

Cross-State Risk Pooling Under Health Care Reform: An Analytic Review of the Provisions in the House and Senate Bills

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Abstract

How health care risk is pooled is of defining importance to health care systems. This paper explores provisions in the House and Senate health reform bills that could pool risk across state lines. These provisions include options for states to jointly operate insurance exchanges and enter into interstate health insurance compacts, as well as the development of national health plan offerings. Using available literature and discussions with an array of experts in the fields of health policy, insurance, regulation, and purchasing pools, the paper summarizes the potential for cross-state pooling and the challenges faced in implementation of the specific strategies.

Section 1

Introduction

How health care risk is pooled is a feature of defining importance to health care systems. Considerable attention has been paid to this issue by policymakers and researchers in their attempt to design successful approaches to health care reform. A wide-ranging set of interests have come to agree that broad-based risk pooling -- through the use of insurance mandates combined with guaranteed issue of coverage, elimination of pre-existing condition exclusions and benefit riders, and prohibitions against premium rating based upon health status -- is necessary to achieve universal (or near-universal) coverage, stability of protection for those already insured, and even cost containment. National health reform legislation currently under consideration reflects this agreement, using health insurance exchanges as mechanisms for structuring new marketplaces to encourage both greater risk pooling and competition.

However, there does not yet appear to be clear consensus, either among policymakers or analysts, as to how large is "large enough" where risk pools are concerned. In addition to identifying the ideal size of pools from a risk-sharing perspective, the extent to which local variation in pricing, products, and carriers should be preserved, and how the current variation in state regulations related to pooling will interact with federal reforms appear far from settled. All are complex matters that will have far reaching importance for individuals' access to adequate affordable medical care under reform.

The federal reforms currently being considered, including the Senate passed Patient Protection and Affordable Care Act (H.R. 3590), the House passed Affordable Health Care for America Act (H.R. 3962), and the proposal developed by President Obama,¹ each would allow

¹ The Obama Administration proposal is structured as a series of modifications to the bill passed by the Senate. The legislative approach currently being pursued is to have the House of Representatives pass the Senate bill, and then have both the House and Senate pass the Administration's proposed modifications using the budget reconciliation

for some pooling of risk across state lines. A delineation of these strategies and their goals and an exploration of how they might work in practice are the focus of this paper. In order to analyze these approaches we have gathered evidence from the literature, which has been presented in full in a separate paper (Pollitz et al 2010)² and is summarized here, and we have gathered an array of expert opinions on the relevant topics. The discussions with experts have been particularly valuable in conceptualizing the practical issues surrounding the reforms, as the types of strategies proposed have not been attempted before, limiting the applicability of past experiences in these areas.

The paper is structured as follows. Section 2 lays out the conceptual goals of cross-state pooling and describes the health reform features related to pooling across state lines. Section 3 provides a background on health insurance pooling. Section 4 summarizes the findings from our literature review. Section 5 provides the discussion topics raised in our conversations with experts and describes how the experts were chosen. Section 6 summarizes the expert opinions provided to us on the cross-state pooling features included in the reform proposals. Section 7 provides a discussion of the conclusions reached, and areas in which additional analytic work would be helpful.

process, which necessitates only a simple majority vote for passage in the Senate. Because only policies affecting the federal budget can be passed through the reconciliation process, non-budget items such as those discussed in this paper cannot be changed through it. As a result, the reader can assume that the Obama proposal is consistent with the Senate approach on the issues presented here.

² Karen Pollitz, Linda J. Blumberg, and Eliza Navarro Bangit. 2009. "Cross State Risk Pooling: A Review of Current Legislation and Literature," report to the US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation.

Section 2.

Goals of Cross-State Pooling and Policy Features Proposed

There are a number of goals that cross-state pooling might theoretically address. The first is the facilitation of offering employer-based coverage in metropolitan areas that cross state lines. For example, an employer in Kansas City, Missouri may very well have employees who live in Missouri and others who live in Kansas. A similar situation would hold for employers in the Washington, DC metropolitan area, where employees at the same firm may live in Washington, DC, Maryland, and Virginia. Employees may seek health care from providers located in their state of residence as opposed to their state of employment, requiring an insurance plan with provider networks spanning multiple states that operate under different insurance regulations. Post reform, when individual and employer mandates apply, the availability of regional or interstate health plans and markets could simplify and facilitate the purchase of coverage for such employers.

Second, it is possible that states with small populations could benefit from increasing the size of their risk pools by joining another state (or states) in insurance purchasing. Small insurance pools are more likely to have greater year to year fluctuation in average health care costs than large pools; consequently, creating risk pools of a critical size could lead to greater stability in health insurance premiums.

Third, insurance regulations currently vary significantly across states. Insurers must be licensed to operate in any state in which they do business, and must comply with specific state laws wherever they do business. Under the comprehensive reforms being considered, minimum federal rules would apply and insurance regulations would vary much less across states; however, some variations would remain. For example, under the Senate bill, age variation in health insurance premiums in the small group and non-group market would be limited to a ratio

of not more than 3 to 1 (i.e., the premium charged a 64 year old could not be more than three times that charged to an 18 year old). However, some states already have tighter age bands than that; for example the age rating limit in Massachusetts is 2:1 and New York prohibits age rating altogether. Some proponents of cross-state pooling hope that it would lead to a reduction in “excess” state insurance regulations, by allowing insurers to operate nationally under the least restrictive state laws. As Devon Herrick of the National Center for Policy Analysis was quoted in a *New York Times* article, "The competition that you want to spur is not just among the companies, but also among the state regulators and the state legislatures and the insurance commissioners. What you really have right now are 50 different protected markets."³

Fourth, advocates have suggested that allowing insurance coverage to be sold across state lines would increase the number of products offered to residents of some states, thereby increasing competition and lowering health care costs.⁴

And finally, certain interstate arrangements – in particular, interstate compacts – offer the potential of simplifying or streamlining certain insurance regulatory tasks. For example, today, health insurance companies must file the policies they sell and regulators may review product filings to ensure policies cover all state mandated benefits and follow other requirements. Post health reform, the application of national minimum standards for health insurance could result in greater standardization of health insurance products and market regulations than exists currently. In such a world, it might be more efficient for state insurance regulators to cooperate with each other to jointly undertake certain regulatory functions that they would otherwise each have to conduct separately. Theoretically, cross-state pooling could likewise reduce insurer

³ David M. Herszenhorn. 2010. “Prescriptions; Let Health Insurance Cross State Lines, Some Say,” *New York Times*, February 14, 2010.

⁴ David M. Herszenhorn. 2010. *New York Times*, op. cit.

administrative costs by allowing them to operate under common market rules across a group of states.

Congressional health care reform bills include three approaches that could result in cross-state risk pooling. We say that these approaches *could*, as opposed to *would*, result in cross-state pooling because their practical effect would be determined by policy decisions at the state and federal levels that are not specified in the bills as written. The three elements of the proposals are: interstate compacts allowing for individual health insurance to be sold and regulated across state lines, multi-state health insurance exchanges, and the development of a national insurance plan option that would be administered by the Office of Personnel Management (OPM), the federal agency that administers the Federal Employees Health Benefits Plan (FEHBP).

The development and implementation of multi-state health insurance exchanges and interstate health insurance compacts would occur at state discretion. The precise pricing rules and administrative authorities used within them would be determined by the participating states subject to federal minimum standards. By contrast, the development of national health insurance plan options would be a federal responsibility – undertaken by the OPM. However, the national plans would nonetheless have to follow specific rules in each state concerning mandated benefits and rates, leaving some uncertainty about the extent of cross-state risk pooling that would occur. Each of these approaches and their potential for risk sharing will be discussed in turn in the sections that follow. But first we provide a background on health insurance risk pooling in order to facilitate the reader’s understanding of the conceptual discussions of the policy options.

Section 3.

Background on Health Insurance Risk Pooling

Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. With a highly skewed distribution of health expenditures - the top 10 percent of spenders account for nearly two-thirds of total health expenditures⁵ - gains to insurers from excluding high-cost enrollees are tremendous. Insurance market regulations are required to prevent risk-selecting behavior by insurers. However, states allow insurers to risk select to varying degrees today so that the carriers can protect themselves from the inherent nature of a voluntary insurance market, where individuals who expect to use significant health care services are those who are most likely to seek coverage. Without such leeway on the part of insurers, individuals may wait to purchase coverage until they know they need medical care, creating strong disincentives for the healthy to enroll. This dynamic would lead to very high premiums, reflecting a high-cost group of enrollees, and compromise the long-run stability of insurance pools. At the same time, however, the consequences of allowing insurers to use such strategies are that many who need adequate and affordable coverage cannot obtain it or maintain it continuously.

In the context of a health care system that is universal - where everyone is insured all of the time (or nearly so) – and where subsidies make coverage more affordable, there would no longer be any reason to allow discrimination by health status. However, even under the auspices of comprehensive health care reform, premium rating would continue to vary across geographic areas.

Health insurance premiums reflect the expected health care costs associated with a particular group of insured individuals and a given set of health benefits (covered services and

⁵ Samuel Zuvekas and Joel Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, vol. 26, no. 1: 249-57, 2007.

cost-sharing requirements of the enrollees), plus an administrative load. The administrative load covers the costs of claims processing, general administration marketing/agent commissions, profit, premium taxes, and adjustments for risk. Under the current system as well as under reform, the groups of insured individuals over which premiums are computed are defined by geography – either place of residence or place of employment. Today, insurers generally subdivide a geographically defined pool of individuals into smaller more homogeneous segments over which to compute premiums (e.g., using gender, health status, claims experience, firm size), but this flexibility would be limited largely to age under reform, at least in individual and small group markets,⁶ and that variation would be limited as well. So, the central unit of risk pooling under reform would be geography, and if cross-state risk pooling were to occur, it would require that premiums be computed using the expected costs of insured populations in more than one state.

Geographic variation in health care costs for a given set of benefits can result from a number of sources. First, input costs such as rent and salaries vary considerably from place to place, as they do for all goods and services. Plus, some areas may rely more heavily on more costly providers, such as teaching hospitals, for example. Such costs go into the production of medical care and must be reflected in premiums. Second, the amount of care provided for a population in one area can be quite different from that provided in another. One population may have a higher incidence of certain types of diseases and conditions, for example due to environmental factors, income distribution, employment patterns, or other reasons. The customary medical practice patterns also vary quite a bit across geographic areas, with prevailing

⁶ An additional rating factor under H.R. 3590 would allow smokers to be charged premiums up to 50 percent higher than that for non-smokers of the same age. In addition, the Senate proposal allows employers to vary insurance premiums by up to 30 percent for employee participation in various “wellness” programs.

norms for hospital admissions and use of high cost technologies and procedures for specific diagnoses making some areas higher cost than others.⁷

Third, state insurance regulations can impact the risk profile of a health insurance pool, and these regulations vary significantly across states. The specific regulations in place will therefore impact the average health care costs of those insured in each state. For example, today, a state that requires insurers to offer insurance coverage to all applicants regardless of health status or history will have a higher cost population of insured individuals than will a state that allows insurers to deny coverage based upon an individual's expected health care costs. Under reform, there would be considerably more uniformity in regulatory rules across states – e.g., all would have guarantee issue policies, prohibit pre-existing condition exclusions, limit variations in rating rules, and require most individuals to enroll in insurance coverage – however, some differences would remain. For example, as noted earlier, some states have and would presumably continue to have tighter limits on premium variation by age than required under the federal proposals. Some states have more mandated health insurance benefits than do others, and this may also continue post-reform, increasing the cost of coverage in some states relative to others.

States vary today in the manner in which they designate rating areas. Some states, such as New Jersey, require insurers to issue statewide rates – in other words, they treat the whole state as a single rating area. Others, such as California, have established a number of sub-state rating areas within which insurers must issue consistent rates. The insurers participating in California's public children's health insurance program, Healthy Families, must set rates within six regions defined by the state. Private insurers in the state use nine regions in rate setting.

⁷ ES Fisher, et al. 2003. "The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care," *Annals of Internal Medicine*, February 18, vol. 138, no. 4, pp. 273-87.

Expanding rating areas to include larger populations means averaging health care costs across areas that may have different cost profiles. As a result, lower cost areas will implicitly subsidize higher cost areas. Consequently, it can be politically difficult to obtain agreement from low cost areas to participate in sharing risk with higher cost areas, while the higher cost areas are happy to participate in such risk spreading.

While sharing risk across geographic areas with different health care cost profiles can be difficult politically, creating stable health insurance risk pools requires a minimum number of covered lives. Too small of an insurance pool leads to significant average cost swings from year to year, prompting insurers to add risk premiums to the core premium charged in an effort to protect themselves from such large variations. Conventional wisdom suggests that the minimum size of a credible insurance pool is 100,000 enrollees,⁸ and definitions of health insurance rating areas should take this into account in order to ensure that carriers are able to enroll sufficiently large populations to make coverage efficient and stable. For example, a rating area in which four insurers actively market coverage should probably have a population of at least 400,000 likely to enroll in private coverage in order for all insurers to have a chance to have a credible pool of insured lives.

A health insurer's ability to provide attractive coverage at competitive prices in a particular geographic area is strongly associated with its ability to obtain discounts for a contracted network of health care providers. An insurer that does not have a provider network in an area effectively cannot operate in that area. Not only do insurers negotiate fee discounts with providers, they may also be able to control utilization of health care services by selectively

⁸ Healthcare Leadership Council, "Making Exchanges Work in Health Care Reform," report by the Committee on Economic Development, <http://www.hlc.org/exchangememo/hc09.pdf>; Elizabeth Carpenter, "Health Reform: National or State Exchanges," New America Foundation blog post, January 14, 2010, http://health.newamerica.net/blogposts/2010/health_reform_national_or_state_exchanges-26294; Marilyn Werber Serafini, "A National Insurance Exchange?" *National Journal*, January 19, 2010, <http://healthcare.nationaljournal.com/2010/01/federal-or-state-insurance-exc.php>Journal.com

contracting with the most efficient providers. In order to obtain significant provider discounts, insurers must be able to demonstrate the ability to deliver the providers a significant share of the insured market. An insurer with a small share of the insurance market has little bargaining leverage with providers. As a result, the start-up costs associated with entering a new insurance market are substantial, and insurers doing so may need to internalize significant losses in the early years in order to offer competitive premiums prior to obtaining meaningful provider discounts. Taking such losses early may allow insurers to build enrollment to the point that they have greater negotiating ability with a sufficiently large spectrum of providers. Due to name recognition, high market share, and long standing tenure in most markets, the Blue Cross Blue Shield plans tend to have the most extensive provider networks.

As a function of the size and geographic breadth of their established provider networks, certain plans may not be able to serve an entire rating area. For example, a closed-panel HMO may be an efficient high quality plan, but may only have contracts with providers in a portion of a large rating area. As a consequence, requiring all insurers to service an entire rating area defined by a state (or, under reform, a group of states) may not make sense from a cost standpoint.

Section 4.

Summary of Findings from Literature Review

There is very little literature that pertains to cross-state, sub-national risk pooling issues as there has been very little such experience in insurance markets to date. Here, we briefly summarize the findings from our review of the literature (Pollitz et al 2009),⁹ which uses literature on health insurance purchasing pools, association health plans, and proposals to allow insurance to be sold across state lines to summarize lessons relevant to proposals for pooling risk across state lines. A full list of references from the complete literature review can be found in appendix A to this report. The detailed description of the components of the Senate and House bills related to cross-state risk pooling is summarized as part of Section 5 of this report.

Lessons from Health Insurance Purchasing Pools for Cross-State Pooling.

There is no experience with cross-state purchasing pools or cross-state health insurance purchasing cooperatives in the United States. However, at least two important lessons can be drawn from state experience that are applicable to cross-state purchasing options. First, analysts agree that within an insurance market, uniformity between insurance regulations operating inside and outside of a purchasing pool are critical (Buchmueller 1997; Hall, Wicks, and Lawlor 2001; Wicks 2002).¹⁰ When consumers have a choice between buying coverage inside and outside of a pool and a regulatory disconnect exists between the two options, risk selection can easily compromise the long-term viability of a purchasing pool.

Second, some state purchasing pools have used state-wide prices, while insurance sold in the markets outside of the purchasing pool used premiums that varied by geographic region

⁹ Karen Pollitz, Linda J. Blumberg, and Eliza Navarro Bangit. 2009. op cit.

¹⁰ Thomas Buchmueller. 1997. "Managed Competition In California's Small-Group Insurance Market," *Health Affairs*, vol. 16, no. 2; Mark Hall, Elliot Wicks, and Janice Lawlor. "HealthMarts, HIPCAs, MEWAs, and AHPs: A Guide for the Perplexed," *Health Affairs*, vol. 20, no. 1; Elliot Wicks. 2002. "Health Insurance Purchasing Cooperatives," Commonwealth Fund Issue Brief, available at: www.commonwealthfund.org/usr_doc/wicks_coops.pdf.

(Curtis, Neuschler, and Forland 2001; Curtis and Neuschler 2005).¹¹ As a result, even though the insurance regulations were the same inside and outside of the purchasing pool, the pricing differential that resulted due to some plans using local prices and others using statewide prices made it difficult for the purchasing pool plans to compete for enrollment in lower than average costs areas. Efforts to pool health insurance risks across state lines would have to be mindful of potentially significant geographic pricing differentials.

Association Health Plans

Association health plans offer an alternative source of coverage to individuals and businesses that might otherwise purchase in traditional individual and small group markets. Associations are established to find other ways of pooling risks. In many cases, association health plans cover individuals and businesses in multiple states and may or may not pool risk across state lines. Often, insurance regulatory jurisdiction and enforcement can be complex for association health plans.

For out-of-state association coverage, regulatory complexity and uncertainty increases. Some states provide limited exemptions from their laws to out-of-state associations while others permit a complete carve out. In states that partially exempt, regulators claim some jurisdiction but will not have the full capacity to oversee and resolve consumer problems and must try, instead, to work with regulators in another state. This can be problematic because state regulators do not always have the ability to monitor and follow-up on actions taken by another state (Kofman, et al. 2006; Kofman, Bangit, and Pollitz 2005).¹²

¹¹ Richard Curtis, Edward Neuschler, and Rafe Forland. 2001. "Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?" *Health Affairs*, vol. 20, no. 1; Richard Curtis and Edward Neuschler. 2005. "Insurance Markets: What Health Insurance Pools Can and Can't Do," California HealthCare Foundation Issue Brief, available at: <http://www.chcf.org/documents/insurance/WhatHealthInsurancePoolsCanAndCantDo.pdf>.

¹² M. Kofman, K. Lucia, E. Bangit, and K. Pollitz. 2006. "Association Health Insurance: What is all the Fuss about?" *Health Affairs*, vol. 25, no. 6.; M. Kofman, K. Lucia, E. Bangit and K. Pollitz. 2005. "Association Health Insurance: Is it Time to Regulate this Product?" *Journal of Insurance Regulation*, vol. 24, no. 1.

Some state regulators have faced challenges in compelling insurers selling through out-of-state associations to respond to inquiries in response to consumer complaints. This makes it more difficult, in particular, to identify fraudulent health plans, which may result in increased consumer vulnerability to unpaid claims. The uneven application of solvency standards to out-of-state association health plan arrangements also adds to consumer vulnerability of unpaid claims (Kofman, Lucia, and Bangit 2003; Kofman et al. 2006).¹³ Research suggests that more associations offer coverage, and insurers sell such coverage, in states where associations are subject to less stringent rules than the traditional individual and small group markets (Kofman et al. 2005; Kofman et al. 2006).¹⁴

Allowing Insurance to be Sold Across State Lines

Over the last ten years, proposals to allow insurers licensed in one state to sell health coverage to residents of any state have been advocated by members of Congress, including 2008 Republican presidential nominee Senator John McCain. The intent of these proposals was that insurers would abide by the insurance regulations in the state where the company was based, as opposed to the regulations of the consumer's state of residence. These proposals have been analyzed by Kofman and Pollitz (2006), Blumberg and Holahan (2008), and Bertko, Nichols, and Carpenter (2008) within the context in which they had been proposed up until now, namely without other insurance market reforms or significant subsidization of coverage for the low income population.¹⁵

¹³ M. Kofman, K. Lucia, and E. Bangit. 2003. "Proliferation of Phony Health Insurance: States and the Federal Government Respond," *Bureau of National Affairs, Inc.*, vol. 23, no. 1; M. Kofman, K. Lucia, E. Bangit, and K. Pollitz. 2006. "Association Health Insurance: What is all the Fuss about?" *Health Affairs*, vol. 25, no. 6.

¹⁴ M. Kofman, K. Lucia, E. Bangit and K. Pollitz. 2005. "Association Health Insurance: Is it Time to Regulate this Product?" *Journal of Insurance Regulation*, vol. 24, no. 1; M. Kofman, K. Lucia, E. Bangit, and K. Pollitz. 2006. "Association Health Insurance: What is all the Fuss about?" *Health Affairs*, vol. 25, no. 6.

¹⁵ M. Kofman and K. Pollitz. 2006. "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change." Georgetown University Health Policy Institute Report, available at: <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf>; Linda Blumberg

All three analyses reach similar conclusions related to the proposals to allow coverage to be sold across state lines. Because under current law states vary in the extent to which they regulate the premium rating and rules of issue governing the sale of health insurance, many insurers could and likely would choose to domicile in the least regulatory states. In this way, insurers could continue to medically underwrite coverage and deny applicants based on health status, even in states that otherwise require guaranteed issue and community rating. Insurers could sell policies with limited covered benefits, even in states that mandate the sale of more comprehensive coverage. Any insurer domiciled in a state maintaining regulations requiring broader based pooling of health risk would attract the higher cost enrollees unable to obtain coverage elsewhere, compromising the viability of those insurance pools and leading states into a regulatory race to the bottom. State insurance regulations could be expected to be eliminated to a great degree, including the eradication of many, if not all, state benefit mandates. In addition, as Kofman and Pollitz point out, legislation that prohibits states from enforcing their own laws and relies upon states to enforce laws in other states raises a host of questions regarding constitutionality and practical enforcement.

The provisions for selling insurance coverage across state lines included in the health care reform bills passed by the House of Representatives and the Senate would be different in significant ways from these prior proposals. In particular, the federal reforms would provide a minimum level of insurance regulations that would be required in every state so insurers would not be able escape these basic requirements by selling across state lines. Also, states would have to affirmatively join a compact for coverage from outside the state to be sold there. However,

and John Holahan. 2008. "An Analysis of the McCain Health Care Proposal,": Urban Institute Health Policy Center brief, available at: http://www.urban.org/UploadedPDF/411755_mccain_health_proposal.pdf; John Bertko, Len Nichols, and Elizabeth Carpenter. 2008. "Across State Lines Explained: Why Selling Health Insurance Across State Lines is Not the Answer," New America Foundation Health Policy Program brief, available at: http://www.newamerica.net/files/nafmigration/Policy_Paper_Across_State_Lines_Explained.pdf.

within an interstate compact, some state laws stronger than the federal minimum requirements could be preempted, leading to potentially significant consequences for risk pooling.

Existing Interstate Insurance Compacts

The current law example of an interstate insurance compact is the one overseeing the sale of life insurance policies, the Interstate Insurance Product Regulation Commission (IIPRC) (see inset for a description of the IIPRC). As a condition of joining the IIPRC, states adopt identical standards; no one state preempts the laws of another. The function of the IIPRC is to provide a forum in which states can adopt identical standards for life insurance policies, and to carry out common administrative regulatory functions (the review and approval of life insurance policy forms) in a single site more efficiently than would take place if policies had to be filed in each state separately. The adoption of identical standards is relatively straightforward for life insurance, which is a relatively simple product involving only financial protection, which is often sold by national companies, and which can easily be purchased by individuals in one state and carried to another. Even so, it took years for the IIPRC to be established and for initial standards to be adopted (Washington State 2008).¹⁶

¹⁶ Testimony of Frances Arricale, Executive Director, Interstate Insurance Product Commission (IIPRC) before the Subcommittee on Capital Markets, Insurance, and Government Sponsored Enterprise, Committee on Financial Services, United States House of Representatives, April 16, 2008. See also Washington State Office of the Insurance Commissioner. 2008. "Feasibility Study of Use of an Interstate Compact to Provide Individual Health Insurance," available at: <http://www.insurance.wa.gov/legislative/reports/LegRptFeasibility.pdf>

The Interstate Insurance Product Regulation Commission

The Interstate Insurance Product Regulation Commission (IIPRC) is a multi-state public entity that facilitates the development of uniform national standards for certain insurance products, including life insurance, annuities, disability income and long-term care insurance. To date, standards have only been adopted for life insurance policies. The IIPRC was created specifically for these kinds of insurance products. Unlike other lines of insurance (e.g., health insurance) product standards for life insurance and annuities tend not to vary much across states. Compared to other lines of insurance, life insurance is a relatively simple product. (For example, a life insurance policy may be structured to pay only a single claim – upon death of the policyholder – while a health insurance policy could pay hundreds of claims for a sick policyholder in a year. A life insurance claim can involve one financial payout while each health insurance claim involves reimbursement of a contracted fee per service with a network of providers.) Further, it is not uncommon for life insurance policyholders to move to other states while maintaining coverage throughout their lives. Life insurance, then, is essentially a nationwide product. A life insurance carrier could be licensed in all or nearly all states; however, the process of filing products for approval in all 50 states can take more than a year. In recognition of these circumstances, the IIPRC was formed.

Working through the National Association of Insurance Commissioners (NAIC) state regulators decided an interstate compact could be used to streamline certain regulatory tasks. Today the IIPRC is used by member states to develop common product standards for life insurance products and, before policies are sold, to review products to ensure they meet IIPRC standards. The NAIC developed a model compact law, which states must enact in order to join the IIPRC. By passing this law, the state in effect delegates its authority to review and approve insurance products to the commission. The governing structure of the IIPRC ensures representation of member states, and ongoing consultation with member state insurance departments and legislatures is an important part of the IIPRC standards development process. At any time, if a member state objects or ceases to agree with IIPRC product standards, the state can opt out of the interstate commission and resume the task of developing its own standards and approving policies before they can be marketed in that state.

Duties delegated to the IIPRC are limited to the development of product standards and policy reviews for these specific lines of insurance. All other state regulatory authority and functions are retained by each member state. Therefore, even though a life insurer receives IIPRC approval of a product, the insurer is still subject to licensure, market conduct audits, financial examinations, investigations, and other rules and regulatory activities of each state in which it sells that policy. Rights and remedies afforded to consumers under state law are also preserved. To date, the IIPRC has 36 Member States representing over half of the life insurance premium volume nationwide.

Health insurance, by contrast, tends to be a local product, reflecting local networks and prevailing prices. The individual health insurance market especially, as a residual market, is also sensitive to the design and operation of employer-based health plans and insurance markets, as well as Medicaid and other public programs. Who participates in the individual market, their needs and circumstances, can vary accordingly. Consumer protections for health insurance are also more varied and complex. For these reasons, one state that considered interstate compacts

for individual health insurance concluded as recently as 2008 that, while it might be technically feasible, challenges to a successful compact were considerable and practically and politically infeasible (Washington State 2008).

Section 5

Approach to the Discussions with Experts

Choosing experts for discussions.

Appendix B lists the experts consulted for this project. In order to get a spectrum of knowledge and perspectives relevant to the issues focused on here, we drew experts from the following areas:

- Those with experience running purchasing pools, the most prominent being in Massachusetts (The Commonwealth Connector) and California (The Health Insurance Plan of California, later PAC Advantage);
- Insurance regulators, especially state insurance commissioners;
- Health policy analysts with particular expertise in private insurance markets and health insurance purchasing pools and who are familiar with the details of current reform proposals;
- Insurance experts with knowledge and understanding of the existing interstate insurance compact for life insurance and who have backgrounds in health insurance as well;
- Those with experience and expertise working with private health insurance plans;
- Some with background in health insurance regulation at the federal level.

Discussion questions covered.

Different discussion topics were delineated prior to the conversations with experts, depending upon their experience and expertise; only select topics were covered with each expert participant. While these topics were used as a guide, the discussions moved to other topics when the conversations moved into other areas. The topic areas developed prior to the discussions are summarized briefly here. A more complete list of the topic areas is provided in Appendix C.

1. Interstate Compacts for Health Insurance. Topics were designed to explore the background related to the only existing interstate insurance compact, which is for life insurance, in order to discern what issues might be relevant for cross state pooling of health insurance. The topics included how the IIPRC experience related to a possible health insurance compact, rate

regulation and rate review under the compact, filing process differences in life and health insurance, handling of consumer issues, bill language on selection of a primary state for regulatory purposes, and experience with interstate compacts for other lines of insurance.

Additional topics were designed to elicit background information from states that have considered the idea of health insurance compacts and the insurance industry perspective on compacts. The discussion topics included the perceived advantages and disadvantages of a compact, how a health insurance compact might be similar or different from the IIPRC, potential duties, a risk spreading role for a compact versus administrative roles, nature of cross state negotiations, and implementation challenges.

2. Multi-State Health Insurance Exchanges. Topics were designed to explore some of the administrative issues involved in running intra-state risk pooling arrangements today, concerns about adverse selection across risk pools, and to elicit expert opinion on the advantages and disadvantages of cross state exchanges. This topic area included risk adjustment, monitoring for risk selection, handling of consumer grievances, impact on local plans of purchasing options outside of the state, data collection on purchasing pool enrollees, geographic pricing differences, and other implementation issues

3. National Plans. Topics were designed to assess the impact of a national plan on the extent of competition in the health insurance exchanges and local health insurance markets and to assess mechanisms for such plans spreading risk across state lines. Topics included premium pricing strategies, network adequacy, the potential for national plans to effectively compete with insurers with longstanding reputations and significant market share prior to reform, and multi-state risk spreading opportunities.

Section 6

Discussion of Cross-state Pooling Potential under Health Care Reform

Three provisions in the House and Senate health care reform bills relate to or create the potential for cross-state pooling of health insurance: those providing for interstate compacts for health insurance regulation, those providing for multi-state health insurance exchanges, and provisions establishing a nationwide health insurance plan option.

Interstate Compacts

Both House and Senate versions of health care reform legislation would authorize the establishment of interstate compacts for health insurance regulation. The ostensible purpose of the Interstate Compact provisions is to promote competition of health plans across state lines and streamline regulation, thereby reducing health insurance costs and increasing the choice of products offered to consumers.¹⁷ Further, as precedent, since 2006 36 states have elected to enter into an interstate compact for life insurance in an effort to streamline regulatory activities and costs for both states and insurers. Recently, Minnesota Governor Pawlenty expressed support for the creation of interstate health insurance compacts.¹⁸ However, to date, there is no history of such compacts for health insurance and there have been no formal studies, including by the NAIC, of how such arrangements might be structured or operate.

In discussions with experts, we explored the feasibility of such compacts and whether experts thought interstate compacts for health insurance could effectively promote the sale of health insurance across state lines or accomplish other stated goals.

¹⁷ David M. Herszenhorn. 2010. *New York Times*, op. cit.

¹⁸ Tim Pawlenty, “Five Ways to Reform Health Care,” *Washington Post*, Sunday, February 14, 2010.

Description of reform bill provisions – Under the House bill, two or more states may form Health Care Choice Compacts to facilitate the purchase of individual (not group) health insurance coverage across state lines. The Secretary of HHS must develop model guidelines for the creation of compacts that provide for the sale of health insurance coverage to residents of all compacting states *subject to the laws and regulations of a primary state* designated by the compacting states. Health Care Choice Compacts could become effective as early as 2015. In addition, HHS guidelines must:

- require health insurance companies issuing coverage in secondary states to maintain licensure in every such state;
- preserve the authority of the state of an individual’s residence to enforce law [the bill does not specify which law-that of the primary or secondary state] relating to nine areas, including market conduct standards, consumer protection standards, and rate review [but not rating rules];
- permit state insurance regulators in secondary states access to records of a health insurance issuer maintained by the primary and other secondary states;
- require disclosure to consumers that the policy may not be subject to all the laws and regulations of the state in which the purchaser resides.

States are not required to enter into compacts, although the bill does provide incentives in the form of grants of up to \$1 million per year per state. States must enact a law to enter into a compact. The bill does not specify whether states must also enact a law to withdraw from a compact.

States that enter a compact must “retain responsibility for the consumer protections of its residents” and residents “retain the right to bring a claim in State court in the State in which the

resident resides.” The bill does not specify whether state enforcement and consumer claims must be based on the laws of the primary or secondary state.

The Senate health care reform bill similarly provides for the establishment of interstate health insurance compacts, with a few key differences. Under the Senate bill, compacts could not become effective before 2016. In addition, like the House bill, the Senate bill requires that a primary state shall have sole regulatory authority – when it comes to certain matters – over insurance sold in other compacting states. However, the Senate bill seems to give flexibility to insurers to designate the primary state. For other specified matters, the Senate bill preserves the regulatory jurisdiction of secondary states; importantly, regulation of rating is one such matter that is preserved for secondary states. Table 1 provides a summary of key provisions in the House and Senate bills’ language on interstate compacts.

Table 1. Key Provisions of the House and Senate Interstate Compact Language

	House bill - H.R. 3962	Senate bill – H.R. 3590
	The Secretary of Health Human Services shall consult with the National Association of Insurance Commissioners to develop model guidelines for the creation of compacts (Sec. 309(b), page 209)	The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts (Sec. 1333(a), page 227)
Effective date	January 1, 2015 (Sec. 309(a), page 209)	Jan 1, 2016 (Sec. 1333(a), page 230)
Regulation within compacts	The sale of health insurance coverage to residents of all compacting States are subject to the laws and regulations of a primary State designated by the compacting States (Sec. 309(b)(1), pages 209-210) Health insurance issuers providing health insurance coverage in secondary States are required to maintain a license to sell insurance in that State (Sec. 309(b)(2), page 210) The authority of the State to enforce laws relating to market conduct, unfair trade practices, network adequacy, consumer protection standards, grievance and appeals, fair claims payment requirements, prompt payment of claims, rate review and review is preserved (Sec. 309(b)(3), page 210) State insurance commissioners and other State agencies in secondary States are allowed access to the records of a health insurance issuer to the same extent as if the policy were written in that State (Sec. 309(b)(4), page 210) An issuer shall provide clear and conspicuous disclosure to consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides (Sec. 309(b)(5), page 210)	Qualified health plans could be offered in the individual markets of the compacting States but only be subject to the laws and regulations of the State in which the plan was written or issued (Sec. 1333(a)(1), page 228) The issuer of any qualified health plan is required 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 described below (Sec. 1333(a)(2)(B), page 228) The issuer of any qualified health plan to which the compact applies continues to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including rating standards), and addressing disputes as to the performance of the contract, of the State in which the purchaser resides (Sec. 1333(a)(2)(A), page 228) States are allowed access to records as if the insurer were licensed in the State (Sec. 1333(a)(2)(B), page 228) An issuer must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides (Sec. 1333(a)(2)(C), page 229)
Requirement to compact	No requirement that a State join a compact (Sec. 309(c), page 211)	No requirement that a State enter into a compact (Sec. 1333(a), page 228, line 2)
State authority	State must specifically enact a law authorizing the State to enter into a compact (Sec. 309(d), page 211) State must retain responsibility for the consumer protections of its residents. Residents retain the right to bring a claim in their State of residency (Sec. 309(e), page 211)	State must specifically enact a law authorizing the State to enter into a compact (Sec. 1333(b), page 229)
Exchange is the exclusive market for individual health insurance	Yes, individual health insurance coverage may only be offered in the Exchange (Sec. 202(c)(1), page 100)	No, individual health insurance coverage may be offered in and outside the Exchange (Sec. 1333(c)(1), page 229)
Other	Annual state grants, not to exceed \$1 million per State, available for activities (including planning activities) related to regulating health insurance coverage sold in secondary states (Sec. 309(f), pages 211-212)	No provision noted

Discussion with experts – Expert discussions about interstate compacts explored issues relating to the feasibility of such arrangements, the extent to which compacts might achieve desired goals, and other technical issues. All those with whom we talked confirmed that no formal process had been undertaken nor had a task force been assembled by the NAIC or others to explore in-depth the advantages, disadvantages, or practicalities related to an interstate compact for health insurance. Also, a number of experts pointed out that no federal legislation is necessary to develop interstate compacts; the fact that no states have sought to establish interstate health insurance compacts to date is likely indicative of the perceived advantages relative to the disadvantages.

Uniformity and interstate health insurance compacts – Most experts commented on the practical feasibility of establishing interstate compacts for health insurance, noting key obstacles that would need to be overcome. In particular, experts thought states would not enter into compacts and share regulatory authority unless they had adopted identical laws and regulations governing health insurance with other compacting states. IIPRC compacting states do this now, though experts pointed out that life insurance varies little across states in terms of product design or regulatory approaches. By contrast, health insurance is a complex product and regulation entails oversight of many dimensions of the product and its marketing (for example, provider network adequacy, utilization review standards, benefit design, etc.) that vary considerably across states. The complexity and variability of health insurance are key reasons cited in one state report that concluded such compacts would not be feasible under current law.¹⁹

Following health reform, the adoption of federal minimum standards could reduce the variability in health insurance products and regulatory standards; however, significant variations could persist. For example, states could continue to mandate coverage of benefits beyond those

¹⁹ Washington State Office of the Insurance Commissioner. 2008. op cit.

required under a federal minimum standard, or could require tighter age rating bands than those permitted under federal law. If states with unlike standards were to compact, certain consumers and insurers could be disadvantaged. For example, if Maine (which limits age rating to 1.5:1) were to compact with Massachusetts (with 2:1 age rating), older Massachusetts residents might seek less expensive coverage in Maine while younger Maine residents might purchase in Massachusetts, resulting in anti-selection that could destabilize risk pools, raising the cost of coverage in more protective states.

As a result, experts suggested that states with unlike markets and standards might not ever elect to compact with each other. It would not be in the political interest of policymakers to put their state residents at a disadvantage. Even if some states with very similar regulatory environments were interested in compacting, agreement on the set of benefits provided across states would be necessary. All in all, the experts did not see many states being interested in pursuing such arrangements. Larger risk pools might seem attractive, but the opportunity for adverse selection is substantial and likely to override potential benefits.

On the other hand, some experts suggested that there may be political incentive for insurers to lobby for the creation of state compacts in order to seek market advantage, even if anti-selection might not benefit consumers. For example, multi-state insurance companies that have a national network might have an advantage over local plans (see below). Commercial companies that can operate in multiple states might have an advantage over Blues plans, which operate under a Blue Cross Blue Shield Association (BCBSA) agreement not to compete against other Blues plans.

Legislation to permit the sale of health insurance across state lines has grown in popularity recently. Bills are pending in at least 17 states currently²⁰ and have gathered political momentum, thanks to industry lobbying, even in states where market rules (eg, community rating and guaranteed issue) are stronger than in most other states. One expert noted that legislation to purchase coverage across state lines was recently introduced in her state and had strong political support, even though her state has stronger market regulations compared to most others.

Provider networks and crossing state lines - Another practical hurdle to the sale of health insurance across state lines cited by many experts had to do with provider networks. A core function of health insurance is to develop and maintain a network of hospitals, doctors, and other health care providers. Because most policies limit coverage to that provided in network – or substantially increase out-of-pocket costs required of beneficiaries obtaining out-of-network care – the adequacy of a plan’s provider network constitutes an important coverage feature. Further, prices negotiated with network providers are key to the overall cost of benefits covered by the plan. Provider networks, by their nature, are local. As a result, it may not be easy for plans to enter new state markets and establish provider networks at competitive prices. One other example provided by an expert was that high cost hospitals in San Francisco mean that maternity benefits are very expensive in the city. Even so, to date, large California insurers with significant market share have been unsuccessful in negotiating lower hospital rates. The expert observed that, in light of this circumstance, it seemed unlikely that an out-of-state insurer – say, from New Mexico - with very little California market share – would have more success in negotiating with the San Francisco hospitals.

²⁰ The states are: California, Colorado, Georgia, Indiana, Maine, Minnesota, North Carolina, Nebraska, New Jersey, New Hampshire, Oklahoma, South Carolina, Pennsylvania, Virginia, Washington, Wisconsin, and Wyoming.

To sell across state lines, health insurers would have to develop or rent provider networks in each market where they operate. Particularly for HMOs with closed panel provider networks, this hurdle could be significant. One expert suggested that there are only two practical ways in which insurers enter new markets successfully: (1) by purchasing a domestic carrier already in the market; or (2) by partnering with a large employer (such as General Motors) in order to have an immediate enrollment base in the new market. The large enrollment base would give the new plan bargaining clout with local providers. Even so, experts wondered whether a local hospital network or physician PPO would ever negotiate to offer a better deal to an out-of-state insurer than it would to a local insurer. And, given the effort involved in entering a new state, one expert suggested insurers might more successfully invest effort in improving their position in markets in which they already operate.

Finally, experts suggested that a primary motivator underlying past proposals to permit the sale of health insurance across state lines was to be able to sell under less restrictive market rules even in states with more restrictive rules (e.g., to be able to medically underwrite products in guaranteed issue states). Once national health care reform is enacted, however, and stronger insurance market rules apply nationwide, experts thought insurers would have less to gain by selling coverage across state lines.

Spreading risk/costs across state lines - Supporters of selling across state lines suggest that this option might offer residents of higher-cost states the choice of less expensive health insurance. However, the reasons why costs vary across states are important to consider. Insurance costs might be higher in State A vs. State B because providers charge higher prices in State A. Higher provider prices might be due to a relative lack of competition in State A's insurance market; but other reasons might also be at play. Features of State A's economy and job markets, income levels, tort systems, and other factors might also have a residual effect on

the cost of health insurance or provider prices in State A. Experts could see why higher-cost states might want to compact with lower-cost states, but expressed skepticism that lower-cost states would be willing to enter into such compacts.

Oversight and enforcement of market regulation across state lines – Another issue cited as important by several state officials was the practicality of regulating health insurance across state lines. Insurance regulators particularly stressed the importance of retaining each state's regulatory jurisdiction over solvency, rating, market conduct, consumer protection, and other aspects of health insurance. State regulators questioned their ability or authority to protect consumers in other states. In particular, legal and constitutional challenges may arise if one state seeks to enforce its laws outside of its jurisdiction.

One expert expressed concern that a state insurance department would face countless litigation challenges from insurers in such circumstances. In addition, another expert raised practical questions about a state's ability to effectively enforce regulations across state lines. For example, if an insurer selling across state lines has only a small market share within the regulating state, the threat of sanction by the regulating state (e.g., to suspend enrollment or withdraw the insurer's license) may not prompt compliance by the insurer in other states where it sells. In other words, if the regulating state purchases little coverage from the carrier, the regulator would have no effective enforcement "hammer".

California experts also pointed out that the dual regulation of health insurance in that state (by the Department of Insurance (CDI) and the Department of Managed Health Care (DMHC)) could complicate regulatory questions in the context of an interstate compact. Currently CDI and DMHC apply somewhat different rules to the health plans they regulate and this is expected to continue after health reform. In addition, one expert noted that California, due

to its sheer size, might not readily join a health insurance compact with any other states because the task of regulating coverage is already so substantial.

One expert noted that regulatory conflicts under the IIPRC have not yet been tested. So even in the simpler context of life insurance, the compact's ability to resolve regulatory conflicts across states without the need for litigation is unclear.

Another expert believes that the language in the Congressional health reform proposals is quite protective with regard to the authority provided the Secretary of HHS. The Secretary could, for example, issue rules or standards to approve interstate compacts only in cases where compacts adopt the highest common denominator of rules across all of the compacting states and provide for effective enforcement of those rules. The Secretary could exercise federal authority to prevent the weakening of strong state consumer protection standards. However, additional resources would be needed at the federal level to perform these types of evaluations and oversight. There is no history of regulation of private health insurance at the federal level. In addition, potential conflicts could arise between a desire for a strong federal involvement in private health insurance and the NAIC's traditional role of preserving state authority in such matters.

Multi-state and Regional Health Insurance Exchanges

Both bills provide for the operation of health insurance exchanges by states. In addition, both bills would permit the establishment of multi-state or regional exchanges, although provisions vary somewhat.

Description of reform bill provisions -- Under the House bill, a national health insurance exchange would be established by the federal government. The exchange would be the exclusive market for individual health insurance; only grandfathered policies could continue to

be sold outside of the exchange. Individuals and eligible employers could participate in the exchange. By 2015, eligible small employers would be those with up to 100 employees; thereafter larger employers might also be permitted to participate at the federal government's discretion. Employers participating in the exchange would make a minimum defined contribution on behalf of their employees, but employees would select their own individual coverage, paying the difference between the actual premium and the employer's contribution. Employers would also have the option of continuing to provide group health benefits by purchasing an insured group health insurance policy outside of the exchange or by offering a self-insured group health plan.

The exchange would negotiate with health plans to offer qualified health benefit packages at the best price to exchange participants. The exchange would also administer low income subsidies for individuals and engage in other activities, such as provide for annual open enrollment periods, develop plan comparison information, and provide consumer assistance services. The exchange would not regulate health insurance, but would coordinate with state and federal regulators to ensure that exchange participating insurers meet all regulatory requirements, such as modified community rating.

Under the House bill, states or groups of states would be permitted to operate exchanges, subject to federal approval. [section 308, p. 203] If approved, state-based exchanges would operate instead of the national health insurance exchange. State-based exchanges could not compete; no more than one exchange could operate with respect to any one state. [p 205] If the federal government determined that a state-based exchange did not meet all requirements, it could take back some of the functions of the state-based exchange or close it altogether.

Under the Senate bill, each state would establish and operate an exchange for individual health insurance coverage starting in 2014. The exchange would not be an exclusive market for

individual coverage; instead, individual policies could continue to be sold through the individual market outside of the exchange. States would also establish SHOP exchanges for small group health insurance coverage. The SHOP exchange would not be an exclusive market either; instead, small businesses would have the choice to purchase small group policies outside of the exchange or to self-fund. Although the exchanges would not constitute exclusive marketplaces, insurers would be required to pool risk regardless of where coverage was sold. Specifically, insurers would be required to consider all of their individual policyholders (both in and out of the exchange) as members of a single risk pool. [p 178] Likewise, insurers would be required to consider all of their small group policyholders (in and out of the exchange) as members of a single risk pool. Insurers that sell both in and outside of an exchange would have to offer the same products and price them identically. Risk adjustment methods will be developed by HHS and applied to all individual and small group policies (other than grandfathered policies) sold in and outside of exchanges. [section 1343 p. 249] States would have the option of merging their individual and small group markets.

Qualified individuals and small employers could participate in the exchange. The Senate bill defines “small employer” as firms with up to 100 employees. States would have discretion to allow larger employers to participate in the exchange beginning in 2017. Similar to the House bill, exchange duties under the Senate bill would include certification of qualified health plans, administration of subsidies, and development of plan comparison materials and other consumer assistance services.

Under the Senate bill, States would be allowed to establish subsidiary exchanges (for example, for northern and southern California) as long as each subsidiary operates in a geographically distinct area. States could also establish regional or interstate exchanges with Secretarial approval.

Discussion with experts – We summarize these discussions by delineating the rationales raised for establishing multi-state exchanges, and we then present discussions on considerations related to risk adjustment across state lines and the political and administrative issues involved with developing cross-state exchanges.

Four rationales for establishing multi-state exchanges - States might consider joining together to offer regional or multi-state exchanges for four reasons. First, administrative economies of scale could be significant. Exchanges will need to develop subsidy administration and eligibility protocols, consumer ombudsman services, plan comparison materials, and other new programs and functions in order to organize health insurance markets and make them operate more competitively. Experts thought it could make sense, for example, for several small states to join together and undertake these tasks in common. Experts who are regulators, however, stressed that within multi-state exchanges, it would be important for each state's Department of Insurance to retain its regulatory jurisdiction and authority.

Second, regional exchanges might also make sense in large metropolitan areas that cross state boundaries. Residents may reside in one jurisdiction but work and obtain health insurance in another. Today, in advance of health reform, insurers make adjustments in order to do business in such areas. For example, two Blues plans operate in Kansas – Kansas BCBS and Kansas City BCBS. Kansas BCBS operates statewide except for the Kansas City metro area. Kansas City BCBS sells coverage only in the metro area and is licensed in both Kansas and Missouri. To the extent these two states have different rules governing health insurance, KCBCBS follows the more stringent rule for all of its policies. In the context of health reform that provides for individual and employer mandates, it will be important to adopt structures that facilitate the purchase of coverage, making health insurance as affordable, efficient, and administratively simple as possible. For firms whose workers reside in different jurisdictions,

regional exchanges could simplify coverage choices, the administration of subsidies, enforcement of mandates, and other key reform changes.

Third, multi-state exchanges might be established to promote pooling across state lines. However, whether risk pooling across state lines might occur would depend on the rating areas for health insurance that states establish. As discussed above, it seems unlikely that a lower-cost state would agree to pool risks and costs with a higher-cost state. Under both bills, states will establish geographic rating areas for health insurance, subject to federal approval. [§2701(a)(2) of House bill; §213(a)(2) of Senate bill] Therefore, for example, even though Kansas and Missouri might decide to jointly operate a single exchange for their residents, if the cost of coverage across these two states is very dissimilar, they might decide to maintain distinct rating areas within the exchange for Kansas and Missouri, and might even maintain sub-state rating areas.

Fourth, multi-state exchanges could serve to create the necessary critical mass of insured persons to establish stable risk pools by combining markets in small population states. A number of experts mentioned that the minimum size for a credible risk pool is 100,000 lives. Thus multi-state exchanges could be particularly useful for sparsely populated regions of the U.S. However, experts pointed out that some of the same obstacles that occur in the context of selling insurance across state lines would also occur in cross-state exchanges. For example, to operate in a multi-state exchange and operate everywhere within it, insurers would need to develop and maintain provider networks that reached broadly across the region. A Wyoming insurer may be unable to establish a robust provider network in Idaho, for example. In addition, experts noted introducing additional plans into small population areas would have the effect of further fragmenting existing risk pools, particularly in the absence of effective risk adjustment.²¹

²¹ Plus one expert noted that having many plans within an exchange can seem attractive from a choice perspective, but can also make purchasing pools significantly less flexible. Getting 25 health plans to do something uniformly

Risk adjustment – Several of our expert discussions involved the issue of risk adjustment, how it is used in states and risk pools today, and what relevance it might have for cross-state pooling. Both health reform bills provide for risk adjustment. Even after medical underwriting is prohibited, there is a chance that risks might distribute unevenly across insurers, accidentally or as a result of consumer and/or insurer behavior that leads to adverse selection. Risk adjustment is a tool to even out maldistribution of risks across plans. For example, if one plan within an exchange enrolls a disproportionate share of the population with diabetes, a risk adjustment could be applied to take some premium revenue from other plans and transfer it to the plan with sicker enrollees. In this way, plans are not financially or competitively penalized for enrolling higher need people and enrollees do not face higher premiums for choosing a plan that tends to be more attractive to those with serious conditions.

The potential for adverse selection or risk selection increases if health insurance is sold in multiple markets – for example, both inside and outside of an exchange. There may be incentives for insurers or agents to steer risk to one market or another in order to gain a competitive advantage. Under the Senate health reform bill, health insurance can be offered by insurers both inside and outside of the exchange. However, carriers must pool the experience of coverage they sell both inside and outside of the exchange, and charge the same premium for a policy regardless of where it is offered. The Senate bill also provides for risk adjustment to be applied for all policies and carriers in the individual market, whether in or outside of the exchange. A similar risk adjustment requirement applies to small group coverage.

In the case of multi-state exchanges, the opportunity for selection dynamics increases, based on the factors discussed previously. If rules and required plan features within a multi-state

takes a great deal of work and planning. Insurers are much better at developing quickly implemented strategies to avoid bad risks than an exchange with many plans can be at preventing risk segmentation. One expert also pointed out that to the extent that multi-state exchanges or enlarged markets increase the number of plans offered, the task of administering and regulating the market can be more difficult.

exchange varied at all from those governing plans operating outside of the exchange in even one state, significant adverse selection could occur, possibly raising costs for all enrollees across the participating states in a multi-state exchange. While the Senate bill provides for the potential implementation of a risk adjustment mechanism across exchange and non-exchange plans, there is no practical experience with such a strategy, and it would be difficult under the most uniform of circumstances. For example, there is no available data today to assess the extent to which the Massachusetts Connector is adversely selected against relative to Massachusetts plans that do not participate in the Connector.

Effective risk adjustment is important in the context of exchanges generally, but would be critical for cross-state exchanges. While significant advances have been made in the development of risk adjustment technology (the DxCG model was cited by those in two states as the program used²²), access to sufficient data can be a constraint. The more claims/utilization information provided by the carriers, the better the risk adjustment software can do in assessing the relative risk of enrollees. However, one expert stressed that shortcomings in data collection can hinder the effectiveness of risk adjustment. In California, for example, many managed care plans do not collect detailed outpatient or prescription drug data as a matter of course. Insurers also vary in the specificity of data they collect – for example, some may collect the first three digits of a diagnosis code for a patient while others may collect four or five digits of the code. Getting insurers to collect and report uniform claims and diagnosis data for risk adjustment purposes will require an investment of resources and time.

There are many decisions that must be made to implement risk adjustment successfully, for example, will adjustments be made prospectively based on the characteristics of enrollees at

²² DxCG is one of the commercially available claims-based risk assessment tools. A recent study analyzed the relative predictive accuracy of these tools, see Ross Winkelman, et al. 2007. “A Comparative Analysis of Claims-Based Tools for Health Risk Assessment,” Society of Actuaries. Available at <http://soa.org/files/pdf/risk-assessmentc.pdf>.

the beginning of the plan year, retrospectively based upon utilization during the past year, or some combination? What types of health conditions will be used as a basis for risk adjustment and how will they be weighted relative to each other in the computation of the adjustment? All risk adjusters do not come up with the same answers, making these decisions carry significant financial implications for different plans. Within a multi-state exchange, states would need to agree on these choices as well as what to do in circumstances wrought from the exchange participation being voluntary for insurers. For example, insurers being assessed under risk adjustment due to enrolling a healthier than average risk pool could decide to leave the exchange to avoid paying. How would this be handled? Performing risk adjustment without standardized health plans across the boundaries of the purchasing pool would also be very difficult, one expert noted.

Political and administrative issues involving multi-state exchanges - Another expert noted that multi-state exchanges would tend to dilute the policymaking locus to a non-politically accountable level. For example, state A might seek to increase insurer competition by limiting the exchange options to three carriers, while state B would oppose this approach. Or, in the course of certifying exchange eligible plans and insurers, if consumer complaints (for example, involving network adequacy) arise against a carrier in one state but not in another, the multi-state exchange would have to weigh whether to decertify the plan despite the fact that residents of one state may not be unhappy with it. These types of disagreements could cause conflicts between member states of the same exchange. Thus, the ability to make decisions that could improve the functioning of the market become more difficult with a multi-state exchange.

In summary, exchange policy will be a constant balancing act between spreading risk, maintaining insurer participation, and, in the case of multi-state exchanges, ensuring that competing interests of different states are handled satisfactorily. A number of experts believed

that multi-state exchanges would be limited to a small number of cases as a result, or alternatively, would focus on shared administrative structures and efficiencies as opposed to risk sharing.

National Plan Options

Description of reform bill provisions --The Senate reform bill also provides for the development and sale of national health insurance plan options. These options would be administered by OPM, which administers the FEHBP. Under the Senate bill, OPM would contract with at least two health insurers to offer a national plan option in each exchange in each state. [sec 1334 p. 230] At least one of the contracting insurers would have to be a non-profit carrier.

The national plan would have to offer policies that consist of the federally established essential health benefits; however, states could require that additional benefits which they mandate also be covered under the national plan. [p 234] At least one national plan in each state will not cover abortion services. States that have more protective rating requirements (i.e., age bands smaller than 3:1) could also require the national plan to follow its rating rules. [p 235-6]

Discussion with experts - Experts questioned whether the availability of such national plan options would increase choice or promote competition or risk pooling, either within states or across state lines. In particular, experts pointed out that FEHBP carriers today already operate in multiple states and wondered how a national plan would add to the number of carriers in any particular area. If Aetna would contract with OPM to offer a national plan, for example, would it compete against itself in states where it already sells coverage locally? Or would a national BCBS plan compete against a state BCBS plan? In the event that a national plan would

constitute a new player in a given state market, experts also were skeptical that the national plan would be able to negotiate more favorable rates with providers in each local area.

In addition, the national plan structure in the Senate bill might not necessarily result in more affordable premiums. One expert noted that OPM is not known as a particularly aggressive price negotiator with insurers. Instead OPM assumes that competition for market share within FEHBP will lead carriers to offer coverage for the best price.

The provisions related to the national plan in the bills indicate that state rating rules will apply. Therefore, it would not seem that the national plans would lead to cross-state risk pooling. The rating area is the geographic area within which risks are pooled.

Section 7

Conclusions

Summary of Findings.

The House and Senate health care reform bills each contain three components that could potentially lead to spreading of risk across multiple states. These provisions are: interstate health insurance compacts, multi-state health insurance exchanges, and the creation of national health insurance plans. It is possible that these mechanisms could lead to cross state pooling of health risk. However, variations in state insurance regulations, geographic pricing differences, and the complexities involved with insurers entering new markets mean that states may choose not to enter into voluntary cross state ventures (i.e., compacts or exchange) and even in the case of national insurance plans or where states do enter cross state ventures, there may be little or no actual spreading of risk across geographic borders.

Risk sharing would require insurers to set identical insurance premiums for two or more states with different underlying health care costs and regulatory frameworks. In this way, a low cost state would implicitly subsidize the medical care of a higher cost state with which they are pooled; an attractive prospect for the high cost state, but not for the low cost one. In addition, many insurers, such as HMOs and integrated health care systems that contract directly with local providers, may be unwilling or unable to create provider networks that reach across multiple states. For these insurers, it may not be feasible to achieve sufficient provider discounts to make it profitable to increase their service areas so dramatically. In the case of national plans, state specific rates would be necessary for insurers to use, since uniform national rates would make it impossible for the plans to compete for market share in low cost states and could cause significant private market disruption in high cost states. With state specific rates, there simply is no cross state pooling by definition.

In the case of metropolitan areas that cross state lines, it is possible that a regional exchange could be established exclusively for a metropolitan area. Such an action would recognize that the practical geographic boundaries of an insurance market are not necessarily the same as the political boundaries. A regional exchange (say, for the Washington DC metro area) would require cooperation of all of the political jurisdictions involved. In particular, coordination between each jurisdiction's insurance regulators would be important to ensure that market rules and consumer protections are consistently enforced.

Outside of risk sharing, however, there may be some administrative advantages of multi-state exchanges and interstate compacts for health insurance. For example, a number of small states could come together to jointly develop the administrative structures necessary to operate a health insurance exchange. Insurance within such joint exchanges could still be sold at state-specific prices and plans offered could vary by state. However, the exchange web site (sure to be a critical component of exchange marketing strategies), data collection mechanisms for monitoring insurer operating practices and for performing risk adjustment, enrollment processes, federal subsidy determination processes, etc. could be developed and operated together, saving on administrative costs for participating states. Such collaborations could be particularly helpful for states with metropolitan areas that cross state borders.

Regulatory and consumer protection concerns would likely make the delineation and implementation of interstate compacts complex. Unlike the much simpler regulations and market structure of life insurance, which does operate under an interstate compact for many states, health insurance plans are much more varied, and are regulated and priced very differently across states. Experts also expressed considerable concern that making a primary state responsible for enforcing regulations across states could compromise the enforcement of consumer protections and regulations in the other compacting states. Again, however, some

administrative efficiencies could be created through compacts if uniform processes for product review and certification could be created.

While there was significant agreement among the experts consulted on the findings summarized here, considerable uncertainties remain. There is no experience with multi-state exchanges, and the types of purchasing pools that operate today or have operated in the recent past are different from those proposed in the legislation in significant ways. As a consequence, a multi-state exchange's ability to generate administrative savings for participants is merely theoretical at this point, and the extent to which states will be interested in developing them is a real unknown. Likewise, it was agreed that the experience with the IIPRC should not be considered indicative of the potential for interstate health insurance compacts and that the gains from them are unclear; however, a number of experts noted their concern that the inclusion of compacts in federal legislation might encourage state legislators to create them.

Policy Implications.

Interstate Health Insurance Compacts - Some experts predicted that, due to the complexities involved in creating workable compacts, the lack of compacts today, and the fact that gains to states and insurers from entering into them are very unclear, few if any would be developed. Such an outcome would not be problematic from a federal perspective, as the compacts are permitted at state option. However, the Secretary would be responsible for approving or rejecting proposed compacts, and a framework for evaluating them will be necessary. The Secretary would have considerable discretion in this regard, and, among other issues, would have to decide whether to intervene in cases where a compact's primary state would undermine stronger regulations in another more highly regulated compacting state. In addition, the monitoring of a compact's resources and activities devoted to oversight of market

operations and enforcement of consumer protections in all member states will be an important role for the federal government, as primary states attempt to perform necessary duties for larger geographic areas and populations than they do today.

Finally, it is possible that other types of cooperative agreements between state insurance regulators could be achieved that would be more similar to the IIPRC than to the Health Choice Compacts described in health reform bills. In particular, states might agree to share or collaborate on certain administrative tasks – such as policy form review - while retaining for each state authority to enforce its own laws.

Multi-State Exchanges - If some states decide to create multi-state exchanges, it seems likely that they will serve more as administrative entities than as vehicles for risk spreading across states. This should not pose any major problems or concerns for the federal government. However, federal guidance and even, perhaps, intervention at times, may prove to be important in resolving potential inter-state conflicts for states jointly operating exchanges. The Secretary will also need a framework for evaluation whether multi-state exchanges could in any way increase federal costs or impede access to care for those residing in participating states.

National Health Insurance Plans - OPM may find it difficult to find commercial health insurers able to operate in all 50 states without competing with their already existing business in many states. While the bills call for full national participation, no provisions were made for the case that this was not feasible. In addition, the national plans may not prove competitive in those areas in which they do not currently have provider networks or where their provider networks are not strong. If that is the case, the importance of operating in those areas should be considered. It is also possible, in theory, to structure a national plan as a self-funded plan.

Directions for Future Research/Analysis.

Legislators have not fully delineated the goals and expectations that they have for the three components of the health care bills explored in this work. As a result, if passed, there is very little guidance for the Administration to rely upon for advising states on whether they should pursue them or how to do so. State proposals for interstate compacts and multi-state exchanges must be evaluated for approval at the federal level, and the standards for doing so should be made available to states prior to their developing their plans.

In order for states to use their time and resources effectively, it would be not only helpful, but essential for the Administration to clearly outline its goals for these provisions, the acceptable framework in which they could operate, and the outcomes that must be measured to evaluate their operations over time. Such work should be done in conjunction with experts on private health insurance markets, the operation of exchanges, and regulation of health insurance at the state level. Without such an effort, there will be considerable confusion at the state level with regard to their appropriate interpretation and response to these provisions.

Appendix A

Full List of References from Literature Review

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Appendix B

List of Experts Consulted

Jay Angoff, Partner, Mehri and Skalet; former Insurance Commissioner for the State of Missouri, and former director of private health insurance activities, Health Care Financing Administration, 1997-98.

Kevin Beagan, Deputy Commissioner and Director of the State Rating Bureau, Division of Insurance, Commonwealth of Massachusetts

John M. Bertko, consultant, adjunct staff at RAND, visiting scholar at the Brookings Institution, former chief actuary for Humana Inc.

Brendan Bridgeland, director, Center for Insurance Research

Gary Claxton, Vice President and Director of the Health Care Marketplace Project, Kaiser Family Foundation

Leslie Cummings, Executive Director, Managed Risk Medical Insurance Board, State of California

Rick Curtis, President, Institute for Health Policy Solutions

John Grgurina Jr., CEO, The San Francisco Health Plan

Jon Kingsdale, Executive Director, Commonwealth Health Insurance Connector, Commonwealth of Massachusetts

Mila Koffman, Superintendant of Insurance, State of Maine

Ed Neuschler, Senior Program Officer, Institute for Health Policy Solutions

Herb Olson, General Counsel, Vermont Department of Banking, Insurance, Securities, and Health Care Administration

Sandy Praeger, Commissioner, Kansas Department of Insurance and Chair of the NAIC Health Insurance and Managed Care Committee

Appendix C

Discussion Topics Prepared for Conversations with Experts

Risk pool administrative issues and adverse selection concerns:

- Risk adjustment – extent to which it is being used in existing pools, the type of adjustment made, if any, and how its effectiveness can be measured.
- Monitoring of risk selection – approaches, data collected, availability of comparable data from plans outside the pool, and any difficulties in obtaining it.
- Perceptions of the hypothetical experience of accepting enrollees from other states into the exchanges; impacts on administrative duties and any other complexities envisioned.
- Handling of insurance grievances from consumers; changes that would be necessary with cross-state purchases, both from others purchasing within your state and your residents purchasing elsewhere.
- The impact on competition among the local plans in state pools if residents had the ability to purchase outside the state.
- The current House and Senate reform bills provide for interstate compacts under which only one state in the compact would be responsible for enforcing insurance regulations. Discuss possible mechanisms for making such an approach work.
- Data on enrollees in and out of purchasing pool plans; measurement objectives with regard to differences between pool and non-pool plans, enrollment, and risk selection.
- Handling of geographic pricing differences within states; efforts to pool risk across geographic areas with different prices; reasons for or against such pooling.
- The impact of a national plan, as specified in the House and Senate bills on competition and selection in a state and in an exchange.

Experience with interstate insurance compacts:

- How the interstate insurance compact for life insurance (IIPRC) experience may relate to issues of interstate compacts for health insurance or the notion of pooling across state lines for health insurance products. General background information about the existing IIPRC and any general thoughts on how this might relate to health insurance.
- Difficulties in getting compacts legislatively enacted, and length of process.
- Operation of rate regulation and rate reviews under the compact. Timing on IIPRC issue of standards for rate filings for life insurance.
- Differences in the filing process for life insurance vs. health insurance.
- State opt outs of an IIPRC standard.
- Consumer issues that have arisen with respect to the IIPRC (e.g., grievances) and how they are handled.
- Experience with interstate compacts for other lines of insurance.

- The concept of pooling across state lines and how it would relate to IIPRC.
- Language in House bill regarding health insurance, in particular the provision that allows the selection of a primary state among compacting states as having the regulations that would be followed for all.
- Additional information about interstate compacts that could be helpful for us to know in the context of health insurance.
- Additional thoughts about how interstate compacts and pooling across state lines might affect health insurance.

Past consideration of interstate health insurance compacts:

- The advantages/disadvantages of an interstate health insurance compact.
- How a health insurance compact might be similar to or different from the Interstate Insurance Product Regulation Commission (IIPRC).
- Potential duties of an interstate health insurance compact.
- Potential for a risk spreading role for a compact as well as a purely regulatory or administrative one.
- Nature of negotiation of compacts across states.
- Implementation challenges.
- In the event of a compact achieving agreement on uniform regulatory standards for the individual market, ways in which differences in other sectors of the states' health coverage systems (e.g., employer based coverage, Medicaid) might affect or be affected by a compact.
- The IIPRC did not move forward until a majority of the states had joined. Appropriateness of the same threshold number of states health insurance compacts.

Cross state pooling and health reform:

- The experience to date with cross-state pooling, e.g. association health plans, MEWAs; the central regulatory issues; stability of pooling arrangements over time.
- Advantages/disadvantages from creating cross-state exchanges, specifically, risk issues and monitoring concerns and how they would differ from state-specific exchanges.
- The impact of a national plan on competition and pricing, both inside and outside an exchange.
- Advantages/disadvantages of the type of interstate health insurance compacts allowed in the current versions of the House and Senate health reform bills.
- Best structure for such compacts.
- Types of states and state groupings that would most likely come together to create such compacts.

- Risk spreading issues that might arise as a result of interstate compacts, and how premium rating might work most effectively in such a context.
- In the event of a compact achieving agreement on uniform regulatory standards for the individual market, ways in which differences in other sectors of the states' health coverage systems (e.g., employer based coverage, Medicaid) might affect or be affected by a compact.

Industry perspective on sale of health insurance in multiple states:

- Goals that insurance companies have for interstate compacts, e.g., streamlining of regulatory issues, administration, different pooling arrangements, others.
- Concerns that insurers might have regarding interstate compacts.
- Reasons why an insurer might not be willing to participate in an interstate compact.
- Different impacts of compacts on local and national plans.
- Impact of compacts on competition across insurers of different types (HMOs, PPOs, Integrated Health Systems (IHS), etc.)?
- A national plan's impact on risk pooling in states that otherwise mandate benefits above those included in the national plan.
- Ability of a state chartered HMO, IHS, or Blues plan to sell coverage in other states.
- Insurer pricing of policies that are sold in cross-state exchanges.
- Experience of insurers today with cross-state pricing in multi-state market areas.

Federal government perspective:

- Federal government oversight of interstate compacts and cross-state exchanges; types of information that would be important to collect; types of resources that the federal government would need to evaluate and oversee such compacts/exchanges.
- Approaches by which the federal government could assess whether compacts could decrease coverage or increase the deficit, as specified in the legislation.
- Processes via which the federal government and state governments could work together with regard to interstate compacts and cross-state exchanges; extent to which such interactions are likely to be cooperative in nature, and the best structures for them.
- Federal perspective on the advantages/disadvantages of interstate compacts and cross-state exchanges.
- Process by which the federal government would evaluate the fitness of cross-state exchanges and the potential impact on federal subsidy levels if the Senate bill language giving primary exchange responsibility to the states prevails.