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# Selling Health Insurance Across State Lines

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There is considerable discussion concerning the revision or replacement of the Affordable Care Act (ACA). One of the revisions is to allow an insurance company to get a policy approved in any state<sup>1</sup> and then sell it in any other state without having to meet any of the requirements imposed by the other state. The proponents assert this will lead to more competition, which will lead to lower premiums for health care services.

Although the topic entails all health insurance, this paper concentrates on the confluence of these principles as they apply to the small group and individual market, with additional focus on individual health insurance premiums. In most instances, large group plans have the ability to enroll eligible persons across state lines, as long as they are members of the group.

This paper discusses various aspects of the suggested revision and comes to the conclusion that, absent changes in the uniformity of benefit, rate and underwriting reforms required by the ACA, cross-state selling in and of itself:

1. Will produce no change in health care costs, and
2. Could result in less competition.

## PROLOGUE

A basic tenet of the free market school of economic theory is that competition leads to more efficient production of products, which, therefore, results in lower costs to the consumer.

One of the continuing problems involved in the financing of health care services is the persistent rise in the cost of premiums charged by insurance companies to provide health insurance.

Applying the basic tenet concerning competition to the problem of rising premiums, many observers have proposed to encourage competition by allowing any company licensed in any state to market health insurance in any other state if the product was approved in any state.



A basic premise of capitalism is that the sale price of an item should be sufficient to cover the cost of the product, including its costs of developing, manufacturing, marketing and distributing, plus an amount for profit or risk or for the development of other products.

With respect to health insurance, the premiums charged by an insurance company must be sufficient to pay the benefits promised plus the costs of doing business, with a margin for risks, contingencies or addition to surplus.

In the larger group market, we assume the buyer or its consultants are sophisticated and can negotiate a fair premium rate for a given set of benefits. In this market, purchasers have the means to hire specialized employees or consultants to represent their interests when negotiating with insurers.

On the other hand, in the smaller group and individual markets, the sophistication leans heavily in favor of the insurance company, with very little ability of the consumer to negotiate on his or her own. Therefore regulators have a role to play to even the playing field between consumer and insurer.

## CURRENT STATUS

Currently each state has the right to and does issue its own laws concerning health insurance and insurance companies. These laws detail, to varying degrees, almost every aspect of the business of insurance. These include such things as financial requirements for entry into the market as well as remaining in the market, limits on who may be involved in ownership or management of the company, types of policies that may be offered, types of providers that must be covered, whether these policies and their premium rates need to be approved by regulators, the ability of consumers to appeal, and mandating not only what benefits must be included, but what may be excluded.

For insurance intended to cover the wide range of medical needs, the federal government, through the ACA, has mandated a minimum set of benefits (which are very comprehensive compared to the pre-ACA market in most states), a restriction on the variation in rates by age, and a limit upon the portion of the premium that may be allocated to anything other than the benefits or taxes. For individual policies, this latter limit is approximately 20 percent of the premiums charged to all policyholders in the individual market in the state.

Individual states retain the right to approve policies and their rates and to require broader benefits.<sup>2</sup> However, the ACA removed the ability of states to allow the sale of medical policies that offer fewer benefits than those mandated by the federal law, thereby resulting in significantly less variation in benefits among the states than prior to implementation of the ACA.

The ACA allows the U.S. Office of Personnel Management (OPM) to oversee the selling of health insurance in a manner similar to that of selling across state lines.<sup>3</sup> It does require the states to agree to participate. Approximately 36 states are participating in this.

In summary, under the ACA, we have a federally mandated set of benefits,<sup>4</sup> a federally mandated limit on the gross profit of an insurance company, and a federally mandated set of rating rules<sup>5</sup> and underwriting rules as well as variations in premium rates presumably reflecting differences in costs.

Currently, there are many insurance companies that sell across state lines even though they must modify their policies to meet the standards of each state in which the policy is sold.

## ADVANTAGES TO AND OTHER EFFECTS UPON THE INSURANCE COMPANY

What are the advantages to an insurance company of being able to get a health insurance policy approved in one state and sell it in any other state without meeting any of the requirements of the other states?

Among the states and territories, there is a widespread variation in laws and regulations concerning such items as:

- Financial requirements of the insurance company
- The relationship between premium rates and expected claims. The ACA has a retrospective restriction, the Minimum Loss Ratio, that requires the insurance company to pay 80 percent of the premium as claims or refund to the policyholder. In setting premiums, the states (and insurance companies) vary in the approach they take toward the estimates of prospective claims. This results in a variation in the acceptable premium rates.

- Types of medical providers (hospitals, doctors, pharmacies, etc.)
- Breadth of coverage

In addition to the ACA standard benefits, some states have added a few of their own.

- Process for claims appeal
- Policy language (what must be included)
- Advertising of policy benefits
- Size of type used in policy

By requiring approval in only one state, the insurance company eliminates the expenses it would have in filing in other states. It eliminates the variations in benefits, premium rate requirements and all the other variations needed to meet the other state's requirements. On the other hand, it still must meet the benefits and premium rate limits that are mandated by the ACA.

Theoretically, an insurance company whose policy is approved in a state with the fewest number of additional mandates can price the product at a lower premium than the insurance company whose policy is approved in a state with additional mandates.

The reduction in premium level is achieved on a number of fronts, including:

1. The elimination of the costs involved in filing in each state
2. The elimination of the marginal costs for mandated benefits
3. For some, the reduction in the capital and surplus required of the insurance company. Some territories have very low capital and surplus requirements.
4. Avoidance of paying premium taxes in the other states. States may have difficulty collecting premium taxes from an insurance company that is not licensed to do business within that state.

In the individual and small group market, insurance companies that do not provide coverage for the additional mandated benefits will have a price advantage. If they do not have to pay premium taxes in those states, the advantage is compounded.

As a result, insurance companies, large and small, will be forced to gravitate to the jurisdiction with the least amount of oversight and regulation in order to take, maintain or attain a competitive advantage.

Eliminating mandated benefits does not, by itself, decrease the overall costs of health care. It only decreases the portion of health care expenses to be covered by the insurance policy. On the other hand, requiring health insurance companies to cover these benefits usually increases the utilization of these

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benefits, the charges made by providers for these benefits, and the administrative expenses of the insurance companies. This results in a need for an increase in premium rates.

Eliminating the requirement to be licensed in other states will allow smaller, regional companies to compete in other states. However, they will face a major obstacle, which is the establishment of a provider network with competitive reimbursement levels.

A primary factor in reducing the costs of health care, while maintaining the good health of the individual, is to limit services to those doctors and other medical professionals who will provide the right service at the right time for a reasonable cost. Insurance companies' networks should be established within that framework.

It will be extremely difficult for a small regional insurance company to enter a new market and find a significant number of providers who will agree to the discounts and limitations similar to those granted to those insurance companies with large blocks of insureds.

It is also difficult for a new insurance company to be able to initially price its product appropriately. There are a number of factors causing this, including:

1. Health care costs vary dramatically from one community to the other. The data used by an insurance company to price its policy is based upon its own experience. The claim costs in another state will not be the same, and the insurance company will have to estimate the differences. Companies can hire consultants who have information on costs across the country, but this will be an additional expense, and their estimated costs may not reflect those that the company will incur because of differences in claims practice and enrollment.
2. The market is such that insureds tend to stay with the company with which they are familiar. The newly arrived insurance company will find its initial policyholders include a large number of persons who are discontented with their previous company and who have higher-than-average claim costs.

If, as a result, the insurance company has underestimated the costs, it can face a large loss from which it may take a long time, if ever, to recover. The ability to replace capital resulting from losses is limited by the minimum medical ratios in the ACA. Therefore, once a loss is sustained, it may require multiple years to replace this capital via normal business practices because the insurance company cannot raise future premium rates to include a recapture of the amounts it lost in prior years.

In the free market business of insurance, the companies with the biggest surplus will be able to subsidize their health insurance line. By undercutting the premium needed, they will force the smaller companies to leave the market. This is contrary to one intention of the proposed revision.

The bigger surpluses of the larger insurance companies give them another advantage in having the capital to establish the provider networks needed to be competitive.

Based upon examinations of minimum loss ratio exhibits, the amounts attributed to general overhead, excluding claim administration and marketing, were less than 4 percent of premium. Therefore, if we eliminate the state-mandated benefits and eliminate the need for insurance companies to get approvals in every state, it would be surprising if the initial effect would be to reduce the premiums materially. However, this will not stem the overall health care cost trends. After the initial dip, the premium rates necessary to cover the costs of the benefits will continue to rise.

Some states, such as New York, do not allow insurance companies to charge a rate that varies by age. They require a rating basis that averages the costs of all the persons insured by the insurance company within the community, often referred to as pure community rating.

A company subject to this pure community-rating requirement will be at a tremendous disadvantage in competition with a company selling across state lines. The latter is allowed to vary premiums by age. As such they can charge younger persons less than older ones.

If both insurers provide the same benefits, younger persons will buy coverage from the out-of-state insurance company. This will drive the average claim costs of the domestic insurance company higher and result in an increase in the pure community rate. The cycle continues. As the pure community rate goes higher, more people gravitate to the out-of-state insurance company. Eventually, the domestic insurance company will be left with only the very old and sick persons.

The domestic insurance company is left with three choices:

1. It withdraws from the state, leaving the market to the out-of-state insurance company.
2. It withdraws its health insurance policies from the state's approval and, if its domestic state permits it, develops a policy that is approved in another state that can be age-rated. It then returns to its domestic market as if it was a foreign insurance company.
3. It moves its state of domicile, which is a drastic measure and one that would not be taken lightly, or forms a subsidiary in the other state and allows the subsidiary to sell using the parent's provider network and marketing and administrative resources.

## STATE OF UNINTENDED CONSEQUENCES

The intent of permitting insurance companies to sell across state lines is to increase competition and reduce the costs of health insurance. There is a good possibility the most likely scenario will be to decrease competition and, without affecting the cost of health care, allow premium rates to increase faster than required by the rise in health care costs.

Competition will decrease because the larger insurance companies are in a better position to:

1. Buy business (by subsidizing premiums in order to increase their market share)
2. Maintain the networks of providers needed to reduce costs and improve the quality of health care
3. Market the product

These practices will make it extremely difficult for smaller companies to make a profit in these markets. As a secondary result of the lack of competition, premium rates will rise even if the 20 percent cap on gross profits remains in effect.

Many states have strict controls on the premium rates a company can charge. There are a number of jurisdictions concerned only with whether the premium rates are sufficient to pay the expected benefits and are not concerned with the level of expected loss ratios.

Therefore, once an insurance company has the major share of insureds in a state, it can increase its premium beyond that which might be reasonable for an expected 80 percent loss ratio. Even though it must return 80 percent of the gross premium as either claims or premium refunds, it keeps a larger dollar amount.

For example, let us assume the health care benefit costs are \$76,000,000 for the year. In a competitive environment, the insurance company may have charged \$100,000,000. In this case, it refunds \$4,000,000 and keeps \$20,000,000 expenses and profit. Without competition, the insurance company might

charge \$125,000,000. The refund becomes \$24,000,000 and the insurance company retains \$25,000,000 for expenses and profit. In this scenario, the insurance company has incurred almost no additional expense and the extra \$5,000,000 goes directly into surplus. Though the insureds' refund is increased by \$20,000,000, they had to pay an extra \$25,000,000 in premiums to receive it.

## EPILOGUE

As noted in this paper, premiums must be adequate to pay the costs. This was true before the ACA. It is true during the ACA and it will be true with whatever, if anything, replaces or revises the ACA.

If we want to lower the costs of health care, we must focus on those factors involved in the cost of providing health care. When health care costs are lowered, then premium rates will follow. ■

*This article was authored by Larry with inspiration from discussions generated from the Conference of Consulting Actuaries (CCA) Healthcare Community and is being submitted to further the conversation among actuaries and non-actuaries alike. These comments do not necessarily reflect the views of the CCA, the CCA members or any employers of CCA members, and should not be construed in any way as being endorsed by any of the aforementioned parties. We welcome other opinions and thoughts on the subject.*



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## ENDNOTES

- 1 A state means the 50 states of the United States of America, the District of Columbia and the U.S. Territories.
- 2 From Kaiser Health News: State coverage mandates vary widely. They may require coverage of broad categories of benefits, such as emergency services or maternity care, or of very specific benefits such as autism services, infertility treatment or cleft palate care. Some mandates require that certain types of providers' services be covered, such as chiropractors. They may apply to all individual and group plans regulated by the state, or they may be more limited.
- 3 <https://www.federalregister.gov/documents/2015/02/24/2015-03421/patient-protection-and-affordable-care-act-establishment-of-the-multi-state-plan-program-for-the>
- 4 Technically there is slight variation across state lines for ACA-mandated benefits because each state was allowed to establish its own essential health benefit benchmark plan. However, since the 10 required essential benefits were identified in federal legislation, the variation among states due to variation in benchmark plans is minimal.
- 5 There are a few states that have adopted even stricter rating rules than those required under the ACA (New York and Vermont have pure community rating), and a couple of states have adopted unique age curves.