R. 64 (requesting the Department of Insurance “to study and make recommendations with respect to . . . [t]he feasibility to sell health insurance across states lines”); 2011 Mont. H.J.R. 33 (directing a committee to evaluate “whether an exchange can be used to facilitate the sale of health insurance across state lines and, if so, what changes in state law may be necessary”).
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 - 23 Interview with Maine state official, Aug. 10, 2012.
 - 24 Interview with Georgia insurer, Aug. 17, 2012.
 - 25 *Id.*
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 - 48 *Supra* n. 26.
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 - 51 State officials and industry representatives in Georgia, Maine, Washington and Wyoming noted that some small business trade associations supported enactment of their respective bills. However, in Georgia, Maine and Wyoming the bills were limited to the sale of individual health insurance policies only. They made no changes to these states’ small group laws. This may be a reason why small business groups have not taken an active role in implementing the law.