crowell moring

CLIENT ALERT

CMS Issues Proposed Rules on Rate Review, Risk Pools, Guaranteed Availability and Renewability, and Fair Premiums Under Patient Protection and Affordable Care Act (Comments due by Dec. 26, 2012)

Nov.29.2012

The Centers for Medicare and Medicaid Services ("CMS") published in the Federal Register on Monday, November 26, 2012 a notice of proposed rulemaking ("NPRM") seeking comments on, *inter alia*, the implementation of the Patient Protection and Affordable Care Act's ("PPACA") policies related to guaranteed availability, guaranteed renewability, rate review, single risk pools, and fair health insurance premiums.

Specifically, the NPRM would require issuers offering non-grandfathered health insurance coverage to accept, with few exceptions, every individual or employer who applies for coverage in the individual or group market. Also, the NPRM would require issuers to renew all coverage in the individual and group markets subject to certain limited exceptions.

The NPRM also proposes three changes to the existing rate review program: (1) states seeking state-specific thresholds (i.e., different from the 10% federal threshold) would have to submit proposals by August 1 of each year, CMS would review the proposals by September 1 of each year, and if approved, a state-specific threshold would be effective January 1 of the following year; (2) issuers would have to use a standard federal form to submit data relating to proposed rate increases 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 rate increases to be filed; and (3) states would have to comply with additional criteria and factors to have an Effective Rate Review Program.

Additionally, the NPRM would require issuers to treat all of their non-grandfathered business in the individual market and the small group market, respectively, as a single risk pool.

With respect to fair health insurance premiums, the NPRM aims to establish standardized rating methodologies for at least some categories, in part, to facilitate easier use of the risk adjustment methodology in Section 1343 of the PPACA, increase transparency, and simplify the selection of benchmark plans under IRC section 36B. The NPRM implements PHS Act section 2701, which only allows non-grandfathered health insurance issuers in the individual and small group markets to vary premiums based on the following factors beginning in 2014: (1) whether the plan or coverage applies to an individual or family; (2) geographic 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. These limits on rate variation will also apply in the large group market beginning in 2017 if the health insurance coverage is available through an Affordable Insurance Exchange ("Exchange"). As a result, many of the rating factors currently in use today, *e.g.*, health status, claims experience, gender, occupation, broader age bands will be prohibited.

A more detailed discussion of small group rating and the four rating factors are included below.

Small Group Rating

The NPRM proposes that issuers calculate rates for employees and their dependents on a per-person basis—as if each person were in the individual market—and then determine the group premium by totaling the premiums for each covered individual. The proposed rule would allow a similar practice, provided that the calculation of the group rate is based on the total premiums for each covered individual after the allowable rating factors have been associated with the appropriate individuals. Calculating the premium in accordance with the proposed rule would enable the issuer to comply with the requirements that the age and tobacco use factors are apportioned to each family member, per PHSA § 2701(a)(4). The allowable rating factors, such as tobacco use and age, would be associated to specific individuals.

Significantly, under the proposed rule, employers would have flexibility to determine how to allocate their contributions to different employees' coverage. An employer could elect to set the employee contribution as a percentage of the underlying cost of the employee's coverage—such as by requiring smokers and older employees to make higher contributions because of their higher risk, while nonsmokers and younger employees would pay lower contributions. This employee contribution allocation method may help employers to meet minimum participation requirements and increase overall uptake rates. The proposed rule suggests that using per-member rating would enable more accurate pricing for premium changes based on employee hires and departures.

Alternatively, the employer could use a composite rate by adding the per-person rates, dividing the total by the number of employees to determine the group's average rate, and requiring employees with similar family compositions to pay the same contribution. This approach to composite rating differs subtly from current practice. At present, issuers may use composite rating that takes into consideration rate factors that are unavailable under the proposed rule, such as industrial code and average employee age, to determine an average employee rate that is adjusted based on family tiers.

Family Rating & Persons Included under Family Coverage

The proposed rule makes several major changes to family rating. First, rating variations permitted based on age and tobacco use must be applied to the portion of the premium allocable to each family member. Thus, the same premium amount would be charged for each family member of the same age and tobacco use status.

Second, the family premium is determined by the sum of the covered family members, including up to the three oldest family members under age 21. Effectively, this caps the number of children taken into consideration when calculating the family premium. There is no cap on the number of family members over age 21 that are included in the premium calculation. Age 21 was selected as the cut-off point between inclusion as a child or an adult so that it is consistent with the cut-off proposed for the rule on age rating and the requirement that child-only policies be made available to those under 21.

CMS has solicited comments on whether there should be a cap on the number of child and adult family members whose premiums should be taken into account in determining the family premium. CMS also has requested comments about the appropriate age cut-off for the per-child cap, such as whether the cap should be aligned with the dependent coverage cut-off of age 26.

Third, the proposed rule reiterates that use of a family tier, family composition multipliers to a base family rate, or determination of a family premium based on the policyholder's or oldest adult's age is prohibited by PHSA § 2701(a)(4) to the extent that the multipliers or base premiums vary based on age or tobacco use because issuers may not rate individuals using factors that do not apply to them individually.

However, states may require issuers to use a family tier rating methodology and multipliers provided that the state uses pure community rating without consideration of age or tobacco use. Any multipliers used in such a rating system would need to be actuarially justified. Depending on the family tier methodology, states may be required to submit their proposed family tiers to CMS at least 30 days after the publication of the final rule to support the accuracy of the risk adjustment methodology. The proposed rule would use the per-member rating methodology as the default approach for states using pure community rating without family tier methodologies or for issuers voluntarily using pure community rating.

Finally, CMS seeks comments on whether the final rule should specify categories of family members that must be included in rate setting for family policies and who should be included as family members for purposes of these policies—e.g., employee or individual market policyholder, spouse or partner, biological and adopted children, stepchildren, foster children, grandchildren, etc.

Geographic Rating

PHSA § 2701(a)(2) directs states to establish geographic rating areas, subject to approval by CMS. If the state fails to act or the proposed rating area is inadequate, such as by failing to include a sufficient number of people, then CMS is authorized to establish the rating areas. Geographic rating factors must be actuarially justified. These rating areas would apply equally to all non-grandfathered health insurance coverage in the individual or small group market. The proposed rule sets an upper limit of seven (7) geographic rating areas per state to afford states flexibility to address local market conditions and population requirements.

The proposed rule sets forth three alternatives for establishing geographic rating areas: (1) one rating area for the entire state; (2) rating areas based on counties or three-digit zip codes; or (3) rating areas based on metropolitan statistical areas ("MSAs") and non-MSAs. A rating area established under one of these alternatives need not be geographically adjacent; that is, a rating area could be comprised of all non-MSA portions of a state even though they are geographically scattered. Use of one of these three alternatives in developing a rating area would be presumed adequate. States are free, however, to propose their own standards, which would be subject to approval. If a state fails to establish a rating area in accordance with the proposed rule, CMS has flexibility as to which standard to apply.

Age Rating

The PHSA allows an issuer of non-grandfathered health insurance coverage in the individual or small group market to vary premium rates by age within a 3:1 ratio for adults. The 3:1 ratio is controversial because it greatly narrows the range of permissible age adjustments (some states allow 5:1 or greater) and therefore raises the rates of younger individuals. The concern is that younger, healthy individuals will choose to forego insurance at these higher rates and pay the penalty instead. The NPRM appears in part designed to address this concern.

While seeking comment on its approach, CMS states that it interprets the PHSA statutory language requiring rates to vary within a ratio of 3:1 as applying only to adults age 21 and older. For individuals under age 21, rates must be actuarially justified based on a standard population.

In seeking to further standardize the age rating methodology between different health insurance coverage, CMS proposes a number of standard measurement points and definitions to be used in age rating. CMS proposes that enrollees' age factors and

bands should be determined based on age at policy issuance and renewal. Additionally, CMS proposes that the following standard age bands should be used in all states and markets: a single age band for 0-20 years, one-year age bands from for ages 21 through 63, and a single age band for 64 years and older. CMS also proposes that a uniform adult age rating curve apply between issuers within the same state in the individual and small group markets. The uniform age rating curve CMS proposes is constructed on gross premium amounts and is based on the assumption that issuers will vary premiums to the greatest extent permissible within the 3:1 adult age rating constraint. Finally, in apparent recognition of the pricing hardship resulting from the compressed age ratio of 3:1, the NPRM proposes to flatten the curve at each end of the age spectrum, so that the largest annual increases will fall on those in the middle of the age range (ages 30-55) rather than the youngest or oldest in the spectrum. Consistent with other aspects of the NPRM, CMS seeks comments on each of these points.

CMS also acknowledges that states and issuers would still have flexibility in age rating within the bounds of the points above. For example, a state law could prescribe a narrower ratio for adults such as 2:1. CMS also proposes that states would have the option to designate a uniform age curve that differs from the one determined by CMS.

Tobacco Use Rating

The PHSA allows an issuer of non-grandfathered health insurance coverage in the individual or small group market to vary premium rates based on tobacco use within a 1.5:1 ratio. This aspect of the PHSA is controversial among the states because rating for tobacco use can be perceived as discriminatory against persons with an addiction or against the poorer populations where tobacco use is higher.

The NPRM proposes that the 1.5:1 ratio specified in the PHSA need not remain constant between different age bands, *i.e.* a 1.3:1 ratio could be used for a younger adult and a 1.4:1 ratio could be used for an older adult. Unlike a standard age curve, CMS proposes that states or issuers have the flexibility to determine the appropriate rating factor within the 1.5:1 ratio. Importantly, states still have the flexibility to require premium rates to vary within a narrower ratio such as 1.25:1 or to prohibit issuers from varying premium based on tobacco use altogether (such as California recently did in the small group market).

While many states currently allow issuers in individual and small group markets to vary premiums on tobacco use, there is not a consistent definition of tobacco use among the states for rating purposes. Rather than proposing a uniform definition for tobacco use, CMS specifically invites comments on how tobacco use should be defined, the possible use of a single stream-lined application to collect information concerning tobacco use in connection with other enrollment-related processes for an Exchange, alternatives for identifying tobacco use, and how information should be collected for health insurance coverage offered outside an Exchange. CMS does, however, propose that the definition of tobacco use be consistent with the approach taken with health-contingent programs designed to prevent or reduce tobacco use under PHSA 2705(j) such that a tobacco user participating in a tobacco cessation program would have the opportunity to avoid paying the full amount of the tobacco surcharge permitted here.

* * *

Given the wide array of proposed changes, the NPRM invites comments on nearly every page. CMS is moving forward to implement the PPACA, but seeks a significant amount of input and reassurance that it is on the right path through these uncharted waters. Given the amount of public feedback requested, there remains considerable uncertainty as to the content of the final rule, which may have some significant variation from the NPRM.

The material contained in this web site is provided solely for informational purposes and is considered attorney advertising. Prior results do not guarantee a similar outcome.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

William A. Helvestine
Senior Counsel – San Francisco
Phone: +1 415.365.7260
Email: whelvestine@crowell.com

A. Xavier Baker
Partner – Washington, D.C.
Phone: +1 202.624.2842
Email: xbaker@crowell.com

Jacinta Alves
Partner – Washington, D.C.
Phone: +1 202.624.2573
Email: jalves@crowell.com