

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, 150, 154 and 156

[CMS-9972-P]

RIN 0938-AR40

Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement the Affordable Care Act's policies related to fair health insurance premiums, guaranteed availability, guaranteed renewability, risk pools, and catastrophic plans. The proposed rule would clarify the approach used to enforce the applicable requirements of the Affordable Care Act with respect to health insurance issuers and group health plans that are non-federal governmental plans. This proposed rule would also amend the standards for health insurance issuers and states regarding reporting, utilization, and collection of data under section 2794 of the Public Health Service Act (PHS Act). It also revises the timeline for states to propose state-specific thresholds for review and approval by CMS.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR--INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE **FEDERAL REGISTER**].

ADDRESSES: In commenting, please refer to file code CMS-9972-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to

<http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9972-P,

P.O. Box 8012,

Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9972-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, S.W.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Jacob Ackerman, (410) 786–1565, concerning the health insurance market rules;

Douglas Pennington, (410) 786-1553 (or by e-mail: ratereview@hhs.gov), concerning rate review.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (800) 743-3951.

I. Executive Summary

A. Purpose of the Proposed Regulatory Action

1. Need for the Proposed Regulatory Action

Today, consumers with current or past medical problems can be denied health insurance coverage in the vast majority of individual (nongroup) markets (45 states). Similarly, individuals and small employers often find that they have few protections in terms of the premiums that issuers can charge them. For example, in the individual market, 43 states allow health status

rating and 48 states allow age rating (often unlimited). While 37 states explicitly allow gender rating, three states that prohibit gender rating do not require maternity coverage in all individual market policies, meaning that, since maternity coverage requires additional premium in those states, a total of 40 states allow some form of gender rating in practice. In the small group market, 38 states allow health status rating, 48 states allow age rating (often unlimited), 35 states allow gender rating, and 37 states allow industry rating.¹

Sections 2701, 2702, and 2703 of the Public Health Service Act (PHS Act), as added and amended by the Patient Protection and Affordable Care Act (Affordable Care Act), and section 1312(c) of the Affordable Care Act address these problems by extending guaranteed availability (also known as guaranteed issue) protections so that individuals and employers will be able to obtain coverage when it currently can be denied, by continuing current guaranteed renewability protections, by prohibiting the use of factors such as health status, medical history, gender, and industry of employment to set premium rates, by limiting age rating, and by prohibiting issuers from dividing up their insurance pools. These reforms are effective for plan years (group market) and policy years (individual market) starting on or after January 1, 2014.

The implementation of these proposed rules will ensure that every American, for the first time, will have access to affordable health insurance coverage notwithstanding any health problems they may have. In addition, also for the first time throughout the nation, health insurance issuers will be prevented from charging individuals and small employers higher premiums due to enrollees' health status or gender. CMS is issuing these proposed regulations to

¹ Ctr. on Health Ins. Reforms, Georgetown Univ. Health Policy Inst., Individual Market Guaranteed Issue, Individual Health Insurance Market Rate Restrictions, and Small Group Health Insurance Market Rate Restrictions, available at <http://statehealthfacts.org>; Nat'l Women's Law Center, Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act (2012).

provide the necessary guidance to implement these important consumer protections included in sections 2701, 2702, and 2703 of the PHS Act and section 1312(c) of the Affordable Care Act.

In addition, PHS Act section 2723 provides CMS with enforcement authority with respect to health insurance issuers (in certain instances) and group health plans that are non-federal governmental plans in connection with the various health insurance and group health plan standards added by the Affordable Care Act. The proposed rules would make non-substantive changes that clarify the processes that CMS currently uses to enforce such standards. These technical changes seek to eliminate confusion among states, issuers, non-federal governmental group health plans, consumers, and others concerning CMS's enforcement processes.

The proposed rule would also include proposed policy for enrollment in catastrophic plans that are available for young adults and people who would otherwise find health insurance unaffordable.

The proposed rule would also revise the timing of the submission of requests for state-specific thresholds and the effective dates of such thresholds; require that health insurance issuers submit data on proposed rate increases in a form and manner to be determined by CMS, and amend the requirements for a state to have an Effective Rate Review Program. We are proposing these changes to align with the timing of rate submissions of qualified health plans (QHPs), as defined under section 1301 of the Affordable Care Act, in the Exchanges, and to adjust rate review to meet its additional purpose of helping to promote fair market competition beginning in 2014. The law requires that, beginning in 2014, the Secretary of the Department of Health and Human Services (the Secretary), in conjunction with states, monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

The Secretary will monitor these increases to identify patterns that could signal market disruption and assist in oversight of the new market-wide rating reforms created by the Affordable Care Act, which are effective on January 1, 2014.

2. Legal Authority

The substantive authority for these proposed rules is generally sections 2701, 2702, 2703, 2723 and 2794 of the PHS Act and sections 1302(e), 1312(c), and 1560(c) of the Affordable Care Act. PHS Act section 2792 authorizes us to promulgate regulations that are necessary or appropriate to carry out sections 2701, 2702, 2703, 2723, and 2794. Section 1321(a) of the Affordable Care Act authorizes rulemaking with respect to sections 1302(e), 1312(c), and 1560(c).

B. Summary of the Major Provisions of This Proposed Regulatory Action

Proposed 45 CFR 147.102 would require issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014, and the large group market if such coverage is available through an Affordable Insurance Exchange (Exchange) starting in 2017, to limit any variation in premiums with respect to a particular plan or coverage to age and tobacco use within limits, family size, and geography.

Proposed §147.104 would require issuers offering non-grandfathered health insurance coverage to accept every individual or employer who applies for coverage in the individual or group market, as applicable, subject to certain exceptions (for example, limits on network capacity).

Proposed §147.106 would require issuers to renew all coverage in the individual and group markets, subject to certain exceptions (for example, non-payment of premiums or fraud).

The proposed revisions in 45 CFR part 154 would make three changes to the existing rate review program. Proposed revisions in §154.200 would require states seeking state-specific thresholds to submit proposals for such thresholds by August 1 of each year and require CMS to review the proposals by September 1 of each year. If approved, a state-specific threshold would be effective January 1 of the following year. Proposed revisions in §154.215 and §154.220 would require health insurance issuers to submit, in a standardized format to be specified by the Secretary, data relating to proposed rate increases that are filed in a state on or after April 1, 2013, or effective on or after January 1, 2014 in a state that does not require the rate increases to be filed. Proposed revisions in §154.301 would add criteria and factors for a state to have an Effective Rate Review Program, including that the state receives from all issuers proposing rate increases data and documentation about the rate increases in the standardized form specified by the Secretary; reviews the information for proposed rate increases greater than or equal to the review threshold; and makes information publicly available through its Web site.

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

Proposed §156.155 generally would codify section 1302(e) of the Affordable Care Act regarding catastrophic plans.

The proposed revisions in 45 CFR part 150 would clarify that CMS uses the same enforcement processes with respect to the requirements of 45 CFR part 147, which implements provisions added by the Affordable Care Act, as it does with respect to the requirements of 45

CFR parts 146 and 148, which pre-date the Affordable Care Act. Additional revisions would conform certain sections in 45 CFR part 144 to the clarification concerning the scope of 45 CFR part 150.

C. Costs and Benefits

The provisions of this proposed rule, combined with other provisions in the Affordable Care Act, will improve the individual health insurance market by making insurance affordable and accessible to millions of Americans who currently do not have affordable options available to them. The shortcomings of the individual market today have been widely documented.² Between 50 and 129 million Americans, if they tried to purchase coverage in the individual market, would be denied coverage entirely or would have their premiums “rated up,” and would likely have coverage for certain medical conditions excluded.³ In addition, people previously enrolled in individual insurance with high health risks or costs are often further blocked from access to the market as they are put into “closed blocks” of business that are not open to new enrollees, and subject to large premium increases each year. Relatively healthy subscribers can switch into lower-priced, open blocks of coverage, while those who are sick only have the choice of paying the large premium increases or dropping coverage altogether.

These limitations of the individual market are made evident by how few people actually purchase coverage in the individual market. In 2011, approximately 48.6 million people were

² Michelle M. Doty et al., Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2007, The Commonwealth Fund, July 2009; Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011.

³ ASPE, At Risk: Preexisting Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, November 2011.

uninsured in the United States,⁴ while only around 10.8 million were enrolled in the individual market.⁵ The relatively small fraction of the target market that actually purchases coverage in the individual market in part reflects how expensive the product is relative to its value, people's resources, and how difficult it is for many people to access coverage.

The provisions of this proposed rule, combined with other provisions in the Affordable Care Act, will improve the functioning of both the individual and the small group markets. The provision for guaranteed availability will ensure that individuals with health problems who were previously unable to obtain coverage in the individual market will have access to coverage. The provision requiring that age, tobacco use, family size, and geography are the only permissible rating factors, within limits, will ensure that people with greater than average health needs are not priced out of the market. The provision requiring a single risk pool in each market will ensure that rate increases for healthy and less healthy people will be equal over time. Elimination of rating based on gender will mean lower premium rates for women, and the 3:1 limit on the rates charged to older subscribers will result in lower premium rates for older subscribers without shifting significant risk to younger subscribers as would happen under pure community rating. While eliminating gender rating and the limitations on age ratios could affect premium rates for some in some markets, this will be largely mitigated for most people by the availability of premium tax credits, by increased efficiencies and greater competition in the individual market, by measures such as the transitional reinsurance program and temporary risk corridors program to stabilize premiums, and by expected improvements in the overall health

⁴ Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement, Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2011.

⁵ Source: CMS analysis of June 2012 Medical Loss Ratio Annual Reporting data for 2011 MLR reporting year, available at <http://cciio.cms.gov/resources/data/mlr.html>.

status of the risk pool. The availability of premium tax credits through Exchanges starting in 2014 will result in lower net premium rates for most people currently purchasing coverage in the individual market, and will encourage younger and healthier enrollees to enter the market, improving the risk pool and leading to reductions in premium rates for current policyholders.⁶ Additionally, young adults and people for whom coverage would otherwise be unaffordable will have access to a catastrophic plan that will have a lower premium, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing. Similarly, the minimum coverage provision will lead to expansion in the number of purchasers and improvements in the health of the risk pool. Further, premium rates are expected to decline as a result of the administrative efficiencies from eliminating underwriting, and, more importantly, due to the effects of greater competition in the individual market created by Exchanges. Lower premium rates are expected to lead to further increases in purchase, and a further improvement in the risk pool.

We solicit comments on additional strategies consistent with the Affordable Care Act that CMS or states might deploy to avoid or minimize disruption of rates in the current market and encourage timely enrollment in coverage in 2014. For example, these strategies could include instituting the same enrollment periods inside and outside of Exchanges (as proposed in this rule) or a phase-in or transition period for certain policies. Additionally, we are examining ways in which states could continue their high risk pools beyond 2014 as a means of easing the

⁶ Congressional Budget Office, Letter to Honorable Evan Bayh, providing an Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, November 30, 2009; Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011; Fredric Blavin et al., The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State, Urban Institute, March 2012.

transition. Ensuring premiums are affordable is a priority for the Administration as well as states, consumers, and insurers, so we welcome suggestions for the final rule on ways to achieve this goal while implementing these essential consumer protections.

Issuers may incur some one-time fixed costs in order to comply with the provisions of the final rule, including administrative and marketing costs. Administrative costs are, however, expected to decrease as a result of the elimination of medical underwriting to determine premium amounts. Issuer revenues and expenditures are also expected to increase substantially as a result of the expected increase in the number of people purchasing individual market coverage, which is projected to exceed 50 percent of current enrollment.⁷ We are soliciting information on the nature and magnitude of these costs and benefits to issuers, and the potential effect of the provisions of this rule on premium rates and financial performance.

In addition, states may incur costs if they choose to establish their own, new geographic rating areas and age rating curves. We are also requesting information on such costs.

The proposed amendments to the rate review program would help issuers to avoid significant duplication of effort for filings subject to review by using the same standardized template for both non-QHPs and QHPs. Additionally, the collection of rate information below the rate review threshold and use of a standardized data template would provide the Department of Health and Human Services (HHS) and state departments of insurance with the ability to conduct the review and approval of products sold inside and outside an Exchange and ensure market stability. Health insurance issuers would incur administrative costs to prepare and submit

⁷ Congressional Budget Office, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf> (Table 3).

the data.

In accordance with Executive Orders 12866 and 13563, we believe that the benefits of this regulatory action would justify the costs.

II. Background

The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010. The Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. These laws are collectively referred to as the Affordable Care Act.

A. Legislative Overview Prior to the Affordable Care Act

The current individual and small group health insurance markets generally are viewed as dysfunctional, placing consumers at a disadvantage due to the high cost of health insurance coverage, resulting from factors such as lack of competition, adverse selection, and limited transparency. In the past ten years, average total premiums for group and individual health insurance coverage have increased substantially.⁸ Similarly, the share of premium paid by employees in the group market has increased, as well as the amounts that employees pay in out-of-pocket costs.⁹

In 2007, 62 percent of personal bankruptcies were attributable to medical expenses. Many of these individuals and families either had health insurance that did not provide adequate coverage for their medical expenses or lost medical coverage due to illness.¹⁰

In addition to affordability concerns, many people have difficulty finding and enrolling in

⁸ Schoen, C., et al., State Trends in Premiums and Deductibles, 2003-2010: The Need for Action to Address Rising Costs, Realizing Health Reform's Potential, p. 5 (Nov. 2011).

⁹ Claxton, G., et al., Health Benefits in 2010: Premiums Rise Modestly, Workers Pay More Toward Coverage, Health Affairs, 29, no.10 (2010):1942-1950.

¹⁰ Himmelstein, D., et al., Medical Bankruptcy in the United States, 2007: Results of a National Study, The American Journal of Medicine, Vol. 122, No. 8, 741-746.

coverage options. If employer-based coverage is not available, a person may find that affordable individual market coverage is not available due to medical underwriting. Research has shown that individuals could be denied coverage based even on common medical conditions such as asthma, depression, hypertension, and knee injuries.¹¹ Even if a person is accepted for coverage in the individual market, that coverage may be conditioned on paying higher premiums, preexisting condition exclusion waiting periods, and even permanent exclusions of coverage for certain medical conditions. One study found that 38 percent of persons seeking individual market coverage reported it very difficult or impossible to find the coverage they needed.¹² Uninsured individuals are more likely to report not having routine medical check-ups, not receiving recommended medical treatments, and not refilling prescriptions.¹³

Among other policies, the Affordable Care Act expands affordable coverage to uninsured Americans through the private health insurance market. When fully implemented, its reforms will make health insurance coverage more affordable and accessible for individuals and families, many of whom could not previously get or afford coverage. The insurance market reforms will help ensure that no individual or small employer is denied insurance coverage, and that, once issued, coverage cannot be non-renewed due to health factors. Premiums charged by health insurance issuers may only vary by certain factors. Further, each issuer will have a single risk pool for its business in the individual market and a single risk pool for its business in the small group market (unless a state decides to merge the markets). This risk pool provision will spread

¹¹ Pollitz, K., How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health (2001).

¹² Collins, S., et al., Gaps in Health Insurance: Why So Many Americans Experience Breaks in Coverage and How the Affordable Care Act Will Help (April 2011).

¹³ Doty, M., et al., When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help, *Realizing Health Reform's Potential*, p. 3 (Aug. 2011).

risk more evenly among consumers, which will help keep premiums more affordable.

Prior to the Affordable Care Act, title XXVII of the PHS Act included certain insurance market protections for individuals and employers that were added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA provided guaranteed renewability of coverage to individuals and employers, broad guaranteed availability rights to small employers, and narrower guaranteed availability rights in the individual market for certain individuals leaving group coverage. In practice, relatively few individuals exercise their HIPAA rights to individual market guaranteed availability due to the high costs of such coverage in many states and the requirement that they first exhaust any available continuation coverage, such as COBRA, which is often unaffordable.¹⁴ HIPAA did not include any protections to ensure that all persons could obtain affordable coverage in the individual market. Thus, most individuals could be medically underwritten and denied coverage by issuers in the vast majority of states. HIPAA also did not include any limits on premium variation or requirements regarding risk pooling that would have made health insurance coverage more affordable for individuals and small employers. HIPAA included enforcement provisions allowing CMS to enforce these and other requirements of title XXVII of the PHS Act with respect to health insurance issuers (in some instances) and group health plans that are non-federal governmental plans.

Both before and after HIPAA, a number of states enacted limited, incremental reforms to improve access and increase affordability in their individual and group insurance markets.

¹⁴ COBRA continuation coverage permits some employees and their dependents, in some circumstances, to remain temporarily covered under an employer's group health plan after coverage would otherwise end. But because a former employee must usually pay the entire premium amount (including both the amount paid as an active employee and the amount previously contributed by the employer), plus a 2-percent administrative fee, COBRA coverage may be unaffordable for many people.

HIPAA explicitly recognized the role of the states as the primary insurance regulators where their standards were at least as protective as HIPAA. Although the level of activity varies by state, most states have adopted guaranteed availability and renewability reforms consistent with HIPAA, and several states have adopted rating standards. For example, one recent survey of state insurance market rules found that all states require guaranteed availability in the small employer market.¹⁵ The same survey found that 41 states had implemented “alternative mechanisms” for guaranteed availability for HIPAA-eligible individuals, while the remaining states used the federal fallback mechanism.¹⁶ However, only five states (Maine, Massachusetts, New Jersey, New York, and Vermont) went beyond HIPAA to require that all issuers accept all applicants in the individual market, with limited exceptions.¹⁷ With respect to guaranteed renewability, one survey reported that 48 states require it in the small group market¹⁸ and another survey reported that all 50 states require it in the individual market.¹⁹ While HIPAA did not include any provisions addressing rating or pooling, 47 states have one or more requirements in the small group market and 18 states have one or more requirements in the individual market.²⁰

Despite the advances in some states, only five states (Maine, Massachusetts, New Jersey,

¹⁵ Ctr. on Health Ins. Reforms, Georgetown Univ. Health Policy Inst., Small Group Health Insurance Market Guaranteed Issue and Individual Market Guarantee Issue, available at <http://statehealthfacts.org>.

¹⁶ Ctr. on Health Ins. Reforms, Georgetown Univ. Health Policy Inst., Small Group Health Insurance Market Guaranteed Issue and Individual Market Guarantee Issue, available at <http://statehealthfacts.org>.

¹⁷ Ctr. on Health Ins. Reforms, Georgetown Univ. Health Policy Inst., HIPAA Rules, available at <http://statehealthfacts.org>.

¹⁸ Pollitz, K., et al., Early Experience with the “New Federalism” in Health Insurance Regulation, Health Affairs, 19, no.4 (2000):7-22.

¹⁹ Fuchs, B., Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s (2004) at p. 7.

²⁰ Ctr. on Health Ins. Reforms, Georgetown Univ. Health Policy Inst., Small Group Health Insurance Market Rate Restrictions and Individual Market Rate Restrictions, available at <http://statehealthfacts.org>.

New York, and Vermont) have adopted a comprehensive set of guaranteed availability and community rating reforms in both their individual and small group markets that meet or exceed those in the Affordable Care Act. Only Massachusetts, which enacted a landmark health reform law in 2006 that coupled insurance market reforms with an insurance exchange, premium subsidies, and a minimum coverage provision, has succeeded in covering nearly all residents of the state. In 2011, only 3.4 percent of Massachusetts residents were uninsured, compared to 15.7 percent nationally.²¹ In contrast, individuals with medical conditions in the 45 states without guaranteed availability and rating reforms often find themselves with few – or even no – coverage options at affordable prices.

B. Overview of the Changes in the Affordable Care Act

Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added provisions to part A of title XXVII of the PHS Act relating to health insurance issuers in the group and individual markets and group health plans that are non-federal governmental plans.²² As relevant here, these provisions include PHS Act sections 2701 (fair health insurance premiums), 2702 (guaranteed availability of coverage), and 2703 (guaranteed renewability of coverage), which apply to health insurance coverage offered by health insurance issuers.²³ These

²¹ Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement, Table HI06. Health Insurance Coverage Status by State for All People: 2011.

²² The Affordable Care Act also added section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans other than non-federal governmental group health plans. The market requirements discussed in this proposed rule apply to health insurance issuers offering health insurance coverage.

²³ Under the HIPAA enforcement structure, the states (or, if they lack authority or fail to substantially enforce, CMS) take enforcement actions against health insurance issuers that fail to comply with the requirements of PHS Act sections 2701-2703. See Code §4980D(d); ERISA §502(b)(3); PHS Act §2723.

provisions will establish 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.

Section 2701 regarding fair premiums applies to the individual and small group markets generally, and to the large group market if a state permits large employers to purchase coverage through an Exchange.²⁴ Pursuant to section 1312(f)(2)(B) of the Affordable Care Act, a state may permit large employers to purchase through an Exchange starting in 2017. Sections 2702 and 2703 apply to the individual and group (small and large) markets. These provisions apply to health insurance coverage in the respective markets regardless of whether such coverage is a QHP offered on Exchanges. Section 1255 of the Affordable Care Act provides that PHS Act sections 2701, 2702, and 2703 are effective for plan years (in the individual market, policy years) beginning on or after January 1, 2014.²⁵ Section 1251(a)(2) of the Affordable Care Act specifies that grandfathered health insurance coverage is not subject to sections 2701, 2702, and 2703 of the PHS Act. In addition, the Affordable Care Act amended the HIPAA enforcement provision that previously was applicable to group health insurance coverage and non-federal governmental group health plans by expanding its scope to include individual health insurance coverage and by renumbering the provision as PHS Act section 2723.

The preemption provisions of PHS Act section 2724(a)(1) apply so that the requirements of the Affordable Care Act are not to be “construed to supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage

²⁴ The applicable definitions for individual market, small group market, and large group market are found in PHS Act section 2791(e) and section 1304(a) of the Affordable Care Act.

²⁵ “Plan year” and “policy year,” for purposes of these proposed rules, are defined at 45 CFR 144.103. These terms are defined differently than “plan year” and “benefit year” as used in connection with QHPs (45 CFR 155.20).

except to the extent that such standard or requirement prevents the application of a requirement” of the Affordable Care Act. Section 1321(d) of the Affordable Care Act applies the same preemption principle to requirements of title I of the Affordable Care Act. As mentioned, state laws that impose stricter requirements on health insurance issuers than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.²⁶

Section 1312(c) of the Affordable Care Act creates a single risk pool standard, applicable to both QHPs and non-QHPs, in the individual and small group markets; in addition, states may choose to have a merged individual and small group market pool. Although the Affordable Care Act does not provide an explicit effective date for section 1312(c), we interpret it to be effective for plan years (in the individual market, policy years) beginning on or after January 1, 2014, given its dependence on and interaction with the new market reforms, as well as its explicit reference to the establishment of the Exchanges in 2014. Section 1312(c) does not apply to grandfathered health plans.

Lastly, section 1302 of the Affordable Care Act specifies levels of cost-sharing protections that health plans will offer, including in subsection (e) a catastrophic plan for young adults and people who cannot otherwise afford health insurance.

C. Rate Increase Disclosure and Review

Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act, which directs the Secretary, in conjunction with the states, to establish a process for the annual review

²⁶ In addition, although not the subject of this proposed rule, section 1252 of the Affordable Care Act generally provides that any standard or requirement adopted by a state pursuant to title I of the Affordable Care Act (or an amendment made by title I) shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. Sections 1302(e) and 1312(c) of the Affordable Care Act and the amendments to PHS Act sections 2701, 2702, and 2703 are all found in title I of the Affordable Care Act.

of “unreasonable increases in premiums for health insurance coverage.” The statute provides that health insurance issuers must submit to the Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794 also specifies that beginning with plan years beginning in 2014, the Secretary, in conjunction with the states, shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. Section 2794 of the PHS Act does not apply to grandfathered health insurance coverage, nor does it apply to self-funded plans.²⁷

On May 23, 2011, CMS published a final rule with comment period (76 FR 29964), to implement the annual review of unreasonable increases in premiums for health insurance coverage called for by section 2794. Among other things, CMS established a process by which all proposed rate increases above a defined threshold in the individual and small group markets would be reviewed by a state or by CMS to determine whether or not the rate increases are unreasonable. These rates would be reviewed by the state in states with Effective Rate Review Programs and by CMS in states without Effective Rate Review Programs. For 2011, the review threshold was a rate increase of 10 percent or more. CMS also established a process for a state to set a state-specific threshold for future calendar years.

We are proposing revisions to the rate review program that would standardize and streamline data submission, fulfill the new requirement beginning in 2014 that the Secretary monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange, and establish new standards that incorporate the effect of the market

²⁷ In addition, through regulation, section 2794 does not apply to health insurance issuers offering health insurance coverage in the large group market.

reform provisions that take effect in 2014.

III. Provisions of the Proposed Regulations

Collectively, the proposed regulations regarding modified community rating, guaranteed availability, guaranteed renewability, and risk pooling create the foundation for a competitive and accessible health insurance market starting in 2014. The Affordable Care Act allows individuals and employers to obtain and renew health insurance coverage without regard to enrollees' health status. Health insurance premiums will no longer be based on enrollees' pre-existing conditions or gender, and health insurance issuers no longer will be able to divide up their risk pools (also known as blocks of business) in order to discriminate against less healthy individuals. These proposed rules would clarify health insurance issuers' obligations under these reforms.

These proposed rules regarding insurance market reforms are inextricably linked to several other reforms in the Affordable Care Act that function to expand access to and affordability of coverage. For example, subtitle D of title I of the Affordable Care Act authorizes the establishment of Exchanges where individuals and small employers can enroll in QHPs and creates certain premium stabilization programs for the reformed marketplace. Further, Code section 36B provides for premium tax credits for eligible individuals who enroll in QHPs through Exchanges. Similarly, Code section 45R provides for small business tax credits for eligible employers who enroll in health insurance coverage through the Small Business Health Options Program (SHOP). Although these other reforms are not the subjects of this proposed rule, they do influence the options available for implementing this proposed rule.

As noted, the proposed rule would make technical changes to clarify the processes that

CMS uses to enforce Affordable Care Act reforms with respect to issuers and non-federal governmental group health plans. The proposed rule also would codify the policies related to catastrophic plans.

A. Fair Health Insurance Premiums (Proposed §147.102)

PHS Act section 2701 provides that health insurance issuers may vary premium rates for health insurance coverage in the individual and small group markets²⁸ based on a limited set of specified factors. The factors are, with respect to a particular plan or coverage: (1) whether the plan or coverage applies to an individual or family; (2) rating area; (3) age, limited to a variation of 3:1 for adults; and (4) tobacco use, limited to a variation of 1.5:1.²⁹ All other rating factors are prohibited. Thus, PHS Act section 2701 effectively prohibits several factors currently in use today, such as health status, claims experience, gender, industry, occupation, and duration of coverage, among others. Other factors that might be considered for rating purposes, such as eligibility for tax credits, prior source of coverage, and credit worthiness, also are prohibited. The practice of “re-underwriting” also is prohibited. Re-underwriting refers to issuers increasing premiums at renewal for existing customers because they incurred claims or experienced worsening health during a policy year.³⁰

²⁸ Consistent with our later discussion of the single risk pool provision, all non-grandfathered health insurance coverage offered through associations and multiple employer welfare arrangements (MEWAs) is subject to the modified community rating rules applicable to the appropriate market, as defined by PHS Act section 2791(e)(1), (3), and (5) (definitions of individual market, large group market, and small group market, respectively).

²⁹ The age, tobacco use, and geographic factors are multiplicative. For example, the maximum variation for both age (for adults) and tobacco use is 4.5:1 (3 times 1.5:1), putting aside the issue of wellness discounts, which are discussed later in this preamble. The family rate calculation could be additive or multiplicative, depending on whether a per-member or family tier rating methodology is used, as explained later in this preamble.

³⁰ In addition, health insurance issuers currently are prohibited from requiring any individual to pay a premium greater than that for another similarly situated individual enrolled in group health insurance coverage on the basis of a health factor. Further, issuers currently are prohibited from charging persons enrolled in group or individual health insurance coverage higher premiums due to genetic information. PHS Act sections 2702, as in

For purposes of family coverage, any premium variation for age and tobacco use must be applied to the portion of premium attributable to each family member. PHS Act section 2701(a)(2)(A) specifies that states can establish one or more rating areas. PHS Act section 2702(a)(2)(B) provides that CMS may establish rating areas if a state does not establish them. CMS, in consultation with the NAIC, will define permissible age bands. All non-grandfathered health insurance coverage in the individual and small group markets is subject to the requirements in this section.³¹ In addition, health insurance coverage in the large group market is subject to these requirements, inside and outside an Exchange, if a state permits such coverage to be offered through an Exchange starting in 2017.³² As discussed earlier, we welcome comments on whether and how this proposed rule could be modified to simultaneously secure the protections required by law and keep premiums affordable for individuals and small employers purchasing non-grandfathered health insurance coverage in these markets.

1. State and Issuer Flexibility Related to Rating Methodologies

While PHS Act section 2701 limits how issuers may vary premiums, the statute does not specify detailed rating methodologies. By rating methodology, we refer to the array of choices made in setting prices – for example, the age curves an issuer would use to distribute rates within the 3:1 limit on adult rates as enrollees grow older. The rating methodology also could include

effect when the Affordable Care Act was enacted (group market), and 2753 (individual market). In addition to these requirements, starting in policy years beginning on or after January 1, 2014, issuers will be prohibited from requiring any individual enrolled in non-grandfathered individual market coverage to pay a premium greater than that for another similarly situated individual on the basis of a health factor. PHS Act section 2705.

³¹ By law, issuers must transition all non-grandfathered small group and individual market coverage issued prior to January 1, 2014, to these adjusted community rating rules in the first plan year (small group market) or the first policy year (individual market) beginning on or after January 1, 2014, even if the issuers previously used other rating rules for products in these markets.

³² These requirements apply to health insurance coverage and therefore are not applicable to self-insured plans.

the method for computing rates in the small group market and the methods for computing family premiums. In current practice, most aspects of rating methodology are left to the discretion of health insurance issuers, subject to oversight by the states. As discussed later, greater standardization in rating methodologies starting in 2014 is advantageous for a number of reasons, including consumer protection, improved transparency, improved competition, and administrative simplification. We discuss various types of choices in rating methodology in more detail in the succeeding sections of this preamble, and welcome comment on them.

This proposed rule implements our authority under PHS Act section 2701 and would apply to all non-grandfathered health insurance coverage in the individual and small group markets starting in 2014. This rule proposes to standardize rating methodologies, particularly with respect to age rating and certain aspects of family rating, for health insurance coverage in the individual and small group markets when the market reforms go into effect in 2014. This proposed rule allows flexibility for states and issuers in rating methodology when it comes to certain aspects of family, tobacco, age, geography, and small group rating.

More standardization with respect to rating methodologies is advantageous in many respects. First, the risk adjustment methodology under section 1343 of the Affordable Care Act will need to accommodate permissible rating factors under PHS Act section 2701.³³ A standardized rating methodology for all plans within a state would enhance the transparency, predictability, and accuracy of risk adjustment because the risk adjustment methodology would account for rating as it is applied by issuers. For example, without a specified age curve, the risk

³³ For additional background, see CCIIO, *Risk Adjustment Implementation Issues* (2011), pp. 17-23, available at: http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf.

adjustment methodology would have to rely upon an estimate of a state-level average age curve. This estimate, when applied to specific issuers, could lead to a loss of accuracy in the calculation of a plan's average actuarial risk to the extent the issuer's rating curve varies from the estimated average curve. To the extent there is decreased accuracy in the risk adjustment methodology as a result of such an approximation, its goals of promoting competition based on service and effective care, rather than risk selection, may be undermined and consumers and issuers would be negatively affected.

Furthermore, some core functions of the Exchange, such as calculating rates for QHPs and determining the benchmark plan for purposes of the premium tax credit under Code section 36B, would be simplified if issuers used the same age curves, age bands, and family rating methods. The second lowest cost silver plan is the benchmark plan that will be used to determine the maximum amount an applicant can receive for premium tax credits. If issuers choose their own age curves, age bands, and family rating methods, the definition of the second lowest cost silver plan would likely vary by applicant. In contrast, standardizing rating methodologies will result in all applicants having the same plan from the same issuer as the second lowest cost silver plan, regardless of the applicant's age and family composition, in a given rating area. This will improve price transparency for consumers by facilitating their ability to identify the second lowest cost silver plan. Lastly, allowing differences in rating methodologies between issuers in the same market in a state could provide an avenue for adverse selection.

The following sections discuss the proposed rating methodology. We welcome comments on the areas where and the extent to which state and issuer flexibility in rating methodologies versus a more standardized approach is desirable.

2. Small Group Market Rating

Two rating methods are used currently in the marketplace to generate small group market rates. The first method, known as composite rating, uses the rating characteristics of an entire small group, such as the average employee health risk,³⁴ average employee age, geography, group size, and industrial code, to determine an average per-employee rate (along with corresponding average family tier rates) for the small group. We understand that a few states require this approach. In states without such requirements, issuers generally use this approach for groups with, for example, more than ten employees. In contrast, under the second method, the issuer calculates a separate rate for each employee's coverage based on the allowable rating factors for that employee and then sums each individual rate to determine the total group premium. This approach is often used for very small groups (for example, those with ten or fewer employees).

Given that PHS Act section 2701 does not distinguish between individual and small group market rating, we propose that issuers would calculate rates for employee and dependent coverage in the small group market on a per-member basis, in the same manner that they would calculate rates for persons in the individual market, as discussed below, and then calculate the group premium by totaling the premiums attributable to each covered individual. Per-member rating is required by PHS Act section 2701(a)(4), which specifies that the age and tobacco use factors be apportioned to each family member. However, as discussed below, this proposed rule does not preclude the possibility that employees and their dependents would be charged amounts

³⁴ The HIPAA non-discrimination provisions currently prohibit individual employees enrolled in a group health plan from being required to pay higher premiums or make higher contributions based on their health status (26 CFR 54.9802-1; 29 CFR 2590.702; 45 CFR 146.121).

based on their group's average, rather than amounts based on their own specific factors, notwithstanding that issuers must base the total premium for a group on its actual current enrollment. We propose that states which anticipate requiring premiums to be based on average enrollee amounts submit information to CMS not later than 30 days after the publication of the final rule to support the accuracy of the risk adjustment methodology.

In the group context, the allowable rating factors, including tobacco use, would be appropriately associated with specific employees and dependents. Additionally, with per-member rating, premium changes for new hires and departures during the year would be priced more accurately, an issue of particular importance in smaller groups. And in the SHOP, when employees are offered choices among plans and issuers, the additional cost or savings resulting from an employee's plan choice would also be priced more accurately, ensuring that each issuer receives appropriate premiums for the individuals choosing its health plans.

The use of per-member rating would give employers flexibility to choose how to allocate their contributions to employees' coverage. PHS Act section 2701 governs the basis upon which an issuer may permissibly charge different groups or individuals different rates for the same insurance product, but it does not specify how an employer will allocate the premium contributions among employees.³⁵ Although many variations may be consistent with applicable

³⁵ Employer/employee contribution levels are subject to other laws. PHS Act section 2705(b) prohibits group health plans from discriminating based on health status against similarly situated individuals in terms of contribution amounts. This nondiscrimination requirement generally was carried over to the Affordable Care Act from HIPAA. The relevant HIPAA authorities currently in effect for group health plans and group health insurance coverage are Code section 9802, ERISA section 702, and PHS Act section 2702 (prior to being renumbered and amended by the Affordable Care Act), as well as 26 CFR 54.9802-1, 29 CFR 2590.702, and 45 CFR 146.121. Guidance concerning employer/employee contributions has been provided by the Equal Employment Opportunity Commission in connection with the age discrimination requirements (29 CFR 1625.10(d)(4)(ii)).

state and federal law, we anticipate that there are two primary ways employee contributions may be determined.

An employer may choose to set the employee contribution as a percentage of the underlying cost of the employee's coverage. Under this option, older employees and smokers would make higher contributions toward coverage, reflecting their higher risk and permissible rate variation based on age and tobacco use. Younger employees would make lower contributions, which may improve the perceived value of insurance for these employees and increase take-up rates, making it easier for the employer to meet any minimum participation rate requirement that may apply.

Alternatively, after the issuer develops rates using the per-member methodology, an employer may elect to generate a composite rate in which each employee's contribution for a given family composition is the same, as most employers offering coverage do today, by adding the per-member rates and dividing the total by the number of employees to arrive at the group's average rate and determine employer and employee contributions based on that composite rate. This flexibility for small employers would take into account that many employers, states, and issuers are already accustomed to composite rating, it is relatively simple, and this method may be beneficial to older employees. However, this composite method may differ from how composite rates often are developed today. This decision will be up to employers.

We seek 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. In particular, we seek comment on the implications of this approach for employers and

employees, whether it is more compatible with employee choice in the SHOP, and whether it leads to more accurate pricing of employee choices.

3. Family Rating

PHS Act section 2701(a)(1)(A)(i) 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.

The rule proposes that issuers add up the rate of each family member to arrive at a family premium.³⁶ However, we propose that the rates of no more than the three oldest family members who are under age 21 would be taken into account in computing the family premium. This policy is intended to mitigate the premium disruption for larger families accustomed to family tier structures, which typically cap the number of children taken into consideration in setting premiums. We propose a cut-off age of 21 for this cap so that it is consistent with the cut-off age used in the proposed rule on age rating, as well as the requirement that child-only policies be available to those under age 21. We do not propose a similar cap on the number of family members age 21 and older whose per-member rates would be added into the family premium.

Consistent with PHS Act section 2701(a)(4), the proposed per-member approach to family rating ensures that any variation in premium by age or tobacco use is applied to the appropriate family member. Per-member rating also simplifies the administration of risk adjustment because the risk associated with each family member would be easily identified. We

³⁶ Under this approach, the issuer would charge the same per-member premium for all family members of the same age and tobacco use status. The issuer could not charge different rates for family members of the same age and tobacco use status based on their status, for example, as the policyholder, spouse, or dependent.

solicit comments on the use of the per-member build-up methodology for individual and small group market coverage. In addition, we request comments on 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 appropriate cut-off age for a per-child cap (for example, whether this should be aligned with the extension of dependent coverage to age 26 instead).

Currently, some issuers apply specified family tier or family composition multipliers to a base premium to arrive at a family rate. Other issuers may determine a family premium rate based upon the policyholder or oldest adult's age. These current practices are impermissible under PHS Act section 2701(a)(4) to the extent that the multipliers or the base premium vary based on age or tobacco use, since some family members would be rated using factors that do not apply to them individually. However, this conflict does not exist in a state that does not permit variation based on age or tobacco use.

Accordingly, the proposed rule would permit a state to require issuers to use a standard family tier methodology (with corresponding multipliers) if the state requires pure community rating, without any adjustments for age or tobacco use. The multipliers for the tiers would need to be actuarially justified to ensure that health insurance issuers could not charge excessively high premiums to individuals or families that would render meaningless their guaranteed availability rights under PHS Act section 2702. PHS Act section 2701 does not require that issuers use a two-tier structure (that is, individual and family). For example, a state would be able to specify a four-tier structure (that is, individual; individual and spouse; individual and child/children; and all other families). If a state anticipates adopting such a policy in the event this proposed approach is finalized, we propose such states submit relevant information on their

proposed family tiers to CMS no later than 30 days after the publication of the final rule to support the accuracy of the risk adjustment methodology.

We propose that if a state has pure community rating in place, but does not adopt a uniform family tier methodology (with corresponding multipliers), the per-member rating methodology would apply as the default. In a state that does not require community rating, an issuer that voluntarily uses pure community rating would need to use per-member rating, given the absence of a uniform family tier methodology in that state. We solicit comment on whether, instead of permitting flexibility in the final rule, states with pure community rating should also use the per-member approach that would be used in states that allow age and tobacco use adjustments.

4. Persons Included Under Family Coverage

Currently, issuers have considerable flexibility in determining how to set rates for family policies and in defining which family members may be on the same policy, subject to federal and state laws requiring coverage of certain individuals (for example, dependent children under age 26 pursuant to PHS Act section 2714, if a plan or issuer otherwise offers dependent child coverage). Our research indicates that covered family members typically include the employee or individual market policyholder; a spouse or partner, as defined by state law; biological children; adopted children; and children placed for adoption. Sometimes other classes of people are covered, such as stepchildren, grandchildren, other children related by blood, foster children, and children under guardianship.

We request comments on whether the final rule should specify the minimum categories of family members that health insurance issuers must include in setting rates for family policies,

or whether we should defer to the states and health insurance issuers to make this determination. We also request comments on the types of individuals who typically are included under family coverage currently, including types of covered individuals who would not meet the classification of tax dependents. We note that any family member not covered under a family policy would be eligible for an individual policy pursuant to guaranteed availability of coverage under PHS Act section 2702.

5. Rating for Geography

PHS Act section 2701(a)(1)(A)(ii) provides that rates may vary by rating areas. PHS Act section 2701(a)(2) provides that a state must establish one or more rating areas within that state. CMS is charged with reviewing the adequacy of the rating areas established by a state. If the state's rating areas are inadequate (for example, they do not cover a sufficient number of individuals) or a state does not act, CMS may establish such rating areas. Although section 2701 does not specify the maximum variation for a rating area factor, in contrast to its specifying the maximum age factor (3:1 for adults) and the maximum tobacco factor (1.5:1), a rating area factor should be actuarially justified to ensure that issuers do not charge excessively high premiums that would render meaningless the guaranteed availability rights of individuals and employers under PHS Act section 2702.

Currently, in most states, issuers have considerable flexibility in establishing their rating areas. The rule proposes that a state could establish no more than seven rating areas within the state along geographic divisions, generally consistent with the maximum number in states today. The proposed rule makes no distinction between health insurance coverage offered inside or outside an Exchange, so these rating areas would apply equally to all non-grandfathered

coverage in the individual or small group market.

The choice of a maximum of seven areas in the proposed rule is based on the higher-end of the number of rating areas that states currently have established in the individual and small group markets (for example, Massachusetts, New Jersey, and Oregon). We believe that setting an upper limit on the number of rating areas provides states with the flexibility needed to designate rating areas that are adequately sized and accommodate local market conditions, while avoiding an excessive number of rating areas that would be confusing to consumers and not reflect significant market differences. We solicit comments on the maximum number of rating areas that may be established within a state and the potential standards for determining an appropriate maximum number.

Taking into account the spectrum of current rating rules regarding geography and the need for state flexibility to account for local market conditions, the proposed rule includes three standards for the geographic divisions based on standards that we understand states and issuers currently use for rating areas. A state could select one of the approved standards that we would presume “adequate” or submit its own standard, which would be subject to approval. These are: (1) one rating area for the entire state; (2) rating areas based on counties or three-digit zip codes (that is, areas in which all zip codes share the same first three digits); or (3) rating areas based on metropolitan statistical areas (MSAs) and non-MSAs. The proposed rule would not require that all the sections of a rating area be geographically adjacent. For example, a state could create a rating area comprised of all non-MSA portions of a state that have similar health care costs.

Under the first standard, there would be one rating area for the entire state. While this approach would make it easier to establish and monitor rating areas, it may be most practical in

states where there is not significant variation in health care costs among the different regions of the state.

Under the second standard, the rating areas would be based on counties or three-digit zip codes. A state using this method would be expected to use either counties or three-digit zip codes, but not both. In the United States, there are 3,068 counties, varying greatly in size and population. There are approximately 455 three-digit zip codes in the United States. Three-digit zip codes generally cover larger areas than a county. Current NAIC rating guidance notes that many small group plans currently use rating areas based on three-digit zip codes or counties.³⁷

Under the third standard, rating areas could be based on the state's MSAs and non-MSAs. MSAs encompass at least one urban core with a population of at least 50,000 people, plus adjacent territory that has a high degree of social and economic integration with the core. MSAs are always established along county boundaries, but may include counties from more than one state. The 367 MSAs in the United States include approximately one-third of the counties and 83 percent of the population of the United States. MSAs could provide a convenient and established method of grouping counties into larger areas. Further, current NAIC rating guidance suggests that MSAs be considered as one possible standard for rating areas. For MSAs that cross state boundaries, we propose that these should be divided between the respective states if the MSA option is adopted. States with counties not encompassed by an MSA could create one or more non-MSA rating areas for those counties. For states with more than seven MSAs and non-MSA areas, we propose that these states combine some of the areas into no more than

³⁷ NAIC, Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance (2003), p. 33.

seven rating areas based on a reasonable methodology, such as cost similarity.

We request comments regarding the use of these proposed standards for rating areas, as well as comments regarding other options for standards for geographic divisions and other relevant factors that could be used for developing rating areas. We request comments from states that already have standard rating areas regarding what changes, if any, would be necessary to meet one or more of the proposed standards and the proposed limit of having no more than seven rating areas. We also request comments on whether the final rule should establish minimum geographic size and minimum population requirements for rating areas and whether state rating areas currently in existence should be deemed in compliance with this provision.

To the extent a state establishes rating areas using the proposed standards, that is one rating area for the entire state, or no more than seven rating areas if counties, three-digit zip codes, or MSAs/non-MSAs are used, we propose that the state's rating areas would be presumed adequate. We propose that CMS would take a more active role in assessing the adequacy of the state's rating areas when a state designates rating areas based on geographic divisions other than those identified in the proposed rule.

In the event that a state does not establish rating areas consistent with the proposed standards, the one-area-per-state standard would apply, unless we applied one of the other standards to designate rating areas in a particular state. In that case, we likely would be inclined to use the MSA/non-MSA standard. To the extent that we establish a state's rating areas, we would work with the state, local issuers, and others to determine how best to establish rating areas responsive to local market conditions.

We recognize that states and issuers need lead time to update pricing models and make

related system changes to accommodate potentially new rating areas in 2014. To support the accuracy of the risk adjustment methodology, we propose that states needing such lead time submit relevant information on their rating areas to CMS within 30 days after the publication of the final rule. Lastly, we recognize that states may wish to establish or modify their rating areas after 2014. For example, states might wish to modify rating areas in light of local utilization and cost patterns, issuer service areas, or changes in MSA designations. We request comments on appropriate schedules and procedural considerations related to rating area designations for plan years after 2014.

6. Rating for Age

PHS Act section 2701(a)(1)(A)(iii) provides that the premium rate charged by an issuer for non-grandfathered health insurance coverage in the individual or small group market may vary by age, but may not vary by more than 3:1 for adults. The statute does not specify a premium rating limitation for children, but it provides that the 3:1 adult ratio must be “consistent with section 2707(c)” of the PHS Act. Section 2707(c), in turn, requires that child-only plans be made available to individuals under age 21.

We believe the statutory language supports an interpretation that the 3:1 age rating limitation was intended to apply only to adults age 21 and older. Further, we believe that PHS Act section 2702 supports a requirement that issuers set actuarially justifiable child rates using a standard population, to prevent the charging of unjustified premiums that would, in effect, prevent individuals under age 21 from exercising their guaranteed availability rights. Accordingly, we propose to allow rates to vary within a ratio of 3:1 for adults (defined for purposes of this requirement as individuals age 21 and older), and that rates must be actuarially

justified based on a standard population for individuals under age 21, consistent with the proposed uniform age curve discussed later in this section. We request comment on this approach.

We propose that enrollees' age factors and bands should be determined based on an enrollee's age at policy issuance and renewal, so that age rating factors are applied on a consistent basis by all issuers and that consumers (including those purchasing policies covering multiple family members) do not receive multiple premium increases each year. This is the same measurement point as the first day of a plan or policy year, which is the age determination point for catastrophic plans. We request comments on whether other measurement points (for example, birthdays) might be more appropriate.

PHS Act section 2701(a)(3) directs CMS, in consultation with the NAIC, to define "permissible age bands" for purposes of age rating. Age bands are simply ranges of sequential ages. In the context of health insurance, they are often used to segregate where the slope of premium rate variation by age changes, the most common being that the slope is zero within the band (that is, does not change), and non-zero from one band to the next band in the sequence (for example, persons aged 30 to 34 pay the same premium, but lower than those age 35 to 39, who pay the same premium to each other, and similarly for age 40 to 44, etc.).

In accordance with section 2701(a)(3), we consulted with the NAIC, through its Health Care Reform Actuarial (B) Working Group, concerning the permissible age bands to be defined by CMS. The NAIC Working Group did not make specific recommendations, but provided valuable feedback regarding state regulation of age bands, issuer practices, and important policy considerations related to possible age band standards. Although state standards vary, and issuers

that set their own age bands do so using a variety of different methods, our discussions with the industry indicate that bands smaller than five years are common in the individual market. Taking into consideration the feedback we received from NAIC, we propose the following standard age bands for use in all states and markets subject to the rating rules of PHS Act section 2701:

- 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.

We propose these age bands for a number of reasons. First, with respect to children, we are proposing a single age band for child ages 0-20 to reflect the generally small differences in costs between children of various ages (other than newborns and very young children). We believe that a single age band for children will simplify and make risk adjustment methodologies more efficient, and allow consumers to more easily compare and predict costs as children age, particularly if the consumer has children that are several years apart in age. We solicit comments on whether multiple age bands or a single age band for children are appropriate.

Second, with respect to adults ages 21 to 63, we propose one-year age bands so that consumers would experience steady, relatively small premium increases each year due to age. If broader age bands are adopted (for example, five-year bands), consumers would experience larger premium increases when they reach the end of one age band and move into the next. Although five-year bands are currently common in the small group market, we are also proposing to apply the same age-band structure to the small group market to align with our

proposal that the per-member rating buildup approach be used in both the individual and the small group markets. We request comment on this approach.

Finally, we propose a single age band for adults age 64 and older largely to facilitate compliance with the Medicare Secondary Payer requirements when per-member rating is used for older individuals in the small group market. Medicare Secondary Payer requirements generally prohibit an employer with 20 or more employees from charging Medicare-eligible employees a premium that is higher than the premium charged to non-Medicare-eligible employees (section 1862(b)(1)(A) of the Social Security Act, 42 USC 1395y(b)(1)(A); 42 CFR 411.102(b), 411.108(a)(6)). Consequently, we believe that the highest age band used to generate individually rated premiums must begin before age 65, when individuals generally are not eligible for Medicare based on age. We believe this proposed age band is reasonable because individuals age 64 and older represent only a small proportion of enrollees in the individual and small group markets, and are likely to have similar claims costs despite their age differences. We seek comment on this approach.

This proposed rule would direct health insurance issuers within a market in a state to use a uniform age rating curve. An age curve is a specified distribution of relative rates across all age bands. Reflecting statutory requirements, our proposed age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive. We believe that using uniform age bands and rating curves will simplify identification of the second lowest cost silver plan used to determine premium tax credits, and will provide an incentive for issuers to compete to offer plans that provide the best value across the entire age curve. Doing so will also promote the accuracy of the risk adjustment program established under section 1343

of the Affordable Care Act, which is essential to ensuring market stability in the reformed marketplace, and reduce the potential for adverse selection.³⁸ A standardized rating methodology for all plans within a state would also enhance the transparency, predictability, and accuracy of the risk adjustment program because the risk adjustment methodology could account for age rating as it is applied by issuers.

We are proposing to apply the same default age rating curve to both the individual and small group markets. Our proposed uniform age curve assumes that issuers will vary premiums to the greatest extent permissible within the 3:1 age rating constraint for adults (or narrower ratios as provided under state law). We have constructed our proposed age curve based on gross premium amounts, which includes administrative, overhead, and marketing costs in addition to the amount attributable to enrollee claims costs, without accounting for any tax credits that may offset a consumer's premium costs. Because our analysis of premiums found evidence that issuers do not vary their age curves across much of the 21-64 age band in significant amounts across geography or product types, we do not believe that applying a uniform rating curve to individual and small group markets would disadvantage issuers according to the geographic region they are licensed in, or the value of the coverage that the product/plan type offers.³⁹

Our review of base premium rates for 60,000 covered lives (based on data reported on HealthCare.gov by a sample of regional issuers operating in different regions of the country) has

³⁸ We have developed our proposed age curve based on our assumptions of the distribution of claims costs by age in the post-2103 market. Although it is difficult to exactly predict the composition of the post-2013 market and the actual claims costs that will be incurred, we developed our proposed age curve using assumptions that are consistent with those utilized for the risk adjustment program, as described in our Premium Stabilization Rule (77 FR 17220).

³⁹ We measured the value of plan coverage by approximating plan actuarial value (AV) on the same scale that we use to separate plans into four metal tiers. For the purposes of our analysis, we designated plans with AVs of 0.55-0.75 as "low value" plan designs, 0.75-0.85 as "medium value" plan designs, and 0.85-0.95 for "high value" plan designs.

shown that base premium rates vary according to age at a mostly consistent rate, and are largely unaffected by product type/plan design or geographic region.⁴⁰ Furthermore, an examination of the large group insurance market demonstrates clear evidence that issuers generally utilize an underlying cost curve that varies by age in a manner that is independent of the value of the plan coverage.⁴¹ The analysis of the large group market is particularly relevant as a predictor of post-2014 individual and small group market rating practices because the large group market is characterized by coverage for most essential benefits, has guaranteed availability of coverage, and does not use person-specific underwriting; these types of rates will likely be more characteristic of those of the reformed 2014 individual and small group market. Consequently, we do not believe that issuers need the flexibility to vary age curves across product/plan designs or geographic regions after taking into account the requirement for a 3:1 rating restriction, or that applying a uniform age curve to issuers in the individual and small group markets will lead to any significant disturbance in issuer pricing practices across different geographic regions or plan designs. Therefore, we are proposing that CMS's uniform age curve would apply by default in a state, unless a state adopted a different uniform age curve. We request comment on the application of a single, default age curve to the individual and small group market based on the above assumptions and the methodology for doing so.

We propose that we would fit our uniform age curve to the 3:1 adult age rating limit by

⁴⁰ Reporting of base premium rates for the individual market to HealthCare.gov does not take into account any additional premium due to health status, which is commonly added in the individual market. These rates, therefore, are not necessarily the actual premiums paid by the 60,000 enrollees in those plans.

⁴¹ For the purposes of this analysis, we analyzed two separate employer databases with data from a combination of large and small employers. One database consisted of 303,000 individuals with 12 continuous months of coverage (to account for seasonal variation in claims costs) that were employed at firms with 50-250 employees. The second database of large employer coverages (including self-insured employers) was composed of 33 million individuals with 12 months of continuous coverage.

“flattening” the ends of the age curve derived from expected claim cost patterns in a manner that accommodates the 3:1 premium ratio limit for the highest and the lowest adult ages. Under this approach, when other factors (for example, mix of gender, tobacco use, geographic region, and plan type) are held constant among ages, the rate of premium change from one age to the next will closely mirror the rate of expected claims costs, except for those ages closest to age 21 and age 64.⁴² As compared to an approach that would proportionally compress the curve (that is, the relationship between premiums by age) for all ages, this proposed approach would ensure that the fewest number of individuals (or employees, in the small group market) would be affected by the 3:1 premium ratio constraint, thereby mitigating premium disruption for the largest number of consumers, and reducing the need for significant risk adjustment across age bands. We propose that we would revise our default curve periodically to reflect our most current knowledge of the individual and small group market (for example, enrollment, population distribution, and cost patterns) following implementation of 2014 reforms. We request comment on our proposed approach for fitting the proposed adult age curve to the statutorily specified 3:1 premium ratio.

With respect to the age curve for children’s ages, we have constructed a proposed default curve using a single age band for ages 0-20, using the same data sources that we used to derive our proposed adult age curve, as described above. The value of our proposed default age curve for ages 0-20 was supported by the actual experience for those ages. The shift from the child age curve at age 20 to the adult age curve at age 21 could result in a premium differential for these

⁴² For younger ages near age 21 and older ages closer to 64, the change of premium rates from one age to the next higher age would be lower than the change in expected claims costs for those ages.

ages that is not reflected in issuers' current rating practices. However, given the low premiums for individuals in these age groups, as well as the relative premium stability from age 21 through early 30s under the standardized age curve, we do not anticipate that this differential would result in a significant financial burden on consumers. While we do not believe that this discontinuity undermines the accuracy of the methodology we used to develop our proposed child and adult age curves, we request comment on potential implications that the transition from the proposed child curve to the proposed adult curve may have for issuers and consumers. We also seek comment on the proposed rating curve, including whether it is generally consistent with current insurer rating practices and minimally disruptive to the current market within the confines of the rating restrictions and reforms under the Affordable Care Act.

CMS Proposed Standard Age Curve

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

Although we are proposing a uniform age rating curve for the reasons described above,

our proposed approach would maintain flexibility for states and issuers regarding certain aspects of age rating. In most states, premium rates for health insurance coverage are permitted to vary by age to the extent that issuers can actuarially justify such rates; this practice could continue within the boundaries of the proposed policy. A state law that prescribed a narrower ratio for adults (for example, 2:1) or prohibited different adult rates altogether would not be preempted under PHS Act section 2724(a)(1) since such state law would not “prevent the application” of section 2701.⁴³ To support the accuracy of the risk adjustment methodology, we propose that states using narrower ratios submit relevant information on their ratios to CMS no later than 30 days after the publication of the final rule. We also seek input on the consequences of these choices in terms of the likely percentage premium increases that consumers will face when aging from one age band to another, the impact on the administration and accuracy of risk adjustment, the administration of premium tax credits, and consumer convenience. We propose that states would have the option to designate a uniform age curve other than the CMS age curve. If a state anticipates using its own age curve, we propose the state submit relevant information on its proposed curve to CMS no later than 30 days after the publication of the final rule to support the accuracy of the risk adjustment methodology.

7. Rating for Tobacco Use

PHS Act section 2701(a)(1)(A)(iv) provides that health insurance issuers in the individual and small group markets cannot vary rates based on tobacco use by more than 1.5:1.⁴⁴ As

⁴³ In addition, section 1334(c)(5) of the Affordable Care Act, pertaining to multi-state plans, indicates that states may require “more protective” age rating requirements that are lower than 3:1 in their individual and small group markets.

⁴⁴ The interaction of PHS Act section 2701 with the wellness program rules under PHS Act section 2705(j) is discussed later in this section.

mentioned, PHS Act section 2701(a)(4) provides that the rating variation for tobacco use applies based on the portion of premium that is attributable to each family member covered under the plan. A state law that prescribes a narrower ratio (for example, 1.25:1) or prohibits varying rates for tobacco use altogether would not be preempted since such state law would not impose a standard or requirement that conflicts, or makes it impossible to comply, with permissible rating practices under federal law, and thus would not prevent the application of PHS Act section 2701.⁴⁵ If a state anticipates adopting narrower ratios for tobacco use, we propose that the state submit relevant information on their ratios to CMS no later than 30 days after the publication of the final rule.

Currently, many states allow health insurance issuers in the individual and small group markets to vary premiums based on tobacco use. In addition, many states limit the amount by which premiums can vary due to tobacco use by allowing use of that factor only within their overall health status limits. For example, the NAIC's Small Employer Health Insurance Availability Model Act (1993 Version) does not specifically identify tobacco use as a permissible rating factor, but allows its use within the overall 1.67:1 ratio for the health status of the employees or dependents of the small employer.

There is not a clear and consistent definition of tobacco use among the states for rating purposes. Numerous states such as Louisiana, Maine, Massachusetts, Minnesota, and New Mexico allow tobacco use to be considered as a rating factor in both the individual and small

⁴⁵ Although not the subject of this NPRM, we note that the tobacco use rating factor is not taken into account in determining the amount of the premium tax credit under Code section 36(b)(3)(C).

group markets. While these states provide a definition of what constitutes a tobacco product, they do not specifically define “tobacco use.”

We understand that issuers typically rely on self-reported data, such as information from applications and health risk assessments, to determine tobacco usage. Since applications and health risk assessments vary from issuer to issuer, there is wide variation in how issuers define tobacco use.

One possible approach for purposes of implementing this provision upon which we invite comment would be to include one or more questions on tobacco use in the single streamlined application under §155.405, or in connection with other enrollment-related processes for an Exchange. We specifically invite comment on the possible use of the single streamlined application to collect information concerning tobacco use in connection with a premium surcharge, as well as alternative options for identifying tobacco use, as well as how the information should be collected with respect to health insurance coverage offered outside an Exchange.

The proposed rule does not prohibit issuers from varying the tobacco use factor used for a particular age band, as long as any variation is not greater than 1.5:1, the maximum variation for tobacco use under PHS Act section 2701(a)(1)(A)(iv), and is consistent with other applicable law, including the HIPAA nondiscrimination provisions. In other words, an issuer could use a lower tobacco use factor for a younger individual (for example, 1.3:1) compared to an older individual (for example, 1.4:1), as long as the factor does not exceed 1.5:1 for any age group. In contrast to the age rating factor, where we are proposing that issuers utilize a standard age curve, we are proposing that states or issuers have the flexibility to determine the appropriate tobacco

rating factor within a range of 1:1 to 1:1.5, consistent with the wellness requirements discussed below. We seek comments on this approach.

We also considered how the requirements under PHS Act section 2701(a)(1)(A)(iv) would interact with rewards for tobacco cessation offered as part of employer wellness programs. Tobacco cessation programs are a common aspect of employers' wellness programs. Prior to the enactment of the Affordable Care Act, the Departments of HHS, Labor, and the Treasury (jointly, the Departments) published final rules regarding the nondiscrimination and wellness program provisions under HIPAA (71 FR 75014, Dec. 13, 2006, referred to as the 2006 regulations).⁴⁶ The HIPAA wellness requirements implemented in these 2006 regulations were set forth in section 2702 of the PHS Act (with parallel provisions contained in ERISA section 702 and Code section 9802). While PHS Act section 2702 did not specifically impose any limit on rewards that could be offered under wellness programs, the 2006 regulations provided that plans and issuers could offer a reward that does not exceed 20 percent of the total cost of coverage in a health-contingent wellness program, provided specified consumer-protection conditions were met.⁴⁷

The Affordable Care Act added a new PHS Act section 2705(j), effective for plan years beginning on or after January 1, 2014. Section 2705(j) largely reflects the wellness provisions

⁴⁶ See 26 CFR 54.9802-1; 29 CFR 2590.702; 45 CFR 146.121. Prior to the issuance of the final 2006 regulations, the Departments published interim final regulations with request for comment implementing the HIPAA nondiscrimination provisions on April 8, 1997 at 62 FR 16894, followed by proposed regulations regarding wellness programs on January 8, 2001 at 66 FR 1421.

⁴⁷ The 2006 regulations also required that a wellness program be reasonably designed to promote health or prevent disease; give eligible individuals an opportunity to qualify for the reward at least once per year; make the reward available to all similarly situated individuals (and offer a reasonable alternative standard to any individual for whom it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard during that period (or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard)), and, in all plan materials describing the terms of the program, disclose the availability of a reasonable alternative standard.

from the 2006 regulations, with a few clarifications and modifications. Under PHS Act section 2705(j), plans and issuers generally can offer a reward of up to 30 percent of the cost of coverage⁴⁸ for participation in a wellness program that is based on an individual satisfying a standard that is related to a health status-related factor (“health factor”), subject to certain conditions. PHS Act section 2705(j) also authorizes the Departments to increase the maximum reward to as much as 50 percent of the total cost of coverage if they determine such an increase to be appropriate.

Contemporaneously with the publication of this proposed rule, the Departments are publishing a notice of proposed rulemaking (NPRM) under section 2705(j), which proposes to increase the maximum reward under a wellness program in group health coverage from 20 percent to 30 percent of the cost of coverage. The rule further proposes an increase of an additional 20 percentage points (to 50 percent) to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.

We propose in this rule that the definition of “tobacco use” for purposes of section 2701 be consistent with the approach taken with respect to health-contingent programs designed to prevent or reduce tobacco use under section 2705(j). That is, by proposing to raise the maximum permissible reward for participating in a tobacco cessation program in the wellness rule, we are proposing that a health insurance issuer in the small group market would be required to offer a tobacco user the opportunity to avoid paying the full amount of the tobacco use surcharge permitted under PHS Act section 2701 if he or she participates in a wellness program meeting

⁴⁸ While this new 30 percent limit is set forth in PHS Act section 2705(j), because the existing 20 percent limits were established by regulation, in the case of grandfathered health plans governed by the old version of section 2702, the 20 percent limit is proposed to be increased by the Departments in proposed regulations published contemporaneously with the publication of this proposed rule.

the standards of PHS Act section 2705(j) and its implementing regulations.⁴⁹

There are several positive aspects to implementing PHS Act sections 2701 and 2705(j) in a coordinated manner with respect to tobacco use in the small group market. Rather than have the tobacco use surcharge under PHS Act section 2701 be strictly a negative financial incentive, this approach would encourage tobacco users to pursue tobacco cessation remedies offered under their employers' wellness programs, enhancing their long-term health and potentially reducing health care costs. It also would alleviate underreporting for tobacco use since tobacco users who disclose their tobacco use would not automatically have to pay the premium surcharge, but could instead participate in the employer's cessation program. Finally, group health plans and health insurance issuers with wellness programs may find it administratively more efficient to implement the two provisions concurrently given that employers are familiar with the requirements of wellness programs associated with increased premiums related to a health factor. We welcome comments on this proposal and other ideas for coordinating the implementation of the tobacco surcharge under PHS Act section 2701 and the wellness provisions under PHS Act section 2705(j).

We also invite comment on possible definitions of "tobacco use" that could be applied for purposes of sections 2701 and 2705(j). One possible definition would rely on self-reporting as to whether the individual would be considered a tobacco user. Another possibility may be what some issuers use today: a defined amount of tobacco use within a specified look-back period. A third possibility may be to define "tobacco use" as regular, and not infrequent or sporadic,

⁴⁹ The wellness program NPRM proposes that the additional increase in the size of the reward for wellness programs designed to prevent tobacco use would not be limited to the small group market, to provide consistency across markets and to provide large group, self-insured, and grandfathered employment-based plans the same additional flexibility to promote tobacco-free workforces as small, insured, non-grandfathered health plans.

tobacco use (perhaps including some standard of frequency). Another option would define a tobacco user as one who uses tobacco with sufficient frequency so as to be addicted to nicotine. Regardless of how tobacco use is defined, we are proposing that the definition of “tobacco use” for purposes of section 2701 be consistent with the approach taken with respect to health-contingent wellness programs designed to prevent or reduce tobacco use under section 2705(j).

PHS Act section 2705(b) also prohibits issuers from charging enrollees in the individual market higher premiums based on health factors. However, PHS Act section 2705(j) does not apply to the individual health insurance market. To the extent there is any conflict between PHS Act sections 2701 and 2705 as applied to the individual market, we think the more specific language of PHS Act section 2701 allowing tobacco use surcharges prevails over the more general language of PHS Act section 2705 prohibiting premium differences based on health factors. In other words, issuers could implement the tobacco use surcharge in the individual market without having to offer wellness programs. However, we solicit comments on whether and how, consistent with PHS Act sections 2701 and 2705, the tobacco surcharge in the individual market could be combined with the same type of incentive to promote tobacco cessation that is available in the group market.

B. Guaranteed Availability of Coverage (Proposed §147.104)

PHS Act section 2702 provides that health insurance issuers that offer health insurance coverage in the individual or group market in a state must accept every individual and employer in the state that applies for coverage, subject to certain exceptions. These exceptions allow issuers to limit enrollment: (1) to certain open and special enrollment periods; (2) to an employer’s eligible individuals who live, work, or reside in the service area of a network plan;

and (3) in certain situations involving network capacity and financial capacity.

PHS Act section 2702 generally is based on the HIPAA provision for guaranteed availability in the small group market. Compared to HIPAA, however, the Affordable Care Act: (1) expands guaranteed availability beyond the small group market to include the individual and large group markets as well; (2) requires the establishment of open enrollment periods; (3) establishes new special enrollment periods in addition to those in HIPAA; and (4) eliminates the guaranteed availability exception for coverage offered only to bona fide association members in the small group market. Accordingly, this proposed rule generally is based on the HIPAA rule for guaranteed availability in the small group market (§146.150). In addition, the proposed rule would add a new marketing standard pursuant to PHS Act section 2702 that is identical to that applicable to QHPs established under 45 CFR 156.225.

The proposed rule would direct that issuers offer coverage to and accept any individual or employer in the state that applies for such coverage – regardless of health status, risk, or medical claims and costs – with limited exceptions.⁵⁰ Issuers would be required to offer all products that are approved for sale in the applicable market. We believe that the protections of the Affordable Care Act apply to all non-grandfathered health insurance coverage in an applicable state market. Accordingly, beginning in 2014, even non-grandfathered “closed blocks” of business would be available to new enrollees, subject to the limited exceptions discussed below. We welcome comments on this proposal.

We propose that issuers offering health insurance coverage in the group market would

⁵⁰ Other federal laws may restrict the health insurance coverage products available to certain individuals. For example, individuals must meet certain requirements related to residency, citizenship/immigration status, and non-incarceration in order to buy QHPs through an Exchange (45 CFR 155.305(a)).

maintain a year-round open enrollment period for employers to purchase such coverage, while issuers offering coverage in the individual market would offer plans during open enrollment periods (including the initial open enrollment period) consistent with those required by Exchanges for individual market QHPs. The effective dates of such coverage would align with the Exchange standards for the appropriate market (if any, in the case of the large group market). These standards are intended to minimize adverse selection by setting consistent open enrollment periods for the insurance marketplace, regardless of whether individuals or employers choose to purchase outside or through an Exchange. We solicit comments on whether this proposal sufficiently addresses the open enrollment needs of individual market customers whose coverage renews on dates other than January 1 and whether aligning open enrollment periods with policy years (based on a calendar year) in the individual market is more desirable. Given that employer groups generally pose less of an adverse selection risk than individuals and issuers currently are willing to offer them coverage at any point in the year, we believe that a year-round enrollment period for large and small employers will not be burdensome on issuers nor change the status quo in most states.

Prior to the Affordable Care Act, the HIPAA provision for guaranteed availability in the small group market had allowed issuers to establish employer contribution rules and group participation rules that small employers must meet in order to qualify for guaranteed availability, as allowed under applicable state law. PHS Act section 2702 does not include the contribution and participation exception to guaranteed availability; however, PHS Act section 2703 does include such an exception for guaranteed renewability. We are concerned that failing to provide a small employer contribution and participation exception to guaranteed availability by

regulation would trigger adverse selection against the small group market, given its year-round open enrollment period, vis-à-vis the individual market, which has a time-limited open enrollment period. In other words, some individuals could use the open-ended enrollment period for small employers to buy insurance only as medical needs arise, thereby creating instability in the small group market and increasing premiums for other small employers. Thus, the proposed rule would allow issuers to condition year-round open enrollment in the small group market on a small employer being able to satisfy the same contribution and participation requirements at issuance that the issuer is permitted to consider at renewal, either as allowed by state law or, in the case of a QHP offered in the SHOP, as permitted by §156.285(c). Establishing this requirement by rule effectively would preserve the status quo under HIPAA. If the final rule includes this requirement, we would also adopt corresponding changes in §155.725, which establishes the enrollment periods in the SHOP.

The proposed rule sets forth that issuers make available special enrollment periods in both the individual and group markets for individuals and plan participants and beneficiaries in connection with the events that would trigger eligibility for COBRA coverage under ERISA section 603.⁵¹ This set of special enrollment events is in addition to the special enrollment events provided under PHS Act section 2704(f) for loss of eligibility for other coverage or dependent special enrollment (that is, the special enrollment rights originally created under

⁵¹ For employees, COBRA events include a loss of coverage due to voluntary or involuntary termination of employment for reasons other than gross misconduct and reduction in the number of hours of employment. For spouses of covered employees, these events include a loss of coverage due to reasons that would make the employee eligible for COBRA, the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee. For children of covered employees, these events include a loss of coverage due to reasons that would make the employee eligible for COBRA, the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, death of the covered employee, and loss of dependent child status under plan rules.

HIPAA for group health insurance coverage and group health plans⁵²) and §155.420(d) and §155.725(a)(3) (the special enrollment rights for QHPs). The proposed rule directs that the election period would be 30 calendar days, which is generally consistent with the HIPAA standard. However, we request comment as to whether another standard, such as 60 calendar days, generally consistent with the Exchange standard, is more appropriate.⁵³ The proposed rule also would include standards regarding the effective dates of coverage modeled upon the effective dates of coverage provided for the QHP special enrollment events under §155.420(b). We also request comments on whether health insurance issuers in the individual market should provide to enrollees in their products a notice of special enrollment rights similar to what is currently provided to enrollees in group health plans (§146.117(c)).

In addition, the proposed rule would include provisions allowing issuers with network plans to limit guaranteed availability to employers with eligible individuals who live, work, or reside in the plans' service areas. While PHS Act section 2702(c)(1)(A) does not explicitly include a corresponding exception allowing issuers to limit the sale of individual market coverage to individuals who live or reside in the individual market plan's service area, failing to recognize such an exception would eliminate an issuer's ability to define a service area for its individual market business within a state. Moreover, references to persons with individual market coverage in paragraph (c)(1) and subparagraph (c)(1)(B) of PHS Act section 2702

⁵² The special enrollment framework originally created under HIPAA for special enrollment due to loss of eligibility for other coverage and dependent special enrollment is 30 days. The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 also added special enrollment rights to ERISA, the PHS Act, and the Code that allow employees to enroll in a group health plan or group health insurance coverage upon termination of Medicaid or CHIP coverage or eligibility for a premium assistance program under Medicaid or CHIP. Under these circumstances, an employee must request special enrollment within 60 days.

⁵³ See 26 CFR 54.9801-6, 29 CFR 2590.701-6, and 45 CFR 146.117 (HIPAA); and 45 CFR 155.420 (Exchange).

suggest that such persons with individual market coverage also were intended to be described in paragraph (c)(1)(A). Accordingly, the proposed rule would clarify that individual market coverage also may limit enrollment to those individuals who live or reside in a service area.

Issuers with network plans also would not have to offer coverage to employers and individuals if they demonstrated to the appropriate state authority that they lacked the capacity to deliver services adequately to additional groups or individuals due to their existing contractual obligations to current group contract holders and enrollees. Issuers would need to apply the denial of guaranteed availability uniformly to all employers and individuals, without regard to the enrollees' claims experience or health status-related factors. Issuers invoking this exception generally would be barred from offering new coverage for at least 180 calendar days after coverage is denied, as directed by PHS Act section 2702(c)(2).

As noted, PHS Act section 2702 does not include an explicit guaranteed availability exception allowing issuers to limit the offering of certain products to members of bona fide associations. However, in the appropriate circumstances, we think that the network capacity exception to guaranteed availability could be used to provide a basis for limiting enrollment in certain products to bona fide association members. Additionally, while the guaranteed availability exception for bona fide association coverage is not allowed under the statute, we are interested in whether and how a transition or exception process for bona fide association coverage could be structured to minimize disruption while maintaining consumer protections. We seek comment on this issue.

Similarly, issuers would not have to offer coverage to employers and individuals, uniformly and without regard to claims experience, if they demonstrate to their applicable state

authority (if required) that they lack the financial capacity to sell additional coverage. Issuers invoking this exception also would be barred from offering new coverage for at least 180 calendar days, as directed by PHS Act section 2702(d)(2).

Lastly, the proposed rule would include as a minimum standard a more detailed marketing standard in connection with guaranteed availability that had not been included in the earlier HIPAA rule. Nonetheless, it is similar to the guidance we provided in Health Care Financing Administration Bulletin No. 98-01 that interpreted the HIPAA provisions related to guaranteed availability in the individual and small group markets. Bulletin No. 98-01 stated that the PHS Act prohibited issuers from setting agent commissions for sales to HIPAA-eligible individuals and small groups so low that they were discouraged from marketing policies to such individuals and groups.⁵⁴ Pursuant to section 1311(c)(1)(A) of the Affordable Care Act, QHP issuers are required to comply with applicable state laws and regulations regarding marketing by health insurance issuers and not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs (§156.225). The proposed rule would adopt this standard and apply it to the entire marketplace in order to ensure consistency in the marketing of plans inside and outside of the Exchanges and leverage existing state oversight mechanisms.

The intent of this policy is for states to continue their traditional role of regulating marketing activities of issuers, consistent with §156.225. We reiterated this point in guidance issued on November 29, 2011, where we indicated that we will apply existing state standards on

⁵⁴ Available at: http://cciio.cms.gov/resources/files/Files2/10112011/hipaa_98_01_508.pdf.pdf.

marketing materials in states where a federally-facilitated Exchange operates.⁵⁵ We note that the NAIC’s Model Unfair Trade Practices Act 880-1 has been adopted in a “substantially similar manner” by 46 states, and the NAIC’s Advertisements of Accident and Sickness Insurance Model Regulation 40-1 has been adopted in a “substantially similar manner” by 44 states. Both the Model Act and Regulation include comprehensive marketing standards for issuers.⁵⁶

We propose these marketing standards to minimize the potential for the adverse selection that could result if plans sold through Exchanges were subject to different marketing standards from plans sold outside of the Exchanges. A common standard covering the entire insurance market can protect the efficient operation of all markets and reduce confusion for consumers. As stated in Bulletin No. 98-01, which interpreted the HIPAA guaranteed availability requirement, marketing practices that fall below these standards represent a failure by issuers to offer required coverage. We propose that all issuers comply with state laws regulating the marketing of insurance unless the state has no laws regulating marketing or has laws which are below the federal minimum standard, in which case the federal minimum standard would govern. We solicit comment on this federal minimum standard.

Concerns have been raised about the ability of individuals to manipulate guaranteed availability each year. While PHS Act section 2703 allows an issuer to nonrenew coverage for an individual who has not paid premiums, PHS Act section 2702 does not include an exception

⁵⁵ CMS, “State Exchange Implementation Questions and Answers. Available at: http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf

⁵⁶ Section 4 of the NAIC Model Act prohibits “an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of its insurance business, which is untrue, deceptive or misleading.” Section 5 of the NAIC Model Regulation provides that the format and content of advertisements of accident and sickness insurance must “be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive.”

allowing issuers to refuse to cover individuals with histories of non-payment under other policies either with the same issuer or other issuers. Nonetheless, we recognize the concerns that such potential gaming raises in relation to adverse selection, fairness to consumers maintaining continuous coverage, and the financial stability of issuers participating in the individual market. We solicit comments on possible ways to discourage consumers from abusing guaranteed availability rights (for example, by ensuring enrollees cannot use open and special enrollment periods to facilitate such abuses) while ensuring consumers are guaranteed the protections afforded to them under the law.

C. Guaranteed Renewability of Coverage (Proposed §147.106)

PHS Act section 2703 directs that any health insurance issuer offering health insurance coverage in the individual or group market must renew coverage at the option of the plan sponsor or individual, with certain exceptions, which are more fully discussed below in connection with the proposed rule text. PHS Act section 2703 is based largely on the HIPAA provision for group market guaranteed renewability, but generally expands its scope to include both the group and individual markets.⁵⁷ While section 2703 does not include the individual market in its guaranteed renewability exceptions for uniform modifications of coverage and loss of bona fide association membership, nonetheless, we believe PHS Act section 2742 continues to provide a

⁵⁷ Prior to being amended and renumbered as PHS Act section 2703 by the Affordable Care Act, the HIPAA guaranteed renewability requirements for the group market were found at PHS Act section 2712. The HIPAA guaranteed renewability requirements continue to apply with respect to grandfathered group market coverage in 2014 and beyond (and with respect to all group market coverage before 2014). Section 1251 of the Affordable Care Act specifically excludes grandfathered health plans from the effect of the amendments in the Affordable Care Act. The Affordable Care Act did not modify PHS Act section 2742, which continues to require guaranteed renewability in the individual market, including with respect to grandfathered health plans in the individual market.

basis for those exceptions. This proposed rule generally is based on the corresponding HIPAA rule (§146.152).

The proposed rule would direct health insurance issuers offering health insurance coverage in the individual or group market to renew or continue in force the coverage at the option of the plan sponsor or individual, as applicable, with certain exceptions. These exceptions include: (1) nonpayment of premiums by the plan sponsor, or individual, as applicable; (2) an act or practice that constitutes fraud or an intentional misrepresentation of material fact under the terms of coverage performed by the plan sponsor or individual, as applicable; (3) in the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules pursuant to applicable state law; (4) the issuer is ceasing to offer coverage of this type, acting uniformly without regard to claims experience or health status-related factor (an issuer may also modify the health insurance coverage for a plan offered to a group health plan at renewal); (5) for network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer could limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and (6) for coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the association ceases, but only if the coverage terminated uniformly without regard to any health status-related factor relating to any covered individual. In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more

associations, the reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

In addition, the proposed rule would set requirements for issuers closing blocks of business. In any case where an issuer decides to discontinue offering a particular plan offered in the group or individual market, that plan may be discontinued by the issuer in accordance with applicable state law in the particular market under certain circumstances. An issuer who elects to discontinue offering all health insurance coverage in a market (or markets) in a state may not issue coverage in the state’s market (or markets) involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed, as directed by PHS Act section 2703(c)(2)(B).

Only at the time of renewal may issuers modify the health insurance coverage for a plan offered to a group health plan in the large group market, and small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with state law and is effective uniformly among group health plans with that plan.⁵⁸

PHS Act section 2703(b)(6) retains a guaranteed renewability exception for an employer’s loss of membership in a bona fide association. Although not the subject of this proposed rule, PHS Act section 2742(b)(5) continues to provide a guaranteed renewability exception for an individual’s loss of membership in a bona fide association.

Under §155.430(b), an Exchange may terminate an enrollee’s coverage, and permit a

⁵⁸ Although PHS Act section 2703 does not contain a corresponding exception for uniform modification of coverage in the individual market, PHS Act section 2742 continues to provide a basis for such an exception in the individual market.

QHP issuer to terminate such coverage, under certain circumstances. These circumstances are: (1) the enrollee is no longer eligible for coverage in a QHP; (2) payments of premiums for coverage of the enrollee cease and any grace period(s) have been exhausted; (3) the enrollee's coverage is rescinded due to fraud or misrepresentation; (4) a QHP terminates or is decertified; or (5) the enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period. Although some QHP termination of coverage events correspond to PHS Act non-renewal events (for example, nonpayment of premiums), other events do not (for example, a QHP's loss of certification). With respect to those instances, we request comments on whether an issuer would have to renew that coverage on a non-QHP basis, outside the Exchange, if applicable, to affected enrollees.

We are aware that issuers may need to make some plan design changes for non-grandfathered coverage issued between March 23, 2010 and January 1, 2014 in order to comply with the standards of the Affordable Care Act that are effective for the 2014 plan and policy years. In addition, on an ongoing basis, issuers may need to make some cost-sharing adjustments at renewal to ensure that policyholders' plans remain at the same actuarial value level from year to year. We believe that issuers can make these types of policy changes consistent with the uniform modification of coverage requirements under PHS Act sections 2703 and 2742, and solicit comments on whether our interpretation should be explicitly incorporated into text of the final rule.

D. Applicability of the Proposed Rules under PHS sections 2701, 2702, and 2703 and Section 1312(c) of the Affordable Care Act to Student Health Insurance Coverage

Section 1560(c) of the Affordable Care Act provides that nothing in title I of the

Affordable Care Act, or an amendment made by title I, “shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable federal, state, or local law.” Title I of the Affordable Care Act includes the rating, guaranteed availability, guaranteed renewability, and single risk pool provisions that are discussed in this proposed rule.

We have interpreted section 1560(c) to mean that if particular requirements in the Affordable Care Act would have, as a practical matter, the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under federal, state or local law, such requirements would be inapplicable pursuant to the rule of construction in section 1560(c).

We previously provided student health insurance coverage with exceptions from the HIPAA guaranteed availability and renewability requirements applicable to the individual market (§147.145(b)(1)). Consistent with that policy, this proposed rule would provide student health insurance coverage with exceptions from the Affordable Care Act’s guaranteed availability and renewability requirements to ensure that enrollment in these policies is limited to students and their dependents.

Under this proposed rule, student health insurance coverage would be included in an issuer’s individual market single risk pool, as described below. Nonetheless, given the differences between the student health insurance market and other forms of individual market coverage, we solicit comment on whether the final rule should allow issuers to maintain a separate risk pool for student health insurance coverage. We also seek comment on whether the

final rule should provide any modifications with respect to the generally applicable individual market rating rules in connection with student health insurance coverage.

E. Single Risk Pool (Proposed §156.80)

Section 1312(c)(1) and (2) of the Affordable Care Act states that a health insurance issuer must consider all of its enrollees in all health plans (other than grandfathered health plans) offered by the issuer to be members of a single risk pool in the individual market and small group market, respectively.⁵⁹ This requirement applies to health plans both inside and outside of an Exchange for both markets. Section 1312(c)(3) of the Affordable Care Act provides a state with an option to merge its individual and small group markets, in which case all non-grandfathered plans' risk would be merged. To support the accuracy of the risk adjustment methodology, we propose that states that intend to merge their individual and small group market pools in 2014 inform us no later than 30 days after the publication of the final rule. Lastly, section 1312(c)(4) of the Affordable Care Act renders inapplicable any state law requiring grandfathered health plans to be included in the single risk pool(s).

The proposed rule would largely codify the statutory language and clarify that the single risk pool requirement applies on a state-by-state basis and only to forms of non-grandfathered individual and small group market coverage subject to PHS Act section 2701. Thus, excepted benefit and short-term limited duration policies, for example, would not be subject to the single risk pool requirement. Also, this requirement would not be enforced against health insurance coverage issued to plans with fewer than two participants who are current employees (for

⁵⁹ By law, issuers are required to transition all non-grandfathered small group and individual market coverage issued prior to January 1, 2014, to the appropriate single risk pool in the first plan year (small group market) or the first policy year (individual market) beginning on or after January 1, 2014.

example, retiree-only plans) (see 75 FR 34538, 34539-40 (June 17, 2010)).

Section 1312(c) of the Affordable Care Act represents a change from current market practice. Today, issuers often maintain several separate risk pools within their individual and small group market business, often as a way to segment risk and further underwrite premiums. For example, the NAIC's Small Employer Health Insurance Availability Model Act (1993 Version), adopted by a majority of states, allows issuers to maintain up to nine blocks of business in the small group market, subject to a limitation that the index rates between the blocks not vary by more than 20 percent. A 2004 study by the American Academy of Actuaries noted that the current regulatory climate in most states allows issuers to open and close books of business in the individual market at will, effectively causing many long-term policyholders in closed blocks to face very high premium increases at renewal because issuers can refuse to pool their claims experience with that of the newer or healthier policyholders.⁶⁰

Beginning in 2014, issuers are no longer able to deny coverage based on applicants' health status and are limited in the types of rating factors they can apply in setting premiums in the individual and small group markets. Without a single risk pool rule, these prohibitions against traditional underwriting could incentivize issuers to find ways to segment the market into separate risk pools and charge differential premiums based on segmented risk, a de facto mechanism for underwriting. As a result, this statutory requirement that an issuer consider all of its enrollees in all plans (other than grandfathered plans) offered by the issuer to be members of a single risk pool in the individual market or small group market, respectively, prevents issuers

⁶⁰ American Academy of Actuaries' Rate Filing Task Force, Report to the NAIC's A&H Working Group of the Life & Health Actuarial Task Force, at 3-4. See also NAIC, White Paper: An Exploration of Potential Regulatory Measures Intended to Prevent Individuals at Later Durations of Non-Group Major Medical Products from Receiving Higher Rate Increases than Those at Early Durations (2008).

from creating separate pools in order to segment high risk and low risk enrollees. While risk adjustment will address some risk segmentation, the single risk pool requirement provides another layer of protection against adverse selection among plans and protects consumers by requiring issuers to consider the risk of all enrollees when developing and pricing unique plans.

To implement the single risk pool protection, we propose that the claims experience of the enrollees in all non-grandfathered plans of an health insurance issuer in the individual or small group market within a state (or both, if the risk pools of the individual and small group market are merged within a state) be combined so that the premium rate of a particular plan is not adversely impacted by the health status or claims experience of its enrollees. For rates effective starting January 1 2014, a health insurance issuer would use the estimated total combined claims experience of all non-grandfathered plans deriving from providing essential health benefits within a state market to establish an index rate (average rate) for the relevant market. The index rate would be utilized to set the rates for all non-grandfathered plans of the issuer in the market. After setting the index rate, an issuer would 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.

The premium rate for any given plan could not vary from the resulting index rate, except for the following factors:⁶¹

- The actuarial value and cost-sharing design of the plan;

⁶¹ However, as described in §147.102 of this proposed rule, the specific premiums charged for particular enrollees would be permitted to vary based on family size, geographic rating area, and age and tobacco use, within limits.

- 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 are able to negotiate better discounts, construct efficient networks, or manage care more efficiently;
- Plan benefits in addition to the essential health benefits. The additional benefits must be pooled with similar benefits provided in other plans to determine the allowable rate variation for plans that offer these benefits; and
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

The index rate, the market-wide adjustment based on total expected payments and charges for the risk adjustment and reinsurance programs, and the variations for individual plans would have to be actuarially justified. Furthermore, all such actuarially justified adjustments would have to be implemented by issuers in a transparent fashion, consistent with state and federal rate review processes. We seek comment on the approach described above, and on the proposed plan-specific adjustments to the index rate. This proposed rule would apply both when rates are initially established for a plan and at renewal. We expect that percentage renewal increases generally would be similar across all plans in the same risk pool, but might differ somewhat due to the permitted product differences described above. We are considering allowing additional flexibility in product pricing in 2016 after issuers have accumulated sufficient claims data. We request comments on this approach.

F. CMS Enforcement in Group and Individual Insurance Market (Various Provisions in Parts 144 and 150)

Part 150 of title 45 of the CFR sets forth our enforcement processes for all of the requirements of title XXVII of the PHS Act with respect to health insurance issuers and non-federal governmental group health plans. The scope of part 150 includes our processes for enforcing the requirements of title XXVII of the PHS Act added by the Affordable Care Act, given that the statutory enforcement provisions that part 150 implements, PHS Act sections 2723 and 2761, apply to all of parts A and B of title XXVII.

This proposed rule would make a number of conforming changes in various sections of parts 144 and 150 intended to clarify the applicability of enforcement procedures to the PHS Act requirements added by the Affordable Care Act. For example, we are proposing to replace the term “HIPAA requirements” with “PHS Act requirements” throughout part 150 to make clear that the part 150 processes would be used for enforcing not only the requirements emanating from HIPAA, but also the Affordable Care Act and other legislation enacted subsequent to HIPAA. Similarly, the proposed rule would add, where appropriate, references to part 147 (that is, the Affordable Care Act’s group and individual market requirements) alongside references to parts 146 and 148 (the group and individual market requirements pre-dating the Affordable Care Act).

While these proposed changes should clarify to stakeholders our interpretation concerning part 150, the lack of these revisions in part 150 currently in no way prejudices our continued use of part 150 in connection with enforcing the requirements of part 147 prior to the issuance of a final rule.

G. Enrollment in Catastrophic Plans (Proposed §156.155)

Section 1302(e) of the Affordable Care Act outlines standards for offering catastrophic

plans, which we propose to codify in §156.155. In paragraph (a)(1), we propose that a plan is a catastrophic plan if it meets all applicable requirements for health insurance coverage in the individual market (including but not limited to those requirements described in 45 CFR parts 147 and 148) and is offered only in the individual market. In proposed paragraph (a)(2), we specify that a catastrophic plan does not offer coverage at the bronze, silver, gold, or platinum coverage levels described in section 1302(d) of the Affordable Care Act and in proposed paragraph (a)(3), we clarify that a catastrophic plan does not provide coverage of essential health benefits until the enrolled individual reaches the annual limitation in cost sharing in section 1302(c)(1) of the Affordable Care Act. Proposed paragraph (a)(4) codifies the statutory requirement that a catastrophic plan must cover at least three primary care visits per year before reaching the deductible. We do not propose here to prohibit an issuer from imposing cost sharing in connection with these primary care visits so long as other applicable law (for example, PHS Act section 2713) permits.

In paragraph (a)(5), we propose codifying the statutory criteria identified in section 1302(e)(2) of the Affordable Care Act that lists the individuals who are permitted to enroll in a catastrophic plan. In paragraph (a)(5)(i), we propose that individuals younger than age 30 before the beginning of the plan year are eligible to enroll in catastrophic plans. If an individual enrolled in a catastrophic plan reaches age 30 during a plan year, we propose that the individual can remain enrolled in the catastrophic plan for the remainder of the plan year. In paragraph (a)(5)(ii), we propose that the second group of individuals eligible to enroll in a catastrophic plan are those who have been certified as exempt from the individual responsibility payment because they cannot afford minimum essential coverage, or they are eligible for a hardship exemption.

In paragraph (b), we propose to codify the exception found in section 1302(e)(1)(B)(i) of the Affordable Care Act by proposing that a health plan may not impose cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services identified in PHS Act section 2713. We note that a catastrophic plan must provide coverage for such services without regard to whether the enrollee accessing the service has reached the cost-sharing maximum.

In paragraph (c), we propose that if more than one person is covered by a single catastrophic plan, such as a non-self only plan, then each individual enrolled must meet at least one of the two eligibility criteria in proposed paragraph (a)(5). For example, a couple could enroll in a catastrophic family plan if one of them was under age 30 and the other had received a certificate of exemption in accordance with section 1302(e)(2)(B) of the Affordable Care Act.

H. Rate Increase Disclosure and Review (Part 154)

To account for the market changes in 2014, many of which are detailed in this proposed rule; to fulfill the statutory requirement beginning in 2014 that the Secretary, in conjunction with the states, monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange; and in an effort to streamline data collection for issuers and states, we propose three changes to the existing rate review program under 45 CFR part 154.

First, we propose to amend §154.200(a)(2) and (b), so that states seeking state-specific thresholds submit proposals to CMS by August 1 of each year; that the Secretary publish a notice no later than September 1 of each year concerning whether a state-specific threshold applies in a state; and that any state-specific threshold be effective on January 1 of each year following the Secretary's notice. We are proposing these changes in order to align with the timing of rate

submissions of QHPs in the Exchanges, as well as market-wide rating rules created by the Affordable Care Act, which are effective January 1, 2014. We welcome comments on these proposed changes in the submission date and the effective date of state-specific thresholds.

Second, we propose to amend §154.215 to direct health insurance issuers to submit data and documentation regarding rate increases on a standardized form in a manner determined by the Secretary. Beginning in 2014, section 2794(b)(2)(A) of the Affordable Care Act directs that the Secretary, in conjunction with states, “monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.” The purpose of this policy is to identify patterns that could indicate market disruption, which could occur given the additional standards that apply to qualified health plans, and to oversee the new, market-wide reforms. To assist the Secretary in carrying out this new monitoring function, we propose modifying the rate review standards by extending the requirement that health insurance issuers report information about rate increases above the review threshold to all rate increases, as is already the policy in the vast majority of states. Under this proposal, each issuer would submit the same set of files for all of their products in the same market, pursuant to work conducted in partnership with the NAIC to ensure consistency between the NAIC’s System for Electronic Rate and Form Filing (SERFF) and HHS’s Health Insurance Oversight System (HIOS) and to promote efficiency in data collection for states and issuers. The same type of information is currently collected by most states today, but in a variety of non-standardized formats. States would continue to have the authority to collect additional information, above this baseline, to conduct more thorough reviews or rate monitoring. The review threshold, described in

§154.200, would continue to be used to determine which rates must be reviewed rather than just reported.

Under the current rate review program, CMS collects rate filing information from issuers proposing increases of 10 percent or greater, including in states with Effective Rate Review Programs. This data collection allows the Secretary to ensure the public disclosure of information on such increases as required by the statute. Collecting rate filing information on all rate increases in applicable markets would provide CMS, in partnership with states, the necessary data to gauge how 2014 market changes are affecting rate changes for consumers both inside and outside the Exchange and to fulfill its obligation under section 2794(b)(2)(A) of the PHS Act. Additionally, the improved data collection would allow states and CMS, where applicable, to adapt their rate review processes to include the changes to the individual and small group markets that begin in 2014. Primary among these changes to the individual and small group market is the single risk pool requirement. Beginning with rates effective in 2014, pursuant to section 1312(c) of the Affordable Care Act, all rates must be based on claims experience calculated from all claims of all products an issuer has within a state in either the individual or small group market (or both if the state merges the individual and small group markets into a combined risk pool). This means that products can no longer be reviewed as completely unique, but rather must include experience of the entire market (single risk pool). Accordingly, when any product has a rate increase, all other products with enrollment or projected enrollment would be reported to assure the single risk pool requirement was appropriately implemented to promote fair market competition.

Additionally, collecting rate filing data in a standardized format, as proposed, would reduce the burden on issuers because the data would be used for purposes beyond rate review, including Exchange functions like QHP certification and premium tax credit and cost-sharing reduction verification. Rather than requiring multiple data submissions to conduct these various reviews, this proposal would provide state and federal regulators the information they need in one place. CMS incorporated feedback from state regulators facilitated through the NAIC and health plans in developing this proposal.

CMS will propose for comment through the Paperwork Reduction Act of 1995 (PRA) process a standardized data template form for health insurance issuers to use for submitting the data for rate increases. The template was developed with input from the NAIC and other stakeholders. The goal of a standardized data template is to provide state regulators with a baseline of information necessary to conduct the review and approval of products sold inside and outside an Exchange as new market rules go into effect in 2014. In order to help assure a competitive health insurance market, CMS anticipates releasing only information collected that is determined to not include trade secrets and is approved for release under the Freedom of Information Act.

This data collection is intended to create greater uniformity for effective rate review information, creating efficiencies and also providing issuers with a standardized, electronic format for submitting this uniform data. Issuers would no longer be required to submit the same type of data in different formats to different regulators. We request comments through the corresponding PRA comment process on the proposed information collection authorized under §154.215, as proposed to be amended, and the additional burden, if any, it would impose on

health insurance issuers and the states. The improved rate review data and information collection outlined in the PRA would allow issuers to submit a baseline set of rate review data in a standardized form and format, which should, on net, reduce the burden of providing similar data in multiple formats to each state and the federal government. We also welcome comments on the need for and impact of the extension of the reporting requirement below the review threshold and whether alternative approaches to monitoring and oversight should be considered (e.g., auditing).

Third, we propose to modify the standards for an Effective Rate Review Program in response to the market changes in 2014 for rate filings subject to review. We propose revisions in §154.301(a)(3) so that a state with an Effective Rate Review Program would review the following additional elements as part of its rate review process: (1) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the federal reinsurance and risk adjustment programs; and (2) 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 reforms rules as required by the Affordable Care Act. The 10 percent review threshold, as finalized in §154.200 (76 FR 29964), will remain unchanged. Thus, only proposed rate increases of 10 percent or more will be subject to a determination of whether they are unreasonable, unless the Secretary changes the threshold in a time and manner specified in 76 FR 29964, or a state requests (and the Secretary approves) a different threshold under §154.200.

Additionally, we propose to revise §154.301(a)(4) by adding additional factors that states must take into consideration when conducting their examinations. Specifically, we propose that,

in reviewing the impact of cost-sharing changes, the impact on the actuarial value of the health plan must be considered in light of the requirement under section 1302(d) of the Affordable Care Act that a plan meet one of the metal levels in terms of actuarial value. We also propose that, in reviewing benefit changes to a plan, a state must consider the impact of the changes on the plan's essential health benefits and non-essential health benefits. The impact of the changes on pricing, including the rating limitations on age and tobacco use under PHS Act section 2701, must also be considered.

We also propose to add new paragraphs (xii), (xiv), (xv), and (xvi) to §154.301(a)(4), to ensure that states take into account, to the extent possible, the following additional factors (which are necessary to carry out some of the market reforms going into effect in 2014) when conducting an examination of a rate review filing:

- Other standardized ratio tests (in addition to the medical loss ratio) recommended or required by statute, regulation, or best practices;
- The impacts of geographic factors and variations;
- The impact of changes within a single risk pool to all products or plans within the risk pool; and
- The impact of federal reinsurance and risk adjustment payments and charges.

The above proposed revisions and additions to §154.301(a)(4) are driven by provisions of the Affordable Care Act that are effective in 2014. CMS intends to work with states to ensure states continue to have Effective Rate Review Programs. Comments are solicited on the impact on states created by these proposed changes and whether there are additional factors that should be considered in reviewing rate increases starting in 2014.

In §154.301(b), we propose revisions to ensure that a state with an Effective Rate Review Program makes available on its Web site, at a minimum, the same information in Parts I, II, and III of each Rate Filing Justification that CMS makes available on its Web site. We propose that a state may, instead of providing access to the information contained in Parts I, II, and III of each Rate Filing Justification, provide a link to CMS's Web site where consumers can find such information.

Finally, in §154.225 and §154.330, we propose to replace the term "Preliminary Justification" with the term "Rate Filing Justification," to reflect more appropriately the rate filing information that would be reported under this proposed rule.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. This proposed rule contains information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs with an estimate of the annual burden, summarized in Table IV.1. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.

- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this proposed rule that contain information collection requirements (ICRs).

A. ICRs Regarding State Disclosures [§147.102(a)(1)(iii), §147.102(a)(1)(iv), §147.102(b)(1), §147.102(c)(2), §147.102(c)(3), §147.102(e), §156.80 (c)]

The proposed rule would direct states to submit to CMS information on their rating and risk pooling requirements if different than the federal standards. In §147.102(a)(1)(iii), we propose that a state inform CMS if it adopts a narrower age rating ratio than 3:1, and in §147.102(a)(1)(iv), we propose that a state inform CMS if it adopts a narrower rating ratio for tobacco use than 1.5:1. In §147.102(b)(1), we propose that a state submit information to CMS regarding its geographic rating areas. In §147.102(c)(2), we propose that a state with pure community rating submit information to CMS about its uniform family tiers and corresponding multipliers, if any. In §147.102(c)(3), we propose that a state inform CMS if it requires premiums to be based on average enrollee amounts in the small group market. In §147.102(e), we propose that a state submit information on its uniform age rating curve to CMS. Finally, in §156.80(c), we propose that a state inform CMS if it elects to merge its individual and small group market risk pools. Because we do not know how many states will choose to determine their own geographical rating areas, age rating curves, and family tier structures; adopt narrower age or tobacco rating factors; require premiums to be based on average enrollee amounts in the small group market; or merge their individual and small group market risk pools, we have

estimated the burden for one state. We seek comments on how many states are likely to submit their own rating and risk pooling rules.

The burden associated with this requirement is the time involved for states to provide to CMS information on the rating factors and requirements applicable to their small group and individual markets. If a state adopts narrower rating ratios for age or tobacco use, or chooses to merge their individual and small group market risk pools, the state will inform CMS. We estimate that it will take 20 minutes for a state to prepare and submit a report to CMS for each of these disclosures, for a total burden of one hour and a cost of approximately \$31 for all three reports combined. If a state develops geographical rating areas (some states will default to one rating area for the entire state), it will provide a report on the rating areas to CMS. We estimate that it will take one hour for a state to prepare and submit a report to CMS on its geographical rating areas, for a burden of one hour and a cost of approximately \$31. If a state develops an age rating curve, the state will report the state's age rating curve to CMS. We anticipate that most states will default to national age curve. For states that designate their own curve, we estimate that it will take three hours for each state to prepare and submit a report on its age rating curve, for a burden of three hours and a cost of \$92. If a state is community rated and designates a uniform family tier structure, the state will report family tier structure information to CMS. We estimate that very few states will designate family tier structures and that it will take one hour to prepare and submit a report to CMS. The burden for reporting family tier structure information is estimated to be one hour, and a cost of approximately \$31. If a state requires premiums in the small group market to be based on average enrollee amounts, it will submit that information to CMS. We estimate that it will take one hour for a state to prepare and submit the report on small

group market premiums to CMS, for a burden of one hour and a cost of approximately \$31. The total burden for all disclosures is seven hours and approximately \$215 per state, if a state needs to disclose all seven rating requirements.

Table IV.1: Annual Reporting, Recordkeeping and Disclosure Burden

Regulation Section(s)	OMB Control No.	Number of respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting (\$)	Total Labor Cost of Reporting (\$)	Total Capital/Maintenance Costs (\$)	Total Cost (\$)
Age Ratio: §147.102(a)(1)(iii); Tobacco Ratio: 147.102(a)(1)(iv); Rating areas: §147.102(b)(1); Family Tier: §147.102(c)(2); Small Group Market Premium: §147.102(c)(3); Age rating curve: §147.102(e); Risk Pool Merger: §156.80 (c)	N.A.	1	7	1	7	\$30.67	\$214.69	0	\$214.69

B. ICRs Regarding Rate Increase Disclosure and Review (§154.215, §154.301)

This proposed rule would require that health insurance issuers use a standardized data form, as specified by the Secretary, to report information about a proposed rate increase. In addition, this proposed rule would direct states with Effective Rate Review Programs to consider additional information (as a baseline) in their rate review processes. The existing information collection requirement (OMB Control Number 0938-1141) includes a data template that is currently used by issuers seeking rate increases to submit data to CMS. CMS is publishing an updated data template for public comment, in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35).

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web Site at <http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage> or e-mail your

request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office at 410-786-1326.

If you comment on these information collection requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, CMS-9972-P. Fax: (202) 395-5806; or Email: *OIRA_submission@omb.eop.gov*.

V. Regulatory Impact Analysis

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

A. Summary

As stated earlier in this preamble, this proposed rule would implement the Affordable Care Act's requirements on health insurance coverage related to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, and catastrophic plans. These provisions are generally effective for plan or policy years beginning on or after January 1, 2014. In addition, this proposed rule would amend the standards for health insurance issuers and states regarding reporting, utilization, and collection of data under the rate review program.

CMS has crafted this proposed rule to implement the protections intended by Congress in the most economically efficient manner possible. We have examined the effects of this proposed rule as required by Executive Order 13563 (76 FR 3821, January 21, 2011), Executive Order

12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). In accordance with OMB Circular A-4, CMS has quantified the benefits, costs and transfers where possible, and has also provided a qualitative discussion of the benefits, costs and transfers that may stem from this proposed rule.

B. Executive Orders 13563 and 12866

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a proposed rule -- (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in

the Executive Order.

A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (e.g., \$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the OMB. OMB has designated this proposed rule as a “significant regulatory action.” Even though at this time it is uncertain whether it is likely to have economic impacts of \$100 million or more in any one year, CMS has provided an assessment of the potential costs, benefits, and transfers associated with this proposed regulation.

1. Need for Regulatory Action

Sections 1302(e) and 1312(c) of the Patient Protection and Affordable Care Act (Affordable Care Act), and sections 2701, 2702, and 2703 of the Public Health Service Act (PHS Act), as added and amended by the Affordable Care Act, create certain standards related to fair health insurance premiums, guaranteed availability, guaranteed renewability, risk pools, and catastrophic plans applicable to non-grandfathered health insurance coverage starting in 2014. These proposed regulations would provide the necessary guidance to implement these important consumer protections. The current individual and small group health insurance markets generally are viewed as dysfunctional, placing consumers at a disadvantage due to the high cost of health insurance coverage, resulting from factors such as lack of competition, adverse selection, and limited transparency. In addition to affordability concerns, many people have difficulty finding and enrolling in coverage options. If employer-based coverage is not available, a person may find that affordable individual market coverage is not available due to medical underwriting. The provisions of this proposed rule, combined with other provisions in the Affordable Care Act, will improve the functioning of both the individual and the small group

markets and make insurance affordable and accessible to millions of Americans who currently do not have affordable options available to them. In addition, this proposed rule would amend the existing rate review standards under section 2794 of the PHS Act to reflect the new market conditions in 2014.

2. Summary of Impacts

In accordance with OMB Circular A-4, Table V.1 below depicts an accounting statement summarizing CMS's assessment of the benefits, costs, and transfers associated with this regulatory action. The period covered by the regulatory impact analysis (RIA) is 2013–2017.

CMS anticipates that the provisions of these proposed regulations would ensure increased access and improve affordability of health insurance coverage in the individual and small group markets. Individuals who are currently unable to obtain affordable coverage because of their medical history, their health status, gender or age will be able to obtain such coverage once the proposed rules are in effect along with other provisions of the Affordable Care Act, leading to an increase in the number of people with health insurance. Newly insured individuals and individuals with expanded coverage will have increased access to health care, improving utilization of preventive care and health outcomes and protection from the risk of catastrophic medical expenditures, leading to financial security. In addition, an issuer seeking a rate increase would submit data and documentation about the rate increase using a standardized format, which would provide CMS the data necessary for monitoring rate increases, enable consistent reporting between CMS and the states and eliminate issuer burden arising from having to use different formats for submitting the data to states and to CMS. In accordance with Executive Order 12866, CMS expects that the benefits of this proposed regulatory action would justify the costs.

Table V.1: Accounting Table

Benefits:				
Qualitative: * Increase in enrollment in the individual market leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures * Lower premium rates in the individual market due to the improved risk profile of the insured, competition, and pooling * A common marketing standard covering the entire insurance market, reducing adverse selection, improving market oversight and competition and reducing search costs for consumers * Decrease in administrative costs for issuers due to elimination of medical underwriting and coverage exclusions * Prevent duplication of effort for rate review filings subject to review by setting forth a standardized template for both non-QHPs and QHPs * Provide state departments of insurance with more capacity to conduct meaningful rate review and approval of products sold inside and outside an Exchange by using a standardized data template				
Costs:	Estimate ⁶²	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$16 million	2012	7%	2013-2017
	\$16 million	2012	3%	2013-2017
Administrative costs related to submission of data by issuers seeking rate increases below the rate review threshold				
Qualitative: * Costs incurred by issuers to comply with provisions in the proposed rule * Costs incurred by states choosing to establish rating areas and age rating curves * Costs related to possible increases in utilization of health care for the newly insured * Costs incurred by states for disclosure of rate increases, if applicable				
Transfers:				
Qualitative: * Lower rates for individuals in the individual and small group market who are older and/or in relatively poor health, and women; and potentially higher rates for some young men which will be mitigated by provisions such as premium tax credits, risk stabilization programs, access to catastrophic plans, and the minimum coverage provision * Reduction in uncompensated care for providers who treat the uninsured and increase in payments from issuers * Decrease in out-of-pocket expenditures by the newly insured and increase in health care spending by issuers, which will be more than offset by an increase in premium revenue				

3. Anticipated Benefits, Costs and Transfers

In developing this proposed rule, CMS carefully considered its potential effects including

⁶² These estimates are exclusive of each other. Therefore, the total cost is estimated to be no higher than \$16 million.

both costs and benefits. Because of data limitations, CMS did not attempt to quantify all of the benefits, costs and transfers resulting from this proposed rule. Nonetheless, CMS was able to identify several potential qualitative impacts which are discussed below.

There are diverse state laws and industry practices currently in place that result in a wide variation in premium rates (henceforth referred to as “rates”) and coverage for individual and group health insurance markets. Regarding the individual market, only five states have both guaranteed issue for at least some products and modified or pure community rating requirements, while in other states, issuers can deny health insurance coverage or charge higher premiums to people with medical conditions.⁶³ Currently, 11 states and the District of Columbia have rate bands, which allow issuers to vary rates only within a certain range of the average rate, two states bar rating based on age, and five states bar rating based on tobacco use in the individual market.⁶⁴ In the small group market, 36 states and the District of Columbia have rate bands, 12 states have community rating requirements, two states do not allow rating based on age and 16 do not allow rating based on tobacco use. In many states, women are charged higher premiums than men - only 14 states bar gender rating in the individual market while 15 states do not allow gender rating in the small group market. Of the states that bar gender rating in the individual market, only three of those states require maternity coverage in all policies, meaning that women in the other states can be charged additional premiums for maternity coverage.

Currently, only five states have guaranteed issue in the individual market. Studies show that 48 states require guaranteed renewability in small group market while all 50 states provide

⁶³ GAO, Private Health Insurance: Estimates of Individuals with Preexisting Conditions Range from 36 Million to 122 Million, GAO-12-439, March 2012.

⁶⁴ Kaiser Family Foundation, Focus on Health Reform: Health Insurance Market Reforms: Rate Restrictions, June 2012.

some level of guaranteed renewability in the individual market. In addition, HIPAA already provides guaranteed renewability of coverage to individuals and employers, irrespective of state law. Therefore, this provision is not expected to have any significant effect in that regard.

Starting in 2014, issuers in the individual and small group markets will only be allowed to vary rates based on age and tobacco use within specified ranges, family size, and geography (the fair health insurance premium requirement). Issuers generally will accept every individual and employer that applies for health insurance coverage (the guaranteed availability requirement), and must also renew or continue health insurance coverage at the option of the plan sponsor or individual (the guaranteed renewability requirement). In addition, issuers must have single risk pools for each of the individual and small group markets, or a single merged risk pool, if a state so elects, which will include all individuals enrolled in all non-grandfathered plans in the applicable market (the single risk pool requirement).

The provisions of the proposed rule will affect the characteristics of enrollees, enrollment and premium rates in the individual and small group markets. In addition, there are other provisions of the Affordable Care Act that will be effective by 2014, such as establishment of the Exchanges, premium tax credits, and the minimum coverage provision, that relate to the provisions in this proposed rule. These provisions will improve access to and affordability of health insurance coverage. Therefore, it is appropriate to take into consideration the effect of all these provisions in this analysis, even though not all of them are the focus of this proposed rule. It should be noted that the impact of these provisions may vary between states, because of the differences in current regulatory frameworks.

We solicit information and data on any industry practices and procedures that would be

affected by the implementation of these provisions and any related costs and savings, including administrative, operating, and information technology related costs, and anticipated effects on premium rates and financial performance.

The provisions of this proposed rule would also modify the existing Effective Rate Review Program to take into account market rule changes in 2014. Specifically, a state must include additional elements in its rate review process, like a review of the reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the federal reinsurance and risk adjustment programs and 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 reforms rules as required by the law.

a. Benefits

In 2011, 48.6 million people in the United States were uninsured.⁶⁵ In addition, an estimated 29 million adults were underinsured in 2010.⁶⁶ Studies have shown that people without health insurance have reduced access to health care, higher out-of-pocket costs, higher mortality rates and receive less preventive care.⁶⁷ Uninsured and underinsured people are also

⁶⁵ Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement, Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2011.

⁶⁶ Cathy Schoen Michelle M. Doty, Ruth H. Robertson and Sara R. Collins, Affordable Care Act Reforms Could Reduce The Number Of Underinsured US Adults by 70 Percent, *Health Affairs*, 30, no.9 (2011):1762-1771.

⁶⁷ The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance*, Washington, D.C., 2011, citing a number of studies on the effects of being uninsured; ASPE, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills*, 2011 (<http://aspe.hhs.gov/health/reports/2011/valueofinsurance/rb.shtml>); Sara R. Collins, Ruth Robertson, Tracy Garber, and Michelle M. Doty, *The Income Divide in Health Care: How the Affordable Care Act Will Help Restore Fairness to the U.S. Health System*, The Commonwealth Fund, February 2012 ; J. Doyle, *Health Insurance, Treatment and Outcomes: Using Auto Accidents as Health Shocks*, *Review of Economics and Statistics*, 87(2): 256-270, 2005 ; S. Dorn, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*, Urban Institute , 2008; Cathy Schoen, Michelle M. Doty, Ruth H. Robertson and Sara R. Collins, *Affordable Care Act Reforms Could Reduce The Number Of Underinsured US Adults by 70 Percent*, *Health Affairs*, 30, no.9 (2011):1762-1771.

more likely to be unable to pay their medical bills, have medical debt, and experience financial difficulties.

The provisions of this proposed rule and other changes implemented by the Affordable Care Act will increase enrollment in the individual and small group markets. According to the Congressional Budget Office (CBO), there will be approximately 23 million enrollees in Exchange coverage by 2016. CBO estimates that, by 2016, the number of uninsured will be reduced to up to 30 million.⁶⁸ Access to catastrophic plans is likely to further increase the number of insured. Newly insured individuals and individuals with expanded coverage will have access to better health care and experience a reduction in out-of-pocket costs. Ample research demonstrates that access to insurance coverage improves utilization of preventive care, improves health outcomes, and creates less financial debt, which would lead to better financial security.⁶⁹ The State of Massachusetts passed similar health reforms in 2006, and now has the lowest uninsured rate in the country. In 2011, only 3.4 percent of Massachusetts residents were uninsured.⁷⁰ This has resulted in increased access to health care, including preventive care and

⁶⁸ “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” Congressional Budget Office, July 2012.

⁶⁹ T. Gross and Notowidigdo, Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid, *Journal of Public Economics*, 95(7-8):767-778, 2011; J. Doyle, Health Insurance, Treatment and Outcomes: Using Auto Accidents as Health Shocks, *Review of Economics and Statistics*, 87(2): 256-270, 2005; Amy Finkelstein, et al., The Oregon Health Insurance Experiment: Evidence from the First Year, National Bureau of Economic Research Working Paper No. 17190, July 2011; Institute of Medicine, Care without coverage: too little, too late, National Academies Press, 2002; J. Ayanian et al., Unmet Health Needs of Uninsured Adults in the United States, *JAMA* 284(16):2061-9, 2000; Andrew P. Wilper, et al., Health Insurance and Mortality in US Adults. *American Journal of Public Health*, 99(12) 2289-2295, 2009; S. Dorn, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality, Urban Institute, 2008; Jack Hadley, Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition, *JAMA*. 2007;297(10):1073-1084. doi: 10.1001/jama.297.10.1073; K. Cook et al., Does major illness cause financial catastrophe?, *Health Services Research* 45, no. 2, 2010.

⁷⁰ Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement, Table HI06. Health Insurance Coverage Status by State for All People: 2011.

fewer individuals with high out-of-pocket spending.⁷¹

Research shows that individuals in relatively poor health experience difficulty obtaining health insurance coverage. This results in lack of adequate access to health care and higher out-of-pocket expenses for these individuals. According to a recent study by GAO, between 36 million and 122 million adults age 19 to 64 years old (or between 20 and 66 percent of the adult population) have medical conditions that could result in issuers denying them coverage or charging higher premiums.⁷² Of these, an estimated 88-89 percent live in states that do not have insurance protections provided by the fair health insurance premium and guaranteed availability provisions of the Affordable Care Act. The GAO study estimated that health care expenditures for adults with medical conditions are, on average, between \$1,504 and \$4,844 more per year than for other adults. Similarly, a study by HHS found that there are between 50 million and 129 million non-elderly individuals with a medical condition, including between 4 and 17 million children under age 18, and up to 25 million of these adults and children are uninsured.⁷³ A 2007 study by the Commonwealth Fund found that 36 percent of adults ages 19 to 64 were denied coverage or charged a higher price because of their medical conditions.⁷⁴ Another study found that, in 2010, 35 percent of nonelderly adults who shopped for health insurance coverage in the individual market were denied coverage or received coverage exclusions for medical

⁷¹ Kaiser Family Foundation, Focus on Health Reform: Massachusetts Health Care Reform: Six Years Later, June 2012.

⁷² GAO, Private Health Insurance: Estimates of Individuals with Preexisting Conditions Range from 36 Million to 122 Million, GAO-12-439, March 2012.

⁷³ ASPE, At Risk: Preexisting Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, November 2011.

⁷⁴ Michelle M. Doty et al., Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2007, The Commonwealth Fund, July 2009.

conditions.⁷⁵ The Affordable Care Act's provision on guaranteed availability will bar issuers from denying coverage to individuals based on their health status or any other factor, and the provision on fair insurance premiums will prevent issuers from charging a higher premium to individuals based on health status. The proposed rule will ensure that individuals who would have been denied coverage or charged excessively high premium rates, for reasons such as medical conditions or high expected medical costs, will now be able to obtain health insurance at an affordable cost. In addition, young adults and people for whom coverage would otherwise be unaffordable will have access to a catastrophic plan that will have a lower premium, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing.

The provisions of this proposed rule and other changes implemented by the Affordable Care Act will increase enrollment in the individual market. An analysis by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT)⁷⁶ estimated that the characteristics of enrollees in the individual market will be significantly different, especially due to the addition of people who would have been uninsured in the absence of the Affordable Care Act. CBO and JCT estimated that relatively more new enrollees in the individual market would be younger and healthier and likely to use less medical care, and the addition of new enrollees would result in average premium rates in the market being 7 to 10 percent lower in 2016 all else held constant. According to CBO and JCT, the characteristics of people in the large and small

⁷⁵ Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011.

⁷⁶ Congressional Budget Office, Letter to Honorable Evan Bayh, providing an Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, November 30, 2009.

group markets would change slightly, and projected premium rate changes would range from a 1 percent decrease to a 2 percent increase.

Currently, health insurance issuers may maintain several blocks of business, or “pools,” for their individual and small group market business. Most states place some restrictions on the number of small group blocks of business. However, the individual market generally has not been subject to similar restrictions. In the past, some issuers used separate pools to segment risks, resulting in large rate increases for less-healthy enrollees. A single risk pool will tend to lower rates in the individual market by including younger, healthier individuals in the pool and ensuring that newer and more long-term policyholders are pooled together. In the small group market, a single risk pool will stabilize rates.

The guaranteed availability provision may result in some adverse selection - individuals with poor health who would have been denied coverage before in some states will now be able to obtain health insurance. However, according to CBO and JCT,⁷⁷ adverse selection will be mitigated principally by the minimum coverage provision and the availability of premium tax credits, which will make insurance affordable for millions of Americans for whom it is currently unaffordable. Other factors such as fixed open enrollment periods will also help to mitigate adverse selection. The Affordable Care Act also establishes transitional reinsurance and temporary risk corridor programs and a permanent risk adjustment program, which will provide payments to issuers providing coverage to high-risk individuals, to mitigate the potential effects of adverse selection. These programs will provide payment stability to issuers and reduce

⁷⁷ Congressional Budget Office, Letter to Honorable Evan Bayh providing An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, November 30, 2009.

uncertainty in insurance risk in the individual market and in the small group market, in the case of the permanent risk adjustment program.

Administrative costs for issuers will be lowered because of the elimination of medical underwriting and banning coverage exclusions. Costs should decrease for processing new applications for coverage and implementing the ban on coverage exclusions in the individual and small group markets. This, in turn, could contribute to lower premium rates.

The proposed rule also would require all health insurance issuers marketing group or individual health insurance coverage to comply with the same marketing standards as issuers offering QHPs within the Exchanges. This minimizes the potential for the adverse selection that could result if plans sold through Exchanges were subject to different marketing standards from plans sold outside of the Exchanges. A common standard covering the entire insurance market would also ensure consistency in market oversight, increase competition and reduce search costs for consumers.⁷⁸

The proposed amendments to the Effective Rate Review Program would help issuers to avoid significant duplication of effort for filings subject to review by using the same standardized template for both non-QHPs and QHPs. Issuers would also no longer be required to submit the same type of data in different formats to different regulators. Additionally, the use of a standardized data template would provide state departments of insurance and CMS as applicable with more information to conduct the review and approval of products sold inside and outside an Exchange, monitor rates to detect patterns that could signal market disruption, and

⁷⁸ R. Cebul et al., *Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance*, *American Economic Review* 101(5): 1842-1847, 2011.

oversee the market-wide rules.

b. Costs

Under the proposed rule, issuers will likely incur some one-time, fixed costs in order to comply with the provisions of the final rule, including administrative expenditures for systems and software updates and changes in marketing. In addition, states may incur costs in order to establish geographic rating areas and uniform age rating curves.

In addition to these administrative costs, insurance coverage can lead to increased utilization of health services for individuals who become newly insured. While a portion of this increased utilization may be economically inefficient, studies that estimated the effects of Medicare found that the cost of this inefficiency is likely more than offset by the benefit of risk reduction.^{79,80}

We solicit data on the timing, nature and magnitude of these potential administrative and other costs and savings associated with the proposed rules relative to current practices, including merging the individual and small group markets into a single risk pool in a state, if the state chooses to do so. We also request information on whether the changes in rating rules would require issuers to undertake any systems and operational changes, and we solicit data on any related costs and potential savings as well as potential effects on premiums and financial performance. We are also soliciting information on how standardizing rating areas could affect rates. In addition, we are requesting information on any potential costs incurred by states to establish rating areas and uniform age rating curves if they choose to do so.

⁷⁹ Finkelstein, A, McKnight R: "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out Of Pocket Medical Spending " *Journal of Public Economics* 2008, 92:1644-1668.

⁸⁰ Finkelstein, A., "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," National Bureau of Economic Research. Working Paper No. 11619, Sept, 2005.

The proposed rule would also direct states to provide information to CMS about their rating and risk pooling practices in several key areas, as applicable. They include: age and tobacco rating factors, age rating curves, family tier structure, composite rating in the small group market, geographical rating areas, and combined individual and small group market risk pools. As discussed in the Collection of Information Requirements section, we estimate a total burden of approximately \$215 for a state to submit information in all seven areas.

Health insurance issuers seeking rate increases below the rate review threshold would submit data using the standardized data template and would incur administrative costs to prepare and submit the data. Based on CMS's experience with the 2011 MLR reporting year, there are 2,010 health insurance issuers (company/state combinations) offering coverage in the individual market in all states and 1,050 issuers offering coverage in the small group market in all states, while there are 2,294 unique issuers offering products in one or both markets. Most issuers would already have to provide this information to their respective states. We anticipate a total of 7,650 submissions for rate review increases annually in both markets. Based on past experience, we anticipate that approximately 1,200 of these submissions will be for rate increases at or above the threshold and the remaining 6,450 submissions will be for rate increases below the threshold. We assume that each submission will require 11 hours of work by an actuary (at a cost of \$225 per hour), including minimal time required for recordkeeping. Therefore, the increase in administrative costs for all issuers seeking rate increases below the threshold would be approximately \$16 million, with an average of \$7,000 per issuer. It should be noted that there are administrative efficiencies gained by helping issuers to avoid significant duplication of effort for filings subject to review by using the same standardized template for both non-QHPs and

QHPs across all states, and because the vast majority of states currently require all rate increases to be filed; these efficiencies are not quantified in this rule.

Additionally, all issuers seeking rate increases would need to adjust their systems to provide the data required in the standardized data template. We seek comments on the extent of these costs and plan to incorporate an estimate in the final rule.

For filings subject to review, states with Effective Rate Review Programs would be expected to use the data submissions in their reviews; however, it is not expected to increase review costs.

c. Transfers

As discussed elsewhere in the preamble, most aspects of rating methodology today are left to the discretion of health insurance issuers, subject to oversight by the states. In most states, issuers may vary premium rates based on a number of factors such as age, health status, and gender. In 2010, 60 percent of non-elderly adults who shopped for insurance coverage in the individual market had difficulty finding affordable coverage.⁸¹ Also, as a result of current gender rating, premium rates for women are significantly higher than those for men. According to a study by the National Women's Law Center, 92 percent of best-selling plans currently practice gender rating.⁸² The provision of fair premiums will allow issuers to vary rates based on only a limited number of factors and within specified ranges. Since rating based on gender and health will no longer be allowed, rates for some older, less healthy adults and women may

⁸¹ Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011.

⁸² National Women's Law Center, Turning to Fairness: Insurance discrimination against women today and the Affordable Care Act, Washington, D.C., March 2012.

decrease. While these rules could increase rates for younger, healthier adults and for some men, other factors will mitigate the effects of reformed rating practices, such as choices of and competition among plans on Exchanges, greater pooling of risks through the Exchanges, premium tax credits, the risk stabilization programs, access to catastrophic plans, and the minimum coverage provision.

As people who were previously uninsured obtain coverage, their out-of-pocket expenses are expected to decrease while the issuers' spending will increase, which is expected to be mitigated by an increase in premium revenues. Expansion in health insurance coverage will also reduce the amount of uncompensated care for providers that treat the uninsured. Millions of people without health insurance now use health care services for which they do not fully pay, shifting the uncompensated cost of their care to health care providers, people who do have insurance (in the form of higher premiums), and state and local governments.⁸³ Providers of uncompensated care try to recover the money by increasing the amounts charged to insurance companies, which results in higher premiums for individuals with private insurance. The cost of uncompensated care for the previously uninsured will be transferred from the providers (for example, hospitals and physicians), governmental programs and charitable organizations to the individuals and issuers of their health insurance coverage. Reduction in the number of uninsured would reduce the amount of uncompensated care and could lead to a decrease in private health insurance rates.

C. Regulatory Alternatives

⁸³ Families USA, Hidden Health Tax: Americans Pay a Premium (Washington, DC: Families USA, 2009) (<http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf>).

Under Executive Order 12866, CMS is required to consider alternatives to issuing rules and alternative regulatory approaches.

Under the proposed rule, all issuers in a state would use a uniform age rating curve. CMS considered the alternative of allowing issuers to set their own rating curve. Under the alternative, issuers would have more flexibility and might incur lower upfront, fixed costs (for example, systems and software updates) to comply with the proposed rule. A uniform age rating curve, however, would improve the accuracy of risk adjustment, increase consumer transparency when comparing prices across plans, and make it simpler to identify the second lowest cost silver plan for purposes of obtaining tax credits.

CMS also considered the alternatives of including a tobacco component for the rating curve and keeping the rating factor for tobacco use separate from the wellness program rules. These alternatives would reduce flexibility for the issuers with respect to rating for tobacco use and would provide no alternative to the tobacco surcharge, which could discourage disclosure of tobacco use. Under the proposed rule, a health insurance issuer in the small group market would be able to implement the tobacco use surcharge to employees only in connection with a wellness program that effectively allows tobacco users to reduce their premiums to the level of non-tobacco users by participating in a tobacco cessation program or satisfying another reasonable alternative. This proposal is designed to discourage underreporting of tobacco use and encourage tobacco users to enter cessation programs and improve their health and reduce health care costs.

CMS believes that the provisions of this proposed rule strike the best balance of extending protections of the Affordable Care Act to consumers while preserving the availability

of such coverage and minimizing market disruptions to the extent possible.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a “small entity” as -- (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000 (states and individuals are not included in the definition of “small entity”). CMS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed in the Web Portal final rule published on May 5, 2010 (75 FR 24481), CMS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for “small” business established by the SBA (currently \$7 million in annual receipts for health issuers).⁸⁴

In addition, CMS used the data from Medical Loss Ratio annual report submissions for the 2011 MLR reporting year to develop an estimate of the number of small entities that offer comprehensive major medical coverage. These estimates may overstate the actual number of

⁸⁴ Table of Small Business Size Standards Matched to North American Industry Classification System Codes, effective March 26, 2012, U.S. Small Business Administration, available at www.sba.gov.

small health insurance issuers that would be affected, since they do not include receipts from these companies' other lines of business. It is estimated that there are 22 small entities each with less than \$7 million in earned premiums that offer individual or group health insurance coverage and would therefore be subject to the requirements of this proposed regulation. These small entities account for less than five percent of the estimated 466 issuers that would be affected by the provisions of this rule. Thirty six percent of these small issuers belong to holding groups, and many if not all of these small issuers are likely to have other lines of business that would result in their revenues exceeding \$7 million. For these reasons, CMS expects that this proposed rule will not affect small issuers.

This rule proposes requirements that may affect health insurance premiums in the small group market. We expect that many employers that purchase health insurance coverage in the small group market would meet the SBA standard for small entities. As mentioned earlier in the impact analysis, the impact on premiums is likely to be small and may even lead to lower rates in the small group market.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any proposed rule that includes a Federal mandate that could result in any expenditure in any one year by state, local or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold level is approximately \$139 million.

UMRA does not address the total cost of a proposed rule. Rather, it focuses on certain categories of cost, mainly those "Federal mandate" costs resulting from--(1) imposing

enforceable duties on state, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs.

This proposed rule would give state governments the option to establish rating areas within the state and uniform age rating curves. There are no mandates on local or tribal governments. State governments may incur administrative cost related to the option of establishing rating areas and uniform age rating curves. However, if the state government does not act, CMS may establish the rating areas and uniform age rating curve in that state. State governments would also incur administrative costs related to disclosure of rating and pooling requirements to CMS, which are estimated to be \$215 per state. The private sector (for example, health insurance issuers) will incur administrative costs related to the implementation of the provisions in this proposed rule. This proposed rule would not impose an unfunded mandate on local or tribal governments. However, consistent with policy embodied in UMRA, this proposed rule has been designed to be the least burdensome alternative for state, local and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications.

As discussed earlier in the preamble, states are the primary regulators of health insurance coverage. States would continue to apply state laws regarding health insurance coverage. However, if any state law or requirement prevents the application of a Federal standard, then that

particular state law or requirement would be preempted. If CMS determines that a state does not meet the criteria for an Effective Rate Review Program, then CMS would review a rate increase subject to review to determine whether it is unreasonable. If a state does meet the criteria, then CMS would adopt that state's determination of whether a rate increase is unreasonable. States would continue to apply state law requirements regarding rate and policy filings. State requirements that are more stringent than the Federal requirements would be not be preempted by this proposed rule. Accordingly, states have significant latitude to impose requirements with respect to health insurance coverage that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policymaking discretion of the states, CMS has engaged in efforts to consult with and work cooperatively with affected states, including consulting with National Association of Insurance Commissioners.

Throughout the process of developing this proposed rule, CMS has attempted to balance the states' interests in regulating health insurance issuers and Congress's intent to provide uniform protections to consumers in every state. By doing so, it is CMS's view that it has complied with the requirements of Executive Order 13132. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this rule, HHS certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 for the attached proposed rule in a meaningful and timely manner.

G. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small

Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and state regulation of health insurance.

45 CFR Part 150

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 144, 147, 150, 154, and 156 as set forth below:

PART 144 – REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

1. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

2. Section 144.101 is amended by revising paragraphs (d)(1) and (d)(2) to read as follows:

§144.101 Basis and purpose.

* * * * *

(d) * * *

(1) States that fail to substantially enforce one or more provisions of part 146 concerning group health insurance, one or more provisions of part 147 concerning group or individual health insurance, or the requirements of part 148 of this subchapter concerning individual health insurance.

(2) Insurance issuers in States described in paragraph (d)(1) of this section.

* * * * *

3. Section 144.102 is revised to read as follows:

§144.102 Scope and applicability.

(a) For purposes of 45 CFR parts 144 through 148, all health insurance coverage is generally divided into two markets – the group market and the individual market. The group market is further divided into the large group market and the small group market.

(b) The protections afforded under 45 CFR parts 144 through 148 to individuals and employers (and other sponsors of health insurance offered in connection with a group health plan) are determined by whether the coverage involved is obtained in the small group market, the large group market, or the individual market.

(c) Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage under 45 CFR parts 144 through 148. If the coverage is offered to an association member other than in connection with a group health plan, or is offered to an association's employer-member that is maintaining a group health plan that has fewer than two participants who are current employees on the first day of the plan year, the coverage is considered individual health insurance coverage for purposes of 45 CFR parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law. If the health insurance coverage is offered in connection with a group health plan as defined at 45 CFR 144.103, it is considered group health insurance coverage for purposes of 45 CFR parts 144 through 148.

(d) Provisions relating to CMS enforcement of parts 146, 147, and 148 are contained in part 150 of this subchapter.

PART 147 – HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

4. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

5. Section 147.102 is added to read as follows:

§147.102 Fair health insurance premiums.

(a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market--

(1) The rate may vary with respect to the particular plan or coverage involved only by determining the following:

(i) Whether the plan or coverage covers an individual or family.

(ii) Rating area, as established in accordance with paragraph (b) of this section.

(iii) Age, except that the rate must not vary by more than 3:1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under paragraph (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph and the age band in paragraph (d) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal shall be used. Nothing in this paragraph prevents a state from requiring the use of a ratio narrower than 3:1 in connection with establishing rates for individuals who are age 21 and older. A state that uses a narrower ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS.

(iv) Tobacco use, except that such rate shall not vary by more than 1.5:1 for like individuals who vary in tobacco usage. (See § 147.110, related to prohibiting discrimination based on health status and programs of health promotion or disease prevention.) Nothing in this paragraph prevents a state from requiring the use of a ratio narrower than 1.5:1 in connection with establishing rates for individuals who vary in tobacco usage. A state that uses a narrower

ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS.

(2) The rate must not vary with respect to the particular plan or coverage involved by any other factor not described in paragraph (a)(1) of this section.

(b) Rating area. (1) A state may establish rating areas within that state for purposes of applying this section and the requirements of title XXVII the Public Health Service Act and title I of the Patient Protection and Affordable Care Act. A state that establishes rating areas shall submit to CMS information on its rating areas in accordance with the date and format specified by CMS.

(2) If a state's rating areas are not consistent with paragraph (b)(3) of this section, or if a state does not establish rating areas, the standard under paragraph (b)(3)(i) of this section shall apply unless CMS establishes rating areas within the state applying one of the standards under paragraph (b)(3)(ii) of this section.

(3) A state's rating areas will be presumed adequate if one of the following requirements are met:

(i) There is only one rating area within the state.

(ii) There are no more than seven rating areas based on the one of the following geographic divisions: counties, three-digit zip codes, or metropolitan statistical areas/non-metropolitan statistical areas.

(4) Notwithstanding paragraph (b)(3) of this section, a state may propose to CMS for approval other existing geographic divisions on which to base rating areas or a number of rating areas greater than seven.

(c) Application of variations based on age or tobacco use. With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(1)(iii) and (a)(1)(iv) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage.

(1) Per-member rating. The total premium for family coverage must be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest family members who are under age 21 must be taken into account.

(2) Family tiers under community rating. If a state does not permit any rating variation for factors that otherwise would be permitted under paragraphs (a)(1)(iii) and (a)(1)(iv) of this section, the state may elect to require that premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers established by the state. A state that establishes uniform family tiers and corresponding multipliers shall submit to CMS information on its uniform family tiers and corresponding multipliers in accordance with the date and format specified by CMS. If a state does not establish uniform family tiers and the corresponding multipliers, the per-member rating methodology under paragraph (c)(1) of this section will apply in that state.

(3) Application to small group market. In the case of the small group market, the total premium charged to the group shall be determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable. Nothing in this section shall preclude a state from requiring issuers to offer, or an issuer from voluntarily offering, to a group premiums that are based on average enrollee

amounts, provided that the total group premium is the same total amount derived in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable. A state that requires premiums based on average enrollee amounts shall submit to CMS information on its election in accordance with the date and format specified by CMS.

(d) Uniform age bands. The following uniform age bands apply for rating purposes under paragraph (a)(1)(iii) of this section:

(1) Child age bands. A single age band for individuals age 0 to 20.

(2) Adult age bands. One-year age bands starting at age 21 and ending at age 63.

(3) Older adult age bands. A single age band for individuals age 64 and older.

(e) Uniform age rating curves. Each state must establish a uniform age rating curve for rating purposes under paragraph (a)(1)(iii) of this section and submit to CMS information on its uniform age rating curve in accordance with the date and format specified by CMS. If a state does not establish a uniform age rating curve by a date specified by CMS, a default uniform age rating curve established by CMS shall apply in that state which takes into account the rating variation permitted for age under state law.

(f) Special rule for large group market. If a state permits health insurance issuers that offer coverage in the large group market in the state to offer such coverage through an Exchange starting in 2017, the provisions of this section applicable to coverage in the small group market shall apply to all coverage offered in the large group market in the state.

(g) Applicability date. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2014.

(h) Grandfathered health plans. This section does not apply to grandfathered health plans.

6. Section 147.104 is added to read as follows:

§147.104 Guaranteed availability of coverage.

(a) Guaranteed availability of coverage in the individual and group market. Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance 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 applicable market, and must accept any individual or employer that applies for any of those products.

(b) Enrollment periods. A health insurance issuer may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) Open enrollment periods -- (i) Group market. A health insurance issuer in the group market must permit an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group market, a health insurance issuer may decline to offer coverage to a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules, as defined in §147.106(b)(3), pursuant to applicable state law and, in the case of a QHP offered in the SHOP, as permitted by §156.285(c) of this subchapter. With respect to coverage in the small group market, and in the large group market if such coverage is offered in a Small Business Health Options Program (SHOP) in a state, coverage shall become effective consistent with the dates described in §155.725(h) of this subchapter.

(ii) Individual market. A health insurance issuer in the individual market must permit an individual to purchase health insurance coverage during the initial and annual open enrollment periods described in §155.410(b) and (e) of this subchapter, with such coverage becoming effective consistent with the dates described in §155.410(c) and (f) of this subchapter.

(2) Special enrollment periods. A health insurance issuer in the group market and individual market shall establish special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. Enrollees shall be provided 30 calendar days after the date of the qualifying event to elect coverage, with such coverage becoming effective consistent with the dates described in §155.420(b) of this subchapter. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(c) Special rules for network plans. (1) In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may do the following:

(i) Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work, or reside in the service area for the network plan, and limit the individuals who may apply for the coverage in the individual market to those who live or reside in the service area for the network plan.

(ii) Within the service area of the plan, deny coverage to employers and individuals if the issuer has demonstrated to the applicable state authority (if required by the state authority) the following:

(A) It will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees.

(B) It is applying paragraph (c)(1) of this section uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees, and dependents.

(2) An issuer that denies health insurance coverage to an individual or an employer in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer coverage in the individual or group market, as applicable, within the service area to any individual or employer, as applicable, for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) Application of financial capacity limits. (1) A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated to the applicable state authority (if required by the state authority) the following:

(i) It does not have the financial reserves necessary to underwrite additional coverage.

(ii) Is applying this paragraph (d)(1) uniformly to all employers or individuals in the group or individual market, as applicable, in the state consistent with applicable state law and without regard to the claims experience of those individuals, employers and their employees (and

their dependents) or any health status-related factor relating to such individuals, employees, and dependents.

(2) An issuer that denies group health insurance coverage to any employer or individual in a state under paragraph (d)(1) of this section may not offer coverage in the group or individual market, as applicable, in the state before the later of either of the following dates:

(i) The 181st day after the date the issuer denies coverage.

(ii) The date the issuer demonstrates to the applicable state authority, if required under applicable state law, that the issuer has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) An applicable state authority may provide for the application of this paragraph (d) on a service-area-specific basis.

(e) Marketing. A health insurance issuer and its officials, employees, agents and representatives must comply with any applicable state laws and regulations regarding marketing by health insurance issuers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage.

(f) Applicability date. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2014.

(g) Grandfathered health plans. This section does not apply to grandfathered health plans.

7. Section 147.106 is added to read as follows:

§147.106 Guaranteed renewability of coverage.

(a) General rule. Subject to paragraphs (b) through (d) of this section, a health insurance issuer offering health insurance coverage in the individual or group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable.

(b) Exceptions. An issuer may nonrenew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums. The plan sponsor or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) Fraud. The plan sponsor or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.

(3) Violation of participation or contribution rules. In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law. For purposes of this paragraph (b) the following apply:

(i) The term “employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(ii) The term “group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(4) Termination of plan. The issuer is ceasing to offer coverage in the market in accordance with paragraph (c) or (d) of this section and applicable state law.

(5) Enrollees' movement outside service area. For network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under §147.104(c)(1)(i).

(6) Association membership ceases. For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(c) Discontinuing a particular product. In any case in which an issuer decides to discontinue offering a particular product offered in the group or individual market, that product may be discontinued by the issuer in accordance with applicable state law in the applicable market only if the following occurs:

(1) The issuer provides notice in writing to each plan sponsor or individual, as applicable, provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 calendar days before the date the coverage will be discontinued.

(2) The issuer offers to each plan sponsor or individual, as applicable, provided that particular product the option, on a guaranteed issue basis, to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in that market.

(3) In exercising the option to discontinue that product and in offering the option of coverage under paragraph (c)(2) of this section, the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(d) Discontinuing all coverage. (1) An issuer may elect to discontinue offering all health insurance coverage in the individual or group market, or all markets, in a state in accordance with applicable state law only if the issuer meets all of the following conditions:

(i) The issuer provides notice in writing to the applicable state authority and to each plan sponsor or individual, as applicable, (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued.

(ii) All health insurance policies issued or delivered for issuance in the state in the applicable market (or markets) are discontinued and not renewed.

(2) An issuer that elects to discontinue offering all health insurance coverage in a market (or markets) in a state as described in this paragraph (d) may not issue coverage in the applicable market (or markets) and state involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(e) Exception for uniform modification of coverage. Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the following:

(1) Large group market.

(2) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with state law and is effective uniformly among group health plans with that product.

(f) Application to coverage offered only through associations. In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, the reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

(g) Applicability date. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2014.

(h) Grandfathered health plans. This section does not apply to grandfathered health plans.

8. Section 147.145 is amended by revising paragraph (b)(1) to read as follows:

§147.145 Student health insurance coverage.

* * * * *

(b) Exemptions from the Public Health Service Act.

(1) Guaranteed availability and guaranteed renewability. (i) For purposes of sections 2741(e)(1) and 2742(b)(5) of the Public Health Service Act, student health insurance coverage is deemed to be available only through a bona fide association.

(ii) For purposes of section 2702(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage shall not be required to accept persons who are not students or dependents of students in such coverage.

(iii) For purposes of section 2703(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage shall not be required to renew or continue coverage for individuals who are no longer students or dependents of students.

* * * * *

**PART 150 – CMS ENFORCEMENT IN GROUP AND INDIVIDUAL INSURANCE
MARKETS**

9. The authority citation for part 150 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

10. Section 150.101 is amended by revising paragraphs (a) and (b)(2) to read as follows:

§150.101 Basis and scope.

(a) Basis. CMS's enforcement authority under sections 2723 and 2761 of the PHS Act and its rulemaking authority under section 2792 of the PHS Act provide the basis for issuing regulations under this part 150.

(b) * * *

(2) Enforcement with respect to health insurance issuers. The states have primary enforcement authority with respect to the requirements of title XXVII of the PHS Act that apply to health insurance issuers offering coverage in the group or individual health insurance market. If CMS determines under subpart B of this part that a state is not substantially enforcing title XXVII of the PHS Act, including the implementing regulations in parts 146, 147, and 148 of this subchapter, CMS enforces them under subpart C of this part.

11. Section 150.103 is amended by--

- a. Removing the definition of “HIPAA requirements;”
- b. Revising the definition of “Individual health insurance policy or individual policy;”

and

- c. Adding the definition of “PHS Act requirements” in alphabetical order.

The revision and addition read as follows:

§150.103 Definitions.

* * * * *

Individual health insurance policy or individual policy means the legal document or contract issued by the issuer to an individual that contains the conditions and terms of the insurance. Any association or trust arrangement that is not a group health plan as defined in §144.103 of this subchapter or does not provide coverage in connection with one or more group health plans is individual coverage subject to the requirements of parts 147 and 148 of this subchapter. The term “individual health insurance policy” includes a policy that is –

- (1) Issued to an association that makes coverage available to individuals other than in

connection with one or more group health plans; or

(2) Administered, or placed in a trust, and is not sold in connection with a group health plan subject to the provisions of parts 146 and 147 of this subchapter.

PHS Act requirements means the requirements of title XXVII of the PHS Act and its implementing regulations in parts 146, 147, and 148 of this subchapter.

* * * * *

12. In 45 CFR part 150, remove the words “HIPAA requirement” or “HIPAA requirements,” and add in their place “PHS Act requirement” or “PHS Act requirements,” respectively, wherever they appear in the following places.

- a. Section 150.103, in the definition of “Complaint”.
- b. In the heading of subpart B of part 150.
- c. Section 150.201.
- d. Section 150.203, in the introductory text and paragraphs (a) and (b).
- e. Section 150.205(d) and (e)(1).
- f. Section 150.207, in the section heading and text.
- g. Section 150.209.
- h. Section 150.211, in the introductory text.
- i. Section 150.213(b) and (c).
- j. Section 150.217, in the introductory text.
- k. Section 150.219(a).
- l. Section 150.221(a).
- m. Section 150.301.

- n. Section 150.303(a) introductory text, (a)(3), and (b).
- o. Section 150.305(a)(1), (b)(2), and (c)(2).
- p. Section 150.309.
- q. Section 150.311, in the introductory text and paragraphs (d), (f) introductory text, (f)(3), and (g).
- r. Section 150.313(a) and (e)(3)(iv).
- s. Section 150.317(a)(1) and (a)(3).
- t. Section 150.319(b)(1) introductory text, (b)(1)(ii), and (b)(1)(iii).
- u. Section 150.343(a).
- v. Section 150.465(c).

PART 154 – HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

13. The authority citation for part 154 continues to read as follows:

Authority: Section 2794 of the Public Health Service Act (42 U.S.C. 300gg-94).

14. Section 154.200 is amended by revising paragraphs (a)(2) and (b) to read as follows:

§154.200 Rate increases subject to review.

(a) * * *

(2) * * * A State-specific threshold shall be based on factors impacting rate increases in a State to the extent that the data relating to such State-specific factors is available by August 1. States interested in proposing a State-specific threshold for approval are required to submit a proposal to the Secretary by August 1.

(b) The Secretary will publish a notice no later than September 1 of each year, to be

effective on January 1 of the following year, concerning whether a threshold under paragraph (a)(1) or (a)(2) of this section applies to the State; except that, with respect to the 12-month period that begins on September 1, 2011, the threshold under paragraph (a)(1) of this section applies.

* * * * *

15. Section 154.215 is revised to read as follows:

§154.215 Submission of rate filing justification.

(a) If any product is subject to a rate increase, a health insurance issuer must submit a Rate Filing Justification for all products on a form and in a manner prescribed by the Secretary.

(b) The Rate Filing Justification must consist of the following Parts:

(1) Standardized data template (Part I), as described in paragraph (d) of this section.

(2) Written description justifying the rate increase (Part II), as described in paragraph (e) of this section.

(3) Rating filing documentation (Part III), as described in paragraph (f) of this section.

(c) A health insurance issuer must complete and submit Parts I and III of the Rate Filing Justification described in paragraphs (b)(1) and (b)(3) of this section to CMS and, as long as the applicable State accepts such submissions, to the applicable State for any rate increase. If a rate increase is subject to review, then the health insurance issuer must also complete and submit to CMS and, if applicable, the State Part II of the Rate Filing Justification described in paragraph (b)(2) of this section.

(d) Content of standardized data template (Part I): The standardized data template must include the following as determined appropriate by the Secretary:

- (1) Historical and projected claims experience.
 - (2) Trend projections related to utilization, and service or unit cost.
 - (3) Any claims assumptions related to benefit changes.
 - (4) Allocation of the overall rate increase to claims and non-claims costs.
 - (5) Per enrollee per month allocation of current and projected premium.
 - (6) Three year history of rate increases for the product associated with the rate increase.
- (e) Content of written description justifying the rate increase (Part II): The written

description of the rate increase must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase and including the following:

(1) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary.

(2) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

(f) Content of rate filing documentation (Part III): The rate filing documentation must include an actuarial memorandum that contains the reasoning and assumptions supporting the data contained in Part I of the Rate Filing Justification. Parts I and III must be sufficient to conduct an examination satisfying the requirements of §154.301(a)(3) and (4) and determine whether the rate increase is an unreasonable increase. Instructions concerning the requirements for the rate filing documentation will be provided in guidance issued by CMS.

(g) If the level of detail provided by the issuer for the information under paragraphs (d) and (f) of this section does not provide sufficient basis for CMS to determine whether the rate

increase is an unreasonable rate increase when CMS reviews a rate increase subject to review under §154.210(a), CMS will request the additional information necessary to make its determination. The health insurance issuer must provide the requested information to CMS within 10 business days following its receipt of the request.

(h) Posting of the disclosure on the CMS Web site:

(1) CMS promptly will make available to the public on its Web site the information contained in Part II of each Rate Filing Justification.

(2) CMS will make available to the public on its Web site the information contained in Parts I and III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information as defined in CMS's Freedom of Information Act regulations, 45 CFR 5.65.

(3) CMS will include a disclaimer on its Web site with the information made available to the public that explains the purpose and role of the Rate Filing Justification.

(i) CMS will include information on its Web site concerning how the public can submit comments on the proposed rate increases that CMS reviews.

16. Section 154.220 is revised to read as follows:

§154.220 Timing of providing the rate filing justification.

A health insurance issuer must submit a Rate Filing Justification for all rate increases that are filed in a State on or after April 1, 2013, or effective on or after January 1, 2014 in a State that does not require the rate increase to be filed, as follows:

(a) If a State requires that a proposed rate increase be filed with the State prior to the implementation of the rate, the health insurance issuer must submit to CMS and the applicable

State the Rate Filing Justification on the date on which the health insurance issuer submits the proposed rate increase to the State.

(b) For all other States, the health insurance issuer must submit to CMS and the State the Rate Filing Justification prior to the implementation of the rate increase.

§ 154.225 [Amended]

17a. In §154.225(a), introductory text, remove the words “Preliminary Justification” and add in their place “Rate Filing Justification.”

§ 154.230 [Amended]

17b. In §154.230(b) and (c)(1), remove the words “Preliminary Justification” and add in their place “Rate Filing Justification.”

18. Section 154.301 is amended as follows:

- a. Amending paragraph (a)(3)(i) by removing “; and” and adding in its place a period.
- b. Amending paragraphs (a)(4)(i), (a)(4)(ii), and (a)(4)(vi) through (a)(4)(x) by removing the semicolons and replacing them with periods.
- c. Amending paragraph (a)(3)(xi) by removing “: and” and adding in its place a period.
- d. Revising paragraphs (a)(4)(iii) through (a)(4)(v), and (b).
- e. Redesignating paragraph (a)(4)(xii) as paragraph (a)(4)(xiii) and adding new paragraphs (a)(3)(iii), (a)(3)(iv), (a)(4)(xii), and (a)(4)(xiv) through (a)(4)(xvi).

The revisions and additions read as follows:

§154.301 CMS’s determinations of effective rate review programs.

(a) * * *

(3) * * *

(iii) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the Federal reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.

(iv) 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 reforms rules as required by the Affordable Care Act.

(4) * * *

(iii) The impact of cost-sharing changes by major service categories, including actuarial values.

(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.

(v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.

* * * * *

(xii) Other standardized ratio tests recommended or required by statute, regulation, or best practices.

* * * * *

(xiv) The impacts of geographic factors and variations.

(xv) The impact of changes within a single risk pool to all products or plans within the risk pool.

(xvi) The impact of Federal reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

* * * * *

(b) Public disclosure and input. In addition to satisfying the provisions in paragraph (a) of this section, a State with an Effective Rate Review Program must provide, for the rate increases it reviews, access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS's Web address for such information) and have a mechanism for receiving public comments on those proposed rate increases.

* * * * *

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

19. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321, 1322, 1324, 1334, 1342–1343, and 1401–1402, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18042).

20. Section 156.80 is added to subpart A to read as follows:

§156.80 Single risk pool.

(a) Individual market. A health insurance issuer shall consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the individual market in a state,

including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(b) Small group market. A health insurance issuer shall consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the small group market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(c) Merger of the individual and small group markets. A state may require the individual and small group insurance markets within a state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger of risk pools shall submit to CMS information on its election in accordance with the date and format specified by CMS.

(d) Index rate -- (1) In general. Each plan year or policy year, as applicable, a health insurance issuer shall establish an index rate for a state market based on the total combined claims costs for providing essential health benefits within the single risk pool of that state market. The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the state. The premium rate for all of the health insurance issuer's plans in the relevant state market must use the applicable index rate, as adjusted for total expected market-wide payments and charges under the risk adjustment and reinsurance programs, subject only to the adjustments permitted in paragraph (d)(2) of this section.

(2) Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a

particular plan from its index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(i) The actuarial value and cost-sharing design of the plan.

(ii) The plan's provider network, delivery system characteristics, and utilization management practices.

(iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(iv) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

(e) Grandfathered health plans in the individual and small group market. A state law requiring grandfathered health plans to be included in a single risk pool described in paragraph (a) or (b) of this section shall not apply.

(f) Applicability date. The provisions of this section apply for plan years (as that term is defined in §144.103 of this subchapter) in the group market, and for policy years (as that term is defined in §144.103 of this subchapter) in the individual market, beginning on or after January 1, 2014.

21. Section 156.155 is added to subpart B to read as follows:

§156.155 Enrollment in catastrophic plans.

(a) General rule. A health plan is a catastrophic plan if it meets the following conditions:

(1) Meets all applicable requirements for health insurance coverage in the individual

market (including but not limited to those requirements described in parts 147 and 148 of this subchapter), and is offered only in the individual market.

(2) Does not provide a bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the Affordable Care Act.

(3) Provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act once the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act is reached.

(4) Provides coverage for at least three primary care visits per year before reaching the deductible.

(5) Covers only individuals who meet either of the following conditions:

(i) Have not attained the age of 30 prior to the first day of the plan year.

(ii) Have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of the Affordable Care Act.

(b) Coverage of preventive health services. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services, in accordance with section 2713 of the Public Health Service Act.

(c) Application for family coverage. For other than self-only coverage, each individual enrolled must meet the requirements of paragraph (a)(4) of this section.

CMS-9972-P

Dated: May 15, 2012

Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: August 6, 2012

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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