Proposed Market Reform Rules Overview
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Prepared by DC HRIC Insurance Subcommittee
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Topic	Reference #(Page #)	Summary	Impact on District
Effective Date of Single Risk Pool	Background (pp. 18-19)	ACA's creation of a single risk pool standard, applicable to both QHP's and non-QHP's, in the individual and small group markets is effective for plan years beginning on or after January 1, 2014. Does not apply to grandfathers plans (in existence on or prior to 3/23/2010)	N/A- This was anticipated by implementers.
Fair Health Insurance Premiums	147.102 (p.22)	Codifies rating restrictions- health insurance carriers can only rate based on: • Whether plan coverage applies to individuals or families; • Rating area; • Age (limited to 3:1); and • Tobacco use (limited 1.5:1)	District has already codified these restrictions on underwriting.
		Effectively prohibits the following rating factors: • Health status, claims experience, gender, occupation, duration of coverage, eligibility for tax credits, prior source of coverage and credit-worthiness.	Confirm applicability in relation to existing DC Code- move to codify if lacking.
		Re-underwriting (changing rates because of claims incurred during plan year) prohibited.	
		For family coverage, rating factors must be applied to the portion of premium attributable to each family member.	
State and Carrier Flexibility Related to Rating Methodologies	147.102 (1) (pp.23-25)	Proposes to standardize rating methodologies, particularly with respect to age rating and certain aspects of family rating, for health insurance coverage in the individual and small group markets when the market reforms go into effect in 2014. This proposed rule allows flexibility for states and issuers in rating methodology when it comes to certain aspects of family, tobacco, age, geography, and small group rating.	Federal comment period on standardized approach concludes on 12/26/2012.

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Proposed Standardized Small Group Rating Methodology	147.102 (2) (pp.26-27)	Propose that carriers would calculate rates for employee and dependent coverage in the small group market on a per-member basis, in the same manner that they would calculate rates for persons in the individual market and then calculate the group premium by totaling the premiums attributable to each covered individual.	
		Calls on states/District to submit any plan to CMS that would require premiums to be based on average enrollee amount	
Employer Contribution Methods	(p.28)	*Option 1:* An employer may choose to set the employee contribution as a percentage of the underlying cost of the employee's coverage. • Older employees and smokers would make higher contributions towards coverage while younger employees would make lower contributions- aimed at improving take up rates for healthier risks.	
		Option 2: An employer, after a carrier develops rates using the per-member methodology, can elect to generate a composite rate in which each employee's contribution for a given family composition is the same by adding the per-member rates and dividing the total by the number of employees to arrive at the group's average rate and determine employer and employee contributions based on the composite rate. • Virtually identical to current contribution practices in the small group market.	Similar to Employee Reference Plan model presented by the Insurance Subcommittee. HHS is seeking comment on efficacy of these methods until 12/26/2012
Family Rating	147.102(3) (pp.29-31)	Proposes that carriers add up the rate of each family member to arrive at the family premium and the rates of no more than the three oldest family members under 21 can be taken into account	Ensure consistency with DC Code.
		Carriers cannot: • Apply specified family tier or family composition multipliers to a base premium to arrive at family rate; or • Determine rate based upon policyholder or oldest adult's age.	

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Age Rating	147.102(6) (pp.36-44)	Proposed rating bands (in consultation with NAIC): • Children (single band, 0-20 years, all premiums the same) • Adults (one year age bands 21-63 years) • Older adults (single band, 64+ years, all premiums the same)	
		Directs carriers to use a uniform age rating curve for the individual and small group market	
		Proposed CMS age rating table (**p.43, see appendix**)	
Small Group Open Enrollment	(p.53)	Proposed rule allows carriers to condition year-round open enrollment in the small group market on a small employer being able to satisfy the same contribution and participation requirements at issuance that the issuer is permitted to consider at renewal, either as allowed by state law or, in the case of a QHP offered in the SHOP.	Follow up with E&E to ensure this is consistent w/planning and anticipated requirements.
Guaranteed *Availability* of Coverage	147.104 (pp. 50-58)	Codifies the following exceptions for carriers to limit enrollment to: • Certain open and special enrollment periods; • An employer's eligible individuals who live, work, or reside in the service of a network plan; and • Certain situations involving network capacity and financial capacity.	
		Proposes to allow carriers with network plans to limit guaranteed availability to employers with eligible individuals who live, work, or reside in the plans' service areas. • "... (HHS) think(s) 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."	

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Guaranteed *Availability* of Coverage (*continued*)	147.104	Sets forth that carriers make available special enrollment periods in both the individual and group markets for individuals and plan participants in connections with events that trigger COBRA eligibility.	Confirm this special enrollment period taken into consideration by E&E and accounted for in our requirements.
Guaranteed *Renewability* of Coverage	147.106	Codifies the following exceptions for carriers to limit plan renewal: • Nonpayment of premiums; • An act of fraud or misrepresentation; • (Group coverage) Plan sponsor fails to comply with any group participation rules; • Carrier ceases to offer coverage of a particular type; • (Network plans) There is no longer any enrollee under the plan that lives, works, or resides in carrier service area; • (Coverage made available through one or more associations) An employer's membership in association ceases.	Evaluate existing DC Code in order to address potential inconsistencies and omissions pursuant to these requirements.
	(p.60)	Plan modifications can only be made at time of renewal.	
Single Risk Pool	156.80 (pp.63-	Reiterates the ACA requirement that carriers must consider all of its enrollees in all health plans (non-grandfathered) to be members of a single risk pool in the individual and small group market. • Will not be enforced against coverage issued to plans with fewer than two participants who are current employees; or • Excepted benefit and short-term limited policies.	HHS requires that the District inform them no later than 30 days after the final rule is published of the intention to merge the risk pools of the small group and individual markets.
	p.65	Proposes that in order to implement the single risk pool, the claims experience of the enrollees in all non-grandfathered plans of a carrier in the individual or small group market be combined so that the premium rate of a particular plan is not adversely impacted by the health status or claims experience of enrollees. An index rate would be derived and a market-wide adjustment would be made based on total expected market-wide payments under the RA and ReI programs.	

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Single Risk Pool (*continued*)	(pp.65-66)	Premium rate can't vary from index rate, except for the following factors: • AV and cost-sharing design of plan; • Plan's provider network and delivery system characteristics; • Benefits above and beyond EHB (must be pooled with similar benefits to determine allowable rate variations); and • With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.	
Catastrophic Plans	156.155 (pp.67-69)	A plan is considered "catastrophic" if it meets all applicable requirements for health insurance coverage for and is only offered in the individual market.	District has awaited this guidance. Must follow up with carriers to determine any potential operation issues in implementation.
		These plans will not provide coverage of the EHB until the enrollee reaches the annual limitation on cost-sharing.	
		Must cover at least three primary visits per year before reaching the deductible.	
		Only available to; • Individuals 30 or younger; • Those exempted from individual responsibility mandate because they can't afford available coverage; or • Those eligible for a hardship exemption.	
Rate Increase Disclosure and Review	154 (pp.69-75)	This section fulfills the statutory requirement that HHS monitor premium increases of health insurance in and outside Exchanges.	
		If the District seeks to establish a state-specific threshold for rate increases, we must submit for approval to CMS by 8/1 each year.	Not anticipated.
		Proposes that carriers submit rate increase documentation and data to HHS in a standardized form---the same files processed through HIOS and SERFF would be submitted.	
		All rates effective in 2013 must be based on claims experience calculated from all claims of all products a carrier has within a state in either the individual or small group market (BOTH if the state merges the markets into one risk pool).	Pursuant to the District's recommended market, rates must be based on experience in both markets.

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Rate Increase Disclosure and Review (continued)		Anticipate adoption of streamlined template developed with NAIC and other stakeholders.	
	(p.73)	States operating Effective Rate Review Programs must review these additional elements as part of its rate review process: • Reasonableness of carrier assumptions on the impact of federal reinsurance and risk adjustment programs; and • Carrier's data related to implementation and ongoing utilization of a market-wide single risk pool, EHB, AVs, and other ACA market reforms.	DISB has been recognized by HHS as operating an Effective Rate Review Program.
		10% review threshold will remain unchanged.	
	(p.74)	Additional considerations for states in rate review include: • Impact of AV relative to metal levels; • Impact of changes to the plan's EHB and non-EHBs; • Additional standardized ratio tests in addition to the MLR; • Impacts of geographical factors and variations; • Impact of changes within a single risk pool to all products or plans within the risk pool; and • Impact of federal reinsurance and risk adjustment payments and charges.	Review with rate review team to identify consistencies with current practices.

Appendix I

CMS Proposed Standard Age Curve

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