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December 21, 2012

Gary Cohen  
Deputy Administrator and Director  
Center for Consumer Information and Insurance Oversight (CCIIO)  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Submitted electronically: <http://www.regulations.gov>

**Re: 45 CFR Parts 144, 147, 150, et. al.; Patient Protection and Affordable Care Act;  
Health Insurance Market Rules; Rate Review; Proposed Regulation (CMS-9972-P) -  
AHIP Comments**

Dear Mr. Cohen:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Proposed Rule on Health Insurance Market Rules published November 26, 2012 in the Federal Register [*Federal Register* 77:227 (26 November 2012)]. AHIP is the national association representing health insurance plans that provide coverage to more than 200 million Americans.

The Affordable Care Act (ACA) makes numerous and far-reaching changes to the nation's health care system that will be effective on January 1, 2014. As these changes take effect, health plans are focused on providing recommendations to the proposed regulations that address affordability issues as well as areas that could potentially disrupt coverage for the millions of individuals, families, and employers they serve.

We appreciate that the Department is soliciting feedback on ways to "to minimize disruption of rates in the current market and encourage timely enrollment in 2014." In developing our comments, we solicited hundreds of health plan policy and operations leaders across the nation to develop specific recommendations to achieve this goal. Based on this feedback and the experience of health plans in the states, we believe specific steps are needed to make coverage more affordable, ensure broad participation in the system, and guard against adverse selection. This is especially important during the initial years of implementation when the penalties for not having insurance are at their lowest.

As the Department finalizes these regulations, we also ask that it carefully consider how the proposed regulations interact with statutory provisions that will add to the cost of coverage. For example, the new \$100 billion health insurance tax will add \$5,080 over 10 years to the cost of a

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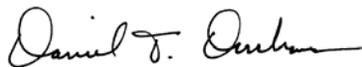
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family's premium in the individual market<sup>1</sup>. In addition, the requirement that all policies cover 10 categories of coverage, many of which are not included in some policies today, will require millions of people to buy coverage that is more comprehensive – but also more costly – than the coverage they currently have. Another provision in the ACA would reduce costs for older individuals purchasing coverage by requiring younger individuals and families in 42 states to pay for higher rates than they do today.

Unless coverage is affordable, younger and healthier people may choose to forgo purchasing insurance until they are sick or injured. If that happens, costs will increase for everyone. This is why it is crucial that more flexibility be provided in the regulations to help ensure broad participation in the system and help mitigate disruption for consumers. While these recommendations will not eliminate cost increases, they will help stabilize the market and set the stage for a broader national conversation on addressing the soaring cost of medical care.

The comments submitted in this letter represent AHIP's initial comments on this proposed rule. Given the limited duration of the comment period, the interactive effect of all of the proposed regulations, and the complexity of the federal/state allocation of responsibilities, we have endeavored to provide a timely reaction to this proposed regulation. We continue to analyze this proposed rule and its relationship to the *Essential Health Benefits / Actuarial Value* proposed regulation and the *Notice of Benefit and Payment Parameters* proposed regulation, as well as the collective impact of these rules. We are aware that the Department is operating within tight timeframes to finalize these regulations and as a result has established only a thirty (30) day comment period, which is shorter than the typical timeframe for proposed rules of this magnitude. As the Department proceeds to finalize these foundational rules and moves forward with implementation, we will continue to provide feedback from health plan operations leaders who are preparing for 2014 by designing benefits, developing products, and pricing offerings.

Sincerely,



Daniel T. Durham  
Executive Vice President  
Policy & Regulatory Affairs



Betsy Pelovitz  
Vice President  
Product Policy

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<sup>1</sup> Oliver Wyman—Estimated Premium Impacts of the Annual Fee on Health Insurance Plans. October 31, 2011.

## **Detailed Comments on Health Insurance Market and Rate Review Rules**

What follows are our detailed comments and recommendations on the Proposed Regulation on the Health Insurance Market Rules and Rate Review. Recognizing that 2014 will be an extremely challenging transitional year, our comments identify different tools that could be employed to help minimize disruption for those with existing coverage and promote stability in the market. We appreciate the opportunity to share this feedback and stand ready to continue to work in partnership with the Department as health reform implementation moves forward.

We have organized our feedback into the following sections:

- I. Guaranteed Availability / Guaranteed Renewability – Additional Strategies Are Necessary to Encourage Participation, Minimize Disruption, and Mitigate Rate Shock;**
- II. Adjusted Community Rating – Additional Steps Can Be Taken to Promote Affordability of Coverage and Minimize Disruption of Rates in the Current Market;**
- III. Single Risk Pool – The Single Risk Pool Requirements Provide Flexibility For Developing Rates and Innovative Health Care and Payment Models;**
- IV. Catastrophic Health Plans – Affordable Catastrophic health Plans Can Promote Market Stability and Encourage Greater Participation;**
- V. Student Health Plans – Consistent Treatment of Student Health Plans is Critical to Promote Affordability and Minimize Disruption;**
- VI. Rate Increase Review Process – The Regulatory Review Process Should Continue to Be Streamlined to Reduce Duplication, Promote Efficiency and Minimize Administrative Costs; and**
- VII. ACA Enforcement – Existing PHSA Enforcement Framework and Recognition of Good Faith Compliance Efforts Will Promote Stability.**

**I. Guaranteed Availability / Guaranteed Renewability (45 CFR §§ 147.104 and 147.106)**

***Additional Strategies Are Necessary to Encourage Participation, Minimize Disruption, and Mitigate Rate Shock***

Incentives to ensure a balanced risk pool and guard against adverse selection are critical, especially during the early years of implementation when the coverage requirement penalties are relatively low. A 2009 report on the Massachusetts experience with a continuous open enrollment environment in the individual market found a significant increase in the number of people who terminated their coverage within six months of purchase.<sup>2</sup> This experience further emphasizes the importance of these enrollment strategies to discourage individuals from waiting to enter the system until after they become sick or have had an accident (which drives up costs for everyone).

In the preamble to the proposed regulation, the Department specifically solicits comments on additional strategies that the CMS or the states might adopt to encourage timely enrollment in 2014. Our recommendations that follow identify a number of additional tools that we believe should be pursued to bolster participation in 2014 and 2015 when the coverage requirement penalties are their lowest.

**Recommendations**

- **We strongly urge the adoption of additional strategies to bolster participation in the early years of implementation and promote stability in the market.** Late enrollment surcharges (similar to the incentives in the Medicare Part B and Part D programs) represent one recognized means of encouraging timely and continuous enrollment. Depending on how they are structured, late enrollment surcharges can also help offset the impact on those with existing coverage from the potential incremental adverse selection related costs of late enrollees.

Another approach would limit the coverage options available for late enrollees (i.e., those who do not enroll at the first opportunity). For example, there could be a restriction for late enrollees to bronze level plans for the first year of coverage. This policy would prevent a high risk consumer from enrolling in a more generous plan (e.g., platinum plan) when they delay enrollment until a medical condition arises. Another option would permit a waiting period from the first date of coverage for late enrollees. The use of such waiting periods prevents individuals from dropping in and out of coverage based on their medical needs.

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<sup>2</sup> Welch, D.K. and Giesa, K.; Massachusetts Division of Insurance; "An Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Non-Group Health Insurance Markets," (June 2010).

A national approach would be supported by the Department's broad authority to promulgate regulations under the Public Health Service Act Amendments to ACA:

The Secretary \* \* \* may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this subchapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this subchapter.<sup>3</sup>

If such policies are not adopted nationally, the Department could provide greater clarity around state flexibility to adopt these types of enrollment strategies that will be necessary to ensure a balanced risk pool, especially during the early years of implementation.

We also suggest the incorporation of a definition for the term *late enrollee* in 45 CFR Part 147 that builds on the existing federal standard [codified at 42 U.S.C. 300gg-3(b)(3)] with the addition of a reference to the individual market, as follows:

*Late enrollee* means: "with respect to coverage under an individual or a group health plan, a participant or beneficiary who enrolls under the plan or policy other than during -- (A) the first period in which the individual is eligible to enroll under the plan or policy, or (B) a special enrollment period."

- **We broadly support the proposed regulation's approach to aligning the open enrollment periods for the outside market with those codified in the Exchange final rule.** We agree with the Department that the adoption of consistent open enrollment periods will help minimize adverse selection between the Exchange and outside market.
- **We appreciate the consideration with respect to potential abuses of guaranteed availability rights, their impact on adverse selection, and fairness to consumers with continuous coverage.** Specifically, we support the Department's approach regarding small employer contribution and participation requirements. We agree that failing to pursue this strategy "would trigger adverse selection against the small group market, given its year-round open enrollment period, vis-à-vis the individual market,

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<sup>3</sup> 42 U.S.C. § 300gg-92; see also *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006) (provisions that allow agency to regulate as "necessary in the public interest" and as "necessary or proper to effectuate the purposes" of statute delegate to "an agency broad power to enforce all provisions of the statute").

which has a time-limited open enrollment period.”<sup>4</sup> The application of minimum contribution and participation requirements across the entire group market (including large group) would help further mitigate selection concerns.

In addition, we urge further consideration of ways to close other potential enrollment loopholes (e.g., restricting coverage for individuals who lose prior coverage due to a history of non-payment of premium or fraudulent activity). The guaranteed renewability standards provide a specific exception which allows an issuer to non-renew coverage for non-payment of premium. While the guaranteed availability standards do not include similar language, we request clarification that states have flexibility to adopt strategies in this area to minimize the cost-shift and protect consumers acting in good faith.

- **We support the proposed approach that establishes an applicability / effective date for coverage in the individual market for the market reforms for policy years beginning on or after January 1, 2014.** We note that as a result of the “rolling effective date” based on policy years beginning on or after January 1, 2014, there will likely be some individuals and families who will choose to continue their pre-2014 coverage (rather than select other coverage during the initial open enrollment period) with their policy year ending after March 31, 2014. Further, these consumers will not be able to continue their coverage under the pre-2014 policy. While these individuals would also be eligible to select other coverage during the first open enrollment period, we further propose that those consumers who elect to continue their existing coverage would be offered a 2014 policy at renewal from the same carrier, unless one of the limited exceptions to guaranteed renewability applies (e.g., market exit or network or financial capacity). We support allowing carrier flexibility to make this offer through: (a) an update to an existing policy form; or (b) issuance of a new policy form.
- **We support the proposed flexibility that would allow individual states to develop transition plans to sunset their high-risk pools after January 1, 2014, and migrate the population into the reformed market in an orderly fashion.** We further suggest clarification that if a state sunsets its high risk pool, it should close to new enrollment to coincide with the availability of guaranteed issue coverage, e.g., January 1, 2014, so that individuals are encouraged to timely enroll during the initial open enrollment period. An orderly migration of high-risk pool enrollees to the individual market is critical, given that – under one analysis – the introduction of these high-risk individuals will cause rates to rise for all individual market enrollees by 10-15%.<sup>5</sup> Events that would have previously triggered high risk pool enrollment opportunities – such as a denial of coverage because of a pre-existing condition or development of a medical condition – will not be relevant in a guarantee issue environment.

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<sup>4</sup> Federal Register 77:227 (26 November 2012) p. 70597.

<sup>5</sup> Bela Gorman (Gorman Actuarial, LLC) and Jonathan Gruber, Ph.D. (MIT Department of Economics), November 17, 2011. Prepared for the Minnesota Department of Commerce.

- **We support the Department’s approach to focus the application of the guaranteed availability and guaranteed renewability requirements to comprehensive, major medical insurance.** We encourage further regulatory clarity with respect to certain plans and insurance products. A November 2012 presentation by the Centers for Consumer Information and Insurance Oversight (CCIIO) clarifies the types of coverage that will be subject to or excluded from the 2014 market reforms.<sup>6</sup> In addition, the proposed regulation notes that certain types of coverage (i.e., short-term limited duration coverage and excepted benefits) are not subject to the single-risk pool.<sup>7</sup> We recommend that the regulation provide additional clarification for expatriate coverage with respect to guaranteed availability and guaranteed renewability. Similar to the treatment for student health plans, expatriate coverage should be allowed to ensure that enrollment (at issuance and renewal) is limited to expatriate employees and their dependents.
- **We request clarification of the special rules for network plans under the guaranteed availability standards outlined under §147.104(c).** Specifically, we urge an interpretation that promotes stability and minimizes disruption in the market when a network plan may not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing policy holders and enrollees. This could include, but not be limited to, situations where an issuer is unable to extend coverage to employers in its service area in the group market (acting uniformly to all employers without regard to claims experience or health status-related factors) due to capacity concerns, but is still able to accept new enrollees in the individual market.
- **We urge the Department to provide further guidance on how to approach guaranteed renewability when an employer fluctuates in size from the large group market to the small group market upon renewal.** Employers that move from the large group to the small group market at renewal may find that their existing large group coverage does not follow all of the ACA small group reforms.
- **The regulation should explicitly acknowledge the Department’s position that certain plan design changes can be made consistent with the federal uniform modification of coverage requirements.** As noted in preamble of the proposed regulation, “...on an ongoing basis, issuers may need to make some cost-sharing adjustments at renewal to ensure that policyholders’ plans remain at the same actuarial value level from year to year.”<sup>8</sup> This regulatory certainty should be provided for both the individual and group markets.

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<sup>6</sup> CMS Presentation: Health Insurance Market Rules, Rate Review (November 26, 2012).  
<http://cciio.cms.gov/resources/files/market-rules-nprm-11-26-2012.pdf>

<sup>7</sup> Federal Register 77:227 (26 November 2012) p. 70600.

<sup>8</sup> Id.

The Health Insurance Portability and Accountability Act (HIPAA) guaranteed availability and guaranteed renewability provisions provide a strong foundation for the 2014 individual and group ACA market reforms. The adoption of familiar standards and concepts is important for consumer education efforts and will also support a more orderly implementation process. We believe there are additional areas where closer alignment with the existing standards under HIPAA would further promote market stability and minimize disruption for those with existing coverage.

### Recommendations

- **We encourage the Department to incorporate language from the HIPAA individual market guaranteed availability requirements into 45 CFR Part 147 that clarifies the treatment of: (1) family coverage, (2) conversion policies, and (3) wellness programs.**<sup>9</sup> This will also ensure consistent treatment of grandfathered and non-grandfathered plans for guaranteed availability and guaranteed renewability purposes.

*Family Coverage: “An issuer in the individual market is not required to offer a family coverage option with any policy form.”*

*Conversion Policies: “An issuer offering health insurance coverage in connection with a group health plan is not deemed to be a health insurance issuer offering individual health insurance coverage solely because the issuer offers a conversion policy.”*

*Wellness Programs: “This section does not prevent an issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates, or modifying otherwise applicable copayments or deductibles, in return for adherence to programs of health promotion and disease prevention.”*

- **We urge recognition of the different segments of the group market – small employer market and large employer market – in the guaranteed renewability standards related to discontinuation of all coverage.** Recognition of the differences between the small group and large group portions of the employer-sponsored market is important to promote stability across the entire group market. Specifically, we are concerned that forcing an issuer to exit both segments of the group market will be unnecessarily disruptive for employers of all sizes and limit the number of choices available both in the outside market, as well as in SHOP Exchanges.

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<sup>9</sup> 45 CFR §148.120(g)(1), (3), and (5).

We offer the following edits to 45 CFR §147.106(d)(1) to address this concern:

*“(d) Discontinuing all coverage. (1) An issuer may elect to discontinue offering all health insurance coverage in the individual, small group or large group market, or all markets, in a state in accordance with applicable state law only if the issuer meets all of the following conditions...”*

- **Consistent with existing federal standards under HIPAA, states should have flexibility to allow issuers to no longer actively market a product or plan and close it to new enrollment.** The proposed changes for the treatment of non-grandfathered products or plans that are no longer actively marketed are unnecessary and will disrupt the market for little to no consumer benefit. We offer an alternative approach for these non-grandfathered products to better support consumer choice and encourage innovation, while maintaining consumer protections. This careful balance can be accomplished by adding an “actively market” criteria to the guaranteed availability standard as follows:

*(a) Guaranteed availability of coverage in the individual and group market. Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual or group market in a state must offer to any individual or employer in the state all products that are approved for sale and actively marketed in the applicable market, and must accept any individual or employer that applies for any of those products.*

Concerns related to closed blocks of business in today’s market would be significantly mitigated – if not eliminated – in the reformed environment since all non-grandfathered coverage would comply with all of the other 2014 market reforms (e.g., guaranteed renewability, single risk pool and adjusted community rating standards, the process for review of rate increases). This approach allows a consumer to keep the coverage they have (if they like it) while also providing the opportunity, on a guaranteed issue basis, to pursue other coverage options. It also encourages the development of new or innovative benefit designs (e.g., value-based designs, network structures, provider payment approaches, utilization management techniques) by allowing carriers flexibility to update their available products in a market, in accordance with state law, without needing to actively market all products (some of which will have outdated provisions).

- **We also are concerned about the retroactive application of the proposal related to non-grandfathered products that are no longer actively marketed, when handled in accordance with state law, prior to implementation of this new federal standard.** Requiring blocks of non-grandfathered business that were closed prior to the publication of the final rule will require considerable effort and cause market disruption with little or

no consumer benefit. Consumers will be able to freely choose among actively-marketed, guaranteed issue, ACA-compliant policies both inside and outside of Exchanges during the initial open enrollment period. There is no need to retroactively force the reopening of these blocks, and this can be avoided by incorporating language similar to HIPAA guaranteed availability requirements.<sup>10</sup>

We offer the following for consideration:

*This section does not require issuers to reopen blocks of business closed under applicable State law on or before [30 days after publication of the final rule].*

## **II. Adjusted Community Rating (45 CFR § 147.102)**

### ***Additional Steps Can Be Taken to Promote Affordability of Coverage and Minimize Disruption of Rates in the Current Market***

As noted throughout our comments, incentives to ensure a balanced risk pool and guard against adverse selection are critical, especially when the coverage requirement penalties are at their lowest in 2014 and 2015. During these early years of implementation, it is especially important to encourage individuals and small employers with existing coverage to stay in the system and to facilitate new entrants into the system. Declining or weak enrollment destabilizes insurance markets and increases premiums for enrollees of all ages.

Creating a regulatory environment in which incentives are aligned will be crucial to creating a workable and viable marketplace. While these policies and our specific recommendations will not eliminate all cost increases, they will help control for known challenges and set the stage for a broader national conversation on addressing affordability and the underlying rising cost of medical care itself.

The proposed regulation establishes a single age band for children ages 0 through 20, one-year age bands for adults ages 21 through 63, and a single band for individuals ages 64 and older. According to CMS, this approach will assist in selecting the second lowest cost silver plan for determining premium tax credit amounts and promoting the accuracy of the risk adjustment program.

#### **A. Proposed Age Rating Curve & Age Band Compression**

Currently 42 states use age bands of 5:1 or greater when developing premiums in the individual market. The move to a 3:1 age band ratio in 2014 is just one of the other

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<sup>10</sup> 45 CFR §148.120(g)(6).

major ACA provisions that will lead to an affordability challenge for millions of individuals in 2014. In addition to restrictive age rating, there are other required rating reforms, mandatory essential health benefits and minimum actuarial values, a new \$100 billion health insurance tax (2014-2023) as well as new fees and compliance costs that will all play a major factor in making coverage unaffordable. Higher rates for the younger population combined with low mandate penalties during the first years of the ACA implementation will result in adverse selection because younger individuals are likely to choose not to purchase coverage. When these younger individuals do not enroll, destabilization of the individual market will occur, premiums will increase in the individual market for enrollees of all ages, and enrollment will decline. The long-term impact on the implementation of the ACA will be significant without a more calibrated approach.

### **Recommendations**

- **We support the incorporation of additional strategies to mitigate rate shock, minimize disruption, and promote stability during the critical early years of implementation.** While addressing one component will not prevent cost increases, it will have an important, positive impact on premium pricing for young families and individuals purchasing coverage on their own. Specifically, we recommend that for 2014 and 2015 (while the individual mandate penalty amounts are not yet fully implemented), urging the Department to delay implementation of the 3:1 age band by requiring that states achieve up to a 5:1 age band ratio for health insurers in the individual and small group market. As understood under the current proposed rule, states that have a narrower age band ratio (e.g., 2:1) or pure community rating would not be impacted by this delay period.

The recent proposed regulation on the health insurance market rules further emphasizes the need to minimize disruption and promote affordability by soliciting comments on additional strategies consistent with the ACA that HHS or states might deploy to avoid or minimize disruption of rates in the current market and to encourage timely enrollment in coverage in 2014. We believe that the Secretary has the authority to afford this delay. The Secretary already has recognized her discretion to implement the ACA requirements through “transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices.”<sup>11</sup>

#### ***B. Child Age Band: Ages 0-20***

The Department’s stated aim in creating the child age band is to simplify and make risk adjustment methodologies more efficient and to allow consumers to more easily compare and predict costs as children age. Under the per-member rating methodology,

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<sup>11</sup> CMS Affordable Care Act Implementation FAQs: Set 8 (March 19, 2012), Q2.

issuers are only able to count rates for the three oldest family members under age 21 when calculating family premiums. CMS notes that this cap is “intended 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.”<sup>12</sup>

The child rating factor would apply uniformly to all individuals ages 0 through 20, regardless of their status as a dependent child, employee, or policyholder for coverage in the individual market.

Our comments below are intended to be considered as a package of recommendations to the proposed child age band requirements as a means to minimize disruption and rate shock for consumers.

### Recommendations

- **We recommend the Department further consider different options to address the premium differential and accompanying “rate shock” that will occur for individuals aging from the child age band to the adult age curve.** As noted in the preamble, this shift from age 20 to age 21 “could result in a premium differential for these ages that is not reflected in issuers’ current rating practices.”<sup>13</sup> We have concerns about the potential “rate shock” for individuals aging into the adult age curve and urge CMS to work with interested stakeholders to consider ways to smooth this transition.
- **We urge removal of the cap on only counting the three oldest family members under 21 when calculating family premiums.** The proposed cap represents a change from how family premiums are calculated in the market today. Some issuers in the group market use family tier structures that generally permit counting of the employee and spouse in addition to a set number of dependent children. In the individual market and for some issuers in the group market, all family members (both parents – if applicable – and all dependent children) are counted. The proposed cap would be a dramatic departure from these current rating practices.

We believe that the current cap should be removed, and, instead CMS should adopt a method similar to the household count under the federal guidelines. This approach would more closely align with the eligibility guidelines used for federal programs, including the advance premium tax credit, and identify income levels for up to eight persons per family / household. This proposed change would keep premiums more affordable and avoid disruption for individuals and smaller families, since otherwise the health care costs for larger families would need to be accounted for in

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<sup>12</sup> Federal Register 77:227 (26 November 2012) p. 70591.

<sup>13</sup> Federal Register 77:227 (26 November 2012) p. 70594.

determining the index rate, without the same offset of premiums that smaller families would need to pay for each family member.

- **We recommend clarification that any limitation on the count of individuals under a family policy is limited to dependent children.** The current proposed policy in the regulation is a limitation on the number of “family members” under the age of 21. We believe that any limitation on the number of individuals should align with family members who are classified as dependent children or other dependent adults. Other individuals associated with the family for purposes of exchange subsidy determinations should be eligible for coverage under the family policy if they are otherwise eligible for coverage in accordance with permissible health plan and state law definitions for eligibility.
- **We urge the Department to clarify that the lowest adult rating factor (1.000) would apply to individuals who would otherwise be charged a child rate based on the age under certain circumstances.** We believe there are instances when an adult in the child age band (e.g., ages 18 through 20) should be assigned the lowest rating factor on the adult age rating curve, including when the individual is: (1) a parent or primary policyholder for coverage in the individual market; or (2) an employee enrolled in a group health plan. Under this approach, the child rating factor would apply to child dependents under a family policy and would appropriately account for the different cost impact between a family plan (which covers dependents in addition to the primary policyholder) when compared to a self-only plan.
  - Example #1: Under the proposed rule, parents who are both 19 years old who have a child would all be charged a child rate. Our proposal would align with the common practice to assign at least one adult rating factor to the policyholder under an individual or family policy.
  - Example #2: Similarly under a group plan, as proposed by this regulation, workers ages 18 through 20 would be charged a child rate. Such a policy is contrary to how adult workers are rated today and could distort hiring incentives for employers. We propose adult workers ages 18 through 20 be rated using the adult rating factor.

C. Determination of Persons Covered Under Family Policy

The proposed regulation seeks comment on defining who is covered under a family policy. As the regulation notes, issuers make such determinations based on demand in the market. State laws also define who is eligible for coverage under a family policy and may include adopted children, foster children, and domestic partners, among others.

## Recommendations

- **We support the current practice of states and issuers making determinations on persons covered under family coverage.** States should retain authority over coverage under a family policy. As noted in the preamble, individuals in a household that may not be covered under a family policy will be eligible for an individual policy.

We urge CMS to be consistent with the sub-regulatory guidance related to the Dependent Coverage of Children to Age 26 interim final regulation that permits alignment with the Internal Revenue Codes definition of “child” under 26 USC §152(f)(1). A previously issued Affordable Care Act Implementation FAQ noted that a plan or issuer would be in compliance with the Dependent Coverage of Children to Age 26 requirements if the:

*“...plan limits health coverage for children until the child turns 26 to only those children who are described in section 152(f)(1) of the Code. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.”<sup>14</sup>*

We encourage CMS to follow a similar approach for determining eligibility for persons covered under a family policy.

### D. Adult Age Bands: Ages 21-63

The proposed regulation applies the 3:1 age band to adults ages 21 through 63 using single year age bands. This approach is meant to ease premium increases from year to year as compared to the use of larger age bands (e.g. five year bands).

## Recommendation

- **We support the Department’s proposal to use single year age bands for the adult population.** This approach will smooth rate changes as an individual enrollee ages and maintain a low rating factor for individuals at the beginning of the curve.

### E. Older Adult Age Band: Age 64 and Older

The proposed regulation establishes a uniform age rating curve with a single age band for individuals ages 64 and older. The preamble notes that age 64 was chosen to align

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<sup>14</sup> CMS Affordable Care Act Implementation FAQs: Set 1 (September 20, 2010), Q14.

with Medicare Secondary Payer requirements that prohibit charging higher premiums to Medicare-eligible employees than non-Medicare-eligible employees in employer groups with 20 or more workers. CMS also notes that individuals in this age band would: (a) comprise a small portion of the individual and small group markets; and (b) have similar claims costs.

### **Recommendations**

- **We support the single age band for individuals at the high end of the age band.** We recommend linking the lowest age in this band to one year below the Medicare eligibility age to provide an automatic adjustment in the age curve should the eligibility age for Medicare be modified in the future.
- **We support additional flexibility for instances when Medicare is the primary coverage and when Medicare is the secondary coverage.** We encourage CMS to recognize the price differential between (1) workers who are 65 or older and enrolled in small group (less than 20 workers) coverage where Medicare is the secondary coverage; and (2) persons ages 65 or older in other forms of coverage where Medicare is the primary payer. We request CMS to allow flexibility on rating for these instances.

#### *F. Adjustments to Age*

The proposed regulation suggests that age rating factors be applied on a consistent basis for issuers and consumers so there are clear expectations and enrollees do not experience premium increases multiple times each year. To accomplish this goal, CMS proposes that the application of the age bands and rating factors be determined based on an enrollee's age at policy issuance and renewal.

### **Recommendation**

- **We support efforts to minimize premium increases within a policy or plan year as an enrollee ages into the next age band.** AHIP supports the approach noted in the proposed regulation to streamline age rating adjustments by allowing them to occur at policy or plan issuance and renewal. In addition, we support issuer flexibility to apply an age rating factor – for instances outside of a policy or plan issuance or renewal – when a person is added to a family policy or an employee is added to a group plan. This will allow appropriate adjustments to the family or employer premium based on the new enrollee's age at the time of enrollment.

*G. Geographic Rating Areas: State Designated Areas*

The proposed regulation identifies several options for the states to establish their own geographic rating areas, including: (1) one single rating area for the state; and (2) no more than seven rating areas based on counties, three-digit zip codes, or Metropolitan Statistical Areas (MSAs) and non-MSAs. States that choose from these options would be deemed in compliance with the rating area requirements. States may also propose other existing geographic divisions or a number of rating areas greater than seven; however, CMS proposes that it must approve such state action.

**Recommendations**

- **We strongly urge an extension of the list of options that are deemed compliant to include state-designated, geographic rating areas that are established by law, regulation, or other regulatory guidance.** Maintaining existing rating areas in a state will minimize disruption and potential rate increases for consumers. Several states passed laws or promulgated regulations establishing rating areas after an open and transparent dialogue with stakeholders. We recommend that CMS deem these state-established rating areas as in compliance with the geographic rating requirements, which will reduce the volume of information that states must report to CMS. This would include, but not be limited to, state flexibility to adopt more than seven rating areas, to use five-digit zip codes, or establish other geographical divisions.

Recognizing that some states may choose to adopt or amend their geographic rating area standards in response to the proposed regulation, we propose a deadline for doing this for 2014 policies and plans that is the earlier of (1) 30 days after publication of the final rule; or (2) 30 days prior to a state's rate filing deadline for 2014 policies and plans. This would allow states to take action in the first quarter of 2013, while also providing sufficient time and a level of certainty for issuers to meet state rate filing deadlines. Given the extremely short timeframe for action, we suggest that this approach be announced by the Department through sub-regulatory guidance as soon as practicable.

- **We urge removal of the cap on the number of allowable rating areas.** The proposed regulation places a ceiling of seven on the number of rating areas permitted in a state. The Department notes that setting an upper limit on the number of rating areas provides states with flexibility while avoiding an excessive number of rating areas that would be confusing to consumers and not reflect significant market differences. We believe that this cap is artificial and will not allow for adequate flexibility to rate based on actuarially-justified differences in health care costs and utilization patterns. If the rating areas are too large, there may be a scenario where lower-medical cost cities and neighborhoods are subsidizing the higher-medical cost

cities and neighborhoods. We encourage CMS to remove this cap and promote state flexibility to establish rating areas that reflect its size, diversity, population, price differentials, and utilization patterns.

- **The regulations could also be clarified to ensure the adoption of uniform geographic rating areas within a single state across the individual and small group markets.** Several states have established rating areas by product line (e.g., one for individual market and one for small group market). We propose requiring states to select one approach that would be uniformly applied in both the individual and small group markets.
- **Additional guidance would also be helpful to clarify how rating area factors should be applied for small employers with multi-state employees.** The proposed regulation does not address scenarios where a small employer has employees in multiple states. We seek clarification that the rating factor used for all employees in these circumstances is based on the situs of the contract rather than the location of each employee's residence.

#### *H. Geographic Rating Areas: State Default*

The proposed regulation outlines the two default options for those circumstances where a state takes no action to establish rating areas or CMS finds the rating areas proposed by a state to be inadequate. The default options identified are: (1) a single rating area for the state; or (2) another option deemed appropriate by CMS (after consultation with stakeholders).

#### **Recommendations**

- **We strongly urge removal of a single rating area for the entire state as a default option.** This option would not reflect differences in the underlying health care costs within a state, even those with large rural and sparsely populated areas.
- **We suggest modification to the alternative standard to require CMS to actively engage state insurance departments and interested stakeholders to establish geographic rating areas within 30 days of the publication of the final rule for states that take no action.** This expediency is necessary to have clear rating areas established for issuers that are under deadlines to file rates in early 2013.

#### *I. Rating Methodology for the Small Group Market*

The proposed regulations direct issuers to use a per-member rating methodology in the individual and small group markets. Issuers must add up the rates of each family

member to determine the family premium, but only take into account the rates for the three oldest family members under the age of 21.

### **Recommendations**

- **We urge support for issuer flexibility with respect to the rating methodology (such as the use of a composite rating approach) in the small group market for coverage issued outside of the Exchange.** We note that the development of rates for small groups using a composite rating or other alternative methodology would not produce materially different rates for the employer group as compared to a per-member rating approach. Under these methodologies, issuers must conform to the adjusted community rating standards, the single risk pool requirements, and the risk adjustment program – among other ACA rating provisions.

Allowing flexibility with respect to the rating methodology will minimize disruption for those with existing coverage and reduce administrative burdens in those markets that do not use per-member rating today. Mandating movement to a per-member rating methodology in the small group market will cause significant administrative and operational challenges. For example, with every employee who leaves or is hired, the total group premium will fluctuate in a non-uniform manner (possibly every month), as will employer contributions to premiums. In addition, in the small group market outside of an Exchange the employer group stays together and there is no access to premium subsidies or cost-sharing reductions. It would be an unnecessary disruption for both issuers and employers to require a different methodology than the composite rating generally used today.

#### *J. Tobacco Use Rating: Capturing Accurate Data*

The proposed regulation clarifies that issuers may use a lower tobacco use factor (e.g., 1.3:1) for a younger enrollee, as long as the factor does not exceed 1.5:1 for any age group. The Department also remarks on the lack of uniformity on a definition of “tobacco use” and efforts to identify accurate information on tobacco use.

### **Recommendations**

- **We support the proposed approach that allows issuers to vary tobacco rating by age.** This policy allows issuers to more accurately implement tobacco use rating factors and vary the rates of tobacco users based on age.
- **We encourage the adoption of uniform, concise questions on tobacco use for inclusion on applications for coverage in the Exchange and in the outside market.** Similar to the comments we submitted on the Individual and Small Group

Insurance Application (September 4, 2012), we proposed the following tobacco use questions:

*Tobacco Use: The application currently includes tobacco use as a Y/N question. We recommend that the question be redrafted in two parts as follows: "Have you used tobacco in the last twelve months?" and "Are you currently using tobacco products?"*

We support the inclusion of separate tobacco use questions for each individual enrolling for coverage. An applicant should also be required to attest to the accuracy of his or her answers regarding tobacco use accompanied by a strong enforcement of penalties associated with this attestation. We further suggest that this type of question should not be used in states where tobacco is not allowed as a rating variable (e.g., New Jersey).

For those seeking coverage through the Exchange, we recommend that the Exchange adopt a uniform definition of tobacco use to mitigate the potential for adverse selection with the outside market. Further, the Exchange should determine, based on information in the uniform application, whether the applicants constitute a tobacco user for purpose of use of the tobacco rating factor.

We strongly urge consideration of the same uniform definition for the collection of tobacco use data in the individual and small group markets outside of an Exchange. Having uniform questions and a twelve-month look-back period will help issuers identify tobacco users and mitigate adverse selection that may occur if different tobacco use questions are used for coverage sought through the Exchange compared to the outside market.

- **The Department should continue to refine the guidance related to tobacco cessation programs, including a clearer definition of the consequences for failing to provide accurate information in response to the tobacco use questions.** The tobacco use rating factor is a means to reward healthy behaviors in the form of lower premiums. Individuals should be discouraged from providing inaccurate responses to such questions on their application for coverage through the threat of penalties. For example, an enrollee would be required to pay the difference in premium (between what was charged and what would have been charge for a tobacco user) and a penalty for providing inaccurate information. Such consequences will encourage accurate responses on applications and recognize that inaccurate answers drive up premiums for non-tobacco users. The regulation should strike a careful balance between encouraging healthy behaviors and minimizing the administrative burden and costs associated with implementation of these new requirements.

*K. Tobacco Use Rating in the Small Group Market*

The proposed regulation restricts the use of tobacco as a rating factor in the small group market. CMS proposes to only allow a tobacco use “surcharge” in connection with a wellness program that allows tobacco users to reduce their premiums to the level of non-tobacco users by participating in a tobacco cessation program or satisfying another reasonable alternative. The Department notes that this proposal “is designed to discourage underreporting of tobacco use and encourage tobacco users to enter cessation programs and improve their health and reduce health care costs.”<sup>15</sup> This link between the tobacco use rating factor and employer wellness tobacco cessation programs would apply to small group health plans, but not to individual market policies.

For many years prior to enactment of the ACA, issuers have partnered with employers, clinicians, community-based organizations, and public health experts to prevent tobacco use and improve the health of members and communities. According to an AHIP survey of member health plans in January 2008, nearly all (97 percent) health plans were offering interventions for tobacco use, including screening and counseling services and coverage for prescription medications.<sup>16</sup> Another survey found that, for the last ten years, the majority of health plans (approximately 90 percent) have provided coverage for at least one type of pharmacotherapy for tobacco cessation.<sup>17</sup> Health plans have a long-standing commitment to evidence-based prevention and wellness programs and services, including tobacco cessation, for more than a decade.

**Recommendations**

- **To minimize disruption in the small group market, we urge the Department to remove the proposed link between the use of tobacco as a rating factor and employer tobacco cessation wellness programs.** The allowance for the use of tobacco as a rating factor should be viewed separately from the provisions related to wellness programs. The tobacco use rating factor is a means to adjust rates based on the expected higher claims experience of tobacco users. Such adjustments must be actuarially justified. An employer wellness program is intended to encourage healthy behavior, often through the use of financial incentives. However, because of the ill effects of past tobacco use on an individual’s health status, the expected claims of a tobacco user who completes a cessation program may not decline to the expected claims level of a non-tobacco user.

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<sup>15</sup> Federal Register 77:227 (26 November 2012) p. 70609.

<sup>16</sup> Kottke TE, Jordan CO, O’Connor PJ, Pronk NP, Carreón R. Readiness of US health plans to manage cardiometabolic risk. *Prev Chronic Dis* 2009;6(3):A86. Available from URL: [http://www.cdc.gov/pcd/issues/2009/jul/08\\_0142.htm](http://www.cdc.gov/pcd/issues/2009/jul/08_0142.htm).

<sup>17</sup> McPhillips-Tangum C, Rehm B, Carreon R, Erceg CM, Bocchino C. Addressing tobacco in managed care: results of the 2003 survey. *Prev Chronic Dis* 2006 Jul. Available from: URL: [http://www.cdc.gov/pcd/issues/2006/jul/05\\_0173.htm](http://www.cdc.gov/pcd/issues/2006/jul/05_0173.htm).

- **We have concerns about the administrative costs of linking a tobacco cessation program in the small group market with the tobacco use rating factor.** Wellness programs are increasingly common in the large group market, but most small employers today do not provide such programs to their employees. There are considerable administrative and operational hurdles to implementing this policy in time for employer coverage in 2014. Small employers often do not have the same robust human resource capabilities as large employers to facilitate a wellness program for their employees and would face challenges meeting the federal requirements (e.g., sending notifications to employees about the wellness program, ensuring access to reasonable alternatives, offering a health risk assessment, deciding on appropriate financial incentives, etc.). In addition, issuers will face operational challenges when developing rates. Health plan actuaries must make assumptions when pricing products and whether employers will offer wellness programs is a considerable unknown variable.
- **There are also adverse selection concerns with the proposed approach that allows small employers to elect whether to offer a tobacco cessation program.** There are potential selection challenges within the small group market, because the proposed linkage creates a disincentive for employers with a workforce that uses tobacco to offer a tobacco cessation program (because they can effectively eliminate the tobacco use surcharge for their employees). Under the single risk pool requirements of this proposed regulation, the pool will include employers who offer cessation programs and employers who do not. By linking the tobacco use surcharge and a cessation program, the employers who offer cessation programs will be effectively subsidizing those employers who choose not to offer such programs.
- **If the requirements are retained in the proposed rule, we strongly encourage the Department to modify the standard related to tobacco cessation programs from one that requires “participation” to one that requires “successful completion.”** The proposed regulation appears to link the use of tobacco as a rating factor to an individual’s “participation” in a cessation program. We suggest that linking the tobacco use surcharge to the “successful completion” of such a program is the more appropriate standard to prevent gaming and potential abuses. Further, we urge the Department to tie the first available reduction or elimination of the tobacco use surcharge to 2015 rates, following an individual’s successful completion of a wellness tobacco cessation program in 2014. This approach will provide issuers with additional time to develop employer wellness programs that include tobacco cessation programs, engage the small employer market, and establish administrative processes for implementing this policy.

### III. Single Risk Pool (45 CFR § 156.80)

#### ***The Single Risk Pool Requirements Provide Flexibility for Developing Rates and Innovative Health Care and Payment Models***

The proposed regulations provide standards for pooling risk in the individual and small group markets including the creation of an index rate and allowable adjustments to that rate. The regulations identify the following adjustments to the index rate: (1) actuarial value (AV) and cost-sharing design of the plan; (2) provider network, delivery system characteristics, and utilization management practices; (3) plan benefits in addition to the essential health benefits; and (4) for catastrophic plans, the recognition of the unique characteristics of the eligible population. Issuers would make market-wide adjustments to the index rate based on expected payments and charges under the risk-adjustment and reinsurance programs.

#### **Recommendations**

- **We ask for clarification that the single risk pool standard applies to each licensed entity in a state.** This standard was noted in a CMS presentation<sup>18</sup> that was released contemporaneously with this proposed regulation, but was not included in the regulatory language. We ask that CMS include language in the regulation to clarify that the risk pooling standards apply at the licensed entity level.
- **We urge the Department to provide further guidance and additional flexibility around the allowable adjustments to the index rate.** We seek clarification on the Department's approach and expectations with respect to adjustment of the index rate for risk-adjustment and reinsurance. A CMS presentation<sup>19</sup> identified "risk adjustment and stabilization payments" as allowable adjustments to the index rate at what appears to be the plan-level; however, the proposed regulation appears to require this adjustment at the market-level. We also support allowing additional flexibility to adjust the index rate at the plan-level for the induced utilization and adverse selection that can occur with differences in cost sharing amounts.

The *Notice of Benefit and Payment Parameters* proposed regulation specifically seeks comments on whether an adjustment to the index rate should be allowed "for the pooled, expected Exchange user fees for the set of health plans offered in a particular market" and / or a broader set of administrative costs.<sup>20</sup> We support a policy that allows a market-wide adjustment to the index rate for these fees, as well as distribution costs, agent and broker commissions, and all administrative costs. A broad inclusion of fees, commissions and administrative costs as allowable adjustments will streamline the

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<sup>18</sup> CMS Presentation: Health Insurance Market Rules, Rate Review (November 26, 2012).

<sup>19</sup> Ibid.

<sup>20</sup> Federal Register 77:236 (7 December 2012) p. 73182.

creation of an index rate and resultant product rate filings, both inside and outside of an Exchange. We support a level playing field inside and outside the Exchange and agree with the Department that this additional flexibility would help protect against adverse selection.

- **We also support the approach proposed for catastrophic health plans and student health plans that will promote the availability of affordable coverage options.** We offer further comments on these particular coverage options below.

#### **IV. Catastrophic Health Plans (45 CFR § 156.155)**

##### ***Affordable Catastrophic Health Plans Can Promote Market Stability and Encourage Greater Participation***

The proposed regulation allows an adjustment factor to the index rate for an issuer's individual market single risk pool to reflect the expected impact of the specific eligibility categories for catastrophic health plans. Further, the *Notice of Benefit and Payment Parameters* proposed regulation suggests that catastrophic plans be risk-adjusted as a separate risk pool from the general (metal level) pool. Under this approach, catastrophic plans with less-than-average actuarial risk (compared with other catastrophic plans) would be assessed charges while catastrophic plans with higher-than-average actuarial risk would receive payments.

##### **Recommendations**

- **We support the Department's consistent treatment of catastrophic plans across the different proposed federal regulations as one way to promote affordability and assure adequate participation in the marketplace, particularly for younger and lower-income individuals seeking more affordable coverage options.**
- **In addition, there appears to be an inadvertent technical error in the cross-reference under 45 C.F.R. §156.155(c).** Our review identified what appears to be a technical error in the cross-reference to the eligibility criteria for catastrophic plans under 45 C.F.R. §156.155(c). We offer the following edit for consideration:

*(c) Application for family coverage. For other than self-only coverage, each individual enrolled must meet the requirements of paragraph ~~(a)~~(4) (a)(5) of this section.*

**V. Student Health Plans (45 CFR §§ 147.145 and 156.80)**

***Consistent Treatment of Student Health Plans Critical To Promote Affordability and Minimize Disruption***

As noted in the preamble of the proposed regulation, the Department has interpreted Section 1560(c) of the ACA to “mean that if particular requirements in the Affordable Care Act would have, as a practical matter, the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under federal, state or local law, such requirements would be inapplicable...”<sup>21</sup> Student health plans were previously provided exceptions to the guaranteed availability and guaranteed renewability standards in the individual market to ensure that enrollment is limited to students and their dependents. In addition, we appreciate the similar treatment provided for these plans with respect to separate pooling for minimum loss ratio (MLR) purposes under the MLR interim final rule, as well as risk-adjustment under the *Notice of Benefit and Payment Parameters* proposed regulation.

**Recommendations**

- **We support the Department’s continuing consistent treatment of student health plans across the different adopted and proposed federal regulations as it will help assure that these plans remain available as an option to students.** In response to the Department’s solicitation of feedback on these topics, we urge that for purposes of the market reforms that this coverage should neither be included as part of the individual market single risk pool nor subject to the individual market rating requirements, as this coverage has historically been treated as a type of group coverage for rating purposes. Accordingly, we recommend that states have flexibility to continue to regulate student insurance plans as they do today for purposes of pooling and rating.

Adopting this consistent approach across all of the market reform requirements for these plans is critical to ensuring the continued viability of this product for hundreds of thousands of students and dependents, thereby fostering affordable choice and minimizing disruption for those with existing coverage. This treatment will also help ensure that these plans remain available as an option to students facing a variety of coverage needs – from foreign students complying with the U.S. Department of Education requirements, such as medical evacuation, to domestic students facing out-of-area coverage restrictions on their parents’ policies.

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<sup>21</sup> Federal Register 77:227 (26 November 2012) p. 70600.

**VI. Rate Review Increase Process (45 CFR §§ 154.200, 154.215, 154.220, 154.225, 154.230, 154.301)**

***The Regulatory Review Process Should Continue To Be Streamlined To Reduce Duplication, Promote Efficiency and Minimize Administrative Costs***

The health insurance market reform regulation also proposes several revisions to the federal rate review, amending the prior regulation, including: requiring insurers to file any rate increase in the individual and small group market, not just increases that meet or exceed the threshold for review of unreasonable rates; requiring that those be filed in a rate filing justification format to be required by CMS; and requiring that states review the additional criteria added for a state to be deemed as having an “effective” rate review program. These criteria include review of insurers’ use of a single risk pool, adjusted community rating elements, inclusion of essential health benefits, the impact of cost sharing on actuarial values, and the assumptions used in estimates for reinsurance and risk adjustments in the rates. The proposed regulation also changes the timing of the required use of the new rate filing justification format for reporting and filing to be effective for all rates filed in states on or after April 1, 2013, or effective on or after January 1, 2014.

In the cost section of the preamble, the proposed rule estimates a per rate filing cost of \$2,475<sup>22</sup> and also seeks input on the extent of the costs of systems adjustments to provide the data required in the standardized data template. Over the past two weeks, AHIP conducted a survey of member health plans about expected costs associated with the expanded rate review process and the proposed filing standards under the PRA Notice on *Rate Review Information Collection*.<sup>23</sup> The results of our survey show an average per filing cost of \$4,296, about 170 percent higher than the CMS estimate. In addition, survey respondents implementing the one-time systems changes for each health plan – not including any ongoing costs – estimated expected costs of between \$500,000 and \$1 million.<sup>24</sup>

**Recommendations**

- **We support an approach that recognizes state authority in rate oversight, leverages state regulatory expertise and knowledge of their markets and consumer needs and gives the states flexibility in demonstrating an effective rate review program.** The current Rate Review regulations correctly defer to the authority of

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<sup>22</sup> This estimate is based on 11 hours of additional actuarial work time at a rate of \$225 per hour. See Supporting Statement for Paperwork Reduction Act Submission: Rate Review Information Collection, 45 CFR Part 154, CMS Form Number: 10379 (November 20, 2012).

<sup>23</sup> Paperwork Reduction Act Submission: Rate Review Information Collection, 45 CFR Part 154, CMS Form Number: 10379 (November 20, 2012).

<sup>24</sup> AHIP Center for Policy and Research. (2012, December). *Health Plans’ Estimated Costs of Compliance with Expanded Federal Rate Review and with Data Collection for Risk Adjustment and Reinsurance*. Retrieved December 26, 2012, from <http://www.ahip.org/HPCostsCompliance2012/>

the states in monitoring and regulating rates and markets. The revisions to the effective rate review regulations provide for states' continued role in rate review, while also creating duplicative filing requirements and potentially inconsistent data submission requirements. The Department currently receives information from the states related to rates and we encourage the use of this existing process as the vehicle for the Secretary, in conjunction with the states, to monitor premium increases inside and outside the Exchange.

- **We recommend that the language of the rule be revised to reflect that states with effective rate review programs will receive rates reported, and eliminate the dual reporting requirement - except in those states without an effective rate review program.** We further recommend that the Department provide states with flexibility in demonstrating an effective rate review program by: accepting state regulators' attestations that they are reviewing the criteria noted above (found in §154.301 (a)(3) (iii),(iv), (4) (iii - v), and (xii - xvi); and allowing states that need to amend their statutes, regulations, or filing guidance to meet the new requirements a sufficient period of time to do so. We are also concerned with the proposed expansion in the PRA Notice on *Rate Review Information Collection*<sup>25</sup> that extends this burdensome and unnecessary reporting requirement to all rates, which would include rate decreases and static rates.
- **We recommend that as CMS further refines rate increase reviews, it streamlines the rate filing format and process to avoid duplication of effort and minimize additional administrative costs.** As noted above, health plans will incur costs for each additional rate filing in excess of the cost estimated by CMS, as well one-time and ongoing systems cost to comply with the expanded filing requirement. We will provide additional comments on how the rate filing justification format can be improved and the process streamlined in a separate response to the PRA Notice on *Rate Review Information Collection*.<sup>26</sup>
- **We also recommend clarification that the rate review requirements do not extend to expatriate coverage.** We understand that the substantial majority of this coverage is considered large group coverage in today's market; however, we believe this clarification would be helpful to minimize disruption when the definition of small group is expanded in 2016 to include employers with up to 100 employees.

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<sup>25</sup> Paperwork Reduction Act Submission: Rate Review Information Collection, 45 CFR Part 154, CMS Form Number: 10379 (November 20, 2012).

<sup>26</sup> Id.

## **VII. ACA Enforcement (45 CFR §§ 144.101 and 150.101)**

### ***Existing PHSA Enforcement Framework and Recognition of Good Faith Compliance Efforts Will Promote Stability***

The proposed regulation includes technical revisions to clarify that CMS will continue to use the same enforcement process as it has used with respect to the federal requirements that pre-date the ACA. Specifically, the enforcement process allows states to exercise primary enforcement over health insurance regarding the federal individual and group market reforms. CMS would have enforcement authority only if the state notifies CMS that it has not enacted legislation to enforce, or is not otherwise enforcing, or if CMS determines that the state is not substantially enforcing a federal market reform.

### **Recommendations**

- **We support the continuation of the existing enforcement process, whereby states retain primary enforcement responsibility over health insurance issuers.** We also encourage the continued collaboration between federal and state regulators, along with the streamlining of overlapping regulatory and data collection requirements to avoid unnecessary duplication, promote efficiency in the system, and minimize administrative costs.
- **To manage the massive changes that will occur with little time allowed for thorough testing of implementation efforts of this magnitude, it is crucial for the Department to recognize the good faith compliance efforts of all parties during the early years of implementation with a continuation of the enforcement approach set out in the first set of ACA FAQs.<sup>27</sup>** This could be accomplished by reissuance or a restatement of the Department's commitment to working together with stakeholders to help them comply with the new requirements and with consumers to understand the new law. Further, we urge an approach that builds a strong foundation for an effective and viable marketplace in the initial years of implementation by emphasizing "assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law."<sup>28</sup> Throughout our comment letter we offer different suggestions for transitions, safe harbors, and other policies designed to ensure smooth implementation of the new market reforms while also minimizing disruption for those with existing coverage.
- **We also ask that the Department add safe harbor language in the final rule to recognize good faith compliance efforts in certain circumstances where state law**

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<sup>27</sup> CCIIO, Affordable Care Act FAQs – Set 1 (September 20, 2010).

<sup>28</sup> *Id.*

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**may conflict with the federal standard.** Specifically, we urge the Department to provide a safe harbor and clarify that federal penalties will not apply to an issuer or other stakeholder that, in good faith, takes action in compliance with state law (that may conflict with federal standards) until such time that the Department completes its substantial enforcement investigation, determines that a state is not substantially enforcing the law, and begins its enforcement of the federal requirements.