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May 6, 2019

Seema Verma, MPH

Administrator

Centers for Medicare & Medicaid Services

Attention: CMS-9921-NC

P.O. Box 8016

Baltimore, MD 21244-8016

RE: 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

Dear Administrator Verma:

On behalf of the over 80,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on *Patient Protection and Affordable Care Act (PPACA); Increasing Consumer Choice through the Sale of Individual Health Insurance Coverage across State Lines through Health Care Choice Compacts*, published in the *Federal Register* on March 11, 2019.

CMS issued this RFI in response to the Trump Administration's Executive Order (E.O.) 13813, "Promoting Healthcare Choice and Competition Across the United States," which directed federal agencies to examine strategies to reduce health insurance costs, including by selling private insurance across state lines.<sup>1</sup> In an attempt to achieve this objective, the Agency seeks stakeholder input on how to leverage the authority granted to states by Section 1333 of the PPACA to facilitate the development of Health Care Choice Compacts (HCCCs), under which two or more states may enter into an agreement that permits health insurers to offer qualified health plans (QHPs) in the individual market in any state involved in the agreement.<sup>2</sup> CMS asserts that such a sales model would increase competition in the insurance market and lower the costs of insurance coverage.

The ACS—which is a scientific and educational association of surgeons founded in 1913 to enhance the quality of surgery by setting high

<sup>1</sup> 82 F.R. 48385

<sup>2</sup> 42 U.S.C. § 18053



standards for surgical education and practice—is committed to the implementation of delivery and payment systems that offer patients access to a broad range of timely and high-quality services. While we support the overarching goal of increasing the affordability of comprehensive health insurance, the ACS is concerned that CMS’ efforts to encourage interstate insurance sales in order to meet the directives of E.O. 13813 could result in market instability and significantly disrupt consumer protections and health plan performance.

We do not believe that the actions described in this RFI fully account for the intricacies of how health insurance is sold and regulated, and perhaps more importantly, they do not address the true drivers of insurance costs. **The ACS has strong concerns that interstate insurance sales could impede meaningful, in-network access to all medically necessary services on a timely and geographically-accessible basis, shift out-of-pocket expenses onto patients, create narrow networks of specialty providers, and unfairly reduce reimbursement rates for physicians.** We provide feedback below for consideration as the Agency explores various mechanisms for health insurance market reform.

## INCREASED COSTS FOR PATIENTS

CMS asserts in this RFI that interstate insurance sales will provide consumers with more affordable health plan options. However, the College believes that insurers established in states with less rigorous benefit mandates may try to design “bare bones” plans in order to attract healthy out-of-state consumers living in areas with more substantial coverage requirements by allowing these customers to forgo benefits they do not think they will want or need in order to pay lower premiums. Such insurers could deny coverage to consumers with pre-existing conditions or could increase the costs of premiums for less healthy consumers in an effort to discourage them from applying for a health plan, making it more difficult for them to obtain or afford coverage.

**We believe that such benefit designs could leave consumers with plan offerings that include too few benefits and will not provide access to the full spectrum of items, services, and clinicians they need to best manage their health conditions.** Patients who purchase less comprehensive plans may avoid visiting a primary care provider or specialist for symptoms of minor illnesses or injuries because their insurance does not cover physician office visits; delays in care due to limited insurance coverage can often result in a trip to an emergency department (ED) should a patient’s symptoms become exacerbated. Given

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the higher costs of care in the facility setting, it is probable that these patients will ultimately incur more out-of-pocket expenses for seeking treatment in the ED than if they had earlier and broader access to more routine care in the office setting.

The ACS also worries that cross-state insurance sales could significantly segment the patient risk pool, as out-of-state plans with sparse coverage packages may appeal primarily to consumers with minimal health risks, leaving local insurers that offer more comprehensive plans with the sickest, highest-cost consumers, potentially resulting in much higher premiums for these customers who are left to purchase coverage from within their own state. With fewer healthy consumers paying into their state's risk pool to offset the cost of care for sicker individuals in a state's insurance market, such in-state insurers may no longer be able to afford to provide adequate coverage for its residents and may need to significantly increase premiums, reduce benefits, or weaken consumer protections in order to compete with out-of-state plans. **Thus, we disagree with CMS that the sale of insurance across state lines will increase consumer choice, as premiums for all except the healthiest of patients are likely to rise when such patients seek cheaper coverage in other states, and many consumers could find that they actually have fewer affordable and comprehensive coverage options to choose from.**

## INADEQUATE PROVIDER NETWORKS

In order for insurers to sell plans across state lines, they must form provider networks by establishing reimbursement agreements with clinicians and healthcare facilities. A study performed by the Georgetown University Health Policy Institute Center on Health Insurance Reforms—which examined legislation that has been enacted in six states (Georgia, Kentucky, Maine, Rhode Island, Washington, and Wyoming) to require, encourage, or study the feasibility of cross-state health insurance sales or the formation of interstate health insurance compacts—found that out-of-state insurers face tremendous difficulties in building networks of local providers, and insurers reported such network issues as the most significant roadblock to market entry, far exceeding concerns about states' regulatory requirements.<sup>3</sup> Out-of-state insurers seeking to offer plans across state lines must not only work to attract new members by building a sufficient network of providers and offering premiums comparable to in-state plans but must also amass a membership base large enough to

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<sup>3</sup> Corlette, S., Monahan, C., Keith, K., & Lucia, K. (2012). *Selling health insurance across state lines: An assessment of state laws and implications for improving choice and affordability of coverage*. Georgetown University Health Policy Institute Center on Health Insurance Reforms.

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negotiate competitive reimbursement rates with hospitals, physicians, and providers (which in turn affects overall premiums); such efforts can be particularly onerous when existing in-state insurers already have well-established relationships with providers in the area.

**The College is concerned that out-of-state insurers will be at a competitive disadvantage when trying to establish strong networks, and we believe this challenge will result in inadequate provider networks that are deficient in specialists and other key clinicians.** Out-of-state insurers may not be able to contract with the full battery of providers necessary to offer comprehensive coverage for their members, and may instead sell plans with narrow, insufficient networks with limited provider options in the members' home area in order to produce lower premiums rather than high-quality benefit designs that manage patients' overall care costs. Thus, patients may incur higher out-of-pocket costs when treated by providers with whom the insurer was unable to negotiate competitive in-network rates. In addition, they might have to pay out-of-network rates for specialty care not covered by the insurer or could unknowingly receive out-of-network care and incur unanticipated charges for services rendered by an out-of-network surgeon or other clinician even if such care is furnished at an in-network facility. **The ACS believes that health plans that leave members underinsured or unable to access medically necessary care are unacceptable, and we strongly oppose any policies that unfairly shift costs onto patients or result in surprise medical bills.**

## REGULATORY AND ADMINISTRATIVE CHALLENGES

In this RFI, CMS seeks input on ways to enable insurers to sell health plans in multiple cross-state markets. However, the ACS wishes to highlight that, regardless of any policy changes made by CMS or other federal agencies, the PPACA already allows for states to enter into HCCCs subject to approval by the Secretary of the Department of Health and Human Services (HHS). States may also enter into other, non-HCCC interstate compacts without seeking approval from HHS. Although states have such broad authority, no states have entered into any form of compact for health insurance. CMS notes in the RFI that several states have passed laws authorizing such arrangements but have not taken any further action to implement these laws, and the Agency questions why states have not pursued implementation.

In the same Georgetown University Health Policy Institute Center on Health Insurance Reforms study, state officials and insurers reported that

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they were resistant to joining compacts like HCCCs largely due to a lack of guidance establishing clear regulatory authority for each participating state; for example, state officials expressed confusion over whether primary states (i.e., a consumer's home state) would have the ability to enforce their regulations and provide consumer protections for their residents who purchase a health plan from another state (i.e., the secondary state) through an insurance compact, or vice versa. Officials and insurers in each of the states studied also noted that, unlike other types of insurance (e.g., life insurance), which are often standardized and not network-based, health insurance is an extremely complex product that is delivered through highly localized networks and subject to diverse state standards. Respondents indicated that navigating these complexities, along with the administrative processes required to establish rules under which an interstate health insurance compact would operate, demand more time and resources than states are willing to commit, and is one of the top reasons why efforts to implement compacts have floundered.<sup>4</sup>

**The ACS believes that CMS has significantly underestimated the administrative hurdles and complicated regulatory dynamic of cross-state health insurance sales, and we wish to reiterate that states and insurers have both reported that it is impractical to cooperatively govern interstate plans without loss of consumer protection.** The College is concerned that allowing out-of-state insurers that are not licensed to sell products in a consumer's state of residence could significantly hinder or eliminate insurance regulators' capacity to assist patients with insurance complaints because the plan was purchased in another state.

**We maintain that the Agency's venture to encourage interstate insurance sales is a misguided approach to make healthcare more affordable and ignores the primary cause of high insurance prices—the cost of delivering care.** As previously described, the sale of insurance across state lines has the potential to reduce access to coverage while increasing premiums for customers. In addition to these risks, CMS also fails to account for the significant differences in care costs, along with the difficulties associated with building adequate networks of local providers, within and between states. Models such as the HCCC may segment patient risk pools rather than creating market competition, and disadvantages insurers offering more robust coverage and consumer protections. **As the Agency considers any new policies that could dramatically change**

<sup>4</sup> Corlette, S., Monahan, C., Keith, K., & Lucia, K. (2012). *Selling health insurance across state lines: An assessment of state laws and implications for improving choice and affordability of coverage*. Georgetown University Health Policy Institute Center on Health Insurance Reforms.

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**insurance markets across the country, we urge CMS to ensure that there are proper federal- and state-level accountability and oversight for health plans and ask that any such policies include strict enforcement mechanisms for care access and quality to protect patients' ability to receive necessary treatment.**

The ACS appreciates the opportunity to provide feedback on this RFI, and we look forward to continuing dialogue with CMS on ways to provide high-quality care at lower costs for patients. If you have any questions about our comments, please contact Vinita Ollapally, Regulatory Affairs Manager, at [vollapally@facs.org](mailto:vollapally@facs.org).

Sincerely,

David B. Hoyt, MD, FACS  
Executive Director

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