Is GOP Idea Déjà vu All Over Again?

Selling coverage across state lines dusts off an old idea that has new legs.

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A cornerstone of the Republican replacement of the ACA and one that the party's presumptive nominee, Donald Trump, has embraced, is to let individuals buy health insurance across state lines—that is, from a company licensed (sometimes called "domiciled") in a state other than the one they are living in. Selling insurance across state lines is second on Trump's seven-item list for "health care reform to make America great again."

Supporters say it's like getting only the shows you want from Netflix instead of buying a cable TV package with a lot of channels you don't want. Opponents counter that's actually a tired idea that's akin to letting states set their own car safety standards and, in effect, having them apply in others, so you could buy a car in a state that doesn't require airbags and drive it in your own traffic-crazed state that does require them.

But there's no disputing that the idea of buying and selling insurance across state lines has been kicking around for years. John McCain and Mitt Romney both included it in their health reform proposals. And it was the centerpiece of the Health Care Choice Act of 2005, introduced by two Republicans, former Rep. John Shadegg of Arizona and former Sen. Jim DeMint of South Carolina (the legislation went nowhere). "What's old is new again," says Patricia Riley, president and executive director of the National Academy for State Health Policy (NASHP).

Allowed already

Some laws and regulations on the books allow health insurers to sell individual coverage across state lines, although the concept exists more in theory than in practice. Georgia, Maine, and Wyoming have passed such laws. Rhode Island's 2008 statute limits out-of-state policies to neighboring Massachusetts and Connecticut, so some proponents of out-of-state policies don't think it accomplishes the purpose of creating a broader insurance market. Kentucky's law is limited to a feasibility study of allowing states to join forces and create a regional market for health insurance. Sabrina Corlette, a research professor at the Center on Health Insurance Reforms at Georgetown University's Health Policy Institute, who coauthored a 2012 report on selling health insurance across state lines, says to her knowledge no health plan has taken advantage of the state laws that allow it to happen. "There's been a lot of moving and shaking, but I would be absolutely shocked if I heard from an insurance company that one of these state laws was the reason they came into commercial market," she says.

Even the ACA has a provision that allows for the sale of individual health coverage across state lines, but "in a very, very limited way," says Brittany La Couture, health policy counsel at the conservative American Action Forum. The ACA permits multistate plans (MSPs) but they have to be sold through the ACA exchanges and meet a host of other federal regulations, as La Couture pointed out in an October 2014 paper on interstate health insurance. Included among those other regulations is a requirement that MSPs operate in all 50 states by 2018.

"Blue Cross/Blue Shield was the only insurer to submit an application to participate in the MSP program," La Couture wrote. "This lack of competition in the multistate 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."

An older federal statute, the McCarran–Ferguson Act of 1945, poses another obstacle in the cross-state sale of individual policies. McCarran–Ferguson gives states the power to regulate all types of insurance and establish licensing requirements. The ACA enables MSPs by overriding the McCarran–Ferguson strictures. Were the ACA to be repealed, Republicans would have to find another way to get around the 70-year-old statute if they wanted to open the door to cross-state health insurance.

Why cross the line?

A belief in the power of free markets underpins the thinking of the proponents of interstate health insurance. Letting people buy health insurance available in another state would give people more choices and not restrict them to a health plan that meets their home state's insurance regulations. "Some states mandate that acupuncture be covered, and a lot of people would argue that's not one that they should be required to pay for," says La Couture. More consumer choices would result in insurers competing on price, proponents say. "As long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up," says Trump's proposal.

Michael Cannon, director of health policy studies at the libertarian Cato Institute, says letting people buy coverage outside their home states would have the effect of spurring regulatory competition among the states. Because the licensing requirement is a barrier to entry into a market, it shields one state's regulations from the feedback loop that would otherwise tell regulators that they have gone overboard, he argues. It also prices some people out of the market because health plans have coverage that people don't necessarily want. Competition from out-of-state plans might push regulators in some states to jettison coverage mandates that an interstate market might reveal are unwanted, says Cannon.

In the true free interstate health insurance market, Cannon doesn't worry about the so-called race to the bottom—states getting rid of regulations so they can become havens for barebones health plans. "If those regulations are valuable, if people are suffering without them, it's going to affect people in that state, too, and they are going to push the legislators in that state to reinstate some of those regulations," he says. There is a self-correcting mechanism, Cannon says: "That's why it's a race to equilibrium, not a race to the bottom."

But Richard Kirsch says a race to the bottom is exactly what would happen if health insurers could sell products ignoring the rules of the states they are selling in. Kirsch, a senior fellow at the liberal Roosevelt Institute, sees the cross-state selling as spelling the end to all the consumer protections of the ACA. The result, he said, would be the proliferation of "junk insurance."

The lack of consumer protection is a huge flaw in letting people buy insurance out of state, contend the critics. And what if a person has a problem with her insurance company (not an uncommon experience)? Maybe a bargain hunter in, say, Georgia, gets a good deal from an insurer in Oregon. But if she wants to file a complaint, it will be with the Oregon Division of Financial Regulation in Salem, more than 2,000 miles away.

But it isn't just liberals that object to cross-border insurance markets. John R. Graham, a senior fellow at the National Center for Policy Analysis, a Dallas think tank that argues for market-based approaches to public policy issues, called selling insurance across state lines a "red herring" in an opinion piece published in *The Hill*last fall. In Graham's view, prices set by the provider network associated with a health plan are the biggest determinant of insurance rates, not the familiar punching bag of state-level mandates. People in New York might get a better rate from an insurer in Utah, but only if they are prepared to hop on a plane and get their medical care in Salt Lake City, he wrote.

Indeed, the biggest barrier to selling health insurance in another state could be all the time and effort in setting up a provider network. "It's the network, stupid," says Georgetown's Corlette. Building a network from scratch is "very difficult and extremely expensive," she says. "It requires not only a lot of man hours to go sign up all these doctors and hospitals, but when you're a brand new carrier with no enrollment, how do you convince a provider to not only sign up with you but to also give you any kind of discount? You have no clout. You have no ability to negotiate a decent rate. If you can't get a decent rate from your providers, how do you offer a competitively priced premium?"

Controlling costs by other means

Cannon, at Cato, says networks are not just overrated but backward. A health plan doesn't need to have a provider network, he says, and can control costs by other means such as cost sharing. Tiered cost sharing is one model that could replace the old managed care model based on contracts, discounts, and all the care and feeding required of a provider network, he says.

In Cannon's view, regulatory competition would make it easier for carriers to create their own networks. "There's a lot of value to be provided from integrated, prepaid group plans like Group Health Cooperative and Kaiser Permanente," he says, the former in Washington State, the latter in California and seven other states and the District of Columbia. The reason they haven't moved into other states "is because of these monopolistic licensing regimes in every state." In March, Group Health approved a proposal to be acquired by Kaiser Permanente, a deal that is still subject to regulatory review.

Dramatic change

But since the idea of selling plans across state lines first gained traction about a decade ago, the health care delivery system has changed dramatically, notes NASHP's Riley. "Now in the era of

accountable care organizations and integrated care delivery, there are increasingly big health systems," she says. "It almost doesn't matter how many insurance companies you have because they have to negotiate with the same health system."

A lot would have to happen legislatively to let people buy health coverage licensed in another state. Step one would be to repeal the ACA. Step two would be to tweak McCarran–Ferguson to exempt health plans from state regulations. Step three would be to enact an ACA replacement that would actually create some kind of regulatory landscape to allow cross-border health plans. Even if the election breaks so the GOP gains control of the White House and the Congress, there are all those interest groups to contend with. One important one is America's Health Insurance Plans (AHIP).

"Selling across state lines presents significant operational challenges when it comes to designing coverage options and review and approval of insurance," says Clare Krusing, an AHIP press officer. "This would upend the traditional review-and-approval structure while also making it a challenge for health plans to design coverage options tailored to the local markets."

But at least the anti-ACA forces have put forward one idea beyond simply getting rid of the law they loathe. "There's always been this criticism of ObamaCare without the alternative, so at least now we have an alternative and I think that's always a healthy discussion," Riley says.

And it could be a very healthy discussion that goes on right through to Election Day on November 8.