

# Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers

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## Contributors:

Elizabeth Abbott, Health Access  
Amy Bach, United Policyholders  
Birny Birnbaum, Center for Economic Justice  
Bonnie Burns, California Health Advocates  
Sabrina Corlette, Georgetown University Health Policy Institute  
Joseph P. Ditré, Consumers for Affordable Health Care  
Stephen Finan, American Cancer Society Cancer Action Network  
Carrie Fitzgerald, First Focus  
Kathleen Gmeiner, UHCAN Ohio  
Marguerite Herman, Consumer Advocates: Project Healthcare

Timothy Stoltzfus Jost, Washington and Lee University School of Law  
Peter Kochenburger, University of Connecticut School of Law  
Adam Linker, North Carolina Justice Center  
Sarah Lueck, Center on Budget and Policy Priorities  
Jennifer Mishory, Young Invincibles  
Stephanie Mohl, American Heart Association  
Lynn Quincy, Consumers Union  
Andrea Routh, Missouri Health Advocacy Alliance  
Barbara Yondorf, Colorado Consumer Health Initiative  
Cindy Zeldin, Georgians for a Healthy Future

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**Elizabeth Abbott**

*Director of Administrative Advocacy*  
Health Access  
1127 11th Street, Ste. 234  
Sacramento, CA 95814  
916-497-0923 x 201  
eabbott@health-access.org

**Amy Bach**

*Executive Director*  
United Policyholders  
381 Bush Street, 8th Floor  
San Francisco, CA 94104  
415-393-9990  
amy.bach@uphelp.org

**Birny Birnbaum**

*Executive Director*  
Center for Economic Justice  
1701 A South Second Street  
Austin, TX 78704  
512-912-1327  
cej@cej-online.org

**Bonnie Burns**

*Training and Policy Specialist*  
California Health Advocates  
53080 Elvas Avenue  
Sacramento, CA 95819  
916-231-5110  
bburns@cahealthadvocates.org

**Sabrina Corlette**

*Research Professor and Project Director*  
Center on Health Insurance Reforms  
Georgetown University  
Health Policy Institute  
3300 Whitehaven Street, N.W.,  
Ste. 5000  
Washington, DC 20057  
202-687-0880  
sc732@georgetown.edu

**Joseph P. Ditré**

*Executive Director*  
Consumers for Affordable Health Care  
12 Church Street, P.O. Box 2490  
Augusta, ME 04338-2490  
207-622-7083  
jditre@mainecahc.org

**Stephen Finan**

*Senior Director of Policy*  
American Cancer Society  
Cancer Action Network  
901 East Street NW  
Washington, DC 20004  
202-661-5780  
sfinan@cancer.org

**Carrie Fitzgerald**

*Senior Policy Advisor for Health*  
First Focus  
1110 Vermont Ave. NW, Ste. 900  
Washington, DC 20005  
202-657-0663  
carrief@firstfocus.net

**Kathleen Gmeiner**

*Project Director*  
UHCAN Ohio  
370 S. Fifth Street  
Columbus, OH 43215  
614-456-0060 x 223  
kgmeiner@uhcanohio.org

**Marguerite Herman**

*Consumer Advocates: Project Healthcare*  
515 E. 18th Street  
Cheyenne, WY 82001  
307-638-1468  
Marguerite.herman@gmail.com

**Timothy Stoltzfus Jost**

*Professor*  
Washington and Lee University  
Virginia Organizing  
School of Law, Lewis Hall,  
East Denny Circle  
Lexington, VA 22802  
540-458-8510  
jostt@wlu.edu

**Peter Kochenburger**

*Executive Director and Associate Clinical*  
*Professor of Law*  
Insurance Law Center  
University of Connecticut School of Law  
65 Elizabeth Street  
Hartford, CT 06105  
860-570-5177  
peter.kochenburger@law.uconn.edu

**Adam Linker**

*Health Policy Analyst*  
North Carolina Justice Center  
224 South Dawson Street  
Raleigh, NC  
919-861-2074  
Adam.linker@ncjustice.org

**Sarah Lueck**

*Senior Policy Analyst*  
Center on Budget and Policy Priorities  
820 First Street NE, Suite 510  
Washington, DC 20002  
202-408-1080  
lueck@cbpp.org

**Jennifer Mishory**

*Deputy Director*  
Young Invincibles  
1536 U Street NW  
Washington, DC 20009  
202-339-9338  
jen.mishory@younginvincibles.org

**Stephanie Mohl**

*Government Relations Manager*  
American Heart Association  
1150 Connecticut Ave. NW #300  
Washington, DC 20036  
202-785-7909  
Stephanie.mohl@heart.org

**Lynn Quincy**

*Senior Policy Analyst*  
Consumers Union  
1101 17th Street NW, Suite 500  
Washington, DC 20036  
202-462-6262  
quinly@consumer.org

**Andrea Routh**

*Executive Director*  
Missouri Health Advocacy Alliance  
606 East Capitol Ave.  
Jefferson City, MO 65101  
573-634-9800  
arouth@mohealthalliance.org

**Barbara Yondorf**

*Board Member*  
Colorado Consumer Health Initiative  
c/o Yondorf Assoc.  
2211 Clermont Street  
Denver, CO 80207  
303-329-7912  
byondorf@gmail.com

**Cindy Zeldin**

*Executive Director*  
Georgians for a Healthy Future  
100 Edgewood Ave. NE, Ste. 815  
Atlanta, GA 30303  
404-418-6179  
czeldin@healthyfuturega.org

# Introduction and Disclaimer

These materials were prepared to assist regulators, lawmakers, and the National Association of Insurance Commissioners (NAIC) during ongoing implementation of the comprehensive insurance reforms called for by the Patient Protection and Affordable Care Act of 2010 (ACA). The purpose of these recommendations is to convey the perspectives of consumer advocates on appropriate standards and guidelines for implementing these reforms, which will go into effect in 2014.

Each chapter includes an overview of the reform and the issue it was designed to address; a summary of any guidance from the federal government on implementation; problems consumers might encounter depending on how the reform is implemented; and recommendations for the NAIC as well as state and federal regulators and lawmakers. There is an executive summary of our recommendations as a quick reference guide beginning on page 1 and a chart in the Appendix that describes the applicability of each of the reforms by market and type of product, although we refer generally to “insurers” throughout these materials.

The enclosed chapters were drafted and/or reviewed by teams of professionals who are currently serving as consumer representatives to the NAIC. We were selected to serve by the NAIC Commissioners and represent millions of American health care consumers across the country. The specific recommendations contained in the materials were not presented to the NAIC or the organizations with which the drafters are affiliated for formal endorsement. Therefore, organizational affiliations are listed for identification purposes only.

These recommendations are limited to the ACA’s insurance reforms and do not address other critical reforms of equal importance to the consumer representatives and millions of consumers, such as the expansion of the Medicaid program, the implementation of health insurance exchanges, the availability of federal subsidies, and the need for meaningful consumer outreach and education, among others. Although outside of the scope of these recommendations, we will continue to be engaged on these issues and work collaboratively with the NAIC, state regulators and lawmakers, and the federal government to help ensure that the ACA meets the needs of consumers across the nation.

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## Executive Summary of Consumer Recommendations for Regulators and Lawmakers

### Guaranteed Issue and Guaranteed Renewal

- **State regulators and lawmakers** and **HHS** should:
  - Establish standardized annual open enrollment periods for the fully insured individual market outside of the exchange that coincide with the annual open enrollment periods held by the exchanges and are sufficiently long to allow people to understand their options and obligations.
  - Mandate an initial open enrollment period for the fully insured individual market outside of the exchange that lasts at least six months and is consistent with the initial open enrollment period of the exchange from October 1, 2013 to March 31, 2014.
- **State regulators and lawmakers** should:
  - Establish a special enrollment period of at least 60 days from the date of a triggering event and extend the rules and protections related to enrollment periods for qualified health plans to plans outside of the exchange.
  - Promote and explain the new guaranteed issue requirements and enrollment periods through consumer education and outreach activities that are accessible to diverse populations, young adults, individuals with disabilities, and individuals for whom English is not their first language, among others.
  - Require insurers to inform consumers about enrollment periods by including a prominent and continuous announcement on the insurer's website with a clear explanation that coverage is available on a guaranteed issue and guaranteed renewal basis.
  - Ensure that families can purchase a single family policy, rather than be required to purchase individual policies for each family member.
  - Ensure or promote the availability of comprehensive, affordable child-only policies for children under the age of 19.
  - Repeal minimum contribution and participation requirements in the small group market.

### Elimination of Preexisting Condition Exclusions

- **State regulators and lawmakers** should:
  - Prohibit insurers from unreasonably delaying the issuance of a policy.
  - Prohibit insurers from collecting or requesting health information or other personal information beyond what is needed to apply allowable rating factors before an individual is accepted for coverage and broadly define the types of prohibited information to include personal information that relates to health status or that might be used as a proxy for health status, such as credit information or family history.
  - Prohibit insurers from acquiring or requesting information beyond what is included on the uniform enrollment form and extend the exchange's privacy protections and limitation on the collection of personal information to the markets outside of the exchanges.
  - Prohibit insurers from discriminating against individuals on the basis of factors that relate to health status or may be proxies for health status, such as credit information and family history.
- **HHS** should:
  - Actively identify and prohibit insurers from using any factors to determine eligibility that may be related to health status but are not reflected in the non-exhaustive list in Section 2705 of the Public Health Service Act.

## Rating Reforms

- The **NAIC** should:
  - Recommend to HHS that it adopt standardized, national age bands to implement the ACA's age rating requirements.
  - Consider the importance of minimizing rate shocks and cliffs as well as the affordability of coverage for older and younger Americans when making recommendations to HHS on standardized, national age bands.
  - Assist states in establishing age bands and geographic rating areas by the end of 2012 to provide insurers with adequate time to establish and submit rates for approval.
  - Engage consumers, insurers, and employers to develop recommendations on wellness incentives that are neither discriminatory nor subterfuges for health status rating for those who do not or cannot meet specified health-status related targets.
- **State regulators and lawmakers** should:
  - Establish age bands and geographic rating areas by the end of 2012 to provide insurers with adequate time to establish and submit rates for approval.
  - Commission a study to analyze the potential options for rating areas and, in particular, the impact that different rating areas will have on premiums in the individual and small group markets.
  - Impose rate bands on geographic area rating factors to limit wide premium variation within a state.
  - Consider rating restrictions that are more protective than the requirements under Section 2701.
  - Ensure that the single risk pool requirement of the ACA applies consistently to all products in the individual and small group markets to effectively prohibit insurers from segmenting the risk pool.
  - Ensure that rate review processes are robust ahead of new regulatory requirements in 2014 by, at a minimum:
    - Enacting prior approval authority over all insurance carriers in all markets, including the association market.
    - Adapting rate review processes to ensure that insurers have not relied on any factors other than family size or composition, geographic area, age, and tobacco use and verify that rate variation from these four factors complies with federal requirements under Section 2701.
    - Adopting additional requirements for determining whether rates are justified and reasonable, such as reviewing provider contracts and cost-containment goals.
    - Promoting meaningful consumer input and engagement in rate review through transparency, advance notice to consumers that their insurance company has filed a new rate or rate increase, a standardized and easy-to-understand process for consumer participation that allows any consumer or consumer advocacy organization to monitor all insurers' rate requests, and requirements that insurers and officials post understandable rate filings online that can be easily sorted by filing date and insurer.
- **HHS** should:
  - Adopt standardized, national age bands to implement the ACA's age rating requirements.
  - Consider the importance of minimizing rate shocks and cliffs as well as the affordability of coverage for older and younger Americans in adopting standardized, national age bands.
  - Define permissible age bands by the end of 2012 to provide insurers with adequate time to establish and submit rates for approval.

## Definition of Small Group Market

- **State regulators and lawmakers** should:
  - Conduct robust analysis and modeling to understand the effects of expanding the definition of small employer and merging the individual and small group markets.
  - Explore and adopt policies prior to 2016 to minimize market disruption associated with changes to the definition of the small group market, such as rate shock or cliffs.
  - Consider, at a minimum, adopting a phased approach to applying new rules, such as rate review authority or the ACA's new rating restrictions, to businesses with 51 to 100 employees ahead of 2016.
  - Consider whether broadening the definition of small employer ahead of 2016 or merging the individual and small group markets can facilitate smooth transitions for consumers as they move between jobs or experience life changes.
  - Be wary of efforts to escape the ACA's new consumer protections for the small group market through loopholes, such as the use of low-attachment point stop loss coverage, and actively monitor shifts towards self-insurance and subsequent effects on premiums in the small group market.

## Limitation on Waiting Periods

- **State regulators and lawmakers** should:
  - Consider eliminating waiting periods in the individual market and being more protective than the federal standard for fully insured group plans by limiting the use of waiting periods or further restricting these periods to 60 days or fewer.
  - Prohibit insurers from imposing benefit-specific waiting periods (if allowed under federal rules) that could be used to discourage enrollment of high-risk individuals in certain plans.
  - Impose an ongoing, affirmative obligation on insurers to review applications even when waiting periods apply so that individuals and employees are enrolled in coverage immediately following the end of the waiting period.
- **HHS, the Department of Labor, and the Department of Treasury** should:
  - Clarify that insurers cannot apply benefit-specific waiting periods because such waiting periods would disproportionately affect individuals whose conditions existed before their coverage began.

## Coverage for Participating in Approved Clinical Trials

- **State regulators and lawmakers** and **HHS** should:
  - Define “life-threatening condition” to encompass diseases and conditions that may not be immediately life-threatening but could result in death if not treated, such as coronary heart disease, multiple sclerosis, and stroke, among others.
  - Define and interpret the definition of “life-threatening condition” to allow a patient’s health care professional to make the ultimate determination of whether a particular disease is life-threatening to a specific patient if not treated.
  - Clarify that qualifying individuals are permitted to go out of network to participate in an approved trial if there is not a participating provider for their trial in their health plan’s network that is willing to accept them.
  - Adopt the Medicare definition of “routine patient costs” to avoid uncertainty and confusion about what an insurer must cover.

## Essential Health Benefits, Including State-Mandated Benefits

- **HHS** should:
  - Prohibit the use of all benefit substitutions, both within and among benefit categories, and clarify that states can decide to prohibit or restrict such substitutions.
  - Require insurers to, at a minimum:
    - Offer habilitative services at parity with rehabilitative services.
    - Offer more than one prescription drug per category or class.
    - Cover broad pediatric benefits instead of only pediatric oral and vision care.
  - Define a method for states to pay for benefits that exceed the essential health benefits that includes a *de minimis* threshold, such that benefits with very minimal additional costs don’t have to be repaid by the state.
  - Adopt a marginal cost analysis approach for determining the cost of state-mandated benefits that is evidence-based and reflects any savings associated with reduced use of acute and long-term care services as well as societal benefits.
- **State regulators and lawmakers** should:
  - Adopt a public, transparent process to establish the state’s essential health benefits benchmark plan by, at a minimum:
    - Identifying potential benchmark plan options, releasing detailed plan information (including information about benefit exclusions and limits) for consideration by the public, and providing meaningful opportunities for public comment and discussion regarding the benchmark plan.
    - Considering public comments when choosing the benchmark plan.
    - Scrutinizing benchmark options and any allowable conversions from dollar to non-dollar limits, such as visit limits, to ensure they do not circumvent meaningful coverage through benefit exclusions or limits.
    - Comparing the coverage provided in the benchmark plan options to existing coverage in the state to ensure that the choice of benchmark does not undermine benefits consumers need.
    - Informing the public about how they considered the factors required by statute in adopting a benchmark plan, such as ensuring that the essential health benefits package reflects an appropriate balance among the ten categories and accounts for the health needs of diverse segments of the population.
  - Set essential health benefits standards that reflect existing state-mandated benefits and are more protective than federal requirements by, at a minimum:
    - Prohibiting or limiting the use of benefit substitutions (if allowed under federal rules) both within and among benefit categories.

- Subjecting benefit substitutions (if allowed under federal rules) to a heightened level of regulatory scrutiny to ensure that substitutions do not result in the elimination or limitation of important services or benefits that disadvantage people with high-cost health care needs and promote adverse selection by, for example:
  - Disallowing variation in certain types of benefits or categories.
  - Specifying certain allowable benefit-related substitutions and prohibiting any others.
  - Creating a benefit standard that is consistent across all tiers or all plans within a tier.
- Enabling consumers to make simple comparisons about their coverage options.
- Ensuring that the regulators have sufficient capacity to make the detailed actuarial equivalence determinations and market conduct reviews necessary to ensure that insurers are complying with federal requirements.
- Using prior approval rate and form review authority to evaluate actuarial equivalence for benefit substitutions and non-dollar limits, such as visit limits, and savings generated by benefit substitutions made by insurers.
- Defining habitative services to include the maintenance of function.

### Actuarial Value, Limitations on Cost-Sharing, and Catastrophic Coverage

- **HHS and state regulators and lawmakers** choosing to use a state-specific actuarial value calculator modified to reflect the state's needs should:
  - o Use a robust microsimulation model, sophisticated enough to model the large majority of cost-sharing provisions in the large majority of plans sold on the individual and small group markets (including medical deductibles, coinsurance, out-of-pocket maximums, cost-sharing for “carved out” services like prescription drug benefits or mental health, and other service-specific cost-sharing such as copays, per admission deductibles, and tiered drug pricing, among others) to calculate actuarial value.
  - o Require an independent actuary to certify that unique plan designs fit the model appropriately and make the resulting analysis available to the public.
  - o Ensure that the metal tiers and actuarial value measurements are meaningful and easy for consumers to understand by, at a minimum:
    - Conducting consumer testing to identify the most consumer-friendly vocabulary and format for displaying actuarial value and the metal tiers.
    - Displaying each plan's actual actuarial value estimate in addition to the metal tier.
    - Considering the provision of additional decision support tools, beyond the metal tiers and actuarial value measures, to help consumers choose among plans.
    - Requiring insurers to use materials with easy-to-understand disclosures about what is—and what is not—covered in addition to a plan's actuarial value and metal tier.
    - Considering whether to standardize cost-sharing for all plans at a given tier level.
- **State regulators and lawmakers** should:
  - o Ensure that there is a level playing field inside and outside the exchange by adopting uniform market rules by, at a minimum:
    - Considering prohibiting insurers from offering catastrophic coverage only outside of the exchange to avoid segmenting the state's broader risk pool.
    - Requiring insurers to follow the same rules and offer the same coverage both inside and outside the exchange.
    - Ensuring that the ACA's “single risk pool” requirement works effectively.
    - Ensuring that the marketing of catastrophic plans is properly regulated and does not mislead consumers.
    - Ensuring that consumers with access to catastrophic plans are also informed about federal subsidies to purchase coverage through the exchange and the availability of Medicaid.

### Stop Loss and Self-Insurance

- The **NAIC** should:
  - o Adopt a Guideline Revision based on the study commissioned by the Health Actuarial (B) Task Force to raise the minimum specific and aggregate attachment points for the NAIC Stop Loss Insurance Model Act.
  - o Amend the NAIC Stop Loss Insurance Model Act to reflect the minimum specific and aggregate attachment points for stop loss insurance based on the study commissioned by the Health Actuarial (B) Task Force.
- **State regulators and lawmakers** should:
  - o Ban stop loss insurance for small employers altogether or require stop loss coverage to be subject to the same laws that apply to regular health insurance.



- o Adopt new regulatory authority or enhance existing authority to regulate stop loss insurance by establishing or increasing minimum individual specific attachment points to at least \$60,000 consistent with the interpretation of the Health Actuarial (B) Task Force.
- o Actively monitor—and regulate in response to—shifts towards self-insurance and any subsequent trends in premiums in the small group market, which could result in adverse selection in both the exchange and the outside insured market.
- o Actively monitor—and regulate in response to—shifts towards self-funding in student health insurance plans.
- o Ensure that self-funded student health insurance plans give the same protection to students that fully insured plans are required to provide.
- o Increase state regulation of fully insured student health insurance plans.
- o Avoid converting student health plan coverage from fully insured to self-funded plans.
- **HHS, the Department of Labor, and the Department of Treasury** should:
  - o Clearly define the terms “self-insured” and “issuer offering group health insurance coverage” to ensure that a small group can only claim self-insured status if the plan bears substantial risk and the insurer complies with the requirements of the ACA.
  - o Adopt the minimum specific and aggregate attachment points for stop loss insurance associated with a self-insured plan consistent with the study commissioned by the Health Actuarial (B) Task Force.
  - o Actively monitor—and regulate in response to—shifts towards self-insurance in small businesses, which could result in adverse selection in both the exchange and the outside insured market.

### Limited Medical Benefit Plans

- The **NAIC Limited Medical Benefit Plan (B/D) Working Group** should:
  - o Interpret their charge broadly to include excepted benefits and mini-med plans since the NAIC itself uses the term “limited benefits” to describe a wide variety of non-comprehensive health insurance plans.
  - o Adopt a broad definition of “limited medical benefit plans” to include excepted benefit plans and mini-med plans as defined under federal law.
  - o Include excepted benefit plans—such as hospital indemnity, other fixed indemnity and specified disease and illness policies—and mini-med plans in its charge to “review issues related to limited medical benefit plans” because such plans raise issues related to limited medical benefit products.
  - o Emphasize the importance of transparency and disclosures to ensure that consumers are able to make meaningful choices about their coverage options.
  - o Conduct a survey of state regulators to assess trends in the marketing and sale of limited medical benefit plans, including “stacked” fixed indemnity and mini-med plans.
  - o Include both regulatory and disclosure initiatives in the efforts being coordinated.
  - o Provide additional clarity with respect to how product utility will be determined and measured.
- In the event that the NAIC Limited Medical Benefit Plan (B/D) Working Group does not interpret its charge to include excepted benefits and mini-med plans, the **NAIC Health Insurance and Managed Care (B) Committee** should:
  - o Issue a separate charge directing the Working Group to address these issues.
- **State regulators and lawmakers** should:
  - o Issue, if they have not yet done so, the NAIC’s model Consumer Alert on limited medical benefit and mini-med plans.

### Risk Adjustment

- **State regulators and lawmakers** should:
  - o Evaluate whether to administer a state-specific risk adjustment program, by considering the benefits of doing so which include, among others, the ability to:
    - Ensure that the state’s risk adjustment program is as robust, predictive, and transparent as possible by establishing a state-specific data collection and validation approach as well as promoting insurer confidence to minimize adverse selection.
    - Use robust data collected during the risk adjustment process for policymaking decisions.
    - Leverage existing sources of state data and collection tools.
    - Use risk adjustment data to enforce the ACA’s new requirements such as medical loss ratios, rate review, and a single risk pool for the individual and small group market.

- o Administer a state-specific risk adjustment program by:
  - Adopting a centralized approach to data collection with uniform rules for data reporting and how claims will be used to determine risk scores.
  - Developing a prospective risk adjustment model based on projected costs, similar to the one used under Medicare Part C.
  - Utilizing an all-payer claims database (if available) to administer risk adjustment as a rich source of claims data that can serve as a source of predictable data.
  - Refining risk adjustment methodology on a regular, timely basis to safeguard the accuracy of the risk adjustment program.
- o Adopt a transparent rulemaking process to implement the risk adjustment program by, at a minimum:
  - Ensuring that all decisions are subject to public notice and comment.
  - Indicating how the state plans to comply with federal requirements and meet the intended goals of the risk adjustment program.
  - Prohibiting financial conflicts of interest on the governing board of the risk adjustment entity.
- o Establish uniform standards for regulating the market inside and outside the exchange.
- **HHS** should:
  - o Develop a robust risk adjustment methodology that will result in accurate, timely collections and payments, encourage cost-efficiency, and discourage fraud and abuse.
  - o Conduct frequent audits of insurer data, place additional audit requirements (including on independent auditors), and enforce risk adjustment regulations.
  - o Refine risk adjustment methodology on a regular, timely basis.
  - o Ensure that risk adjustment, reinsurance, and risk corridors programs work together to limit adverse selection.

## Reinsurance

- **HHS** and **state regulators and lawmakers** that opt to use reinsurance parameters that differ from those prescribed by HHS should:
  - o Adopt a methodology that requires reinsurance entities to collect and distribute reinsurance funds in an equitable manner.
  - o Adopt a methodology that ensures that care coordination and management programs reflect state-specific needs.
  - o Not adjust risk adjustment calculations for payments that insurers might receive under the reinsurance program.
  - o Ensure that reinsurance, risk adjustment, and risk corridors programs work together to limit adverse selection.
- **State regulators and lawmakers** should:
  - o Justify any deviations from HHS' methodology and make their notice of benefit and payment parameters available to the public with a period for comment.
  - o Collect reinsurance contributions from insurers in the fully insured market to exercise control over these contributions.
  - o Continue to operate their high risk pools until the state is confident that enrollment of high risk pool enrollees will not destabilize the exchange.
  - o Ensure that reinsurance, risk adjustment, and risk corridors programs work together to limit adverse selection.

## Risk Corridors

- **HHS** should:
  - o Establish risk corridors requirements that are consistent with leveraging data reporting requirements for MLR.
  - o Use actual data at the plan-level rather than projected data.
  - o Refrain from using data that is aggregated at the insurer level.
  - o Determine a baseline amount of allowable costs or payment liability reflecting the experience of other insurers.
  - o Ensure that risk corridors, risk adjustment, and reinsurance programs work together to limit adverse selection, particularly to avoid overcompensating insurers for adverse selection.



## Guaranteed Issue and Guaranteed Renewal

With nearly 50 million uninsured people in 2010,<sup>1</sup> the United States faces a crisis in ensuring that all individuals have available, adequate, and affordable health insurance coverage. Being uninsured has serious consequences: uninsured consumers have worse health outcomes and higher medical debt than the insured.<sup>2,3</sup> And the cost of medical care provided to the uninsured has significant economic implications. Yet despite the country's high uninsured rate and the devastating human and economic consequences of being without coverage, most states do not require insurers to offer coverage to individuals and, until recently, neither did the federal government. Without such a requirement, insurers in the individual market may deny coverage to individuals because of age, gender, preexisting conditions, and other factors of their choosing.

To improve the availability of health insurance and continued access to coverage, the ACA requires insurers to accept every employer and individual that applies for coverage or renews coverage at the option of the employer or individual.<sup>4</sup> These requirements will be effective January 1, 2014.

The consumer representatives to the NAIC strongly support these requirements as essential to ensuring that health insurance is available to consumers, particularly those with preexisting conditions. We believe that coordinated open enrollment periods, enforcement, and consumer outreach and education will be critical to assuring that consumers fully benefit from these important protections.

### Background

Section 1201 of the ACA amends Sections 2702 and 2703 of the Public Health Service Act. These provisions apply to insurers offering coverage in the individual and group markets.<sup>5</sup>

*Section 2702.* Section 2702 requires insurers to accept every employer and individual that applies for coverage and permits insurers to establish open enrollment periods during which employers and individuals can apply for coverage.<sup>6</sup> Outside of the open enrollment period, consumers may enroll in coverage only under certain circumstances. Enrollment periods, with proper protections and significant outreach and education, can help simplify the process of enrolling in coverage and help minimize adverse selection. Insurers must also establish special enrollment periods for “qualifying events” designated by the Employee Retirement Income Security Act of 1974 (ERISA) which include life events such as the death of the insured and divorce, among others.<sup>7</sup> This section of the law also requires the Secretary of the United States Department of Health and Human Services (HHS) to promulgate regulations related to open enrollment periods.

Prior to the ACA, there were no federal requirements that coverage be available to individual consumers on a guaranteed issue basis.<sup>8</sup> And only six states currently require insurers to offer such coverage on a guaranteed issue basis. Section 2702 dramatically expands access to coverage—particularly to consumers who were previously unable to obtain coverage in the individual market—and will help ensure that coverage is available to all, regardless of their health status.

The ACA further increases the availability of coverage in the small group market. Even though the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires plans in the small group market to be sold on a guaranteed issue basis,<sup>9</sup> the ACA eliminated some of the exceptions to this requirement, such as requiring a small business to contribute a minimum percentage of the premium for their employees or ensuring that a minimum number of the company's employees participate in the plan.<sup>10</sup> Although these requirements were eliminated under the ACA, many states have laws regarding minimum contribution and participation requirements in the small group market.

Section 2703 requires insurers to renew or continue coverage if the individual or employer wishes to remain enrolled.<sup>11</sup> The ACA preserves existing requirements under HIPAA that require insurers to renew coverage on a guaranteed basis with some exceptions, such as the nonpayment of premiums and fraud, among others.<sup>12</sup>

### **Problems Consumers Might Encounter**

We are concerned that consumers may not realize the full benefit of Sections 2702 and 2703 without action by state and federal regulators. To ensure that these provisions are implemented successfully, we recommend that states establish open enrollment periods that are consistent both inside and outside of the exchange, easy for consumers to understand, and sufficiently long to allow consumers to understand their options and enroll in a plan that is right for them.

First, we strongly support the establishment of an initial open enrollment period for the fully insured individual market from October 1, 2013 to March 31, 2014 that is consistent with the initial open enrollment period of the exchange. This initial open enrollment period should last at least six months to ensure that consumers have the opportunity to enroll in coverage as they become aware of their rights and obligations under the ACA.

Second, because of the risk of confusing consumers, we recommend that HHS adopt annual national open enrollment periods for the fully insured individual market that apply uniformly to all 50 states and the District of Columbia. These uniform national open enrollment periods should coincide with the open enrollment periods held by the exchanges for consistency and to capitalize on public awareness and outreach regarding the ACA's new benefits and requirements.

In the absence of a uniform national standard for the initial and annual open enrollment periods, states should set initial and annual open enrollment periods that apply consistently to the individual market outside the exchange and coincide with the exchange open enrollment period in each state. If regulators fail to do so, each insurer could adopt a unique open enrollment period, resulting in confusion about when to enroll for each plan as consumers juggle multiple and potentially overlapping open enrollment periods. Consumers may face similar confusion if insurers are allowed to set rolling enrollment periods based on, for example, the birth month of the consumer rather than open enrollment periods based on calendar months. Such confusion would have significant consequences and could result in consumers missing critical opportunities to obtain health insurance coverage in a timely manner. In addition, having a standardized open enrollment period inside the exchange, but not requiring insurers offering coverage in the outside market to do the same could result in adverse selection in the exchange.

Third, mandatory special enrollment periods allow individuals to enroll in coverage when they face significant life changes. Regulators should specify the length of the special open enrollment period to ensure that eligible consumers can obtain the coverage they need when potentially facing a life crisis. We support a special enrollment period of at least 60 days from the date of a triggering event, which is consistent with the special open enrollment period rules established by HHS for qualified health plans, to give eligible consumers the opportunity to enroll in coverage outside of an open enrollment period when they need it. To maximize consumer understanding and limit adverse selection, many of the rules and protections related to special enrollment periods for exchange plans should also be extended to plans outside of an exchange.

Fourth, we encourage the repeal of existing state laws that specify minimum contribution and participation requirements in the small group market. These laws should be repealed because they will be inconsistent with the ACA beginning in 2014 and could result in confusion among insurers, regulators, and small employers. In addition, states should ensure that consumers have access to coverage that meets their family's needs. For example, consumers should have the option to purchase a single family policy, rather than being required to purchase individual policies for each family member. Allowing families to purchase a family policy could prevent consumers from having to worry about separate cost-sharing issues for each family member. And, for families with children not eligible for Medicaid or CHIP in need of private coverage—such as children being raised by grandparents that receive coverage through the Medicare program—states should ensure or promote the availability of comprehensive, affordable child-only policies for children under age 19.

Finally, consumers may not always be aware of their rights and obligations under federal and state law. To keep consumers informed, regulators should require insurers to provide adequate and timely notice of enrollment periods by including a prominent and continuous announcement of the enrollment periods on the insurer's website with a clear explanation that coverage is available on a guaranteed issue and guaranteed renewal basis. In addition, state and federal regulators, health insurance exchange staff, and consumer assistance programs should promote and explain the new guaranteed issue requirements and enrollment periods through consumer education and outreach activities that are accessible to diverse populations, young adults, individuals with disabilities, and individuals for whom English is not their first language, among others.

## Recommendations

To ensure that the protections of Sections 2702 and 2703 are fully enjoyed by all consumers, the consumer representatives to the NAIC make the following recommendations:

- Federal and state regulators should mandate an initial open enrollment period for the fully insured individual market outside of the exchange that lasts at least six-months and is consistent with the initial open enrollment period of the exchange from October 1, 2013 to March 31, 2014, to ensure that consumers have sufficient opportunity to enroll and make informed choices as they become aware of their new rights and obligations under the ACA.
- HHS should establish standardized annual open enrollment periods that apply to the fully insured individual market outside of the exchange in all 50 states and the District of Columbia and coincide with the annual open enrollment periods held by the exchange.
- In the absence of a federally designated open enrollment period, state regulators and lawmakers should set standardized open enrollment periods for the fully insured individual market outside of the exchange that is consistent with the annual open enrollment periods held by the exchange, easy for consumers to understand, and sufficiently long to allow consumers to enroll and make informed choices about their coverage.
- State regulators and lawmakers should establish a special enrollment period of at least 60 days from the date of a triggering event and extend the rules and protections related to special enrollment periods for qualified health plans to plans outside of the exchange.
- State regulators and lawmakers should require insurers to inform consumers about enrollment periods by including a prominent and continuous announcement of the enrollment periods on the insurer's website with a clear explanation that coverage is available on a guaranteed issue and guaranteed renewal basis.
- State and federal regulators, health insurance exchange staff, and consumer assistance programs should promote and explain the new guaranteed issue requirements and enrollment periods through consumer education and outreach activities that are accessible to diverse populations, young adults, individuals with disabilities, and individuals for whom English is not their first language, among others.
- State lawmakers should repeal minimum contribution and participation requirements in the small group market, which contradict Section 2702's promise of coverage on a guaranteed issue basis.
- State regulators and lawmakers should ensure that families can purchase a single family policy, rather than being required to purchase individual policies for each family member, to prevent families from having to worry about separate cost-sharing issues under multiple policies.
- State regulators and lawmakers should ensure or promote the availability of comprehensive, affordable child-only policies for children under the age of 19.



## Elimination of Preexisting Condition Exclusions

Almost half of all Americans may be affected by preexisting conditions, which can range from high blood pressure to asthma to cancer.<sup>13,14</sup> Fearing an increased risk of illness, insurers have historically denied or limited coverage for individuals with preexisting conditions to avoid the losses associated with costly medical care.<sup>15</sup>

Limiting or excluding coverage for individuals with preexisting conditions has resulted in a significant barrier to accessing care, particularly for those ineligible for public programs or without access to group health insurance through an employer.<sup>16</sup> To help eliminate this barrier, the ACA prohibits insurers from denying or limiting coverage for all individuals because of a preexisting condition effective January 1, 2014. For children under the age of 19, the ACA banned this practice effective September 23, 2010.<sup>17</sup>

The consumer representatives to the NAIC believe that the ban on preexisting condition exclusions is one of the ACA's most important protections. We make a number of recommendations to assist state and federal regulators and lawmakers in implementing this protection to ensure that coverage is readily accessible to consumers and meets the needs of those who rely on it the most.

### Background

Section 1201 of the ACA adds Section 2704 to the Public Health Service Act and applies to insurers offering individual or group coverage.<sup>18</sup> Section 2704 prohibits insurers from imposing any preexisting condition exclusions, as defined in federal law, with respect to plans or coverage.<sup>19</sup>

Under current state and federal law, most private health insurers can choose whether to provide health insurance—and how much coverage to provide—to individuals with a preexisting condition.<sup>20</sup> Thus, insurers commonly use medical underwriting when evaluating applications for coverage and for individuals with preexisting conditions they may deny coverage entirely, charge a higher premium, or exclude benefits for preexisting conditions.<sup>21</sup> For an individual who obtains a policy that does not cover the care necessary to treat a preexisting condition, the consequences can be devastating. For example, in today's market in most states, a 28-year old woman with a history of hypertension is likely to find that her insurer will refuse to pay for any care associated with her hypertension or resulting conditions and complications. Indeed, hypertension is the most commonly reported medical condition among adults that results in an insurer's refusal to issue or provide coverage.<sup>22</sup>

Although there are some existing limitations on preexisting condition exclusions in the small group market,<sup>23</sup> Section 2704 significantly expands the scope of these consumer protections.<sup>24</sup> First, Section 2704 helps ensure that individuals with preexisting conditions do not face delays in obtaining the type of coverage they need. Current federal law allows insurers in the small group market to exclude coverage for preexisting conditions for up to 12 months, or 18 months for late enrollees, with the ability to credit an individual's prior coverage against this period.<sup>25</sup> Because the ACA eliminates the use of these exclusions, consumers will be able to receive the benefits they need as soon as they obtain health insurance coverage, regardless of whether they had prior creditable coverage.

Second, Section 2704 dramatically increases protections in the individual market where federal law has not previously limited the use of preexisting condition exclusions. Under the ACA, insurers will be required to cover the full range of essential health benefits for all individual policyholders regardless of whether they have a preexisting condition. Although some states have capped the amount of time a policy can impose a preexisting condition exclusion, this practice is common in today's market and, between 2007 and 2010, more than one-third of those who attempted to buy coverage in the individual market—9 million people—were denied because of a preexisting condition, charged a higher price because of a preexisting condition, or had a specific health problem excluded from their coverage.<sup>26</sup>

Closely related to the ACA's ban on preexisting condition exclusions, Congress prohibited insurers from discriminating against individuals on the basis of health-status related factors.<sup>27</sup> These factors include health status, medical condition (both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability including conditions arising out of acts of domestic violence, disability, and any other health status-related factors determined appropriate by the federal government.<sup>28</sup> Enforcement of these non-discrimination requirements—and further designation of factors that may be proxies for health status such as credit information and family history—will be critical to ensuring that consumers can obtain coverage even if affected by a preexisting condition.

### Problems Consumers Might Encounter

Although the ACA ushers in significant new protections, consumers could face difficulty in obtaining health insurance coverage that fully meets their needs if these protections are undermined. Even though insurers are prohibited from limiting coverage based on preexisting conditions, insurers have access to a tremendous amount of information about an individual's health status long before an applicant is accepted for coverage,<sup>29</sup> and we are concerned that insurers could use this information to steer higher-risk enrollees towards or away from certain plans. For example, insurers can use various databases to review individuals' claims history, credit information, or other data that could be used as a proxy for health status and could identify would-be enrollees that have preexisting conditions.

If allowed to consider such information before issuing coverage, insurers could discourage high-risk individuals from enrollment. For example, if a consumer applies for coverage in 2014, an insurer might review her medical claims history and learn that she has a history of hypertension. Although not allowed to deny her coverage or exclude treatment for her condition from the policy, the insurer might then extend the period between when the consumer applies for coverage and when coverage is issued, thereby incentivizing her to look for a different source of coverage.

Allowing insurers to evaluate health status information or related information before an individual enrolls in coverage essentially sanctions continued discrimination against consumers with preexisting conditions, which is one of many industry practices that the ACA set out to eliminate. If insurers use this information to discourage individuals from enrolling, it could prevent consumers from obtaining the coverage of their choice and risk the possibility of adverse selection by continuing to divide sick consumers from the healthy. We strongly encourage states to prohibit insurers from unreasonably delaying the issuance of a policy and from collecting or requesting health information or other personal information before an individual is accepted for coverage. In doing so, states should broadly define the types of information to include personal information that relates to health status or that can be used as a proxy for health status including, but not limited to, claims history, family history, and credit information, among others. In addition, states should 1) prohibit insurers from acquiring or requesting information beyond what is included on the uniform enrollment form; and 2) extend the exchange's privacy protections and limitation on the collection of personal information to the markets outside of the exchanges.

### Recommendations

To ensure that Section 2704 is successfully implemented and benefits all consumers, the consumer representatives to the NAIC make the following recommendations:

- State regulators and lawmakers should prohibit insurers from unreasonably delaying the issuance of a policy.
- State regulators and lawmakers should prohibit insurers from collecting or requesting health information or other personal information beyond what is needed to apply allowable rating factors before an individual is accepted for coverage.
- State regulators and lawmakers should prohibit insurers from acquiring or requesting information beyond what is included on the uniform enrollment form and extend the exchange's privacy protections and limitation on the collection of personal information to the markets outside of the exchanges.

- State regulators and lawmakers should broadly define the types of information to include personal information that relates to health status or that can be used as a proxy for health status including, but not limited to, claims history, family history, and credit information, among others.
- Consistent with the ACA's nondiscrimination provisions, state regulators and lawmakers should prohibit insurers from discriminating against individuals on the basis of health-status related factors or factors that may be proxies for health status, such as credit information and family history.
- HHS should actively identify and prohibit the use of factors to determine eligibility that may be related to health status but are not reflected in the non-exhaustive list in Section 2705 of the Public Health Service Act.





## Rating Reforms

In most states, insurers are allowed to charge higher premiums to individuals in poor health or with risk factors for health problems.<sup>30,31</sup> For example, insurers can charge different premiums based on individual characteristics such as health history, gender, age, place of employment, area of residence, the use of health services, and credit history. When faced with high premiums, many individuals with preexisting conditions or other risk factors—those people who need coverage the most—often cannot afford to obtain health insurance and, thus, become uninsured.<sup>32</sup>

To prevent discrimination in the form of higher rates against individuals in poor health, the ACA prohibits insurers from varying premiums based on an individual's health status.<sup>33</sup> Under the ACA, insurers will be allowed to vary rates based solely on whether a policy covers an individual or a family; the geographic area within a state; age; and tobacco use.<sup>34</sup> These requirements will be effective January 1, 2014.

The consumer representatives to the NAIC strongly support these new rating standards, which are critical to ensuring that consumers, particularly those with preexisting conditions, have access to affordable coverage. We make a number of recommendations to assist state and federal regulators and lawmakers in implementing this important protection in a way that ensures that consumers do not face discrimination because of their health status.

### Background

Section 1201 of the ACA adds Section 2701 to the Public Health Service Act and allows insurers to vary rates based solely on an enrollee's family composition; geographic area; age; and tobacco use.<sup>35</sup> This provision applies to insurers offering coverage in the individual and small group markets.<sup>36</sup> This provision will also apply to fully insured non-grandfathered coverage in the large group market if a state allows large groups to purchase through the exchange as the ACA permits beginning in 2017.<sup>37</sup>

Under current state law, rate restrictions vary significantly by market. In the individual market, 32 states do not restrict how insurers can set rates for individuals, and only 7 states prohibit insurers from varying premiums based on health status.<sup>38</sup> In contrast, in the small group market, the majority of states—48 states and the District of Columbia—restrict how insurers can set rates, but only 12 states prohibit insurers from varying premiums based on health status.<sup>39</sup>

Because the majority of states allow insurers to set rates using health status and other factors, Section 2701 ushers in significant change by requiring insurers in the individual and small group markets to use adjusted community rating, with variation allowed for only four factors: family composition; geographic area; age; and tobacco use.<sup>40</sup> Section 2701 limits the allowable variation associated with age and tobacco use by prohibiting insurers from charging an older adult in the oldest age band more than 3 times the rate of a younger person in the youngest rate band and prohibiting insurers from charging tobacco users more than 1.5 times the rate of a non-tobacco user's rate.<sup>41</sup>

States and the NAIC may wish to establish age bands and geographic rating areas by the end of 2012 to provide insurers with adequate time to establish and submit rates for approval.<sup>42</sup> Section 2701 directs the Secretary of HHS to define permissible age bands in consultation with the NAIC.<sup>43</sup> Section 2701 also requires each state to establish rating areas subject to approval by the Secretary who will determine whether the rating areas are adequate.<sup>44</sup> If deemed inadequate, the Secretary may establish a state's rating areas.<sup>45</sup>

To ensure that consumers fully benefit from the new rating rules under Section 2701, states will need to establish robust and comprehensive rate review processes. Effective in 2010, the ACA required each state, or HHS on behalf of a state, to determine whether a proposed rate increase of 10 percent or more in the individual or small group market is actuarially justified.<sup>46</sup> Effective, robust rate review processes will be critical in 2014 as the ACA's broader market reforms go into effect.<sup>47</sup>

## Problems Consumers Might Encounter

The ACA will significantly change the way insurers set rates and could dramatically improve access to affordable health coverage for millions of Americans, particularly those with preexisting conditions. We make a number of recommendations regarding implementation of these rules and their enforcement through the rate review process.

*Rating Restrictions Should Be Meaningful.* States have significant flexibility in defining geographic areas. Under current law in most states, insurers may vary their rates by geographic area, such as zip code or county.<sup>48</sup> While geographic rating can account for the way that health care delivery costs vary in different areas, studies have suggested that this variation may not result solely from the underlying differences in costs.<sup>49,50</sup> State regulators will need to ensure that geographic rating cannot be used as a proxy for health status rating in less healthy communities, or be a mechanism for segmenting the risk pool based on geography.<sup>51</sup> For example, geographic rating, if not properly implemented, could make coverage less affordable for those that live in a poor area with a relatively unhealthy population.<sup>52</sup>

We recommend that states 1) commission studies to analyze the options for rating areas and, in particular, analyze the impact that different rating area options have on premiums in the individual and small group markets; and 2) limit variation of geographic area rating factors. Doing so could limit the effect of market segmentation and encourage insurers to negotiate lower prices from providers in high-cost areas while protecting consumers from the use of geographic rating as a proxy for experience rating.

In consulting with HHS on establishing permissible age bands, we recommend that the NAIC support the adoption of standardized, national age bands for both the individual and small group markets. In making its recommendations, the NAIC should consider the importance of ensuring that individuals and small businesses do not face large rate increases as they move from one age band to another, known as “cliffs” and the impact of age bands on affordability for younger and older Americans. In making a recommendation on age bands, the NAIC should ensure that there is consistency across both the individual and small group markets.

*States Should Consider Further Restricting the Use of Rating Factors.* The rating restrictions in Section 2701 are minimum requirements, and states should consider adopting rating restrictions that are more protective than these federal requirements. We believe that both HHS and states have the authority to establish an outside cap on the rating factors to further protect consumers, particularly older individuals, from being priced out of the health insurance market. In addition, while Section 2701 introduces new rating restrictions, the ACA allows employers to offer incentives to employees of up to 30 percent—and potentially 50 percent—of the cost of their coverage if they meet employer-defined health targets.<sup>53</sup> We are concerned about the possible use of wellness premium incentives as a mechanism to circumvent the ACA's prohibition on health status underwriting and penalize employees that are unable to meet health status targets. Indeed, there is evidence that some plans are charging higher premiums, deductibles, or other forms of cost-sharing to enrollees unable to meet certain health status targets.<sup>54</sup> To address this issue, the NAIC should engage consumers, insurers, and employers to develop wellness incentives that protect consumers from discrimination, are consistent with Section 2701, and provide rewards, rebates, or bonuses for participating in programs that effectively promote wellness, rather than penalize employees.

*States Should Avoid Risk Segmentation.* The consumer protections in the ACA could be undermined if insurers are allowed to segment risk by geographic area, population, or product. The ACA requires insurers to consider all enrollees in all of their plans in the individual and small group markets, respectively, to be members of a single risk pool and further allows states to merge their individual and small group markets.<sup>55</sup>

To avoid risk segmentation, we recommend that states ensure that the “single risk pool” requirement extends to all entities and products in the individual and small group markets, to the extent not already required under federal law. All products offered in the individual market, including association coverage, child-only coverage, non-grandfathered closed blocks, and catastrophic coverage, should be considered part of the same risk pool for rating purposes. This should be required at the holding company level so that carriers cannot set up subsidiaries to carve out healthier risks; if a state does not prohibit the use of subsidiaries, state regulators should refuse to license subsidiaries established solely to facilitate risk segmentation. Further, although fixed indemnity products are excepted benefits if structured appropriately, state regulators should actively monitor such plans to ensure that they comply with federal law. By prohibiting insurers from segmenting certain products, consumers will have access to more affordable coverage and can receive the full benefits promised under the ACA.

*States Should Strictly Enforce the ACA’s New Rating Rules Using Meaningful Rate Review Processes.* To help enforce the ACA’s new rating requirements, states will need to adapt their rate review process to, for example, ensure that insurers have not relied on any factors other than those permitted and that rate variation complies with federal requirements. Review of rates should be conducted before a rate is implemented, and all states should extend authority to their insurance department to disapprove rates that do not meet the new rating standards or are unreasonable, excessive, inadequate, or unfairly discriminatory. For states without prior approval authority over rates, we encourage states to grant the authority to review, approve, deny, and modify proposed rates and increases for all entities and in all markets, including the association market.

We also encourage states to look beyond these four factors in reviewing whether rates are justified and reasonable. Some states have used the rate review process to promote delivery system reform by, for example, requiring insurers to submit copies of contracts with providers as part of the rate review process or requiring providers to meet certain quality goals, such as a reduction in the rate of preventable hospital readmissions.<sup>56,57</sup> We recommend that states leverage their rate review authority to promote affordability, quality, and accessibility.

In addition, consumer input and engagement in rate review is critical to ensuring that the state has a transparent oversight process and that consumers are benefitting from the ACA’s protections. We are concerned that there is insufficient consumer input and engagement because consumers do not understand how rates are developed and because the rate review process in many states is inaccessible to consumers. For example, some states require a consumer to physically visit the insurance department to view a rate filing, and accessing the SERFF filing system can be extremely cumbersome for all but the most sophisticated as consumers and consumer advocacy organizations are unable to review and analyze rate filings based on the date the filing was submitted.

In our recommendations to states implementing rate review requirements in 2010, we emphasized the need to promote transparency by making all filings and accompanying documentation part of the public record; removing trade secret and other exceptions to disclosure; providing sufficient advance notice to policyholders to allow them to participate in or comment on rate filing processes; providing a well-publicized and meaningful process for consumers to participate in and provide input into rate reviews and hearings; and requiring insurers and the state to post rate filings online in easy-to-understand language; among other recommendations.<sup>58</sup> These recommendations remain true in 2012 and will be as, if not more, important in 2014.

## Recommendations

To ensure that Section 2701 is successfully implemented and benefits all consumers, the consumer representatives to the NAIC make the following recommendations:

- The NAIC should recommend to HHS that it adopt standardized, national age bands to implement the ACA’s age rating requirements and consider the importance of minimizing rate shocks and cliffs as well as the affordability of coverage for older and younger Americans when making recommendations to HHS.
- The NAIC should engage consumers, insurers, and employers to develop recommendations on wellness incentives that are neither discriminatory nor subterfuges for health status rating for those who do not or cannot meet specified health-status related targets.
- The NAIC, states, and HHS should establish age bands and geographic rating areas by the end of 2012 to provide insurers with adequate time to establish and submit rates for approval.
- State regulators should ensure that geographic rating is not used as a proxy for health status rating. To do so, regulators should, at a minimum:

- o Commission a study to analyze the potential options for rating areas and, in particular, the impact that different rating area options will have on premiums in the individual and small group markets; and
- o Impose rate bands on geographic area rating factors to limit wide premium variation within a state.
- State regulators should consider rating restrictions that are more protective than the requirements under Section 2701.
- State regulators should ensure that the single risk pool requirement of the ACA applies consistently to all products in the individual and small group markets to effectively prohibit insurers from segmenting the risk pool.
- State regulators should ensure that their rate review processes are robust ahead of new regulatory requirements in 2014. State regulators should, at a minimum:
  - o Enact prior approval authority over all insurance carriers in all markets, including the association market;
  - o Adapt rate review processes to ensure that insurers have not relied on any factors other than family size or composition, geographic area, age, and tobacco use and verify that rate variation from these four factors complies with federal requirements under Section 2701;
  - o Adopt additional requirements for determining whether rates are justified and reasonable, such as reviewing provider contracts and cost-containment goals, to leverage rate review authority to promote affordability, quality, and accessibility; and
  - o Promote meaningful consumer input and engagement in rate review through transparency, advance notice to consumers that their insurance company has filed a new rate or rate increase, a standardized and easy-to-understand process for consumer participation that allows any consumer or consumer advocacy organization to monitor all insurers' rate requests, and requirements that insurers and officials post understandable rate filings online that can be easily sorted by filing date and insurer.
- HHS should adopt standardized, national age bands to implement the ACA's age rating requirements and consider the importance of minimizing rate shocks and cliffs as well as the affordability of coverage for older and younger Americans.



## Definition of the Small Group Market

Small employers are least likely to offer health insurance coverage for employees.<sup>59</sup> Although small employers may have a number of reasons for not doing so, many are significantly concerned about the costs of coverage.<sup>60,61</sup>

To help improve the affordability of health insurance coverage for small groups as well as usher in additional consumer protections, the ACA adopts significant changes to the way the small group market is defined and regulated. These changes include increasing the number of employees defined as a small group from 50 to 100 employees and giving express federal permission for states to merge their individual and small group markets to establish a single risk pool.<sup>62</sup>

The consumer representatives to the NAIC strongly support these changes, which are critical to broadening the risk pool and ensuring that small employers and their employees have access to affordable coverage. We make a number of recommendations to state and federal policymakers to help ensure that the ACA's market reforms are implemented in a way that minimizes market disruption in the small group market and broadens the risk pool for small employers and their employees.

### Background

The ACA ushers in significant new protections for employers and employees in the small group market including, but not limited to, new medical loss ratio standards; state and federal rate review authority to improve the affordability of health insurance premiums; new rating requirements that prohibit the use of health status in setting rates; and a minimum essential health benefits package. The ACA also provides eligible small employers with premium tax credits to help make health coverage more affordable.<sup>63</sup> Here, we focus our recommendations on the ACA's definition of small employer and the opportunity to merge a state's individual and small group markets.

*Definition of Small Employer.* Section 1304 of the ACA defines a “small employer” as an employer with an average of at least one but not more than 100 employees during the preceding calendar year.<sup>64</sup> This requirement is effective on January 1, 2016.<sup>65</sup> Until then, Section 1304 allows states to define a small employer as an employer with no more than 50 employees, which is consistent with the definition of small employer established by HIPAA.<sup>66</sup>

Existing laws regarding the small group market often vary by state, product, and the size of the small employer. Consistent with federal law, most states—37 states and the District of Columbia—have defined a small employer as an employer with two to 50 employees.<sup>67</sup> Further, some states have separate regulatory rules, such as rating requirements, for smaller groups such as those with two to 25 employees.<sup>68</sup>

Effective in 2016, Section 1304 will eliminate this variation. By defining a small employer as an employer with one to 100 employees, Section 1304 is expected to significantly broaden each state's small group market and expand some state regulatory authority to include additional insurers and products.

*Merging the Individual and Small Group Market.* Section 1312 of the ACA expressly allows states to merge their individual and small group markets if the state finds doing so to be appropriate.<sup>69</sup> States can take this action at any time. Most states,

with a few exceptions such as Massachusetts, have maintained separate individual and small group markets.<sup>70</sup> However, a number of states have begun studying the effects of merging their markets and the feasibility of doing so ahead of 2014.<sup>71,72</sup> By merging the two markets, states can broaden their risk pool and build upon the ACA's requirement that each insurer consider all enrollees in all of its plans to be members of a single risk pool.<sup>73,74</sup>

## Problems Consumers Might Encounter

The ACA will significantly change the way the small group market is defined and regulated as well as extend new consumer protections to millions of Americans. To ensure that these new protections are as robust as possible, we make a number of recommendations regarding regulation of the small group market.

First, in making decisions about the small group market, states should conduct analysis and modeling to understand the effects of expanding the definition of small employer to 100 employees and merging the individual and small group markets. Data about these markets will be critical to understanding the effects that the ACA's new consumer protections will have on consumers as well as businesses with 51 to 100 employees. For example, studies have shown that merging the individual and small group markets is expected to result in significant decreases in premiums for those in the individual market, with slight increases in premiums for those in the small group market.<sup>75</sup> State regulators and lawmakers will want to consider these effects when making policy decisions that affect both markets.

Although the definition of small employer will increase to 100 employees in 2016 (with the option for states to act sooner to adopt this definition), states can take steps before then to minimize market disruption associated with this change. In particular, states may want to explore policies that can mitigate sudden increases in premiums for some employers, such as "rate shock" or a shift towards self-insurance by businesses with 51 to 100 employees. For example, states could apply their rate review authority, implement the 2014 rating restrictions, or mandate the coverage of essential health benefits to these employers ahead of 2016 and phase in application of the new rules to this group.

Second, we are particularly concerned that the ACA's new requirements could incentivize businesses with 51 to 100 employees to shift towards self-insurance, resulting in risk segmentation and adverse selection against the fully insured small group market. In response, states should be wary of efforts to escape these new consumer protections through loopholes such as low attachment point stop loss coverage, particularly for small employers who often lack sophisticated human resources departments. Federal and state regulators should actively monitor and regulate in response to shifts towards self-insurance among small businesses.<sup>76</sup>

Third, state policymakers should recognize that many consumers often transition between being employed by a small business, unemployed, or self-employed. To help meet the needs of consumers with changing life circumstances, state regulators and lawmakers should consider whether merging the individual and small group markets can enable smooth transitions between jobs or during life changes.

## Recommendations

The consumer representatives to the NAIC make the following recommendations to ensure that all small employers and their employees have access to the full protections of the ACA, to minimize market disruption, and to establish a broadened small group market:

- State regulators should conduct robust analysis and modeling to understand the effects of expanding the definition of small employer and merging the individual and small group markets.
- State regulators and lawmakers should explore and adopt policies prior to 2016 to minimize market disruption associated with changes to the definition of the small group market, such as rate shock or cliffs. States should consider, at a minimum, adopting a phased approach to applying new rules, such as rate review authority or the ACA's new rating restrictions, to businesses with 51 to 100 employees ahead of 2016.
- State regulators and lawmakers should consider whether broadening the definition of small employer ahead of 2016 or merging the individual and small group markets can facilitate smooth transitions for consumers as they move between jobs or experience life changes.
- State regulators should be wary of efforts to escape the ACA's new consumer protections for the small group market through loopholes, such as the use of low-attachment point stop loss coverage, and actively monitor shifts towards self-insurance in the small group market as well as subsequent effects on premiums.



## Limitation on Waiting Periods

Access to timely health insurance coverage—and the medical benefits it affords—can be critical for consumers, especially those with preexisting conditions. Yet, individuals with seeming access to coverage through an employer, for example, may be forced to wait before becoming eligible for coverage or obtaining benefits. Such a delay is common: in 2011, 72 percent of new employees were forced to wait before obtaining health insurance coverage from their employer.<sup>77</sup> For nearly one-third of covered workers, this delay lasted for 3 months or more.<sup>78</sup>

These waiting periods can discourage enrollment or result in burdensome and costly delays in obtaining coverage. To promote access to coverage more immediately, the ACA limits insurers from imposing excessive waiting periods of more than 90 days effective January 1, 2014.<sup>79</sup>

The consumer representatives to the NAIC believe that the ACA takes an important step forward in providing timely access to health insurance coverage for new employees, their families, and individuals. We make a number of recommendations to help ensure that consumers face as few burdens as possible in obtaining coverage and receive the full benefits of the ACA's new reforms.

### Background

Section 1201 of the ACA adds Section 2708 to the Public Health Service Act.<sup>80</sup> This provision limits insurers offering individual or group coverage from imposing waiting periods for coverage that exceed 90 days.<sup>81</sup> Such waiting periods—“the period that must pass ... before the individual is eligible to be covered for benefits”<sup>82</sup>—are typically applied by employers to delay the enrollment of new employees in a group health plan.

Current federal law allows employer-sponsored group insurers to impose a waiting period before coverage takes effect, and there are few restrictions on waiting periods under state law. Thus, employers have discretion in determining the length of their waiting period, which, for example, could last for 6 months or more. As noted above, nearly one-third of covered workers—29 percent—faced a waiting period of 3 months or more and 6 percent of workers were forced to wait for coverage for 4 months or more.<sup>83</sup> Although Section 2708 continues to allow employers to impose a waiting period, it limits these waiting periods to 90 days. Section 2708 also applies the limitation on excessive waiting periods to insurers offering coverage in the individual market.<sup>84</sup>

### Problems Consumers Might Encounter

While Section 2708 prohibits excessive waiting periods for individuals and groups, we believe that states can—and should—do more for consumers by promoting continuous coverage and prohibiting insurers from delaying enrollment of high-risk individuals in coverage.

Waiting periods disrupt the continuity of coverage, can discourage enrollment, and leave consumers more vulnerable to costs associated with medical care and maintaining other coverage.<sup>85</sup> Waiting periods—among other causes of coverage disruption such as preexisting condition exclusions—may also have economic consequences by reinforcing job-lock and discouraging business creation.<sup>86,87</sup> Although Section 2708 prohibits excessive waiting periods and defines such periods as those lasting more than 90 days, most new employees do not face waiting periods of such length, and states should further limit such periods.<sup>88</sup>

We are concerned that waiting periods, even after the ACA's new standards, could be used to discourage high-risk individuals from enrolling in a particular plan if insurers can attach waiting periods to specific benefits, such as chemotherapy or autism treatments. We caution that benefit-specific waiting periods—even where they apply to all individuals—would disproportionately affect individuals whose conditions existed before their coverage began and may violate nondiscrimination laws if targeted to a particular illness or disability.<sup>89</sup> To prevent insurers from applying waiting periods in a way that discriminates against individuals who need a certain type of benefit, we recommend that the federal and state regulators clarify that insurers cannot apply benefit-specific waiting periods and prohibit them from doing so.

## Recommendations

The consumer representatives to the NAIC make the following recommendations to minimize the burdens facing consumers caused by waiting periods so that they can receive the full benefits of the ACA's 2014 reforms:

- State regulators and lawmakers should consider eliminating waiting periods in the individual market and being more protective than the federal standard for fully insured group plans by limiting the use of waiting periods or further restricting these periods to 60 days or fewer.
- State regulators and lawmakers should prohibit insurers from imposing benefit-specific waiting periods (if allowed under federal rules) that could be used to discourage enrollment of high-risk individuals in certain plans.
- State regulators and lawmakers should impose an ongoing, affirmative obligation on insurers to review applications even when waiting periods apply so that individuals and employees are enrolled in coverage immediately following the end of the waiting period.
- HHS and its partner agencies should clarify that insurers cannot apply benefit-specific waiting periods because such waiting periods would disproportionately affect individuals whose conditions existed before their coverage began.





## Coverage for Participating in Approved Clinical Trials

While participating in a clinical trial can benefit an individual consumer through access to medical experts and treatment, the primary benefit of participation accrues to all Americans through the advancement of medical knowledge. Yet, participation in clinical trials is very low: fewer than five percent of cancer patients and only six percent of patients with severe chronic illnesses do so.<sup>90,91</sup> These low participation rates mean that research takes longer, costs more, and ultimately results in delays in the development of new therapies or a lag in evidence about the safety and effectiveness of existing therapies.

Lack of health insurance coverage for routine services is a significant barrier to patient participation in clinical trials. To encourage such participation, the ACA requires insurers to cover routine medical costs for individuals participating in approved clinical trials.<sup>92</sup> Thus, insurers must cover those costs that would otherwise be covered if an individual were not enrolled in a clinical trial.

The consumer representatives to the NAIC strongly support this important consumer protection because it removes a major obstacle to patient participation in clinical trials. This new requirement will help encourage and enable research that benefits not just individual patients but all of society.

### Background

Section 1201 of the ACA establishes Section 2709 of the Public Health Service Act.<sup>93</sup> Among other requirements, Section 2709 prohibits insurers from denying or limiting coverage of routine patient costs associated with a qualified individual's participation in an approved clinical trial for the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions.<sup>94</sup> This requirement applies to all insurers offering non-grandfathered individual or group health insurance plans.<sup>95</sup>

Even for insured patients, the costs of routine care associated with participation in a clinical trial can be excluded from coverage, thereby preventing an individual from participating in a study they might otherwise be eligible for.<sup>96</sup> Although some states address coverage for clinical trials, current laws vary by disease and the extent of coverage.<sup>97</sup> For example, in 2010, 29 states and the District of Columbia had laws mandating coverage for costs associated with participation in clinical trials for cancer.<sup>98</sup> Other states have agreements that provide coverage of a limited patient population such as children or voluntary agreements with insurers to provide clinical trials coverage.<sup>99</sup> And still other states do not address the coverage of clinical trials for cancer or other diseases or conditions.<sup>100</sup>

Section 2709 establishes minimum requirements for the coverage of clinical trials so that consumers in all 50 states and the District of Columbia have access to routine patient costs associated with participation in clinical trials. Because Section 2709 sets a minimum floor, states can retain or adopt additional requirements that exceed the federal requirements.<sup>101</sup>

## Problems Consumers Might Encounter

The denial of access to clinical trials is a significant barrier for patients in accessing new therapies and promoting vital research.<sup>102,103</sup> The ACA has the potential to increase participation in clinical trials and spur the development and study of new and existing therapies. In implementing this new consumer protection, we make a number of recommendations to state and federal policymakers.

First, Section 2709 defines a “life-threatening condition” as “any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.”<sup>104</sup> We believe that this definition should be interpreted broadly so that as many patients as possible may benefit from this protection—and so that our society can also realize the maximum impact of research advances.<sup>105</sup> We strongly encourage HHS and states to provide a greater degree of protection to consumers by defining “life-threatening condition” to encompass the many diseases and conditions that can and do result in death if not treated. In particular, states should clarify that this definition includes conditions which may not be immediately life-threatening but could become so if not treated and are worthy of encouraging participation in clinical research, such as coronary heart disease, multiple sclerosis, and stroke, among others.

Further, in interpreting the definition of “life-threatening condition,” HHS and states should ensure that the definition does not thwart patients’ access to this important consumer protection. Given the degree of variation in how a disease can manifest in specific patients, the ultimate determination of whether a particular disease is life-threatening to a specific patient if not treated is best made by the patient’s health care professional, as envisioned under Section 2709(b)(2).

Second, HHS and states should make it clear that qualifying individuals may go out of network to participate in an approved trial if there is not a participating provider for their trial in their health plan’s network that is willing to accept them. We believe that Section 2709(a)(4) of the ACA intends for qualified individuals to be able to participate in an approved clinical trial even when the enrolling health care professional is not a participating provider in their health plan’s network, particularly if there is not a provider for the qualified individual’s trial participating in their plan’s network and willing to accept them.

The ability to participate in an approved clinical trial out of network is particularly important in rural areas where patients may not have access to academic medical centers and the health care professionals most likely to be conducting medical research. According to the Center for Information & Study on Clinical Research Participation, fewer than four percent of all U.S. physicians participate in clinical trials.<sup>106</sup> The likelihood is therefore high that patients will lack meaningful access to approved clinical trials unless they have the ability to go out of network to participate.

Third, Section 2709 defines “routine patient costs” to include “all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.”<sup>107</sup> We are concerned that, without further elaboration, this definition could result in uncertainty and confusion about what should and should not be covered in some circumstances. Even patients with health insurance that covers routine costs associated with clinical trials often have difficulty getting coverage for some routine expenses, most notably when they experience a complication from their illness or need frequent tests for the monitoring of their condition.

To avoid this uncertainty and confusion, we recommend that HHS and states adopt the Medicare definition of “routine costs,” which is consistent with the ACA’s definition but provides greater clarity. This definition states: “Routine costs in clinical trials include items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service in particular, for the diagnosis or treatment of complications.”<sup>108</sup>

## Recommendations

To ensure that Section 2709 is successfully implemented, the consumer representatives to the NAIC make the following recommendations:

- HHS and state regulators and lawmakers should define “life-threatening condition” to encompass diseases and conditions that may not be immediately life-threatening but could result in death if not treated, such as coronary heart disease, multiple sclerosis, and stroke, among others. Defining this term broadly will allow as many patients as possible to benefit from this protection and ensure that society can realize the maximum impact of research advances.
- HHS and state regulators and lawmakers should further define and interpret the definition of “life-threatening condition” to allow a patient’s health care professional to make the ultimate determination of whether a particular disease is life-threatening to a specific patient if not treated.
- HHS and state regulators and lawmakers should clarify that qualifying individuals are permitted to go out of network to participate in an approved trial if there is not a participating provider for their trial in their health plan’s network that is willing to accept them.
- HHS and state regulators and lawmakers should adopt the Medicare definition of “routine patient costs” to avoid uncertainty and confusion about what an insurer must cover.



## Essential Health Benefits, Including State-Mandated Benefits

Comprehensive health coverage is critical to ensuring that consumers have access to the medical and preventive health services necessary to live healthy lives. Without comprehensive coverage—which includes benefits as basic as ambulatory care and prescription drug coverage—millions of Americans are forced to pay costly medical bills or forgo services that they believed were covered at the moment they need coverage the most.<sup>109,110,111</sup>

While some stakeholders criticize mandated health benefits because of their perceived role in driving up the cost of health care, others argue in favor of the broadest coverage possible.<sup>112</sup> In striking a balance between these views and recognizing the need to guarantee basic health protections for all Americans, the ACA established a minimum set of coverage requirements that includes ten broad categories of medical benefits, limits on cost-sharing, and a minimum value of coverage.<sup>113</sup> Effective January 1, 2014, insurers will be required to cover this “essential health benefits” package for all consumers purchasing coverage as individuals or through a small business.<sup>114</sup>

The essential health benefits package has the potential to transform the adequacy of health insurance coverage and is expected to be included in the coverage of up to 68 million Americans by 2016.<sup>115</sup> The consumer representatives to the NAIC strongly support the adoption of a comprehensive set of essential health benefits that strikes a balance between protection for our most vulnerable populations, including those with chronic diseases and disabilities, and the cost of coverage. We make a number of recommendations to help ensure that state and federal policymakers implement this critical consumer protection in a way that provides meaningful coverage for millions of Americans across the country.

### Background

Section 1302 of the ACA requires insurers offering health insurance to individuals or small businesses to provide coverage that includes—at a minimum—ten categories of defined benefits.<sup>116</sup> In addition, the ACA prohibits insurers in the self-insured and fully-insured individual and group markets from imposing lifetime and annual limits on the dollar value of essential health benefits.<sup>117</sup> The ten categories of essential health benefits are:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.<sup>118</sup>

Although many health insurance policies currently include some of these benefits, these plans are regulated by each state and coverage typically varies in scope, by market, and by state.<sup>119</sup> In establishing the nation's first federal benefits standard, Congress set out to establish a minimum floor of comprehensive benefits, allow consumers to easily compare plans, and improve the quality of coverage nationwide while giving states the flexibility to require coverage that exceeds that mandated by Section 1302(b).

Following the release of reports from the U.S. Department of Labor and the Institute of Medicine,<sup>120,121</sup> HHS released federal guidance indicating its intent to allow each state to select an existing health insurance plan as its “benchmark” for the individual and small group markets.<sup>122</sup> This “benchmark plan”—which must be chosen from among ten plans in each state, as specified by HHS in its guidance—will serve as a reference point for the state's essential health benefits package.<sup>123</sup> If a state fails to identify a benchmark plan by the third quarter of 2012, the state's benchmark plan will be the largest plan based on enrollment in the largest product in the state's small group market.<sup>124</sup> Recognizing that some benchmark plans may not include coverage for all ten categories of benefits required by Section 1302(b), HHS will require states to supplement their benchmark plan using benefits from other benchmark options.<sup>125</sup> The benchmark approach will be evaluated and possibly revisited by HHS in 2016.<sup>126</sup>

Since issuing this bulletin, HHS released additional guidance on the largest three small group market products by state, a series of frequently asked questions, and a final rule on data collection standards to support the definition of essential health benefits.<sup>127,128,129</sup> In its frequently asked questions guidance, HHS indicated that insurers would be permitted to impose non-dollar limits, such as a cap on the number of visits to a physician, that are actuarially equivalent to annual dollar limits under current state law.<sup>130</sup>

Although Section 1302(b) requires coverage of ten general categories of benefits, many states have mandated benefits in the markets they regulate that are not specified in this part of the ACA and may exceed its essential health benefits minimum standards. Mandates can vary significantly between states and range from requiring coverage for basic health services—such as childhood immunizations, screening for colorectal cancer, and diabetes—to benefits that are important but likely to be used by fewer individuals in a given population—such as infertility treatment. By allowing states to choose an existing small group market plan as their benchmark plan, HHS provided states with a way to incorporate many, if not all, of the state's current benefit mandates.<sup>131,132</sup> Because Section 1302(b) sets a minimum federal floor of benefits rather than a ceiling, a state's choice of a benchmark plan does not preclude a state from mandating additional benefits that can help meet the specific needs of the state's population. However, Section 1311(d)(3)(B) of the ACA requires states to pay the costs associated with these benefits for individuals enrolled in qualified health plans sold through the exchange.<sup>133</sup> To date, HHS has not yet indicated how it will calculate or assess the cost of such benefits.

## Problems Consumers Might Encounter

The ACA has the potential to significantly improve the coverage available to millions of Americans by requiring the coverage of essential health benefits. However, the importance of this protection—and the expanded access to critical health services that it provides—may not be realized if state and federal policymakers fail to adopt essential health benefits standards that fully protect consumers. We have a number of concerns related to the adoption of essential health benefits that are chiefly related to ensuring that each state's benchmark plan is comprehensive, non-discriminatory, and transparent.

*Comprehensive Coverage is Critical.* Comprehensive coverage is key to ensuring that consumers receive needed medical care and avoid burdensome medical costs.<sup>134</sup> Because every consumer has different health needs that can change at any moment, coverage must be sufficiently comprehensive to ensure that consumers are protected regardless of their health status. To this end, state policymakers must ensure that the benchmark plan they choose will provide consumers with robust, high-quality coverage.

State policymakers must balance the protection of vulnerable populations with affordability. We recommend that HHS adopt a *de minimis* approach to determining how much a state must pay for benefits that exceed the benchmark plan. Under this approach, HHS would clearly define the threshold of costs that states must pay for any state-mandated benefits that exceed the essential health benefits and permit states not to pay when the costs of a benefit do not reach the threshold. In assessing these costs, we further recommend that HHS adopt a marginal cost analysis approach, rather than an absolute cost approach. A marginal cost analysis approach should be evidence-based and include savings associated with reduced acute and long-term care costs (e.g., reduced hospital admissions or special education costs) as well as societal costs unrelated to health insurance, such as reduced absenteeism and lower school drop-out rates.

*Essential Health Benefits Requirements Must Be Standardized and Easily Enforceable By Regulators.* Consumers will suffer if insurers are granted significant discretion in defining the scope of essential health benefits. In its proposed regulatory approach, HHS indicated that it intends to grant insurers “benefit design flexibility.”<sup>135</sup> This flexibility would allow insurers to adjust both the scope and limits of benefits covered in a way that is “substantially equal” to the benefits of the benchmark plan.<sup>136</sup> Insurers could do so by making substitutions within and, potentially, across benefit categories so long as substitutions are actuarially equivalent.<sup>137</sup>

Such substitutions would allow some insurers to undermine the essential health benefits package. These “substitutions” could be used to conduct “back-door underwriting” by encouraging the enrollment of healthy enrollees at the expense of less healthy consumers who may need a more comprehensive benefit package. For these reasons, while we believe some innovation in benefit design can help consumers by, for example, reducing or eliminating cost-sharing for high value services, we are concerned that allowing substitution of critical benefits will enable insurers to structure their benefits in ways that discriminate against high-risk consumers, such as those with chronic conditions and disabilities. For example, under HHS’ proposed approach, an insurer could choose to dramatically reduce its benefits for rehabilitative and habilitative services and devices—which are disproportionately used by those with disabilities—but increase its benefits for other services that may be less likely to be utilized by the consumer and, thus, less costly to the insurer. Even if actuarially equivalent, allowing insurers to make substitutions could discriminate against high-risk consumers—precisely the type of practice the ACA set out to eliminate.

For these reasons, we object to the use of substitutions that will degrade the value of a minimum standard of mandated benefits; hinder consumer understanding and the ability to make apples-to-apples comparisons among plans; and enable insurers to design plans that fail to provide essential services for some enrollees. In the event that HHS allows insurers to make such substitutions, state policymakers should 1) ban or restrict the use of substitutions both within and among benefit categories; and 2) subject benefit substitutions to a heightened level of regulatory scrutiny to ensure that any substitutions do not result in the elimination or limitation of important services or benefits.

State insurance commissioners should also be wary of allowing insurers to vary plans significantly from a state’s essential health benefits benchmark. If such variation is permitted, regulators will need to conduct additional analysis (and likely invest in greater actuarial resources) to determine whether plans are in compliance with the ACA’s essential health benefits requirements. State insurance commissioners should ensure that they have sufficient capacity to make the detailed actuarial equivalence determinations and market conduct reviews necessary to ensure that insurers are complying with Section 1302(b).

We further object to HHS’ proposed approach of granting plans the discretion to decide which habilitative services to cover if a benchmark plan does not include such coverage and the limits this approach imposes on access to prescription drugs and pediatric benefits. Even if such an approach were adopted on a transitional basis, consumers that rely on critical habilitative services could see a reduction in their existing level of benefits or receive fewer benefits than they had expected to gain under the ACA. To ensure that essential health benefits are meaningful for the consumers that rely on habilitative services, HHS should require such services to be offered at parity with rehabilitative services. In the event that HHS allows insurers to define the scope of habilitative services, state policymakers should formally define habilitative services to include the maintenance of function. A clear definition could significantly reduce the existing administrative burden faced by insurers and consumers when adjudicating the scope of habilitative services and afford consumers, particularly those with disabilities, with the meaningful coverage promised under Section 1302(b).

In addition, HHS’ proposed approach limits access to comprehensive prescription drug coverage by requiring insurers to offer only one drug in each category or class covered in the benchmark plan.<sup>138</sup> This one drug per class requirement will likely result in limited access to critical treatments, particularly for consumers with complex health needs. We recommend that HHS amend its approach to reflect existing prescription drug coverage which is far more comprehensive than one drug per class.<sup>139</sup>

We also believe that HHS’ guidance has not required adequate coverage for pediatric benefits as Section 1302(b) intended. While HHS’ intended approach is focused on pediatric oral and vision benefits, Section 1302(b) lists a requirement for “pediatric services, *including* oral and vision care” (emphasis added) and strongly suggests that the coverage of pediatric benefits not be limited to oral and vision care alone. Thus, we recommend that HHS require insurers to cover full pediatric benefits, including services such as speech therapy and durable medical equipment designed for children, in addition to pediatric oral and vision care.

*Coverage Must Be Transparent.* Each state's essential health benefits package must work for consumers by being easy to understand and not unduly complicated. At a minimum, consumers should be able to understand barriers to care such as exclusions and limitations that prevent them from accessing necessary care when needed.<sup>140</sup> To this end, state regulators should ensure that plan materials are not misleading, include clear labels, and use easy-to-understand disclosures about what is—and what is not—covered. This will be particularly critical if insurers can make substitutions on a year-to-year basis because a consumer's coverage could be changed, potentially dramatically, from one year to the next. For example, HHS' experience with the Medicare Part D program suggests that consumers would like to stay with the health plan they initially select but—due to the fact that health plans make frequent changes to the benefit design and costs—coverage can be altered significantly from the plan originally purchased and, in many cases, may no longer meet the needs of the consumer.

In addition, states should adopt a public, transparent process to set the state's essential health benefits benchmark plan. Among other benefits, doing so would help state policymakers avoid selecting a benchmark plan that contains discriminatory benefit exclusions or limits and—where such exclusions or limits exist—clearly identify and disclose this information to consumers. Exclusions or limits, particularly those related to certain health conditions, can shock consumers who learn that the coverage they relied on may not protect them from potentially devastating medical costs. To ensure that consumers are protected by the state's choice of a benchmark plan, states should adopt a public process to closely scrutinize benchmark options and any allowable conversions to non-dollar limits to ensure they do not circumvent meaningful coverage through benefit exclusions or limits.

State policymakers should also minimize the complexity that consumers will face in purchasing coverage that qualifies for tax subsidies in the exchanges established under the ACA. For example, all qualified health plans must cover pediatric dental benefits. Because qualified dental plans can be offered on the exchange as free-standing plans,<sup>141</sup> we are concerned that insurers offering qualified health plans on the exchange may try to eliminate pediatric dental coverage from their plans and force consumers to obtain a free-standing qualified dental plan to meet this essential health benefit requirement. Forcing consumers to obtain two types of coverage—whether through separate pediatric dental coverage or benefit riders—could generate significant consumer confusion and hinder their ability to easily compare plans.

We support an essential health benefits package that minimizes confusion faced by consumers, regulators, and insurers. By eliminating needless complexity, consumers can make apples-to-apples comparisons and force insurers to begin to compete on cost and quality on a level playing field rather than benefit design.

## Recommendations

To ensure that each state's essential health benefits benchmark plan is comprehensive, non-discriminatory, and transparent, the consumer representatives to the NAIC make the following recommendations:

- HHS should prohibit the use of all benefit substitutions, both within and among benefit categories, and clarify that states can decide to prohibit or restrict such substitutions.
- HHS should require insurers to offer habilitative services at parity with rehabilitative services, offer more than one drug in a certain category or class, and cover broad pediatric benefits instead of only pediatric oral and vision care.
- HHS should adopt a *de minimis* approach to determining how much a state must pay for benefits that exceed the benchmark plan and clearly define the threshold of costs where states must pay for their state-mandated benefits. In other words, if a mandated benefit adds only a *de minimis* amount to the premium, the state should not be required to defray that additional amount. In assessing the costs of mandated benefits, HHS should adopt a marginal cost analysis approach that is evidence-based and reflective of savings associated with reduced use of acute and long-term care services as well as other societal benefits.
- State regulators and lawmakers should adopt a public, transparent process to establish the state's essential health benefits benchmark plan. At a minimum, states should:
  - Identify potential benchmark plan options and release detailed plan information (including information about coverage exclusions and limitations) for consideration by the public;
  - Provide meaningful opportunities for public comment and discussion regarding the benchmark plan;
  - Consider the public comments when choosing the benchmark plan;
  - Scrutinize benchmark options and any allowable conversions from dollar limits to non-dollar limits, such as visit limits, to ensure they do not circumvent meaningful coverage through benefit exclusions or limits;

- o Compare the coverage provided in the benchmark plan options to existing coverage in the state to ensure that the choice of benchmark does not undermine benefits consumers need; and
- o Inform the public about how they considered the factors required by statute in adopting a benchmark plan, such as ensuring that the essential health benefits package reflects an appropriate balance among the ten categories and accounts for the health needs of diverse segments of the population.
- State regulators and lawmakers should set essential health benefits standards that reflect existing state-mandated benefits and are more protective than federal requirements by, at a minimum:
  - o Prohibiting or limiting the use of benefit substitutions (if allowed under federal rules) both within and among benefit categories;
  - o Subjecting benefit substitutions (if allowed under federal rules) to a heightened level of regulatory scrutiny to ensure they do not result in the elimination or limitation of important services or benefits by, for example, disallowing variation in certain types of benefits or categories, specifying certain allowable benefit-related substitutions and prohibiting any others, or creating a benefit standard that is consistent across all tiers or across all plans within a tier;
  - o Enabling consumers to make simple comparisons about their coverage options;
  - o Ensuring that state regulators have sufficient capacity to make the detailed actuarial equivalence determinations and market conduct reviews necessary to ensure that insurers are complying with federal requirements;
  - o Using prior approval rate and form review authority to evaluate actuarial equivalence for benefit substitutions and non-dollar limits, such as visit limits, and savings generated by benefit substitutions made by insurers; and
  - o Defining habilitative services to include the maintenance of function.





## Actuarial Value, Limitations on Cost-Sharing, and Catastrophic Coverage

In focus groups exploring consumers' attitudes towards health insurance, people report they do not want the lowest cost plan, they want the best value plan they can afford. They are clear: value is the amount of coverage they are getting for their premium dollar. However, with few tools to understand what benefits are covered and how much coverage is provided, consumers are currently limited in their ability to make meaningful value comparisons among plans.<sup>142</sup>

To increase access to comprehensive coverage that meets minimum standards, the ACA requires coverage sold in the individual and small group markets to cover ten broad categories of medical benefits, include limits on the cost-sharing consumers face under the plan, and achieve actuarial value targets related to cost-sharing charges.<sup>143</sup> These requirements go into effect January 1, 2014.<sup>144</sup>

We strongly support the use of robust measures of actuarial value as well as the adoption of consumer-friendly methods to communicate the actuarial values of plans and their significance to consumers. We make a number of recommendations to help ensure that the metal tiers and the actuarial value calculations used to categorize plans allow consumers to understand their options, make apples-to-apples comparisons based on the true value of coverage, and ensure that plans meet minimum value standards.

### Background

Actuarial value (AV) is the average share of medical spending paid by an insurance plan for a defined set of covered services across a standard population of consumers that includes the healthy and sick.<sup>145</sup> Beginning in 2014, Section 1302 of the ACA requires insurers in the small group and individual market to align their coverage so it conforms to one of four metal tiers—bronze, silver, gold, and platinum—ranging in AV from 60 to 90 percent.<sup>146</sup> The ACA also applies the concept of AV to the determination of the federally financed cost-sharing reductions and tax credits that people with low and moderate incomes can use to afford coverage in the exchange as well as to the test of whether an employer's offer of coverage is of sufficient value to prevent employees from accessing subsidized coverage through an exchange.<sup>147</sup>

In addition to the four metal tiers, the ACA creates a “catastrophic” health plan open only to individuals who are under the age of 30 or exempt from the requirements to have health insurance because they cannot procure affordable coverage or have experienced a hardship.<sup>148</sup> Catastrophic plans are required to have a high deductible (likely more than \$6,000), will be significantly less comprehensive than the coverage in the metal tiers, and will not qualify for use with federal premium and cost-sharing subsidies.

Further, the ACA establishes annual limits on out-of-pocket spending for plans in the individual and group markets whether sold inside or outside the exchange.<sup>149</sup> These limits cap how much an individual or family must pay in cost-sharing charges (including deductibles, copayments, and co-insurance) under their plans each year. Because the limits apply to all group plans (including those not required to cover the essential health benefits package), the ACA provides an important new protection for consumers facing high-cost health problems. The limit on annual out-of-pocket costs in 2014 will be set at the level

established that year for high-deductible health plans that qualify as health savings accounts under federal tax rules (HSA-HDHPs) and will be indexed to the change in the cost of health insurance after 2014.<sup>150</sup> In 2013, these limits are set at \$6,250 for individuals and \$12,500 for families.<sup>151</sup> These limits are set even lower for low-income individuals and families eligible for federally financed cost-sharing reductions; their out-of-pocket limits may be as low as one-third of the maximum out-of-pocket limits for HSA-HDHPs.<sup>152,153</sup> A plan's out-of-pocket limit is incorporated into the calculation of its AV.

AV—and the coverage levels represented by each metal tier—are intended to set standards for plan value and help consumers compare health plans.<sup>154</sup> Testing shows that the “metal tiers” will help millions of consumers understand the value of their coverage and more easily navigate their health plan choices.<sup>155</sup> In addition to the metal tier designations in the individual and small group markets, all employer health plans must disclose whether the plan covers at least 60 percent of total allowed costs, referred to as the minimum value calculation.<sup>156</sup> The Internal Revenue Service put forth the proposed rules for determining the minimum value of employer plans.<sup>157</sup>

In releasing federal guidance indicating its proposed methodology for calculating AV, HHS has proposed to:

- Develop a dynamic, publicly available AV calculator for plans to use that would produce an estimate of AV after inputting cost-sharing parameters;
- Develop a national standard population—using national claims data that reflects standard unit prices and utilization patterns—but allow states to develop their own standard populations using state claims data or modify the national standard population using sound actuarial practices;
- Develop at least three geographic pricing tiers, with each state assigned to one of these tiers, to allow adjustments for geographic pricing differences;
- Adopt a *de minimis* variation of +/- 2 percentage points in AV; and
- Allow insurers to vary the cost-sharing structures in their plans so long as each plan's AV meets the requirements of one of the four metal tiers.<sup>158</sup>

States are not required to take action to implement the ACA's AV requirements: if a state does not act, insurers will be required to use one of the methods established by HHS to determine the AV of their products, and otherwise conform to federal rules as they relate to AV. However, states may choose to adopt their own AV methodology for a number of reasons:

- Under federal guidelines, states may substitute their own standard populations using state claims data or calibrate the national standard population using sound actuarial practices to make the AV estimates more closely aligned with utilization patterns in their state.
- Regulators may find that having a standard estimate of AV is a useful tool when trying to improve the functioning of the state insurance markets and striving to improve consumer understanding of insurance products.
- Regulators, as part of the essential health benefits standards, may have to oversee determinations of “actuarial equivalence” of multiple benefit plan designs when insurers deviate from the state-specific essential health benefits benchmark plan.<sup>159</sup>

## Problems Consumers Might Encounter

By using a common calculator to provide consumers with a uniform measure of a plan's value, the ACA has the potential to significantly improve the way consumers understand and purchase health insurance. However, the importance of AV may not be realized if state and federal policymakers fail to adopt robust, reliable methods of calculating AV. Regulators and insurers must also ensure that consumers can use this information to compare plans. We make a number of recommendations regarding the ways that AV will be calculated and how such information will be communicated to consumers.

*Consumers Deserve Robust, Comparable Measures of AV.* The methodology that HHS and states adopt to calculate each plan's AV will have tremendous consequences for consumers seeking comprehensive coverage and reliable, comparable measures of plan value. In comments to HHS, we encouraged federal policymakers to develop methodologies that are both robust and accurate. These recommendations are also relevant for states that develop their own calculator or standard population.

Precise AV estimates are necessary because small changes in the AV may reflect significantly higher out-of-pocket costs for consumers—particularly those with health problems such as chronic diseases or disabilities—due to differences in cost-sharing. Consumers should be made aware of even small changes in AV, which could signal the need to further investigate a plan's benefit design.

To ensure that AV calculations are as accurate as possible, policymakers should define the key parts of the calculation—such as the standard population and the scope of medical services—in a way that mimics real-world markets and enables AV and the metal tiers to serve as a reliable indicator for comparing health plans. Furthermore, HHS and state regulators should use a micro-simulation modeling approach to estimate AV, as it is more sophisticated and flexible than a rate book approach.<sup>160</sup> Today's health insurance designs are complex, particularly “innovative” plan designs, and an AV calculator must faithfully capture the overall coverage offered by the large majority of plan designs sold in the market. At a minimum, the calculator should be able to accept dollar-denominated cost-sharing (such as deductibles) but also visit limits and other types of inside limits that raise costs for consumers, particularly if HHS allows insurers to make substitutions within or among categories of essential health benefits (which we do not recommend). Indeed, the flexibility allowed under HHS' intended approach for defining the essential health benefits suggests that the AV will be far less useful for consumers because the essential health benefits package will vary across states and even plans.<sup>161</sup>

Further, the claims data underlying the model must be robust. The claims data should reflect the cost and utilization patterns of a large population enrolled in a generous plan and include significant service level detail so that most plan provisions—such as copays that vary by service—can be modeled. Service-level detail should include the ten categories of essential health benefits and sub-categories that commonly attract differential cost-sharing provisions such as prescription drug tiers. Finally, claims data must accurately reflect the market's average health risk, including high-cost patients.

If state level claims data is used, it must be at least as robust as the national data in terms of the number of records, timeliness, diversity and scope of claims (including over-sampling of high-cost claims), and service level detail. States must be prepared to demonstrate that their data meets federal requirements. States should also use estimation software that is at least as robust as the HHS calculator to ensure that estimates allow for meaningful comparisons of AV levels and benefit designs by consumers.

*Metal Tiers and AV Must Be Easy for Consumers to Understand.* The ACA was designed to improve transparency, and the metal tiers play a central role in helping consumers understand the relative amount of coverage they might receive under their health plan options. Though AV does not provide a complete picture and will not be the sole measure that consumers rely on, it will be an important tool to help consumers navigate their health insurance choices and meets a key need expressed by consumers, the desire to understand overall plan value.

We strongly support the use of consumer testing to better understand how to display a plan's AV and metal tier in a way that is most meaningful to consumers. We also recommend that regulators require insurers to display the plan's actual AV in addition to the metal tier. Seeing a plan's actual AV estimate, especially in light of the proposal for *de minimis* variation allowed, could signal to consumers to look for differences among plan benefit design that could have significant implications for their health needs. This will be particularly important if the plans appear to otherwise be comparable, with similar premiums or deductibles. HHS and states should also consider the possibility of providing additional decision support tools to help consumers choose among plans.

In addition, we recommend that state regulators ensure that consumers are informed about the federal subsidies, the availability of Medicaid, and the high up-front costs associated with catastrophic plans. While the catastrophic plan offered under the ACA may be the lowest-premium option for some individuals, particularly young adults, consumers may not realize the high out-of-pocket costs associated with these plans if a person experiences health problems. In addition, many young adults may be eligible for subsidies that will help them enroll in more comprehensive coverage at a similar cost<sup>162</sup> or coverage under expanded Medicaid programs.

*States Should Consider Further Standardization and Uniform Market Rules, Especially for Catastrophic Coverage.* To provide further assistance to consumers trying to navigate their health plan choices, policymakers could consider further standardization of the benefit design. For example, within their exchange, Massachusetts required plan cost-sharing requirements to be standardized to specific benchmark designs.<sup>163</sup> These designs were the result of significant consumer testing, reflecting the fact that consumers preferred more standardization and found it difficult to compare differences in cost-sharing even among plans within the same metal tier.<sup>164</sup>

In addition, state regulators and lawmakers should ensure that there is a level playing field by adopting market rules that are as uniform as possible inside and outside the exchange. We are concerned that some insurers may try to lure healthier populations away from the exchange by, for example, aggressively marketing catastrophic coverage to young adults outside

of the exchange. This would prevent these individuals from using a federal subsidy for coverage and could lure away this relatively healthy population from the broader exchange risk pool. States should, at a minimum, require insurers to follow the same rules inside and outside the exchange as well as consider 1) whether insurers should be required to offer the same plans inside and outside the exchange and 2) whether insurers should be allowed to sell catastrophic coverage only through the exchange. These measures could help ensure that risk is pooled across both markets and prevent individuals—particularly young adults—from being segregated from the broader exchange risk pool.

## Recommendations

To ensure that consumers have access to robust, precise, and comparable measures of AV, the consumer representatives to the NAIC make the following recommendations:

- Whether using the HHS calculator or a calculator modified to reflect the state, AV should be calculated using a robust microsimulation model, sophisticated enough to model the large majority of cost-sharing provisions in the large majority of plans sold on the market. These provisions include not only medical deductibles, coinsurance and out-of-pocket maximums, but also cost-sharing for services that are “carved out,” like prescription drug benefits or mental health and other service-specific cost-sharing such as copays, per admission deductibles, and tiered drug pricing, among others.
- If a plan has unique cost-sharing or other design features that cannot be easily measured using the HHS or state AV calculator, HHS and state regulators should require an independent actuary to certify that unique plan designs fit the model appropriately and make the resulting analysis available to the public.
- To ensure that the metal tiers and AV measurements are meaningful and easy for consumers to understand, HHS, state insurance departments, and exchange officials should, at a minimum:
  - Conduct consumer testing on the most consumer-friendly vocabulary and format for displaying AV and the metal tiers;
  - Display each plan’s actual AV estimate in addition to the metal tier;
  - Consider providing additional decision support tools, beyond the metal tiers and AV measures, to help consumers choose among plans;
  - Require insurers to use materials with easy-to-understand disclosures about what is—and what is not—covered in addition to a plan’s AV and metal tier; and
  - Consider whether to standardize cost-sharing for all plans at a given tier level.
- State regulators and lawmakers should ensure that there is a level playing field inside and outside the exchange by adopting uniform market rules. States should, at a minimum:
  - Consider prohibiting insurers from offering catastrophic coverage only outside of the exchange to avoid segmenting the state’s broader risk pool;
  - Require insurers to follow the same rules and offer the same coverage both inside and outside the exchange;
  - Ensure that the ACA’s “single risk pool” requirement works effectively;
  - Ensure that the marketing of catastrophic plans is properly regulated and does not mislead consumers; and
  - Ensure that consumers with access to catastrophic plans are also informed about federal subsidies to purchase coverage through the exchange and the availability of Medicaid.



## Stop Loss and Self-Insurance

Self-insured plans play an important role in the American health care system, and many large employers provide comprehensive benefits to their employees at a reasonable cost through self-insured plans.<sup>165,166</sup> However, self-insured plans also present risks and, until only recently, were minimally regulated by the federal government.<sup>167</sup>

The ACA imposes new requirements on insured and self-insured plans, including bans on lifetime and annual limits, young adult coverage up to age 26, and coverage of preventive services without cost sharing, among others. While the ACA takes an important step forward in requiring self-insured plans to provide some consumer protections, self-insured plans do not have to meet a number of the law's most significant reforms that apply to insurers in the fully funded individual and small group market. These protections are among the ACA's most important and are designed to protect consumers, improve access to comprehensive coverage, and stabilize markets and premiums.

Because self-insured plans are not subject to many of these requirements, the consumer representatives to the NAIC are very concerned about a shift towards self-insurance by small employers who purchase low-attachment point stop loss insurance. The widespread availability of this coverage—which is already being marketed to small employers<sup>168</sup>—could cause extensive adverse selection with small groups self-insuring when their group has a healthy risk profile and, because this coverage is not guaranteed renewable, being forced to return to the fully-insured market if and when their risk profile deteriorates. At the same time, small group employees enrolled in self-insured plans will not receive the protections promised under the ACA. We are also concerned that students at institutions of higher education enrolled in self-funded plans do not receive the same protections under the ACA as their counterparts in fully insured student plans.

To help ensure that the ACA's market reforms are implemented in a way that minimizes the risk of adverse selection and provides consumers with the full benefit of the law's protections, we make a number of recommendations to state and federal policymakers.

### Background

*Stop Loss and Self-Insurance.* The ACA introduces significant reforms in the individual and small group markets to help ensure that coverage for individuals and employees is adequate, available, and affordable. For example, insurers offering small group coverage must cover essential health benefits for their employees, pool the risk of all small groups they insure, achieve minimum medical loss ratios, and justify unreasonable premium increases.<sup>169</sup>

Self-insured plans, by contrast, are free from these requirements. Under the Employee Retirement Income Security Act of 1974 (ERISA), states are largely barred from regulating self-insured health plans which are primarily regulated by the federal government.<sup>170</sup>

Although states have little authority over self-insured plans, they can regulate stop loss insurance, which is coverage that operates as reinsurance to limit an employer's risk of self-insuring.<sup>171</sup> Approximately 20 states regulate stop loss insurance for small employers. Some ban it altogether, which makes self-insuring infeasible for small employers, and others require it to be subject to the same laws that apply to regular insurance.<sup>172</sup> For example, New York and Oregon have prohibited stop loss insurance for groups with 50 or fewer employees while Delaware has done so for firms with fewer than 15 employees.<sup>173</sup> New Jersey's insurance commissioner ruled recently that it constitutes an unfair trade practice for insurers to refuse to sell stop loss insurance to small employers based on health risk or conditions.<sup>174</sup> And, by statute, North Carolina requires that stop loss insurance sold to small employers comply with all of the underwriting, rating, and other standards of its small group health insurance reform law.<sup>175</sup>

The majority of the states that regulate stop loss insurance, however, have done so by establishing minimum attachment points to ensure that employers who purchase stop loss coverage are genuinely willing to take on the risk of being self-insured.<sup>176</sup> This was the goal of the NAIC Stop Loss Insurance Model Act, which was issued in 1995 to serve as model legislation for states and provided specific and aggregate attachment points for stop loss insurance for small groups.<sup>177</sup> As of today, the attachment point in the Model Act remains at \$20,000, as set in 1995.<sup>178</sup> Even now, a number of states fail to meet the Model Act's standard by allowing attachment points as low as \$10,000 or not regulating attachment points at all.<sup>179</sup>

In 2012, the ERISA (B) Working Group of the NAIC was charged with “[r]eview[ing] and revis[ing] the *Stop Loss Insurance Model Act* (#92) to take into account medical inflation.”<sup>180</sup> In June 2012, the Health Actuarial (B) Task Force voted to approve the interpretation of a report the NAIC had commissioned from Milliman, Inc., which recommended that the NAIC update its Model Act. This report and the Task Force's interpretation will be considered by the ERISA (B) Working Group and then by the NAIC Health Insurance and Managed Care (B) Committee as the NAIC considers whether to issue a Guideline Revision to the Stop Loss Insurance Model Act.<sup>181,182,183</sup>

*Student Health Plans.* Section 1560 of the ACA preserves the right of institutions of higher education to offer student health insurance plans so long as these plans are permitted by federal, state, and local law.<sup>184</sup> In implementing this requirement, the federal government clarified that most of the ACA's new protections apply to fully insured student health insurance plans.<sup>185</sup> Despite these consumer protections for fully insured coverage, the regulations state that these changes do not pertain to self-funded student health insurance plans.<sup>186</sup>

## Problems Consumers Might Encounter

We are concerned that consumers will not realize the full benefit of the ACA's most important protections if small businesses shift to self-insurance with low attachment point stop loss coverage. We offer a number of recommendations to state and federal regulators and lawmakers to help minimize the risk of adverse selection and ensure that small group employees receive the benefits of coverage of essential health benefits, guaranteed issue, and modified community rating, among other protections.

*Federal Regulators Should Clearly Distinguish Between Self-Insured and Insured Plans.* The ACA's new protections for small business turn on a crucial distinction between self-insured and insured plans. The ACA repeatedly uses the terms “self-insured” and “issuer offering group health insurance coverage,” but does not define the term “self-insured” or clarify when an insurer claiming to offer stop loss coverage is in fact an “issuer offering group insurance coverage.” We urge HHS and its partner agencies to define these terms to ensure that a small group can only claim self-insured status if the plan itself bears substantial risk and that an insurer comply with the requirements of the ACA that apply to “issuers” if the insurer in fact is the primary risk bearer rather than the group health plan.

*NAIC Should Increase the Dollar Value of the Attachment Point in the Model Act and States Should Regulate Stop Loss Insurance.* Under the laws of many states, stop loss insurers can write policies with low specific and aggregate attachment points, mimicking high-deductible medical insurance plans, but continuing to offer coverage with significant benefit gaps.<sup>187</sup> Because the ACA did not extend some of its consumer protections to self-insured plans, these plans can continue to offer coverage at favorable rates to healthy groups while refusing to provide coverage or charging very high rates to unhealthy groups. In addition, because stop-loss coverage is not guaranteed renewable under federal law, many small groups could find themselves dropped by their insurer as their employees get older and the health status of the group declines.

We strongly recommend that the NAIC adopt the interpretation issued by its actuarial experts to raise the specific and aggregate attachment points for the NAIC Stop Loss Insurance Model Act for small groups. This should be done immediately through a Guideline Revision with an eventual amendment to the Model Act. Doing so is consistent with the findings of the Milliman report as well as a June 2012 report conducted by Mathematica Policy Research and would provide a much-needed update to the Model Act whose attachment points have been unchanged since 1995 and are far too low. State legislatures, in turn, should adopt the revised Model Act attachment points.

Regardless of whether the NAIC adopts new attachment points as recommended, states have a number of options to minimize the risk of self-insurance in the small group market. First, states can ban stop loss insurance in the small group market altogether or require it to be subject to the same laws that apply to regular insurance as a number of states have done. Second, states can adopt new regulatory authority or enhance their existing authority to regulate stop loss insurance by establishing or increasing minimum attachment points. To ensure that employers who purchase stop loss coverage are genuinely willing to take on the risk of being self-insured, states should set minimum specific attachment points of at least \$60,000 and raise aggregate attachment points, consistent with the recommendations of the Milliman report and the NAIC's actuarial panels. State regulators should raise attachment points to discourage self-insuring by small employers unable or unwilling to assume the risk of being self-insured.

*State Regulators Should Actively Monitor Shifts Towards Self-Insurance in Small Businesses.* We strongly recommend that state regulators actively monitor shifts towards self-insurance in small businesses, which could result in adverse selection in both the exchange and the outside insured market. If small employers are allowed to self-insure without assuming significant risk, the employers remaining in the fully insured market will likely find themselves in what is essentially a high risk pool, as low risk groups purchase stop loss coverage and remain “self-insured.” This is true because stop loss insurance is likely to be particularly attractive to employers with young, healthy employees. The fact that insurers can “dump” these employers onto the exchange if their health status deteriorates makes the incentive to expand the self-insured market even more attractive.

Other small businesses may be enticed by the recent marketing efforts of stop loss insurers, which increasingly sell coverage with low attachment points as a way to circumvent the ACA's consumer and market protections. Employee benefits advisors and stop loss insurers have already begun touting self-insurance for small employers, and early indicators, including internet advertisements, suggest that such insurers and benefits advisors are beginning to aggressively marketing stop loss insurance to small employers, most of whom do not have sophisticated human resources departments to assist them in making critical coverage decisions.<sup>188</sup> In addition, we are particularly concerned that the ACA's new requirements could create incentives for insurers to market self-insurance with stop loss coverage to groups of 51 to 100 employees that will be included in the definition of “small employer” in all states beginning in 2016.<sup>189</sup> To limit the risk of adverse selection and protect consumers, we strongly encourage state and federal regulators to actively monitor—and regulate in response—to shifts towards self-insurance in small businesses.

*States Should Actively Regulate Self-Insured and Fully Insured Student Health Insurance Plans.* Because the federal government only extended the ACA's protections to fully insured student health insurance plans, we are concerned that institutions of higher education may begin to self-fund in an effort to avoid new requirements. Indeed, there are already examples of states considering, and passing, new legislation to require their public schools to self-fund and exempting these plans from state regulation. Without federal protections and only minimal state oversight, self-funded plans are free to discriminate based on preexisting conditions, offer limited coverage with low annual limits on benefits, and commit a number of consumer abuses that the ACA was designed to eliminate.

To provide young adults with the comprehensive and affordable health insurance promised under the ACA, we recommend that states actively monitor and regulate shifts towards self-funding in student health insurance plans. Because a self-funded student health insurance plan is not a self-insured plan for purposes of federal law, states should actively regulate these plans and apply the ACA's protections that are currently included in all other student health insurance plans. We also encourage state legislatures to increase the often limited state regulations on fully insured student health insurance plans.

## Recommendations

To minimize adverse selection and ensure that small group employees receive the benefits promised under the ACA, the consumer representatives to the NAIC make the following recommendations regarding self-insurance and stop loss coverage:

- The NAIC should adopt a Guideline Revision based on the study commissioned by the Health Actuarial (B) Task Force to raise the specific and aggregate attachment points for the NAIC Stop Loss Insurance Model Act.
- The NAIC should amend the NAIC Stop Loss Insurance Model Act to reflect the minimum specific and aggregate attachment points for stop loss insurance based on the study commissioned by the Health Actuarial (B) Task Force.
- State regulators and lawmakers should 1) ban stop loss insurance for small employers altogether or require it to be subject to the same laws that apply to regular insurance or 2) adopt new regulatory authority or enhance existing authority to regulate stop loss insurance by establishing or increasing minimum individual specific attachment points to at least \$60,000 consistent with the interpretation of the Health Actuarial (B) Task Force.
- State and federal regulators should actively monitor—and regulate in response—shifts towards self-insurance in small businesses which could result in adverse selection in both the exchange and the outside insured market as well as shifts towards self-insurance in student health insurance plans.
- State regulators and lawmakers should also ensure that self-funded student health insurance plans give the same protection to students that fully insured plans are required to provide; increase state regulation of fully insured student health insurance plans by applying all relevant ACA requirements; and avoid converting student health plan coverage from fully insured to self-funded plans.
- HHS and its partner agencies should clearly define the terms “self-insured” and “issuer offering group health insurance coverage” to ensure that a small group can only claim self-insured status only if the plan bears substantial risk and the insurer complies with the requirements of the ACA.





## Limited Medical Benefit Plans

Comprehensive health coverage is critical to ensuring that consumers have access to care when they need it most.<sup>190</sup> Plans that do not offer comprehensive health coverage—such as excepted benefit plans and mini-med plans—pose a number of risks to consumers who could be forced to pay costly medical bills out-of-pocket or forgo services that they believed were covered.

Beginning in 2014, the ACA requires individuals to obtain a minimum level of health insurance coverage, referred to as minimum essential coverage.<sup>191</sup> Such coverage will have to meet the ACA's new requirements by, for example, providing coverage of an essential health benefits package, prohibiting lifetime and annual limits, and prohibiting preexisting condition exclusions, among other consumer protections. However, while the ACA takes an important step forward in improving coverage for millions of Americans, not all types of coverage have to meet the law's significant reforms and a shift towards these products could limit consumers' ability to realize these new benefits and expose them to significant financial risks.

The consumer representatives to the NAIC are concerned about a trend towards limited medical benefit plans and other non-comprehensive coverage to avoid the requirements of the ACA. Such products, if not regulated, could lead consumers to mistakenly believe they are purchasing comprehensive coverage, getting good value for their dollar, or meeting their coverage obligation under the ACA when they are not. To help ensure that consumers are fully informed as well as to limit false and misleading marketing, we make a number of recommendations to the NAIC regarding limited medical benefit plans.

### Background

Although the ACA introduces significant market reforms to help ensure that coverage for individuals and employees is adequate, available, and affordable, excepted benefits are excluded from the ACA's new requirements. These excepted benefit policies are either not health insurance or offer only partial coverage and do not include comprehensive coverage, individual major medical expense coverage, or mini-med plans.<sup>192</sup> Under federal law, excepted benefits include: disability income; liability supplement; general liability; automobile liability; workers' compensation; automobile medical payment; credit-only; limited scope dental or vision; long-term care; nursing home care; specified disease or illness; hospital indemnity or fixed indemnity insurance; Medicare supplement; Tricare supplement; and similar group supplemental coverage.<sup>193</sup>

In 2012, the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee were charged with appointing a Limited Medical Benefit Plan (B/D) Working Group (Working Group) to “coordinate efforts and review issues related to limited medical benefit plans, including: 1) misrepresentation in sales and marketing; 2) product utility; and 3) authorized and unauthorized agents.”<sup>194</sup> The Working Group was also charged with developing recommendations “to address concerns and issues addressed during the review.”<sup>195</sup>

Although the NAIC uses terms related to “limited medical benefit plans” (e.g., “limited benefit health coverage/plan/contract,” “policy that provides limited benefits,” “limited benefit plans,” “limited medical benefit insurance”), these terms are not defined or used consistently by the NAIC in its model acts, model regulations, or other NAIC materials.<sup>196</sup> Adding to this confusion, the Centers for Medicare and Medicaid Services (CMS) has not defined this term in regulation, nor does it appear in the ACA.

## Problems Consumers Might Encounter

Because consumers deserve complete and accurate information about the products they purchase, we strongly support the establishment of the Working Group and its 2012 charge to review issues related to industry abuses such as misrepresentation in sales and marketing. We also applaud the NAIC for its recent release of a model Consumer Alert on limited medical benefit and mini-med plans. We offer a number of recommendations to the NAIC in tackling this important consumer protection issue and helping ensure that limited medical benefit plans, excepted benefit plans, and mini-med plans that do not meet the ACA's minimum essential coverage standards are not misrepresented in sales and marketing, have demonstrated product utility, and are not sold by unauthorized agents or other salespeople.

### *The Working Group Should Define Limited Medical Benefit Plans to Include Excepted Benefit Plans and Mini-Med Plans.*

Excepted benefits and mini-med plans are clearly within the scope of the Working Group's charge to examine "issues related to limited medical benefit plans." We urge the Working Group to interpret its charge broadly to include excepted benefits and mini-med plans consistent with the NAIC's own use of the term "limited medical benefit plans" to describe a wide variety of non-comprehensive health insurance plans.

First, the Working Group should broadly define "limited medical benefit plans." As noted above, the NAIC uses related terms but they are not defined or used consistently in model acts, model regulations, or NAIC materials. The NAIC itself sometimes uses the term "limited benefit" to describe excepted benefit plans: some plans that are excepted benefits under federal law are clearly policies that provide limited benefits under the NAIC Accident and Sickness Insurance Minimum Standards Model Act (Model Act) and the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (Model Regulation).<sup>197,198</sup> For example, specified disease or illness, hospital indemnity, or other fixed indemnity insurance—which are excepted benefits under federal law—fall under one of the NAIC's definitions or usages of the term "limited benefits," and, thus, are within the scope of the Working Group's charge.

Second, the Working Group is responsible for coordinating efforts to "review issues related to limited medical benefit plans." These issues include consumer confusion about whether coverage is comprehensive and the need for meaningful consumer disclosures, among other critical protections. Because some, if not all, types of excepted benefit plans raise issues similar to those raised by limited medical benefit plans, excepted benefits are clearly within the scope of the Working Group's charge regardless of which definition of limited medical benefit plans one adopts.

For example, hospital indemnity, other fixed indemnity, and specified disease and illness policies raise issues similar to those of limited medical benefit plans. These issues have been explored at length by the consumer representatives, and Professor Timothy Jost, an NAIC consumer representative, authored a 2011 article on ACA loopholes that includes a discussion of problems with specified disease and illness coverage and fixed indemnity health insurance, in particular.<sup>199</sup> His article raises points that support our position that, at minimum, hospital indemnity, other fixed indemnity, and specified disease and illness policies should be considered within the Working Group's purview. Among these points, he notes that consumers can often be confused about what is covered under these products and uninformed consumers may purchase, for example, a specified disease policy or a fixed dollar indemnity plan in lieu of comprehensive insurance.<sup>200</sup> This may be especially true for fixed indemnity policies that "can cover a wide range of procedures and look a great deal like comprehensive insurance."<sup>201</sup> Because these same concerns arise with limited medical benefit plans, the Working Group should include these types of plans under its charge regardless of which definition of "limited medical benefit plans" is used.

To generate consistency for regulators and consumers alike, we recommend that the Working Group define "limited medical benefit plans" to include excepted benefit plans and mini-med plans. Because regulators are likely to face similar issues regardless of the type of plan, the Working Group should use its charge to maximize efficiency in the NAIC's review process and help regulators and consumers avoid regulatory gaps. Many of the plans described in the Model Act and Model Regulation, other than comprehensive major medical plans, involve issues "related to" limited medical benefit plans (e.g., misrepresentation in sales and marketing, product utility, authorized and unauthorized agents) and, therefore, fall within the Working Group's charge.

*The Working Group's Efforts Should Reflect the Need for Meaningful Disclosures to Consumers Regarding Limited Medical Benefit Plans.* Although most people will have minimum essential coverage by the end of 2014, some will not, including those for whom the lowest cost health plan exceeds 8 percent of income. These consumers are likely to be targeted by vendors of stand-alone excepted benefit plans and other non-comprehensive options. Because many consumers may be unable to tell that

these plans are neither comprehensive nor regulated under the ACA, it will be essential for consumers to clearly understand whether a plan meets the ACA's requirements through disclosure, consumer education and regulatory enforcement. We are particularly concerned that consumers could be misled by insurers or agents that attempt to “package” excepted benefit plans (e.g., hospital and other fixed indemnity plans) or by companies that define covered services under an excepted benefit plan as broadly as possible (e.g., broadly defined dread disease/critical illness policy).

The Working Group's charge specifically mentions misrepresentation in sales and marketing, product utility and authorized and unauthorized agents as areas of concern. We agree these are critical areas for investigation and regulation and consumers purchasing excepted benefit plans and other non-comprehensive plans face the same issues as those purchasing limited medical benefit plans. Indeed, at least some insurers that have offered so-called mini-med plans in the past appear to be moving to other types of medical products, such as fixed indemnity plans, to avoid the ACA's requirements.<sup>202</sup> If limited benefit products become the wolf in comprehensive plan clothing, we are concerned that the problems of inadequate coverage and false and misleading marketing will continue despite the consumer protections promised under the ACA.

The NAIC has already taken steps towards addressing this issue, and the recently approved NAIC Consumer Alert on limited benefit and mini-med plans provides consumers with several ways to identify a limited medical benefit or mini-med plan, including plans sold as “a cheap alternative to major medical health insurance,” plans with annual limits, and unsolicited calls, emails or faxes. Certain types of excepted benefit plans and other non-comprehensive plans may be marketed in the same way, and consumers deserve the same warnings and protections regardless of the type of plan at issue. To help inform its work, we recommend that the Working Group conduct a survey of state regulators to assess trends in the marketing and sale of limited medical benefit plans, including “stacked” fixed indemnity and mini-med plans.

To ensure that consumers are protected, we recommend that the Working Group emphasize the importance of transparency and disclosures to ensure that consumers are able to make meaningful choices about their coverage options. We further recommend that the Working Group include both regulatory and disclosure initiatives in the efforts being coordinated and provide additional clarity with respect to how product utility will be determined and measured. In particular, all the ACA requirements that apply to comprehensive plans should apply to limited benefit plans that are not clearly inconsistent with the nature of those plans, and any differences that remain should be very clearly disclosed.

## Recommendations

To ensure that health plans that do not meet the ACA's minimum essential coverage standards are not misrepresented in sales and marketing, have demonstrated product utility, and are not sold by unauthorized agents or other salespeople, the consumer representatives to the NAIC make the following recommendations:

- The Working Group should interpret their charge broadly to include excepted benefits and mini-med plans since the NAIC itself uses the term “limited benefits” to describe a wide variety of non-comprehensive health insurance plans.
- The Working Group should adopt a broad definition of “limited medical benefit plans” to include excepted benefit plans and mini-med plans as defined under federal law.
- Even if the Working Group does not define “limited medical benefit plans” to include excepted benefit plans and mini-med plans, the Working Group should include excepted benefit plans—such as hospital indemnity, other fixed indemnity and specified disease and illness policies—and mini-med plans in its charge to “review issues related to limited medical benefit plans” because such plans raise issues related to limited benefit products regardless of which definition of limited benefit plan one uses.
- The Working Group should emphasize the importance of transparency and disclosures to ensure that consumers are able to make meaningful choices about their coverage options and include both regulatory and disclosure initiatives in the “efforts” being coordinated and provide additional clarity with respect to how product utility will be determined and measured.
- The Working Group should conduct a survey of state regulators to assess trends in the marketing and sale of limited medical benefit plans, including “stacked” fixed indemnity and mini-med plans.
- In the event that the Working Group does not interpret its charge to include excepted benefits and mini-med plans, the Health Insurance and Managed Care (B) Committee should issue a separate charge directing the Working Group to address these issues.
- State regulators and lawmakers should issue, if they have not yet done so, the NAIC's model Consumer Alert on limited medical benefit and mini-med plans.



## Risk Adjustment, Reinsurance, and Risk Corridors

Individuals with health conditions and disabilities often face challenges in obtaining health insurance coverage.<sup>203</sup> This is, in part, because insurers that enroll less-healthy individuals, such as those with chronic conditions, face much greater risk than those that enroll relatively healthy individuals. To avoid this increased risk, insurers may “cherry pick” the healthy while avoiding the sick.

To address this barrier to access, the ACA ushers in significant market reforms effective in 2014. Among these reforms, the ACA requires states or the federal government to implement three new mechanisms—risk adjustment, reinsurance, and risk corridors—to reduce the incentive for insurers to avoid higher-risk enrollees.<sup>204</sup> Consumers may not be aware of these programs, but they are an important part of ensuring a stable health insurance marketplace that permits all types of people—including those who have high-cost health care needs—to gain access to comprehensive, affordable coverage as health reform takes full effect.

The risk adjustment program is permanent while the reinsurance and risk corridors programs are temporary measures. All three programs will be critical to stabilizing the individual and small group markets in the initial years of reform “when the risk of adverse selection related to new rating rules and market changes is greatest.”<sup>205</sup> During this period, insurers are likely to face a high degree of uncertainty as new populations gain access to coverage and the ACA ushers in significant consumer protections. This stabilization will help protect insurers from potentially higher costs associated with the newly insured populations and help keep premiums affordable for all consumers.<sup>206</sup>

The consumer representatives to the NAIC strongly support the implementation of robust risk adjustment, reinsurance, and risk corridor mechanisms that protect consumers and minimize market disruption. These programs are critical to ensuring that the exchanges and the law’s most significant reforms—such as the ban on preexisting condition exclusions—are implemented successfully. This section addresses each of these risk-mitigation programs in turn and makes a number of recommendations to help policymakers implement them in a way that most benefits consumers.

## Background

Section 1343 of the ACA requires each state to establish a permanent risk adjustment program that provides payments to insurers that attract a disproportionate number of high-risk enrollees.<sup>207</sup> The risk adjustment program applies to all non-grandfathered plans in the state's individual and small group markets, both within and outside of the exchange, and includes multi-state plans and Consumer Operated and Oriented Plans.<sup>208</sup> States that establish an exchange can choose whether to administer a risk adjustment program or allow HHS to do so.<sup>209</sup> In states that do not establish an exchange, HHS will administer a risk adjustment program.<sup>210</sup>

Under Section 1343, each state, or HHS on behalf of the state, must assess the actuarial risk of each plan and insurer in a given year.<sup>211</sup> If an insurer's risk is below the average actuarial risk for all enrollees in all plans in a given state, this insurer must pay a charge to the state's risk adjustment entity.<sup>212</sup> The state's risk adjustment entity will then distribute these funds to plans with risk that is above the average actuarial risk.<sup>213</sup>

HHS, in consultation with the states, must establish criteria and methods to be used in determining the average actuarial risk for plans within each state.<sup>214</sup> States can choose to adopt this methodology or submit an alternative method to HHS for approval.<sup>215</sup> States that adopt their own methodology must publish the rationale for their methodology and issue a notice of benefit and payment parameters that includes a full description of the risk adjustment model.<sup>216</sup> States that administer their own risk adjustment programs will have flexibility to modify HHS' risk adjustment model or take their own approach on issues such as data collection, the calculation of plan average actuarial risk, calibration data, and the schedule for implementation.

HHS finalized its regulations implementing Section 1343 in March 2012 and issued further guidance to describe how HHS plans to implement the risk adjustment function and methodology in May 2012.<sup>217,218,219</sup>

## Problems Consumers Might Encounter

Risk adjustment is intended to promote competition based on quality and price, rather than avoiding higher-risk enrollees. This program, in conjunction with the reinsurance and risk corridors programs, must be robust to minimize market disruption, ensure the long-term viability of state exchanges, and enable consumers to benefit from the ACA's significant market reforms. We make a number of recommendations regarding the implementation of risk adjustment programs which are chiefly related to data collection, data validation, transparency, and uniformity.

*Data Collection Must Be Robust.* Data collection will be critical to ensuring that risk adjustment programs are successful. Robust risk assessment tools—with high predictive capabilities—will promote confidence that losses will be compensated and, thus, reduce the incentive insurers might have to “cherry pick” the healthiest enrollees.<sup>220</sup> States that choose to administer their own risk adjustment programs have the flexibility to implement state-specific requirements such as a prospective model and a data collection system that can be leveraged for other purposes, such as ensuring that insurers comply with the ACA's new rules. For example, states can use risk adjustment data as part of their rate review process, to enforce medical loss ratio requirements, or to ensure that insurers adopt a single risk pool for all enrollees in the individual and small group markets, among other uses.

We strongly encourage states that operate their own risk adjustment programs to adopt an “intermediate” data collection approach. Under the intermediate approach, insurers submit claims and encounter data for state analysis, which promotes accuracy and credibility among insurers.<sup>221</sup> This approach is consistent with comments from the American Academy of Actuaries which note that data “[c]ollection by the entity administering the risk-adjustment mechanism provides greater opportunity for audit controls and quality review as well as allowing for other uses of the data in analyzing the effectiveness of the risk-adjustment mechanism and updating the risk-assessment model.”<sup>222</sup> While opponents of the intermediate approach have argued that it would compromise patient privacy, HHS applied strong privacy protections to risk adjustment data and prohibits risk adjustment entities from collecting or storing personally identified information.<sup>223</sup>

In its final rule, in states where it is administering risk adjustment, HHS declined to collect medical claims or encounter records.<sup>224</sup> We are concerned that this “distributed” approach grants far too much discretion to insurers—who would collect and store all data—and, as a result, that the risk adjustment program would not be effective in ensuring that risk scores are

justified or calculated correctly without HHS having access to the underlying data. This lack of transparency renders the system highly vulnerable to errors, fraud, and abuse, and threatens the program's credibility.<sup>225</sup> Because of these limitations of the “distributed” approach, we recommend that states adopt a more centralized approach to data collection if they run their own risk adjustment programs.

We support the fact that HHS has clarified that it will run its risk adjustment software on insurers' data, rather than having insurers apply the software themselves. Under this approach, HHS would run risk adjustment software on enrollee data that resides on an insurer's server, calculate risk scores and average risk, and provide risk scores to the insurer.<sup>226</sup> The alternative—allowing insurers to run their own software and report their risk scores to HHS—which HHS considered but appropriately rejected provides too little oversight and is likely to make it difficult for regulators to audit and identify data problems on a timely basis.

*Data Validation Must Be Robust.* Data validation will also be critical, and states and HHS must implement a reliable data validation process irrespective of the data collection approach used. Based on the error rate found in the validation process, the actuarial risk can be adjusted for each plan and, in turn, can allow adjustments to be made in the payments and charges for insurers. Because of the importance of data validation, we support strong federal audit standards and protocols that HHS and states must follow. We, however, are concerned that in states where HHS is administering risk adjustment, it will establish an audit approach under which insurers would hire independent auditors to validate their risk adjustment similar to the process used to verify HEDIS data reporting, as proposed in recent guidance.<sup>227</sup> We instead recommend that HHS directly contract with auditors, as under the Medicare Advantage program, to conduct data validation audits. We also recommend that insurers be required to submit full medical records to HHS for review in a specified timeframe. Finally, we recommend that HHS conduct interim audits over the course of the plan year in order to identify errors and data problems, instead of waiting for retrospective audits well after the end of the plan year.

If HHS goes ahead and allows the use of independent auditors to conduct data validation (even if it conducts complementary audits of the independent auditors), HHS should ensure that this process is as rigorous as possible. For example, HHS could require that the independent auditors do interim checks during the plan year and, if problems are identified, to help the insurers fix those problems. In states that administer their own risk adjustment program, such states can—and should—establish an auditing system with these kinds of heightened requirements and standards, including interim checks, and impose sanctions on insurers that fail to comply with data validation and records maintenance requirements.

*States Should Establish Public, Transparent Processes for Risk Adjustment Decisions.* States that establish their own risk adjustment methodology should adopt a transparent rulemaking process to implement the risk adjustment program. Consumer input is essential, and states should clearly indicate how they plan to comply with federal requirements and meet the intended goals of the risk adjustment program. Because HHS has committed to providing an opportunity for public comment when it administers risk adjustment on behalf of a state, we recommend that states adopt the same procedure to ensure a consistent approach is taken across the nation. State officials should, for example, include an opportunity for public comment on a state's notice of benefit and payment parameters when the state wishes to deviate from the federal methodology.

We also recommend that states impose strong conflict of interest standards for the risk adjustment entity's governing board by prohibiting financial ties to insurers. In addition, states will have to submit summary reports to HHS that include, at a minimum, the average actuarial risk for each plan, the risk adjustment charge or payment for each plan, and information on risk scores and cost trends, including evidence of upcoding and error rates determined under the most recently completed risk adjustment data validation audits. We recommend that these summary reports also be made available to the public.

*States Should Adopt Uniform Market Rules.* Because even highly effective risk adjustment systems will not be able to fully eliminate adverse selection, states must be prepared to manage some adverse selection in the individual and small group markets. The level of adverse selection will depend on how a state regulates plans operating outside the exchanges. We strongly encourage states to minimize the risk of adverse selection by requiring insurers to follow the same rules and offer the same coverage both inside and outside the exchange as well as merge the individual and small group markets. Doing so could encourage insurers to participate in the exchange and reduce the incentive to “cherry pick” healthier enrollees.

## Recommendations

Robust risk adjustment requirements will be critical to ensuring that each state's health insurance exchange and the broader insurance market remain viable and that coverage is affordable for consumers. The consumer representatives to the NAIC provide the following recommendations to state and federal policymakers in implementing a risk adjustment program:

- State policymakers, in evaluating whether to administer a state-specific risk adjustment program, should consider the benefits of doing so which include, among others, the ability to:
  - o Ensure that the state's risk adjustment program is as robust, predictive, and transparent as possible by establishing a state-specific data collection and validation approach as well as promoting insurer confidence to minimize adverse selection;
  - o Use robust data collected during the risk adjustment process for policymaking decisions;
  - o Leverage existing sources of state data and collection tools;
  - o Use risk adjustment data to enforce the ACA's new requirements such as medical loss ratios, rate review, and a single risk pool for the individual and small group market; and
  - o Impose strong conflict of interest standards regarding the board of the state's risk adjustment entity.
- State regulators and lawmakers, in administering a state-specific risk adjustment program, should:
  - o Adopt a more centralized approach to data collection. This approach should include uniform rules for data reporting and how claims will be used to determine risk scores;
  - o Develop a prospective federal risk adjustment model based on projected costs (at least over time), similar to the one used under Medicare Part C. A prospective system would better ensure a level playing field by requiring insurers to set premiums based on prior data and would encourage cost-efficiency since it would be based on projected rather than actual costs;
  - o Utilize an all-payer claims database (if available) to administer risk adjustment as a rich source of claims data that can serve as a source of predictable data; and
  - o Refine risk adjustment methodology on a regular, timely basis to safeguard the accuracy of the risk adjustment program.
- State regulators and lawmakers should adopt a transparent rulemaking process to implement the risk adjustment program. Policymaker should, at a minimum:
  - o Ensure that all decisions are subject to public notice and comment;
  - o Indicate how the state plans to comply with federal requirements and meet the intended goals of the risk adjustment program; and
  - o Prohibit financial conflicts of interest on the governing board of the risk adjustment entity.
- State regulators and lawmakers should establish uniform standards for regulating the market inside and outside the exchange.
- State policymakers should minimize adverse selection by requiring insurers to follow the same rules and offer the same coverage both inside and outside the exchange as well as merge the individual and small group markets.
- HHS should develop a robust risk adjustment methodology that will result in accurate, timely collections and payments; encourage cost-efficiency; and discourage fraud and abuse. Federal regulators should, at a minimum:
  - o Conduct frequent audits of insurer data, place additional audit requirements (including on independent auditors), and enforce risk adjustment regulations;
  - o Refine risk adjustment methodology on a regular, timely basis. Refinements will be critical to the accuracy of the risk adjustment program as new information is added and predictive variables are recalibrated; and
  - o Ensure that risk adjustment, reinsurance, and risk corridors programs work together to limit adverse selection.

## Background

Section 1341 of the ACA requires each state, or HHS on behalf of the states, to establish or contract with one or more nonprofit entities to administer reinsurance in each state's individual market during the first three years of the operation of an exchange.<sup>228</sup> The reinsurance program is designed to provide funding for insurers that cover a disproportionate number of high-risk enrollees. By enabling insurers to share risk, the reinsurance program can help reduce the uncertainty that insurers fear in extending coverage to high-risk individuals.<sup>229</sup>

Beginning on January 1, 2014, insurers are required to make payments to the state's reinsurance entity, or to HHS if it is administering reinsurance on behalf of the state, for three years.<sup>230</sup> The reinsurance entity will then redistribute these payments to insurers that cover high-risk enrollees in the individual market under any plan year beginning between 2014 and 2017.<sup>231</sup> Section 1341 requires HHS to define the methodology to determine how much states must pay to the reinsurance entity; how much must be distributed to insurers in the individual market in the exchange; and how to identify high-risk individuals.<sup>232</sup> States that wish to deviate from the reinsurance methodology proposed by HHS may submit an alternate method for approval using a notice of benefit and payment parameters.<sup>233</sup>

In March 2012, HHS finalized its regulations implementing Section 1341 and provided states with discretion in operationalizing their reinsurance program. First, states are permitted to establish their own payment formula for the reinsurance program so long as modifications are "reasonably calculated" to ensure that contributions are sufficient to cover reinsurance payments.<sup>234</sup> Second, although HHS will collect funds from self-insured plans and third-party administrators, states may choose to collect contributions from insurers in the fully insured market.<sup>235</sup> Third, states will have discretion in setting the frequency of collections by the reinsurance entity.<sup>236</sup> Finally, to fund administrative expenses or additional reinsurance payments, states may choose to collect more funds than would otherwise be collected based on the contribution rate alone.<sup>237</sup>

HHS also will permit states to continue their high risk pools and coordinate them with the reinsurance program but prohibits reinsurance funds from being used towards the high risk pool or any other purpose.<sup>238</sup>

## Problems Consumers Might Encounter

The reinsurance program is an important part of ensuring a stable health insurance marketplace as health reform takes full effect in 2014. We strongly support the implementation of a robust, transparent, and effective reinsurance program and make recommendations below for doing so.

As noted, reinsurance is designed under the ACA to help stabilize premiums "when the risk of adverse selection ... is greatest."<sup>239</sup> Reinsurance can also help guard against "unpredictable swings in costs" for treatment for rare conditions or accidents that have limited data upon which to model their costs for risk assessment.<sup>240</sup> To help broaden the risk pool, reinsurance programs must be credible and transparent so consumers understand how funds are being distributed among insurers and whether exchanges and reforms are being implemented in a way that is sustainable.

First, because states have discretion in selecting the entity that will administer its reinsurance program, states should develop meaningful, transparent standards in selecting a reinsurance entity. For states with an existing reinsurance entity, these same standards should apply and states should evaluate existing entities to ensure that they can comply with federal standards.

Second, for states that adopt their own methodology for reinsurance, we strongly recommend that policymakers provide 1) a justification for any parameters that differ from those set by HHS; and 2) an explanation as to how the methodology is "reasonably calculated" to ensure that reinsurance funds are sufficient to cover the necessary payments. Both should be subject to public comment and review so consumers can understand how states intend to comply with federal requirements.

Third, the methodology adopted by HHS and the states should require reinsurance entities to collect and distribute reinsurance funds in an equitable manner, including any reduction in reinsurance payments, to ensure that insurers participate in the exchange and have no incentives to avoid covering higher-risk individuals. The methodology should also ensure that care coordination and management programs for high-risk conditions reflect state-specific needs, such as the



provider market and, in particular, the availability of primary care physicians or rural health needs. For states with a high penetration of managed and coordinated care plans that delegate risk to provider groups, regulators should take special care that the risk incurred by providers does not restrict enrollment or consumer access to providers who may not be compensated for their increased risk.

Fourth, we support HHS' intended approach not to account in risk adjustment calculations for payments that insurers might receive under the reinsurance program when they have high-risk enrollees.<sup>241</sup> We agree with HHS that adjusting for reinsurance payments would reduce incentives to cover high-risk enrollees as well as increase uncertainty and complexity in modeling.

Finally, states should collect reinsurance contributions from insurers in the fully insured market. Doing so will help regulators exercise control over these contributions and could allow states to, for example, impose sanctions on insurers that fail to meet reinsurance requirements.

## Recommendations

The reinsurance program will be critical to ensuring that each state's health insurance exchange and the broader insurance market remain viable and that coverage is affordable for consumers. The consumer representatives to the NAIC provide the following recommendations to state and federal policymakers in implementing this program:

- The methodology adopted by HHS and the states should 1) require reinsurance entities to collect and distribute reinsurance funds in an equitable manner to ensure that insurers participate in the exchange and have no incentives to avoid covering higher-risk individuals, and 2) ensure that care coordination and management programs reflect state-specific needs.
- States that opt to use reinsurance parameters that differ from those prescribed by HHS should justify any deviations and make their notice of benefit and payment parameters available to the public with a period for comment.
- States should collect reinsurance contributions from insurers in the fully insured market to exercise control over these contributions.
- States should continue to operate their high risk pools until the state is confident that enrollment of high risk pool enrollees will not destabilize the exchange.
- HHS should not adjust risk adjustment calculations for payments that insurers might receive under the reinsurance program.
- HHS and states should ensure that reinsurance, risk adjustment, and risk corridors programs work together to limit adverse selection.

## Background

Section 1342 of the ACA requires HHS to administer a temporary risk corridors program to limit adverse selection and mitigate large losses or profits among qualified health plans (QHPs) offered in the exchange.<sup>242</sup> The risk corridors program applies to qualified health plans sold within the exchanges; any QHPs offered outside an exchange; and health plans that are “substantially the same” as QHPs.<sup>243</sup>

Section 1342 requires HHS to collect a percentage of costs from QHPs with lower than expected costs (plans that fall short of an established target amount by 3 percent) and distribute these funds to QHPs with higher costs (plans that exceed the target amount by 3 percent).<sup>244</sup> If a QHP faces significant losses (defined as losses that exceed 8 percent of the target amount), HHS must distribute additional funding to the QHP.<sup>245</sup> By transferring funding from plans with lower costs to plans with higher costs, risk corridors promote greater payment stability and protect against rating uncertainty by limiting losses and gains.<sup>246</sup> This, in turn, can encourage insurer participation in the exchange and minimize adverse selection.

HHS finalized its regulations implementing Section 1342 in March 2012 and largely required risk corridors requirements to be consistent with existing requirements for the medical loss ratio (MLR) rule where possible.<sup>247</sup> For example, to the extent that an insurer adopts a method for allocating expenses for MLR purposes, the risk corridors methodology must be consistent.<sup>248</sup>

## Problems Consumers Might Encounter

Like risk adjustment and reinsurance, risk corridors are an important part of ensuring a stable health insurance marketplace and minimizing market disruption. To ensure that this program is implemented in a way that best meets the needs of consumers, we make the following recommendations regarding the implementation of the risk corridors program.

While we generally support HHS’ approach in implementing risk corridors thus far, we are concerned about how risk corridors will work in conjunction with the risk adjustment and reinsurance programs. For example, it may be challenging for HHS to separate an appropriate risk corridor payment from risk adjustment and reinsurance payments. If these payments cannot be separated, insurers may be overly compensated for the same enrollees.

Risk corridors must be as accurate as possible. To help ensure that data is accurate, we strongly encourage HHS to 1) use actual data rather than projected data and support the requirement that risk corridors apply at the plan-level rather than aggregated at the insurer-level, and 2) determine a baseline amount of allowable costs or payment liability reflecting the experience of other insurers.

## Recommendations

To help ensure that each state’s health insurance exchange and the broader insurance market remain viable, the consumer representatives to the NAIC provide the following recommendations to state and federal policymakers in implementing the risk corridors program:

- Risk corridors requirements should be consistent with leveraging data reporting requirements for MLR.
- HHS should use actual data at the plan-level rather than projected data. HHS should also refrain from using data that is aggregated at the insurer-level.
- HHS should determine a baseline amount of allowable costs or payment liability reflecting the experience of other insurers.
- HHS and states should ensure that risk corridors, risk adjustment, and reinsurance programs work together to limit adverse selection, particularly to avoid overcompensating insurers for adverse selection.

Provision	Citation(s)	Codification	Effective Date	Individual		Small Group		Large Group	
				Grandfathered Policies	New Policies	Grandfathered Plans	New Plans	Grandfathered Plans	New Plans
Guaranteed Issue	PHSA § 2702	42 U.S.C. §§ 300gg-1	Jan. 1, 2014 <sup>1</sup>	No	Yes	Insured Plans	Insured Plans	No	Insured Plans
Guaranteed Renewal	PHSA § 2703	42 U.S.C. §§ 300gg-2	Jan. 1, 2014 <sup>1</sup>	No	Yes	Insured Plans	Insured Plans	No	Insured Plans
No Preexisting Condition Exclusions	PHSA § 2704	42 U.S.C. § 300gg-3	Jan. 1, 2014 <sup>1</sup>	No	Yes	Yes	Yes	Yes	Yes
Rating Reforms	PHSA § 2701	42 U.S.C. § 300gg	Jan. 1, 2014 <sup>1</sup>	No	Yes	No	Insured Plans	No	Insured Plans <sup>2</sup>
Waiting Periods	PHSA § 2708	42 U.S.C. § 300gg-7	Jan. 1, 2014 <sup>1</sup>	Yes	Yes	Yes	Yes	Yes	Yes
Essential Health Benefits	ACA § 1302	42 U.S.C. § 18022	Jan. 1, 2014 <sup>3</sup>	No	Yes	No	Insured Plans	No	No
State-Mandated Benefits	ACA §§ 1311, 1312	42 U.S.C. §§ 13031, 18032	N/A	Yes	Yes	Yes	Insured Plans	Yes	Insured Plans
AV, Precious Metal Tiers	ACA § 1302	42 U.S.C. § 18022	Jan. 1, 2014 <sup>4</sup>	No	Yes	No	Insured Plans <sup>4</sup>	No	No
Clinical Trials	PHSA § 2709	42 U.S.C. § 300gg-8	Jan. 1, 2014 <sup>1</sup>	No	Yes	No	Yes	No	Yes
Risk Adjustment	ACA § 1343	42 U.S.C. § 18063	Jan. 1, 2014	No	Yes	No	Insured Plans	No	No
Reinsurance	ACA § 1341	42 U.S.C. § 18061	Jan. 1, 2014 to Dec. 31, 2016 <sup>5</sup>	No	Yes	No	Yes <sup>6</sup>	No	Yes <sup>7</sup>
Risk Corridors	ACA § 1342	42 U.S.C. § 18062	Jan. 1, 2014 to Dec. 31, 2016	No	QHPs	No	QHPs	No	No

Note: Except where otherwise specified, the provision applies to fully insured and self-insured plans

<sup>1</sup> This provision becomes effective for plan years beginning on or after January 1, 2014.

<sup>2</sup> If a state permits plans in the large group market to offer coverage through the exchange in 2017, such plans must comply with the ACA's rating reforms.

<sup>3</sup> For plans outside the exchange, this provision becomes effective for plan years beginning on or after January 1, 2014. For plans inside the exchange, this provision goes into effect on January 1, 2014.

<sup>4</sup> Section 2707(b) of the Public Health Service Act requires non-grandfathered group health plans (including self-insured plans) to limit annual cost-sharing in compliance with Section 1302(c) of the ACA.

<sup>5</sup> The reinsurance program applies to plan years beginning in the 36-month period beginning January 1, 2014.

<sup>6</sup> Health insurance issuers and third party administrators on behalf of group health plans are required to make payments to a reinsurance entity which will be distributed to health insurance issuers that cover high-risk individuals in the individual market.

- <sup>1</sup> DeNavas-Walt, C. Proctor, B.D. Smith, J.C. 2011. *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. U.S. Census Bureau, Current Population Reports, P60-239. Washington DC: U.S. Government Printing Office.
- <sup>2</sup> Hadley, J. 2003. *Sicker and Poorer: The Consequences of Being Uninsured*. Washington DC: Henry J. Kaiser Family Foundation (2003).
- <sup>3</sup> Doty, M.M. Edwards, J.N. Holmgren A.L. 2005. *Seeing Red: Americans Driven into Debt by Medical Bills*. Commonwealth Fund (Aug. 2005).
- <sup>4</sup> Public Health Service Act §§ 2702, 2703 (codified at 42 U.S.C. §§ 300gg-1, 300gg-2 (2006)).
- <sup>5</sup> *Id.*
- <sup>6</sup> *Id.* § 2702(b)(1).
- <sup>7</sup> *Id.* § 2702(b)(2).
- <sup>8</sup> Kaiser State Health Facts, *Individual Market Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals)*, 2011, available at <http://statehealthfacts.org/comparetable.jsp?ind=353&cat=7>.
- <sup>9</sup> 42 U.S.C. § 300gg-1 (2006) (formerly 42 U.S.C. § 300gg-11 (2006)).
- <sup>10</sup> *See id.*
- <sup>11</sup> Public Health Service Act 2702, 2703 (codified at 42 U.S.C. § 300gg-1, 300gg-2) (2006)).
- <sup>12</sup> 42 U.S.C. § 300gg-2 (2006).
- <sup>13</sup> HHS. 2011. *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*. <http://www.healthcare.gov/law/resources/reports/preexisting.html> (accessed May 29, 2012).
- <sup>14</sup> United States Government Accountability Office. 2012. *Private Health Insurance: Estimates of Individuals with Pre-Existing Conditions Range from 36 Million to 122 Million*. Washington, DC: GAO-12-439 (Mar. 27, 2012).
- <sup>15</sup> Pollitz, K. Sorian, R. Thomas, K. 2001. *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* Washington DC: Henry J. Kaiser Family Foundation (June 2001).
- <sup>16</sup> Collins, S.R. Doty, M.M. Robertson, R. Garber, T. 2011. *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010*. Commonwealth Fund (Mar. 2011).
- <sup>17</sup> 75 Fed. Reg. 37188, 37189 (Jun. 28, 2010).
- <sup>18</sup> Public Health Service Act § 2704 (codified at 42 U.S.C. § 300gg-3 (2006)).
- <sup>19</sup> *Id.* Federal law defines “preexisting condition exclusion” as “a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.” 42 U.S.C. § 300gg-3 (2006).
- <sup>20</sup> Kaiser State Health Facts, *supra* note 8.
- <sup>21</sup> Jost, T.S. 2009. *The Regulation of Private Health Insurance*. Washington, D.C.: National Academy of Social Insurance, National Academy of Public Administration; Princeton, N.J.: Robert Wood Johnson Foundation.
- <sup>22</sup> United States Government Accountability Office, *supra* note 14.
- <sup>23</sup> 26 U.S.C. § 9801 (2006).
- <sup>24</sup> 75 Fed. Reg. at 37190.
- <sup>25</sup> 26 U.S.C. § 9801(a)(2) (2006).
- <sup>26</sup> Collins *et al.*, *supra* note 16.
- <sup>27</sup> Public Health Service Act § 2705 (codified at 42 U.S.C. § 300gg-4(a) (2006)).
- <sup>28</sup> *Id.*
- <sup>29</sup> Merlis, M. 2005. *Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform*. National Health Policy Forum Background Paper (Apr. 2005).
- <sup>30</sup> Kaiser State Health Facts. *supra* note 8.
- <sup>31</sup> Kaiser State Health Facts. *Small Group Health Insurance Market Rate Restrictions, 2011*, available at <http://statehealthfacts.org/comparetable.jsp?ind=351&cat=7>.
- <sup>32</sup> Collins *et al.*, *supra* note 16.
- <sup>33</sup> Public Health Service Act § 2701 (codified at 42 U.S.C. § 300gg (2006)).
- <sup>34</sup> *Id.* § 2701(a)(1).
- <sup>35</sup> *Id.*
- <sup>36</sup> *Id.*
- <sup>37</sup> *Id.* § 2701(a)(5).
- <sup>38</sup> *Id.*
- <sup>39</sup> *Id.*
- <sup>40</sup> *Id.* § 2701(a)(1).
- <sup>41</sup> *Id.*
- <sup>42</sup> NAIC Exchanges (B) Subgroup Rate Review Plan Management Team. 2012. *Rate Review White Paper*.
- <sup>43</sup> Public Health Service Act § 2701(a)(3).
- <sup>44</sup> *Id.* § 2701(a)(2).
- <sup>45</sup> *Id.*
- <sup>46</sup> *Id.* § 2718.
- <sup>47</sup> Rate review laws and practices vary by state and by market. Some states have adopted a “prior approval” rate review process where insurers are not allowed to implement a rate or rate change until it has been approved by the insurance department. Other states have adopted a “file and use” rate review process where insurance companies must file new and proposed rate changes with the department of insurance, but do not need to receive formal approval before they can implement the rate or rate change.
- <sup>48</sup> NAIC & Center for Insurance Policy & Research. 2011. *Health Insurance Rate Regulation*. [http://www.naic.org/documents/topics\\_health\\_insurance\\_rate\\_regulation\\_brief.pdf](http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf).
- <sup>49</sup> Coburn, A. Ziller, E. Croll, Z. Kilbreth, E. 2012. *The Rural Implications of Geographic Rating of Health Insurance Premiums*. State Health Access Reform Evaluation (May 2012).
- <sup>50</sup> Morrison, M. 2009. *Pueblo Health Insurance Study, January 1, 2003 to December 31, 2006*. Denver, CO: Colorado Department of Regulatory Agencies, Division of Insurance (January 2009).
- <sup>51</sup> Coburn *et al.*, *supra* note 49.
- <sup>52</sup> *Id.*
- <sup>53</sup> Public Health Service Act § 2705 (codified at 42 U.S.C. § 300gg-4 (2006)).
- <sup>54</sup> Volk, J. & Corlette, S. 2012. *Premium Incentives to Drive Wellness in the Workplace: A Review of the Issues and Recommendations for Policymakers*. Washington DC: Center on Health Insurance Reforms, Georgetown University.
- <sup>55</sup> ACA § 1312(c) (codified at 42 U.S.C. § 18032 (2006)).
- <sup>56</sup> Krisch, L. & Ditre, J. 2011. *To Bend the Cost Curve, Modernize Rate Review*. <http://mecahc.blogspot.com/2011/02/to-bend-cost-curve-modernize-rate.html>.
- <sup>57</sup> Bailit, M. & Koller, C. *Using Insurance Standards and Policy Levers to Build a High Performance Health System*. Commonwealth Fund (Nov. 2009).
- <sup>58</sup> NAIC Consumer Representatives. 2010. *PPACA Implementation: Consumer Recommendations for Regulators and Lawmakers*. May 2010.
- <sup>59</sup> Holahan, J. & Chen, V. 2012. *Declining Health Insurance in Low-Income Working Families and Small Businesses*. Washington DC: Urban Institute.
- <sup>60</sup> Families USA & Small Business Majority. 2012. *Good Business Sense: The Small Business Health Care Tax Credit in the Affordable Care Act*. Washington DC: Families USA (May 2012).
- <sup>61</sup> Gencarelli, D.M. 2005. *Health Insurance Coverage for Small Employers*. Washington DC: National Health Policy Forum (Apr. 19, 2005).
- <sup>62</sup> ACA §§ 1304, 1312(c)(3) (codified at 42 U.S.C. §§ 18024, 18032(c)(3) (2006)).

- <sup>63</sup> *Id.* § 1421 (codified at 26 U.S.C. § 45R (2006)).
- <sup>64</sup> *Id.* § 1304(b)(2) (defining “small employer” as follows: “in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employed at least 1 employee on the first day of the plan year”).
- <sup>65</sup> *Id.*
- <sup>66</sup> Pub. L. 104-191 § 2791(e)(4) (1996) (codified at 42 U.S.C. § 300g-91 (2006)).
- <sup>67</sup> Kaiser State Health Facts. *Small Group Health Insurance Market Guaranteed Issue, 2011*, available at <http://statehealthfacts.org/comparetable.jsp?ind=350&cat=7>.
- <sup>68</sup> See Kaiser State Health Facts, *supra* note 31.
- <sup>69</sup> ACA § 1312.
- <sup>70</sup> American Academy of Actuaries. 2009. *Critical Issues in Health Reform: Merging the Small Group and Individual Markets*. Washington DC: American Academy of Actuaries.
- <sup>71</sup> See, e.g., Herbold, J.S. 2011. *Merging the Individual and Small Group Markets*. Milliman Health Care Exchange Issue Brief: Indiana Exchange Policy Committee (May 2011), available at [http://www.in.gov/aca/files/Merge\\_Ind\\_SG.PDF](http://www.in.gov/aca/files/Merge_Ind_SG.PDF).
- <sup>72</sup> Alabama Department of Insurance. 2011. *Alabama Health Insurance Exchange Study Commission Recommendations*. Nov. 2011.
- <sup>73</sup> ACA § 1312(c).
- <sup>74</sup> Blavin, F. Blumberg, L.J. Buettgens, M. Holahan, J. McMorrow, S. 2012. “How Choices in Exchange Design for States Could Affect Insurance Premiums and Levels of Coverage.” *Health Affairs* 31(2):290-298.
- <sup>75</sup> Blavin, F. Blumberg, L.J. Buettgens, M. Roth, J. 2012. *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State*. Washington DC: Urban Institute.
- <sup>76</sup> We offer a number of recommendations on this issue. See *infra* *Stop Loss and Self-Insurance*.
- <sup>77</sup> Henry J. Kaiser Family Foundation & Health Research & Educational Trust. 2011. *Employer Health Benefits: 2011 Annual Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- <sup>78</sup> *Id.*
- <sup>79</sup> Public Health Service Act § 2708 (codified at 42 U.S.C. § 300gg-7 (2006)).
- <sup>80</sup> *Id.*
- <sup>81</sup> *Id.*
- <sup>82</sup> 42 U.S.C. § 300gg-3(b)(4) (2006).
- <sup>83</sup> Henry J. Kaiser Family Foundation & Health Research & Educational Trust, *supra* note 77.
- <sup>84</sup> Public Health Service Act § 2708.
- <sup>85</sup> Gabel, J.R. Pickreign, J.D. Whitmore, H.H. Schoen, C. 2001. “Embraceable You: How Employers Influence Health Plan Enrollment.” *Health Affairs* 20(4):196-208.
- <sup>86</sup> Fairlie, R.W. Kapur, K. Gates, S.M. 2010. *Is Employer-Based Health Insurance A Barrier to Entrepreneurship?* Kauffman-RAND Institute for Entrepreneurship Public Policy.
- <sup>87</sup> See United States Government Accountability Office. 2011. *Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act*. GAO-12-166R (Dec. 2011).
- <sup>88</sup> Henry J. Kaiser Family Foundation & Health Research & Educational Trust, *supra* note 77.
- <sup>89</sup> Although the federal government issued a request for public comment on whether benefit-specific waiting periods principally affect individuals whose condition existed before coverage began, no guidance has been issued in response to the questions. See Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV, 69 Fed. Reg. 78719, 78825 (Dec. 30, 2004).
- <sup>90</sup> National Cancer Institute. 2001. *Doctors, Patients Face Different Barriers to Clinical Trials*, available at <http://www.cancer.gov/clinicaltrials/researchabout/developments/doctors-barriers0401> (Apr. 11, 2001).
- <sup>91</sup> Center for Information & Study on Clinical Research Participation. 2009. *Clinical Trials Amendment*.
- <sup>92</sup> ACA § 1201 (establishing Public Health Service Act § 2709 (codified at 42 U.S.C. § 300gg-8 (2006))).
- <sup>93</sup> *Id.*
- <sup>94</sup> *Id.* § 2709(a).
- <sup>95</sup> *Id.*
- <sup>96</sup> Klamerus, J.F. Bruinooge, S.S. Ye, X. et al. 2010. “The Impact of Insurance on Access to Cancer Clinical Trials at a Comprehensive Cancer Center.” *Clin. Cancer Res.* 16:5997-6003.
- <sup>97</sup> Ellis, S.D. Carpenter, W.R. Minasian, L.M. Weiner, B.J. 2012. “Effect of State-Mandated Insurance Coverage on Accrual to Community Cancer Clinical Trials.” *Elsevier* (Jun. 2012), <http://dx.doi.org/10.1016/j.cct.2012.06.001>.
- <sup>98</sup> Klamerus et al., *supra* note 96.
- <sup>99</sup> *Id.*
- <sup>100</sup> *Id.*
- <sup>101</sup> ACA § 2709(h).
- <sup>102</sup> Klamerus et al., *supra* note 96.
- <sup>103</sup> Ward, E. Halpern, M. Schrag N. et al. 2008. “Association of Insurance with Cancer Care Utilization and Outcomes.” *CA Cancer J Clin.* 58:9–31.
- <sup>104</sup> ACA § 2709(e).
- <sup>105</sup> A broad interpretation is consistent with the intent of Section 2709’s author, Senator Sherrod Brown, who said on the Senate floor that “if we are ever going to find a cure for cancer and diabetes and cardiovascular disease and Alzheimer’s and ALS and the hundreds of other diseases killing millions of Americans each year, we need to encourage in every way possible participation in clinical trials and not put up barriers against participation.” Sen. Sherrod Brown. 2009. Congressional Record 155, 191: S13284.
- <sup>106</sup> Center for Information & Study on Clinical Research Participation. 2012. *Clinical Trials Facts & Figures*, available at: [http://www.ciscrp.org/professional/facts\\_pat.html](http://www.ciscrp.org/professional/facts_pat.html).
- <sup>107</sup> ACA § 2709(a)(2).
- <sup>108</sup> Medicare National Coverage Determination for Routine Costs in Clinical Trials (310.1), implemented 10/9/2007. Available at: <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=1&ncdver=2&bc=BAABAAAAAAAA&>.
- <sup>109</sup> Collins, S.R. Kriss, J.L. Davis, K. Doty, M.M. Holmgren, A.L. 2006. *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*. Commonwealth Fund (Sept. 2006).
- <sup>110</sup> Doty et al., *supra* note 3.
- <sup>111</sup> Seifert, R.W. & Rukavina M. 2006. “Bankruptcy Is the Tip of a Medical-Debt Iceberg.” *Health Affairs* 25(2):w89-w92.
- <sup>112</sup> Bellows, N.M. Halpin, H.A. McMenamain, S.B. 2006. “State-Mandated Benefit Review Laws.” *Health Servs Res* 41(3):1104-1123.
- <sup>113</sup> ACA § 1302 (codified at 42 U.S.C. § 18022 (2006)).
- <sup>114</sup> *Id.* § 1302(b).
- <sup>115</sup> Eibner, C., F. Girosi, C. C. Price, A. Cordova, P. S. Hussey, A. Beckman, and E. A. McGlynn. 2010. *Establishing state health insurance exchanges: Implications for health insurance enrollment, spending, and small businesses*. Santa Monica, CA: RAND Corporation.
- <sup>116</sup> ACA § 1302(b).
- <sup>117</sup> Public Health Service Act § 2711. The prohibition on lifetime limits on the dollar value of essential health benefits went into effect on September 23, 2010. Before 2014, annual limits on essential health benefits may only be established as determined by the federal government.
- <sup>118</sup> *Id.* § 1302(b)(1).
- <sup>119</sup> Institute of Medicine, Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans. 2012. *Essential Health Benefits: Balancing Coverage and Cost*. Eds. Ulmer, C. et al. Washington DC: National Academies Press.
- <sup>120</sup> *Id.*

- <sup>121</sup> United States Department of Labor. 2011. *Selected medical benefits: A report from the Department of Labor to the Department of Health and Human Services*. <http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf> (accessed May 29, 2012).
- <sup>122</sup> HHS, Center for Consumer Information and Insurance Oversight. 2011. *Essential Health Benefits Bulletin*. [http://ccio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) (accessed May 29, 2012).
- <sup>123</sup> *Id.*
- <sup>124</sup> *Id.*
- <sup>125</sup> *Id.*
- <sup>126</sup> *Id.*
- <sup>127</sup> HHS, Center for Consumer Information and Insurance Oversight. 2012. *Essential Health Benefits: List of the Largest Three Small Group Products by State*. <http://ccio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf>.PDF (July 3, 2012).
- <sup>128</sup> HHS, Center for Consumer Information and Insurance Oversight. 2012. *Frequently Asked Questions on Essential Health Benefits Bulletin*. <http://ccio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf> (accessed May 29, 2012).
- <sup>129</sup> 77 Fed. Reg. 42658 (June 20, 2012).
- <sup>130</sup> HHS, *supra* note 128.
- <sup>131</sup> See HHS, *supra* note 122.
- <sup>132</sup> See HHS, *supra* note 128.
- <sup>133</sup> ACA § 1311(d)(3)(B) (codified at 42 U.S.C. § 18031(d)(3)(B) (2006)).
- <sup>134</sup> E.g., Pryor, C. Cohen, A. Prottas, J. 2007. *The Illusion of Coverage: How Health Insurance Fails People When They Get Sick*. Boston, MA: Access Project.
- <sup>135</sup> HHS, *supra* note 122.
- <sup>136</sup> *Id.*
- <sup>137</sup> *Id.*
- <sup>138</sup> See HHS, *supra* note 122.
- <sup>139</sup> See Avalere. 2012. *New Avalere Health Study Shows that State Decisions About "Essential Health Benefits" Could Have Profound Effect on Patient Drug Coverage*. <http://www.avalerehealth.net/wm/show.php?c=&id=896> (accessed May 29, 2012).
- <sup>140</sup> Pollitz, K. Bangit, E. Libster, J. Lewis, S. Johnston, N. 2009. *Coverage When It Counts: How Much Protection Does Health Insurance Offer and How Can Consumers Know?* Washington DC: Center for American Progress Action Fund.
- <sup>141</sup> ACA § 1311(d)(2)(B)(ii) (codified at 42 U.S.C. § 18031(d)(2)(B)(ii) (2006)).
- <sup>142</sup> Kleimann Communications Group Inc. & Consumers Union. 2011. *Early Consumer Testing of Actuarial Value Concepts*. [http://yourhealthsecurity.org/wordpress/wp-content/uploads/2011/10/prescriptionforchange.org\\_testing\\_actuarial\\_value\\_concepts1.pdf](http://yourhealthsecurity.org/wordpress/wp-content/uploads/2011/10/prescriptionforchange.org_testing_actuarial_value_concepts1.pdf) (Sept. 2011) (accessed May 29, 2012).
- <sup>143</sup> ACA § 1302 (codified at 42 U.S.C. § 18022 (2006)).
- <sup>144</sup> *Id.* § 1302(b).
- <sup>145</sup> Quincy, L. & Okrent, D. 2012. *Creating A Usable Measure of Actuarial Value*. (Jan. 2012) [http://www.consumersunion.org/pub/pdf/CU\\_Actuarial\\_Value\\_2012\\_Report.pdf](http://www.consumersunion.org/pub/pdf/CU_Actuarial_Value_2012_Report.pdf) (accessed May 29, 2012).
- <sup>146</sup> *Id.* § 1302(b), (d).
- <sup>147</sup> ACA §§ 1401, 1402 (codified at 26 U.S.C. § 36B (2006); 42 U.S.C. § 18071 (2006)).
- <sup>148</sup> ACA § 1302(e) (codified at 42 U.S.C. § 18022(e) (2006)).
- <sup>149</sup> *Id.* §§ 1302(c), 2707 (codified at 42 U.S.C. § 18022(c) (2006)).
- <sup>150</sup> *Id.*
- <sup>151</sup> See 26 C.F.R. § 601.602.
- <sup>152</sup> ACA § 1402(c) (codified at 42 U.S.C. § 18071(c) (2006)).
- <sup>153</sup> Kaiser Family Foundation. 2010. *Explaining Health Care Reform: Questions About Health Insurance Subsidies*. Apr. 2010.
- <sup>154</sup> HHS, Center for Consumer Information and Insurance Oversight. 2012. *Actuarial Value and Cost-Sharing Reductions Bulletin*. <http://ccio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf> (accessed May 29, 2012).
- <sup>155</sup> Quincy, L. Kingsley, B. Kleimann Communication Group. 2011. *Early Consumer Testing of Actuarial Value Concepts*. Washington, DC: Consumers Union (Sept. 2011).
- <sup>156</sup> ACA § 1302.
- <sup>157</sup> Internal Revenue Service. 2012. *Bulletin 2012-20: Minimum Value of an Employer-Sponsored Health Plan*. (May 14, 2010).
- <sup>158</sup> *Id.*
- <sup>159</sup> Unless prohibited by state law, the HHS bulletin indicates that HHS intends to allow insurers to make covered benefit substitutions within the 10 essential health benefit categories, as long as they are "actuarially equivalent." It is unclear how this determination can be made given that much grosser actuarial estimates are proposed for exclusion from the federal AV calculator.
- <sup>160</sup> McDevitt, R. Watson, T. Lore, R. 2012. *Actuarial Value under the Affordable Care Act: Plan Valuation with the Consumer in Mind*. Washington, DC: Consumers Union (June 2012).
- <sup>161</sup> We also offer a number of recommendations on this issue. See *infra* *Essential Health Benefits, Including State-Mandated Benefits*.
- <sup>162</sup> *Id.* (citing United States Census data).
- <sup>163</sup> Corlette, S. Alker, J. Tuschner, J. Volk, J. 2011. *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned*. (Mar. 2011) <http://www.rwjf.org/files/research/72105massutah201103.pdf> (accessed May 29, 2012).
- <sup>164</sup> *Id.*
- <sup>165</sup> Hyman, D.A. & Hall, M. 2001. "Two Cheers for Employment-Based Insurance." *Yale J. Health Pol'y, L, and Ethics* 2(23):30-35.
- <sup>166</sup> Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits*, *supra* note 77.
- <sup>167</sup> Jost, T. & Hall, M. 2012. "Self Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options." *NYU Annual Survey of Am. Law* (forthcoming).
- <sup>168</sup> For example, the following websites, viewed in May 2012, showed that many employee benefits advisors have begun marketing stop loss to small groups: <http://www.amfrms.com/smallgroup.htm>; <http://www.img-stoploss.com/about-img-stop-loss/IMG-sl-advantage.aspx>; <http://www.assuranthealth.com/corp/ah/HealthPlans/SESelfFunded.htm>; <http://www.spectrumhq.com/>; [http://www.sbisvcs.com/iac\\_group\\_advantage.htm](http://www.sbisvcs.com/iac_group_advantage.htm); <http://www.cigna.com/grouphealthplans/index.html>.
- <sup>169</sup> These new requirements are discussed elsewhere in this document and we offer a number of recommendations to state policymakers on each issue.
- <sup>170</sup> See, e.g., Butler, P. 2000. *ERISA Preemption Manual for State Health Policymakers*. State Coverage Initiatives (Jan. 2000).
- <sup>171</sup> The question may arise whether states are barred from regulating stop loss coverage by ERISA. ERISA prohibits the states from directly regulating employer plans. But ERISA explicitly reserves to the states the right to regulate insurance. Stop loss insurers are insurers, and are thus subject to state regulation. Many state courts and regulators have similarly held that stop loss insurance is subject to state regulation. The Texas Supreme Court recently held, for example, that stop loss insurance is subject to the state's premium tax that applies to normal health insurance. State and federal courts from California, Indiana, Iowa, Kansas, Minnesota, Missouri, and Wisconsin have also taken this or very similar positions. These cases have repeatedly upheld state regulation of stop loss health insurance. See generally Jost & Hall, *supra* note 167.
- <sup>172</sup> Hall, M.A. 2012. "Regulating Stop-Loss Coverage May be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms." *Health Aff* 31:316.
- <sup>173</sup> Del. Code Ann. 18-7218; NY Ins. Law 3231, 4317; Or. Rev. Stat. 742.065.
- <sup>174</sup> New Jersey Dept. of Banking and Insurance. 2011. *Bulletin No. 11-20, Selective Marketing of Stop Loss Coverage* (Oct. 3, 2011).
- <sup>175</sup> N.C. Gen. Stat. § 58-50-130(a)(5).
- <sup>176</sup> Jost & Hall, *supra* note 167.
- <sup>177</sup> NAIC. 1995 *Stop-Loss Insurance Model Act* (#92).
- <sup>178</sup> *Id.*

- <sup>179</sup> *Id.*
- <sup>180</sup> NAIC Regulatory Framework (B) Task Force. *2012 Charges*, available at: [http://www.naic.org/committees\\_b\\_regulatory\\_framework.htm](http://www.naic.org/committees_b_regulatory_framework.htm).
- <sup>181</sup> Milliman, Inc. 2012. *Statistical Modeling and Analysis of Stop-Loss Insurance for Use in NAIC Model Act* (May 2012), available at [http://www.naic.org/documents/committees\\_b\\_hcra\\_wg\\_120606\\_milliman\\_stop\\_loss\\_report.pdf](http://www.naic.org/documents/committees_b_hcra_wg_120606_milliman_stop_loss_report.pdf).
- <sup>182</sup> See, e.g., Ripps, J. 2012. *The Subgroup's Interpretation of the Milliman Report* (May 30, 2012), available at: [http://www.naic.org/documents/committees\\_b\\_hcra\\_wg\\_120606\\_milliman\\_interpretations.pdf](http://www.naic.org/documents/committees_b_hcra_wg_120606_milliman_interpretations.pdf). The subcommittee also recommends substantial increases to the aggregate attachment point minimums. *Id.*
- <sup>183</sup> NAIC Health Insurance and Managed Care (B) Committee. 2012. *Interim Meeting Summary Report*. [http://www.naic.org/documents/committees\\_b\\_120627\\_meeting\\_summary.pdf](http://www.naic.org/documents/committees_b_120627_meeting_summary.pdf) (last accessed July 19, 2012).
- <sup>184</sup> *Id.* § 1560(c) (codified at 42 U.S.C. § 18118 (2006)).
- <sup>185</sup> 45 C.F.R. § 147.145.
- <sup>186</sup> 77 Fed. Reg. 16453, 16455 (Mar. 21, 2012).
- <sup>187</sup> Jost & Hall, *supra* note 167.
- <sup>188</sup> See, e.g., United Benefit Advisors, Small Businesses Blaze a New Trail with Self-Funding (2011), <http://wn.ubabenefits.com/Download.aspx?ResourceID=7630>; Self-Insurance Institute of America, Companies of All Sizes Can Operate Viable; Self-Insured Group Health Plans (2011), [http://www.avalonbenefits.com/news\\_story.php?file=2011-02-14\\_150657.txt](http://www.avalonbenefits.com/news_story.php?file=2011-02-14_150657.txt); George J. Pantos, PPACA: Small Business And Self-Insurance: Dispelling Some Myths (2011), <http://georgegjp.wordpress.com/2011/05/09/ppaca-small-business-and-self-insurance/>; Michael Turpin, A Case for Self Insuring Small Business (2011), <http://thehealthcareblog.com/blog/2011/04/08/a-case-for-self-insuring-small-business/>.
- <sup>189</sup> See chapter on the definition of “small employer” where we offer additional recommendations to state policymakers.
- <sup>190</sup> Collins et al., *supra* note 109.
- <sup>191</sup> ACA § 1501(b) (codified at 26 U.S.C. § 5000A (2006)).
- <sup>192</sup> Jost, T.S. 2011. “Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them,” *Saint Louis University Journal of Health Law & Policy* 5:27. The term “mini-med plan” is not defined in the NAIC Accident and Sickness Insurance Minimum Standards Model Act or the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act but is defined by CMS as plans with total annual benefit limits of \$250,000 or less.
- <sup>193</sup> 42 U.S.C. § 300gg-91(c) (2006).
- <sup>194</sup> NAIC Health Insurance and Managed Care (B) Committee. *2012 Charges*, available at: [http://www.naic.org/committees\\_b.htm](http://www.naic.org/committees_b.htm).
- <sup>195</sup> *Id.*
- <sup>196</sup> See Consumer Representatives to the NAIC Letter to Comm. Robertson. 2012. *RE: Excepted Benefit Plans and the Scope of the Working Group's Charge* (May 25, 2012), available at [http://www.naic.org/documents/committees\\_jt\\_bd\\_lim\\_med\\_ben\\_related\\_docs\\_excepted\\_benefit\\_plans.pdf](http://www.naic.org/documents/committees_jt_bd_lim_med_ben_related_docs_excepted_benefit_plans.pdf). The letter includes a table with the definitions and uses of the term “limited benefits,” “excepted benefits,” and “mini-med” plans by the NAIC and CMS. *Id.*
- <sup>197</sup> *NAIC Accident and Sickness Insurance Minimum Standards Model Act*. MDL-170.
- <sup>198</sup> *Model Regulation To Implement the Accident And Sickness Insurance Minimum Standards Model Act Model Regulation*. MDL-171.
- <sup>199</sup> Jost, *supra* note 192.
- <sup>200</sup> *Id.*
- <sup>201</sup> *Id.*
- <sup>202</sup> Adkisson, T. 2010. “Don't Give Up on Limited Benefit Medical Plans!” *VoluntaryBenefitsMagazine.com* (Jun. 10, 2010, available at: <http://www.voluntarybenefitsmagazine.com/article-detail.php?issue=issue-138&article=don-t-give>).
- <sup>203</sup> E.g., Pollitz, et al., *supra* note 15.
- <sup>204</sup> ACA §§ 1341-1343 (codified at 42 U.S.C. §§ 18061-18063 (2006)).
- <sup>205</sup> *Id.* § 1341(c)(1)(A).
- <sup>206</sup> Park, E. 2011. *Ensuring Effective Risk Adjustment*. Washington DC: Center on Budget and Policy Priorities (May 2011).
- <sup>207</sup> *Id.* § 1343.
- <sup>208</sup> 77 Fed. Reg. 17220, 17223 (Mar. 23, 2012).
- <sup>209</sup> 45 C.F.R. § 153.310.
- <sup>210</sup> *Id.*
- <sup>211</sup> ACA § 1343(a).
- <sup>212</sup> *Id.* § 1343(a)(1).
- <sup>213</sup> *Id.* § 1343(a)(2).
- <sup>214</sup> *Id.* § 1343(b).
- <sup>215</sup> 45 C.F.R. § 153.330.
- <sup>216</sup> *Id.*; see also 77 Fed. Reg. at 17232.
- <sup>217</sup> See generally 77 Fed. Reg. 17220.
- <sup>218</sup> HHS, Center for Consumer Information and Insurance Oversight. 2011. *Bulletin on the Transitional Reinsurance Program: Proposed Payment Operations by the Department of Health and Human Services*. <http://ccio.cms.gov/resources/files/reinsurance-program-bulletin-5-31-2012.pdf> (accessed May 29, 2012).
- <sup>219</sup> In May 2012, the Center for Consumer Information and Insurance Oversight (CCIIO) held a public meeting on risk adjustment and senior HHS officials provided details regarding the approach that HHS intends to take when administering risk adjustment programs on behalf of the states. This information was included in presentations given at the meeting which can be found on the CCIIO website.
- <sup>220</sup> Park, *supra* note 206.
- <sup>221</sup> Park, E. 2011. *Allowing Insurers to Withhold Data on Enrollees' Health Status Could Undermine Key Part of Health Reform*. Washington DC: Center on Budget and Policy Priorities (Dec. 2011).
- <sup>222</sup> American Academy of Actuaries. 2011. *Proposed rule on standards related to reinsurance, risk corridors, and risk adjustment* (Oct. 28, 2011).
- <sup>223</sup> 45 C.F.R. § 153.340.
- <sup>224</sup> 77 Fed. Reg. at 17233.
- <sup>225</sup> Park, *supra* note 221.
- <sup>226</sup> HHS, *supra* note 218.
- <sup>227</sup> See *id.*
- <sup>228</sup> ACA § 1341(c)(1).
- <sup>229</sup> Park, *supra* note 206.
- <sup>230</sup> ACA § 1341(b).
- <sup>231</sup> *Id.*
- <sup>232</sup> *Id.* High-risk enrollees will be identified on the basis of 50 to 100 medical conditions identified as high-risk conditions or another comparably objective method of identification recommended by the American Academy of Actuaries. *Id.* § 1341(b)(2).
- <sup>233</sup> 45 C.F.R. § 153.100.
- <sup>234</sup> *Id.* § 153.230.
- <sup>235</sup> *Id.* § 153.220(b).
- <sup>236</sup> *Id.* § 153.240.
- <sup>237</sup> *Id.* § 153.220.
- <sup>238</sup> *Id.* § 153.250.
- <sup>239</sup> ACA § 1341(c)(1)(A).
- <sup>240</sup> American Academy of Actuaries. 2010. *Letter to Melinda Buntin*. (Sept. 22, 2010).
- <sup>241</sup> CCIIO. 2012. *HHS Risk Adjustment Model*, available at: <http://ccio.cms.gov/resources/files/fm-1c-risk-adj-model.pdf> (accessed June 24, 2012).
- <sup>242</sup> ACA § 1342.
- <sup>243</sup> 77 Fed. Reg. 17220, 17237 (Mar. 23, 2012).
- <sup>244</sup> ACA § 1342(b).
- <sup>245</sup> *Id.*
- <sup>246</sup> Park, *supra* note 206.
- <sup>247</sup> See generally 77 Fed. Reg. 17220.
- <sup>248</sup> *Id.* at 17239.

