Market Reform and Policy Issues for Implementation of Health Reform in North Carolina

Work Group Meeting – Premium Rating Implementation

December 12, 2012

MANATT HEALTH SOLUTIONS

MERCER

OLIVER WYMAN

Agenda

9:30 – 9:40	Welcome and Introductions
9:40 – 9:50	Goals/Objectives of Work Group and Today's Discussion
9:50 – 11:10	Items for Discussion in Work Group • Age Curve – Should the state accept the default age factors or submit a North Carolina-based age curve? If the latter, how should it be calculated? • Tobacco Rating – Should the state impose a standard tobacco rating factor (less than 1.5)? If so, what should it be? If the state does not implement a standardized a factor, how should insurers limit the tobacco rating factor to something lower than 1.5? How should tobacco use be measured?
11:10 – 11:20	*Break*
11:20 – 12:20	Items for Discussion in Work Group, continued: • Geographic Rating Areas – How should geographic rating areas be calculated? Does the methodology change if the state is able to have more than 7 areas?
12:20 – 12:30	Wrap Up and Next Steps

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Overall Project Goal and Rating Work Group Meeting Objectives

Project Purpose: *Develop policy options and recommendations 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)

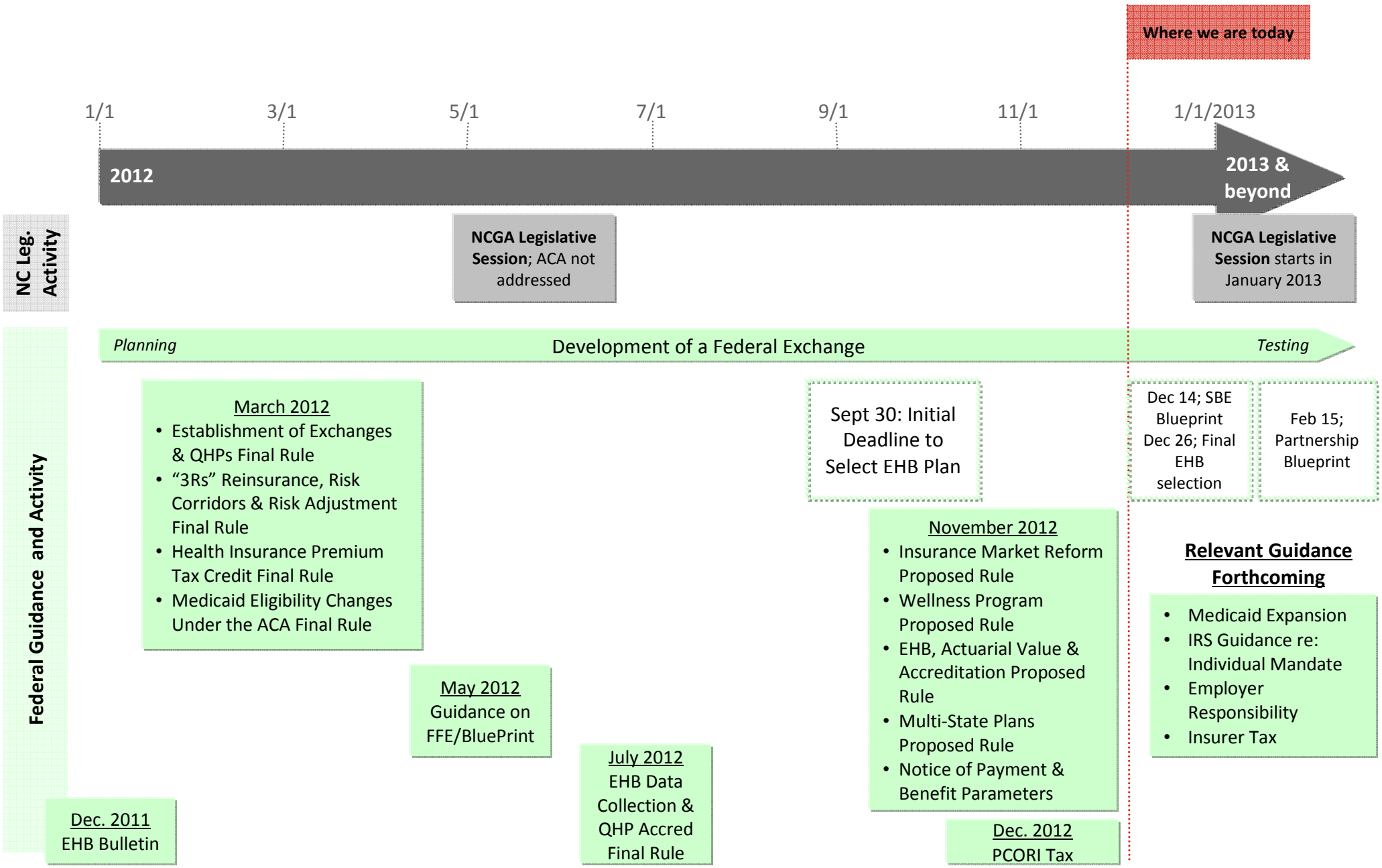
"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study insurance-related 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

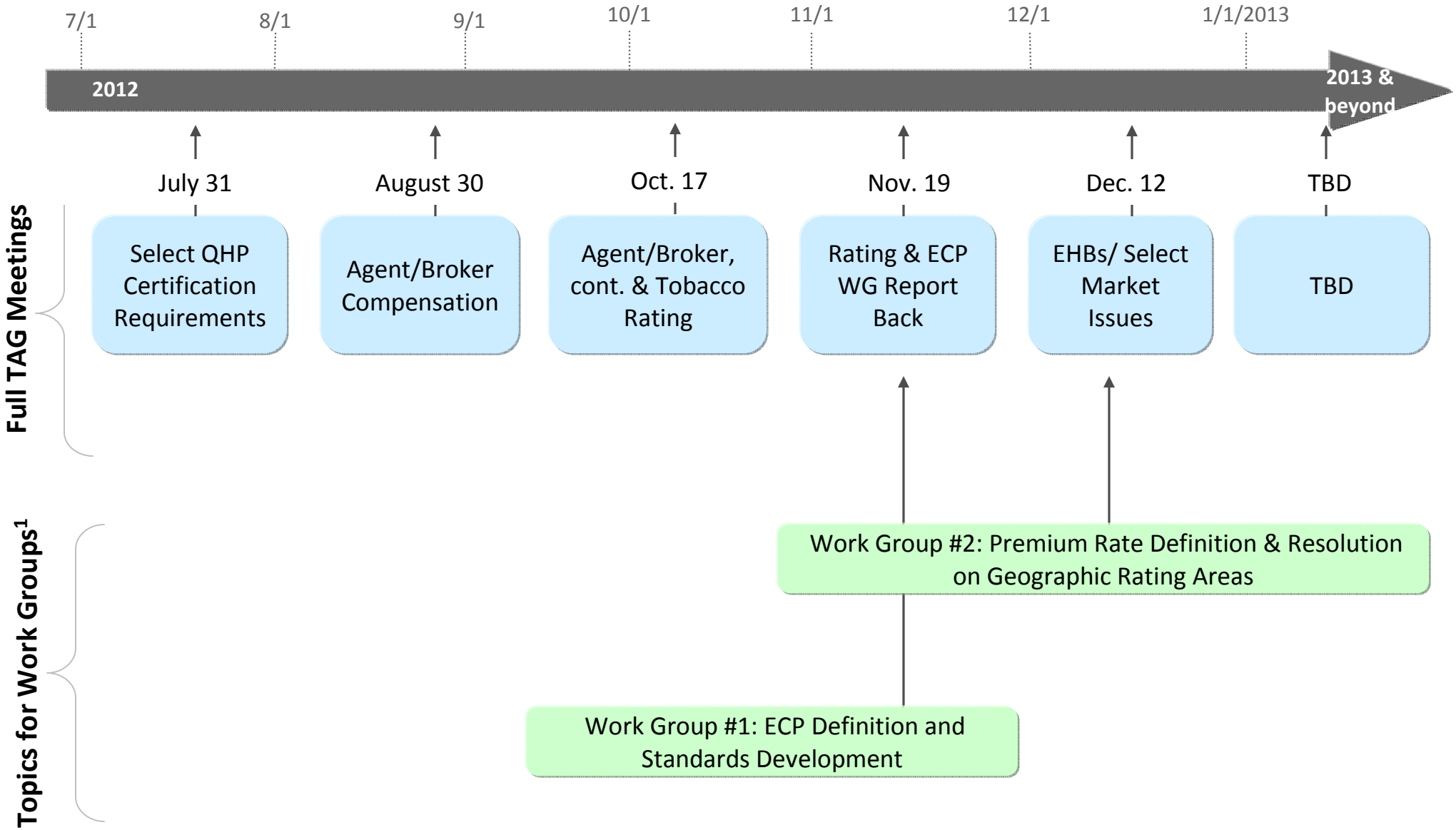
Objectives for Today's Meeting

- Update Background on Age, Tobacco and Geographic Rating Areas vis a vis Recently-Issued Federal Regulations
- Identify Options to Set Before the TAG for Consideration

Market and Exchange Rules/Regulations



TAG Meeting and Work Groups Planning for 2012



[1]*Work Groups will be held as needed to address technical issues and to arrive at options to set before the TAG.*

Rating Implementation Work Group Goal for North Carolina

The goal of the Rating Implementation Work Group is to set forth options and recommendations to implementing rating requirements for broader TAG consideration.

Baseline — ***Continuum of Options for Premium Rating Implementation*** — More

Adjustments to Current State Statutes and Business Practices on a "must have" basis to comply with known minimum ACA requirements

Options/Recommendations between "Adjustment to Current State Statute and Business Practices" and "Broad Standardization in Rating Practices" fall along different points in the continuum

Broad Standardization in Rating Practices, using known ACA requirements as a foundation for broader rating reform

- *Options and recommendations should take into account the potential for the TAG to reach consensus and make a recommendation to the NC DOI on premium rating issues*
- *Options and recommendations can also take into account a gradual process, if needed (e.g., Year One options versus options to be considered in later years)*

Statement of Values to Guide TAG Deliberations

The TAG will seek to evaluate the market reform policy options under consideration by assessing the extent to which they:

- Expand coverage;
- Improve affordability of coverage;
- Provide high-value coverage options in the HBE;
- Empower consumers to make informed choices;
- Support predictability for market stakeholders, competition among plans and long-term sustainability of the HBE;
- Support innovations in benefit design, payment, and care delivery that can control costs and improve the quality of care; and
- Facilitate improved health outcomes for North Carolinians.

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Relevant Laws and Regulations – Federal 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).*

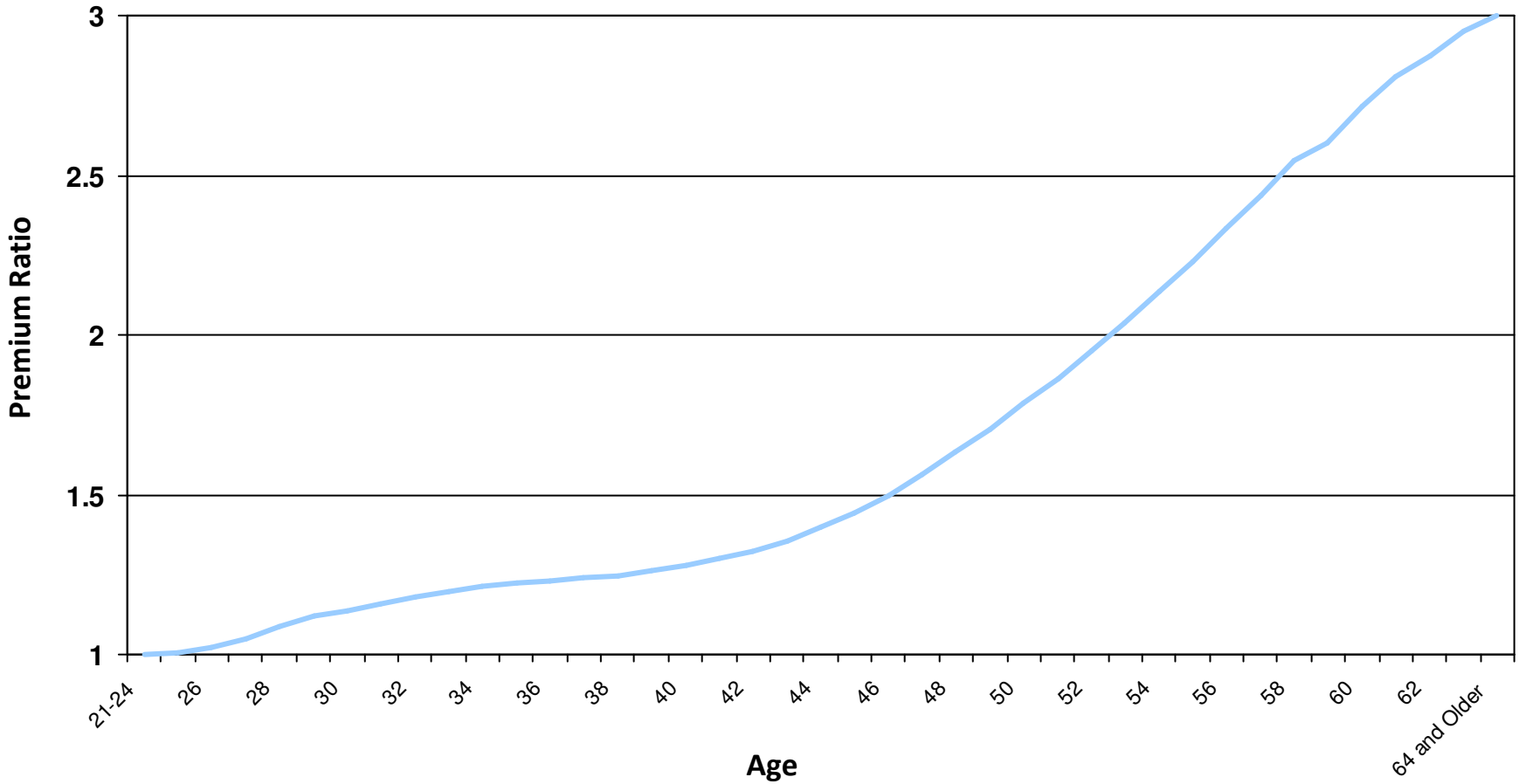
Federal Age Bands and Factors

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+

Federal Age Curve



Relevant North Carolina Laws and Regulations - Age Bands & Factors

North Carolina does not currently have any laws or regulations that prescribe age bands in the individual market or age factors in either the individual or small group markets. North Carolina does prescribe age bands in the small group market.

North Carolina Statute: *(applicable to small group, only)*

Unless the small employer carrier uses composite rating, the small employer carrier shall use the following age brackets:

a. Younger than 15 years;
b. 15 to 19 years;
c. 20 to 24 years;
d. 25 to 29 years;
e. 30 to 34 years;
f. 35 to 39 years;
g. 40 to 44 years;
h. 45 to 49 years;
i. 50 to 54 years;
j. 55 to 59 years;
k. 60 to 64 years;
l. 65 years

Carriers may combine, but shall not split, complete age brackets for the purposes of determining rates under this subsection. Small employer carriers shall be permitted to develop separate rates for individuals aged 65 years and older for coverage for which Medicare is the primary payor and coverage for which Medicare is not the primary payor. NCGS 58-50-130(b)(6)

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 earlier if default age curve was used

Options for Developing a North Carolina-Specific Age Curve

Question: Should North Carolina submit a North Carolina-based age curve?

Options	Additional Details
Yes	• North Carolina should submit a North Carolina-specific age-based curve within 30 days of the final rule • Process for determining curve addressed next
No	• North Carolina should not submit a North Carolina-specific age-based curve and should accept the federal default age factors
Other?	• ?

Options for Discussion - Age Curve

Question: *If the state chooses to submit a North Carolina-based age curve, how should it be calculated?*

Options	Next Steps
Consider Insurer Suggested Curves	• Permit insurers additional time to submit curves, make recommendations on which curves to accept (if multiple ones are set forth) and to meet again to approve or change curve(s)
Other?	• ?

*Based on answer to prior question, could be a process for 2014-2015 or work group could weigh in on options of interest for 2016.

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Relevant Laws and Regulations – Tobacco Rating

The proposed rule gives flexibility to states to establish a narrower ratio across the market and/or for states to give insurers flexibility with respect to 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)*

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 Use in North Carolina

- 20.9% of the adult population in North Carolina (over 1,458,000 individuals aged 18+ years) are current cigarette smokers. North Carolina ranks 38th among the states.
- The smoking-attributable mortality rate among 35+ year adults in North Carolina is 298.4/100,000. Compared to other states, North Carolina ranks 38th in this measure.
- 29.9% of current adult smokers in North Carolina do not have a high school degree, compared to 28.3% with a high school degree and 15.1% with more than a high school degree.

- According to the NC Behavioral Risk Factor Surveillance System, in 2010 low income individuals are more likely to smoke (see table at right)
- **Only 7% of Inclusive Health members self-attest to tobacco use; self-attestation results in a 32% premium hike for these members.**

	Are you a current Smoker?	
Household Income	**Yes**	**No**
Less than $15,000	35.6%	64.4%
$15,000 - $24,999	25.7%	74.3%
$25,000 - $34,999	22.5%	77.5%
$35,000 - $49,999	19.3%	80.7%
$50,000 - $74,999	14.3%	85.7%
$75,000+	11.5%	88.5%

Source: CDC Statistics: http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/pdfs/states/north_carolina.pdf;
IHPS Paper: http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf; and Urban Institute: http://www.urban.org/publications/406892.html.

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) ▪ In small group market, offers option of enrollees disclosing tobacco use without penalty and getting needed assistance to quit smoking	▪ Uncertain how to 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 ▪ In individual market, no option for enrollees disclosing tobacco use to get needed assistance to quit smoking and opt out of higher premiums

Previous TAG Consideration of Tobacco Rating Issue

The TAG discussed considerations related to the tobacco rating factor at its October 2012 meeting and reached the following points of consensus:

- The tobacco rating factor should be limited to less than 1.5 (though the TAG did not reach consensus regarding what the appropriate rating factor would be).
  - Some members wanted to seize a public health opportunity to drive tobacco users toward healthier behaviors, but were concerned that increasing costs for tobacco users may dissuade people from self-disclosing tobacco use or, counter to the goals of the ACA, result in low-income tobacco users opting out of purchasing coverage.
  - Other members felt that a rating factor should not be used for tobacco use and questioned whether other policy levers, such as a direct tobacco tax, might be more appropriate and effective to target tobacco use in the state.
- Additional information could inform assessment of the tobacco rating factor issue, including input from anti-smoking public health experts in the state, forthcoming federal guidance, and additional research into the impact of requiring a premium rate increase for tobacco use (particularly on low-income populations).
- Any further consideration of the issue should take into account concerns related to implementation challenges (e.g., how will carriers be able to identify and monitor those members who uses tobacco?), affordability (e.g., how to ensure that any cost increases are set high enough to drive changes in behavior but not so high that insurance becomes unaffordable for tobacco users), and equity (e.g., how to reconcile the potential subsidization of tobacco users coverage costs by non-users if a tobacco rating factor is not imposed; how to justify rating for tobacco use but not for other potentially risky/unhealthy behavior).

Responses from Other States & Stakeholders

Other States' Approaches to Tobacco Use

- During its July meeting the California Exchange considered options with respect to tobacco use rating factors and recommended that the Exchange conduct further research on the pros and cons of requiring a limited (e.g., 5%) rate-up for tobacco use that would be waived if the enrollee participates in a smoking cessation program.[1]
- VA notes that it is difficult to verify if an individual is a tobacco user or not.[2]
- New Jersey law prohibits carriers in the State from taking tobacco use into account in varying premiums: "If New Jersey wishes to permit plans to vary rates based on tobacco use, it must add this factor to the exclusive list of factors set forth in its statutes and regulations. It also would need to adopt a cap on rate variation based on tobacco use that does not exceed, but may be less than, 150 percent."[3]

Excerpts of National Dialogue

- **Health Access California:** Health Access opposes tobacco surcharges, calling them "illness penalties, not wellness incentives." According to Health Access, AARP, Consumers Union, and the California Pan-Ethnic Health Network also hold this view.[4]

[1] http://www.healthexchange.ca.gov/BoardMeetings/Documents/July_19_2012/CHBE-QHP_Discussion_Draft_7162012.pdf
[2] http://www.naic.org/documents/committees_b_hcra_wg_120503_VHRI_HBE_PWC_7-15-11.pdf
[3] http://www.cshp.rutgers.edu/Downloads/9490.pdf
[4] http://www.familiesusa.org/conference/health-action-2012/conference-materials/Wright.ppt

Options and Action Steps

Question: *Should the state impose a standard tobacco rating factor? If so, how should a factor of less than 1.5 be determined?*

Options	Considerations
Yes, Eliminate tobacco factor	• Eliminate the ability to rate for tobacco use in the individual and small group market
Yes, Determine Process for Lowering the Factor in the Individual and Small Group Market	• Apply a lower tobacco rating factor to the total premium (e.g., 20% versus 50%) and determine a process for deciding what the factor will be to apply uniformly to all insurers • Apply the factor but limit costs to the tobacco user to the lesser of 50% of the premium or a set dollar cap (e.g. $1200 per year) – if permitted under regulation
No	• Allow insurers to decide (see next slide)
Other?	• ???

Options adapted from the IHPS Paper: http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf

Options and Action Steps

Question: *If the state does not implement a standardized a factor, how should insurers limit the tobacco rating factor to something lower than 1.5?*

Options	Action Steps
Allow flexibility	• Allow insurers flexibility to set a factor that is less than 1.5 and across age bands, as permitted by final regulation
Allow flexibility within certain parameters	• Allow insurers to set rating factors below a certain amount (e.g. 1.3) across all age bands • Require insurers to only be able to impose the tobacco surcharge if they offer a wellness program in the individual market that an individual enrollee turns down (similar to the small group market requirements) • Require insurers to not adjust the surcharge by age band (e.g. allowing a younger individual to be subject to a lower surcharge than an older individual)
Other?	• ???

Options and Action Steps

Question: *How should tobacco use be measured?**

Options	Action Steps
Current Smoker	• Define tobacco use as current smoker; no set timeframes around last tobacco use or amount of use
Use within a certain number of months	• Define tobacco use as any amount of tobacco used within a certain number of months • Set months (e.g. 2 months? 6 months?)
Certain amount of use over a certain period of time	• Set use at a certain amount of use (e.g. 1 cigarette a day on average) or a certain period of time (e.g. within the last 2 months)
Other?	• ??

*Unclear how much, if any, flexibility will be given to determine this within a partnership model.

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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))*

NC Statute for small group market only: A carrier shall define geographic area to mean medical care system. Medical care system factors shall reflect the relative differences in expected costs, shall produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas, and shall be revenue neutral to the small employer carrier. *(NCGS: 58-50-130(b)(7))*

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).

Geographic Rating Area Analysis

Percentage of Market (Based on Covered Lives)		# of Products	# of Unique Factors Low	# of Unique Factors High	Weighted Average
	Insurers Using County As the Geographic Area Basis				
96%	Individual Market	5	4	11	6
	Small Group Market	14	4	72/22[1]	24/17[1]
	Insurers Using Zip As the Geographic Area Basis				
4%	Individual Market	12	2	9	5
	Small Group Market	NA	NA	NA	NA

[1] Second number is if the products with 72 factors are excluded from analysis

Notes:

Based on recent data submitted to NC DOI

Analysis does not include products without membership

Analysis of zip codes does not include one insurer who sets factors at the five-level zip code; all others use three-code zip

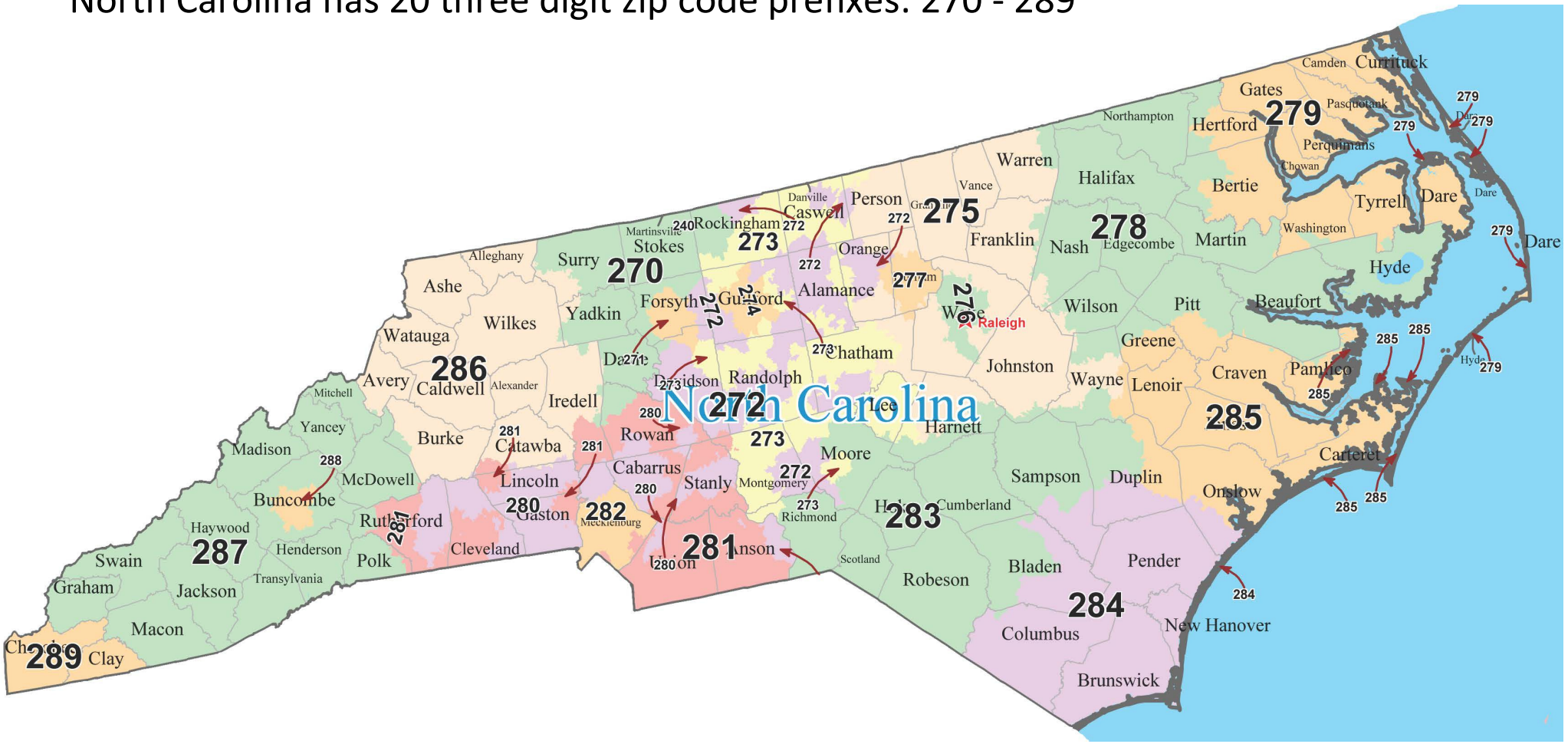
Weighted average based on covered lives; reflect weighted average number of factors

Some insurers use 1 methodology for 1 market, and 1 methodology for another (e.g. zip code for individual and county-level for small group)

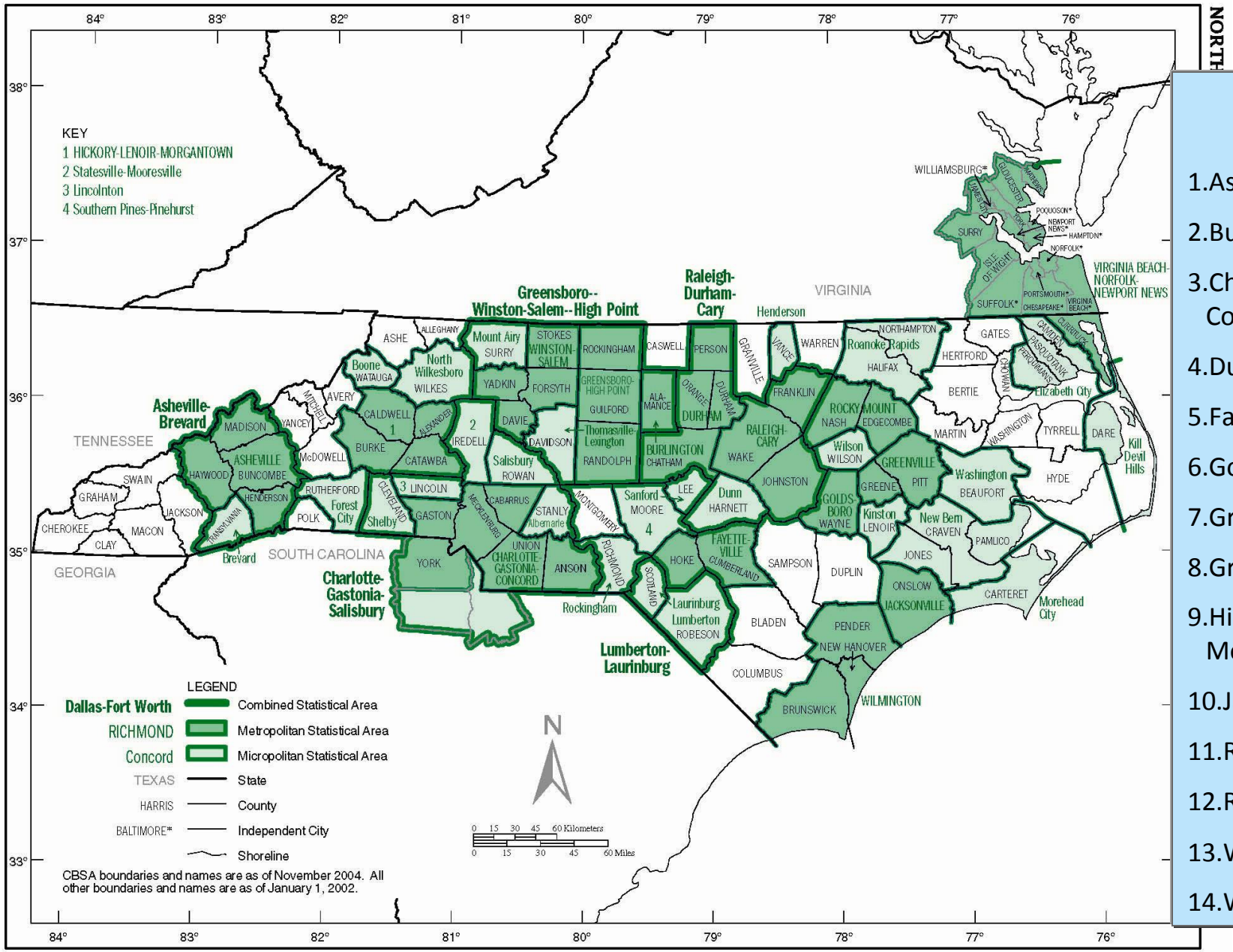
Some insurers have multiple product lines with different rating factors (e.g. 2 small group products with 2 different geographic rating factors)

Three Digit Zip Code Map

North Carolina has 20 three digit zip code prefixes: 270 - 289



Metropolitan Statistical Area Map

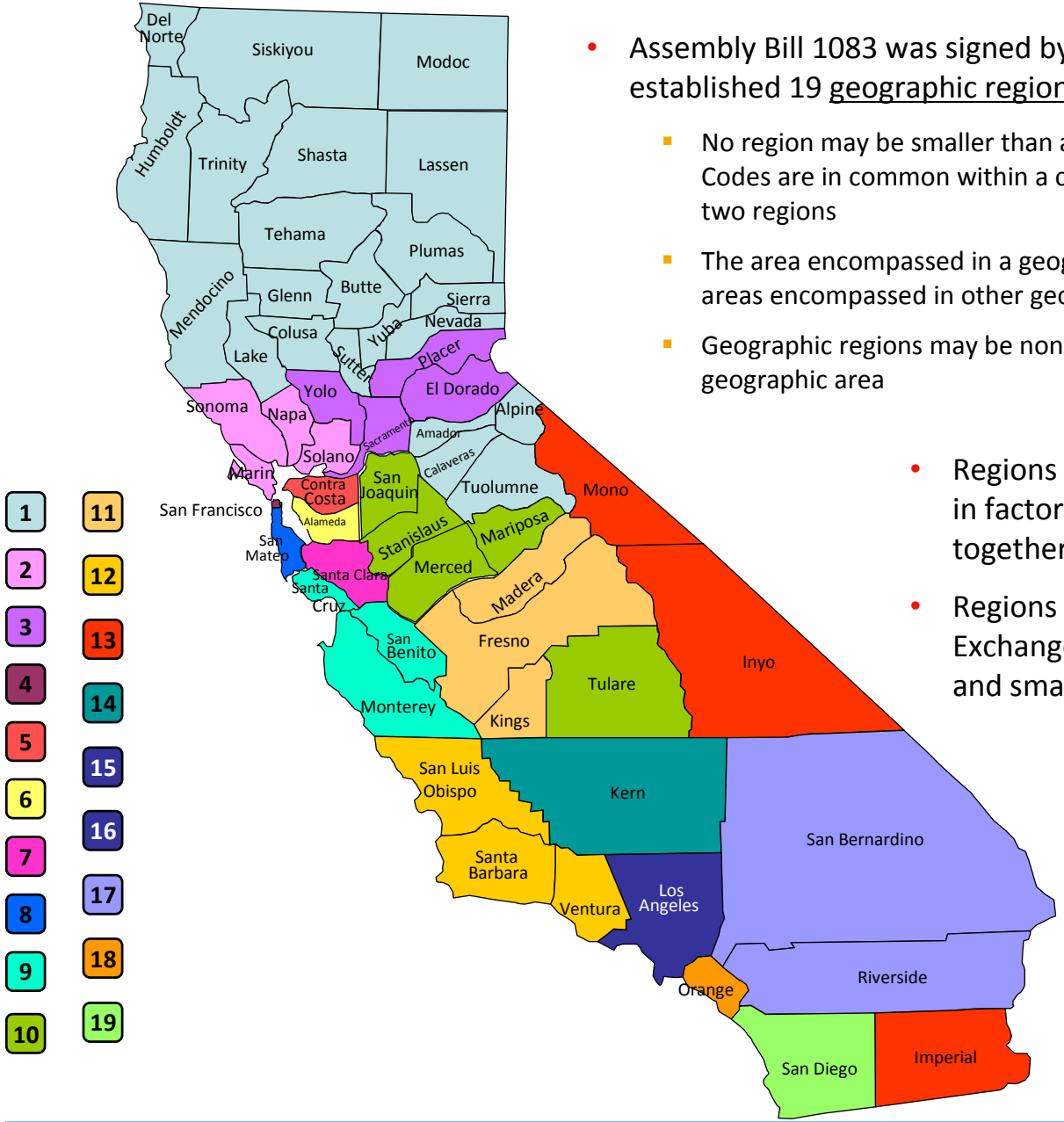


North Carolina Metropolitan Areas

1. Asheville
2. Burlington
3. Charlotte-Gastonia-Concord (NC-SC)
4. Durham-Chapel Hill
5. Fayetteville
6. Goldsboro
7. Greensboro-High Point
8. Greenville
9. Hickory-Lenoir-Morganton
10. Jacksonville
11. Raleigh-Cary
12. Rocky Mount
13. Wilmington
14. Winston

Source: http://www2.census.gov/geo/maps/metroarea/stcbsa_pg/Nov2004/cbsa2004_NC.pdf

California Process



- Assembly Bill 1083 was signed by Governor Brown on September 30th and established 19 geographic regions
  - No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions
  - The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions
  - Geographic regions may be noncontiguous. No plan shall have less than one geographic area

- Regions were established based on the variances in factors, whereby similar factors were grouped together as a proxy for similar medical costs
- Regions are applied both in and out of the Exchange and are the same in both the individual and small group markets

How Should North Carolina Establish Geographic Rating Areas?

Question: *Should the state submit an exception to permit North Carolina to use counties as geographic rating area? (e.g. 100 rating areas?)*

Options	Description
Yes	• Submit an exception based on current market practices and concern over limited options in certain geographic areas
No, Submit Another Exception	• North Carolina should consider another exception, such as asking for up to a select number of rating areas (e.g., 20 with three digit zip codes or 14 with MSAs)
No	• Consolidate rating areas down to seven
Other?	• Other?

How Should North Carolina Establish Geographic Rating Areas?

Question: *If 100 counties is not approved or not desired, how should geographic rating areas be calculated? Does this process change if the state is allowed more than 7 areas?*

Options	Next Steps
"California Process" based on counties	• To be determined by NC DOI, released for comment for insurers, and then finalized by NC DOI • Method starts with 100 counties and works down
"California Process" based on 3-Code Zip	• To be determined by NC DOI, released for comment for insurers, and then finalized by NC DOI • Method starts at 20 and works down
" California Process" based on MSAs	• To be determined by NC DOI, released for comment for insurers, and then finalized by NC DOI • Method starts at 15 (14 MSAs and 1 all other) and works down
Other	• Other?

Agenda

9:30 – 9:40	Welcome and Introductions
9:40 – 9:50	Goals/Objectives of Work Group and Today's Discussion
9:50 – 11:10	Items for Discussion in Work Group • Age Curve – Should the state accept the default age factors or submit a North Carolina-based age curve? If the latter, how should it be calculated? • Tobacco Rating – Should the state impose a standard tobacco rating factor (less than 1.5)? If so, what should it be? If the state does not implement a standardized a factor, how should insurers limit the tobacco rating factor to something lower than 1.5? How should tobacco use be measured?
11:10 – 11:20	*Break*
11:20 – 12:20	Items for Discussion in Work Group, continued: • Geographic Rating Areas – How should geographic rating areas be calculated? Does the methodology change if the state is able to have more than 7 areas?
12:20 – 12:30	Wrap Up and Next Steps

Next Steps

- **Review WG meeting notes once released**

Questions?

Responses from Other States & Stakeholders

Other States' Approaches to Rating Areas

- Some state have established rating areas. Typically, states use counties or zip codes to define those areas.[1]
  - Oregon has 7 rating areas which all carriers must use to set rates without flexibility.
  - New Jersey has 6 geographic rating regions defined in regulation.
- It is likely that states who have set geographic rating areas in existence will rely on those areas to meet the ACA requirement.
- The Commonwealth Connector in Massachusetts — with 6.6 million residents — has three rating areas.[1] These are the same areas which are used throughout the state for non-Connector products.

Excerpts of National Dialogue

- **NAIC:** "Most States will include multiple rating areas, and most States will exhibit wide variation in costs across these rating areas."[2]

[1] http://www.cbpp.org/files/Governance-Issues-for-Health-Insurance-Exchanges.pdf
[2] http://www.naic.org/documents/committees_jt_bd_lim_med_ben_120120_risk_adjustment_implementation_issues.pdf