FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

May 6, 2019

The Honorable Alex Azar, Secretary
United States Department of Health and Human Services
The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services (CMS)
Attention: CMS-9921-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9921-NC, RIN 0938-ZB45, Patient Protection and Affordable Care Act: Increasing Consumer Choice through the Sale of Individual Health Insurance Coverage Across State Lines Through Health Care Choice Compacts

Submitted electronically via Regulations.gov

Dear Secretary Azar and Administrator Verma:

Families USA, a leading national voice for health care consumers, is dedicated to achieving high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation – improvements that make a real difference in people's lives. In all of our work, we strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers.

We write to provide brief comments on the Request for Information (RFI) concerning Health Care Choice Compacts. This RFI seeks to "facilitate the purchase of health insurance coverage across state lines." We have long expressed concerns with policies designed to allow the sale of coverage across state lines if these policies don't include robust consumer protections.[1] The sale of coverage across state lines can create a "race to the bottom" wherein insurance companies can market less comprehensive plans to individuals they consider to be "low-risk" by circumventing more comprehensive state laws. This can contribute to destabilization in the market for comprehensive coverage, with premiums rising as young, healthy individuals are siphoned off into out-of-state plans.

Section 1333 of the Affordable Care Act permits interstate compacts for the sale of insurance with important consumer protections. Under the ACA, only qualified health plans (QHPs) can be sold in other states through a health care choice compact. Additionally, these compacts are only permissible if specifically authorized by state legislation. This requirement is important since states may need to make a number of changes and delegate specific oversight authority, protect solvency, and adjust statewide risk pools if health care compacts are implemented.[2]
The important consumer protections that the ACA requires regarding health choice compacts must be upheld in all future rulemaking. Below we outline specific consumer protections with respect to qualified health plans that should be addressed if CMS promulgates regulations on health care choice compacts:

[1] C. Fish-Parcham. *Perils of Health Insurance Sold Across State Lines*, Washington, DC: Families USA, July 2011.

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1) **State responsibilities to respond to consumer complaints:** Consumers should face no wrong door in filing complaints – they should be able to file a complaint with the insurance department in their own state, or if they contact another state involved in the compact, that state should take their complaint. States should then have clear protocols for informing each other of consumer complaints regarding a company selling across state lines, and for investigating and resolving those complaints, that do not delay resolution for the consumer. Serious or numerous complaints against a plan, no matter which state they originated in, should trigger market conduct investigations that span states.

2) **Clear identification of authorized products:** Section a(1)(B)(iii) of the law requires issuers to "be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each state with regard to the standards…." We are very concerned about sale without licensure – licensure allows state regulators to take action to protect consumers, and regulators of one state have no authority to enforce the laws of another state. Any state laws authorizing interstate compacts should include clear systems for protecting consumers in each state.[3] Regulations should spell out a process by which consumers can readily identify issuers that are authorized to sell in their states so that they will not be fooled by bogus, scam products. Marketplace websites and state insurance websites should help consumers identify the total universe of products that are legitimate QHPs in their states.

3) **State responsibilities for appeals:** Similarly, consumers should face no wrong door in appealing a health plan's decision and seeking external review. States should have procedures for prompt transfer of cases if needed that allow for resolution within allotted time frames for expedited and regular review. States should be able to obtain data on grievances and appeals in formats that allow them to analyze patterns and take action, as they would for other licensed insurers.

4) **Notification of benefit differences:** The law requires notice to consumers that a plan may not adhere to all state mandates, and requires a detailed statement of benefit differences. We request that CMS consumer test model notices for this before promulgating regulations. Further, CMS should test a way to display QHP benefit differences from state law on exchange websites and on the websites of other insurers that may be marketing QHPs so that these will be clear to consumers.

5) **Notification of any-other differences from state-regulated products:** Similarly, notices about other differences that affect consumers should be clear, prominent, simple and consumer-tested.

6) **Public input regarding essential health benefit (EHB) benchmark:** If the rules allow plans under a compact to depart from the EHB benchmark of the issuing state, they should also clearly provide a mechanism for the public in each state to provide comment on the proposed benchmark standards for that product before they go into effect.

7) **Network adequacy:** The law requires issuers to be subject to network adequacy requirements in the consumer's own state. This is an essential protection. Plans are only meaningful if they

[3] See National Association of Insurance Commissioners and the Center for Insurance Policy and Research, "Interstate Health Insurance Sales: Myth v. Reality."

include adequate provider networks, including essential community providers and FQHCs that provide care to underserved communities. Out-of-network billing laws enacted by the states and by the federal government should also apply to these plans.

8) **Rate review process**: The law requires QHPs to be subject to each state's rating standards. Thus, in a state that narrows tobacco rating or age rating, the QHP must be subject to that state's rules. Further, consumers in each state should be able to comment during the rate review process concerning proposed rates of any QHP that will sell plans in their jurisdiction, and likewise, each insurance commissioner should have a role in rate review.

9) **Risk pools:** A mechanism should be established for QHPs to participate in the risk pools of the states where they do business. States would only want to join their risk pools if their risks were comparable; otherwise, merging pools would disadvantage one or the other state.

10) **Solvency:** States would need a clear process for overseeing solvency of any compact serving their residents and protecting residents in the event of insolvency. Therefore, the compact would need some way to participate in the state's guarantee fund.

The challenges of setting up cross-state networks, accounting for state and regional price differences, and distributing risk are barriers to the formation of health care choice compacts. Yet insurers such as Blue Cross Blue Shield now have nationwide networks that serve people when they travel or when their children live or study out of state – stimulating that sort of arrangement may be more useful than health care choice compacts.

We would strongly object to regulations that attempted to further facilitate the sale of short-term limited duration plans, indemnity plans, direct primary care arrangements sold in lieu of coverage, or other non-ACA compliant plans across state lines. These do not serve consumers well nor pay the majority of their costs when they are sick. Many states are still considering what consumer protection legislation they need in light of loosening federal regulations and expanded sale of these plans.[4] With no federal oversight and little state oversight of this market, measures to expand sales of these plans would cause consumers further harm.

Thank you for the opportunity to submit these comments. Should you have questions, please don't hesitate to reach out at cparcham@familiesusa.org or 202-626-3030.

Respectfully submitted,

Sincerely,

Cheryl Fish-Parcham
Director of Access Initiatives

[4] See M. Kona et al, "Direct Primary Care Arrangements Raise Questions for State Insurance Regulators" Commonwealth Fund, October 22, 2018; S.Corlette, et al, *The Marketing of Short-Term Health Plans*, Georgetown University Health Policy Institute, January 31, 2019.