



Insurance Across State Lines

Background

Proposals to allow insurers to sell their policies across state lines have been around for more than a decade with interest at both the state and federal level. Generally, such proposals are aimed at allowing insurers to sell products in multiple states without having to comply with an array of differing laws in every state. States – as the long-standing, primary regulators of health insurance – have the authority to decide whether to allow for the sale of insurance across state lines, and some states have taken action in that regard. Provisions related to this issue have been enacted at the federal level as well.

Federal Activity

Under Section 1333 of the Affordable Care Act (ACA), beginning on or after January 1, 2016, two or more states would be allowed to work together to form "health care choice compacts." Insurers would be permitted to sell qualified health plans to consumers in any state participating in the compact. Plans offered by the insurer in such an arrangement would generally be subject to the laws and regulations of the state where the plan was licensed versus the state where the plan was sold. States forming a Section 1333 compact would be required to pass legislation authorizing such an arrangement and are also required to receive approval from the U.S. Department of Health and Human Services (HHS). HHS could only approve compacts that met certain conditions, such as providing coverage and cost-sharing protections at least equal to the standards in the ACA and not

increasing the federal deficit. Under Section 1333, HHS was also required to consult with the NAIC and develop regulations (by July 1, 2013) regarding the details of how these compacts would work.

However, to date, no regulations – draft or final – have been issued. Of note, the provisions in Section 1333 do not bar states from entering into other types of compacts outside of those envisioned in Section 1333.

State Activity

Before the enactment of the ACA, 18 states had considered legislation to allow for the sale of insurance across state lines. Two of these states passed legislation: Rhode Island (2008) and Wyoming (2010). Post passage of the ACA, three additional states – Georgia, Kentucky, and Maine – have enacted legislation related to sales of insurance across state lines. No states have taken action to implement the health care choice compacts envisioned under the ACA.

- Kentucky's law (2012) authorizes the state to explore the feasibility of an "Interstate Reciprocal Health Benefit Plan Compact" with contiguous states but does not specifically require insurers to sell plans across state lines.
- Georgia's law (2011) permits insurers to sell individual health insurance policies that have been approved for issuance in other states. This law does not address the ACA requirement of applying to HHS to receive approval to form a health care compact.

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- Maine's law (2011) permits the sales of individual health insurance policies that have been authorized for sale in Connecticut, Massachusetts, New Hampshire, or Rhode Island. Maine's law also does not address the ACA requirement of applying to HHS to receive approval to form a health care compact.

Considerations

Several considerations can arise in trying to develop a product that can be sold across state lines.

- Provider Networks. The process of building a network and contracting with providers is complex and time intensive. Out-of-state insurers seeking to offer plans across state lines may face additional challenges in building a provider network with competitive rates (which in turn affects overall premiums), especially when existing in-state insurers have well-established relationships with hospitals, doctors, and other providers.
- Administrative Issues. While health care compacts may simplify administration in some areas, implementation could be challenging in other ways. This includes state as well as health plan resources required to establish, oversee and implement a health care compact or similar arrangement. Other considerations include the complexity of health insurance and whether regulators would be willing to have standards for the sale of health insurance to be set and enforced by regulators in another state.
- Risk Pool Effects. Differing standards for these arrangements could lead to segmentation of the risk pool and higher

costs (and premiums) in certain markets. For example, plans with certain benefit packages (e.g., less generous coverage) sold by out-of-state entities may attract individuals with lower health risks and result in substantially higher premiums for less healthy individuals who remain to purchase coverage within the state.

- Federalism Issues. A new federal law allowing for sale of health plans across state lines would effectively need to preempt state laws and regulations governing health insurance. This may be inconsistent with recent proposals to undo certain provisions of the ACA and return greater power to the states – for example, by giving states greater flexibility and autonomy over health insurance to respond to local market conditions and the needs and preferences of their citizens.

Resources

Health Affairs Blog, [Interstate Insurance Sales: Wishful thinking, Or A Viable Policy Option?](#)

National Council of State Legislatures, [Out-of-State Purchases: Allowing Health Insurance](#)

National Association of Insurance Commissioners, [Interstate Health Insurance Sales: Myth vs. Reality](#)

Robert Wood Johnson Foundation, [Selling Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage](#)

Kaiser Health News, [Selling Insurance Across State Lines](#)

O'Neill Institute for National and Global Health Law, [The Purchase of Insurance Across State Lines in the Individual Market](#)