Summary
On Feb. 22, 2013, the U.S. Department of Health and Human Services (HHS) issued a final rule to implement the Affordable Care Act’s (ACA) fair health insurance premium (adjusted community rating), guaranteed availability (issue), guaranteed renewability, single risk pool, catastrophic plans and rate review provisions.

The final rule clarifies and amends provisions from the Nov. 26, 2012, proposed rule. The provisions of the final rule apply to health insurance coverage for plan years (policy years in the individual market) beginning on or after Jan. 1, 2014.

Related Provisions Under the ACA

Single Risk Pool (applies to non-grandfathered plans)
Health insurance issuers (i.e., licensed entities) in the individual and small group markets must consider all enrollees in all non-grandfathered health plans issued in a particular state to be members of a single risk pool when developing rates and premiums for plan years (policy years in the individual market) effective on or after Jan. 1, 2014. Each issuer must have one individual market pool and one small group market pool in each applicable state. States may choose to require that issuers merge these pools. The final rule also requires:

• Each issuer in a state will have an index rate for each of the individual and small group pools for each plan year (policy year in the individual market). The index rate is based on the total combined claims costs for providing essential health benefits within the single risk pool. If there is not enough claims data available, issuers may use any reasonable source of claims data, including claims from grandfathered business. There may be marketwide adjustments for risk adjustment and reinsurance programs as well as Exchange (also called Health Insurance Marketplace) user fees.

• Premium rates for a particular plan may vary from the marketwide index rate only by several enumerated factors. For example, issuers may modify the marketwide index rate at the individual plan level to adjust for administrative costs (other than Exchange [also called Health Insurance Marketplace] user fees), so long as actuarially justified.
• Plan-specific adjustments to the marketwide index rate must not reflect differences in health status or risk selection.

• Issuers are expected to use pooled allowable claims data as a basis for calculating the plan-specific actuarial value instead of using the HHS actuarial value calculator.

**Fair Health Insurance Premiums (applies to non-grandfathered plans)**

Health insurance issuers may vary the premium rate charged to a specific non-grandfathered individual or small group from the rate established for that particular plan only based on the following factors: family size (individual or family), geography (rating area), age (within a ratio of 3:1 for adults) and tobacco use (within a ratio of 1.5:1).

- **Family rating** – The final rule clarifies that the cap on rating no more than the three oldest individuals under the age of 21 only applies to “covered children.” Employees and spouses under the age of 21 will be rated separately.

- **Small group rating** – Issuers will use the per-member rating methodology in the small group market. States may require issuers to give small groups an average premium amount for each employee in the group, provided that the total group premium equals the premium that would be obtained through the per-member rating approach.

- **Geographic rating** – The final rule clarifies that states may establish different rating areas for the individual or small group markets, but rating areas must apply uniformly within each market and may not vary by product. In addition, the final rule allows much more flexibility for states in terms of what rating area configurations will be presumed adequate. If a state does not establish rating areas, the default will be one rating area for each metropolitan statistical area (MSA) in the state and one rating area for all other non-MSA portions of the state.

- **Age rating** – The maximum 3:1 ratio for age rating applies to adults age 21 and older. The final rule retains the single band for children age 0-20 and a single age band for individuals 64 and older. Age for rating purposes continues to be determined based on the date of policy issuance and renewal; however, individuals who obtain coverage other than at issuance or renewal may be rated as of the age that they are added.

  • No state exceptions to the uniform age bands are allowed under the final rule. States can still set their own age curve within these bands. States may also establish separate age curves for individual versus small group markets.

- **Tobacco rating** – The final rule defines “tobacco use” as use of tobacco an average of four or more times per week within no longer than the past six months, including all tobacco products but excluding religious and ceremonial uses of tobacco. Tobacco use will be based on when a tobacco product was last used. Issuers may vary rates for tobacco only based on individuals who may legally use tobacco under federal and state law (i.e., no tobacco rating for individuals under age 18). If an enrollee provides false or incorrect information about his or her tobacco use, an issuer may retroactively apply the appropriate tobacco use rating factor to the enrollee’s premium, but may not rescind the coverage. The final rule retains the rating for tobacco use within a ratio of 1.5:1. Issuers may vary tobacco rating by age, as long as the tobacco use factor does not exceed 1.5:1 for any age band. The small group market may apply the tobacco rating factor only in connection with a wellness program, allowing a tobacco user to avoid paying the full amount of the tobacco factor by participating in a tobacco cessation program.
**Guaranteed Availability of Coverage (applies to non-grandfathered plans)**

Health insurance issuers are to offer coverage to and accept every employer or individual who applies for coverage in the group and individual market, subject to certain exceptions. Exceptions allow issuers to restrict enrollment in coverage to: 1) open and special enrollment periods, 2) employers with eligible individuals who live, work, or reside in the service area of a network plan, and 3) for situations involving limited network capacity and limited financial capacity. Although guaranteed availability applies to small groups that do not meet an issuer’s minimum participation or contribution requirements (when allowed by state law), the new law permits issuers to restrict the enrollment of these groups to an annual period that begins Nov. 15 and extends through Dec. 15. The final rule specifies that:

- Small and large employers cannot be denied coverage for the failure to satisfy minimum participation or contribution requirements.

- The final rule maintains the requirement that there would be “limited” open enrollment periods in the individual market consistent with Exchange (also called Health Insurance Marketplace) rules (aligning initial and annual open enrollment periods outside the Exchanges [also called Health Insurance Marketplaces] with those inside the Exchanges [also called Health Insurance Marketplaces]). In addition, an individual enrolled in a non-calendar year plan will be entitled to a limited open enrollment period beginning 30 calendar days prior to the individual’s policy renewal date outside the open enrollment period for 2014. States may permit more flexible open enrollment provisions.

- Enrollment periods specific to special circumstances (e.g., loss of other coverage, birth, marriage, etc.) will be 60 days in the individual market (consistent with Exchange [also called Health Insurance Marketplace] rules) and 30 days in the group market.

- Discriminatory marketing practices or benefit designs that discourage enrollment based on health needs in coverage, such as discrimination based on age, disability, race, ethnicity, gender and sexual orientation are prohibited.

- Future guidance will address strategies to limit adverse selection related to guaranteed availability.

**Guaranteed Renewability of Coverage (applies to non-grandfathered plans)**

Health insurance issuers must renew or continue in force coverage in the group and individual market at the option of the plan sponsor or the individual with limited exceptions. Issuers do not have to renew coverage in cases of nonpayment of premium, fraud, violation of minimum participation and contribution requirements, and other circumstances allowed under prior law.

**Rate Review Program**

The final rule largely implements changes to rate review requirements contained in the proposed rule, including the requirement that all rate increases be filed with HHS, not just those of 10 percent or greater. However, the final rule added the requirement that if any product is subject to a rate increase, the issuer must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products.
Catastrophic Plans

The final rule establishes standards for enrollment in catastrophic plans for young adults and people who cannot otherwise afford health insurance. The catastrophic plan will have a lower premium, protect against high out-of-pocket costs and cover recommended preventive services without cost-sharing. The provisions for catastrophic plans apply to coverage offered both inside and outside of an Exchange (also called a Health Insurance Marketplace). To be eligible to enroll in a catastrophic plan, individuals must meet special eligibility criteria provided by the ACA.

Special Plan Types

The final rule exempts all student health insurance coverage from the single risk pool requirements (including guaranteed availability and renewability requirements). Sub-regulatory guidance issued at the time also clarifies that student health insurance coverage is not subject to federal rate review requirements at this time. Additionally, future guidance will be issued on the applicability of the market reform provisions to expatriate plans.

For more information

Consult your UnitedHealthcare representative if you have questions about adjusted community rating or changes under the ACA that take effect in 2014. Or, visit the United for Reform Resource Center at uhc.com/reform and click the adjusted community rating provision.