Overview of Proposed Regulations

December 7, 2012

MERCER

OLIVER WYMAN

Project Goal and Webinar Objectives

Project Purpose: *Develop policy options and considerations and identify areas of consensus to inform the NC DOI actions and recommendations for Exchange-related market reform policies.*

(pursuant to North Carolina Session Law 2011-391)

"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations. The Commissioner shall submit a report to the...General Assembly containing recommendations resulting from the study."

-- Session Law 2011-391

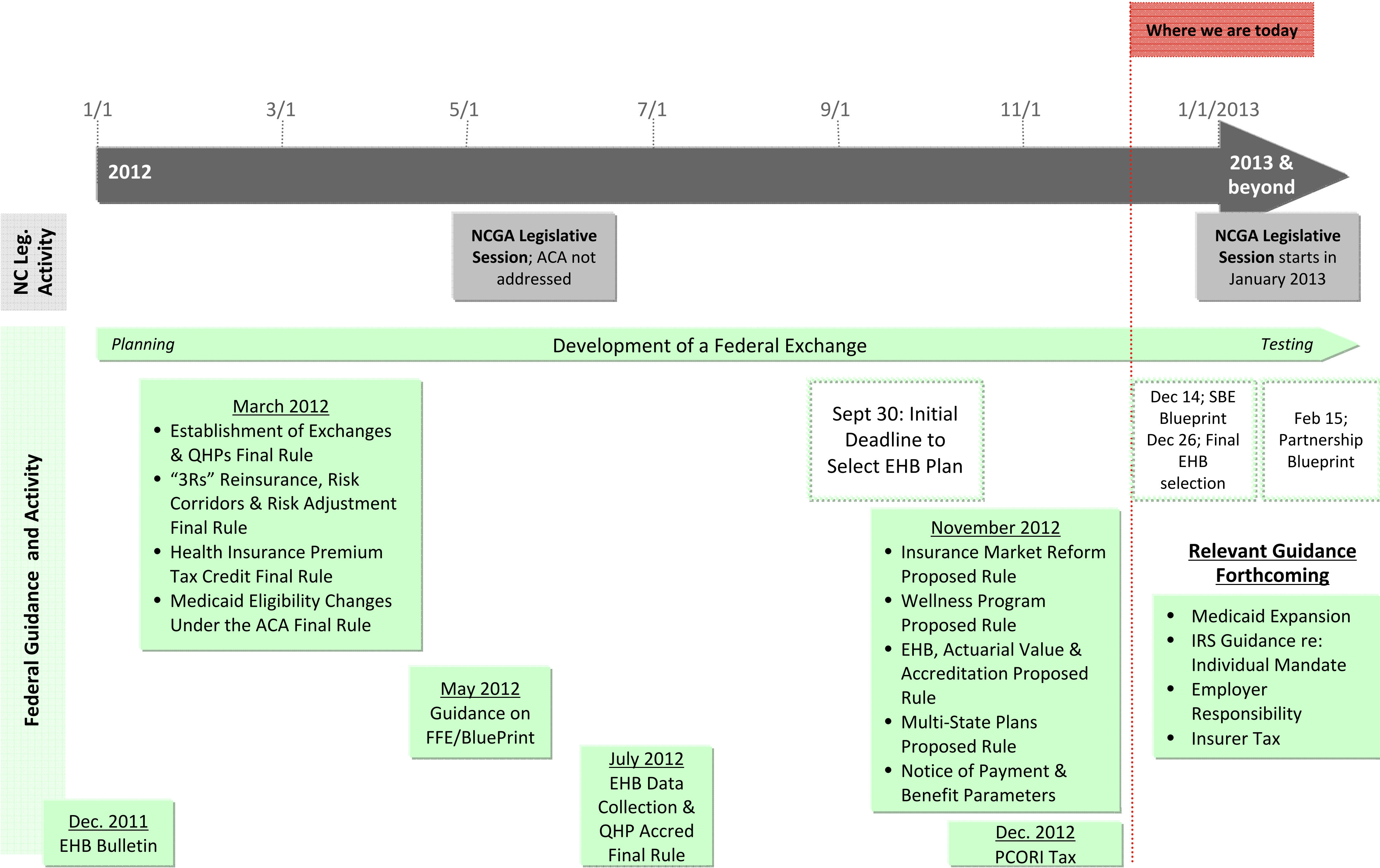
Objectives for Today's Webinar

- Develop a baseline understanding of all relevant rules/guidance issued recently
- Inform the discussion of the TAG 11 meeting regarding essential health benefits and the Rating Implementation Work Group meeting regarding geographic areas, age bands/factors and tobacco rating and other topics

Agenda

- Rules/Guidance Released and Timing for Response
- Proposed Rule: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation
- Proposed Rule: Health Insurance Market Rules; Rate Review
- Proposed Rule: Incentives for Nondiscriminatory Wellness Programs in Group Health Plans
- Proposed Rule: Multi-State Plans
- Other Items:
  - Request for Information: Health Plan Quality Management in Exchanges
  - Benefit Plan and Payment Parameter Notice – 3Rs and Other Updates
- Next Steps

Market and Exchange Rules/Regulations



Post-Election Health Reform Guidance
Released November 20th, 2012

Proposed Rule	Comment Due Date
Essential Health Benefits (EHBs), Actuarial Value, Accreditation	
Proposed rule on essential health benefits, actuarial value, and plan accreditation	December 26 , 2012
Additional information on state essential health benefits benchmark plans	December 26 , 2012
State Medicaid director letter on essential health benefits and the Medicaid benchmark	December 26 , 2012
Actuarial value calculator and methodology	December 26 , 2012
Final notice recognizing entities for accreditation of qualified health plans	NA
Paperwork Reduction Act (PRA) package on accrediting entities	December 26 , 2012
Health Insurance Market Reforms and Wellness Rules	
Proposed rule on health insurance market reforms and rate review	December 26, 2012
Proposed rue on incentives for nondiscriminatory wellness programs in group health plans	January 25, 2013
PRA package for rate review	December 26, 2012
Other PRA Packages	
PRA package on certifying qualified health plans	NA
PRA package on insurer compliance with title XXVII of the Public Health Service Act	NA

Note: Links to these documents are provided in the Appendix

Post-Election Health Reform Guidance
Released November 30 & December 5, 2012

Proposed Rule	Comment Due Date
Establishment of the Multi-State Plan Program	
MSPP Rule	January 4, 2013
Notice of Benefit and Payment Parameters for 2014	
Risk Adjustment, Reinsurance and Risk Corridor Information	December 31, 2013
Medical Loss Ratio (Intersection with 3Rs)	December 31, 2013
Advance Premium Tax Credits and Cost Sharing Reductions	December 31, 2013
Small Business Health Options Program (SHOP) Exchange	December 31, 2013
Federally Facilitated Exchange (FFE) User Fees	December 31, 2013
PCORI Tax	
Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund Final Rule	NA

Note: Links to these documents are provided in the Appendix

Forthcoming Guidance

The Administration is expected to release additional guidance and regulations in the coming weeks and months, including:

- CMS guidance to states regarding Medicaid expansion
- Guidance from the Internal Revenue Service (IRS) on the individual mandate
- Employer responsibility provision
- Health insurance tax

Agenda

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Proposed Rule Summary: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Areas for Further Consideration

- Allows states until December 26th to select a benchmark plan from one of ten options in the state or change selection already made
  - States that do not make a selection will default to the largest plan by enrollment in the small group market
  - Proposes a standard process for selection of benefits not covered in the benchmark package, such as pediatric dental and vision, and a minimum standard for coverage of prescription drugs
- Proposes additional flexibility for habilitative services regardless of if a state defaults
- Proposes to allow states the option of permitting insurer substitution of EHB benefits, within certain parameters

Report Out

- Adopts actuarial value (AV) standard for allowable variation of plans from the metal levels of +/- 2%
- Implements Section 1311 of the ACA, requiring that qualified health plans (QHPs) be accredited on the basis of performance by an accrediting entity recognized by HHS

Report Out: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Actuarial Value	
AV Calculator & Metal Levels	• Issuers will enter cost sharing parameters of plan benefit design into the calculator to determine if the offering meets the requirements of the metal levels' AV • The calculator ▪ Calculates AV based on a set of standard parameters (e.g., deductibles, out-of-pocket limits, coinsurance) ▪ Calculates impact of a limited range of plan cost sharing variations such as the waiver of cost sharing following a set number of provider visits ▪ Uses a national data set to determine the AV of plan designs – in 2015 states may substitute their own data into the calculator subject to federal standards and subject to HHS review and approval ▪ Does not calculate non-standard plan designs – plans may determine AV through alternative means with an actuary • HHS will allow for small variations (+/- 2%) in AV around the metal level requirements
Minimum Value	• Minimum value defined as the employer paying 60% of the allowed cost of plan benefits • Beginning in 2014, sponsors of employer-provided health plans will need to determine whether they provide minimum value • HHS and IRS will make a calculator available to employers to determine whether they are providing minimum value*
Cost Sharing Requirements	• Restates required limits on annual cost sharing- deductible for small group plans may not exceed $2,000 for self-only coverage or $4,000 for other than self-only (e.g., family) • Allows plans that exceed the deductible limit when necessary to achieve the required AV

*Link to calculator: http://cciio.cms.gov/resources/regulations/index.html

Report Out: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Accreditation	
Accreditation	• Opens up phase one accreditation to allow additional organizations to qualify as accreditation entities, increasing choices for accreditation for exchanges, states, and issuers ▪ NCQA and URAC remain eligible accreditation entities for phase one • For QHP accreditation in federal exchanges (including state partnership exchanges), HHS proposes to accept existing accreditation by an accreditation entity on an issuer's commercial or Medicaid lines of business until the fourth year of certification ▪ This timeline recognizes the significant time issuers will need to obtain accreditation ▪ For QHPs without existing accreditation, QHPs must – Schedule accreditation review in their first year of certification of the QHP – Be accredited on their QHP policies and procedures in their second and third years of certification – Be accredited on the basis of local performance by year four

Report Out: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Essential Health Benefits	
Prescription Drugs	• Each plan would be required to include the greater of (1) one drug in each category and class; or (2) the number of drugs in each category and class in the base-benchmark plan ▪ Example: If a base-benchmark plan has none or one drug in a class, the EHB requirement is one drug in that class. If the base-benchmark plan has two or more drugs in a class, the EHB requirement is to have at least that many drugs. ▪ Issuers must submit their lists of covered drugs to the exchange, State, or Office of Personnel Management (OPM), as appropriate • Categories and classes will come from: USP Medicare Part D Model Guidelines Version 5.0 • Issuers must have procedures to allow enrollees to request clinically appropriate drugs not covered by the health plan – the rule does not specify standards for such requests
Payment for State-Required Benefits Beyond EHBs	• Should the state require benefits within QHPs that are not EHBs, the state must assume the full cost of providing such benefits either in the form of (1) payments directly to plan participants or (2) to issuers on behalf of its participants ▪ States may avoid the payment requirement to the extent that the benchmark plan contains state required benefits enacted on or before December 31, 2011 • State required benefits are those involving care, treatment, and services and not those related to provider types, cost sharing, or reimbursement methods ▪ Even though state law requirements may impose costs on plans, the state does not have to pay for them • State payments for state-required benefits that are not EHBs will be calculated by the issuer of the QHP ▪ HHS requested comments on whether payments should be based on the statewide average cost of the state-required benefit or on the actual cost of the QHP delivering the benefit

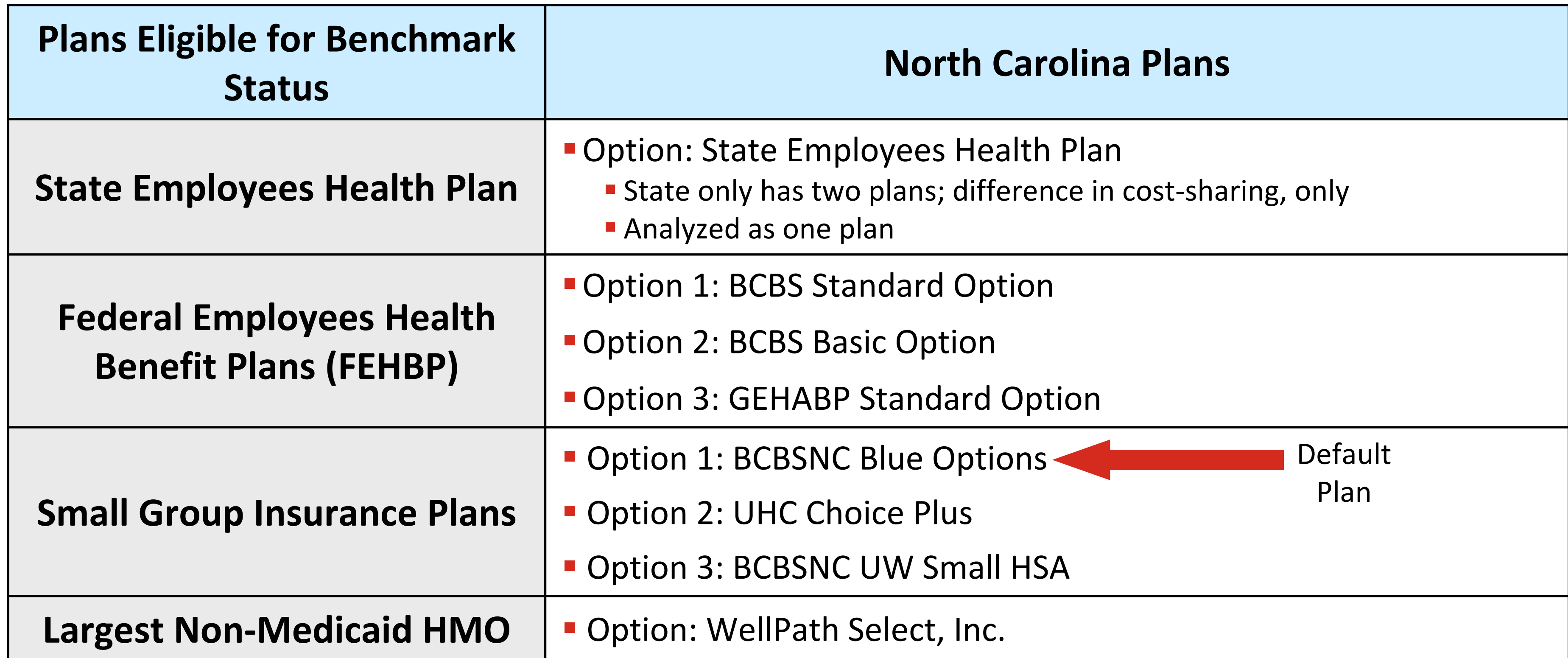
Link to calculator: http://cciio.cms.gov/resources/regulations/index.html

Report Out: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Essential Health Benefits, continued	
Non-discrimination	• A plan may not provide EHBs if its benefits discriminate based on age, life expectancy, disability, medical dependency, quality of life, or other health conditions – the rule does not specify how such possible discrimination would be determined • Extends discriminatory cost sharing test to non-grandfathered plans outside the Exchange • Seeks comments on approaches to ensure EHB-benchmark plans do not include discriminatory benefit designs

Link to calculator: http://cciio.cms.gov/resources/regulations/index.html

Further Consideration: Benchmark Plan Options in North Carolina



Plans Eligible for Benchmark Status	North Carolina Plans

State Employees Health Plan	▪ Option: State Employees Health Plan
	  ▪ State only has two plans; difference in cost-sharing, only
	  ▪ Analyzed as one plan

Federal Employees Health Benefit Plans (FEHBP)	▪ Option 1: BCBS Standard Option ▪ Option 2: BCBS Basic Option ▪ Option 3: GEHABP Standard Option
Small Group Insurance Plans	▪ Option 1: BCBSNC Blue Options ← Default Plan ▪ Option 2: UHC Choice Plus ▪ Option 3: BCBSNC UW Small HSA
Largest Non-Medicaid HMO	▪ Option: WellPath Select, Inc.

A May 2012 report showed no meaningful benefits differences between the benchmark plan options. North Carolina defaulted to the largest small group option plan, BCBSNC Blue Options, in September and the proposed rules offer no compelling reason to alter the default plan.

A complete listing of the benefits offered under BCBS Blue Options can be found at: http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-north-carolina.pdf ; The report on the benefit plan options can be found at: http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/NC%20DOI%20Session%20Law%202011-391%20Study%20Report.pdf

Relevant Proposed Regulations – Habilitative Benefits

The proposed rule gives states the authority to select and define habilitative benefits if the base-benchmark plan does not include coverage for habilitative services. If the state does not define habilitative benefits, the rule proposes that insurers will select the habilitative benefits for inclusion in the EHB.

- "If the base-benchmark plan does not include coverage for habilitative services, the state may determine which services are included in that category." *(§156.110(f) Proposed Rule)*
- If the EHB-benchmark plan does not include coverage for habilitative services, and the state does not determine which services are included, "a plan must include habilitative services that meet one of the following— (i) Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (ii) Are determined by the issuer and reported to HHS." *(§156.115(a)(4) Proposed Rule)*

Considerations for Habilitative Benefits

Since North Carolina's benchmark plan option does not include habilitative services, the state has the option to select the habilitative benefit for the EHB package.

Pros from State-Selection of habilitative benefits	Cons from State-Selection of habilitative benefits
▪ Benefit would be standard across plans, which would streamline certification and discrimination testing ▪ Except in cases of benefit substitution ▪ Consumers/advocates would have an opportunity to weigh in on benefit design at a macro level	▪ Relatively short-timeframe with a number of important issues to sort through (e.g. benefits for autism?); reaching resolution might be difficult ▪ Could limit insurer innovation and product design options

The TAG will be asked to weigh in on whether the state or insurers should define a habilitative benefit for North Carolina and what the appropriate process might be in either scenario.

Relevant Proposed Regulations- Actuarial Substitutions

The proposed rule gives insurers the flexibility to substitute benefits, subjected to certain conditions, if a state allows for benefit substitutions.

Benefit substitution is federally allowed if the insurer meets the following conditions:

1. The substitution is among (not across) categories and is not the prescription drug benefit
2. Submits actuarial equivalence of substituted benefits to the state, that is conducted by a member of the American Academy of Actuaries, based on analysis using generally accepted actuarial principles and uses a standardized population
3. Actuarial equivalence of benefits is determined regardless of cost-sharing *(§156.11b(b) Proposed Rule)*

"Resulting plan benefits are still subject to the requirements of non-discrimination" *(Preamble)*

- A plan is not an EHB if its benefit design, or the implementation of its benefit design, discriminated based on an individual's age, expected length of life, present/predicted disability, degree of medical dependency, quality of life, or other health conditions *(§156.125 Proposed Rule)*

States have the option to enforce a stricter standard on benefit substitution or prohibit it completely *(Preamble)*

Considerations for Substitution of Benefits

Permitting substitution of benefits provides insurers flexibility and offers consumers different options. However it creates administrative and oversight challenges for states that would be tasked with determining the appropriateness of such substitutions and their impact across the market.

Pros of Permitting Insurer Substitution

- Provides insurers flexibility in meeting EHB plan requirements and in product innovation
- Different benefit designs could appeal to different consumers
  - E.g. EHB calls for 15 PT and 10 OT visits and insurer substitutes that with 25 visits for either PT or OT

Cons of Permitting Insurer Substitution

- Insurers would be required to perform actuarial equivalence testing, which will increase costs
- States would need to develop a new testing process to check for both discrimination as well as adverse selection/favorability
  - E.g. States may need to develop a process that tests for clinical appropriateness
- Time frame for certification will be longer if many plans submit substitutions

TAG will discuss if benefit substitutions should be permitted in North Carolina and, if so, the time frames and processes for submission and approval of such substitutions.

Agenda

Proposed Rule Summary: Health Insurance Market Rules; Rate Review

Areas for Further Consideration

- HHS proposes specific rules to implement guaranteed issue and adjusted community rating, including:
  - Insurers will use single-year age bands, with rates changing for each year of age, in implementing the ability to charge older adults up to three times as much as younger adults; two exceptions are (1) everyone under aged 21 will be in one age band and (2) everyone aged 64 or older will be in one age band
  - Each state will have a uniform age rating curve so that the relationship between rates charged the young and the old will be uniform across insurers; states can establish their own curves with an HHS proposed curve serving as a default
  - States may establish up to seven areas for purposes of varying premiums based on location; HHS will establish rating areas if states do not do so; States may propose other existing geographic divisions for approval
- If states do not prescribe a narrower ratio or prohibit varying rates by tobacco use, insurers can charge smokers up to a 50% surcharge
  - Insurers must waive the surcharge in the small group market if a smoker participates in a smoking cessation program

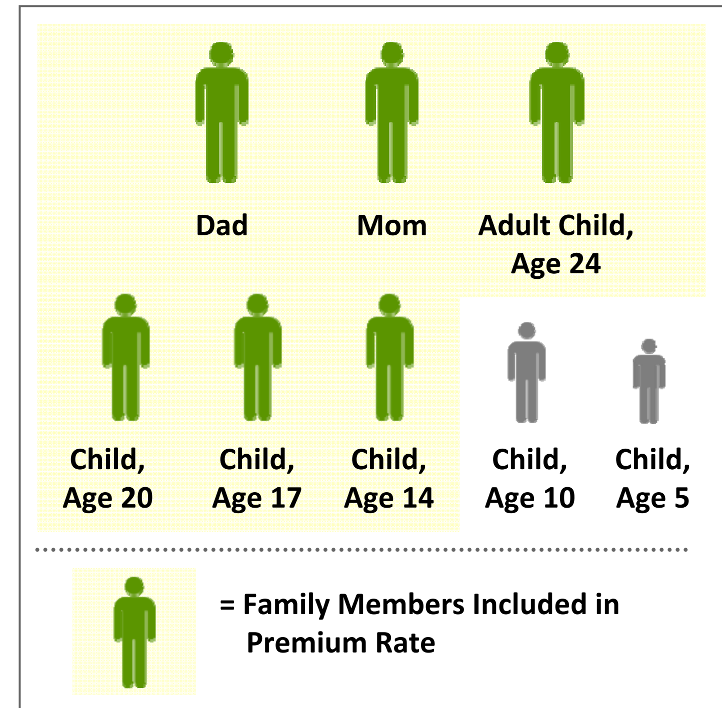
Report Out

- The proposed rules
  - Insurers will not be able to price insurance using family tiers; instead, premiums for no more than three of the oldest family members who are under aged 21 will be taken into account
  - Establish open enrollment periods and marketing standards to ensure people are not discriminated against on the basis of health status
  - Require that insurers treat all enrollees in the individual market as a single risk pool and all enrollees in the small group market as a single risk pool
  - Add new standards for insurer rate reviews by the state and require insurers to report rate increases to HHS
  - Clarify the authority of HHS to enforce the law inside and outside the exchanges

Report Out: Family Tiers

Family Tiers & Rating

- The ACA requires that rates for family policies vary based on age and tobacco use of family members only in proportion to the premium attributable to those individuals
- Aligning individual and group market rating practices will make employee choice models easier to manage for insurers
- Proposes a variant of the per member family rating approach in both the individual and small group markets *(see example)*
  - Each family member aged 21 or older is age and tobacco-rated separately, including children still in the household
  - No more than the first three family members (aged 0 – 20) are rated individually under the 0 – 20 age band; additional family members are not rated
- Permits the use of family tiers in fully community rated states, where everyone pays the same rates without regard to age and tobacco use
- HHS requests comment on:
  - The use of the per-member build-up methodology
  - The appropriate cap, if any, on the number of child and adult family members whose premiums should be taken into account and the cut-off age for a per child cap
  - If states with pure community rating should also use the per-member approach
  - If the final rule should specify the minimum categories of family members or if the decision should be deferred to states/insurers
  - If certain individuals should be included or excluded under family coverage



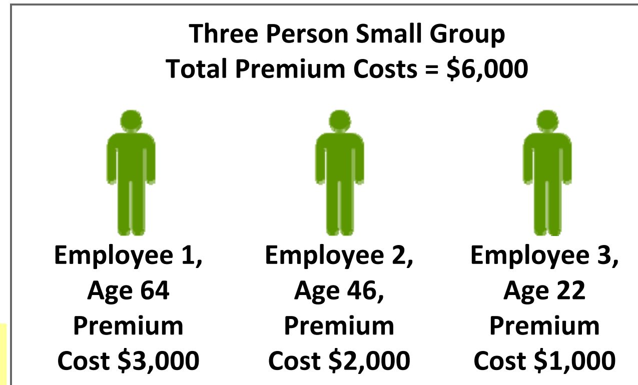
Report Out: Small Group Rating

Small Group Rating and Employer Contribution

- Employer contributions are complicated in the proposed "per member" approach; employees could owe dramatically different amounts for their coverage
  - If the age-rated premiums for the youngest employees are one-third as much as premiums for the oldest employees, then a fixed dollar contribution from the employer that covers 100% of the youngest employee's premium covers only 33% of the oldest employee's premium
- HHS acknowledges two primary ways employee contributions may be determined:
  1. Employer pays a fixed percentage of each employee's age rated premium
  2. Employer generates a composite or average rate for all employees and determines employer and employee contributions based on the composite rate (states may require the composite approach)

  Please see next slide for an illustration of these two methods
- HHS requests comment on the:
  - Alignment of the method for calculating each employee's rate in the small group market with that used to calculate an individual's rate in the individual market and the implications for employees
  - Method's compatibility with employee choice in small business health insurance exchanges and accuracy in pricing

Report Out: Employer Rating Example



Option 1: Employer Contribution on the Underlying Cost of Coverage

Employee	Employer Offers $1K Defined Contribution - Potentially Discriminatory	Employer Covers 50% of Premium Costs - Allowable Approach
Employee 1	New Cost: $2,000; Reduction: 33%	New Cost: $1,500; Reduction: 50%
Employee 2	New Cost: $1,000; Reduction: 50%	New Cost: $1,000; Reduction:50%
Employee 3	New Cost: $0; Reduction: 100%	New Cost: $500; Reduction: 50%

Option 2: Employer Contribution Based on Composite Coverage

Employee	Composite Rating	Employer Offers $1K Defined Contribution
Employee 1 Employee 2 Employee 3	New Premium Cost: $2,000 ($6000/3)	New Cost: $1,000; Reduction 50%

Report Out: Health Insurance Market Rules; Rate Review

Guaranteed Issue with Limited Exceptions

- Insurers must offer coverage to individuals and employers without regard to health status
- Provides an exception to guaranteed issue for insurers that lack the financial capacity to enroll new members and gives those plans special dispensation to limit applications as long as it is not done selectively for a discriminatory purpose
- HHS requests comment on: how to prevent potential abuse if individuals decide not to pay premiums for the last few months of the year and purchase a new policy for January

Open and Special Enrollment Periods in the Individual Market

- Insurers are permitted to limited enrollment periods, but coverage must be available at a minimum during the open enrollment periods set by HHS for exchanges
- The first open enrollment period for exchanges will be October 1, 2013 through March 31, 2014
- Subsequent enrollment periods will be October 15th through December 7th of each year
- Provides for special enrollment periods limited to 30 days after qualifying events
  - Events will be the same as those established under the Employee Retirement Income Security Act (ERISA) for group health plans (e.g., loss of coverage due to divorce or death of the primary member)
- HHS requests comment on:
  - The requirement that open enrollment periods are consistent inside and outside of the exchange and whether aligning open enrollment periods with policy years in the individual market is desirable
  - Whether 60 calendar days (versus 30) should be allowed for special enrollment periods
  - Whether insurers in the individual market should be required to provide enrollees notice of special enrollment rights

Report Out: Health Insurance Market Rules; Rate Review

Single Risk Pool

- Requires insurers to treat the claims experience for their entire book of business in the individual market or small group market as a single risk pool under the ACA
- Requires separate risk pools in the individual and small group markets, except in states that merge the two risk pools
- Rates for all insurers' individual market policies will move up or down together as the overall risk pool gets more healthy or sick, with relatively minor differences attributable to factors such as product and network differences; the same applies in the small group market
- HHS requests comment on the approach to calculating single market risk pools, including the proposed plan-specific adjustments to the index rate, and whether flexibility should be allowed in 2016

Catastrophic Plans

- Catastrophic products are available only to those under 30 years of age and those exempt from the minimum coverage requirements
- Catastrophic products must cover essential health benefits but only after the enrollee reaches the annual deductible
  - Exception for coverage for three primary care visits per year not subject to the deductible ; cost-sharing requirements may not be imposed on any preventive health services
- Allows pricing for catastrophic plans to be based on the non-grandfathered population covered by the issuer that would be eligible for the catastrophic plan, not just those enrolled in the plan

Report Out: Health Insurance Market Rules; Rate Review

New Standards for State Rate Review Programs

- Modifies the standard for an effective state review process to require states to consider new information that will become available in 2014, including:
  - Reasonableness of an insurer's assumptions with respect to risk adjustment and reinsurance programs; insurer data on implementation and utilization of a market-wide single risk pool; essential health benefits, actuarial values, and other ACA reforms; and the impact of rating changes on enrollee risk profiles
- Revises the process for states that wish to replace the 10% federal threshold with a state-specific one
  - States may submit such requests for approval by Aug 1t each year for approval by Sept 1st and use by January 1st
- HHS requests comment on:
  - The proposed changes to the time frames for states seeking state-specific thresholds to submit proposals
  - Whether additional factors should be considered in rate review
  - The impact on states by adding additional factors to consider during the rate review process

National Template for Rate Increase Filings

- Requires insurers to submit to HHS a rate filing justification, using a standard template, for all proposed rate increases, not just those above the federal 10% threshold or any state specific threshold
- HHS will post rate filings, except for trade secrets or other confidential information
- HHS requests comment on the:
  - Need for and impact of the extension of the reporting requirement below the review threshold and what alternative approaches could be considered
  - Information requested on the proposed standardized form

Relevant Laws and Regulations - Age Bands and Factors

The proposed rules prescribe uniform age bands that all states and insurers must follow and offer a federal default age curve to implement the 3:1 ratio. States have the flexibility to submit their own rating curves.

- States must use the following standard age bands in the individual and small group markets for the purposes of age rating, subject to the rating rules of PHS Act Section 2701:
  - Children: A single age band covering children 0 to 20 years of age, where all premium rates are the same (rates must be actuarially justified and based on a standard population)
  - Adults: One year age bands starting at age 21 and ending at age 63
  - Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same *(Insurance Market Rules NPRM §147.102)*
- Health insurance issuers within any market in a state must use a uniform age rating curve; the same rating curve applies to both the individual and small group market *(Insurance Market Rules NPRM §147.102).*
  - A state may apply the default age rating curve developed by CMS *(see next slides)*, or may develop its own standard age rating curve
  - A state planning to use its own standard rating curve must submit the proposed curve to CMS no later than 30 days after publication of the Final Rule
- Age bands and age factors should be determined based on an enrollee's age on the first day of a plan or policy year *(Insurance Market Rules NPRM §147.102).*

Areas where HHS requests comment on Age Bands/Factors are noted in the appendix

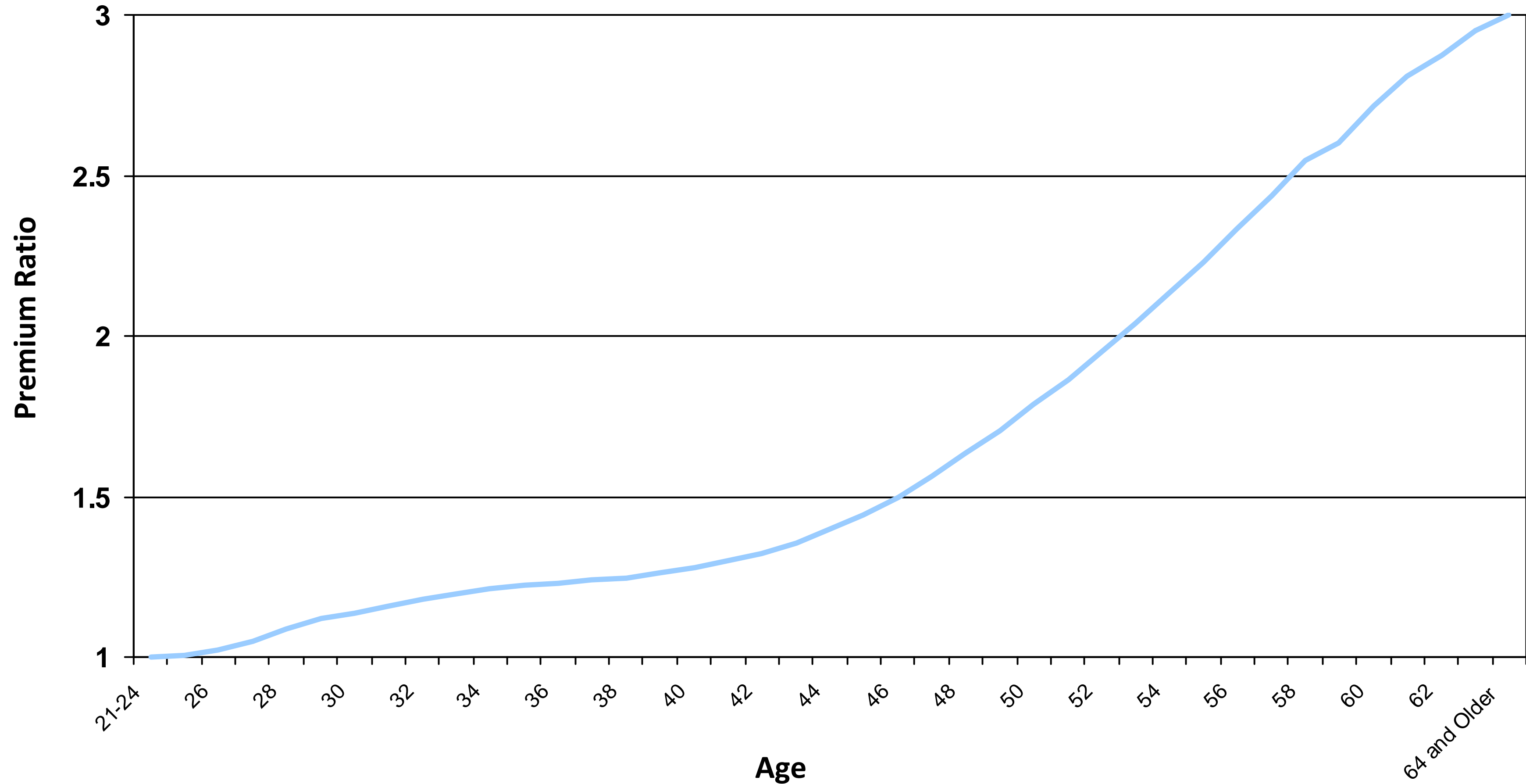
Relevant Laws and Regulations - Age Bands and Factors

Age	Premium Ratio	% Increase	Age	Premium Ratio	% Increase	Age	Premium Ratio	% Increase
0-20	.635	N/A	35	1.222	0.7%	50	1.786	4.7%
21	1.000	57.5%	36	1.230	0.7%	51	1.865	4.4%
22	1.000	0.0%	37	1.238	0.7%	52	1.952	4.7%
23	1.000	0.0%	38	1.246	0.6%	53	2.040	4.5%
24	1.000	0.0%	39	1.262	1.3%	54	2.135	4.7%
25	1.004	0.4%	40	1.278	1.3%	55	2.230	4.4%
26	1.024	2.0%	41	1.302	1.9%	56	2.333	4.6%
27	1.048	2.3%	42	1.325	1.8%	57	2.437	4.5%
28	1.087	3.7%	43	1.357	2.4%	58	2.548	4.6%
29	1.119	2.9%	44	1.397	2.9%	59	2.603	2.2%
30	1.135	1.4%	45	1.444	3.4%	60	2.714	4.3%
31	1.159	2.1%	46	1.500	3.9%	61	2.810	3.5%
32	1.183	2.1%	47	1.563	4.2%	62	2.873	2.2%
33	1.198	1.3%	48	1.635	4.6%	63	2.952	2.7%
34	1.214	1.3%	49	1.706	4.3%	64 +	3.000	1.6%

Must start at 1.0 at age 21

Must end at 3.0 at age 64+

Age Bands/Factors: Standardized Age Curve, Age Bands, and Factors



NC DOI has requested North Carolina specific age curves from insurers interested in proposing an alternative to the federal default age curve.

Age Bands/Factors: Considerations for Selecting an Age Curve

Selecting a state-based curve could allow North Carolina insurers to better set premiums for age based on North Carolina-specific experience. However, the timeline for selection is short and further cuts into the insurer timeframe for rate development.

Pros of Selecting a State-Specific Age Curve	Cons of Selecting a State-Specific Age Curve
▪ Better customized to North Carolina experience	▪ Short time frame for selection as final age curve must be submitted within 30-days of publication of the Final Rule ▪ Shortens insurer time frame to develop rates, which could start now if default age curve was used

The Work Group will discuss if North Carolina should accept the default age curve or submit a North Carolina-based curve. If the latter, the TAG will discuss how the curve should be calculated/selected.

Relevant Laws and Regulations – Tobacco Rating

The proposed rule gives flexibility to states to establish a narrower ratio across the market or, in absence of state regulation, provides guidelines to insurers to vary tobacco rating.

- A state may prescribe a narrower ratio for the tobacco rating factor (e.g., 1.25:1 vs 1.5:1) or prohibit varying rates for tobacco use *(Insurance Market Rules NPRM §147.102)*.
  - If a state plans to adopt a narrower ratio for tobacco use, the state must submit relevant information to CMS within 30 days of publication of the Final Rule *(Preamble)*
- States can be prescriptive with insurers or allow insurers to vary the tobacco use factor overall or by age band (e.g., use a lower tobacco use factor for a younger person than an older person) as long as the factor does not exceed 1.5:1 for any age group *(Insurance Market Rules NPRM §147.102)*
- In the small group market, the surcharge would be tied to a wellness program; insurers can impose the surcharge only if they give enrollees the option of participating in a tobacco cessation program and waive the surcharge for those who participate *(Preamble)*
- In the individual market, HHS does not propose that tobacco surcharges be linked to smoking cessation programs; the ACA does not permit discounts for wellness programs in the individual market *(Preamble)*

Areas where HHS requests comment on Tobacco Rating are noted in the appendix

Tobacco Rating: Affordability Issues at Lower Income Levels

- The federal premium tax credit is based only on premiums before any additional charge for tobacco use. That is, the federal tax credit is not increased for people facing higher premiums due to a tobacco-rating factor. – *Internal Revenue Code 36B(b)(3)(C), as added by ACA 1401*
- The ACA expressly recognizes that a premium of more than 8% of income is not "affordable" and relieves individuals who would have to pay more than this amount for coverage from the individual "mandate" to obtain coverage. – *ACA Section 1501 and 10106*

Practical Implication of Affordability

- The application of a 50% premium factor means lower income tobacco users could face health insurance premiums that are prohibitively expensive relative to their incomes.

	Non-Tobacco User	Tobacco User
Annual Income	$25,000	$25,000
Age-Adjusted Monthly Health Insurance Premium	$300	$300
Maximum % of Income Eligible to Pay for Premiums (after age adjustment)	6.91%	6.91%
Individual's Monthly Health Insurance Premium Responsibility	$144	$144
Tobacco Use Surcharge	$0	$150
Total Monthly Health Insurance Premium	$144	$294
Total Premiums as a % of Income	6.91%	14.11%

Source: IHPS Paper: http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf; and Urban Institute: http://www.urban.org/publications/406892.html. Kaiser Family Foundation: http://healthreform.kff.org/subsidycalculator.aspx?source=QL

Tobacco Rating: Considerations

Rating by tobacco use could ensure that costs associated with tobacco are borne only by users, however the complexities associated with defining "use," identifying users and charging lower-income individuals more makes it attractive for states to consider limiting the factor.

Pros of having a tobacco rating factor	Cons of having a tobacco rating factor
▪ Incorporates public health focus in rating, which could encourage people to quit smoking or not take up smoking ▪ Tobacco users bear the additional costs that come with use, rather than spreading the costs across all people with coverage (including non-users)	▪ Uncertain how to define "tobacco use" or determine if someone uses tobacco ▪ Subsidies for low-income individuals will not be adjusted for tobacco use, meaning that out-of-pocket premium costs would likely be unaffordable to this population ▪ 50% increase in premiums for tobacco users might exceed the expected costs associated with tobacco use and dissuade people from self-disclosing tobacco use

The Work Group will build on the initial TAG recommendation (that tobacco use should be limited to less than 1.5), and discuss if the state should impose a standard cap and, if so, what that cap should be. The Work Group will also address how tobacco use should be measured, if applicable.

Relevant Laws and Regulations – Geographic Rating Areas

The proposed rules set minimum requirements for geographic rating areas, while still permitting states to request flexibility on rating areas.

- In establishing geographic rating areas, a state may use one of three approved standards for geographic rating areas, or submit its own standard, subject to CMS approval. The three approved geographic rating area standards are:
    1. one rating area for the entire state;
    2. no more than seven rating areas based on counties or 3-digit zip codes (i.e., areas in which all zip codes share the first three digits); or
    3. no more than seven rating areas based on metropolitan statistical areas (MSAs) and non-MSAs
- A state may also propose to CMS for approval other existing geographic rating divisions on which to base rating areas, or a number of rating areas greater than seven *(Insurance Market Rules NPRM §147.102(b))*
- All sections of a geographic rating area do not need to be geographically adjacent *(Insurance Market Rules NPRM, Fed Reg 70592)*
- If a state does not establish adequate rating areas or submit information to CMS on those rating areas, CMS will either impose one rating area or establish multiple rating areas within the state in accordance with the standards described above *(Insurance Market Rules NPRM §147.102(b))*

Areas where HHS requests comment on Geographic Rating Areas are noted in the appendix

Geographic Rating Areas

The Rating Work Group and TAG previously discussed geographic rating areas and developed statements on related policy options, which were presented to the TAG at its November 2012 meeting prior to the market rules coming out.

Prior Draft Consensus Points from TAG Meeting:

- North Carolina should elect to use counties in 2014 & 2015 only, if allowed, with plans for evaluating another strategy for the long term.
- If the feds require a cap on the number of areas, NC DOI could establish geographic rating areas to group counties in a way that minimizes market disruption, in a similar manner as California, up to the maximum number permitted under federal rules (once released).

The Upcoming Work Group Meeting:

- Will address specifically how geographic rating areas should be calculated and if the methodology should change if the state is able to have more than seven areas
- Will take into account the data request recently sent by NC DOI to insurers to provide county-level (or three-code zip level, if applicable) rating factors in the individual and small group market

Agenda

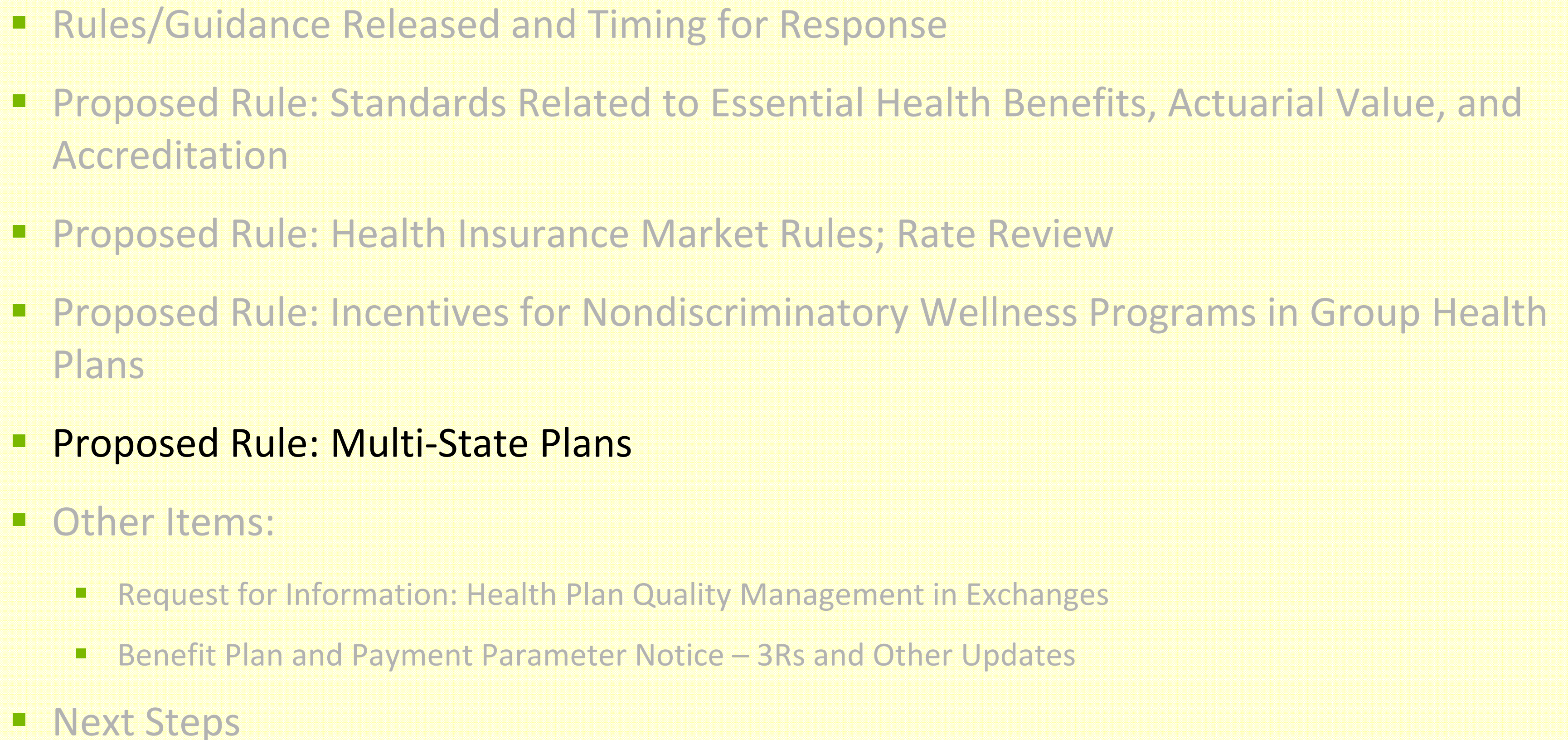
- Rules/Guidance Released and Timing for Response
- Proposed Rule: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation
- Proposed Rule: Health Insurance Market Rules; Rate Review
- **Proposed Rule: Incentives for Nondiscriminatory Wellness Programs in Group Health Plans**
- Proposed Rule: Multi-State Plans
- Other Items:
  - Request for Information: Health Plan Quality Management in Exchanges
  - Benefit Plan and Payment Parameter Notice – 3Rs and Other Updates
- Next Steps

Proposed Rule Summary: Incentives for Nondiscriminatory Wellness Programs in Group Health Plans

Report Out

- Issued jointly by the U.S. Departments of the Treasury, Labor, and HHS
- Focuses on health outcomes-based wellness programs – programs providing discounts on health coverage for participants who, for example, quit smoking or lose weight
- Increases the maximum permissible reward for achieving a particular health outcome to 30% of the cost of health coverage (up from the current level of 20%)
- Increases the permissible discount for participants in tobacco cessation programs to 50%
- Reflects a concern that wellness programs could be used to discriminate against individuals with health conditions; new measures limit this possibility, including:
  - When participants fail to achieve an initial measure or outcome of a wellness program, the plan must offer an alternative; the participant need not demonstrate that achieving the outcome would be medically unreasonable
  - Plans are not permitted to require verification that it is medically unreasonable for a participant to complete the wellness program before offering a reasonable alternative when it is apparent from the participant's condition that he or she is unable to complete the original wellness program
  - When a reasonable alternative is offered, the plan must pay the cost of the program; the plan may impose normal cost-sharing for medical items and services
- Solicits comments on whether evidence-based standards should be used to determine whether a wellness program is truly designed to promote health or is instead subterfuge for underwriting

Agenda

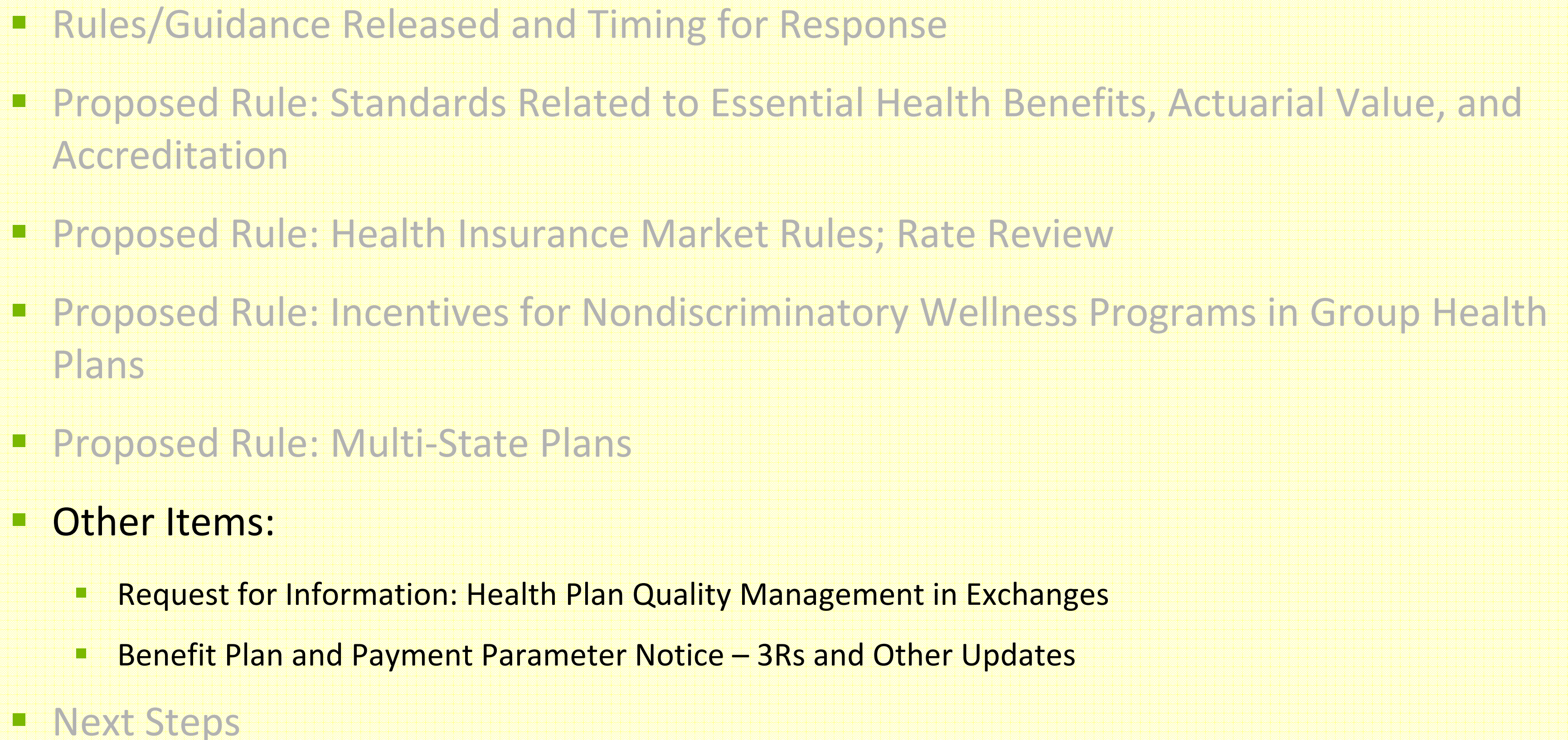


Proposed Rule Summary: Multi-State Plans (MSP)

Report Out

- Confirms that both for-profit and nonprofit insurers are eligible to apply to provide MSPs
- Proposes to model MSP plan selection and contracting on the same approach used by the FEHBP program
- MSPs must offer at least one plan at the gold and silver levels in the individual exchange market and do not have to offer plans in the SHOP during the 4 year phase-in period
- For EHBs, OPM proposed a complex path that would provide MSP insurers with one of two options:
  - EHB benchmark for the state, or
  - Modification of an OPM sponsored FEHBP-benchmark for use in nearly all states
- Requires MSP insurers to follow state and federal laws, with the exception of some variations in the areas of appeals, rating and benefit plan material or information
- OPM will negotiate premiums, profit margins, medical loss ratios and "other terms and conditions of coverage as are in the interest of enrollees"
- Recognizing tension between OPM powers and state "rate and form review" laws, the rule proposed that MSP insurers remain subject to state reviews, with a dispute resolution process when there are disagreements

Agenda



Summary: Health Plan Quality Management in Exchanges

Report Out

- There will be no federal requirements with respect to quality reporting and other quality-related issues in health insurance exchanges until 2016
- State-based exchanges will have the option to defer quality reporting until federal regulations are issued or implement their own quality reporting standards in advance of federal guidance
- The RFI outlines how the ACA's requirements fit with HHS's national quality strategy and acknowledges existing quality measures and rating systems recognized by HHS to accredit insurers under the ACA
- HHS seeks public comment on 15 questions regarding quality improvement through the exchanges; public comment is solicited on three broad topics:
    1. Current Practices: What quality improvement strategies are used in the marketplace today? How is quality measured and tracked over time? What public reporting or transparency initiatives are used today?
    2. Alignment: To what extent can and should quality initiatives in the exchanges be aligned with other quality improvement efforts (e.g., accountable care organizations)? What current data collection and transparency activities could be leveraged? What current state efforts are most relevant for the exchanges?
    3. New Challenges: Are there gaps in current clinical quality measures? What are priority areas for quality rating in the exchanges? How can the exchanges best further quality improvement? What are methodological challenges to public reporting of quality data?

Summary: Benefit Notice and Payment Parameters – 3Rs

Risk Adjustment

- Covers all non-grandfathered health insurance sold in the individual and small group markets
- Model will calculate individual risk scores based on the age, gender, and certain diagnoses of each individual, using the Hierarchical Condition Category (HCC) system used in Medicare; model is concurrent and based on medical claims, only
- Payment and charges to insurers will be designed so that the charges assess against insurers in each state will equal the payments made to insurers, without the need for adjustments; invoices will be sent to plans by June 30th of the year following the benefit year (e.g. June of 2015 for the plan year 2014)
- HHS will use a distributed data approach; insurers must initiate testing with HHS's system by October 2013 with final data submitted by April 30th (e.g. April 30th for the plan year 2014)
- HHS will collect user fees, estimated to be no more than $1 per enrollee per year; user fees will be collected in June and align with invoicing of payments and charges

Reinsurance

- Notice describes a process that is essentially federal; curtails state flexibility in light of short program duration and tight time frames
- Sets reinsurance benefit at $60,000 attachment point, co-insurance rate of 80%, and a cap of $250,000
- HHS proposes to collect all reinsurance contributions from all insurers and group health plans – estimated to be $5.25 per member per month
- Reinsurance distributions will not be tied to the states where contributions were collected

Summary: Benefit Notice and Payment Parameters – 3Rs & Other

Risk Corridors

- Under risk corridors, when QHP insurer profits exceed a certain margin, the insurer will be required to pay a percentage of those profits to HHS; when losses on the QHP exceed a specific amount, HHS will make payments to the insurers
- Corridors come into effect at (+) or (-) 3%
- HHS proposed to revise its calculation of these corridors so that profits are defined as the greater of 3% of premiums or the actual premiums earned by the insurer, less administrative costs and costs of coverage
- Insurers are required to submit information to HHS by July 31st of the year following the benefit year

Medical Loss Ratio (MLR)

- Modifies the MLR definition, for MLR reporting years beginning in 2014, to include premium stabilization amounts as part of the total premium revenue reported to HHS
- The amounts would be: (1) removed for the adjusted earned premium, so they would not have any impact on the amounts used in calculating the MLR denominator and rebates; and (2) included as an adjustment to incurred claims included in calculating the MLR numerator
- Delays the MLR reporting and rebate deadlines beginning with 2014 reporting year to coordinate with reporting cycles of risk adjustment, reinsurance and risk corridors (e.g. MLR reporting due on July 31st instead of June 1st and rebate due dates change from Sept 30th from August 1st)

Summary: Benefit Notice and Payment Parameters – Other

Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs)

- For exchange administration of APTCs and CSRs, the notice:
  - Clarifies how HHS will make APTCs to QHPs in situations in which different family members may qualify for different subsidies
  - Clarifies the consequences when an individual's eligibility for subsidies changes during a year in which some APTCs have already been credited to the individual
  - Proposes a methodology for exchanges to allocate APTC payments in cases where more than one individual in a family is eligible for a tax subsidy and the individuals collectively enroll in more than one QHP policy, QHP or dental plan
- For plan design to achieve required CSRs, the notice:
  - Requires exchanges to certify that all QHP insurers provide plan variations required to obtain the income-based subsidies of the ACA; exchanges, in turn, have to provide HHS information on the AV of all QHPs and variations
  - Three silver plan variations to provide CSRs to enrollees with incomes below 400%FPL: a silver plan variation to provide CSRs to enrollees with incomes below 400% FPL and two variations designed to satisfy ACA provisions to provide additional CSRs to American Indians (one for zero cost sharing variation and one for limited cost sharing)
- For silver level variations, the notice:
  - Requires insurers to provide three variations of silver level plans:
    - Variation 1: Individuals between 100 and 150% FPL (at 94% AV)
    - Variation 2: Individuals between 150 and 200% FPL (at 87% AV)
    - Variation 3: Individuals between 200 and 250% FPL (at 73% AV)
  - To prepare each variation, requires the insurer to first reduce the maximum annual limitation on cost share (e.g. Out of pocket limits)
  - Following annual limitation on cost sharing, each QHP insurer will modify its other cost-sharing to achieve the required AV level for each of the three variations
- For payments to QHPs for CSRs, the notice:
  - Proposes that prior to the benefit year, insurers would provide the exchange with estimates of the total value of the expected CSRs for the silver plan variations and the variations for Indians at all metal levels; insurers may seek advance payment from HHS for CSR payments, which would be subject to reconciliation

Summary: Benefit Notice and Payment Parameters – Other

Small Business Health Options Program (SHOP) Exchange

- For Employee Choices in the Federal SHOP
  - In the notice, HHS proposes to limit the federal SHOP to a purchasing model through which an employer selects a metal level and employees are permitted to enroll in any QHP offered by any insurer in that metal level; comment is sought on whether employers should be allowed to direct employers to a single QHP for all employees (as is common practice today)
  - Comment is also sought on whether employees should be allowed to purchase certain plans at the next highest levels ("buy up"), recognizing that this would increase choice and adverse selection
- For Employer Premium Contribution in Federal SHOP
  - In federal SHOPs, employer contributions will be based on the premium of a "reference plan." Each employer:
    - (a) will select a QHP within the coverage level it has designated for its employees that will serve as the reference plan on which premium contributions will be based
    - b) define a percentage of contributions toward premiums for employees and (as applicable) dependent coverage
    - (c) may choose to establish different percentages for different employee categories (if permitted)
    - (d) will have the opportunity to select either a composite premium or one where employee contributions vary with age (if permitted)
  - Resulting contribution amount will be applied to each employee's premium regardless of the QHP selected
- For Employer Size Calculation
  - For SHOPs, employees will be counted based on full-time equivalents, which could create inconsistent definitions for how a small group is defined in the exchange versus outside of the exchange
- For Minimum Participation Rates in Federal SHOP
  - Established a minimum participate rate of 70% for federal SHOPs
  - Proposes for federal SHOPs to apply a different minimum participation rate in states where a state law sets the rate, or there is evidence that a higher or lower rate is used by the majority of QHP issuers in the small group market outside of the SHOP

Summary: Benefit Notice and Payment Parameters – Other

Small Business Health Options Program (SHOP) Exchange (continued)

- For Agents/Brokers
  - Permits exchanges to provide information only on brokers or agents who have completed required exchange registration and/or training
  - Further clarifies that the federal exchanges will present information on their websites only for required registered and/or trained agents/brokers
  - Requires insurers participating in federal exchanges and SHOPs to pay the same broker compensation inside and outside the exchange for similar health plans
- Insurer Participation in Federal SHOPs:
  - Requires insurers applying to participate in a federal exchange in the individual market to also participate in the SHOP, except where neither the insurer nor any other insurer in the same "issuer group" is participating in the small group market in that state
    - Issuer Group is defined as insurers linked by common ownership or by a common nationally licensed service mark
    - Participation is defined as offering at least silver and gold level QHPs

Federally Facilitated Exchange User Fees

- Proposes a "user fee" to support federal exchange operating costs
  - Notice is silent with respect to how user fees will be applied in state-partnership exchanges
  - Proposes a user fee for 2014 at 3.5% of premium paid for members enrolled in the insurer's QHP
  - Feds seek to align this rate with rates charged by State-based Exchanges and may adjust this rate in the final notice
- HHS is seeking comment on a proposal to pool exchange user fees (or potentially all administrative costs) across a particular market or product
  - While fees would be collected from insurers participating in the federal exchange, HHS appears to be considering a requirement that insurers spread user fee costs evenly to all plans both inside and outside of the exchange

Agenda

- Rules/Guidance Released and Timing for Response
- Proposed Rule: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation
- Proposed Rule: Health Insurance Market Rules; Rate Review
- Proposed Rule: Incentives for Nondiscriminatory Wellness Programs in Group Health Plans
- Proposed Rule: Multi-State Plans
- Other Items:
  - Request for Information: Health Plan Quality Management in Exchanges
  - Benefit Plan and Payment Parameter Notice – 3Rs and Other Updates

- Next Steps

Next Steps

- Attend Upcoming Meetings - December 12th at NC IOM
  - NC DOI Rating Work Group 9:30 am to 12:30 pm to discuss age bands/factors, tobacco rating and geographic rating
  - TAG Meeting from 2:00 to 5:00 pm to discuss Habilitative Benefits and Substitution and other items
    - TAG members invited to sit in on Rating Work Group
  - NC IOM Location: 630 Davis Dr. Ste. 100, Morrisville, NC 27560

Questions?

Appendix

- Glossary
- Links to proposed rules and guidance
- Additional Questions HHS is Requesting Comment on in the Market Rules

Glossary

- ACA – Affordable Care Act
- AV – Actuarial Value
- CMCS – Center for Medicaid and CHIP Services
- CMS – Center for Medicare and Medicaid Services
- EHB – Essential Health Benefit
- ERISA – Employee Retirement Income Security Act
- EPSDT – Early and Periodic Screening, Diagnosis, and Treatment
- FEDVIP – Federal Employees Dental and Vision Insurance Plan
- HHS – Department of Health and Human Services
- HIPPA – Health Insurance Portability and Accountability Act
- IRS – Internal Revenue Service
- MSA – Metropolitan Statistical Areas
- NCQA – National Committee for Quality Assurance
- OPM – Office of Personnel Management
- QHP – Qualified Health Plan
- RFI – Request for Information
- SMDL – State Medicaid Director Letter
- SPA – State Plan Amendment
- USP – United States Pharmacopeial Convention

Post-Election Health Reform Guidance
Released November 20, 2012

Proposed Rule	Link	Comment Due Date
Essential Health Benefits, Actuarial Value, Accreditation		
Proposed rule on essential health benefits, actuarial value, and plan accreditation	http://www.ofr.gov/ofrupload/ofrdata/2012-28362_PI.pdf	December 26 , 2012
Additional information on state essential health benefits benchmark plans	http://www.cciio.cms.gov/resources/data/ehb.html	December 26 , 2012
State Medicaid director letter on essential health benefits and the Medicaid benchmark	http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf	December 26 , 2012
Actuarial value calculator and methodology	http://cciio.cms.gov/resources/regulations/index.html#pm	December 26 , 2012
Final notice recognizing entities for accreditation of qualified health plans	http://www.gpo.gov/fdsys/pkg/FR-2012-11-23/html/2012-28440.htm	NA
Paperwork Reduction Act (PRA) package on accrediting entities	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10449.html	December 26 , 2012

Post-Election Health Reform Guidance
Released November 20, 2012

Proposed Rule	Link	Comment Due Date
Health Insurance Market Reforms and Wellness Rules		
Proposed rule on health insurance market reforms and rate review	http://www.ofr.gov/OFRUpload/OFRData/2012-28428_PI.pdf	December 26, 2012
Proposed rue on incentives for nondiscriminatory wellness programs in group health plans	http://www.ofr.gov/OFRUpload/OFRData/2012-28361_PI.pdf	January 25, 2013
PRA package for rate review	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10379.html	December 26, 2012
Other PRA Packages		
PRA package on certifying qualified health plans	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10433.html	NA
PRA package on insurer compliance with title XXVII of the Public Health Service Act	http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10430.html	NA

Post-Election Health Reform Guidance
Released November 30, 2012 and December 5, 2012

Proposed Rule/Notice	Link	Comment Due Date
Proposed Rule & Notices		
Multi-State Plan Program	http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/html/2012-29118.htm	January 4, 2013
Notice of Benefit and Payment Parameters	http://www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf	December 31, 2011
PCORI Rule	https://www.federalregister.gov/articles/2012/12/06/2012-29325/fees-on-health-insurance-policies-and-self-insured-plans-for-the-patient-centered-outcomes-research	NA

Report Out: Health Insurance Market Rules; Rate Review

Student Health Insurance

- Insurance sold to college and university students will be exempt from the guaranteed issue provision
- Enrollment may be limited to students
- HHS requests comment on whether:
  - Insurers should be allowed to maintain a separate risk pool for student coverage
  - Modifications should be provided to the generally applicable individual market rating rules in connection with student health coverage

Association Plans

- Association coverage cannot be limited to members of the association
- There is ongoing consideration of a "transition or exception process" for existing association coverage
- HHS requests comment on how a transition or exception process for bona fide association coverage could be structured to minimize disruption and maintain consumer protections

Enforcement

- HIPAA enforcement framework also applies to the new ACA rules for insurers
- States will be responsible for enforcement, but HHS has the authority to enforce the rules directly against insurers and impose monetary penalties against non compliant insurers should it determine a state is not substantially enforcing federal law
- HHS will directly enforce the rules for group health plans of state and local government employees

Report Out: Health Insurance Market Rules; Rate Review

Guaranteed Renewability

- Tracks closely to the HIPAA rules for guaranteed renewability in implementing similar ACA Requirements

Rolling Enrollment in the Small Group Market

- Provides for guaranteed issue at any point during the year for small groups
- Consistent with current market practice; small businesses start and fail at all times of the year and do not present the same adverse selection concerns as individuals

Marketing Standards

- Requires compliance with state marketing rules, reflecting deference to states
- Adds an ACA prohibition on marketing practices that have the effect of discouraging enrollment by individuals with significant health needs, aligning the markets inside and outside the exchanges

Report Out: Federal Comments Sought on Age Bands/Factors

Uniform Age Bands

- HHS requests comment on whether:
  - Enrollees' age factors and bands should be set at enrollee age at policy issuance and renewal as opposed to another time frame (e.g., birthday)
  - Multiple age bands or a single age band is appropriate for children
  - One year age bands are appropriate for adults aged 21 to 63
  - A single age band for adults over aged 64 is appropriate and if 64 is an appropriate cutoff

Uniform Age Rating Curves

- HHS requests comment on the:
  - Requirement that rates be actuarially justified based on a standard population for individuals under aged 21
  - Application of a single, default uniform age curve to the individual and small group market in a state
  - Approach for fitting the adult age curve to the statutorily specified 3:1 premium ratio
  - Proposed rating curve, including whether it is generally consistent with current rating practices and minimally disruptive within the confines of the ACA
  - Implications of the transition from the proposed child curve to proposed adult curve for insurers and consumers
  - Consequences of choices in terms of likely premium increases to consumers when aging from one band to the next
  - Impact on administration and accuracy of risk adjustment and administration of premium tax credits and consumer ease

Report Out: Federal Comments Sought on Tobacco Surcharges

Tobacco Surcharges

- HHS requests comment on:
  - Definitions of tobacco usage, ranging from self-reporting to standard measures of frequency or amount
  - Use of a streamlined application to collect information on tobacco use
  - Alternative options for identifying tobacco use
  - Options for collecting information outside the exchange
  - Allowing insurers to vary tobacco use factor for a particular age band, as long as no variation is greater than 1.5:1
  - Requiring insurers in the small group market to offer enrollees the opportunity to avoid paying the full amount of the tobacco use surcharge if they participate in the wellness program
  - Ideas for coordinating wellness provisions with the tobacco surcharge
  - Whether the surcharge should rely on self-reporting
  - Whether the surcharge in the individual market could be combined with the same type of incentive to promote tobacco cessation as is proposed in the small group market

Report Out: Federal Comments Sought on Geographic Rating Areas

Geographic Rating Areas

- HHS requests comment on the:
  - Maximum number of rating areas within a state and standards for determining such number
  - Use of proposed standards (MSAs, three-digit zip codes) and other options
  - Impact of the proposed limit of having no more than seven regions and whether existing rating areas should be deemed in compliance (for states that already have geographic rating areas)
  - Establishment of minimum geographic size and minimum population requirements per region
  - Appropriate schedules and considerations related to modifying areas after plan year 2014