Insurance Market Reform: Guaranteed Issue and Insurance Rating

The Patient Protection and Affordable Care Act and subsequently amended by the Health Care and Education Reconciliation Act are collectively referred to as the "Affordable Care Act". The Affordable Care Act reorganizes, amends, and adds to the provisions of Part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the small group and individual markets.

BACKGROUND

The central objective of the Affordable Care Act is to significantly improve on the accessibility and affordability of quality healthcare to all Americans. The November 26, 2012, Department of Health and Human Services (HHS) Proposed Rule (FR Vol 77, No 227) regarding Health Insurance Market Rules and Rate Review shows the following statistics:

# of States	Individual Market
45	consumers with current or past medical problems can be denied health insurance coverage
43	allow health status rating
48	allow age rating (often unlimited)
37	explicitly allow gender rating
# of States	Small Group Market
38	allow health status rating
48	allow age rating (often unlimited)
35	allow gender rating
37	allow industry rating

To remedy these barriers to entry and to bring fairness into premium rating, the Affordable Care Act introduces insurance market reform to gain access and affordability in the individual and non-grandfathered small group market. Insurance issuers can no longer decline anyone who applies for or renews health insurance and must limit the premium rating factors.

A. Fair Health Insurance Premiums

PHS Act § 2701 limits rating (i.e. limit premium variability) strictly to the following 4 factors:

1) two coverage tiers - an individual or family (using per-member rating[1] or community rating);
2) defined rating area - geographical rating areas must be based on the geographic divisions of counties, three-digit zip codes, or metropolitan statistical areas[2] (MSAs) and non-MSAs.

[1] The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.
[2] The list of MSAs in each state - http://www.census.gov/population/metro/data/def.html

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3) age, except that such rate shall not vary by more than 3 to 1 for adults, and
4) excess rating for tobacco user[3] to vary by no more than 1.5 to 1[4]

Factors such as health history, medical condition, gender and industry of employment can no longer be considered for rate setting beginning on January 1, 2014.

B. Guaranteed Availability of Coverage

Under PHS Act § 2702, each health insurance issuer that offers health insurance coverage in a State must accept every employer and individual in the State that applies for such coverage. A health insurance issuer however may restrict enrollment in coverage to open or special enrollment periods and establish special enrollment periods for qualifying events (under § 603 of the Employee Retirement Income Security Act of 1974[5]).

C. Guaranteed Renewability of Coverage

Under PHS Act § 2703, when a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue existing coverage at the option of the plan sponsor or the individual.

D. Special Risk Pool

Under Affordable Care Act § 1312(c), a health insurance issuer shall consider all enrollees in all health plans (student health insurance will be exempt) offered by such issuer in- or outside the Exchange to be members of a single risk pool. Separately, the single risk pool consideration is given to enrollees in small group markets as well. Further, each State may require the individual and small group insurance markets within the State to be merged into a single risk pool. Recognizing the volatility of claims resulting from these changes, the Affordable Care Act establishes three premium stabilization programs to transfer payments to and among health insurance issuers that cover individuals with higher health risks, to even out the underwriting risks of health insurance issuers and to provide greater payment stability as insurance market reforms are implemented. [Please refer to The Transitional Reinsurance Program.]

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[3] Tobacco use is defined as use of a tobacco product on average of four or more times per week within no longer than the past six months.

[4] Under the Final Regulation allowing a tobacco user the opportunity to avoid paying the full amount of the tobacco rating factor by participating in a wellness program meeting the standards of PHS Act § 2705(j) and its implementing regulations.

[5] "qualifying event" means, with respect to any covered employee, any of the following events which would result in the loss of coverage of a qualified beneficiary:
(1) The death of the covered employee.
(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.
(3) The divorce or legal separation of the covered employee from the employee's spouse.
(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act
(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.
(6) A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

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RATING AREAS

From a geographical rating standpoint and according to the HHS February 25, 2013, Market reform Guidance, the following is the state-by-state geographic rating area(s) per state or jurisdiction.

State	Maximum # of Rating Areas	State	Maximum # of Rating Areas	State	Maximum # of Rating Areas
Alabama	13	Louisiana	9	Oklahoma	5
Alaska	3	Maine	4	Oregon	7
Arizona	7	Maryland	7	Pennsylvania	17
Arkansas	9	Massachusetts	7	Rhode Island	2
California	27	Michigan	16	South Carolina	11
Colorado	8	Minnesota	9	South Dakota	4
Connecticut	5	Mississippi	6	Tennessee	11
Delaware	3	Missouri	10	Texas	26
District of Columbia	2	Montana	4	Utah	6
Florida	21	Nebraska	4	Vermont	2
Georgia	16	Nevada	4	Virginia	12
Hawaii	2	New Hampshire	3	Washington	13
Idaho	7	New Jersey	8	West Virginia	11
Illinois	13	New Mexico	5	Wisconsin	16
Indiana	17	New York	13	Wyoming	2
Iowa	10	North Carolina	16	Puerto Rico	9
Kansas	7	North Dakota	4	Other Territories	1 Each
Kentucky	10	Ohio	17		

In accordance with Affordable Care Act § 2701 (a)(3), HHS has taken into consideration the feedback received from the National Association of Insurance Commissioners (NAIC), and its final regulation issued on February 27, 2013, (FR Vol 78, No. 39) § 147.102(d) adopts the following standard age bands as so specified in the proposed regulation for use in all states and markets subject to the rating rules of PHS Act § 2701:

- Children: A single age band covering children 0 to 20 years of age where all premium rates are the same. HHS suggests that a single age band for children will simplify and make risk adjustment methodologies more efficient and allow consumers to more easily compare and predict costs as children age, particularly if the consumer has children that are several years apart in age.
- Adults: One-year age bands starting at age 21 and through age 63. HHS suggests that consumers would experience steady, relatively small premium increases each year due to age. If broader age bands are adopted (for example, five-year bands), consumers would experience larger premium increases when they reach the end of one age band and move into the next.

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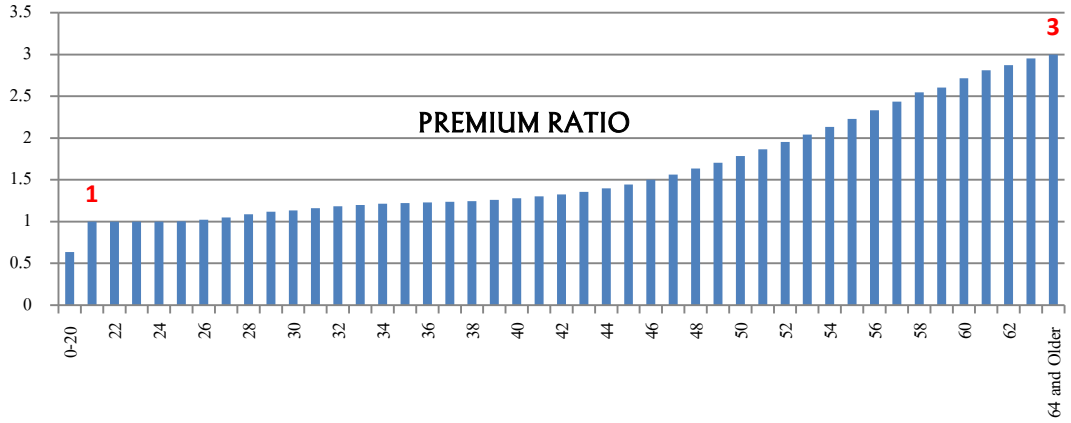
- Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same. HHS proposes this single age band largely to facilitate compliance with the Medicare Secondary Payer requirements.

AGE CURVE

The following age curve has been finalized under §147.102(e) and will be imposed on all states if any state does not establish or propose a uniform age curve by March 29, 2013, for the individual and small group markets for 2014.



The Final Rules precludes a state from requiring issuers to offer (or a small employer from electing to offer) premiums based on average employee amounts where every employee in the group is charged the same premium. HHS notes that the age bands, as implemented by the per-member-rating methodology, are only generally applicable to health insurance coverage in the individual and small group markets and are consistent with the Age Discrimination in Employment Act of 1967, 29 U.S.C. 621.

ENROLLMENT & GUARANTEED AVAILABILITY

The Final Rules also states that small employers cannot be denied guaranteed availability of coverage for failure to satisfy minimum participation or contribution requirements. PHS Act § 2702(b)(1) permits an issuer to limit enrollment in coverage to open and special enrollment periods in the event that minimum participation or contribution requirements are not met. In this case, an issuer may limit its offering of coverage to an annual open enrollment period which is the 30-day period beginning November15 and extending through December15 of each year. Otherwise, the group market will have continuous open enrollment. In the case of individuals, the initial open enrollment period begins October 1, 2013, and extends through March 31, 2014, as so stated under the § 155.410 of the HHS Final Regulation [45 CFR Parts 155] and special enrollment periods under § 155.420(d). In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may limit application for coverage to those who live, work, or reside in the service area for the network plan.

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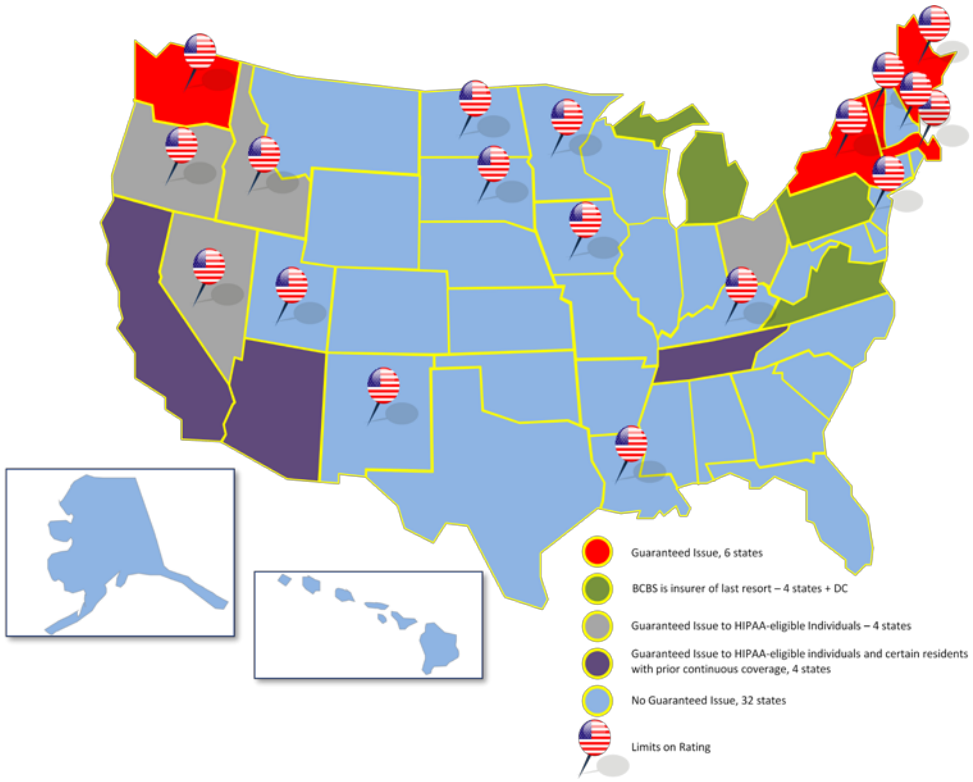
The following are the current states that offer limits on ratings and the guarantee issue status according to Kaiser Family Foundation.



HHS' EXPECTATIONS

HHS believes that requiring a single risk pool in each market will ensure that rate increases for healthy and less healthy people will be equal over time. Elimination of rating based on gender will mean lower premium rates for women, and the 3:1 limit on the rates charged to older subscribers will result in lower premium rates for older subscribers without shifting significant risk to younger subscribers as would happen under pure community rating. 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; 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. The availability of premium tax credits through Exchanges starting in 2014 [refer to ACA Individual (Mandate) Responsibility] will result in lower net premium rates for most people currently purchasing coverage in the individual market and will encourage younger and healthier enrollees to enter the market, improving the risk pool and leading to reductions in premium rates for current policyholders.

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Similarly, the minimum coverage provision will lead to expansion in the number of purchasers and improvements in the health of the risk pool. Furthermore, premium rates are expected to decline as a result of the administrative efficiencies from eliminating underwriting and, more importantly, due to the effects of greater competition in the individual market created by the Exchanges. Lower premium rates are expected to lead to further increases in purchase and a further improvement in the risk pool.

CONCLUSION

Insurance market reform is a necessary component in meeting the central objectives of the Affordable Care Act. There will be unavoidable disruptions and premium dislocations during the transition period beginning in 2014. The grand experiment requires full and robust participation by all Americans in the health insurance pool where not only less healthy Americans gain coverage but the provisions under Individual and Employer Shared Responsibilities are sufficient to encourage or compel young and healthy Americans to be covered in or outside the Exchange. Guaranteeing health coverage to anyone who applies is an important ingredient in getting everyone into the risk pool. As such, insurance companies are stripped of their ability to mitigate moral hazard where individuals wait to purchase insurance when they are sick or in need of medical attention and drop coverage if they recover. Moreover, the collapse and redistribution of rate bands and ratios and the limitation of underwriting factors will reshuffle the insurance underwriting deck where the less healthy and older population will likely see their premiums lowered and subsidized by the remaining insureds in the risk pool. This suggests that the young and the healthy population will likely see their health premiums increase. Although HHS suggests that some of the premium increases for individuals and families at or below 400% Federal Poverty Line will be offset by tax credits and subsidies, such subsidies are ultimately shared through increases in taxes and fees. In the near term, the additional costs arisen from making health care more assessable and affordable to all will be borne by those who are healthy, young, and “wealthy" and those with employer-sponsored health insurance.

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