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May 6, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9921-NC
Baltimore, MD 21244-8016

Re: Increasing Consumer Choice through the Sale of Individual Health Insurance Coverage
Across State Lines Through Health Care Choice Compacts

To Whom It May Concern:

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries,¹ I would like to offer comments in response to the Department of Health and Human Services' request for information (RFI) on selling insurance across state lines through Health Care Choice Compacts. The RFI requests comments on various aspects of expanding access to health insurance across state lines including advantages and disadvantages, implementation issues, and impacts on health insurance coverage and premiums. This comment letter raises various policy considerations and the potential implications of allowing the sale of insurance across state lines.

Selling health insurance across state lines has been proposed by some as a way to achieve two primary goals. The first is to provide more options to consumers in states with few competitors. The share of enrollees having only one participating insurer on the exchange peaked at 26 percent for 2018. In 2019, this share declined to 17 percent, due to insurers entering markets and expanding service areas.² The second goal is to make more affordable coverage available in states with high premiums. Insurance premiums vary considerably from state to state. The impact of allowing cross-state insurance sales on the number of insurance plans available to consumers and the cost of coverage depends on how these plans are regulated and whether other changes are made to insurance market rules.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² Rachel Fehr, Cynthia Cox, and Larry Levitt, [Insurer Participation on ACA Marketplaces, 2014-2019](#), Kaiser Family Foundation, November 14, 2018.

Local Cost of Care and Provider Networks

The ability to lower premiums by allowing cross-state sales of insurance is limited, because the primary driver of health insurance premiums is *local costs of health care* and most health care is delivered close to home by local doctors and hospitals. Regardless of where an insurer is licensed, premiums would reflect the costs of health care in an individual's state of residence. Premiums would reflect local health costs, regardless of where coverage is purchased. This means that individuals in a high-cost area would not necessarily have lower premiums available to them by purchasing coverage from an insurer licensed in a low-cost state.

The local nature of health care markets can present an additional challenge for out-of-state insurers. Negotiated provider networks are an essential tool for holding down premium costs. In order to compete, out-of-state insurers must either develop their own provider networks by negotiating reimbursement agreements with local hospitals and physicians, or purchase access to an existing network. Particular out-of-state insurers such as provider-owned plans, regional insurers, or other smaller carriers that are typically able to achieve competitive provider reimbursement agreements locally could have more difficulty developing provider networks and negotiating provider payments outside their local service area unless they are able to achieve relatively large enrollments. Because medical costs are the largest share of plan premiums, an inability to create competitive provider networks would place these plans at a distinct disadvantage relative to local insurers and large national insurers. This disadvantage would likely dissuade many of these smaller insurers from entering out-of-state markets. Cost savings through other means, such as differences in benefit coverage requirements among states or administrative cost savings, would be small compared to cost savings that can be accomplished through negotiating strong provider contracts.

Regulatory Authority

Regulatory authority and consumer protection laws would need to be clearly defined to protect consumers and create a level market playing field if insurance were sold across state lines. The RFI preamble notes that the issuer would be subject to market conduct, unfair trade practice, network adequacy, and consumer protection standards (including standards related to rating) of the state in which the policyholder resides but subject only to the laws and regulations of the state in which the insurance is written otherwise. Providing regulatory authority for network adequacy based on state of residence is reasonable because it would be difficult for state regulators to regulate out-of-state provider networks. However, it could be problematic for the state of residence to enforce its rules regarding a carrier that is unlicensed in the state because the ultimate enforcement tool is the ability to suspend the company's license. The state where the insurer is licensed has the greatest ability, but not an authoritative inclination to assist consumers who are not residents of their state. The state where the insurer is domiciled would be obligated to respond to the policyholders, but would have less leverage over the insurer operating across

the state line. In addition, there is the possibility of a dual regulatory structure where the consumer may have to contact different states on different issues. States would need to determine in advance which state regulates various aspects to ensure robust consumer protections and determine information-sharing needs between the states in order to facilitate that regulation.

Benefit and Issue/Rating Requirements

Other than the market conduct and other provisions mentioned above, the RFI preamble states that qualified health plans (QHPs) would be subject only to the laws and regulations of the state in which the insurance coverage is written. A key to the sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules. Allowing insurers licensed to sell in any particular state to sell insurance under that state's rules in other states could violate that principle. Because states must agree to participate in the Health Care Choice Compacts, presumably, states would not agree to participate in a compact that would work against their own issue, rating, and benefit coverage rules. However, this would preclude any significant premium savings by allowing consumers to purchase coverage from insurers with less-stringent market rules.

The RFI seeks comments on the implications of allowing short-term limited duration (STLD), farm bureau, or other non-ACA-compliant coverage within a compact to facilitate sales across state lines. STLD coverage usually does not provide coverage at least as comprehensive as exchange coverage.³ Other types of non-ACA-compliant coverage could be comprehensive but do not follow the same issue and rating rules as ACA coverage. If these non-compliant types of coverage are offered alongside traditional ACA products in each state, adverse selection could occur between compact products and the ACA products, especially if subsidies are made available for the non-compliant products.

The ACA harmonized issue and rating rules, which previously had varied by state. Overall medical underwriting, previously allowed in most but not all states, was prohibited by the ACA; insurers can no longer deny coverage or charge higher premiums to individuals with health conditions. The ACA also limited the extent to which premiums could vary by age; prior to the ACA, some states prohibited or limited premium variations by age, whereas others allowed unlimited variations. If non-ACA-compliant compact products to be are given flexibility regarding issue and rating rules, insurers offering these products with less-restrictive rules would attract younger and healthier enrollees, whereas the ACA pool with more-restrictive rules would attract older and less-healthy enrollees. Premiums for ACA coverage with the more-restrictive rules would increase, and the viability of those insurers would be threatened. As a result, older

³ STLD coverage is not subject to guaranteed issue requirements and does not have to provide pre-existing conditions protection. In addition, STLD coverage is not required to cover the ACA essential health benefit (EHB) and other plan design requirements. It may have limits on certain benefit categories or overall coverage limits.

individuals and those with health problems still in ACA plans could find it more difficult to obtain coverage.

The RFI preamble states that issuers of out-of-state coverage would be subject to the rules of rating of the state of policyholder residence. If the coverage is ACA-compliant but the states have different rating rules (for example, different age curves), for risk adjustment to work as intended the coverage should be risk adjusted in the state of policyholder residence (following the rating rules). Out-of-state insurers would be required to develop premium rates for each state they intend to sell in based on each state's rating requirements and average morbidity. If the compact offers non-ACA-compliant coverage, it would be difficult to risk-adjust compact plans with ACA plans due to differing issue, rating, and benefit coverage requirements.

Impact on Competition and Premium Rates

The RFI seeks comments on the impact on competition and premium rates. If rules governing insurance coverage that would be sold under compacts are consistent with those under the ACA, market segmentation could be minimized. However, potential premium savings would also be minimal, as premiums would continue to reflect local health care costs, regardless of location of the insurer.

In general, an increase in the number of participating insurers could lead to more price competition and downward pressure on premiums if the carriers entering the state can charge lower premiums than the carriers currently in the state. But, as described before, out-of-state insurers would have difficulty negotiating favorable provider rates in areas where they do not currently have market share.

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We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202-223-8196 or linn@actuary.org.

Sincerely,

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Chairperson, Individual and Small Group Markets Committee
American Academy of Actuaries