1. Health insurance market reforms
2. Catastrophic plans
3. Enforcement by the states and CMS
4. Rate review
The market rules collectively ensure that individuals and employers will have a minimum set of protections with respect to access to health insurance coverage and greater premium stability in all states, both inside and outside of the Marketplaces.

**Market Reforms**

- **Fair Health Insurance Premiums**
  - Health status and gender not used to set premiums; limits on age rating

- **Single Risk Pool**
  - Issuers cannot use separate risk pools to charge certain enrollees higher rates

- **Guaranteed Availability**
  - Coverage must be offered to all comers, with limited exceptions

- **Guaranteed Renewability**
  - Coverage must be renewed for all policyholders, with limited exceptions
The market reforms apply to non-grandfathered health insurance coverage for plan years (group market) or policy years (individual market) beginning on or after January 1, 2014.

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Small Group</th>
<th>Large Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair Health Insurance Premiums</td>
<td>Yes</td>
<td>Yes</td>
<td>If state allows issuers to sell large group coverage in Exchange (2017+)</td>
</tr>
<tr>
<td>Single Risk Pool</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Guaranteed Availability</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Guaranteed Renewability</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Do NOT apply to grandfathered health insurance coverage, self-funded plans, excepted benefits, or individual short-term limited duration coverage.
Fair Health Insurance Premiums

• Only factors that may be used to vary premium rate are:
  – Family size
  – Geography
  – Age (within 3:1 for adults)
  – Tobacco use (within 1.5:1)

• Age, tobacco use, and geography factors are multiplicative

• All other factors prohibited (e.g., health status, claims experience, gender, industry classification, small group size)
Family Size

- The law requires any rating variation for age and tobacco use to be applied based on the portion of premium attributed to the individual family member.
- Per-member rating is generally required.
- Exception: community rated states (that prohibit rating for age and tobacco use) may establish uniform family tiers and corresponding multipliers.
- 3-child cap: no more than 3 oldest covered children under age of 21 may be taken into account for family rating.
- States and issuers may determine the types of family members covered on a family policy.
Geography

• States to establish uniform rating areas for the entire state
• Rating area standards
  – Counties, 3-digit zip codes, or metropolitan statistical areas (MSAs)
  – Presumed adequate if:
    • State had established rating areas as of Jan. 1 2013; or
    • After Jan. 1 2013, state establishes a number of rating areas totaling no more than number of MSAs in the state plus one
  – States may seek approval from CMS of more rating areas than the number of MSAs plus one
• Default: one rating area for each MSA and one rating area for all non-MSAs in the state (if any)
Age Rating

• Rate may vary based on age within a ratio of 3:1 for adults, defined as individuals age 21 and older; actuarially justified under age 21
• Age determined at policy issuance/renewal
• States to establish uniform age curves or default to the HHS standard age curve set forth in guidance
• Uniform age bands:
  – Children: single age band for ages 0-20
  – Adults: one-year bands between ages 21-63
  – Older adults: single age band for ages 64 and older
Tobacco Rating

• Rates may vary within 1.5:1 ratio for legal use of tobacco
• Tobacco rating may vary by age (e.g., lower tobacco use factor for younger individuals)
• Coordination with wellness rules
  – In the small group market, individuals must be able to avoid the tobacco rating factor by participating in a wellness program that complies with section 2705(j) of the PHS Act
• Definition of tobacco use
  – Use of tobacco on average 4 or more times per week within no longer than the past 6 months, and in terms of time of last use
  – Exemption for religious or ceremonial use of tobacco (e.g., by Native Americans or Alaska Natives)
• States may be more consumer protective
Small Group Rating

• Per-member rating is generally required

• Advantages
  – Assures compliance with PHS Act section 2701(a)(4)
  – Enhances employee choice in the SHOP
  – Promotes accuracy of the risk adjustment methodology

• States (and employers) may require premiums to be based on average enrollee amounts
State Reporting

• For 2014, states must provide to CMS information about the following (as applicable) no later than March 29, 2013:
  – Narrower age rating ratio than 3:1
  – Narrower tobacco rating ratio than 1.5:1
  – State-established age curve
  – State-established or proposed geographic rating areas
  – In community rated states, uniform family tiers and multipliers
  – Use of average enrollee premiums in the small group market
  – Merger of individual and small group market risk pools

• Guidance provides additional details about the state reporting process
Single Risk Pool

- Issuer must use a single risk pool for each of the individual and small group markets when developing rates and premiums
- Single risk pools must be maintained by each licensed issuer in a state (not holding company)
- States can merge the individual and small group market pools (but cannot include grandfathered plans in a risk pool)
• Market-wide index rate (average rate)
  – Based on EHB claims experience of all enrollees in all non-grandfathered health plans in the risk pool
  – Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees

• Permitted plan-level adjustments:
  – Actuarial value and cost-sharing structure
  – Network and delivery system characteristics including utilization management practices
  – Plan benefits in addition to EHB
  – Administrative and distribution costs (excluding Exchange user fees)
  – With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans
Guaranteed Availability

- Must offer coverage to and accept any individual or employer that applies for coverage in the individual or group market
- Exceptions:
  - Employers with employees who do not live, work, or reside and individuals who do not live or reside in service area of a network plan
  - Limited network or financial capacity
- Open enrollment periods
  - Group market: year-round enrollment (except small employers that fail to meet participation/contribution rules may be limited to Nov 15 – Dec 15)
  - Individual market: annual enrollment periods consistent with Exchanges
- “Limited” open enrollment periods
  - Triggering events generally consistent with Exchange special enrollment periods
- Special enrollment periods
  - COBRA triggering events (mainly affects non-Exchange individual market)
Guaranteed Renewability

• Coverage must be renewed or continued in force at the option of the plan sponsor or the individual

• Exceptions:
  – Nonpayment of premiums
  – Fraud
  – Violation of participation/contribution rates (group market only)
  – Enrollees’ movement outside service area
  – Loss of association membership

• Uniform modification of coverage permitted at renewal

• Issuers may terminate a product, but must offer their other products to plan sponsors or individuals

• Issuers may discontinue all coverage in the individual or group market (or both), in accordance with state law
Application to Special Plan Types

• Student health insurance coverage
  – Exemptions:
    • Guaranteed availability
    • Guaranteed renewability
    • Single risk pool
  – Premium rating rules apply, but the rate may be based on a school-specific group community rate if no age or tobacco rating is applied
  – Not currently subject to federal rate review through guidance
Application to Special Plan Types cont’d

• Bona fide associations
  – Exempt from guaranteed renewability; coverage can be cancelled if BFA membership ends
  – No exception from guaranteed availability. But exception for limited network capacity is possible

• State high risk pools
  – Generally not subject to the PHS Act or the Affordable Care Act
  – State discretion whether to continue state high risk pools
Catastrophic Plans

- Individual market only
- Does not meet the AV levels (bronze, silver, gold, or platinum levels of coverage)
- Provides coverage for:
  - EHB after reaching the out-of-pocket limit
  - 3 primary care visits per year before reaching the deductible
  - Preventive services without cost sharing consistent with PHS Act section 2713
- Individuals eligible to enroll:
  - Young adults (< 30)
  - Individuals with a certification of exemption based on hardship or inability to afford or obtain coverage
• The rule clarifies that CMS uses the HIPAA process to enforce ACA requirements against issuers and non-federal government group health plans

• States have primary enforcement authority

• CMS only enforces when:
  – A state notifies CMS that it does not have authority to enforce or is not enforcing
  – CMS determines the State is failing to substantially enforce the requirements
Amendments to Rate Review

- Revise timeline for states seeking state-specific thresholds
- Extend the reporting requirement to all rate increases, ensuring rating reforms consistently monitored inside and outside the Exchange Marketplace
- Streamline data collection for issuers, states, Exchanges, and HHS using a standardized format (unified rate review template)
- Modify the criteria and factors for states to have an effective rate review program
  - Review rate impact of EHB, AV, reinsurance and risk adjustment, single risk pool, and other market reforms
Rating Filing Justification

- For every rate increase:
  - Part I (Unified rate review template):
    - Data needed to review rate increases, including impact of a single risk pool, reinsurance, risk-adjustment, and other rating reforms
    - Identical copies submitted to states and CMS
  - Part III (Actuarial memorandum)
    - Actuarial reasoning/assumptions to support Part I and actuarial attestation

- Only for rate increases subject to review:
  - Part II (Narrative): Consumer-friendly justification for a rate increase
Questions?

- Final rule published February 27, 2012 (78 FR 13406)
- Proposed rule published November 26, 2012 (77 FR 70584)
- For additional questions, e-mail: marketreform@cms.hhs.gov