

Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review Summary of Final Rule

March 4, 2013

On February 27, 2013, the Department of Health and Human Services (HHS) published in the *Federal Register* at 78 *FR* 13406-13492 the final rule to implement policies under the Affordable Care Act (ACA)¹ related to fair health insurance premiums (rating requirements), guaranteed availability, guaranteed renewability, risk pools, and catastrophic plans. It also clarifies the approach used to enforce the applicable requirements of the ACA with respect to health insurance issuers and group health plans that are non-federal governmental plans. In addition, it amends 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), relating to ensuring that consumers get value for their dollars (rate review). The provisions generally apply to health insurance coverage for plan or policy years beginning on or after January 1, 2014.

HHS says that the final rule largely incorporates the provisions of the proposed rule. The most significant provisions that differ from the proposed rule are²:

- HHS clarifies that tobacco use means use of tobacco on average four or more times per week within no longer than the past six months, including all tobacco products but excluding religious and ceremonial uses of tobacco. Tobacco use must be defined in terms of when a tobacco product was last used. Issuers may vary rates for tobacco use only with respect to individuals who may legally use tobacco under federal and state law.
- States are provided additional flexibility to establish geographic rating areas that would be presumed adequate.
- The default rating area standard is modified. There will be one rating area for each metropolitan statistical area and one rating area comprising all non-metropolitan statistical areas in the state. HHS also clarifies the criteria that will be used to determine whether proposed state rating areas are adequate.
- HHS has added events triggering limited open enrollment periods in the individual market, consistent with Exchange special enrollment periods, as well as a one-time limited open enrollment period for the 2014 calendar year for individuals with non-calendar year individual policies.
- HHS establishes 60-day special and limited open enrollment periods in the individual market; a 30-day special enrollment period is provided in the group market.

¹ 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 (ACA).

² See 78 *FR* 13426-7 for HHS' list of changes in the final rule.

- HHS clarifies that if any product is subject to a rate increase, an issuer must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products.

The provisions of the final rule are summarized below. Many of the ACA's market reforms that are implemented by this rule are amendments to prior federal minimum insurance standards that were established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which were codified in the PHS Act (as well as other federal laws). In this summary, the sections of the PHS Act that were added or amended by title I of the ACA are indicated.³

Table of Contents	
I. Background	3
A. Legislative Overview	3
B. Structure of the Final Rule	4
II. Provisions of the Proposed Rule and Analysis and Response to Comments	4
A. Part 144 – Requirements Relating to Health Insurance Coverage	4
1. Subpart A- General Provisions (§144.101 and §144.102)	4
B. Part 147 – Health Insurance Reform Requirements for the Group and Individual Insurance Markets	5
1. Fair Health Insurance Premiums (§147.102)	5
2. State Reporting (§147.103)	12
3. Guaranteed Availability of Coverage (§147.104)	13
4. Guaranteed Renewability of Coverage (§147.106)	17
C. Part 150 – CMS Enforcement in Group and Individual Insurance Markets	18
D. Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review	18
1. Subpart B – Disclosure and Review Provisions	19
2. Subpart C- Effective Rate Review Programs	20
E. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges	21
1. Subpart A – General Provisions	21
2. Subpart B – Standards for Essential Health Benefits, Actuarial Value and Cost-Sharing	23
F. Applicability to Special Plan Types	23
III. Collection of Information Requirements	25
IV. Regulatory Impact Analysis	26

³ A compiled version of the PHS Act as it relates to amendments made by the ACA is available at <http://housedocs.house.gov/energycommerce/ppacacon.pdf>

I. Background

A. Legislative Overview

HHS explains in this section of the preamble how the relevant provisions of the ACA amend title XXVII of the PHS Act and the applicability of each of the provisions.

Subtitles A and C of title I of the ACA reorganized, amended, and added provisions to part A of title XXVII relating to health insurance issuers in the group and individual markets and group health plans that are non-federal governmental plans. 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. These provisions will establish a federal floor that ensures that all individuals and employers in all states have certain basic protections with respect to the availability of the health insurance coverage.

The market rules apply to non-grandfathered health insurance coverage starting in policy year (individual) or plan year (group) beginning on or after January 1, 2014. The market rules do not apply to grandfathered health insurance coverage, self-funded (self-insured) plans, excepted benefits, or individual short-term duration coverage. The following HHS table (not included in the proposed or final rule) identifies the key differences in the application of the major market rules to the different health insurance markets:

	Individual	Small Group	Large Group
Modified Community Rating	Yes	Yes	No, unless a state allows large groups to buy in the Exchange (2017 and thereafter)
Single Risk Pool	Yes	Yes	No
Guaranteed Issue	Yes	Yes	Yes
Renewability	Yes	Yes	Yes
See: http://cciio.cms.gov/resources/files/market-rules-nprm-11-26-2012.pdf			

HHS explains that the ACA also 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 §2723.

Under the preemption provisions of PHS Act §2724(a)(1), the requirements of the ACA 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 except to the extent that such standard or requirement prevents the application of a requirement” of the ACA. Section 1321(d) of the ACA applies the same preemption principle to requirements of title I of the ACA. Therefore, state laws that impose stricter requirements on issuers than those imposed by the ACA will not be superseded by the ACA.

Section 1302 of the ACA specifies levels of cost-sharing protections that health plans will offer, including a catastrophic plan for young adults and people who cannot otherwise afford health insurance.

Section 1312(c) of the ACA creates a single risk pool standard applicable in and out of the Exchange and to both QHPs and non-QHPs. The single risk pool requirement is applied separately to the individual and small group markets. In addition, states may choose to have a merged individual and small group market pool.

Section 1003 of the ACA adds a new §2794 of the PHS Act, which directs the Secretary, in conjunction with the states, to establish a process for the annual review of “unreasonable increases in premiums for health insurance coverage.” Issuers must submit to the Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. Beginning with plan years beginning in 2014, the Secretary, in conjunction with the states, is required to monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. These requirements do not apply to grandfathered health insurance coverage or to self-funded plans. Regulations at 45 CFR 154.101(b) further limit the scope of review to small group and individual market coverage.

B. Structure of the Final Rule

The regulations outlined in this final rule are codified in 45 CFR parts 144, 147, 150, 154, and 156. Part 144 outlines standards regarding the basis, scope, and applicability of 45 CFR Parts 144 through 148. Part 147 outlines standards for health insurance issuers in the group and individual markets related to health insurance reforms. Part 150 outlines standards regarding enforcement. Part 154 outlines standards for health insurance issuers in the small group and individual markets with respect to rate increase disclosure and review. Part 156 outlines standards for issuers of QHPs, including with respect to participation in an Exchange

II. Provisions of the Proposed Rule and Analysis and Response to Comments

The proposed rule was published in the November 26, 2012 *Federal Register*. In response, HHS received approximately 500 comment letters from a wide variety of stakeholders. In addition, HHS consulted with the NAIC through its Health Care Reform Actuarial (B) Working Group to define permissible age bands and consulted with and requested formal, written comments from tribal leaders and representatives about the provisions of this rule that impact tribes.

A. Part 144- Requirements Relating to Health Insurance Coverage

1. Subpart A – General Provisions (§144.101 and §144.102)

HHS had proposed technical changes to these sections of the regulations to clarify enforcement of the ACA health insurance reform requirements and implemented in 45 CFR Part 147. It also proposed to clarify how to determine whether insurance sold through associations is group or individual coverage. The proposed language, repeated below, has been adopted as final—

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.

In response to comments requesting clarification about how to determine whether a group policy should be treated as large group or small group coverage for purposes of applying the PHS requirements when employer group size fluctuates between the definitions, HHS advises that it will issue future guidance on counting employees for determining market size of a group health plan.

B. Part 147-Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Fair Health Insurance Premiums (§147.102)

This section implements PHS Act §2701, which specifies that the only rating factors that issuers may use to vary premium rates for health insurance coverage in the individual and small group markets are: (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. The age, tobacco use, and geographic factors are multiplicative. Thus, the maximum variation for both age (for adults) and tobacco use is 4.5:1 (3 times 1.5:1). The family rate calculation may be additive or multiplicative, depending on whether a per-member or family tier rating methodology is used (see below).⁴

Some commenters requested flexibility in the application of §2701, such as permitting a phase in of the 3:1 age rating factor. HHS responds that it does not have the legal authority to permit any rating factors other than those explicitly permitted by §2701, or to provide for a phase-in of rating provisions such as the age rating or per-member-rating methodology.

⁴ CMS notes that all non-grandfathered health insurance coverage offered through associations and multiple employer welfare arrangements (MEWAs) is subject to the premium rating rules applicable to the appropriate market, as defined by PHS Act §2791(e)(1), (3), and (5) (definitions of individual market, large group market, and small group market, respectively).

a. Family Rating

In §147.102(c)(1), HHS proposed that issuers develop the family premium by adding up the rate of each family member. However, 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. HHS' intent in proposing this measure was 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. HHS proposed a cut-off age of 21 for this cap in order to be consistent with the cut-off age used in the proposed rule on age rating, as well as with the requirement that child-only policies be available to those under age 21.

HHS has adopted the proposed rule as final with the added clarification that the cap applies only to the rates of no more than the three oldest "covered children" under age 21. HHS explains that it has retained the per-member rating because the age and tobacco use factors must be attributable to individuals. Only community rated states, which do not allow rating based on age or tobacco use, are able to implement family-tier-rating (as opposed to per member structures consistent with the ACA). Those states may require all issuers to use a standard family tier methodology with corresponding multipliers and may set the number of tiers in the family-tier structure. If a state has community rating but does not adopt a uniform family-tier structure (with corresponding multipliers), per-member rating will apply in that state.

Some commenters recommended that the final rule defer to the states (and to issuers if permitted by state law) on the categories of family members that must be included on a family policy, noting that state law typically provides the basis for defining familial status. Others urged adoption of a broad definition of family coverage that accounts for all family compositions. HHS does not include in the final rule the minimum categories of family members that must be rated together on a family policy. HHS says that it recognizes that state laws differ with respect to marriage, adoption, and custody and that states are thus best positioned to make decisions regarding family coverage practices. Accordingly, HHS has concluded that states should have the flexibility to require issuers to include specific types of individuals on a family policy. Nothing in these final rules precludes this ability. (If an individual is not eligible for family coverage, he or she will be able to purchase individual coverage on a guaranteed availability basis.)

b. Small Group Rating

HHS had proposed that issuers in the small group market calculate rates for employee and dependent coverage on a per-member basis and then calculate the group premium by totaling the premiums attributable to each covered individual. HHS noted that a state could still require issuers to offer, or an issuer to voluntarily offer, a group premium based on a composite approach, provided that the total group premium equaled the premium that would be derived through the per-member-rating approach. Employers would retain flexibility to decide how to allocate employer contributions to health coverage.

Many commenters supported the per-member rating approach, especially in the Small Business Health Options Program (SHOP) where an “employee choice” model would make composite rating difficult to administer. However, some recommended allowing composite rating in the small group market outside the SHOP, and for “employer choice” coverage inside the SHOP where permitted, to minimize disruption in current issuer rating practices. Others raised concern that moving to per member rating could increase premiums for older workers.

HHS adopts the proposed per-member rating methodology in the small group market as final. HHS restates that nothing in the rule precludes a state from requiring issuers to offer (or a small employer from electing to offer) premiums based on average employee amounts where every employee in the group is charged the same premium. HHS also notes that the age bands, as implemented by the per-member-rating methodology, are only generally applicable to health insurance coverage in the individual and small group markets and are consistent with the Age Discrimination in Employment Act of 1967.

c. Geographic Rating

In §147.102(b), HHS proposed that each state establish rating areas, which would be presumed adequate if they met one of the following: one rating area for the entire state, or no more than seven rating areas based on counties, three-digit zip codes, or metropolitan statistical areas (MSAs) and non-MSA geographic divisions. States would also be permitted to use other actuarially justified geographic divisions, or a number of rating areas greater than seven, with HHS approval to ensure adequacy. For states that did not exercise the option to establish rating areas (or a state’s rating areas were determined to be inadequate), the default would be a single rating area for the entire state or one of the other proposed geographic standards as determined by HHS in consultation with the state, local issuers, and other interested stakeholders. Comments were requested on various aspects of the proposed geographic rating area standards, such as the use of other geographic divisions or factors; the maximum number of rating areas within a state that would be presumed adequate; whether states with existing rating areas would have to make changes to conform to the proposed standards; whether to establish minimum geographic size and population requirements; and the appropriate schedules and procedures for states to modify their rating areas in the future.

Some concerns were expressed that HHS would not extend a presumption of adequacy if a state established more than seven rating areas, even where actuarially justified. Some had concerns about discrimination against rural, underserved or high cost-populations. In response, HHS has modified the language in §147.102(b) to provide states with additional flexibility to establish rating areas that are responsive to local market conditions while protecting consumers from potentially discriminatory rating practices. Specifically, under the final rule, a state may establish one or more rating areas within its borders based on the following boundaries: counties, three-digit zip codes, MSAs/non-MSAs. These will be presumed adequate by HHS if either of the following conditions are satisfied: (1) the state established by law, rule, regulation, bulletin, or other executive action uniform rating areas for the entire state as of January 1, 2013 or (2) the state establishes by law, rule, regulation, bulletin, or other executive action after January 1, 2013 uniform rating areas for the entire state that are no greater in number than the number of metropolitan statistical areas in the state plus one. A state may propose for approval a number of

rating areas greater than seven provided that such rating areas are based on these geographic boundaries.

HHS says in the preamble that the geographic areas may be noncontiguous, but the area encompassed by a rating area must be separate and distinct from those encompassed by other geographic areas. Although HHS had proposed the possibility of approving rating areas based on other geographic divisions, it has concluded that only the specified boundaries would be feasible for implementing the health insurance premium tax credit.

HHS further notes in the preamble that an alternate number of state rating areas will be considered adequate if they: (1) are actuarially justified; (2) are not unfairly discriminatory; (3) reflect significant differences in health care unit costs by rating area; (4) lead to stability in rates over time; (5) apply uniformly to all issuers in a market; and (6) are based on one of the geographic boundaries described above. HHS says that these are the appropriate criteria to ensure state rating areas are adequate and not designed to isolate high-cost populations of the state.

In response to comments, HHS provides additional clarifications related to rating areas:

- Since §2701 of the PHS Act does not limit the amount by which rates may vary based on geography, states and issuers may determine the appropriate variation for the geographic rating area factor. However, a rating area factor should be actuarially justified to ensure that individuals and employers are not charged excessively high premiums that render meaningless the guaranteed availability protections of §2702 of the PHS Act.
- In response to questions about whether states must apply geographic rating areas uniformly across the individual and small group markets in a state, HHS says that §2701 does not prevent a state from establishing different rating areas for the individual or small group markets. However, to preserve the integrity of the single risk pool requirement, rating areas must apply uniformly within each market and may not vary by product. If a state merges its individual and small group markets, rating areas will apply uniformly to both the individual and small group markets in the state.
- In response to comments that states should have the flexibility to align rating areas with service areas to prevent issuer “cherry-picking” of service areas, HHS responds that while the final rule does not require that geographic rating areas be aligned with service areas, it recommends that states consider aligning both rating and service areas (and notes that under the March 27, 2012 final rules for the Exchanges and QHPs, Exchanges have flexibility on several elements of the QHP certification process, including the contracting model, so that Exchanges can appropriately adjust to local market conditions and consumer needs).

Rating areas in default states. With respect to states that do not establish their own rating areas or if HHS determines them to be inadequate, some commenters opposed the use of a single statewide rating area as the default arguing that it would be inappropriate in many states. HHS has modified §147.102(b)(2) to specify that the default will be one rating area for each MSA in

the state and one rating area comprising all non-MSAs in the state. In the preamble, HHS says that these designations will sufficiently reflect actuarially justified differences in health care unit costs by geography and ensure rating areas are established timely, providing certainty to issuers. *Modification of rating areas.* In response to suggestions that states have flexibility to periodically review and modify their rating areas (including default rating areas), HHS says that §147.103 of this final rule provides for the Secretary to issue guidance that will establish a process and timeline for such updating, including the default areas. HHS anticipates that this process will provide sufficient notice to issuers in advance of state rate filing deadlines.

d. Age Rating

HHS had proposed that rates could vary within a ratio of 3:1 for adults (meaning here individuals age 21 and older). Rates would have to be actuarially justified based on a standard population for individuals under age 21, consistent with a proposed uniform age curve. Enrollees' age factors and bands would be determined based on an enrollee's age at policy issuance and renewal. HHS said this would enable age rating factors to be applied consistently by all insurers. Moreover, consumers (including purchasers of policies covering multiple family members) would not receive multiple premium increases each year. Comment was requested on whether other measurement points (e.g., birthdays) might be more appropriate.

In consultation with the NAIC, HHS had proposed to define "permissible age bands" for purposes of age rating. These bands were proposed to apply both to the individual and small group markets—

1. Children: A single age band covering children 0 to 20 years of age, where all premium rates are the same;
2. Adults: One-year age bands starting at age 21 and ending at age 63;
3. Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same.

Comments were requested whether multiple age bands or a single age band for children were appropriate and on the approach for age rating for adults, including the approach for rating those ages 64 and older.

HHS had also proposed to require that issuers within a market use a uniform age rating curve, i.e., a specified distribution of relative rates across all age bands. The 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. The rationale for this approach is to simplify identification of the second lowest cost silver plan used to determine premium tax credits; provide an incentive for issuers to compete to offer plans that provide the best value across the entire age curve; and promote the accuracy of the risk adjustment program. It would also help improve the transparency, predictability, and accuracy of the risk adjustment program because its methodology could account for age rating as it is applied by issuers.

HHS further proposed that its uniform age curve be fit to the 3:1 adult age rating limit by "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. The intent was to 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. HHS proposed to revise its default curve periodically to reflect its most current knowledge of the individual and small group markets following implementation of 2014 reforms. Comment was requested on the default age rating curving, including on the premium impact of the transition from the child age curve to the adult age curve.

In addition, HHS proposed that states using narrower ratios submit relevant information on their ratios to HHS no later than 30 days after the publication of the final rule.

The proposed provisions have been adopted as final without modification. HHS clarifies in the preamble certain policies in response to comment letters.

Nearly all commenters supported the proposal to establish single-year age bands for adults 21 through 63; they also supported determining an enrollee's age for rating purposes once a year at the time of policy issuance or renewal. HHS clarifies that for individuals who are added to the plan or coverage other than on the date of policy issuance or renewal, the enrollee's age may be determined as of the date such individuals are added or enrolled in the coverage.

In response to some comments that states should be given the flexibility to use different age-band structures, HHS restates its view that applying age bands consistently nationwide simplifies identification of the second lowest cost silver plan for calculation of the premium tax credit. States may establish their own age rating curve (and may do so for the individual and small group markets) if the curve incorporates the uniform age bands.

Default age curve. In response to comments about ways to revise the HHS proposed default standard age curve, HHS says that its curve is supported by its analysis of data available through HealthCare.gov and an examination of the large group insurance market. HHS says that it will establish in guidance a default age rating curve that will apply in both the individual and small group markets in states that do not exercise the option to establish their own (or that do not provide information to HHS about their age curve). The guidance will adopt the default age curve as proposed in the November 26, 2012 proposed rule for states that allow a maximum 3:1 ratio for age rating.⁵ For states that adopt narrower ratios for age rating, the default age curve established by HHS will take into account the permissible rating variation for age under state law. HHS intends to revise the default age curve periodically, but no more frequently than annually, to reflect market patterns in the individual and small group markets following implementation of the 2014 market reforms.

Child-only plans. In response to requests for HHS to clarify how age rating applies to child-only plans, HHS says that the child age band and child age curve apply to child-only plans in the same

⁵ Note that this guidance was released on February 27, 2013 as *Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting* at (cciio.cms.gov/resources/files/market-reforms-guidance-2-25-2013.pdf).

manner that they apply to all other individual and small group market coverage. Thus, for example, a 10-year-old child would be charged the same rate based on age whether the child was a dependent on a family policy or enrolled in a child-only plan.

e. Tobacco Rating

Under the proposed rule, issuers would not be prohibited from varying the tobacco use factor applied to a particular age band, as long as any variation was not greater than 1.5:1 and was 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 did not exceed 1.5:1 for any age group. States or issuers would 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.

In addition, HHS had proposed to coordinate application of the tobacco rating rules of PHS Act §2701 with the nondiscrimination and wellness program rules of PHS Act §2705. 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 rating factor permitted under §2701 if he or she participated in a wellness program meeting the standards of §2705 and its implementing regulations. These rules would apply to coverage offered in the large group market in a state that, beginning in 2017, allowed health insurance issuers to offer QHPs in such market through an Exchange. Comments were requested on this proposal and on whether and how the same wellness incentives promoting tobacco cessation could apply in the individual market.

HHS proposed that the definition of tobacco use be consistent with the approach taken with respect to health-contingent wellness programs designed to prevent or reduce tobacco use under §2705 and asked for comment. Some possibilities were suggested. Comment was also solicited on use of the single streamlined application under 45 CFR 155.405 to collect information on tobacco use.

HHS adopts the proposed provisions as final with modifications related to the definition of tobacco use. HHS also provides in the preamble a clarification related to the application by a state of a narrower ratio than 1:5:1 for tobacco use or to prohibit tobacco rating altogether. (Because states may generally impose requirements on issuers that are more consumer protective than those imposed by federal law, the language in proposed §147.102(a)(1)(iv) providing that states may use narrower tobacco rating factors is unnecessary and it has been removed from the final rule.)

While many commenters supported establishing a clear definition of tobacco use as well as standard application questions to determine such use, they were more varied on the question of how to define tobacco use. In the final rule, HHS establishes a definition of “tobacco use” that is based on the National Health Interview Survey with some modification. It is defined as “use of tobacco on average of four or more times per week within no longer than the past six months. Further, tobacco use must be defined in terms of when a tobacco product was last used. Tobacco

includes all tobacco products. However, religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives) are specifically exempt under this final rule.”

HHS says that the approach adopted in the final rule establishes a minimum standard to assure consistency in the individual and small group markets and simplifies administration of the tobacco rating factor. Issuers will have flexibility within the federal definition and as permitted by applicable state law to shorten the applicable period of time from the last regular use of tobacco. Because “four or more” as well as “six months” are federal thresholds, states have the ability to define both the frequency of use per week and the look-back period in ways that are more consumer protective (i.e., a frequency of more than four times per week and a look-back period of less than six months). This is a transitional definition. HHS intends to consult with experts, use experience with the above definition, and study the interaction effects with the permanent risk adjustment program to develop a more evidenced-based definition of tobacco use through future rulemaking or guidance. HHS also intends to conduct consumer testing of language and questions about tobacco use.

In response to some comments that there should be additional consequences for individuals who fail to disclose tobacco use during the application process, HHS advises issuers that if they find that an enrollee has reported false or incorrect information about tobacco use, the issuer may retroactively apply the appropriate tobacco use rating factor to the enrollee’s premium as if the correct information had been accurately reported from the beginning of the plan year. The issuer cannot, however, rescind the coverage on this basis. (More discussion of this may be found at 78 *FR* 13414.)

2. State Reporting (§147.103)

HHS notes that throughout §147.102, it had proposed that no later than 30 days after publication of the final rule, states would have to submit certain rating information to HHS generally to support the accuracy of the risk adjustment methodology, including information about the following:

- The use of a narrower age rating ratio than 3:1 for adults age 21 and older.
- The use of a narrower tobacco rating ratio than 1.5:1 for individuals who use tobacco.
- State-established rating areas.
- State-established age rating curves.
- In states with community rating, the use of uniform family tiers and corresponding multipliers.
- A requirement that premiums be based on average enrollee amounts in the small group market.

In §156.80(c), HHS had proposed that a state inform CMS of its decision to merge the individual and small group markets in a state into a single risk pool.

HHS received no comments about the proposed reporting process. HHS is thus finalizing the state reporting process as proposed although it is consolidating these reporting requirements in a new §147.103 of this final rule. For the 2014 plan or policy year, states must submit information

no later than 30 days following publication of the final rule in a form and manner specified by the Secretary. (Note that this final rule was published on February 27, 2013.) The Secretary is directed to issue future guidance establishing a process and timeline for states to submit information for plan or policy years after 2014 (or for updating a state standard that applies in 2014). States will follow the same process with respect to a state decision to merge the individual and small group markets in a state into a single risk pool.

3. Guaranteed Availability of Coverage (§147.104)

In general. Under the proposed rule, issuers in the individual or group markets would have to offer coverage to and accept any individual or employer in the state for all of the issuer's products approved for sale in the applicable market and accept any individual or employer that applied for those products. This would include all non-grandfathered "closed blocks" of business.

Enrollment Periods. Under the proposed rule, an issuer would be permitted to restrict enrollment in health insurance coverage to open or special enrollment periods. Issuers in the group market would have to permit an employer to purchase coverage for a group health plan at any point during the year. Issuers offering individual market coverage 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. Comments were solicited on whether this proposal sufficiently addressed the open enrollment needs of individual market customers whose coverage renews on dates other than January 1.

Issuers in the individual and group markets would be required to establish special enrollment periods for individuals and plan participants and beneficiaries in connection with the events that would trigger eligibility for COBRA continuation coverage under ERISA section 603 (e.g., loss of coverage due to voluntary or involuntary job termination, changes in family status, etc.) This set of special enrollment events would be in addition to the special enrollment events provided under PHS Act §2704(f) for loss of eligibility for other coverage or dependent special enrollment (that is, the special enrollment rights originally created under HIPAA for group health insurance coverage and group health plans and under §155.420(d) and §155.725(a)(3) (the special enrollment rights for QHPs)). The election period would be 30 calendar days, which is generally consistent with the HIPAA standard, but HHS invited comment on whether to establish a longer election period such as 60 calendar days (generally consistent with the Exchange standard).

Effective Dates of Coverage. 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). HHS requested comments on whether individual market issuers 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)).

Exceptions to Guaranteed Availability. Under the proposed rule, issuers would be permitted to deny coverage to an employer whose eligible individuals do not live, work, or reside in the service area of a network plan (or to an individual who does not live or reside in the service area

of a network plan) and in certain situations involving limited network capacity and limited financial capacity. Also, issuers in the small group market could require small employers to satisfy minimum contribution or group participation requirements, to the extent allowed by state law or, in the case of a QHP offered in the SHOP, as permitted by §156.285(c), and to decline to offer coverage if these standards were not met. The intent of this policy was to prevent adverse selection that would arise as a result of small employers taking advantage of the proposed rule's continuous open enrollment opportunity to wait to purchase a group policy.

Association Plans. In the proposed rule, HHS noted that that §2702 does not include an exception from the guaranteed availability requirement for issuers to limit the offering of certain products to bona fide association plans. HHS said that “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.” HHS asked for comment. (Note that HHS responds to these comments in section II.F.2 of this final rule.)

Marketing standards. Under the proposed rule, an issuer and its officials, employees, agents and representatives would have to comply with any applicable state laws and regulations regarding marketing by health insurance issuers and could not employ marketing practices or benefit designs that would have the effect of discouraging enrollment of individuals with significant health needs in health insurance coverage. This would provide for a consistent standard inside and outside of the Exchanges.

Finally, in response to concerns that have been voiced about the ability of individuals to manipulate guaranteed availability each year, HHS noted in the preamble to the proposed rule that the ACA does not include a provision to allow issuers to refuse to cover individuals with a history of non-payment under other policies. It sought comment on possible ways to discourage consumers from abusing guaranteed availability rights.

Final Rule. In response to comments, HHS has adopted the proposed rule as final but with a number of substantive and technical changes. The major substantive changes relate to open and special enrollment periods and the proposed requirement related to the ability of issuers to deny open enrollment to small employer groups that fail to meet the issuer's minimum contribution or participation requirements. The final rule also expands upon the provisions related to marketing. The changes include the following:

- HHS has changed “permit” to “allow” in several instances in the regulation text.
- In response to those who asked that the term “offer” in §2702 of the PHS Act be interpreted to mean “actively marketed” so that issuers would not be required to reopen closed blocks of business, HHS says that it interprets that section to refer to an issuer offering both new as well as existing coverage. Accordingly, the final rule does not interpret “offer” to mean “actively marketing.” HHS clarifies, however, that while the

rule requires an issuer to accept any individual or employer that applies for coverage, it does not require closed blocks to be actively marketed. Further, only non-grandfathered plans are subject to guaranteed availability.

- HHS has revised §147.104(b)(1) related to open enrollment periods in the group market to say that in the case of a plan sponsor in the small group market that is unable to meet the employer group contribution or group participation rates, an issuer may limit the availability of that group's coverage to an annual enrollment period that begins November 15 and extends through December 15 each year. (This contrasts with the proposed rule which would have permitted the issuer to deny the group guaranteed issue.) HHS says that it has determined that under the law, small employers cannot be denied guaranteed availability of coverage for failure to satisfy minimum participation or contribution requirements. However, the more limited enrollment period established under the final rule is authorized under §2702(b)(1) of the PHS Act.
- In response to some commenters' concerns that the proposed rules implementing the prohibition of discriminatory marketing or benefit designs were too narrowly focused, HHS has amended the proposed regulation text in §147.104(e) to make clear that a health insurance issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals in health insurance coverage based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions. HHS says that this standard will ensure consistency with the prohibition on discrimination with respect to Essential Health Benefits in §156.125, the non-discrimination standards applicable to QHPs under §156.200(e), and the marketing standards in §156.225.
- Although some commenters opposed the proposed rule to align open enrollment periods inside and outside of the Exchange, HHS is adopting the proposed open enrollment periods as final. The proposed rule has been amended, however, to provide for a new (b)(2), which provides that limited open enrollment periods are triggered in the individual market by any of the following events: (1) an individual and any dependents losing minimum essential coverage (but not if loss results from failure to pay premiums on a timely basis or situations allowing a rescission as specified in 45 CFR 147.128 (e.g., fraud)) ; (2) an individual gaining or becoming a dependent through marriage, birth, adoption, or placement for adoption; (3) an individual experiencing an error in enrollment; (4) an individual adequately demonstrating that the plan or issuer substantially violated a material provision of the contract in which he or she is enrolled; (5) an individual becoming newly eligible or newly ineligible for advance payments of the premium tax credit or experiencing a change in eligibility for cost-sharing reductions; (6) new coverage becoming available to an individual or enrollee as a result of a permanent move.
- The final rule also requires an issuer to provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period

beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. HHS notes in the preamble that states may wish to consider other strategies to ease the transition for such non-calendar year policies such as directing issuers to pro-rate premiums for policies covering less than a full year.

- Because HHS agrees with comments that 60-day enrollment periods will promote consistency with the Exchanges and will give consumers the time they need to explore coverage options following a change in life circumstances, the final rule provides for a 60-day election period for the special and limited open enrollment periods in the individual market. However, to avoid inconsistency with the statutory requirement in §2704(f)(1) of the PHS Act that individuals losing group coverage must request special enrollment not later than 30 days after the loss of coverage, the 30-day special enrollment periods for the group market is retained. HHS intends to revise the 60-day provision for SHOP special enrollment periods (included in the March 27, 2012 Exchange final rule) to be consistent with the 30-day rule provided herein. HHS “will monitor the effects of the 60-day election periods has on the individual market and whether or not it is necessary to move to a 30-day election period consistent with the group market.”

- In response to comments related to the ability of states to provide for more protective guaranteed issue requirements, HHS notes that they can do this so long as the state’s requirements do not prevent the application of federal law. For example, a state may require open enrollment periods that allow individuals to purchase coverage more frequently than called for under federal standards. HHS says here that “if a health insurance issuer in the individual market allows for enrollment outside of an open or special enrollment period, the issuer must still comply with all of the individual market provisions of the PHS Act, including the prohibition against pre-existing condition exclusions and the prohibition against discrimination based on health status. An issuer cannot selectively offer enrollment in a plan to individuals outside of open or special enrollment periods in a manner that discriminates among individuals based on a pre-existing medical condition or health status.”

- In the preamble, HHS notes that some commenters expressed concerns about the potential for individuals with histories of non-payment to game guaranteed availability. HHS notes the NAIC’s recommendation that states have flexibility to develop an environment that will discourage adverse selection. Some of the suggested tools that are available to states to limit adverse selection are identified:
 - allowing issuers to require pre-payment of premiums each month;
 - allowing issuers to require payment of all outstanding premiums before enrollees can re-enroll in coverage after termination due to non-payment of premiums;
 - allowing late enrollment penalties or surcharges (similar to those in Medicare Parts B and D);
 - allowing issuers to establish waiting periods or delayed effective dates of coverage;
 - allowing issuers to offset claims payments by the amount of any owed premiums;

- allowing issuers to prohibit individuals who have canceled coverage or failed to renew from enrolling until the second open enrollment period after their coverage ceased (unless they replace coverage with other creditable coverage);
- restricting product availability (for example, to a catastrophic, bronze, or silver level plan) outside of enrollment periods to prevent high-risk individuals from enrolling in more generous coverage when medical needs arise; and
- allowing individuals to move up one metal level each year through the Exchange shopping portal.

In its response to these suggestions, HHS encourages states “to consider approaches to discourage adverse selection while ensuring consumers’ guaranteed availability rights are protected since state policies that limit guaranteed availability are preempted by this law.” HHS intends to address permissible strategies to limit adverse selection in future guidance.

- HHS also notes that while some commenters had recommended that issuers offering individual health insurance coverage be required to offer family coverage, the final rule does not require an issuer to offer family coverage. “While issuers are required to offer all products that are approved for sale in a market, an issuer is not required to offer a family coverage option with every policy form.”

4. Guaranteed Renewability of Coverage (§147.106)

In general. HHS has adopted its proposed provisions in this section as final without modification. Therefore, under the final rule, an issuer offering 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. Exceptions apply in the case of: (1) nonpayment of premiums, including failure to pay premiums on a timely basis; (2) fraud or intentional misrepresentation of material fact in connection with the coverage; (3) violation of participation or contribution rules; (4) termination of the plan by the issuer; (5) enrollee’s movement outside of the service area; and/or (6) membership in an association ceases.

Discontinuing a particular product. If an issuer decides to discontinue offering a particular product offered in the group or individual market, that product may be discontinued in accordance with applicable state law only if the following occurs:

1. The issuer provides written notice of the discontinuation to each plan sponsor or individual, as applicable, explaining that the particular product is being discontinued. The notice is due at least 90 calendar days before the date the coverage will be discontinued.
2. The issuer offers to each affected plan sponsor or individual, as applicable, on a guaranteed issue basis, the opportunity 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. The issuer acts uniformly without regard to the claims experience of those plan 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.

Discontinuing all coverage. An issuer may elect to discontinue offering all coverage in the individual or group market, or all markets, in a state in accordance with state law if the following conditions are met: (1) the issuer provides written notice 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; and (2) all health insurance policies issued or delivered for issuance in the state in the applicable market (or markets) are discontinued and not renewed. Such an issuer would not be able to issue coverage in the applicable market or markets in such state during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

Exception for uniform modification of coverage. Only at the time of renewal may issuers modify the coverage for a product offered to a group health plan in the large group market. This limitation on modifications also applies to the small group market but such changes may only be made (other than only through one or more bona fide associations) if they are consistent with state law and are effective uniformly among group health plans with that product.

Application to coverage offered only through associations. In the case of coverage made available by a health insurance issuer in the small or large group market to employers only through one or more bona fide 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.

C. Part 150 – CMS Enforcement in Group and Individual Insurance Market

Under the ACA and the underlying HIPAA provisions, states have primary enforcement authority for the insurance rules. HHS acts as a fallback – it only enforces if a states notifies HHS that it is not enforcing or HHS determines that the state is failing to enforce the requirements. HHS clarified in the proposed rule that it is using the HIPAA process to enforce ACA requirements against issuers and non-federal government health plans.

Specifically, part 150 of title 45 of the CFR sets forth the enforcement processes for the requirements of title XXVII of the PHS Act with respect to health insurance issuers and nonfederal governmental group health plans. HHS proposed conforming changes in various sections of part 150. In the NPRM, HHS said that these changes were intended to clarify the applicability of enforcement procedures to the PHS Act requirements added by the ACA.

The HHS has adopted the provisions of the final rule without modification.

D. Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review

HHS adopts, with one modification, changes to the rate disclosure and review requirements in Part 154, which were originally finalized in a rule published on May 23, 2011 (76 *FR* 29964). The changes to Part 154 are effective 30 days after publication of this rule, or March 29, 2013.

1. Subpart B—Disclosure and Review Provisions

a. State specific-thresholds (§154.200)

The timeline for states seeking state-specific thresholds for which rate increases are subject to review under section 2794 of the Public Health Service Act is modified as proposed. Specifically, §154.200(a)(2) and (b) now require that that states seeking state-specific thresholds must submit proposals to HHS by August 1 of each year. In addition, the timeline for Secretarial notice and implementation is shifted forward by three months so that the Secretary must publish a notice no later than September 1 of each year concerning whether a state-specific threshold or the 10 percent threshold applies in each state, and any state-specific threshold will be effective on January 1 of each year following the Secretary’s notice. In responding to comments, HHS reiterates that these changes are made to align with the QHP submission schedule and with 2014 market reforms, and notes that moving the timeline forward for state-specific thresholds will give states time to analyze information received as part of the required April 30 QHP filings and request a state-specific threshold.

b. Submission of rating filing justification (§154.215)

HHS adopts as final its proposal to direct issuers to submit data and documentation regarding any rate increase on a form and in a manner determined by the Secretary. The review threshold described in §154.200 will continue to be used to determine which rates must be reviewed rather than just reported. The term “Rate Filing Justification” will replace the term “Preliminary Justification” in §154.225 and §154.230, which relate to filings and requirements of issuers with respect to rates that are subject to review.

Separately from the proposed rule, HHS proposed for comment through the Paperwork Reduction Act of 1995 (PRA) process a “uniform rate review” template form for issuers to use for submitting the data on all rate increases.⁶ This final rule revises the regulatory text to reflect the “uniform rate review” terminology, and language is added to say that the data submission applies to all products “in the single risk pool, including new or discontinuing products.” HHS believes that the additional language reflects the fact that premium rates subject to rate review reporting are shaped by the premium rating standards implemented under the single risk pool requirement and the applicability of guaranteed availability and renewability requirements.

⁶ For the proposed template see: Rate Increase Disclosure and Review Reporting Requirements, www.HHS.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/HHS-10379.html. HHS indicates that it has submitted a collection of information request to OMB reflecting the changes contained in this final rule, and that the requirements are not effective until approved by OMB and assigned a valid OMB control number.

As discussed below regarding collection of information requirements (section V), HHS made changes to the uniform rate review template in response to comments. Relative to the proposed template, these changes reduced the number of data elements required and made other elements optional for the first two years. In the preamble HHS notes that historical experience is only required for existing product/plan combinations represented on the uniform rate review template, and when an issuer includes new business, all premium and claims projections for the new products and plans are included as provided in guidance.

2. Subpart C— Effective Rate Review Programs

HHS finalizes with modifications its proposals to expand the standards for an Effective Rate Review Program at §154.301. In addition to previously finalized requirements, to have an Effective Rate Review Program a state must additionally review as part of its rate review process: (1) the reasonableness of assumptions used by the issuer to estimate the rate impact of the federal reinsurance and risk adjustment programs; and (2) the issuer’s data related to implementation and ongoing utilization of a market-wide single risk pool, EHBs, actuarial values (AVs), and other market reform rules as required by the ACA.

HHS also adds new language to §154.301(a)(4), which requires that states take into account additional factors when conducting examinations of rate filings to the extent that they are applicable to the filing under review. The new factors are: 1) the impact of cost-sharing changes by major service categories, including actuarial values, 2) the impact of benefit changes including EHBs and non-essential health benefits, and 3) the impact of changes in enrollee risk profile and pricing, including the rating limitations on age and tobacco use.

To the extent possible, the following additional factors must also be considered by states when conducting an examination of a rate review filing:

- 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.

HHS does not finalize its proposal to require that states also consider other standardized ratio tests (in addition to the medical loss ratio) recommended or required by statute, regulation, or best practices. Noting that states will likely consider these tests, HHS intends to minimize requirements and give state maximum flexibility in conducting reviews. Efficiencies in using these data for Exchange functions and the risk adjustment and reinsurance programs are also discussed.

A state is not specifically required to use the unified rate review template in order to have an effective rate review program. However, HHS notes that issuers in all states are required under the final rule to submit information to HHS using the unified rate review template, so states and issuers will have an incentive to use the HHS collection tools in order to provide for streamlined data collection.

The proposal regarding public disclosure of rate filings is also finalized. Specifically, in §154.301(b), a state with an Effective Rate Review Program is required, for the rate increase it reviews, to make available on its Web site at least the information contained in Parts I, II, and III of the Rate Filing Justification that HHS makes available on its Web site and must have a mechanism for public comment on those proposed rate increases. A state could meet the requirement for making information available by providing a link to HHS's Web site where consumers can find such information. In discussing comments expressing concern about the public disclosure of confidential or proprietary information, HHS reiterates that it will release only information that is determined not to include trade secrets and is approved for release under the Freedom of Information Act (FOIA). The HHS FOIA regulations provide for health insurance issuers to designate certain information as exempt from disclosure, and if there is a FOIA request, procedures for pre-disclosure notification of the issuer and rules regarding applicability of the exemption would be in effect. HHS also believes that because information would only be released after the annual QHP submission process is concluded, public disclosure of certain rate review information will not undermine competitive market dynamics.

E. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Subpart A – General Provisions

a. Single Risk Pool (§156.80)

This section of the final rule implements requirements of section 1312(c) of the ACA, under which an issuer must consider all enrollees in all the health plans it offers (other than grandfathered health plans) to be members of a single risk pool for a market (the individual, small group, or merged market) when developing rates and premiums for coverage effective beginning in 2014. HHS in the proposed rule clarified 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 §2701.⁷

With a few modifications, the final rule adopts the proposed language, which largely codifies the statutory language. An issuer must develop a market-wide index rate (average rate) based on the total combined EHB claims experience of the enrollees in all non-grandfathered plans in the risk pool. An issuer must then make a market-wide adjustment to the index rate based on the total expected aggregated payments and charges under the risk adjustment and reinsurance programs in a state. The premium rate for any given plan may not vary from the resulting adjusted market-wide index rate, except for the following factors:

- The actuarial value and cost-sharing design of the plan;
- The plan's provider network and delivery system characteristics, and also its management practices;

⁷ This means that excepted benefit and short-term limited duration policies, for example, are not subject to the single risk pool requirement. HHS adds that this requirement would not be enforced against coverage that is issued to plans with fewer than two participants who are current employees (e.g., retiree-only plans).

- Plan benefits in addition to the EHBs, which must be pooled with similar benefits within the single risk pool, and claims experience from additional benefits used to determine rate variations for the plans that offer them;
- Administrative costs, excluding Exchange user fees; and
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

The index rate, the market-wide adjustment to the index rate and the plan-specific adjustments must be actuarially justified and implemented transparently, consistent with state and federal rate review processes.

The modifications from the proposed rule made in response to comments are the addition of the requirement that issuers make a market-wide adjustment for Exchange user fees, while allowing plan-level adjustments for other administrative costs. HHS agrees with commenters that costs associated with Exchange user fees are not related to the unique efficiencies or designs of a particular plan and therefore should be spread evenly across the market inside and outside the Exchange, further protecting against adverse selection. At the same time, HHS believes that issuers should be allowed to reflect distribution costs and other administrative costs at the plan level, to ensure that efficiencies are priced accurately and to promote market competition.

Responding to additional comments regarding the single risk pool provisions, HHS provides several clarifications and observations:

- Plan-specific adjustments to the market-wide index rate must not reflect differences in health status or risk selection. Induced demand is excluded from index rate adjustments because of their actuarial difficulty of distinguishing induced demand from risk selection.
- HHS expects issuers to use their pooled allowable claims data in developing actuarial value adjustments to the market-wide index rate for individual plans. This contrasts with the AV calculator posted on the HHS website for use by plans in meeting requirements under the EHB/AV/Accreditation proposed rule published November 26, 2012. That calculator is based on data sets reflecting a standard population, utilization and unit prices. Further, HHS expects that issuers will proportionally allocate anticipated reinsurance and risk adjustment payments and charges across plans, not differentially allocate them in a manner that would reintroduce risk selection into plan premiums.
- With respect to catastrophic plans, HHS clarifies that issuers may make a plan-specific adjustment to the market-wide index rate to account for differences between catastrophic and non-catastrophic plans in expected average enrollee gross spending and expected average risk adjustment payment transfers. This adjustment would apply uniformly across all catastrophic plans, and should not include plan liability differences due to actuarial value, as these differences should be accounted for in the actuarial value adjustment.
- Recognizing that the lack of EHB claims experience creates challenges for issuers in setting rates in the early years of implementation, HHS clarifies that to establish its index rate in the absence of applicable claims data, an issuer may use any reasonable source of claims data, including experience from grandfathered books of business or from actuarial

rate manuals, as long as these data are used to actuarially estimate the portion of claims data associated with providing coverage for EHBs as required to establish the index rate.

- Citing relevant statutory provisions, HHS clarifies that the single risk pool is to be maintained at the licensed entity level, rather than the holding company level.

2. Subpart B -- Standards for Essential Health Benefits, Actuarial Value, and Cost-Sharing

a. Enrollment in Catastrophic Plans (§156.155)

HHS finalizes its proposed requirements for enrollment in a catastrophic plan. A plan is a catastrophic plan if it (1) meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market, (2) does not offer coverage at the bronze, silver, gold, or platinum coverage level, (3) provides coverage of EHBs only once the enrolled individual has reached the annual limitation in cost sharing in §1302(c)(1) of the ACA, (4) covers at least three primary care visits per year before reaching the deductible, and (5) may not impose any cost sharing for preventive services identified in section 2713 of the PHS Act.

Further codifying the statute, catastrophic coverage is limited to individuals who have not attained the age of 30 prior to the first day of the plan year or who have received a certification of exemption from the individual responsibility payment because they cannot afford minimum essential coverage, or they are eligible for a hardship exemption. If more than one person is covered by a single catastrophic plan, such as a non-self only plan, then each individual enrolled has to meet at least one of these two eligibility criteria.

In discussing comments, HHS clarifies that the provisions regarding catastrophic plans apply to coverage offered both inside and outside the Exchange, and that an individual who has been granted a certificate of exemption from the Exchange based on hardship may use that exemption to establish eligibility to purchase a catastrophic plan outside the Exchange. With respect to the requirement regarding primary care visits, HHS states that the classification of who is a primary care provider is determined by the terms of the health plan or by state law.

F. Applicability to Special Plan Types

1. Student Health Insurance Coverage (§147.145)

Under §1506(c) of the ACA, nothing in title I or an amendment made by title I, “shall be construed to prohibit an institution of higher education from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable federal, state, or local law.” HHS interprets this to mean that if particular ACA requirements would have, as a practical matter, the effect of prohibiting such an institution from offering a student health plan otherwise permitted under federal, state or local law, ACA requirements such as guaranteed availability and renewability, single risk pool, and rating rules would be inapplicable.

In this rule, proposed exemptions for student health coverage from the guaranteed availability and guaranteed renewability requirements are finalized, and HHS additionally exempts non-grandfathered student health insurance from the single risk pool requirements. In the proposed

rule HHS had solicited comments on whether issuers should be permitted to maintain a separate risk pool for student health insurance coverage and whether different premium rating rules should apply. HHS indicates that while some commenters recommended inclusion of student health insurance in the general individual market risk pool, many others noted unique characteristics of student health insurance supporting separate risk pooling. HHS says its decision in this rule to provide an exemption from the single risk pool requirements is based on recognition of differences in how student health insurance coverage generally is rated and administered relative to health insurance generally. Specifically, issuers of student health insurance coverage typically contract with a college or university to issue a “blanket” health insurance policy, from which students can buy coverage, and the policy is generally rated on a group basis based on the total expected claims experience of the students enrolled in the plan. Under the final rule the premium rating rules will still apply to student health insurance, although HHS notes that the exemption from single risk pool requirement allows issuers to base premiums on a school-specific community rate as long as the premiums meet requirements under section 2701 regarding rating for age and tobacco use. HHS states that it views these regulations regarding student health insurance coverage as a transitional policy, and offers its intention to monitor student health coverage and revisit these policies in the future.

2. Bona Fide Association Coverage

HHS finalizes the proposed rule without modification. Consistent with PHS Act section 2702, the rule requires that, beginning in 2014, non-grandfathered health insurance coverage made available in the individual or group market through a bona fide association must be made available to all individuals or employers in a state and market. That is, coverage sold in these markets through bona fide associations may no longer be limited only to association members. HHS notes that nothing prevents an issuer from renewing existing association coverage and, as discussed in the proposed rule, the exception for limited network capacity could provide a basis for limiting enrollment in certain products to bona fide association members.

3. Expatriate Plans

HHS reports receiving comments requesting exemptions for expatriate coverage from the market reform provisions of the ACA, and plans to issue future guidance on the applicability of the final rule to these plans. Commenters argued that the special circumstances of expatriate plans warranted exemption. For example, the rates for expatriate policies must accommodate the regulatory requirements and health care costs of other countries; reflect benefits that are particularly important to expatriates (such as medical evacuation coverage, war risk coverage, and currency fluctuation); and maintain global competitiveness with non-U.S. issuers offering expatriate coverage.

4. State High Risk Pools

HHS responds to commenters asking whether states can continue high risk pools after January 1, 2014 and if so whether they are subject to the market reform rules. In response HHS indicates that where high risk pool coverage is not provided through insurance and is not group health plan coverage, it is not subject to the market reforms set forth in title XXVII of the PHS Act.

However, some states have an alternative mechanism under which issuers (or certain issuers of last resort) guarantee the availability of a product or specific benefit design. In such a case where the state alternative mechanism is individual market insurance coverage, it is subject to the market reforms. HHS notes that individuals enrolled in state high risk pools will have the same rights as others to guaranteed availability for any products offered inside and outside of the state Exchange, and states may not prevent individuals from moving to other products or to a state's Exchange. States will continue to have the discretion to determine whether each state continues to have a high risk pool in order to ease the transition of enrollees to other products, consistent with the February 1, 2013 Minimum Essential Coverage proposed rule (78 FR 7348), which proposed to designate state high risk pools as minimum essential coverage for a period of time to be determined by the Secretary.

III. Collection of Information Requirements

In the proposed rule, HHS described associated information collection requirements (ICRs) and solicited comments on them. In this final rule, the ICRs are reiterated and comments received are discussed. Two main areas are involved: ICRs regarding state disclosures and ICRs regarding rate increase disclosure and review.

ICRs regarding state disclosures. (§147.102(b), §147.102(e), §147.103, §156.80(c))

The final rule directs states to submit to HHS information on their rating and risk pooling requirements if different than the federal standards. Since HHS does 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, it has estimated the burden for one state. HHS does note its expectations with respect to some elements. It expects that states with existing geographic rating areas will maintain them. With respect to age rating curves, it expects that the default standard curve will apply in most states; only one state commented that it would establish its own age rating curve. Similarly, HHS expects that very few states will designate their own family tier structure.

In each case, HHS estimates the burden associated with the reporting requirements as the time involved for states to provide to HHS information on the rating factors and requirements applicable to their small group and individual markets. Estimates of time for state reporting for their own rating areas, rating curves, etc. are provided. The total burden for all disclosures is estimated to be seven hours and approximately \$279 per state, if a state needed to disclose all seven rating requirements. Estimated costs associated with establishing a state age rating curve (\$24,000) and geographic rating areas (\$1,600), which would involve the work of actuaries, are also presented.

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

As described earlier, the final rule requires that issuers disclose all rate increases using the unified rate review template. HHS estimates that a total of 7,650 submissions for rate review increases will be made annually in both markets; 1,200 of these will be for rate increases above

the review threshold. The total cost of annual reporting by all issuers is estimated to be \$19 million; \$16 million for the issuers who as a result of this rule must disclose rate increases that are below the review threshold. HHS notes that there are unquantified administrative efficiencies gained under the final rule by helping issuers to avoid significant duplication of effort for filings subject to review by using the same standardized template for all issuers offering health insurance coverage in the small group or individual markets across all states, and because the vast majority of states currently require all rate increases to be filed.

HHS indicates that it has made changes to the proposed uniform rate review template to address concerns raised in comments received and discussions with issuers and states. Some data elements have been removed and others will remain optional for the first two years. HHS estimates that the number of required data elements has been reduced by 45 percent, and believes that the unified rate review template will not significantly increase the burden on states or industry; rather, it envisions that the data requested in the template will assist states and industry in complying with the market rules.

IV. Regulatory Impact Analysis

OMB has designated the final rule as a “significant” regulatory action. HHS provides a regulatory impact analysis (RIA) of the costs, benefits, and transfers associated with the proposed rule even though at this time it believes that it is uncertain whether the proposal will have economic impacts of \$100 million or more in any one year (the threshold above which such an analysis is required).

HHS presents an accounting table in Table V.1 of its summary of benefits costs and transfers. That table is reproduced at the end of this summary.

In discussing these impacts, HHS points out that differences in current state laws and industry practices will vary the impact of the rule among the states, and in doing so provides relevant data on state laws with respect to the individual market, the small group market, and gender rating of premiums.

In the individual market:

- 5 states have both guarantee issue for some products and modified or pure community rating; in others, issuers can deny coverage or charge higher rates for those with medical conditions; and
- 2 states bar rating based on age, 11 states and DC have rate bands, and 5 states bar rating based on tobacco use.

In the small group market:

- 36 states and the District of Columbia have rate bands;
- 12 states have community rating requirements; and
- 2 states do not allow rating based on age, and 16 states do not allow rating based on tobacco use.

Women are charged higher premiums in many markets:

- 14 states bar gender rating in the individual market and 15 bar gender rating in the small group market; and
- Only 3 of the states that bar gender rating require maternity coverage in all policies.

HHS responds to commenters referencing actuarial studies concluding that premiums will increase in certain markets or for certain age groups, and says that these studies generally do not take into account all the provisions of the ACA and assume that the risk pool will worsen. By contrast, HHS anticipates that the risk pool will improve, and says that different provisions of the law will have opposing effects on premiums. In addition, HHS points out that studies that focus on premiums do not take into account expected reductions in out-of-pocket costs for consumers.

Benefits. In discussing the benefits of the final rule, HHS reviews the literature on the uninsured regarding reduced access to care and higher mortality, and increased financial difficulties. It presents CBO's estimate that by 2017 there will be 27 million fewer uninsured, and the effect that coverage will have on access and outcomes. HHS notes those with poor health experience and their current difficulty in obtaining coverage, and the increased access to coverage and care available under the ACA. HHS cites estimates by the Congressional Budget Office and Joint Committee on Taxation which show an increase in the number of young healthy individuals participating in the individual market that will result in premiums in that market that are 7 to 10 percent lower than they would have been in the absence of the ACA. Benefits of the single risk pool, guaranteed availability, and other provisions of the final rule are discussed.

Costs. With respect to costs, HHS reviews administrative costs incurred by issuers, including one-time fixed costs to comply, including systems and software updates and changes in marketing. In addition, the costs to states of establishing geographic rating areas and age rating curves are discussed, although as noted earlier, HHS anticipates that few states will incur these costs. The estimated costs of compliance with the rating review requirements discussed above are also reviewed. HHS also notes the increase in use and costs arising from expanded insurance coverage, some of which may be economically inefficient, but points to studies finding that the cost of the inefficiency is likely more than offset by the benefit of risk reduction.

Transfers. HHS discusses various transfers that will result from the final rule and other provisions of the ACA. Because rating based on health and gender will no longer be allowed, older and less healthy adults and women may see decreases in premium rates, while younger healthier adults and some men may see increases. HHS notes that the increases may be mitigated by other factors, such as choices and competition and greater pooling of risk in Exchanges, premium tax credits, risk stabilization programs, access to catastrophic plans and the minimum coverage provision. For those newly covered, out-of-pocket expenses will decrease while insurer spending will increase (as will premium collections). The costs of previously uncompensated care will be shifted from providers, charitable organizations and payers broadly to newly covered individuals and their insurers.

Regulatory Flexibility Act

HHS reviews the Regulatory Flexibility Act, which requires analysis of options for small business if a rule has a significant impact on a substantial number of small entities. HHS notes that regulatory impact analyses (RIAs) of prior rules determined that there were few issuers of comprehensive health insurance policies that fell below the size threshold for “small business” (currently \$7 million in annual receipts for health issuers). HHS also notes that the rule affects health insurance premiums in the small group market, with a small impact on premiums and in some cases lower rates.

Unfunded Mandates Reform Act

HHS reviews the Unfunded Mandates Reform Act. It notes that the final rule gives state governments the option to establish rating areas and the age rating curve, with a federal default if a state opts not to act. As noted earlier HHS estimates costs of \$279 per state for administrative costs of disclosing rating and pooling requirements to HHS. Health insurance issuers will incur previously described administrative costs. While the Unfunded Mandate Reform Act threshold for review is costs of about \$139 million, more than set out in HHS’ assessments, HHS says that consistent with the Act it has designed the proposed rule to be a low burden alternative for state, local, and tribal governments and the private sector.

Federalism

HHS reviews the state and federal responsibilities under the proposed rule, and discusses CMS effort to balance the interests of states in regulating health insurance issuers and Congressional intent to provide uniform national consumer protections. HHS certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 in a meaningful and timely manner.

Congressional Review Act

The final rule is subject to the Congressional Review Act. Before it can take effect, HHS must submit to each House of Congress and the Comptroller General a report with a copy of the rule, along with other specified information for review.

Table V.1: Accounting Table

Benefits				
Qualitative:				
<ul style="list-style-type: none"> • Increase in enrollment in the individual and small group 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 • 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 unified rate review template for all issuers offering health insurance coverage in the small group or individual markets. • 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 unified rate review template. • Extend the availability and affordability of student health coverage as a transitional policy. 				
Costs				
	Estimate	Year dollar	Discount rate	Period covered
Annualized Monetized (\$/year)	\$17.3 million	2012	3% or 7%*	2013-2017
<p>*The estimated costs in 2012 dollars (\$17.3 million) are identical at these two discount rates.</p> <p>Administrative costs related to submission of data by issuers seeking rate increases below the rate review threshold, one-time fixed costs to issuers related to rate review data extraction, disclosure of state rating requirements and costs incurred by states choosing to establish rating areas and age rating curves.</p> <p>Qualitative:</p> <ul style="list-style-type: none"> • Additional costs incurred by issuers to comply with provisions in the final rule. • 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:				
<ul style="list-style-type: none"> • 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 essential 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 may be more than offset by an increase in premium revenue. 				