May 6, 2019

Seema Verma, administrator
Centers for Medicare & Medicaid Services
Department of Health and Human 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

As organizations dedicated to promoting the health of our nation's children and pregnant women, we appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information: 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 (HCCCs). We believe that commercial coverage for children and pregnant women, including coverage through qualified health plans (QHPs) must ensure access to timely, affordable, high-quality and age-appropriate health care (including dental, vision and hearing services) that meets their unique needs. Plans must also promote the health of women before, during, and between pregnancies.

We share the agency's goal of increasing access to affordable health care coverage in the commercial market. However, we are very concerned that the implementation of Section 1333 of the Affordable Care Act to allow the sale of health insurance across state lines without sufficient regulatory guardrails could impede, rather than improve, access to timely, affordable and necessary services for children and pregnant women. In particular, we highlight the potential weakening of benefits for children, pregnant women and their families, the challenges of developing comprehensive provider networks across state lines that include providers for all covered benefits, and the lack of clarity regarding regulatory oversight and accountability of plan coverage. Our comments below include recommended policy guardrails that could address some of these concerns. We look forward to working with you to find real solutions that strike the correct balance between affordability and comprehensiveness of coverage for children and pregnant women.

Essential Health Benefit Standards

It is crucial that all commercial coverage options, including interstate insurance plans, provide comprehensive coverage based on consistent, age-appropriate benefit standards that meet the unique needs of children and pregnant women. Consistent benefit standards must not set arbitrary limits on the scope of benefits or frequency of services.

We urge CMS to strengthen its essential health benefit (EHB) requirements for all plans so they meet the unique needs of children and pregnant women, and refer you to our prior communications with you regarding ways to protect families from high out-of-pocket costs[1]. The sale of health insurance across state lines, without strong consumer-focused guardrails, could leave children with serious, chronic, or complex conditions, as well as pregnant women, with inadequate coverage when they need it the most. Under an HCCC, insurers can choose their regulating state and their QHP offerings would be subject to the laws and

[1] See Nov. 27, 2017 letter to Seema Verma re: CMS-9930-P. CMS Notice of Benefit and Payment Parameters for 2019.

regulations of the state in which the coverage is written or issued. In effect, insurers can bypass states with stronger EHB requirements by basing themselves in a state with less stringent regulations.

Though the ability of an insurer to base itself in a less-regulated state may reduce premiums, it could result in higher out-of-pocket expenses for families who may face gaps in coverage. This is particularly problematic, given the current benchmark plan approach to EHBs, which has resulted in wide variation among states in the scope of benefits within each of the 10 benefit categories. As a result, the benefits covered in one state may be less comprehensive than those in another. Therefore, insurers that choose to base themselves in a state with less comprehensive EHB requirements, as would be allowed under the HCCC, could offer plans with less than adequate benefit packages for children, particularly those with serious, chronic or complex conditions, and pregnant women. For example, our review of benchmark plans by both state and EHB category, revealed numerous instances of inadequate coverage for children across states, including coverage with arbitrary visit limits or limits on service frequency.[2] Children often need services with greater frequency and intensity than adults, so certain benefit limits, such as limits on number of visits, frequency of service, or device replacement, established for adults may be inappropriate for children. Arbitrary limits on the scope of benefits or coverage of certain services constricted by age limits can result in inadequate access to care for children.

Furthermore, the revisions to the EHB benchmark selection process, which were adopted in the final 2019 Notice of Benefit and Payment Parameters (Notice) increase opportunities for variation in the scope of benefits among states. We reiterate our strong concerns with this new approach and urge you to reconsider its implementation. As we articulated in our comments on the proposed 2019 Notice[3], the new flexibilities afforded to states and insurers related to benchmark selection could leave children, particularly those with serious, chronic or complex conditions, worse off and their families with higher out-of-pocket costs. Without stronger parameters for states that design their own EHB package from scratch or choose a full benchmark or parts of a benchmark from another state, it is very possible that a state could limit or drop certain benefits of particular importance for children in the interest of lowering premiums. An insurer offering an interstate plan could then base itself in a state with these less comprehensive benefits.

The interstate sale of insurance through HCCCs could also segment the market, by disadvantaging insurers that offer more comprehensive coverage, as well as consumers who seek and need those protections, while decreasing premiums for healthier individuals. As we have emphasized in our prior comment letter[4] opposing expanded access to Short-term Limited Duration insurance, children in families that purchase these plans could face limited benefits with no guaranteed coverage of needed services (e.g., prescription drugs, mental health services, habilitation services and devices). Healthier individuals could be attracted to these less expensive plans and leave vulnerable populations, such as children and pregnant women, who require more comprehensive coverage, with more expensive plans. The result would be a "race to the bottom," for insurers needing to compete with the cheaper, less robust plans being sold across state lines, reducing access to comprehensive coverage for children and pregnant women. Gaps in needed services can have long-term implications for a growing child's ability to reach his or her full potential to become a contributing member of society, especially if the child is experiencing developmental delays or has ongoing health problems.

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[2] See Sept. 30, 2015 Letter to Kevin Counihan re: pediatric coverage in the 2017 Essential Health Benefit Benchmark Plans.
[3] See Nov. 27, 2017.
[4] See April 23, 2018 Letter to the Departments of Health and Human Services, Labor, and the Treasury re: CMS-9924-P. Short-Term, Limited Duration Insurance.

Provider network development

It is critical that a baseline network adequacy standard is established for plans, regardless of the state in which they are based, to ensure that children, pregnant women and their families have access to the providers they need. Furthermore, we urge CMS to recognize both the complexity of building out-of-state provider networks for insurers that may be interested in interstate sales, which impacts the feasibility, competitiveness, and affordability of the products.

Any policies to implement Section 1333 must include specific standards that ensure a full range of in-network pediatric providers for all covered services, regardless of the state in which care is received. Given the regional nature of pediatric specialty care, it is not uncommon for children to travel across state lines to get needed care from a pediatric provider with the requisite training and expertise. The absence of uniform standards combined with the challenges insurers could face when attempting to build provider networks in other states could jeopardize access to appropriately trained in-network providers, including pediatric specialists and subspecialists and maternity-related providers. Inadequate and limited networks may result in care delays with poor medical outcomes that ultimately cost families and insurers more.

Furthermore, there is currently no evidence to demonstrate that the sale of insurance across state lines improves affordability or access to coverage. In addition, no state has enacted legislation to authorize a HCCC and insurers have not shown an interest in offering insurance plans across state lines. This is primarily because out-of-state insurers face challenges in developing networks of providers in other states. A study conducted by Georgetown University's Health Policy Institute looked at all states that had passed legislation broadly authorizing interstate insurance sales. According to this analysis, the legislation has been largely unsuccessful in incentivizing interstate sales due to the localized nature of health care delivery.[5] The barriers to competing with in-state insurers would leave out-of-state insurers attempting to negotiate competitive reimbursement rates. The cost of delivering care and the often dramatic difference in the cost of care between states and regions magnify the difficulties insurers would face in building out-of-state networks while attempting to keep costs down.

Regulatory oversight

Clarity is needed in any future policymaking regarding regulatory authority over insurance plans sold across state lines to ensure that benefit and network adequacy standards are properly enforced. In particular, identification of the primary state regulator could help advance strong enforcement of standards and minimize ambiguity and confusion for regulators, plans and consumers. Furthermore, stringent oversight, monitoring and data transparency guidelines are needed to ensure appropriate enforcement of both state and federal regulatory requirements.

We strongly encourage CMS to delineate regulatory authority for the oversight of health plans sold across state lines. Interstate insurance sales through HCCCs could significantly undermine regulatory roles and protections in states where the insurance product is being sold without sufficient regulatory clarity from CMS. As you know, regulators have historically been reluctant to relinquish their consumer protection enforcement authority in their states, particularly related to benefit and network adequacy standards.[6]

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[5] See 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, 2012.

[6] Ibid.

However, HCCCs could compromise insurance regulators' ability to fulfill their chief consumer protection role, due to the regulatory ambiguity that is likely to be created.

Under a HCCC, QHPs would be subject to the laws and regulations of the originating state where the coverage was written or issued; however, issuers would continue to be subject to market conduct, unfair trade practices, network adequacy, and benefit standards of the state where the enrollee resides. This raises the question of which state is the primary regulator, which would leave state regulators with a lack of clarity in their ability to effectively enforce varying state EHB mandates and network requirements across state lines. Inconsistent enforcement has implications for access to necessary care and covered services for children and pregnant women if state regulators are unclear about which standards they have the authority to enforce to protect these populations.

In addition, we urge CMS to work with states and the National Association of Insurance Commissioners on the collection of data that will enable regulators, as well as stakeholders, to assess whether and how children, pregnant women and families are being served by interstate insurance plans. As we have outlined in previous communications regarding commercial coverage options[7], it is critical that CMS use plan data to document, identify and analyze patterns in consumer behavior and in coverage. The data transparency requirements under Section 2715A of the ACA should serve as a model for data transparency requirements for interstate insurance plans.

In conclusion, we reiterate that we share the agency's goal of increasing access to affordable health care coverage and promoting consumer choice. However, we are very concerned that the facilitation of the sale of insurance across state lines through HCCCs, will spur deregulation and create a "race to the bottom" situation where insurers will place themselves in states with the least burdensome regulations, resulting in weaker benefit requirements. The localized nature of health care delivery also presents a barrier to the development of provider networks that cross state lines, risking access to appropriate providers for children and pregnant women. As a result, children with serious, chronic, or complex conditions and pregnant women may not have access to the comprehensive coverage that is necessary to promote their health and well-being.

We respectfully encourage the agency to work collaboratively with us to identify delivery system reforms and other health care quality improvement initiatives that will reduce health care costs, drive down premiums, and improve care. We look forward to working with you to ensure that all health benefit plans address the unique health care needs of children, pregnant women, and their families.

If we may provide further information or otherwise be of assistance, please contact Jan Kaplan at the Children's Hospital Association, at 202-753-5384 or jan.kaplan@childrenshospitals.org.

American Academy of Pediatrics
Children's Defense Fund
Children's Dental Health Project
Children's Hospital Association
Family Voices
First Focus on Children
March of Dimes
National Association of Pediatric Nurse Practitioners

[7] See April 23, 2018 Letter.