September 6, 2011

Ms. Cheryl D. Allen
United States Office of Personnel Management
1900 E Street, N.W.
Washington, DC 20415

Re: RFI # OPM35-11-R-0001

Dear Ms. Allen:

The undersigned consumer, patient, and labor organizations are writing to offer our comments on the Office of Personnel Management's (OPM) request for information regarding multi-state plans, the nationwide insurance plans that will be offered through the health insurance exchanges. While the request for information was targeted at health insurance issuers who may be interested in contracting with OPM as multi-state plans, we want to express our concerns about exempting multi-state plans from the rules and requirements of the states in which they are offering coverage. Doing this would undermine important consumer protections.

Background

The Affordable Care Act (ACA) establishes a floor of federal rules governing health insurance that will rein in many of the unfair practices that have kept millions of people out of the health insurance market. States, however, will continue to play a primary role in regulating the sale of health insurance to best meet residents' needs and local market conditions. Indeed, in the ACA regulations and sub-regulatory guidance published to date, states are afforded significant flexibility in implementing the law. This will be the case when it comes to health insurance exchanges in particular, where we expect to see significant state-to-state variation in the standards set for qualified health plans, use of selective contracting and rate negotiation, and other consumer protections.

The integration of multi-state plans into the exchanges will have a significant impact on consumers. The ACA stipulates that multi-state plans must be licensed in each state and subject to all requirements of State law not inconsistent with Section 1334. Furthermore, states may choose to require multi-state plans to include additional health benefits that are required of other qualified health plans (QHPs) in the state and may choose to permit only multi-state plans that meet the state's age rating requirements, if the state rules are more protective. However, the statute also allows multi-state plans to be deemed certified for any exchange and grants the Director of OPM authority to negotiate medical loss ratios (MLRs), profit margins, premiums, and any other terms and conditions of coverage in the interests of enrollees.

Consumer Recommendations

Consumer interests are best served by requiring multi-state plans to comply with both federal and state regulations, including all requirements to serve as a QHP in states' exchanges. Multi-state plans should also be subject to any fees and assessments levied to finance the state exchanges.

In today's health insurance market, the majority of states have a single dominant carrier. If that plan, through its parent, becomes a multi-state offering, state regulators could find themselves with limited power to regulate their dominant carrier – an untenable situation. Exempting multi-state plans from state consumer protections could also give them unfair advantages in the marketplace. In addition, we are concerned that adverse selection could occur if multi-state plans are allowed to pool risk separately from other policies offered by the same carrier in the individual and small group markets of a state or are not required to participate fully in the state risk adjustment and temporary reinsurance programs.

We are also concerned that exempting multi-state plans from state consumer protections would lead to confusion and undermine consumer trust. Differently-regulated health plans in the same market within an exchange will confuse consumers about what rights they have and where they can get help. State Departments of Insurance, to whom consumers traditionally look for assistance with problems, must have clear authority to receive and respond to any consumer complaints relating to multi-state plans.

In addition, a decision by OPM to exempt multi-state plans from certain state rules would actually result in all health insurance issuers being exempted from those rules because of the "Level Playing Field" requirement of the ACA (Section 1324). The federal and state rules that must be followed by all of the plans – or by none of the plans – are: guaranteed renewal, rating, pre-existing conditions, nondiscrimination, quality improvement and reporting, fraud and abuse, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure, and benefit plan material or information. It is clear that Congress' intent was to reinforce the requirement that all federal and state rules should apply to multi-state plans. If multi-state plans are exempt from any such laws it could inadvertently eliminate those protections for consumers in *all* plans. This would be a dramatic departure from the traditional federal-state framework for regulating insurance, in which federal law sets a floor of consumer protections, but states may provide more robust protections.

At the federal level the powers given to the Director in Section 1334(a)(4) – negotiating medical loss ratio, profit margin, premiums, and other terms and conditions – should be used only in a way that is more protective of consumers, not less. For example, national MLR aggregation would leave some consumers with less protection than the current state-by-state aggregation approved by the NAIC and HHS. However, OPM could raise the MLR plans are expected to meet in order to be awarded a contract, a standard that is more protective.

Conclusion

We urge that multi-state plans be held to state and federal rules that are at least as protective as their competitors. Compliance with these rules is necessary for the functioning of the exchanges, is required by statute, and will not create a significant barrier to health insurance issuers looking to establish multi-state plans. Those that are most likely to contract with OPM already offer coverage across a number of states and have sufficient experience meeting the consumer protection requirements of multiple jurisdictions. On the other hand, the negative effects on consumers would be significant if multi-state plans are exempt from regulatory oversight by state insurance departments, programmatic oversight and requirements of state insurance exchanges, or federal MLR requirements.

We appreciate this opportunity to offer our input and look forward to working with you further as you implement the multi-state plan program. If you have any questions about our comments, please contact Christine Monahan or Kirsten Sloan at the National Partnership for Women & Families at (202) 986-2600.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
Community Catalyst
Consumers Union
Epilepsy Foundation
Health Care for America Now (HCAN)
Families USA
National Partnership for Women & Families
Service Employees International Union
Timothy Stoltzfus Jost

COMMENTS FROM CONSUMER REPRESENTATIVES TO THE NAIC

August 24, 2011

Ms. Cheryl D. Allen
United States Office of Personnel Management
1900 E Street, N.W.
Washington, DC 20415

Re: RFI # OPM35-11-R-0001

Dear Ms. Allen:

On behalf of the Consumer Representatives of the National Association of Insurance Commissioners (NAIC), we are writing in support of the NAIC's August 10, 2011 response to your RFI relating to OPM's implementation of the Multi-State Plan program. As consumer advocates, we collectively represent millions of consumers and patients, both insured and uninsured, across the country. We join with the NAIC in expressing our significant concerns about the negative impact consumers could face if Multi-State Plans are in any way exempted from the rules and requirements of the states in which they're offering coverage.

While the August 10, 2011 letter from the NAIC ably captures our concerns, we want to highlight two issues of particular importance to consumers, below:

Don't Preempt State Consumer Protections

Because the Patient Protection and Affordable Care Act (ACA) allows Multi-State Plans to be automatically deemed certified for state Exchanges, we would be very concerned if this results in those plans being in any way exempted from regulatory oversight by state insurance departments or the programmatic oversight and requirements of state insurance exchanges.

States establishing and operating their own insurance exchanges will likely wish to set standards and rules that serve the unique needs of their residents and businesses. For many states, this may mean engaging in "active purchasing," which could include setting additional certification requirements for qualified health plans (QHPs), developing performance-based contracts for participating QHPs, standardizing benefits beyond the minimum federal requirements, and increasing the transparency of plan offerings. If Multi-State Plans are not required to meet *all* of each State's requirements for QHPs, it will effectively negate states' attempts to develop exchanges that meet the needs of the local population and undermine efforts to provide consumers and small business owners with higher value insurance products.

We appreciate your attention to these comments, and are happy to assist you as you develop the Multi-State Plan program as required by the ACA. Should you have any questions for us, please contact Sabrina Corlette, Research Professor at the Georgetown University Health Policy Institute, at (202) 687-0880 or sc732@georgetown.edu.

Sincerely,

Sabrina Corlette, Georgetown University Health Policy Institute
Timothy S. Jost, NAIC Consumer representative
Beth Abbott, Health Access
Georgia Maheras, NAIC Consumer representative
Stephen Finan, American Cancer Society-Cancer Action Network
Joe Ditre, Consumers for Affordable Health Care
Daniel Schwarcz, University of Minnesota School of Law
Bonnie Burns, California Health Advocates
Kim Calder, National MS Society
Peter Kochenburger, NAIC Consumer representative
Barbara Yondorf, Colorado Consumer Health Initiative
Lynn Quincy, Consumers Union
Sonja Larkin-Thorne, NAIC Consumer representative
Amy Bach, United Policyholders
Karrol Kitt, NAIC Consumer representative
Brendan Bridgeland, Center for Insurance Research
Stephanie Mohl, American Heart Association
Barbara Rea, Equality State Policy Center

Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage

By Sabrina Corlette, Christine Monahan, Katie Keith and Kevin Lucia

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The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

October 2012

Executive Summary

Proposals to authorize the sale of private health insurance "across state lines" are often promoted to address the challenges of high health insurance costs and a lack of choice among insurers and have been a core component of alternative health reform proposals since the mid-2000s. Critics, however, argue that across state lines proposals would lead to deregulation and a "race to the bottom" where health insurers relocate to the states with the least burdensome regulations.

Despite the often forceful arguments for and against across state lines proposals, there has been little opportunity to assess how they work in practice. To understand the impact of across state lines proposals on the availability of health insurance and the competiveness of state health insurance markets, we analyzed legislation that has been enacted in six states—Georgia, Kentucky, Maine, Rhode Island, Washington and Wyoming—to require, encourage or study the feasibility of allowing the sale of health insurance across state lines or the formation of interstate health insurance compacts. To gain a more in-depth understanding of the laws' impact, we also reviewed related materials such as regulations, studies and reports and conducted interviews with government officials and insurers.

We find that while across state lines proposals cite many important goals—such as enhancing consumer choice, increasing competition and making insurance more affordable—the across state lines proposals as currently enacted in six states do not address the true drivers of health insurance costs nor do they adequately take into account the complexity of how insurance products are sold and regulated. The proposals also underestimate the administrative hurdles necessary for full implementation. As a result, none of the across state lines laws resulted in a single insurer entering a new market or the sale of a single new insurance product.

Key Findings

- **To date, although all states have long had the authority to do so, only six have enacted across state lines legislation.** Georgia, Maine and Wyoming enacted legislation allowing the sale of insurance across state lines. In addition, Maine and Wyoming encourage the formation of interstate compacts. After failed attempts to pass across state lines legislation, Kentucky, Rhode Island and Washington enacted legislation requiring their insurance departments (DOIs) to research and evaluate the feasibility of allowing the sale of policies across state lines or forming interstate compacts.
- **The stated purpose of laws permitting the sale of health insurance across state lines and the formation**

Introduction

Historically, private health insurance has been regulated at the state level, resulting in significant variation across the country in the rules and consumer protections that apply to insurance companies and the products they sell. While certain standards appear to be consistent across states, such as financial solvency requirements, other requirements, such as benefit mandates, rating rules and requirements to offer or continue coverage, vary widely.[1]

In many ways, this variation has led to the creation of distinct regulatory regimes across the 50 states and, some argue, hinders the competitiveness of health insurance markets and limits access to affordable health insurance for consumers. To address such challenges, some policymakers have called for the sale of private health insurance "across state lines."[2] Allowing insurers to do so would authorize an out-of-state health insurer to sell products in multiple states without complying with all of the different insurance laws in each of those states.

States have long been able to authorize the sale of insurance across states lines. This remains true even as new federal laws established a more active role for the federal government in the regulation of health insurance. These laws include the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Protection Act of 1996 (HIPAA) and, most recently, the Patient Protection and Affordable Care Act of 2010 (ACA). While such laws set minimum national standards for group and individual health insurance, states continue their role as the primary regulators of health insurance, and have significant flexibility in how they implement and enforce the federal standards.

A Brief History of Across States Lines Proposals

Proposals to facilitate the sale of private health insurance across state lines have been considered at both the federal and state level. The concept of across state lines policies was first introduced at the federal level by Representative John Shadegg and Senator Jim DeMint in the Health Care Choice Act of 2005.[3] Shadegg and DeMint's proposal would allow insurers to be governed by the rules of the state in which they are domiciled, referred to as the "primary state," rather than the rules of the state in which they are selling a product, referred to as the "secondary state." The Health Care Choice Act did not pass and Congress has yet to pass federal across state lines legislation.

With or without changes to federal law, states already have full authority to decide whether or not to allow sales across state lines and, if so, under what circumstances.

With or without changes to federal law, states already have full authority to decide whether or not to allow sales across state lines and, if so, under what circumstances. For example, a state may allow the sale of policies from insurers in any other state or choose to allow out-of-state insurers on a more limited basis, such as from neighboring states. In addition, states have the ability to determine which regulatory and enforcement functions remain under their jurisdiction. Across state lines proposals are consistently popular among state legislators: for example, at least 17 states considered some version of such legislation during the 2012 legislative session.[4]

In addition to these traditional across state lines proposals, states and the federal government have enacted interstate compact legislation. Under such proposals, compacting states establish a standard set of rules and processes to govern the sale of health insurance within the boundaries of the compact. Compacting states would choose to adopt the standards of a given state or mutually develop and adopt a new set of uniform standards.

Although federal legislation is not necessary for states to enter into compacts, the ACA includes a provision authorizing states to enter into "health care choice compacts" subject to approval by the Secretary of the U.S. Department of Health and Human Services (HHS) beginning January 1, 2016.[5] Under the ACA, "health care choice compacts" must meet a number of criteria that include, for example, subjecting insurers to certain standards of the state in which the purchaser of a

issue or community-rated policies, insurers operating under the rules of more protective states would attract a disproportionately unhealthy risk pool and thus face higher costs and be unable to compete against insurers operating under the rules of states with fewer regulatory requirements. While critics acknowledge that allowing the sale of across state lines policies could increase the availability of lower premium plans for some, they argue that this is true only for the healthiest customers who may be able to access lower-cost plans while premiums would increase significantly for individuals with pre-existing conditions or families who need more comprehensive coverage.[10,11]

While critics acknowledge that allowing the sale of across state lines policies could increase the availability of lower premium plans for some, they argue that this is true only for the healthiest customers who may be able to access lower-cost plans while premiums would increase significantly for individuals with pre-existing conditions or families who need more comprehensive coverage.

Researchers have identified parallels between across state lines proposals and the market for health insurance sold through associations.[12,13] Already, many states exempt health insurance that is sold through an out-of-state, or national, association from some or all standards that apply to their traditional health insurance markets.[14] Researchers have found that such exemptions can negatively impact markets and undermine consumer protections.[15] For instance, by allowing national association plans to bypass state rate and form filings (and, instead, simply certify that they are in compliance), regulators often only learn of noncompliance after problems have occurred through consumer complaints or market conduct investigations. In addition, some regulators have reported barriers to assistance for consumers covered by a national association due to jurisdictional issues and resource constraints.[16] Critics argue that across state lines legislation could have the same deleterious effects on state markets.

Others have noted both constitutional and practical limitations of across state lines legislation, particularly in the context of federal across state lines proposals.[17] With full implementation of the insurance provisions of the ACA, under which a significantly more robust federal floor of insurance regulation will be in place, the deregulatory impact of across state lines proposals is likely to be tempered.[18] Nonetheless, states' ability to adopt or maintain stronger rules than those required by federal law could be preempted if a federal across state lines law were enacted.[19,20]

About This Study

Despite the often forceful arguments for and against across state lines proposals, there has been little opportunity to assess how they would work in practice. To understand the impact of across state lines proposals on the availability of health insurance and the competiveness of state health insurance markets, we reviewed state legislative proposals that promote the sale of insurance across state lines, as well as proposals to encourage the formation of interstate health insurance compacts. We identified a total of six states that have enacted an across state lines or compacting law: Georgia, Kentucky, Maine, Rhode Island, Washington and Wyoming. We analyzed these laws as well as administrative materials such as regulations, studies and reports generated as a result of these laws. To gain a more in-depth understanding of the laws' impact, we also conducted interviews with government officials and insurers.

This study does not include all legislative activity regarding across state lines proposals. Instead, the analysis is limited to fully enacted legislation that encourages the sale of across state lines policies or requires an evaluation of such proposals. Thus, we did not address legislative resolutions (which may not be binding in all states) on across state lines proposals[21] or legislation regarding the role of health insurance exchanges in facilitating across state lines sales.[22]

This study also does not address state "Health Care Compact" bills designed to nullify the ACA and allow states to circumvent federal requirements on all federal health care programs (including Medicare and Medicaid). This type of legislation is broader than the health insurance compacting laws discussed below, which are focused solely on the regulation of private health insurance, and is outside the scope of this paper.

The findings in this paper are the authors' alone and should not be attributed to any individuals or groups with whom we consulted.

State officials and insurers reported that laws to encourage the sale of health insurance across state lines and the formation of interstate compacts were largely supported by advocates seeking a "silver bullet" to address the challenges of high costs and a lack of choice among insurers.[24] Insurers indicated that they remained largely neutral on the efforts to pass across state lines legislation, noting that the bills were typically promoted by think tanks and legislators that often act as their "friends" on other issues.[25]

Respondents in some states noted that across state lines proponents were frequently looking for an "alternative" to the ACA and similar state efforts to expand coverage to the uninsured. At the same time, with the exception of Washington, respondents reported that across state lines bills moved forward largely without much organized backing from business groups, the insurance industry, or other health care stakeholders in the states. As one state official put it, "this [bill] was an effort by lawmakers to say, 'yes, we're doing something' [about the cost of health insurance]."[26] An industry observer noted, "[the bill] became part of the Rotary Club speeches in which legislators pointed to their accomplishments."[27] In Washington, a state business association was the major proponent of the across state lines law.[28]

Respondents in some states noted that across state lines proponents were frequently looking for an "alternative" to the ACA and similar state efforts to expand coverage to the uninsured.

In Rhode Island, Washington and Kentucky, failed attempts to pass across state lines legislation evolved into laws requiring the insurance departments to study the issue. This evolution may have resulted from a lack of political support for bills that would have exempted insurers from regulatory oversight; opposition from state DOIs reluctant to cede regulatory authority; and concerns raised by consumer groups about maintaining existing consumer protections.

Across State Lines Laws: Are They Working? Reports from Six States

Interviews with officials in the six states suggest that across state lines proposals have been unsuccessful at meeting their stated goals. First, of the three states requiring feasibility studies, only two states completed such studies. Regulators in both states—Kentucky and Washington—concluded that there were significant roadblocks to implementation and neither the regulators nor the legislature took further action. Second, the two states that implemented across state lines laws (Georgia and Wyoming) report similar implementation challenges. No out-of-state insurers have entered either of these markets or indicated their intent to do so as a result of the states' across state lines legislation.

Interviews with officials in the six states suggest that across state lines proposals have been unsuccessful at meeting their stated goals.

Study States. Of the three states requiring studies on the feasibility of across state lines proposals and the formation of interstate compacts (Exhibit 3), only Rhode Island's study has not been completed. Rhode Island officials indicated that the study likely would have been completed if stakeholders had shown more interest in the study's conclusions, but noted that they have not been contacted about the issue since the law's passage.[29] There has been similar disinterest from insurers: a regional health insurer based in Massachusetts indicated only minimal interest in the legislation, noting that Rhode Island's regulatory requirements are a comparatively low priority in deciding whether to enter the market.[30]

In contrast, Kentucky's legislation did not require the DOI to conduct a study, but simply expresses the intent to "explore the feasibility" of entering into an "Interstate Reciprocal Health Benefit Plan Compact" with contiguous states.[31] The insurance commissioner subsequently sent letters to the insurance commissioners of Kentucky's seven contiguous states (Missouri, Illinois, Indiana, Ohio, West Virginia, Virginia and Tennessee), asking if they had interest in joining in such a compact. Kentucky regulators reported engaging in a number of discussions with regulators in these states, but ultimately concluded that there were significant roadblocks to the implementation of a compact. Among other challenges, regulators pointed to open questions such as how each state's benefit mandates and consumer protections would be treated as well as which state would enforce legal

Exhibit 4: State Requirements for Across State Lines Laws, September 2012

State	Requirements
Georgia	• **Regulatory Oversight.** The DOI must approve individual health insurance products if they are approved for sale in another state, so long as the insurance company is licensed in Georgia. Domestic insurers must also be permitted to sell products equivalent to those out-of-state products. All products, even those approved for sale in another state, must be filed with the DOI. • **Consumer Disclosure.** The products must include a notice to consumers that the benefits of the policy "may primarily be governed by the laws of a state other than Georgia," and the marketing materials must include a side-by-side chart comparing the benefits covered by the policy with the benefits required to be covered under Georgia law.
Maine	• **Regulatory Oversight.** Individual health insurance policies marketed by a "regional" insurer can be sold in Maine without a "Certificate of Authority" (or license) from the state. To be a regional insurer, a company must be licensed to sell individual policies in Massachusetts, New Hampshire, Connecticut or Rhode Island. Although exempt from many of Maine's insurance rules (such as benefit mandates), insurers must comply with certain Maine laws, including: consumer disclosure requirements about benefits and exclusions; network adequacy; grievance procedures; and rating rules. In addition, insurers licensed in Maine are allowed to sell products duplicating those offered in other regional states by their affiliates, or those offered in Maine by regional insurers. • **Consumer Disclosure.** Applications and policies must disclose to consumers that the policy is "governed by the laws and rules of (regional insurer's or health maintenance organization's state of domicile). This policy may not be subject to all the insurance laws and rules of the State of Maine," including coverage of certain benefit mandates. Consumers are advised to review the policy's terms and conditions of coverage.
Wyoming	• **Identify Similar States for Policy Approval.** The insurance commissioner must identify five states with health insurance laws that are consistent with Wyoming's laws and approve insurance policies for sale in Wyoming if approved for sale in the identified states. • **Regulatory Oversight.** Insurers must hold a license in Wyoming and meet actuarial and solvency standards established by the National Association of Insurance Commissioners (NAIC). The commissioner may subject out-of-state carriers to certain specified requirements such as the payment of premium taxes and high risk pool assessments; registration for service of process; submission to financial examinations; and compliance with fraud and abuse laws, unfair claims settlement practices, external review requirements and laws regarding timely payment of claims. The commissioner may suspend or revoke the sale of out-of-state policies, if the laws of the state in which the sponsoring company is domiciled are determined to "egregiously harm" Wyoming residents. • **Explore an Interstate Compact.** The insurance commissioner is required to explore the creation of a consortium with other insurance commissioners of "like-minded" states. Once reciprocity is established, insurance companies would be authorized to choose a state in the consortium to be the "primary" state for regulation purposes. The insurer must be licensed and approved for doing business in the primary state before it can sell products in the other member states ("secondary" states). The laws of the primary state would govern the marketing and sale of those products in the secondary states.

Sources: Authors' review of state legislation and regulation.