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REFORM Update

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The Centers for Medicare and Medicaid Services (CMS) recently proposed new rules for insurance carriers. The newly proposed rating rules restrict the factors small group and individual health plans can use to develop rates. Small group and individual insurance carriers will also need to cover essential health benefits. These changes will play a significant role in 2014 renewals.

Small group employers will directly be affected by the rating rule changes. In 2014, when the "play or pay" provisions become effective, some employers may decide to discontinue group health plan coverage. Employers who choose to "get out" may want to consider paying all or part of their employees' premium for non-subsidized individual coverage in the Exchange. Individual premiums will likely be much higher than the contributions for group health coverage. The new rating rules, the prohibition on medical underwriting and the requirement to cover essential health benefits will dramatically influence rates in the individual insurance market in 2014.

This *Reform Update* reviews the proposed rules for the insurance market:

- Overview of the current individual health insurance market
- Guaranteed available and renewable coverage
- Fair health insurance premiums
- Rules for risk pools
- Catastrophic health plans

Overview of the Current Individual Health Insurance Market

Because most employers deal primarily with large group health insurance, they are not always aware of the restrictions in the individual insurance market. Health care reform will cause significant changes in this market in 2014. To understand the importance of these changes, you need to understand how this market operates today.

State law governs the individual insurance market. Each state has different rules for rate setting and underwriting:

- Forty-five states allow carriers to deny coverage for individual applicants.
- Forty-three states allow carriers to determine rates based on health.
- Forty-eight states allow rating based on age (unlimited age rating bands are common).
- Thirty-seven states allow gender rating, and three states that do not allow gender rating allow additional premiums to be charged for maternity coverage.

In addition, rating rules also differ for the small group market:

- Thirty-eight states allow rating based on health.
- Forty-eight states allow rating based on age.
- Thirty-five states allow gender rating.
- Thirty-seven states allow industry rating.

The 2014 rules will radically change how carriers in the individual and small group market set rates.

Guaranteed Availability and Renewability of Coverage

In 2014, individual and small group health insurance carriers will be prohibited from medically underwriting applicants for non-grandfathered coverage. Small groups will be defined as groups with up to 50 employees in 2014 and 2015. In 2016 that number will rise to groups with up to 100 employees. Although states can use the 100-employee threshold in 2014 and 2015, it appears that few will. In 2017, states may allow large group health coverage to be offered through the Exchange.

Carriers will be unable to deny coverage based on pre-existing medical conditions or any other factors. This requirement could potentially cause a problem if people decide not to purchase health insurance until they have an actual need to use it. Several health care reform provisions will protect insurance carriers against this adverse selection. In particular, people will be limited as to when they can apply for coverage:

- During the initial enrollment period (October 1, 2013 through March 31, 2014)
- During annual open enrollment (October 15 through December 7 each year)
- Mid-year special enrollments, available under a number of circumstances including:
    - Events that would trigger eligibility under COBRA coverage
    - Loss of eligibility for other coverage
    - HIPAA special enrollment opportunity
    - Special enrollment rights for qualified health plans (QHPs) in the Exchange

People must apply for mid-year enrollment within 30 calendar days of the triggering event. The proposed rules ask for comments on whether the 30-day period is sufficient or if more time should be allowed.

In the small group market, coverage will depend on when the employee enrolls. Like employer plans today, small group plans will offer an annual open enrollment period. This period will typically align with the employer's renewal date. Mid-year enrollment in the employer plan will be permitted for the special enrollment situations HIPAA defines.

The proposed rule will allow insurers with small group network plans to limit enrollment to people who live or work in the network's service area. Individual carriers can limit enrollment to those who live in the service area.

Insurance carriers with network plans will not be forced to cover applicants if they can demonstrate to state authorities that they cannot deliver adequate services to these potential members. This standard would have to be applied uniformly to all employers and individual applicants. Carriers granted this exception will be barred from offering new coverage for at least 180 days after they deny coverage.

Once they grant coverage, carriers must continue to renew the coverage regardless of the insured's health.

However, carriers in the individual and small group market **are not** required to renew coverage in the following situations:

1. Non-payment of premiums.
2. Fraud or intentional misrepresentation of a material fact by the plan sponsor or individual.
3. For group coverage, the plan sponsor's failure to comply with a material plan provision regarding employer contributions or participation requirements.
4. The insurance carrier ceases to offer this type of coverage in the market.
5. The individual moves outside the service area of the plan.
6. The employer terminates membership in the employer association that provides the coverage.

Exchanges can permit a qualified health plan to terminate an insured's coverage in any of the following circumstances:

1. The individual is no longer eligible for QHP coverage.
2. The individual has failed to pay premiums and all required grace periods have been exhausted.
3. The individual has committed fraud or has intentionally misrepresented a material fact.
4. The QHP is terminated or decertified.
5. The individual changes from one QHP to another during open enrollment or a special enrollment period

In general, coverage is guaranteed to be available and renewable when the new rules take effect in 2014.

Fair Health Insurance Premiums

For individual and small group health insurers in 2014, a number of rating rules will differ from most rating rules in the states today.

The following are key aspects of the new rating rules:

- Premiums can be rated for family size.
- Premiums can be age-rated; however, the rates for adults must be within a 3:1 ratio. This simply means that the highest rate tier cannot be more than three times the lowest rate tier.
- Premiums can be rated for geography.
- Premiums can be tobacco-rated. This rating is limited to a 1.5:1 ratio.

These are the only factors carriers can use to determine rates. They will no longer be able to rate on any of the following factors, which are commonly used today:

- Pre-existing conditions
- Health status
- Claims history
- Duration of coverage
- Gender
- Occupation
- Small employer size
- Small employer industries

The practice of re-underwriting is also prohibited. In other words, insurance carriers can no longer increase premiums at renewal because of an individual's claims experience during the year.

Insurance carriers will have to rate each member as of 2014. For two-person or family coverage, any premium increase because of a member's age or tobacco use must be applied **only to that member's portion of the premium**. For family coverage, the new rule proposes that the rates of the three oldest family members under age 21 be used to calculate the family rate. This cap will not apply to family members over age 21. Their rates will be added to the family premiums. For example, assume a married couple, both aged 45, want to cover their six children (ages 2, 4, 6, 8, 10 and 12) under family coverage. Their family rate would include the rate of both parents added to the member rates for the children aged 8, 10 and 12.

The proposed rules request comments regarding how to define the family members who may be included on the same policy. State and federal laws will influence this determination. For example, if the policy covers dependent children, then they must remain eligible until age 26. Depending on the

comments it receives, the government may provide more details for situations like this, or it may be left to the states to decide.

Premiums can be age-rated in 2014, but there will be limits. Health care reform mandates that the oldest age rate tier be no more than three times the youngest age rate tier. The government intended this rate relationship to apply to adults age 21 or older. The age used to determine rates should be the age as of the policy issue date and each renewal date. This approach ensures that rates will not be adjusted mid-year because of an age change.

The proposed rules offer the following standards for age bands:

- ***Children:*** A single age band covering children from 0 to 20 years of age, with all premium rates the same
- ***Adults:*** One-year age bands starting at age 21 and ending at age 63
- ***Older Adults:*** A single age band covering individuals age 64 years of age and older, with all premium rates the same

Health insurance carriers within a state market must apply a uniform rating curve among age rate categories. CMS has proposed the following standard age curve:

Age	Premium Ratio	Age	Premium Ratio	Age	Premium Ratio
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.953
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and older	3.00

States can use a different rating curve, but CMS must approve it first.

Premiums can be rated based on geography, but there will be limits. A state can establish between one and seven rating areas. CMS must review the adequacy of the state's rating areas. There is no explicit limit on the relationship between state rating areas. These areas do need to be actuarially justified to make sure that carriers are not charging excessively high premiums. If CMS finds the rating areas inadequate, or the state fails to establish them, then CMS may step in to set them.

The proposed rules set forth several standards for developing geographic rating areas:

1. One rating area for the entire state
2. Rating areas based on counties or on the first three digits of zip codes
3. Ratings based on metropolitan and non-metropolitan statistical areas

Premiums can also be rated for tobacco use. Individual and small group markets can vary rates by a 1.5:1 ratio. An insurance carrier may choose to rate tobacco at a lower ratio. **This rating applies only to the portion of the premium for the smokers in the family.** No clear and consistent definition for tobacco use exists among the states. These proposed regulations seek comments on tobacco rating, including:

- How should tobacco use be defined for rating purposes?
- How should tobacco use be determined? Should one or more questions on tobacco use be included on the application?
- Should insurers be allowed to vary tobacco ratings based on age? For example, apply a 1.3:1 ratio at younger ages and a 1.4:1 rating at older ages?

The new rules also propose that small group health insurance issuers allow smokers to avoid the tobacco rating by participating in a wellness program. This requirement aligns the tobacco use rating with the way employer wellness plans handle these "surcharges." Essentially, it means the insured must be offered an alternative to avoid the tobacco surcharge. The requirement will not apply to individual policies.

These rules will apply to non-grandfathered individual and small group coverage in 2014. If a state allows large group plans to be offered in the Exchange in 2017, then these rules will also apply to the large group market for coverage offered in the Exchange. For many carriers, this will be a significant departure from their current method of rate development.

Rules for Risk Pools

Health care reform requires health insurance issuers to maintain a single statewide risk pool for their individual market and a separate pool for their small group market. The single risk pool will apply to non-grandfathered plans. A state can merge the individual and small group experience into one pool. Premiums would then be developed using the experience of the whole pool.

The single risk pool will not apply to:

- Any HIPAA-excepted benefits or short term limited duration policies
- Retiree-only health plans

The rules provide information specific to insurance carriers for rate development.

Catastrophic Health Plans

Catastrophic health plans will have actuarial values that fall below the bronze (60%) level of benefits. Health care reform will allow insurers to offer catastrophic health plans to anyone meeting either of the following requirements:

- Adults under age 30
- People who otherwise have unaffordable coverage

A catastrophic plan must cover at least three primary care visits a year before the deductible is met. Cost-sharing can apply to this limited office visit coverage, unless health care reform prohibits it. For example, cost-sharing is not permitted for preventive services.

Concluding Thoughts

These rules include additional details on the measures CMS will adopt to enforce many of these provisions.

In addition, CMS is amending the process for calculating the Medical Loss Ratio. More information on the Medical Loss Ratio can be found at http://www.mcgrawwentworth.com/Reform_Update/2012/Reform_Update_36.pdf

Many of the details in these proposed regulations directly affect individual and small group insurance carriers. However, employers need to understand how dramatically the insurance carriers' rating systems will change in 2014. For small employers, the increases in 2014 may be unexplainable as the new rating rules apply.

Employers wishing to terminate their medical plans, or looking at not covering some employees should understand the impact these rules will have on their employees. Individual premiums for older employees will be higher in the Exchange than they are under group coverage.

Adopting these new rules for individual and small group market products will challenge insurance carriers. They have very little lead time to change their rating systems.