

November 26, 2012

## Proposed HHS Rules Implementing the Affordable Care Act's Health Insurance Market Provisions Promise Considerable Change to Existing Industry Practices

---

The U.S. Department of Health and Human Services (HHS) proposed regulations on November 20 that would implement the Affordable Care Act's (ACA) dramatic reforms of the way health insurance is priced and sold in the individual and small group markets, previously a concern largely for state legislators and regulators. By 2022 these changes are anticipated to affect 53 million Americans, whether they purchase insurance through a health insurance exchange or outside the exchange. These changes, effective in 2014, are the most significant in health insurance regulation in more than a generation.

The proposed rules implement key ACA provisions, including the requirements that insurance be sold to all individuals and small businesses that apply and at rates that are not influenced by preexisting conditions.<sup>1</sup> In order to make sure these requirements are fairly implemented, the proposed rules would require major changes to current industry practices.

HHS will consider comments on the proposed rules received by December 26. Final rules are expected to be published in early 2013 and will be effective for plan years beginning on or after January 1, 2014.<sup>2</sup>

### Executive Summary

The ACA requires insurers who sell in the individual or small group<sup>3</sup> markets inside and outside of health insurance exchanges to offer coverage to anyone who applies, regardless of health status (a policy known as guaranteed issue). Insurers may not vary premiums by health status or any factor other than age, tobacco use, geography or family composition (a policy known as adjusted community rating). While insurers may vary premiums for a particular health insurance product based on age, the premium they may charge the oldest adults may be no more than three times the premium charged the youngest adults. Insurers may also charge higher premiums to those who use tobacco, but no more than 50 percent more than non-tobacco users.

The proposed rules build on the 1996 Health Insurance Portability and Accountability Act (HIPAA), which required guaranteed issue in the small group market (2-50 employees) and guaranteed renewability in the individual market. Forty-eight states reinforced the guaranteed issue requirement in the small group market by imposing some restrictions on the ability of insurers to price older and sicker workers out of the market. However, most states also currently permit variation based on age greater than the 3:1 ACA limit and most allow some rating based on health status or claims experience. In the individual market, only five states have guaranteed issue and adjusted community rating today.

To implement guaranteed issue and adjusted community rating, HHS is proposing several specific rules, including:

---

<sup>1</sup> "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review", 77 Fed. Reg. 70584 (Nov. 26, 2012).

<sup>2</sup> These rules do not apply to grandfathered health insurance coverage that predates the ACA and has not been substantially changed since then. HIPAA rules continue to apply to grandfathered health insurance coverage.

<sup>3</sup> Beginning in 2016, "small group" will refer to the group health plan of an employer with 100 or fewer employees. Before then, states have the option to use the 100-employee cutoff or keep the current commonly used definition of 50 or fewer employees.

- In implementing the ability to charge older adults up to three times as much as younger adults, insurers will use single-year age bands, with rates changing for each year of age, so the premium increases as people get older will be relatively modest and without major jumps. There will be two exceptions to single-year age bands: everyone under aged 21 will be in one age band and everyone aged 64 or older will be in one age band.
- Each state will have a uniform age rating curve. This means that while insurers can charge different rates based on age, the relationship between rates charged the young and the old will be uniform across insurers. States can establish their own curves, with an HHS proposed curve serving as the default for states that do not act (see Figs. 1 and 2, below).
- Insurers will not be able to price insurance using family tiers (such as individual and spouse, individual plus one child, or family). Instead, insurers will need to price each adult family member individually and up to the three oldest children to create a family rate (see Fig. 3, below).
- States may establish up to seven areas for purposes of varying premiums based on location. Therefore, insurers cannot vary rates by ZIP code or other small geographic area, as many are allowed to do now. HHS will establish rating areas if states do not act to do so.

Although insurers can charge smokers up to a 50 percent surcharge, insurers must waive the surcharge in the small group market if a smoker participates in a smoking cessation program. In some areas where states have flexibility, such as age rating curves and geographic rating areas, they will have to act within 30 days of the final market rules being published to avoid defaulting to a federal solution. In other areas, such as restricting age rating more than the federal rules do or prohibiting tobacco surcharges, states will have an ongoing right to impose their own rules.

The ACA and these rules are intended to moderate premium differences between older and sicker enrollees and younger and healthier enrollees, although other ACA provisions, such as tax credits for health insurance premiums, the individual coverage mandate and catastrophic plans, will mitigate the impact on younger and healthier enrollees.

The proposed rules also:

- establish open enrollment periods and marketing standards to ensure that people are not discriminated against on the basis of health status;
- implement the ACA requirement that insurers treat all enrollees in the individual market as a single risk pool and all enrollees in the small group market as a single risk pool, in contrast with the current practice of segmenting risk pools to keep higher-risk individuals in pools with higher premiums;
- add new standards for insurer rate reviews by states and require reporting to HHS on all rate increases;
- make technical changes to clarify the authority of HHS to enforce the law, inside and outside the exchanges, in the event a state is not substantially enforcing these new rules.

The following detailed analysis of the proposed rules highlights areas in which HHS is soliciting public comment.

## Key Provisions

### Uniform Age Bands

The proposed rules implement the 3:1 age band and prescribe uniform age bands that all states and insurers must follow in both the individual and small group markets. Section 147.102(d)<sup>4</sup> specifies three bands:

<sup>4</sup> All references to section numbers are to proposed new sections of Title 45 of the Code of Federal Regulations.

- **Child age band.** The proposed rules specifies a single age band for children aged 0 to 20. This is a blended approach between current practice in the individual market, where the youngest children (0-1 or 0-2) are typically a separately rated group, and the small group market, where children are typically lumped together in one or two family tiers without regard to individual characteristics.
- **Adult age bands.** The rules create one-year age bands for adults, starting at aged 21 and ending at aged 63. One-year age bands are common in the individual market, while five-year bands are the norm in the small group market today. One-year rate bands smooth out rate increases due to aging, and allow carriers to calibrate rates more finely for employees picking a group plan under an employee choice model. HHS notes that this approach simplifies implementation of its proposal to use a per-member rating buildup in both the individual and small group markets, as discussed below.
- **Older adult age band.** The proposal specifies a single age band for adults aged 64 or older. This group is primarily covered by Medicare, and represents only a small proportion of enrollees in the individual and small group markets. HHS concludes that they “are likely to have similar claims costs despite their age differences.”<sup>5</sup>

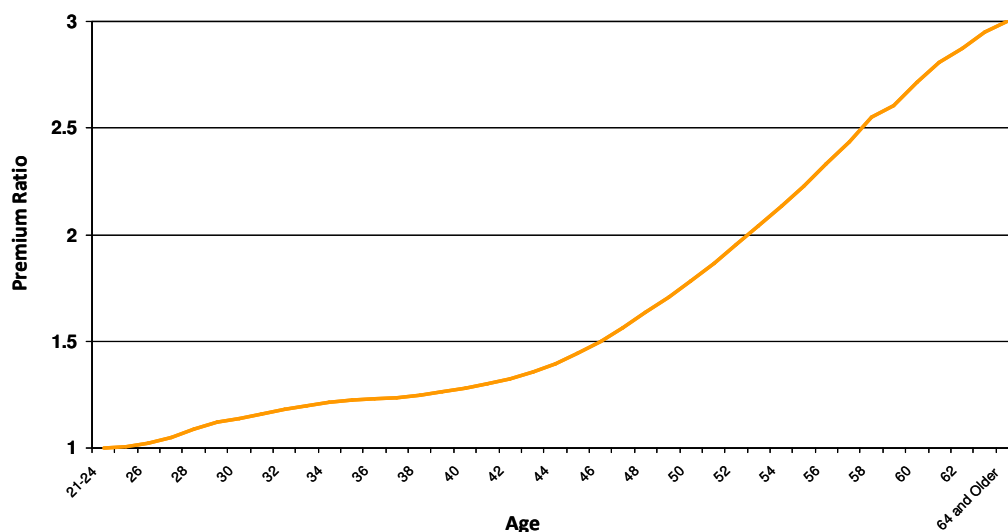
HHS requests comment on whether:

- enrollees’ age factors and bands should be set at enrollee age at policy issuance and renewal as opposed to another time frame (e.g., birthday);
- multiple age bands or a single age band for children is appropriate;
- one-year age bands for adults ages 21 to 63 are appropriate;
- a single age band for adults over aged 64 is appropriate and if aged 64 is an appropriate cutoff.

### Uniform Age Rating Curves

The proposed rules build on uniform age bands by requiring a uniform age rating curve in each state that all insurers must follow in setting their age-rated premiums. HHS has proposed a default curve (see Figs. 1 and 2), but Section 147.102(e) gives states the flexibility to design their own uniform curve.

**Figure 1: HHS-Proposed Standard Age Curve**



<sup>5</sup> 77 Fed. Reg. at 70594.

**Figure 2: HHS-Proposed Standard Age Factors & Percent Increase by Year**

Age	Premium Ratio	% Increase	Age	Premium Ratio	% Increase	Age	Premium Ratio	% Increase
0-21	.635	N/A	35	1.222	0.7%	50	1.786	4.7%
21	1.000	57.5%	36	1.230	0.7%	51	1.865	4.4%
22	1.000	0.0%	37	1.238	0.7%	52	1.952	4.7%
23	1.000	0.0%	38	1.246	0.6%	53	2.040	4.5%
24	1.000	0.0%	39	1.262	1.3%	54	2.135	4.7%
25	1.004	0.4%	40	1.278	1.3%	55	2.230	4.4%
26	1.024	2.0%	41	1.302	1.9%	56	2.333	4.6%
27	1.048	2.3%	42	1.325	1.8%	57	2.437	4.5%
28	1.087	3.7%	43	1.357	2.4%	58	2.548	4.6%
29	1.119	2.9%	44	1.397	2.9%	59	2.603	2.2%
30	1.135	1.4%	45	1.444	3.4%	60	2.714	4.3%
31	1.159	2.1%	46	1.500	3.9%	61	2.810	3.5%
32	1.183	2.1%	47	1.563	4.2%	62	2.873	2.2%
33	1.198	1.3%	48	1.635	4.6%	63	2.952	2.7%
34	1.214	1.3%	49	1.706	4.3%	64 +	3.000	1.6%

Under the default age curve HHS proposes, and as described in Figures 1 and 2, insurers would set a premium for one age that would determine rates for the rest of the age distribution. For example, if an insurer in a state using the default curve chooses to charge a nonsmoking 21-year-old \$100 per month, the insurer would be required to charge a nonsmoking 46-year-old \$150 per month, based on the 21-year-old's 1.0 premium ratio and the 46-year-old's 1.5 premium ratio.

Implementation of a uniform age curve reflects a significant shift from current market practices, under which insurers set their own age factors to rate policies. HHS believes a uniform age rating curve will simplify several elements of federal health reform and make them more likely to succeed in their implementation: a standardized age rating methodology will “enhance the transparency, predictability, and accuracy of the risk adjustment program,” because the methodology could account for age rating as uniformly applied rather than rely on assumptions that would not be as accurate if different insurers were incorporating the age of their enrollees into their premiums using different rating curves.<sup>6</sup> Additionally, most individuals buying insurance through exchanges will be eligible for premium tax credits. Those credits are calculated based on the premium charged for the second lowest cost silver plan available to the individual.<sup>7</sup> Without a uniform age rating curve, the determination as to which silver plan is the second lowest cost could vary depending on how old an individual is, significantly increasing the complexity in calculating tax credits. Finally, a uniform curve makes it easier for consumers to compare plans.

HHS requests comment on:

- the requirement that rates must be actuarially justified based on a standard population for individuals under aged 21;
- the application of a single, default uniform age curve to the individual and small group market in a state;
- the approach for fitting the adult age curve to the statutorily specified 3:1 premium ratio;
- the proposed rating curve, including if it is generally consistent with current rating practices and

<sup>6</sup> *Id.* The ACA establishes a risk adjustment program in each state, to be operated by the state or HHS, in which insurers with healthier enrollees will be assessed charges and insurers with sicker enrollees will receive payments, to help prevent premium increases that might occur because of guaranteed issue and adjusted community rating.

<sup>7</sup> Health plans sold in Exchanges will be identified by a metal level that represents a defined actuarial value. Silver plans will have a 70% actuarial value.

- minimally disruptive within the confines of the ACA;
- implications that the transition from the proposed child curve to the proposed adult curve may have for insurers and consumers;
- consequences of choices in terms of likely premium increases to consumers when aging from one band to the next, the impact on administration and accuracy of risk adjustment, and administration of premium tax credits and consumer ease.

### Tobacco Surcharges

The ACA allows insurers to impose a premium surcharge of up to 50% on tobacco users.<sup>8</sup> In the small group market, this surcharge would be tied to a wellness program, so that insurers can impose the surcharge only if they give enrollees the option of participating in a tobacco cessation program and waive the surcharge for those who participate. Providing the option to waive the surcharge in the small group market may prompt greater honesty in individuals admitting to tobacco use and potentially improve overall health.

For the individual market, tobacco surcharges, because they were specifically permitted in the ACA, are an exception to the general prohibition on basing premium differences on health factors. However, HHS does not propose to require that tobacco surcharges in the individual market be linked to smoking cessation programs because the ACA does not permit discounts for wellness programs in the individual market. While the ACA does instruct HHS to test individual market wellness discounts in ten states, no guidance has been released on this pilot program.

Unlike age, family and geographic rating, where states and insurers must follow uniform standards, the rules permit states to prohibit tobacco surcharges or allow them at whatever level the state chooses up to a maximum of 50%, including a more nuanced program in which surcharges vary by age. For example, young smokers might pay smaller surcharges than older smokers. States, in turn, can be prescriptive with insurers or give them the option of whether to impose tobacco surcharges, as is common today.

Finally, HHS recognizes that insurers have relied on different approaches to determine tobacco usage, and seeks comment on possible definitions of tobacco usage, ranging from self-reporting to standard measures of frequency or amount.

HHS requests comment on:

- use of a streamlined application to collect information concerning tobacco use;
- potential alternative options for identifying tobacco use;
- options for how information should be collected outside the exchange;
- allowing insurers to vary tobacco use factor for a particular age band, as long as any variation is not greater than 1.5:1;
- requiring insurers in the small group market to offer enrollees the opportunity to avoid paying the full amount of the tobacco use surcharge if they participate in a wellness program;
- other ideas for coordinating wellness provisions with the tobacco surcharge;
- whether the tobacco surcharge should rely on self-reporting and how tobacco use should be defined: as a particular amount of tobacco use, as regular use of tobacco, or as addiction to tobacco;
- whether the tobacco surcharge in the individual market could be combined with the same type of incentive to promote tobacco cessation as is proposed in the small group market.

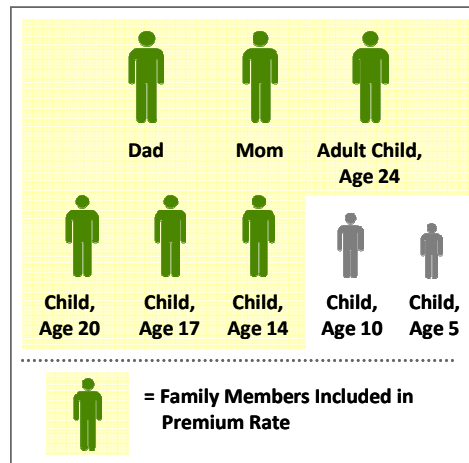
### Family Rating

Today in the individual market, premiums are generated for families using a “per member” approach -- rating each family member separately and then adding the individual rates to get a family rate. In the group market, the typical approach is use of family tiers in which premiums are based on family composition (employee or self-only, self plus spouse, etc.), with the self plus spouse priced at twice the self-only price, and various family compositions priced at other ratios to the self-only price. Section

<sup>8</sup> The various rating factors are multiplicative. For example, a smoking older enrollee can be charged up to 4.5 times as much as a nonsmoking younger enrollee.

147.102(c) proposes to impose a variant of the per member approach in both individual and small group markets, illustrated in Figure 3: each family member aged 21 or older (including children still in the household) is age and tobacco-rated separately, the first three children (aged 0-20) are rated individually under the 0-20 age band, and any additional children are not rated. Large families benefit from family rates: regardless of how many people under aged 21 are covered on a family policy, only the oldest three children will be taken into account in pricing. Conversely, children 21 or over pay more, in some cases, than they would under a traditional “family tier” approach.

**Figure 3: Example of Family Rating**



HHS offers two rationales for this significant departure from current practice. First, the ACA requires that, in family policies, rates vary based on age and tobacco use of family members only in proportion to the premium attributable to those individuals. HHS interprets this to require that when insurers price family policies based on age and tobacco use, they price each family member individually and then sum the individual premiums for a family premium. This is not compatible with a family tier approach, unless a state adopts pure community rating, with no variation for age and tobacco use, as discussed below.

Second, HHS observes that aligning individual and group market rating practices will make employee choice models easier to manage for insurers, since employees and their families will be priced individually when they are split among multiple insurers based on employee choice of coverage. While this does facilitate employee choice models, it also creates challenges for employers who want to make defined contributions to their employees.

The rules do permit the use of family tiers in fully community rated states, where everyone pays the same rates without regard to age and tobacco use.<sup>9</sup>

HHS requests comment on:

- the use of the per-member build-up methodology;
- the appropriate cap, if any, on the number of child and adult family members whose premiums should be taken into account in determining the family premium and the cut-off age for a per child cap;
- if states with pure community rating should also use the per-member approach;
- if the final rule should specify the minimum categories of family members or if the decision should be deferred to states/insurers;
- if certain individuals should be included or excluded under family coverage.

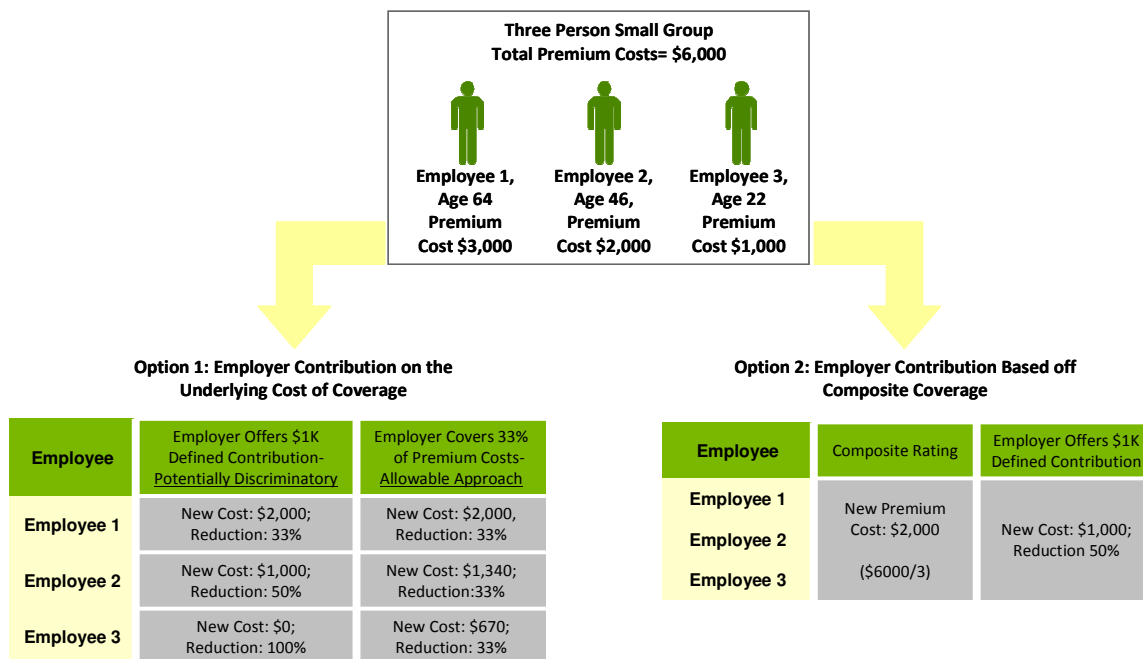
<sup>9</sup> States are permitted to impose additional requirements on insurers that do not prevent the application of the ACA. HHS said imposing pure community rating, or age rating more narrow than 3:1, would not prevent the application of the ACA's rating rules. 77 Fed. Reg. at 70595.

### Small Group Rating and Employer Contribution

One advantage of the family tier approach is that it allows employers to move to a defined contribution approach without raising questions about fair treatment of employees. Under this approach, providing each employee with the same fixed dollar contribution results in each employee owing the same amount for his or her own coverage, and any differences in what the employee owes for family coverage are based solely on differences in family composition.

The situation is complicated under the “per member” approach, where the same fixed dollar contribution can result in employees owing dramatically different amounts for their coverage. If, for example, age-rated premiums for the youngest employees are one-third as much as premiums for the oldest employees, then a fixed dollar contribution from the employer that covered 100% of the youngest employee’s premium would only cover 33% of the oldest employee’s premium.

**Figure 4: Example of Small Group Rating and Employer Contribution**



HHS does not address the potential for discrimination this presents, noting that “employer/employee contribution levels are subject to other laws.”<sup>10</sup> However, after observing that “many variations of [employer-employee contributions] may be consistent with applicable state and federal law,” HHS says, “we anticipate that there are two primary ways employee contributions may be determined.”<sup>11</sup> The options are (1) the employer pays a fixed percentage of each employee’s age-rated premium, or (2) the employer generates a composite or average rate for all employees<sup>12</sup> and then determines employer and employee contributions based on the composite rate. The proposed rule permits either approach and allows states to require the composite approach. Figure 4 illustrates the various approaches.

HHS requests comment on:

- the alignment of the method for calculating each employee’s rate in the small group market with that used to calculate an individual’s rate in the individual market and the implications for

<sup>10</sup> 77 Fed. Reg. at 70590 n.35.

<sup>11</sup> 77 Fed. Reg. at 70591.

<sup>12</sup> The arithmetic is simple: add the per-member rates and divide by the number of employees to determine the group’s average rate. HHS notes that this is easy to do and that much of the market is accustomed to composite rating, though this method of composite rating may differ from methods in use today.



- employees;
- the method's compatibility with employee choice in small business health insurance exchanges and accuracy in pricing.

### Geographic rating areas

Section 147.102(b) permits states to establish up to seven geographic rating areas within the state and to allow actuarially justified rate variations by rating area. While the proposed rules appear to require all insurers to use the same state-established rating areas, they would give states the flexibility either to set rating factors for each area or to permit insurers to use actuarially reasonable rating factors for each area; the latter is common in states today with state oversight to ensure that variations are not excessive, or based on impermissible factors, such as differences in health status. The rule, which does not require that all sections of a rating area be geographically adjacent, describes three common building blocks for rating areas—counties, three digit zip codes, and metropolitan statistical areas (MSAs)—and gives states a strong incentive to use one of these options. Rating areas that rely on these options will be presumed adequate whereas other approaches will require case-by-case HHS approval.

The rules also allow states to seek exceptions to the seven area limit. Although the rule describes seven rating areas as “the higher end of the number of rating areas” used by states today, the preamble recognizes that some states have more and requests comments on “whether state rating areas currently in existence should be deemed in compliance with this provision.”<sup>13</sup>

HHS recognizes that geographical rating areas are a matter of local market conditions, and notes that states may wish to establish or modify their rating areas after 2014 based on local utilization and cost patterns, insurer service areas, or changes in MSA designations. If a state does not define adequate rating areas, HHS will work with the state and local insurers, with an “inclination” to use the MSA approach.

HHS requests comment on:

- the maximum number of rating areas within a state and standards for determining such number;
- the use of proposed standards (MSAs, three-digit zip, one area per state) and other options;
- the impact of the proposed limit of having no more than seven regions and whether existing rating areas should be deemed in compliance (for states that already have geographic rating areas);
- the establishment of minimum geographic size and minimum population requirements per region;
- the appropriate schedules and considerations related to modifying areas after plan year 2014.

### Guaranteed Issue with Limited Exceptions

Section 147.104(a) tracks closely to the HIPAA rules for small groups in implementing the ACA requirement that insurers offer coverage to individuals and employers without regard to health status. HHS notes that guaranteed issue in the individual market may be vulnerable to abuse if individuals decide not to pay their premiums for the last few months of the year and then purchase a new policy for January. HHS solicits comments on how to prevent such abuse, without curtailing guaranteed issue rights. Section 147.104(d) provides an exception to guaranteed issue for insurers that lack the financial capacity to enroll new members. Because network plans may have limited service areas and limited network capacity within the service area, the rule would also give these plans special dispensation to limit applications as long as it is not done selectively for a discriminatory purpose.

### Open and Special Enrollment Periods in the Individual Market

While insurers generally will be required to offer coverage to anyone who applies, the timing of enrollment will become a key issue. Insurers may want to limit individuals to enrolling at certain times of the year to discourage individuals from waiting until they are sick to apply for coverage. Section 147.104(b) permits limited enrollment periods, but requires that coverage be available at a minimum during the same open enrollment periods set by HHS for exchanges. The first open enrollment period for exchanges will be October 1, 2013, through March 31, 2014. Subsequent open enrollment periods for exchanges will be

<sup>13</sup> 77 Fed. Reg. at 70592.



October 15 through December 7 of each year (which time frame parallels the period for enrollment in Medicare Parts C and D).

The ACA also provides for special enrollment periods, which are limited to 30 days after qualifying events. Such events will be the same as those established under ERISA for group health plans and include loss of coverage due to divorce or death of the primary member.

HHS requests comment on:

- the requirement that open enrollment periods are consistent both in and out of the exchange and whether aligning open enrollment periods with policy years in the individual market is desirable;
- whether 60 calendar days (versus 30) should be allowed for special enrollment periods;
- whether insurers in the individual market should be required to provide enrollees notice of special enrollment rights.

### Guaranteed Renewability

Section 147.106 tracks closely to the HIPAA rules for guaranteed renewability in implementing similar ACA requirements.

### Rolling Enrollment in the Small Group Market

Section 147.104(b)(1) provides for guaranteed issue at any point during the year for small groups. This provision is consistent with current market practice and reflects the fact that small businesses start and fail at all times of year, and do not present the same adverse selection concerns as individuals.

### Marketing Standards

In order to avoid circumvention of the guaranteed issue requirement, Section 147.104(e) requires compliance with state marketing rules and adds an ACA prohibition on marketing practices that have the effect of discouraging enrollment by individuals with significant health needs. The former requirement reflects deference to the states, and the latter aligns the markets inside and outside the exchanges since this federal standard is already applicable to qualified health plans.

### Student Health Insurance

Section 147.145 provides that insurance sold to college and university students will be exempt from the guaranteed issue provision – enrollment may be limited to students.

HHS requests comment on whether:

- insurers should be allowed to maintain a separate risk pool for student coverage;
- modifications should be provided to the generally applicable individual market rating rules in connection with student health coverage.

### Association Plans

The regulations do not provide a similar exception for coverage sold through bona fide associations, so it would appear that association coverage cannot be limited to members of the association. However, HHS does mention bona fide associations in the context of network plans and says there is ongoing consideration of a “transition or exception process” for existing association coverage.<sup>14</sup>

HHS requests comment on:

- how a transition or exception process for bona fide association coverage could be structured to minimize disruption and maintain consumer protections

### Enforcement

Section 150.101 clarifies that the HIPAA enforcement framework also applies to the new ACA rules for insurers. States will be responsible for enforcement, but if HHS determines a state is not substantially enforcing federal law, HHS has the authority to enforce the rules directly against insurers, undertaking

<sup>14</sup> 77 Fed. Reg. at 70598.

form reviews and other insurance supervision techniques, and may impose civil monetary penalties against noncompliant insurers. HHS also directly enforces these rules for group health plans of state and local government employees.

### **New Standards for State Rate Review Programs**

The proposed rules make several changes in HHS oversight of state rate review processes. The current program grows out of the ACA requirement that states meet federal standards for rate review, with federal review of rate increases in states that do not meet the federal standards. Forty-four states have met federal standards for effective rate review programs in the individual and small group markets, including a requirement that all proposed rate increases of 10% or more be reviewed to determine whether they are actuarially reasonable. Some state regulators are authorized under state law to deny unreasonable rate increases; HHS does not have that authority under federal law but does publish its rationale when it finds a rate increase unreasonable.

Section 154.301 modifies the standard for an effective state rate review process to require states to consider new information that will become available in 2014, including the reasonableness of an insurer's assumptions with respect to the risk adjustment and reinsurance programs; the insurer's data on implementation and utilization of a market-wide single risk pool, essential health benefits, actuarial values and other ACA reforms; and the impact of rating changes on enrollee risk profiles.

Section 154.200 revises the process for states that wish to replace the 10% federal threshold for rate reviews with a state-specific threshold. States may submit such requests for approval by August 1 each year. HHS will notify states of approval by September 1, and any approved thresholds will take effect on January 1 of the following year.

HHS requests comment on:

- the proposed changes to the timeframes for states seeking state-specific thresholds to submit proposals;
- whether additional factors should be considered in rate review;
- the impact on states by adding additional factors to consider during the rate review process.

### **National Template for Rate Increase Filings**

Section 154.215 requires insurers to submit to HHS a rate filing justification, using a standard template, for all proposed rate increases, not just those above the federal 10% threshold or any state specific threshold. HHS describes these filings as necessary to carry out its responsibilities, in conjunction with the states, to monitor premium increases through an exchange or outside an exchange. HHS also emphasizes that the new template could streamline data collection for insurers and states and points to its work with the National Association of Insurance Commissioners to bring consistency to state and federal electronic filing systems. States will continue to have authority to collect additional information, however, so efficiency gains will depend on the extent to which states rely on the new template in place of various state-specific requirements today.

The new rate filing template will have three parts: standardized data on claims experience, unit cost and utilization trends, and other product-specific information; a description of the justification in narrative form that identifies the most significant factors causing the increase; and an actuarial memorandum with the reasoning and assumptions supporting the proposed increase. The new requirements apply to all rate increases filed in states after April 1, 2013, or effective after January 1, 2014, if the rate increase is not required to be filed in a state. HHS will post the filings, except for trade secrets or other confidential information.

HHS requests comment on:

- the need for and impact of the extension of the reporting requirement below the review threshold and what alternative approaches could be considered;
- the information requested on the standardized form used to submit data/documentation regarding rate increases.

### Single Risk Pool

Section 156.80 requires insurers to treat the claims experience for their entire book of business in the individual market or small group market as a single risk pool under the ACA. The proposed rule requires separate risk pools in the individual and small group markets, except in states that merge the two risk pools. The “single risk pool” approach is a marked change from current practice, especially in the individual market, where it is common practice to open new underwritten books of business to draw the healthiest enrollees out of aging books of business. The result is a proliferation of risk pools, such that the same insurer may file rate increases for an older book of business that are multiple times higher than those for a newer book of healthier risks.

Under the ACA, however, the rates for all an insurers’ individual market policies will move up or down together as the overall risk pool gets more healthy or sick, with relatively minor differences attributable to factors such as product and network differences. The same applies in the small group market. The long term result should be more price stability in the market, with rate increases spread more evenly across all individuals and groups.

HHS requests comment on:

- the approach to calculating single market risk pools (including the proposed plan-specific adjustments to the index rate) and whether flexibility should be allowed in 2016.

### Catastrophic Plans

Section 156.155 clarifies some issues with respect to catastrophic products, which are available only to those under 30 years of age and those exempt from the minimum coverage requirements. Catastrophic products must cover essential health benefits but only after the enrollee reaches the annual deductible. The one exception is coverage for three primary care visits per year not subject to the deductible. In order to keep prices low for such policies, the rules provide for a limited exception to the single risk pool by allowing catastrophic plans to be priced based on expected enrollment, while otherwise being in the same risk pool as other products.

### State Flexibility On Rating

If a state wants to vary from the minimum rating thresholds set forth by HHS, or if a state elects to merge its individual and small group market, it must submit information to HHS within 30 days of publication of the final rule. Items where states have flexibility under the rating rule are:

- *Small Group Market Rating.* States may require premiums to be based on average enrollee amounts in the small group market;
- *Family Rating.* States with pure community rating must submit information about their uniform family tiers and corresponding multipliers, if any;
- *Rating for Geography.* States may establish rating areas;
- *Rating for Age.* States may adopt a narrower age rating ratio than 3:1 and may use their own uniform age rating curve;
- *Rating for Tobacco Use.* States may adopt a narrower tobacco use ratio than 1.5:1.

### Conclusion

With comments due by December 26, we expect final rules will be published early in 2013. Given the rapid turnaround necessary for successful implementation of these rules, we recommend that interested stakeholders submit comments as soon as possible. Even after the final rules are published, some issues may remain open since HHS has given states the flexibility to customize several parameters. The late release of these proposed rules will make the current timeline challenging, given that insurers will need to begin selling policies compliant with these rules as of October 1, 2013.

\*\*\*\*\*

**About Manatt, Phelps & Phillips, LLP**

Manatt, Phelps & Phillips, LLP, is one of the nation's leading law firms, with offices strategically located in California (Los Angeles, Orange County, Palo Alto, San Francisco and Sacramento), New York (New York City and Albany) and Washington, D.C. The firm represents a sophisticated client base – including Fortune 500, middle-market and emerging companies – across a range of practice areas and industry sectors. For more information, visit [www.manatt.com](http://www.manatt.com).

**About Manatt Health Solutions**

Manatt Health Solutions is a division of Manatt, Phelps & Phillips, LLP. Its interdisciplinary team provides strategic business advice, policy analysis, project implementation, and coalition-building and advocacy services to clients in the areas of health information technology, healthcare access and coverage, including development of new healthcare delivery system models. MHS professionals also provide counsel on financing, reimbursement, restructurings, and mergers and acquisitions to clients in the healthcare sector. For more information, visit [www.manatthealthsolutions.com](http://www.manatthealthsolutions.com).

200801274.1