November 20, 2012

Overview: Proposed Rule for Health Insurance Market Reforms

The Centers for Medicare & Medicaid Services (CMS) is publishing a proposed rule to implement sections 2701, 2702, and 2703 of the Public Health Service Act (PHS Act), as added and amended by the Patient Protection and Affordable Care Act (Affordable Care Act), and sections 1302(e) and 1312(c) of the Affordable Care Act collectively called the "market reforms." These provisions would apply to non-grandfathered health insurance coverage in the individual and small group markets for plan years (group market) and policy years (individual market) starting on or after January 1, 2014, and the large group market, if such coverage is available through the Affordable Insurance Exchange (Exchange), for plan years and policy years starting on or after January 1, 2017. The market reforms provide new rating parameters for health insurance premiums, extend guaranteed availability (also known as guaranteed issue) protections to the individual market; continue current guaranteed renewability protections; prohibit issuers from dividing up their insurance pools; clarify the approach used to enforce the applicable requirements of the Affordable Care Act with respect to issuers and group health plans that are non-federal governmental plans; and provide coverage and enrollment guidelines for catastrophic plans.

The following is a summary of the market reforms. The proposed rule can be found at: http://cciio.cms.gov/resources/regulations/index.html.

1. Fair Health Insurance Premiums (Proposed § 147.102)

Proposed 45 CFR 147.102 would require health insurance issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014, and the large group market if such coverage is available through an Exchange starting in 2017, to limit any variation in premiums with respect to a particular plan or coverage to age, tobacco use, subject to wellness program requirements in the small group market, family size, and geography. The proposed rule prohibits the use of other rating factors such as health status, medical history, gender, and industry of employment to set premium rates. Under the proposed rule the age, tobacco use, and geography factors would be multiplicative. For example, under our intended approach, the oldest adult who used tobacco could be charged 4.5 times more than the youngest adult who did not use tobacco since the age and tobacco use factors would be multiplied (3 x 1.5). Family premiums generally would be determined by adding up the premiums of each family member.

While this rule establishes a federal floor that ensures all individuals and employers have certain basic protections with respect to the availability of the health insurance coverage in all states, this rule does not prevent states from enacting stronger consumer protections than these minimum standards.

a. Age

The proposed rule would allow rates to vary within a ratio of 3:1 for adults, defines permissible age bands, and proposes a uniform age curve. The 3:1 age rating limitation applies only to adults age 21 and older. For enrollees under 21, rates must be actuarially justified and based on a standard population. Age factors and age bands should be determined based on an enrollee's age on the first day of a plan or policy year. The proposed rule includes the following standard age bands:

- Children: A single age band covering children 0 to 20 years of age, where all premium rates are the same.
- Adults: One-year age bands starting at age 21 and ending at age 63.
- Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same.

In addition, the proposed rule would direct that issuers within any market in a state use a uniform age rating curve established by CMS or the state. The proposed rule applies the same age rating curve to both the individual and small group markets. If a state anticipates using its own age curve, the state must submit relevant information on its proposed curve to CMS no later than 30 days after the publication of the final rule to support the accuracy of our risk adjustment model and facilitate timely review. If a state does not establish its own age curve, then a standard age rating curve established by CMS shall apply in the state. The standard age curve is based on a 3:1 ratio for adults. States using narrower ratios should submit relevant information on their ratios to CMS within 30 days after the publication of the final rule. CMS proposes the following standard age curve:

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and Older	3.000

b. Tobacco Use

The proposed rule would allow rates to vary by no more than 1.5:1 for tobacco users. State law can prescribe a narrower ratio or prohibit varying rates for tobacco use. States that anticipate using narrower ratios should submit relevant information to CMS within 30 days after the publication of the final rule. Issuers could use a lower tobacco use factor for a younger person than an older person as long as the factor does not exceed 1.5:1 for any age group. States or issuers would have the flexibility to determine the appropriate tobacco rating factor within 1:1 to 1.5:1, consistent with the wellness program requirements. In addition, issuers in the small group market may implement the tobacco use surcharge (as described in section 2705 of the PHS Act) for employees only as part of a wellness program. Issuers in the individual market may implement the tobacco use surcharge without offering wellness programs.

c. Family Size

The proposed rule provides that issuers may vary rates based on whether a plan covers an individual or a family. PHS Act section 2701(a)(4) provides that, with respect to family coverage, the rating variation permitted for age and tobacco use must be applied based on the portion of the premium attributable to each family member covered under a plan. Proposed § 147.102(c)(2) provides that if a state does not permit any rating variation for age and tobacco use, then the state may elect to require that premiums for family coverage be determined by using uniform family tiers and corresponding multipliers established by the state. A state shall submit its election of family tiers and corresponding multipliers to CMS within 30 days of the publication of the final rule. If a state does not establish uniform family tiers and corresponding multipliers, then the per-member rating methodology under § 147.102(c)(1) shall apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member. Proposed § 147.102(c)(3) provides that if a state requires composite rating in the small group market, the state should notify CMS within 30 days from the publication of the final rule. Otherwise, the per-member rating methodology will be utilized in the state's small group market.

d. Geography

The proposed rule would require states that establish rating areas to submit to CMS information on those rating areas within 30 days of the publication of the final rule. The rating areas would be presumed adequate if they met one of the following two requirements:

- Only one rating area within the state; or
- No more than seven rating areas geographically dividing the states on the basis of counties, three-digit zip codes or metropolitan statistical areas/non-metropolitan statistical areas (MSA/non-MSA).

If a state does not establish adequate rating areas, or a state does not submit to CMS information on those rating areas in accordance with the format specified by CMS, then CMS would impose one rating area for the state or, in the alternative, establish multiple rating areas in the state. A state could propose to CMS, and CMS could approve, alternative geographical divisions of the rating area or more than seven rating areas.

2. Guaranteed Availability of Coverage (Proposed § 147.104)

Expanding upon HIPAA's general availability provisions for the small employer market, proposed § 147.104 would require issuers offering non-grandfathered health insurance coverage to accept every individual or employer who applies for coverage in the individual or group market, as applicable. However, issuers could limit enrollment: (1) to certain open and special enrollment periods; (2) to an employer's eligible individuals who live, work, or reside in the service area of a network plan; and (3) in certain situations involving network capacity and financial capacity. In addition, individuals would have new special enrollment rights in the individual market when they experience certain losses of other coverage.

3. Guaranteed Renewability of Coverage (Proposed § 147.106)

Proposed § 147.106 reaffirms the current HIPAA protections that individuals and employers have with respect to coverage renewal. The provision would require issuers to renew all coverage in the individual and group markets, subject to certain exceptions (for example, non-payment of premiums or fraud).

4. Single Risk Pool (Proposed § 156.80)

Proposed § 156.80 generally would require issuers to treat all of their non-grandfathered business in the individual market and small group market, respectively, as a single risk pool. Each state would have the authority to choose to direct issuers to merge their non-grandfathered individual and small group pools into a combined pool.

The proposed rule requires that an issuer use the total combined claim experience derived from providing essential health benefits within the individual or small group market (or merged market, if applicable) in a state to establish an index rate (average rate) for that particular market. The pool's index rate would be used to set the rates for all products of the issuer in that particular market. An issuer then would be required to make the following market-wide adjustment to the index rate based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in a state.

The index rate could then be modified for specific products using only the following factors:

- The actuarial value and cost-sharing design of the product;
- The product's provider network and delivery system characteristics, as well as utilization management practices. This factor is intended to pass savings onto consumers where issuers negotiate robust provider discounts, construct efficient networks, or manage care more intensely; and
- Benefits provided by the product in addition to essential health benefits. The additional benefits must be pooled with similar benefits provided in other products to determine the allowed rate variation for products that offer these benefits; and
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

5. Catastrophic Plans (Proposed § 156.155)

Proposed § 156.155 generally would codify § 1302(e) of the Affordable Care Act regarding catastrophic plans which provides for enrollment in catastrophic plans. Catastrophic plans would have a lower premium, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing—providing affordable, individual market coverage options for young adults under the age of 30 and people for whom coverage would otherwise be unaffordable.

CMS Enforcement in the Insurance Market

The proposed revisions in 45 CFR part 150 would clarify that CMS uses the same enforcement processes with respect to the requirements of 45 CFR part 147, which implements provisions added by the Affordable Care Act, as it does with respect to the requirements of 45 CFR parts 146 and 148, which pre-date the Affordable Care Act. Additional revisions would conform certain sections in 45 CFR part 144 to the clarification concerning the scope of 45 CFR part 150. The enforcement process or framework allows states to exercise primary enforcement authority over health insurance issuers regarding the provisions of part A of title XXVII of the PHS Act, which includes these federal law requirements. CMS has enforcement authority over the issuers in a state if the state notifies CMS that it has not enacted legislation to enforce or is not otherwise enforcing, or if CMS determines that the state is not substantially enforcing a provision (or provisions) of part A of title XXVII of the PHS Act.