Policy Snapshot

Selling Health Insurance Across State Lines: *Evidence from Previous CHBRP Analyses*

October 2017

Background

On September 27, 2017 President Trump discussed with reporters his intent to sign an Executive Order to allow consumers to buy health insurance "across state lines". Because no other details of this Executive Order have been released, it is unclear which insurance markets this Order would impact or when it would go into effect. This policy snapshot provides an overview of efforts to introduce similar legislation federally and within California within the past 10 years, along with findings from the California Health Benefits Review Program (CHBRP) analyses of related California legislation and how the findings inform current discussion. This background may be helpful for policymakers in assessing potential impacts of an Executive Order within California.

Current Federal Law and Federal Proposals

- Health insurance in the individual and small group markets has been primarily regulated by states; responsibilities include ensuring timeliness of payments to providers, financial solvency of insurance companies, network adequacy, consumer protections, and benefit mandates. The Affordable Care Act (ACA) established federal standards for health insurance coverage requirements such as minimum benefit requirements, other consumer protections, and rate requirements.
    - The ACA[1] includes a provision that states can form "health care choice compacts", which would allow states to partner and offer health insurance across state lines. Insurers selling through these compacts would only be subject to the laws and regulations of the state where the policy is written or issued, with some exceptions.[2] The Compacts may only be approved if the coverage is determined to be at least as comprehensive and affordable as coverage available through the state Marketplaces. As of October

[1] Patient Protection and Affordable Care Act, 42 U.S.C., § 1333.
[2] Kaiser Family Foundation. (2017). Compare Proposals to Replace the Affordable Care Act.

2017, four states (GA, KY, ME, OK) have approved laws allowing Compacts, but no insurers have offered plans under these agreements.[3]

- Three federal proposals to repeal or amend the ACA included a provision to allow insurers to sell plans across state lines.[4]
  - *A Better Way: Our Vision for a Confident America* was a framework drafted by House Speaker Paul Ryan in 2016 and included the proposal to allow consumers to purchase health insurance from an insurer licensed in a different state. Other details were not included.
  - *Empowering Patients First Act* (2015) and *Obamacare Replacement Act* (2017) included similar provisions that would permit non-group insurers to designate a primary state in which to be licensed, and sell policies in secondary states subject to regulation in the primary state.
- During President Trump's campaign, he released a health care vision that included support for allowing insurers to sell insurance across state lines, with the stated goal that such a policy shift would increase market competition.[5]

State and California Legislation

In addition to the four states with laws allowing Compacts, two additional states have similar laws signed prior to the passage of the ACA (RI, WY) allowing insurers to sell health insurance policies across state lines.[6] As of October 2017, no insurers have offered plans across state lines under these state laws. At least 15 other states, including California, have considered legislation within the past 10 years allowing insurers to sell insurance across state lines. Between 2007 and 2010, California introduced three bills; however, none of these bills were signed into law.

California Legislation

- Assembly Bill (AB) 1904[7] introduced in 2010 would have allowed insurers domiciled in another state to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by the Department of Health Care Services (DMHC) or a certificate of authority from the California Department of Insurance (CDI).[8] Insurers would not be subject to California state health insurance benefit mandates.
- Senate Bill (SB) 92[9] introduced in 2009 would have allowed insurers domiciled in another state to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by DMHC or a certificate of authority from CDI. This bill also would have allowed an in-state insurer to offer, market, and sell a plan or policy that does not include all state-mandated benefits to individuals with incomes below 350% of the federal poverty level if the plan is approved by DMHC or CDI and the individual consents.
- SB 365[10] introduced in 2007 would have allowed insurers domiciled in another state to offer, sell, or renew a health plan or insurance policy in California without holding a license issued by DMHC or a certificate of authority from CDI.

[3] Cauchi, R. (2017). Allowing Purchasers of Out-of-State Health Insurance. National Conference of State Legislators.
[4] Kaiser Family Foundation. (2017). Compare Proposals to Replace the Affordable Care Act.
[5] Health Care to Make America Great Again. (n.d.). Available at https://assets.donaldjtrump.com/Healthcare_Reform.pdf
[6] Cauchi, R. (2017). Allowing Purchasers of Out-of-State Health Insurance. National Conference of State Legislators.
[7] California Health Benefits Review Program (CHBRP). (2010). Analysis of Assembly Bill 1904: Out of State Carriers. Report to California State Legislature.
[8] More information about California's bifurcated regulatory system is included in CHBRP's resource *Estimates of Sources of Health Insurance in California in 2018*.
[9] California Health Benefits Review Program (CHBRP). (2009). Analysis of Senate Bill 92: Health Care Reform. Report to California State Legislature.
[10] California Health Benefits Review Program (CHBRP). (2007). Analysis of the Potential Impacts of Senate Bill 365: Out-of-State Carriers. Report to California State Legislature.

CHBRP Analyses of California Legislation

CHBRP conducted analyses of the three California bills examining the medical effectiveness, cost impacts, and public health impacts within the first year post-implementation.

Medical Effectiveness

The most recent CHBRP analysis was conducted in 2010 and examined the medical effectiveness of 31 of 44 health insurance benefit mandates in effect at that time.[11] A majority of the mandates were found to have *clear and convincing* or *a preponderance of evidence* demonstrating their effectiveness. A sizable number were found to have *ambiguous* evidence of effectiveness or *insufficient evidence* available to make a conclusion. A handful of mandates were found to be not medically effective based on a *preponderance of evidence*. More information about the current number of California state mandates and the interaction with federal law and regulation is included in the *Impact of an Executive Order on California* section below.

Cost Impacts

CHBRP estimated the cost impacts of these bills by creating different scenarios post-implementation. Scenarios included "maximum-impact" meaning 100% of people enrolled in state-regulated health insurance plans or policies would switch to a "limited-mandate plan" offered by an insurer domiciled outside of California, as well as other more limited scenarios that projected a portion of people enrolled in individual or small group market plans or policies and with incomes below a certain threshold would switch to "limited-mandate plans."

- In 2010, the cumulative annual cost of the state's mandated benefits was between 5% and 19% of total premiums for health insurance products. However, federal legislation and regulation along with additional state mandates enacted since 2010 likely reduces this estimate.
- "Maximum-impact" scenarios resulted in total health expenditure decreases of more than 2% one year post-implementation and an increase in the number of insured people in California. There was also a substantial shifting of costs from an insurer to an enrollee for benefits that would no longer be covered but would still be utilized. These extreme hypothetical scenarios are highly unlikely to occur.
- More limited scenarios predicted total health expenditure decreases of less than 0.10% one year post-implementation and an increase in the number of insured people in California, although substantially fewer than the "high-impact" scenario. These limited scenarios also included a substantial shifting of costs from an insurer to an enrollee for benefits that would no longer be covered but would still be utilized. These scenarios are within the range of possibility of occurrence.

Public Health Impacts

In all scenarios within the three analyses, allowing the sale of "limited-mandate plans" would result in a reduction in the number of uninsured people. Reducing the number of uninsured people in California has a public health benefit, as people who are uninsured are less likely to have access to primary care services, are diagnosed at more advanced stages of illness, and have a higher risk of death than people with health insurance. However, more enrollees may have insurance coverage that is less comprehensive and may be responsible for out-of-pocket costs for services no longer covered. This could result in enrollees being underinsured, exposing them to increased financial and health risks. The impacts of enrollees switching to a "limited-mandate plan" on mortality and morbidity vary based on the benefit no longer covered. For example, no longer covering certain cancer screenings would have a broader population impact than no longer covering medical formulas and foods for persons with phenylketonuria.

[11] 13 mandates were not analyzed because 9 mandates did not require coverage for a specific heath care service or coverage for a specific disease or condition, 3 addressed coverage for pharmaceuticals and could not be summarized within the allotted time period, and 1 requires coverage for a vaccine that is not yet available (i.e., the AIDS virus).

Consumer Protections

Insurers domiciled in other states would not be subject to California's consumer protection regulations. This would require enrollees covered by these "limited-mandate plans" to go to the state that regulates their health insurance product to file appeals and resolve any consumer complaints or denied claims. Insurers domiciled in other states would also be exempt from California-specific requirements regarding financial reporting and solvency as well as timely payment to providers. The requirements and capacity to monitor solvency vary across states, and funds that are established to pay for claims if a carrier becomes insolvent may not cover out-of-state consumers or may not be adequate to pay for all eligible consumers. Additionally, while all states require insurers to pay claims in a timely fashion, it is unclear whether other states have protections similar to California.

Impact of an Executive Order on California and Looking Ahead

The findings from CHBRP analyses conducted in 2007, 2009, and 2010 illustrate the limited potential to reduce premiums and health expenditures by allowing insurers domiciled in other states to sell health insurance products within California. However, given changes in federal and state policy since then, the projected savings are likely to be smaller today. This policy change could also likely result in a small reduction in the number of uninsured persons in the state, depending on the markets impacted. In 2018, CHBRP estimates approximately two-thirds (62%) of Californians would be enrolled in plans regulated by DMHC or CDI, including those enrolled in DMHC-regulated Medi-Cal Managed Care plans.[12] One-third (31%) of Californians will have health insurance associated with some other regulator, such as Medicare, or those who are enrolled in self-insured products and therefore not subject to state regulation. Of the 15.4 million Californians enrolled in state-regulated private insurance, 61% are associated with the large group market.

Enrollees in the individual and small group markets may be more likely to switch to "limited-mandated plans" due to price sensitivity. Enrollees with fewer health needs may also be more likely to switch to these plans. However, enrollees with chronic illnesses or who develop conditions while enrolled in the "limited-mandate plans" may experience higher out-of-pocket costs than if they were enrolled in a plan regulated by DMHC or CDI.

Since the last CHBRP analysis was conducted in 2010, additional state mandates have been chaptered into law, in addition to implementation of the ACA. The ACA included provisions that require non-grandfathered health insurance products in the individual and small group markets to include "Essential Health Benefits" and women's preventive services. Insurers selling across state lines would still be required to offer products that meet these requirements, meaning the number of benefits mandated within California that could be removed from plans is more limited than the total number of health insurance benefit mandates. As of January 2017, there are 69 health insurance benefit mandates in California, but some mandates only apply to the "group" market, meaning health insurance plans and policies in the individual market are not subject to these requirements.[13]

Some changes in benefit offerings may impact women's health, such as the California requirement to *offer* coverage for infertility treatments (group only), requirement to allow women to obtain an annual supply of self-administered hormonal contraceptives, and cover services related to cancer screenings and treatment. While some federal protections exist for women obtaining health insurance through the individual and small group markets, women enrolled in large group plans may be at risk if their employer decides to only offer "limited-mandate plans" without these benefits.

If additional federal action such as changes to the Essential Health Benefits or other federal regulation interacted with an Executive Order to allow insurers to sell health insurance products across state lines, there is a potential for insurers to create products that are even more limited and could be more similar to plans offered on individual markets across the country prior to the implementation of the ACA. As federal and state governments continue to grapple with the affordability of health insurance, policymakers face the challenge of balancing affordability with comprehensiveness of benefits. Further analysis of the potential impacts of selling insurance across state lines will be required if an Executive Order is signed to ensure Californians are able to access affordable and comprehensive health insurance coverage.

[12] California Health Benefits Review Program (CHBRP). (2017). Estimates of Sources of Health Insurance in California in 2018.
[13] California Health Benefits Review Program (CHBRP). (2017). Estimates of Sources of Health Insurance in California in 2018.

ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP analyses and other publications are available at http://www.chbrp.org/.

CHBRP Staff

Garen Corbett, MS, Director
John Lewis, MPA, Associate Director
Adara Citron, MPH, Principal Policy Analyst
Sabrina Woll, Policy Associate
Karen Shore, **PhD,** Contractor*
An-Chi Tsou, PhD, Contractor*

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116
info@chbrp.org

*Karen Shore, PhD, and An-Chi Tsou, PhD, are Independent Contractors who work with CHBRP to support legislative analyses and other special projects on a contractual basis.

CHBRP is an independent program administered and housed by the University of California, Berkeley, in the Office of the Vice Chancellor for Research.

Acknowledgements

This policy snapshot was prepared by Adara Citron, MPH, and Garen Corbett, MS, both of CHBRP staff.

CHBRP assumes full responsibility for the policy snapshot and the accuracy of its contents.