

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

November 30, 2012

On November 26, 2012, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) published in the *Federal Register* a notice of proposed rulemaking to implement policies under the Affordable Care Act (ACA) related to fair health insurance premiums (rating requirements), guaranteed availability, guaranteed renewability, risk pools, and catastrophic plans. The proposed rule also would clarify 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 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), relating to ensuring that consumers get value for their dollars (rate review). It also revises the timeline for states to propose state-specific thresholds for premium rate review and approval by CMS.

Written comments, identified by file code CMS-9972-P, may be submitted to CMS. **The 30-day comment period closes on December 26, 2012.**

Key provisions of the proposed rule are summarized below. Many of the ACA's market reforms that would be implemented by this proposed 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 of the proposed rule, the sections of the PHS Act that were added or amended by title I of the ACA are indicated.¹

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¹ 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>

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I. Executive Summary

A. Purpose and Need

The rationale for new market rules, as established by the ACA, is explained in this overview section.² 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 have few protections in terms of the premiums that issuers can charge them.³ In 43 states, issuers selling in the individual market are allowed to use health status in determining premiums and 48 states allow age rating (often unlimited) in establishing premiums. While 37 states explicitly allow gender rating, three states that prohibit the use of gender rating do not require maternity coverage in all individual market policies, meaning that, since maternity coverage requires higher premiums 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.

Sections 2701, 2702, and 2703 of the PHS Act, as added and amended by §1312(c) of the ACA, address these aspects of the current individual and small group insurance markets. They extend guaranteed availability (also known as guaranteed issue) protections so that individuals and

² 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).

³ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided for guaranteed issue of insurance sold in the small group market but not in the individual market and did not affect the rates (premiums) that insurers could charge for both individual and small group policies. HIPAA also requires issuers in both the individual and small group markets to provide for guaranteed renewability of coverage, with certain exceptions (such as non-payment of premiums and fraud).

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.

As a result of these ACA insurance market reforms, CMS says that Americans, for the first time, will have access to affordable health insurance coverage notwithstanding any health problems they may have. Nationwide, health insurance issuers will be prevented from charging individuals and small employers higher premiums due to enrollees' health status or gender (or many other risk factors that are currently used today to price insurance in these markets).

In addition, PHS Act §2723 gives CMS (technically, the Secretary of HHS) enforcement authority with respect to health insurance issuers (in certain instances) and group health plans that are nonfederal governmental plans in connection with the various health insurance and group health plan standards added by the ACA. The proposed rules would make non-substantive changes that clarify the processes that CMS currently uses to enforce such standards.

Another ACA provision covered by this proposed rule provides for catastrophic plans to be available for young adults and people who would otherwise find health insurance unaffordable.

Finally, CMS includes in this proposed rule: (1) a revised policy related to the timing of the submission of requests for state specific rate review thresholds and the effective dates of such thresholds, (2) a requirement that health insurance issuers submit data on proposed rate increases in a form and manner to be determined by CMS, and (3) amendments to the current requirements for a state to have an Effective Rate Review Program. The Secretary will monitor these rate increases to identify patterns that could signal market disruption and assist in oversight of the new market-wide rating reforms created by the ACA, which are effective on January 1, 2014.

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 (see below), family size, and geography.

Proposed §147.104 would require issuers offering non-grandfathered 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:

1. States seeking state-specific thresholds would be required to submit proposals for such thresholds by August 1 of each year; CMS would have 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.
2. Health insurance issuers would be required 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.
3. Criteria and factors would be added to the regulations for a state to have an Effective Rate Review Program, including that the state: (1) receive from all issuers proposing rate increases data and documentation about the rate increases in the standardized form specified by the Secretary; (2) review the information for proposed rate increases greater than or equal to the review threshold; and (3) make information publicly available through its Web site.

Proposed §156.80 generally would require 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 §1302(e) of the ACA regarding catastrophic plans.

C. Costs and Benefits⁴

CMS concludes a discussion of the benefits and costs of the proposed rule with the finding that benefits would justify the costs. The following includes key arguments from this section. CMS notes that millions of Americans have difficulty in purchasing coverage on the individual market because of their past or present health status and other factors used by insurers in most states to underwrite and rate (price) policies. Moreover, CMS notes that many who do obtain coverage on the individual market experience significant rate increases each year as a result of the way in which insurers price on the basis of blocks of business. “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.” The individual market is relatively small (about 10.8 million in 2011) in part because it is unaffordable or unavailable for many who would otherwise seek their coverage through it.

CMS recounts how each of the ACA individual and small group market provisions will make insurance more affordable and available for millions of Americans. CMS believes these reforms should prove especially helpful for those who currently are denied insurance or who face significantly higher and often unaffordable premiums because of age, gender, health status or

⁴ See also the summary of the Regulatory Impact Analysis below.

medical history or other risk factors. For example, the ACA 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. CMS also notes that “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 [for coverage purchased through the Exchanges], 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 status of the risk pool.” Additionally, young adults and people for whom coverage would otherwise be unaffordable will have access to a catastrophic plan, which will have a lower premium but will protect against high out-of-pocket costs and cover recommended preventive services without cost sharing.

CMS notes that an additional major factor to make insurance more available and affordable is the ACA’s minimum coverage provision (i.e., the individual mandate) that will bring many people who would otherwise go uninsured into the risk pool of insured individuals. Also, premiums will be held down by administrative efficiencies gained from eliminating underwriting, and due to the effects of greater competition in the individual market created by Exchanges.

CMS seeks comments on additional strategies consistent with the ACA 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. Such strategies could include, for example, 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, CMS advises that it is examining ways in which states could continue their high risk pools beyond 2014 as a means of easing the transition.

CMS notes that issuers (insurers) may incur some one-time fixed compliance costs, including administrative and marketing costs, although administrative costs are 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% of current enrollment, according to Congressional Budget Office estimates. **CMS asks for 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.**

States may incur costs if they choose to establish their own, new geographic rating areas and age rating curves. **CMS is requesting information on such costs.**

With respect to the ACA rate review program, CMS says that the proposed amendments would help issuers avoid duplication of effort for filings subject to review by using the same standardized template for both non-QHPs and QHPs.⁵ Additionally, the collection of rate information below the rate review threshold and use of a standardized data template would provide 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 the data.

⁵ QHPs are Qualified Health Plans sold through the Exchanges.

II. Background

A. Legislative Overview Prior to the Affordable Care Act

CMS describes in the preamble ways in which the current individual and small group health insurance markets are 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.” Premiums have risen substantially over the last decade and the share of premiums paid by employees has also increased as well as their out-of-pocket costs. CMS also notes the large number of personal bankruptcies attributable to the high burden placed on individuals as a result of being inadequately insured. In addition, CMS describes some of the major non-financial barriers to obtaining coverage such as medical underwriting that may result in denials of coverage or preexisting condition exclusion periods and the complexity of navigating an insurance market which lacks transparency.

HIPAA. CMS notes that prior to the ACA, title XXVII of the PHS Act included certain insurance market protections for individuals and employers that were added by HIPAA. Because the ACA amended this section of the PHS Act, CMS explains how HIPAA relates to the ACA, explains how states regulated insurance in the individual and small group markets pre and post HIPAA, and the ways in which HIPAA provided for federal enforcement of its rules in states that failed to meet federal minimum requirements. (HIPAA explicitly recognized the role of the states as the primary insurance regulators where their standards were at least as protective as HIPAA.) Some states did go further than HIPAA in establishing more protective laws for consumers, and Maine, Massachusetts, New Jersey, New York and Vermont 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 ACA. Only Massachusetts, which enacted a 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 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

CMS 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 all individuals and employers have certain basic protections with respect to the availability of the health insurance coverage in all states.

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 CMS table (not included in the NPRM⁶) 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 Exchange (2017+)
Single Risk Pool	Yes	Yes	No
Guaranteed Issue	Yes	Yes	Yes
Renewability	Yes	Yes	Yes

CMS 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.

As noted earlier, §1312(c) of the ACA 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. CMS notes that although the ACA does not provide an explicit effective date for this section, it interprets it to be effective for plan years (in the individual market, policy years) beginning on or after January 1, 2014. This section does not apply to grandfathered health plans.

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

⁶ See: <http://cciio.cms.gov/resources/files/market-rules-nprm-11-26-2012.pdf>

C. Rate Increase Disclosure and Review

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.

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 §2794. In this rule, 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.

CMS is 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 reform provisions that take effect in 2014.”

III. Provisions of the Proposed Regulations

CMS notes again the intent of these proposed regulations and also references other provisions of the ACA that will work along with the ACA market reforms to expand private insurance coverage by making it more affordable and accessible, including the Exchanges, the premium tax credits for eligible individuals who enroll in QHPs through Exchanges, and the 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.”

A. Fair Health Insurance Premiums (§147.102)

Under PHS Act §2701, health insurance issuers may vary premium rates for health insurance coverage in the individual and small group markets based on a limited set of factors, 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 1.5:1.⁷ All other rating factors are prohibited. 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

⁷ For purposes of family coverage, any premium variation for age and tobacco use must be applied to the portion of the premium attributable to each family member.

(see below).⁸ “Re-underwriting,” which refers to issuers increasing premiums at renewal for existing customers because they incurred claims or experienced worsening health during a policy year, is also prohibited.

This section of the ACA also permits states to establish one or more rating areas; if a state fails to do so, then CMS may establish them. CMS, in consultation with the NAIC, will define permissible age bands (and has done so, as discussed below).

All non-grandfathered health insurance coverage in the individual and small group markets is subject to the requirements in this section. In addition, 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. **CMS welcomes 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 coverage in these markets.**

1. State and Issuer Flexibility Related to Rating Methodologies

The ACA did not specify the method that insurers must use to establish their premiums (i.e., rates or prices). For example, it does not specify the method that an issuer would use to distribute rates within the 3:1 limit on adult rates as enrollees grow older. Nor does it specify how to apply family size differences or the method for computing rates in the small group market. Currently, such decisions are left to the discretion of health insurance issuers, subject to state oversight.

This proposed rule implements CMS’ authority under PHS Act §2701 to regulate premiums. The requirements would apply to all non-grandfathered health insurance coverage in the individual and small group markets starting in 2014. Rating methodologies, particularly with respect to age rating and certain aspects of family rating, would be standardized for coverage in the individual and small group markets.

CMS gives several reasons why some standardization is required. First, the risk adjustment methodology under §1343 of the ACA will need to accommodate permissible rating factors. 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. To the extent there is decreased accuracy in the risk adjustment methodology as a result of having to approximate how, for example, age differences are accounted for in the rates, 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. Second, some core functions of the Exchange, such as calculating rates for QHPs and determining the benchmark plan for purposes of the premium tax credit, would be simplified if issuers used the same age curves, age bands, and family rating methods. If issuers choose their own, the definition of the second lowest cost silver plan (to which the premium

⁸ CMS notes that 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 §2791(e)(1), (3), and (5) (definitions of individual market, large group market, and small group market, respectively).

subsidies are tied) would likely vary by applicant. In contrast, standardizing 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 describes the proposed rating provisions. **CMS welcomes 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

In the current small group market, issuers use one of two methods to generate rates for their policies. Composite rating uses the rating characteristics of an entire small group, such as the average employee health risk, 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. 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. Under an alternative per-member approach, 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.

Since §2701 of the ACA does not distinguish between individual and small group market rating, CMS proposes that issuers 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 (see below) and then calculate the group premium by totaling the premiums attributable to each covered individual. However, nothing in the proposed rule would preclude a state from requiring issuers to offer, or an issuer from voluntarily offering, to a group a group premium based on a composite approach, providing that the issuer base the total premium for a group on its actual current enrollment. CMS proposes 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.⁹

CMS notes the advantages of its proposed per-member rating methodology for small employers, including the fact that within the SHOP exchange, it would give employers flexibility to choose how to allocate their contributions to employees' coverage. An employer may 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 could encourage greater take-up by such

⁹ The 30-day timeline is noted in the preamble but is referenced in the proposed rule as "in accordance with the date and format specified by CMS".

employees and make it easier for the employer to meet any minimum participation rate requirement that an issuer may apply.

The flexibility being proposed by CMS for an issuer to use the composite rating takes into account that many small employers, states, and issuers are already accustomed to composite rating 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.”

CMS seeks comment on the alignment of the method for calculating each employee’s rate in the small group market with the method used to calculate an individual’s rate in the individual market. In particular, CMS seeks 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

Under PHS Act §2701(a)(1)(A)(i), issuers may vary rates based on whether a plan covers an individual or a family. Under §2701(a)(4), 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.

CMS proposes that issuers add up the rate of each family member to arrive at a family premium. 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. CMS’ intent is 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. CMS proposes 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 with the requirement that child-only policies be available to those under age 21. CMS does 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.

CMS notes that consistent with PHS Act §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.

CMS solicits comments on the use of the per-member build-up methodology for individual and small group market coverage. In addition, comments are requested 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).

CMS further proposes in §147,102(c)(2) that a state be permitted 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 issuers could not charge excessively high premiums to individuals or families that would render meaningless their guaranteed availability rights under PHS Act §2702. A state would be required to submit its election of family tiers and corresponding multipliers to CMS within 30 days of the publication of the final rule. If a state does not establish uniform family tiers and corresponding multipliers, then the per-member rating methodology under §147.102(c)(1) would apply. Under proposed §147.102(c)(3), if a state requires composite rating in the small group market, then the state should notify CMS within 30 days from the publication of the final rule. Otherwise, the per-member rating methodology would be utilized in the state's small group market.

CMS solicits 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

CMS observes that currently issuers have 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.¹⁰ 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. **CMS seeks comment on whether the final rule should specify the minimum categories of family members that issuers must include in setting rates for family policies or whether CMS should defer to the states and issuers to make this determination. Comment is also requested on the types of individuals who typically are included under family coverage, including types of covered individuals who would not meet the classification of tax dependents.** (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 §2702.)

5. Rating for Geography

Under PHS Act §2701(a)(1)(A)(ii), rates may vary by rating areas. Section 2701(a)(2) requires a state to establish one or more rating areas within that state. The Secretary (the preamble says CMS) is directed to review the adequacy of the rating areas established by a state. If the state's rating areas are inadequate or a state does not act, the Secretary may establish such rating areas. CMS notes that "a rating area 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."

CMS notes that in most states, issuers currently have flexibility in establishing their rating areas. Under its proposed rule, 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

¹⁰ An example is that a plan or issuer that otherwise offers dependent coverage must offer coverage to dependent children up to age 26 under the ACA.

proposed rule makes no distinction between coverage offered in or outside of the Exchange. Thus, rating areas would apply equally to all non-grandfathered coverage in the individual or small group market. The seven rating area maximum is viewed by CMS as providing states with needed flexibility to designate areas that are adequate in size and can accommodate local market conditions while avoiding an excessive number that would be confusing to consumers and not reflect significant market differences. **CMS seeks comment on the maximum number of rating areas and the potential standards for determining that maximum number.**

CMS proposes three standards for the geographic divisions based on current practice. A state could select one of the approved standards that CMS would presume “adequate” or could submit its own standard, which would be subject to CMS approval—

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.

All sections of a rating area would not have to be geographically adjacent. Thus, a state could create a rating area comprised of all non-MSA portions of a state that have similar health care costs.

CMS includes in the preamble information on the number of rating areas that would result using the different standards and the rationales for each. Regarding MSAs that cross state boundaries, CMS proposes that these 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, CMS proposes that these states combine some of the areas into no more than seven rating areas based on a reasonable methodology, such as cost similarity.

CMS requests comments on 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. It also requests 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. Comments also are sought on whether the final rule should establish minimum geographic size and minimum population requirements for rating areas and whether state rating areas in existence today should be deemed in compliance with this provision.

Again, to the extent a state establishes rating areas using the above proposed standards, the state’s rating areas would be presumed adequate. 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. If a state does not establish rating areas consistent with the proposed standards, the one-area-per-state standard would apply, unless CMS applied one of the other standards to designate rating areas in a particular state. In that case, CMS likely would be inclined to use the MSA/non-MSA standard. To the extent that

CMS establishes a state's rating areas, it would work with the state, local issuers, and others to determine how best to establish rating areas responsive to local market conditions.

CMS notes that it recognizes that states and issuers need lead time to update pricing models and make related systems changes to accommodate potentially new rating areas in 2014.

Accordingly, CMS proposes 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.

CMS recognizes that states may wish to establish or modify their rating areas after 2014. CMS requests comments on appropriate schedules and procedural considerations related to rating area designations for plan years after 2014.

6. Rating for Age

Under PHS Act §2701(a)(1)(A)(iii), 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. No premium rating limitation for children is specified by the statute, 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.

CMS believes that the ACA language supports an interpretation that the 3:1 age rating limitation was intended to apply only to adults age 21 and older. Further, CMS believes that PHS Act §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. CMS thus proposes to allow rates to vary within a ratio of 3:1 for adults (meaning here 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 described below. **Comment is requested on this approach.**

Under the proposed rule, enrollees' age factors and bands would be determined based on an enrollee's age at policy issuance and renewal. CMS says 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 is requested on whether other measurement points (e.g., birthdays) might be more appropriate.**

PHS Act §2701(a)(3) directs CMS, in consultation with the NAIC, to define “permissible age bands” for purposes of age rating. CMS explains what age bands are (ranges of sequential ages) and their use in deciding how premiums of a plan are to vary based on age. CMS consulted with the NAIC, through its Health Care Reform Actuarial (B) Working Group, concerning the permissible age bands to be defined by CMS. Although the Working Group did not make specific recommendations, it provided “valuable feedback” regarding state regulation of age bands, issuer practices, and important policy considerations related to possible age band standards. Taking into consideration the NAIC feedback, CMS proposes the following standard

age bands for use in all states and markets subject to the rating rules of PHS Act §2701. These bands are 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.

CMS explains the rationale for selecting these bands (e.g., the cost differences are small for children ages 0-20; one year age bands for adults through age 63 result in relatively small premium increases each year due to age instead of more dramatic changes that would occur if the bands were larger and the consumer moved from one band to the next; and the single age band for 64-65 year olds would facilitate compliance with Medicare Secondary Payer requirements where per-member rating is used for older adults in the small group market).¹¹ CMS seeks **comments on whether multiple age bands or a single age band for children are appropriate. Comments also are requested on the approach for age rating for adults, including the approach for rating those ages 64 and older.**

CMS further proposes that issuers within a market be required to use a uniform age rating curve, which is a specified distribution of relative rates across all age bands. CMS explains that 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 that it will simplify identification of the second lowest cost silver plan used to determine premium tax credits; will provide an incentive for issuers to compete to offer plans that provide the best value across the entire age curve; and will promote the accuracy of the risk adjustment program. A standardized rating methodology for all plans within a state also helps 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.

A table showing the premium ratio for each age is included at 77 *FR*70595 (see “CMS Proposed Standard Age Curve”)

CMS advises that the proposed age curve is 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.¹²

¹¹ 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.

¹² CMS notes that it developed the proposed age curve based on its assumptions of the distribution of claims costs by age in the post-2013 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).”

CMS describes the data that it used to examine how premiums currently vary by age in the private insured small and larger group markets. Based on its findings, CMS concludes that its proposed approach will not result in “any significant disturbance in issuer pricing practices across different geographic regions or plan designs.” It is thus proposing that the uniform age curve would apply by default in a state, unless a state adopted a different uniform age curve. If a state anticipates using its own age curve, then the state would have to 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. **Comment is requested on the application of a single, default age curve to the individual and small group market based on the CMS assumptions and the methodology for doing so.**

CMS further proposes 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. When other factors (e.g., 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. CMS says that its 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. CMS would revise its default curve periodically to reflect its most current knowledge of the individual and small group market (e.g., enrollment, population distribution, and cost patterns) following implementation of 2014 reforms. **CMS requests comment on: (1) its proposed approach for fitting the proposed adult age curve to the statutorily specified 3:1 premium ratio; (2) potential implications that the transition from the proposed child curve to the proposed adult curve may have for issuers and consumers; and (3) 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 ACA.**

CMS explains that while it is proposing a uniform age rating curve for the reasons described in the preamble, its proposed approach would maintain flexibility for states and issuers regarding certain aspects of age rating. In most states, premium rates are currently 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. To support the accuracy of the risk adjustment methodology, CMS proposes 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. **CMS seeks 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.**

7. Rating for Tobacco Use

PHS Act §2701(a)(1)(A)(iv) provides that issuers in the individual and small group markets cannot vary rates based on tobacco use by more than 1.5:1. PHS Act §2701(a)(4) provides that the rating variation for tobacco use applies based on the portion of premium attributable to each family member covered under the plan. A state law that prescribes a narrower ratio (e.g., 1.25:1) or prohibits varying rates for tobacco use altogether would not be preempted. If a state anticipates adopting narrower ratios for tobacco use, CMS proposes that the state submit relevant information on their ratios to CMS no later than 30 days after the publication of the final rule.

CMS notes that rating for use of tobacco is permitted in many states, although many also 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. No clear and consistent definition of tobacco use exists among the states for rating purposes. To determine tobacco use, issuers typically rely on self-reported data such as information from applications and health risk assessments, which also vary.

CMS invites comment on ways to implement the tobacco rating provision and whether 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. Alternative options for identifying tobacco use may be suggested, as well as how the information should be collected with respect to health insurance coverage offered outside an Exchange.

Under the CMS proposed rule, issuers would not be prohibited from varying the tobacco use factor used for 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. **CMS seeks comments on this approach.**

Tobacco Use and Wellness Programs. The ACA added a new PHS Act §2705(j), effective for plan years beginning on or after January 1, 2014. Under this provision,¹³ plans and issuers generally can offer a reward of up to 30% of the cost of coverage 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 §2705(j) also authorizes the Departments of HHS, Labor and Treasury to increase the maximum reward to as much as 50% of the total cost of coverage if they determine such an increase to be appropriate.

Contemporaneously with the publication of this proposed rule, the HHS and the Departments of Treasury and Labor are publishing a notice of proposed rulemaking (NPRM) to implement §2705(j).¹⁴ That rule further proposes an increase of an additional 20 percentage points (to 50%) to the extent that the additional percentage is in connection with a program designed to prevent

¹³ As detailed in the preamble, this provision is based on 2006 final regulations. (See 77 FR 70596)

¹⁴ See also the detailed summary of this proposed rule prepared by Health Policy Alternatives.

or reduce tobacco use. CMS proposes in this proposed market reform rule that the definition of “tobacco use” for purposes of §2701 be consistent with the approach taken with respect to health-contingent programs designed to prevent or reduce tobacco use under §2705(j). In other words, by proposing to raise the maximum permissible reward for participating in a tobacco cessation program in the wellness rule, CMS is proposing that an 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 if he or she participates in a wellness program meeting the standards of PHS Act § 2705(j) and its implementing regulations.¹⁵

CMS says that its proposed 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 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. **CMS welcomes comments on this proposal and other ideas for coordinating the implementation of the tobacco surcharge and the wellness program provisions.**

CMS also invites comment on possible definitions of “tobacco use” that could be applied for both §2701 and §2705(j). One is to rely on self-reporting; another may be a defined amount of tobacco use within a specified look-back period; yet another may be to define “tobacco use” as regular, and not infrequent or sporadic, tobacco use (perhaps including some standard of frequency); or to define a tobacco user as one who uses it with sufficient frequency so as to be addicted to nicotine. Regardless of how tobacco use is defined, CMS is proposing that the definition of “tobacco use” for purposes of §2701 be consistent with the approach taken with respect to health-contingent wellness programs designed to prevent or reduce tobacco use under §2705(j).

Finally, CMS notes that PHS Act §2705(b) also prohibits issuers from charging enrollees in the individual market higher premiums based on health factors. However, PHS Act § 2705(j) does not apply to the individual health insurance market and CMS concludes that issuers could implement the tobacco use surcharge in the individual market without having to offer wellness programs. **However, CMS solicits comment on whether and how, consistent with PHS Act §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.**

¹⁵ CMS notes that 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.

B. Guaranteed Availability of Coverage (§147.104)

Under PHS Act §2702, issuers that offer 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.

CMS explains that PHS Act §2702 generally is based on the HIPAA provision for guaranteed availability in the small group market. The ACA provision goes beyond HIPAA, however, in expanding guaranteed availability to include the individual and large group markets; requiring the establishment of open enrollment periods; and establishing additional special enrollment periods. It also eliminates the guaranteed availability exception for coverage offered only to bona fide association members in the small group market. The proposed rule is accordingly based on the HIPAA guaranteed availability rule (§146.150), with changes to reflect the ACA provisions. In addition, the proposed rule adds a new marketing standard that is identical to that applicable to QHPs established under 45 CFR 156.225 (relating to the rules for QHP Minimum Certification Standards).

Thus, under the proposed rule, issuers would be directed to 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. Issuers would be required to offer all products approved for sale in the applicable market. This includes all non-grandfathered coverage in the applicable state market. This means that beginning in 2014, even non-grandfathered “closed blocks” of business would be available to new enrollees, subject to the limited exceptions noted below. **CMS welcomes comments on this proposal.**

Enrollment. 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. These standards are intended to minimize adverse selection by setting consistent open enrollment periods for the marketplace, regardless of whether individuals or employers chose to purchase outside or through an Exchange. **Comments are solicited 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.**

CMS notes that although the ACA does include the HIPAA provision that an issuer can require a small employer to meet employer contribution and participation rules¹⁶ in order to qualify for

¹⁶ 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. “Group participation rule” means

guaranteed renewability, the ACA does not apply that requirement to guaranteed availability. CMS is concerned that if it does not make such an exception apply to guaranteed availability by regulation, adverse selection would result in the small group market, given its year-round open enrollment period. Thus, CMS proposes to allow issuers in the small group market to decline to offer coverage to a plan sponsor that is unable to comply with a material plan provision relating to employer group 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).

CMS further proposes 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 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 is 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 §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. **CMS requests comment as to whether another standard, such as 60 calendar days, generally consistent with the Exchange standard, is more appropriate.** 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). **CMS requests 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)).**

Network Plans. Special rules related to guaranteed availability are proposed for network plans. An issuer that offers coverage in the group and individual market through a network plan may:

- 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.
- 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) that it will not have the capacity to deliver services adequately to enrollees of any additional groups or individuals because of its obligation to existing contract holders and enrollees and that it is applying the denial of guaranteed availability uniformly to all employers and individuals, without regard to the enrollees' claims experience or health

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.

status-related factors. Issuers that invoked this exception would be barred from offering new coverage for at least 180 calendar days after coverage is denied.¹⁷

Association Plans. CMS notes that PHS Act §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. CMS says 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.” **CMS seeks comment on this issue.**

Financial capacity limits. CMS proposes that issuers would not have to offer coverage to employers and individuals, uniformly and without regard to claims experience of those individuals, employers and their employees (and their dependents), if they demonstrate to their applicable state authority (if required) that they lack the financial capacity to sell additional coverage. An applicable state authority could provide for this exception on a service-area-specific basis. Issuers who invoke the financial capacity exception would be barred from offering new coverage for at least 180 calendar days.

Marketing standards. CMS proposes that 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.

CMS notes that this is a more detailed standard in connection with guaranteed availability than had been included in the HIPAA rule but is similar to HHS interpretive guidance for HIPAA.¹⁸ Under §1311(c)(1)(A) of the ACA, QHP issuers are required to comply with applicable state laws and regulations regarding marketing by 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. This standard would be adopted by this proposed rule so that consistent standards apply to the market inside and outside of the Exchanges and existing state oversight mechanisms are leveraged. States would continue their traditional role of regulating marketing activities of issuers. CMS reiterated this point in guidance issued on November 29, 2011, indicating that it would apply existing state standards on marketing materials in states where a federally-facilitated Exchange operates.¹⁹

¹⁷ CMS notes that PHS §2702(c)(1)(A) does not explicitly include an exception allowing issuers to limit sale of individual market coverage to individuals who live or reside in the plan’s service area. However, failing to include such an exception would eliminate an issuer’s ability to define a service area for its individual market businesses. CMS also believes that the statutory construction indicates intent to include such an exception and, for this reason, the proposed rule would clarify that individual market coverage also may limit enrollment to those individuals who live or reside in a service area.

¹⁸ See HHS Bulletin No. 98-01.

¹⁹ CMS notes that “the NAIC’s Model Unfair Trade Practices Act 880-1 has been adopted in a ‘substantially similar

In sum, CMS proposes that all issuers comply with state laws regulating the marketing of insurance unless the state has no such laws or has laws which are below the federal minimum standard. If that is the case, then the federal minimum standard would govern. **CMS seeks comment on this federal minimum standard.**

Finally, in response to concerns that have been voiced about the ability of individuals to manipulate guaranteed availability each year, CMS notes 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. **CMS seeks comment 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 (§147.106)

PHS Act §2703 directs that any issuer offering coverage in the individual or group market must renew coverage at the option of the plan sponsor or individual, with certain exceptions. Although based on the HIPAA guaranteed renewability provision for the group market, §2703 is more expansive by also applying guaranteed renewability requirements to the individual market. CMS notes that the ACA provision does not, however, include the individual market in its guaranteed renewability exceptions for uniform modifications of coverage and loss of bona fide association membership. CMS is proposing to do this through regulation, saying that PHS Act §2742 provides the basis for it to do so.

Under the proposed rule, an issuer offering coverage in the individual or group market would be required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable. Exceptions would 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.²⁰

CMS notes in the preamble that under §155.430(b), an Exchange may terminate an enrollee's coverage, and permit a QHP issuer to terminate such coverage under certain circumstances. Examples include that the enrollee is no longer eligible for coverage in a QHP or that the

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."

²⁰ The exception in this case is 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. (§147.106 (b)(6)). CMS notes in the preamble that in the case of coverage made available by an 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.

enrollee changes from one QHP to another during an open or special enrollment period. Some of these events do not correspond to the PHS Act non-renewal events (e.g., a loss of QHP certification). **CMS seeks comments on whether an issuer would have to renew that coverage on a non-QHP basis, outside the Exchange, if applicable to affected enrollees.**

Discontinuing a particular product. Under the proposed rule, if an issuer decides to discontinue offering a particular product (the preamble says “blocks of business”) 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, 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. CMS proposes that 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 during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

Exception for uniform modification of coverage. CMS proposes that 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.

CMS explains in the preamble that issuers may need to make plan design changes for non-grandfathered coverage issued between March 23, 2010 and January 1, 2014 to comply with ACA standards effective for 2014 plan and policy years. They may also need to make some cost-sharing adjustments at renewal so that plans remain at the same actuarial value level from year to year. CMS “believes 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[s] 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, 2703 and Section 1312(c) of the ACA to Student Health Insurance Coverage

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.” CMS 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 the rating rules, guaranteed availability and renewability and single risk pool (see below), would be inapplicable.

CMS previously provided student health insurance coverage with exceptions from the HIPAA guaranteed availability and renewability requirements applicable to the individual market. Consistent with that policy, this proposed rule would provide student coverage with exceptions from the ACA’s guaranteed availability and renewability requirements so that enrollment in these policies is limited to students and their dependents. (Technically, the proposed rule deems such coverage to be available only through a bona fide association.)²¹ In addition, student coverage would be included in an issuer’s individual market single risk pool. Nonetheless, “given the differences between the student health insurance market and other forms of individual market coverage,” **comment is requested on whether the final rule should allow issuers to maintain a separate risk pool for student coverage and on whether the final rule should provide any modifications with respect to the generally applicable individual market rating rules in connection with such coverage.**

E. Single Risk Pool (§156.80)

Under §1312(c)(1) and (2) of the ACA, an 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. This requirement applies to health plans both inside and outside of an Exchange for both markets. Under §1312(c)(3), a state may merge its individual and small group markets, in which case all non-grandfathered plans’ risk would be merged. Section 1312(c)(4) renders inapplicable any state law requiring grandfathered health plans to be included in the single risk pool(s). CMS proposes that, in order to support the accuracy of the risk adjustment methodology, states that intend to merge their individual and small group market pools in 2014 inform CMS no later than 30 days after the publication of the final rule.²²

²¹ See §147.145 (b)(1).

²² The 30-day timeline is noted in the preamble only but is referenced in the proposed rule as “in accordance with the date and format specified by CMS”. See §156.80(c).

The proposed rule would largely codify the statutory language. It would also 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 §2701.²³ CMS describes in the preamble how the single risk pool requirement is a significant but needed change from current practice. Since issuers should now be prohibited under the ACA from using traditional underwriting practices to screen out high risks²⁴ (or charge them higher premiums), the single risk pool requirement will help discourage issuers from segmenting the market into separate risk pools. The ACA risk adjustment program will also help in this regard. “[T]he 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.”

Under the proposed rule, the claims experience of the enrollees in all non-grandfathered plans of an issuer in the individual or small group market within a state (or both, if the risk pools are merged) would be combined. This would help prevent the premium rate of a particular plan from being adversely impacted by the health status or claims experience of its enrollees. For rates effective starting January 1 2014, an issuer would use the estimated total combined claims experience of all non-grandfathered plans deriving from providing essential health benefits (EHBs) 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 actuarially justified 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. (CMS explains that this 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 EHBs. 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.

In addition, actuarially justified adjustments would have to be implemented by issuers in a transparent fashion, consistent with state and federal rate review processes. **Comment is requested on the approach described above, and on the proposed plan specific adjustments to the index rate.**

²³ This means that excepted benefit and short-term limited duration policies, for example, would not be subject to the single risk pool requirement. CMS 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).

²⁴ Specific premiums can vary however according to family size, geographic rating area, and age and tobacco use, within specified limits.

The proposed rule would apply both when rates are initially established for a plan and at renewal. CMS expects 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. CMS is considering allowing additional flexibility in product pricing in 2016 after issuers have accumulated sufficient claims data. **Comments are requested on this approach.**

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

Under the ACA and the underlying HIPAA provisions, states have primary enforcement authority for the insurance rules. CMS acts as a fallback – it only enforces if a state notifies CMS that it is not enforcing or CMS determines that the state is failing to enforce the requirements. CMS clarifies 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 set forth the enforcement processes for all of the requirements of title XXVII of the PHS Act with respect to health insurance issuers and nonfederal governmental group health plans. CMS would make conforming changes in various sections of part 150 as well as part 144 (relating to health insurance coverage) intended to clarify the applicability of enforcement procedures to the PHS Act requirements added by the ACA. CMS notes that “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 [see above proposed rules] prior to the issuance of a final rule.”

G. Enrollment in Catastrophic Plans (§156.155)

Section 1302(e) of the ACA outlines standards for offering catastrophic plans. Under the proposed rule, 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. A catastrophic plan does not offer coverage at the bronze, silver, gold, or platinum coverage level. It provides coverage of EHBs only once the enrolled individual has reached the annual limitation in cost sharing in §1302(c)(1) of the ACA. In addition, the plan must cover at least three primary care visits per year before reaching the deductible. CMS notes that a catastrophic plan is allowed to impose cost sharing in connection with these primary care visits so long as other applicable law (for example, PHS Act §2713 related to coverage of certain preventive services) permits.

Further codifying the statute, catastrophic coverage would be limited under the proposed rule 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 would have to meet at least one of these two eligibility criteria.

H. Rate Increase Disclosure and Review (Part 154)

CMS is proposing the following changes to the existing rate review program under 45 CFR part 154.

Rate increase subject to review. CMS would 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. CMS explains that it is proposing these changes to align with the timing of rate submissions of QHPs in the Exchanges, as well as market-wide rating rules created by the ACA. **Comments are welcome on these proposed changes.**

Submission of rating filing justification. CMS would amend §154.215 to direct issuers to submit data and documentation regarding rate increases on a standardized form in a manner determined by the Secretary.²⁵ CMS says that this policy is intended to identify patterns that could indicate market disruption, which could occur given the additional standards that apply to QHPs, and to oversee the new, market-wide reforms. In addition, CMS would modify the rate review standards by extending the requirement that 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.” 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. 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.²⁶

Under the current rate review program, CMS collects rate filing information from issuers proposing increases of 10% or greater, including in states with Effective Rate Review Programs. This allows the Secretary to ensure the public disclosure of information on such increases as required by the ACA. CMS says that collecting rate filing information on all rate increases in applicable markets would provide it, 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. The improved data collection also 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, primarily, the single risk pool requirement. This will mean that products can no longer be reviewed as completely unique, but rather must include experience of the entire market. Accordingly, when any product has a rate increase, all other products with

²⁵ This is based on §2794(b)(2)(A) of the ACA which directs the Secretary, in conjunction with states, to “monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.”

²⁶ See also the proposed regulation text at §154.220 related to issuer timing of providing the 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. Conforming amendments would also be made. “Preliminary Justification” would be replaced with “Rate Filing Justification”.

enrollment or projected enrollment would be reported to assure the single risk pool requirement was appropriately implemented to promote fair market competition. CMS also says that 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. 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 issuers to use for submitting the data for rate increases.²⁷ The template was developed with input from the NAIC and other stakeholders. To help assure a competitive 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. **Comments are requested 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 issuers and the states. Comments also are welcome 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).**

CMS's determination of effective rate review programs. CMS also proposes to modify the standards for an Effective Rate Review Program. A state with an Effective Rate Review Program would 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, and other market reform rules as required by the ACA. The 10% review threshold, as finalized in §154.200 (76 FR 29964), will remain unchanged.

Additionally, CMS proposes to revise §154.301(a)(4) by adding additional factors that states must take into consideration when conducting their examinations. In reviewing the impact of cost-sharing changes, the impact on the actuarial value of the health plan would have to be considered in light of the requirement under §1302(d) of the ACA that a plan meet one of the metal levels in terms of actuarial value. In reviewing benefit changes to a plan, a state would also have to consider the impact of the changes on the plan's EHBs and non-essential health benefits. The impact of the changes on pricing, including the rating limitations on age and tobacco use, would also have to be considered.

CMS also proposes to add new language 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:

²⁷ See: Rate Increase Disclosure and Review Reporting Requirements, www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10379.html

- 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.

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), CMS proposes 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. A state could, 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.

IV. Collection of Information Requirements

CMS is required, under the Paperwork Reduction Act of 1995, to solicit comment on information collection requirements (ICRs), and identifies four areas for comment.

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of the estimates of the 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.

CMS is soliciting public comment on each of these issues for the following sections of the proposed rule that contain information collection requirements:

A. ICRs Regarding States 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. Since CMS 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. **CMS seeks comments on how many states are likely to submit their own rating and risk pooling rules.**

CMS says that 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. 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 \$215 per state, if a state needed to disclose all seven rating requirements.

V. Regulatory Impact Analysis

OMB has designated the proposal as a “significant” regulatory action. CMS 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).

CMS presents an accounting table in Table V.1 of its summary of benefits costs and transfers. The information is summarized below.

Table V.1: Accounting Table (from proposed rule)	
Benefits	
Qualitative:	
<ul style="list-style-type: none"> • Increased enrollment in the individual market leading to improved health 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: Annual monetized costs (\$/year), for 2013-2017, expressed in 2012 dollars (estimate is the same at 3% and 7% discount rates). The costs are administrative costs related to submission of data by issuers seeking rate increases below the rate review threshold.	\$16 million
Qualitative	
<ul style="list-style-type: none"> • 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	
<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 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.

CMS notes that 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 DC 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.

CMS reviews the policy changes that would be put in place under the proposed rule and **solicits information and data on any industry practices that would be affected, and any related costs and savings, including administrative, operating, and information technology-related costs, and anticipated effects on premium rates and financial performance.**

Benefits

CMS reviews the literature on the uninsured: reduced access to care and higher mortality, and increased financial difficulties. It presents CBO's estimate that the number of uninsured will be reduced by up to 30 million individuals, and the effect that coverage will have on access and outcomes. CMS 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.

Costs

CMS reviews administrative costs incurred by issuers, including one-time fixed costs to comply, including systems and software updates and changes in marketing. In addition, states may incur costs to establish geographic rating areas and uniform age rating curves.

CMS also notes the increase in use and costs arising from expanded insurance coverage, some of which may be economically inefficient, but points to studies that the cost of the inefficiency is likely more than offset by the benefit of risk reduction.

Health insurance issuers seeking rate increases would incur administrative costs. CMS estimates the following, based on the 2011 MLR reporting year:

- Number of issuers:
 - 2,010 issuers (company/state combinations) offer coverage in the individual market;
 - 2,294 issuers offer coverage in the small group market; and
 - 2,294 unique issuers offer products in one or both market.
- Rate review submissions:
 - 7,650 submissions for rate review increases annually;
 - 1,200 submissions for rate review increases at or above the threshold; and
 - 6,450 submissions for rate increases below the threshold.
- Costs: total administrative costs of about \$7,000 per issuer, or \$16 million.

CMS solicits data on a number of elements of the cost estimates, including the timing, nature and magnitude of the potential administrative and other costs and savings associated with the proposed rules, including merging the individual and group markets in states that choose to do so. CMS requests information on whether changes to rating rules would require issuers to undertake systems and operational changes, and on related costs and potential savings and effects on premiums and financial performance. CMS solicits information on how standardizing rating areas may affect rates, and information on any potential costs incurred by states to establish rating areas and uniform age rating curves if they choose to do so.

Transfers

CMS notes current rating practices (as it does in the preamble) and the ACA provisions that will allow issuers to vary rates based only on a limited number of factors within specified ranges. Since rating based on health and gender will no longer be allowed, older and less healthy adults and women may see decreases in rates, while younger healthier adults and some men may see increases. CMS 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.

With increased coverage, out-of-pocket expenses may decrease while insurer spending increases. It will also reduce uncompensated care for providers and the resulting cost shift to private insurance rates.

Regulatory Flexibility Act

CMS 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. CMS notes that RIAs on 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). CMS 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

CMS reviews the Unfunded Mandates Reform Act. It notes that it gives state governments the option to establish rating areas and age rating, with CMS stepping in if the state opts not to act. CMS also estimates costs of \$215 per state for administrative costs of disclosing rating and pooling requirements to CMS. 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 CMS' assessments, CMS says that consistent with the Act it has designed the proposed rule to be the least burdensome alternative for state, local, and tribal governments and the private sector.

Federalism

CMS reviews the state and federal responsibilities under the proposed rule, and notes that it has consulted with and worked cooperatively with affected states. 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 proposed rule is subject to the Congressional Review Act. Before it can take effect, CMS 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.