Overview: Final Rule for Health Insurance Market Reforms

The Centers for Medicare & Medicaid Services (CMS) published a final rule on February 27, 2013 (78 FR 13406) to implement sections 2701, 2702, 2703, and 2794 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), 1312(c), and 1560(c) of the Affordable Care Act, collectively called the "market reforms." These provisions apply to non-grandfathered health insurance coverage for plan years (small group market) and policy years (individual market) starting on or after January 1, 2014. The guaranteed availability (also known as guaranteed issue) and guaranteed renewability protections also apply in the large group market for plan years starting on or after January 1, 2014. The fair health insurance premium rating requirements also apply to large group health insurance coverage, if such coverage is available through the Affordable Insurance Exchange (Exchange), for plan years starting on or after January 1, 2017.

The market reforms provide new rating parameters for health insurance premiums; extend guaranteed availability protections to the individual market; continue current guaranteed renewability protections; prohibit health insurance 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 standards regarding catastrophic plans.

The following is a summary of the market reforms. The final rule can be found at http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf.

1. Fair Health Insurance Premiums (Section 147.102)

The final rule directs issuers offering non-grandfathered health insurance coverage in the individual and small group markets for plan or policy years 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 variations based on age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography. The final 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 final rule, the age, tobacco use, and geography factors are multiplicative. For example, under this approach, the oldest adult who uses tobacco may be charged up to 4.5 times more than the youngest adult who does 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 final rule allows rates to vary based on age within a ratio of 3:1 for adults, defines permissible age bands, and provides for a default uniform age curve to be established in guidance. The 3:1 age rating limitation applies to adults age 21 and older. For enrollees under 21, rates must be actuarially justified based on a standard population. Age factors and age bands

must be determined based on an enrollee's age on the date of policy issuance or renewal. For individuals who are added to the plan or coverage on a date other than the date of policy issuance or renewal, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage. The following standard age bands must be used in all states and markets subject to section 2701 of the PHS Act:

- 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 final rule directs issuers within a market in a state to use a uniform age rating curve established by CMS or the state. If a state anticipates using its own age curve for 2014, the state must submit relevant information on its proposed curve to CMS no later than March 29, 2013 to support the accuracy of the risk adjustment methodology and facilitate timely review. If a state does not establish its own age curve, then a standard age rating curve established by CMS applies in the state. The standard age curve is based on a 3:1 ratio for adults. States using narrower ratios for 2014 must submit relevant information on their ratios to no later than March 29, 2013. The following default standard age curve is published through subregulatory guidance:

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 final rule allows 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 use narrower ratios for 2014 must submit relevant information to CMS no later than March 29, 2013. Health

insurance issuers may 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 will 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 rating factor (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.

Under the final rule, "tobacco use" is defined as the use of a tobacco product or products four or more times per week within no longer than the past 6 months by legal users of tobacco products (generally those 18 years and older) and includes all tobacco products. The rule clarifies that the term tobacco use does not include religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives). Tobacco use must be defined by issuers in terms of the time since the individual's last use of a tobacco product.

c. Family Size

The final 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. Section 147.102(c)(2) of the final rule 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. For 2014, a state must submit its election of family tiers and corresponding multipliers to CMS no later than March 29, 2013. If a state does not establish uniform family tiers and corresponding multipliers, then the per-member rating methodology under § 147.102(c)(1) will apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member. The final rule imposes a cap of no more than three covered children under the age of 21 whose per-member rates are taken into account in determining the family premium.

d. Rating in the Small Group Market

The final rule requires that per-member rating methodology be utilized in the small group market. States can require, however, that issuers calculate average employee premium amounts for each employer, provided that the total group premium equals the premium that would be derived through the per-member-rating approach. If a state requires average employee premium amounts in the small group market for 2014, the state must notify CMS no later than March 29, 2013.

e. Geography

The final rule requires states that establish rating areas for 2014 to submit to CMS information on those rating areas no later than March 29, 2013. The final rule provides that a state's rating areas must be based on one the following geographic divisions: counties, three-digit zip codes, or metropolitan statistical areas (MSAs) and non-MSAs, and will be presumed adequate if either of the following conditions are met:

- As of January 1, 2013, the state had established by law, rule, regulation, bulletin, or other executive action uniform geographic rating areas for the entire state; or

- After January 1, 2013, the state establishes by law, rule, regulation, bulletin, or other executive action for the entire state no more geographic rating areas than the number of MSAs in the state plus one.

Under these standards, geographic rating areas may be noncontiguous, but the area encompassed by a geographic rating area must be separate and distinct from areas encompassed by other geographic rating areas. If a state had established geographic rating areas on or before January 1, 2013 that did not follow these geographic boundaries, the state will have an opportunity to adjust their proposed rating areas before the default rating area is applied.

A state may propose to CMS, and CMS may approve, a greater number of rating areas if the areas are based on counties, three-digit zip codes, or MSAs and non-MSAs. CMS will determine that a state's rating areas are adequate if they: (1) are actuarially justified; (2) are not unfairly discriminatory; (3) reflect significant differences in health care unit costs by rating area; (4) lead to stability in rates over time; (5) apply uniformly to all issuers in a market; and (6) are based on one of the geographic boundaries described above.

If a state does not establish adequate rating areas, or a state does not submit to CMS information on those rating areas in the form and manner specified by CMS, the default rating area will be one rating area for each MSA and one rating area for all the remaining non-MSA areas (if any).

2. Guaranteed Availability of Coverage (Section 147.104)

Expanding upon guaranteed availability provisions for the small employer market under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), section 147.104 of the final rule requires issuers offering non-grandfathered health insurance coverage to offer coverage to and accept every individual or employer who applies for coverage in the individual or group market, as applicable. However, issuers may limit enrollment to certain open and special enrollment periods and certain situations involving network capacity and financial capacity. Additionally, networks plans may limit enrollment to employers with employees live, work, or reside and individuals who live or reside in the service area of a network plan.

In the individual market, annual enrollment periods will be consistent with those established for the Exchanges. The group market will allow for year-round enrollment. However, for small employers that fail to meet contribution or minimum participation requirements, while coverage cannot be denied altogether, an issuer may limit its offering of coverage to an annual enrollment period beginning on November 15 and extending through December 15 of each year.

Under the final rule, individuals will also have new special and limited open enrollment rights in the individual market when they experience certain significant life changes. Under section 147.104(b)(2) of the final rule, limited open enrollment periods are triggered by the following events:

- An individual or dependents losing minimum essential coverage.
- An individual gaining or becoming a dependent through marriage, birth, adoption, or placement for adoption;
- An individual experiencing certain errors in enrollment;
- An individual adequately demonstrating that the plan or issuer substantially violated a material provision of the contract in which he or she is enrolled;
- An individual becoming newly eligible or newly ineligible for advance payments of the premium tax credit or experiencing a change in eligibility for cost-sharing reductions; and

- New coverage becoming available to an individual or enrollee as a result of a permanent move.

In addition, the final rule provides a one-time limited open enrollment period for individuals with non-calendar year policies in the individual market to transition to a calendar year policy.

The final rule provides a 60-day election period for the special and limited open enrollment periods in the individual market, but maintains 30-day special enrollment periods for the group market.

Finally, the final rule extends the Exchange marketing standards to the entire health insurance market. Under these marketing standards, issuers must comply with state marketing standards and not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals based on race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

3. Guaranteed Renewability of Coverage (Section 147.106)

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

4. Student Health (Section 147.145)

Section 147.145 of the final rule exempts student health insurance coverage from the guaranteed availability and guaranteed renewability requirements of PHS Act sections 2702 and 2703 added by the Affordable Care Act to ensure that enrollment in student health insurance plans may be limited only to students and their dependents.

In addition, the final rule provides that non-grandfathered student health insurance coverage is not subject to the single risk pool requirement of section 1312(c) of the Affordable Care Act. The premium rate charged by an issuer offering student health insurance coverage may be based on a school-specific group community rate if, consistent with section 2701 of the PHS Act, the issuer offers the coverage without rating for age or tobacco use. CMS will monitor student health insurance coverage during the transition to the reformed market and revisit this policy in the future.

5. Single Risk Pool (Section 156.80)

Section 156.80 of the final rule generally requires health insurance issuers to treat all of their non-grandfathered business in the individual market and in the small group market as single risk pools. Each state will have the authority to direct issuers to merge their non-grandfathered individual and small group risk pools into a combined risk pool.

The final rule requires that a health insurance issuer use the total combined claims 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 market's risk pool index rate will be used to set the rates for all products of the issuer in that particular market. An issuer then will make a 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. A market-wide adjustment to the index rate will also be made for Exchange user fees.

The index rate may be modified for specific plans using only the following factors:

- The actuarial value and cost-sharing design of the plan;
- The plan'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;
- 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;
- Administrative costs other than Exchange user fees; and
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

6. Catastrophic Plans (Section 156.155)

Section 156.155 of the final rule implements section 1302(e) of the Affordable Care Act, which provides standards for enrollment in catastrophic plans. Catastrophic plans generally will 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.

7. CMS Enforcement in the Insurance Market

Under this enforcement standard, states exercise primary enforcement authority over health insurance issuers regarding the provisions of title XXVII of the PHS Act, which includes the market reform 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 title XXVII of the PHS Act.