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Update: Health Insurance Reforms and Rate Review

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Background

The Patient Protection and Affordable Care Act (ACA) included health insurance market reforms designed to ensure that individuals and small businesses could not be denied coverage or be charged significantly higher premiums because of an individual's health status. While some of the market reforms enacted in the ACA were designed to go into effect shortly after enactment (e.g., requiring issuers and employer-sponsored plans to cover adult children up to age 26 on a parent's health plan, and limiting pre-existing condition exclusions) the most sweeping reforms will go into effect for plan years beginning January 1, 2014.

Health Insurance Reform Requirements for the Group and Individual Insurance Markets

Purpose of the proposed rule

On November 20, 2012, the Center for Medicare and Medicaid Services (CMS) issued [proposed rules](#) on the implementation of insurance market reforms and changes to existing rate review regulations. In describing the purpose of the proposed regulations, CMS provides an overview of the current enrollment and rating practices in the individual (non-group) and small group insurance markets, noting significant variation in premiums based on age, gender and industry of employment. The proposed regulations provide agency guidance on provisions of the ACA requiring guaranteed availability (or guaranteed issue) to individuals and employers and guaranteed renewability by prohibiting the use of factors such as health status, medical history, gender and industry of employment to set rates. The proposed rule limits age-rating and prohibits insurers from segregating insurance pools for group market plan years and individual policy years beginning after January 1, 2014. Proposed rules apply to non-grandfathered plans.

Enforcement (42 CFR §144 and §150)

The proposed rule clarifies that CMS has the authority to enforce insurance market reforms in states that choose not to enforce these proposed rules, as well as other requirements outlined in the Health Insurance Portability and Accountability Act (HIPAA).

Insurance Premium Rating – “Fair health insurance premiums” (Proposed 42 CFR §147.102)

Premiums in the individual and small group health insurance markets may vary only by individual or family coverage, by geographic rating area, by age, and by whether an individual uses a tobacco product. Age rating is limited to a 3:1 for like individuals aged 21 and over. Rates must be actuarially justified based on a standard population for individuals under age 21, consistent to the proposed uniform age curve. CMS proposes age factors be applied based on enrollee's age at the time of issuance and renewal, to assure consistency and to avoid increase during a policy year. Variation in rate must be actuarially

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justified, conforming to the uniform age rating curve. The rule clarifies that nothing prevents a state from requiring age rating narrower than 3:1 – however, states must report ratios to CMS.

In the rule preamble, CMS notes the importance of utilizing standardized rating methodologies in age and family rating. CMS argues that standardization would enhance transparency, predictability, and accuracy of risk adjustment and also facilitate application of core functions of the Exchange, such as calculating rates for qualified health plans (QHPs) and determining benchmark plans for the purposes of the tax credit. However, CMS notes that the rule preserves flexibility for states and issuers in establishing methodologies for family, tobacco, age, geography and small-group rating.¹

The rule proposes uniform age bands to be applied for age rating, and seeks comment on whether and how state and issuer flexibility in rating methodologies versus a standardized approach is more desirable.² Each state must establish a uniform age rating curve and submit it to CMS for approval. In the event that a state does not submit a rating curve by a date to be specified by CMS, the HHS Secretary will apply a default rating curve established by CMS. The default will take into account the rating variation permitted for age under state law, and would apply to both the individual and small group markets thusly:

- Single age band covering children age 0 to 20;
- One-year age bands for adults age 21 to 63 (CMS's proposed standard age curve for this age group can be found in the preamble to the rule at p. 43); and
- Single age band for adults age 64 and over.

Plans may charge higher premiums for enrollees that use tobacco, but premiums may not vary by more than 1.5:1. As with age rating, states may require issuers to meet a narrower ratio, but must report that ratio to CMS. In setting premiums, variation based on age and tobacco must be applied based on the portion of the premium attributable to each family member. To the extent that the state does not permit variation based on age and tobacco use, states may choose to require that premiums be determined by using uniform family tiers and corresponding multipliers, but states must report variation in rules to CMS.

*Small group premiums*³ – CMS notes in the preamble that different rating methods are currently used to generate small group market rates. Noting that the ACA does not distinguish between individual and small group markets, the proposed rule suggests calculating rates on a per-member basis then totaling premiums to generate a group rate. The rule, however, does not preclude states from requiring rates based on a group's average rate. CMS notes that use of the per-member rating gives employers flexibility to choose how to allocate their contributions to employees' coverage, noting that while the rule applies to issuer premium charges, it does not address employer allocation of premiums. CMS seeks comment on how this policy will affect employers and employees. Under the proposed rule, the total premium charged

¹ Preamble at 22.

² Preamble at 25.

³ Preamble at 28.

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to a small group is determined by summing premiums of covered participants or beneficiaries. States may require issuers to offer, or issuers may voluntarily offer, premiums based on average enrollee amounts, provided the total group premium is the same.

*Large group market premiums*⁴ - To the extent that a state permits health insurance issuers offering coverage in the large group market to offer coverage through an Exchange (state option available in 2017), the provisions applicable to the small group market will apply in the large group market. CMS notes that health insurance coverage in the large group market is subject to these requirements, both inside and outside the Exchange, if a state chooses this option. CMS seeks comments on how the proposed rule could be modified to both secure protections and keep premiums affordable in the individual and small group markets.

*Family Rating Variation*⁵ - The rule proposes that issuers total the rate of each family member to arrive at a family premium, and further proposes that the rates of the three oldest family members under age 21 be taken into account to compute the family premium in order to mitigate premium disruption for larger families, which typically cap the number of children charged a premium. The cap would not apply to family members over age 21. CMS seeks comments on this approach, as well as whether the final rule should specify the minimum categories of family members that issuers must include in setting rates for family policies.

*Geographic Rating Areas*⁶ - States may establish rating areas within the state, and must submit rating areas to CMS for approval. CMS will review the adequacy of the state-established rating areas. While the statute does not specify maximum variation, CMS will require actuarial justification to ensure that issuers do not set rates so as to render meaningless the guaranteed availability provisions. Rating areas apply equally to all non-grandfathered plans, whether offered inside or outside an Exchange. CMS seeks comments on the maximum number of rating areas that may be established within a state, and potential standards for determining the appropriate number.

Under the proposed rule, rating areas will be presumed adequate if they meet one of the following criteria: there is a single rating area within the state; or there are no more than seven rating areas based on counties, three-digit zip codes, or metropolitan statistical areas. CMS also permits states to establish alternative rating areas, so long as they are submitted to and approved by the HHS Secretary. In the event that rating areas do not meet federal requirements or states do not establish rating areas, CMS will establish rating areas based on the criteria outlined above.

Guaranteed availability of coverage (Proposed 42 CFR §147.104)

A health insurance issuer offering coverage in the individual or group market in a state must offer to any individual or employer in the state all products that are approved for sale in the market, and they must accept any individual or employer. Issuers in the individual market may restrict enrollment to open or

⁴ Preamble at 23.

⁵ Preamble at 29-31.

⁶ Preamble at 32-35.

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special enrollment periods, and special enrollment periods in both the individual and group markets would be triggered by the same events that trigger eligibility for COBRA coverage under the Employee Retirement Income Security Act (ERISA), in addition to those events provided under section 2704(f) under the Public Health Service Act.

Issuers offering coverage in the group market must permit an employer to purchase health insurance coverage for a group health plan at any point in the year; however, to avoid potential risk selection, issuers could condition year-round open enrollment on a small employer being able to satisfy the same contribution and participation requirements at time of issuance that the issuer is permitted to consider at renewal, either as allowed under state law or in the case of a QHP offered in a Small Business Health Options Program (SHOP).

Plans offering coverage in the individual and small group markets must establish special enrollment periods for qualifying events as defined under section 603 of ERISA. Enrollees must have 30 days after their qualifying event to elect coverage.

Exceptions to Guarantee Issue

Network Capacity – Health insurers offering coverage in the group and individual markets through a network plan issuer may limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the network plan service area, and may limit coverage in the individual market to those who live in the service area for the plan. Plans may also deny coverage to employers and individuals if the issuer has demonstrated that it does not have the capacity to deliver services adequately to enrollees of additional groups and individuals, and that the denial of coverage is applied uniformly to all employers and individuals without regard to enrollee health status. Issuers may not enroll additional individuals or groups for a period of 180 days after coverage is denied.

Using Network Capacity to Limit Access to Association Plans – Notably, although CMS indicates that the ACA does not include an explicit guaranteed issue exception limiting the offering of products to bona fide associations, CMS indicates that the network capacity exception could be used to provide a basis for limiting enrollment in certain products to bona fide association members. CMS asks for comment on this issue as well as whether and how a transition or exception process could be structured to minimize disruption while maintaining consumer protections.⁷

Financial capacity limits – Health insurance issuers may deny coverage in the group or individual markets if the issuer has demonstrated to the applicable state authority (if required under state law) that the issuer does not have the financial reserves necessary to underwrite additional coverage and the coverage denials are applied uniformly to all employers or individuals in the market in the state consistent with state law, and without regard to the claims experience of individuals and employers denied coverage. Issuers denying coverage under financial capacity limits may not offer coverage in the group or

⁷ Preamble at 55.

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individuals market in the state before the latest of the 181st day after coverage denial. Denial of coverage due to financial reserves does not preclude an issuer from renewing coverage already in force.

Marketing

A health insurance issuer, and its officials, employees, agents and representatives must comply with applicable state law and regulation governing marketing, and may not employ market practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant needs in health insurance coverage. CMS indicates that the agency will apply state marketing rules in states in which a federally-facilitated Exchange operates. CMS solicits comments on ways to discourage consumers from abusing guaranteed issue rights.⁸

Guaranteed Renewability (Proposed 42 CFR §147.106)

A health insurance issuer offering health insurance in the individual and small group markets must renew coverage at the option of the plan sponsor or individual. Plans may modify health insurance coverage for a product offered in the large group market and the small group market (to the extent it is consistent with state law) only at the time of renewal of the product. For plans in the large group or small group markets that are offered only through associations, the “plan sponsor” is deemed to include a reference to the employer.

Exceptions to Guarantee Renewal

The following are allowable exceptions to the guaranteed renewal requirement:

Non-payment of Premiums - Plan sponsor or individual failed to pay premiums or contributions in accordance with the terms of coverage, including timeliness requirements.

Fraud – Plan sponsor or individual has performed an act of fraud or intentional representation of a material fact.

Violation of participation or contribution rules - Plan Sponsor failed to comply with a material plan provision relating to employer contribution (requirements relating to the minim level or amount of employer contribution toward the premium) or group participation rules (relating to the minimum number of participants or beneficiaries that must be enrolled, i.e. specified percentage of eligible population).

Enrollee movement outside service area - In the case of network plans, there is no longer “any enrollee under the plan” who lives, resides or works in the service area of the issuer, and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment under the guaranteed issue requirements relating to network plans.

⁸ Preamble at 58.

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Association membership ceases - For coverage offered in the small and large group market through one or more bona fide associations, plans may not renew or discontinue coverage if the employer's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor related to a covered individual. CMS notes that the ACA does not include the individual market in its guaranteed renewability exceptions for uniform modifications of coverage and loss of bona fide association membership, but also notes that it believes that the underlying statute (section 2742 of the PHSA) continues to provide the authority.⁹

Discontinuing a product - Issuers may also refuse to renew a policy where the issuer discontinues offering a product in the group or individual market. Discontinuance must be made in accordance with applicable state law and only where the issuer:

- Provides written notice to each plan sponsor or individual at least 90 calendar days prior to coverage discontinuation;
- Offers to each sponsor or individual the option to purchase other coverage currently offered by the issuer on a guarantee issue basis; and
- Acts uniformly without regard to the claims experience of the sponsor or individual, or any health status-related factor relating to any covered individuals.

Health insurance issuers may discontinue all coverage offered in the individual or group markets or both in accordance with applicable state law if the plan provides written notice to each plan sponsor or individual at least 180 days prior to the date of coverage. All policies issued or offered in the applicable state market (individual, small group, or both) must be discontinued and not renewed. Issuers that discontinue offering all health insurance coverage in a market or markets in a state may not issue coverage in the applicable market in the state for a period of 5 years, beginning on the date of discontinuation of the last coverage not renewed.

Applicability to Student Health Coverage

If particular requirements in the ACA would have the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under federal, state or local law, the requirements are inapplicable. CMS clarifies that guarantee issue and guarantee renewal requirements should not preclude a policy from limiting enrollment to students and their dependents. CMS notes that student insurance coverage is included in an issuer's individual market risk pool and seeks comments on how to allow issuers to maintain a separate risk pool for student health insurance coverage, as well as whether the rule should provide any modification in market rating rules.¹⁰

⁹ Preamble at 59.

¹⁰ Preamble at 63.



Changes to Premium Rate Review and Disclosure Requirements (Proposed §154)

CMS proposes three changes to the existing rate review program that was established by final rule on May 23, 2011. An [earlier Implementation Brief](#) provided an overview of the Disclosure and Review of Unreasonable Health Insurance Premium Rate Increases final rule, which was promulgated to implement §1003 of the ACA by adding §2794 of the Public Health Service Act. Generally, the rate review program sets up a process for the HHS Secretary, in conjunction with the states, to conduct an annual review of “unreasonable” increases in premiums for health insurance coverage. Issuers must submit to the Secretary and the state all justifications for unreasonable premium increases prior to the implementation of the increases.¹¹ The program also requires the Secretary and the states to monitor premium increases in health plans offered through insurance exchanges. The rate review program does not apply to large group plans, grandfathered plans, or self-funded plans.¹²

The May 23, 2011 final rule established the formal process by which all rate increases above a specified threshold in the individual and small group markets would be reviewed by a state if the state has an Effective Rate Review Program, or reviewed by CMS if the state does not have such a program. The final rule also set a review threshold for rate increases of 10% or more for 2011, and established a process for states to set state-specific thresholds for future years.

The current proposed rule would make three significant revisions to the rate review program aimed at standardizing and streamlining data submission, and includes certain new standards needed to effectuate the insurance market reforms that take effect in 2014.

First, CMS proposes in §154.200 to amend the dates associated with the state option to establish its own state-specific thresholds for what constitutes an “unreasonable” premium increase. The purpose of this change is to align with the timing of rate submissions for QHPs in exchanges, as well as the market-wide rating rules under the ACA.¹³ States would need to submit proposals to CMS for state-specific thresholds by August 1 of each year, CMS would need to approve such thresholds by September 1, and any CMS-approved state-specific threshold would take effect on January 1 following the CMS approval.¹⁴

Second, CMS proposes to extend the requirement that issuers report information regarding rate increases above the review threshold to all rate increases. The rate review threshold would still determine which rates must be reviewed, rather than just reported. To accomplish this, proposed §154.215 requires issuers to submit data and documentation regarding all rate increases on a standardized form as determined by the Secretary and which must include various specific types of data.¹⁵ If the rate increase is subject to review (rather than simply reporting) because it exceeds the threshold for an unreasonable increase, the issuer must submit additional justification documentation.¹⁶

¹¹ Preamble at 70588.

¹² *Id.*

¹³ Preamble at 70602.

¹⁴ 77 FR 70584, 70615 (to be codified at §154.200).

¹⁵ 77 FR 70584, 70615 (to be codified at §154.215).

¹⁶ 77 FR 70584, 70615 (to be codified at §154.215(c)).

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Third, CMS proposes to modify the standards for what constitutes an “Effective Rate Review Program” that a state may choose to establish in order to conduct the rate review itself instead of CMS. Proposed §154.301 adds the requirement that states must include a review of, among several other new factors, the “reasonableness of the assumptions used by the health insurance issuer to estimate the rate impact of the federal reinsurance and risk adjustment programs” and a review of “the health insurance issuer’s data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values, and other market reform rules required by the ACA.”¹⁷ Moreover, a state running an Effective Rate Review Program must post on its website documentation for the rates it reviews and provide a mechanism public comment about the rate increase.¹⁸

Single Risk Pool (Proposed §156.80)

Issuers must consider all enrollees in all non-grandfathered plans to be members of a single risk pool in the individual and small group markets, respectively, whether offered directly or through an Exchange. States may choose to merge its individual and small group markets. CMS proposes that states choosing to merge markets into a single risk pool effective in 2014 provide notice to CMS no later than 30 days following publication of the final rule to assure accuracy in risk adjustment methodology. The pooling requirement would not apply to excepted benefit and short-term limited duration policies, nor will it be enforced for coverage issued to plans with fewer than two participants who are current employees (retiree-only plans). For rates effective starting January 1, 2014, an issuer would estimate the total combined claims experience of all non-grandfathered plans deriving from providing essential benefits within a state market to develop an index or average rate, then would make market-wide adjustments to the index rate based on total expected market-wide payment and charges under the risk adjustment and reinsurance programs in a state. Rates may vary only based on actuarial value and cost sharing design, network and delivery system characteristics, including utilization management practices, plan benefits beyond essential health benefits (must be pooled with similar benefits provided in other plans), and for catastrophic plans, the expected impact of the specific eligibility categories for the plan. CMS seeks comment on how to ensure index rate and adjustments are transparent and consistent with federal and state rate review processes.

Enrollment in Catastrophic Plans (Proposed §156.155)

Coverage Requirements - Catastrophic plans must meet all applicable requirements for health insurance coverage in the individual market, except that the plan does not offer coverage at the bronze, silver, gold or platinum coverage levels. The plan does not offer essential health benefits until the enrolled individual reaches the annual cost-sharing limit, except that the plan must cover at least three primary care visits per year before reaching the deductible. Plans may impose cost sharing for the primary care visits. Plans may not impose cost sharing for preventive services identified under section 2713 of the PHSA.

¹⁷ 77 FR 70584, 70616 (to be codified at §154.301(a) (3) (iii) and (iv)).

¹⁸ 77 FR 70584, 70616 (to be codified at §154.301(b)).

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Eligibility – Individuals younger than age 30 may enroll in catastrophic plans. Enrollees turning 30 during the plan year may continue for the duration of the plan year. In addition, individuals who have been certified as exempt from the individual responsibility payment because they cannot afford minimum essential coverage or are eligible for a hardship exemption. Each individual enrolled in a policy must meet the eligibility test (i.e. each member of a family plan).