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

Work Group Meeting – Premium Rating Implementation

October 22, 2012

MANATT HEALTH SOLUTIONS

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Agenda

2:00 – 2:15	Welcome and Introductions
2:15 – 2:45	Goals/Objectives of Work Group and Today's Discussion
2:45 – 3:45	Items for Discussion in Work Group • Geographic Rating Areas
3:45 – 4:00	*Break*
4:00 – 4:50	Items for Discussion in Work Group, continued: • Age Composition- Adult and Children
4:50 – 5:00	Wrap Up and Next Steps

Manatt Health Solutions & Oliver Wyman Overview

MANATT HEALTH SOLUTIONS
A DIVISION OF MANATT, PHELPS & PHILLIPS, LLP

- Policy and business advisory division of Manatt, Phelps & Phillips, LLP focused on:
  - Federal Health Reform
  - Health Coverage & Access
  - Federal & State Policy
  - Advocacy
  - Health Information Technology Strategy
  - Strategic Planning & Analysis
  - Healthcare Financing & Reimbursement
  - Strategic Partnerships
  - International Health Policy

OLIVER WYMAN

- **An international management consulting firm and subsidiary of Marsh & McLennan**
- Consultants are on the leading edge of federal healthcare reforms
- Strong actuarial practice with expertise in all aspects of commercial coverage
- Actuarial practice also supports state and federal regulators, commercial insurers, HMOs and other risk taking entities.
- Extensive experience in the development, filing and review of health insurance rates.

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Overall Project Goal and Rating Work Group Meeting 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)

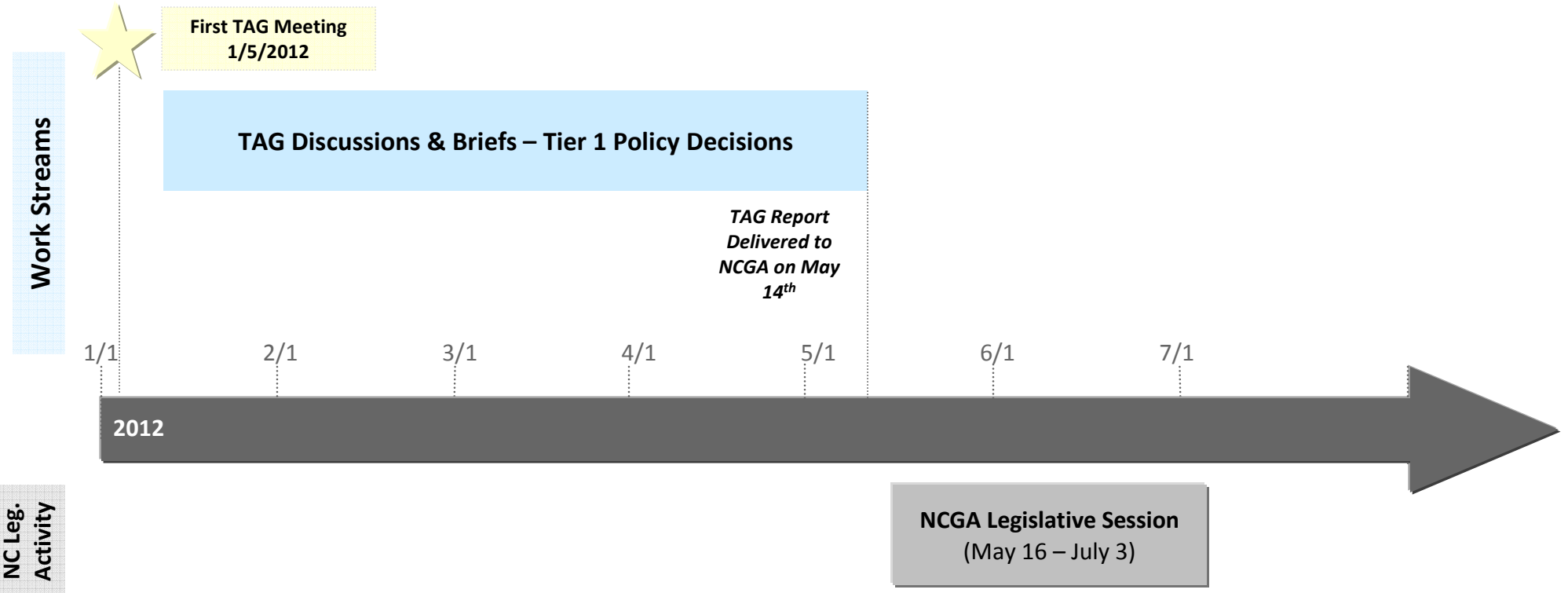
"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study insurance-related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

- Explain the Role and Expectations of the Work Group in Relation to the Overall Project and Role of the Technical Advisory Group (TAG)
- Provide Background on Age and Geographic Rating Areas, including Federal Regulations, State Statute and Existing Market Place Practices
- Identify Options to Set Before the TAG for Consideration

Past Project and Regulatory Timeline



Federal Guidance and Activity

Planning — Development of a Federal Exchange — *Testing*

Recent Relevant Guidance Already Issued

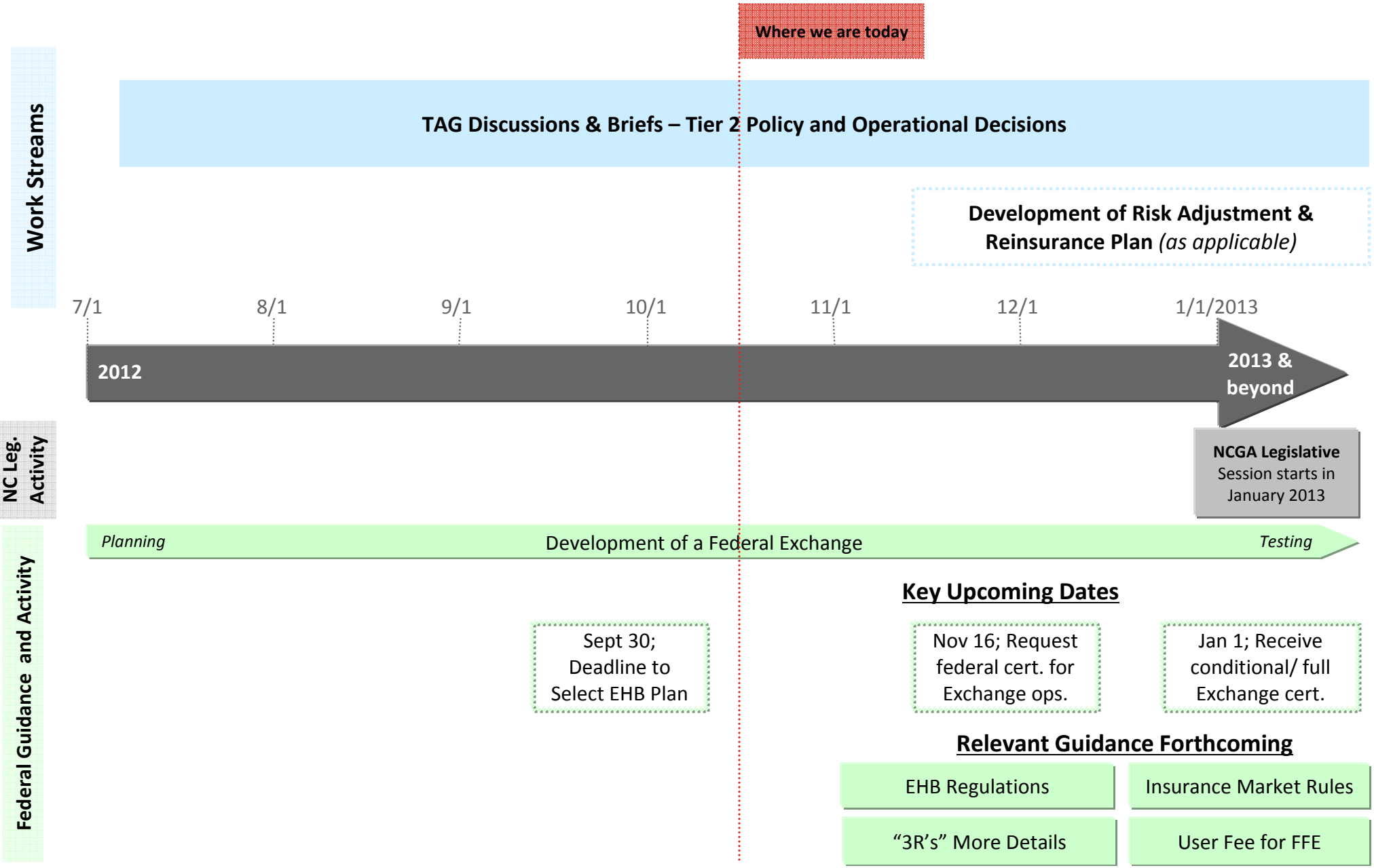
EHB Bulletin (Dec. 2011)

- **Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers Final and Interim Final Rules (March 2012)**
- **"3R's" Reinsurance, Risk Corridors & Risk Adjustment Final Rule (March 2012)**
- **Medicaid Eligibility Changes under the ACA Final Rule (March 2012)**
- **Health Insurance Premium Tax Credit Final Rule (March 2012)**

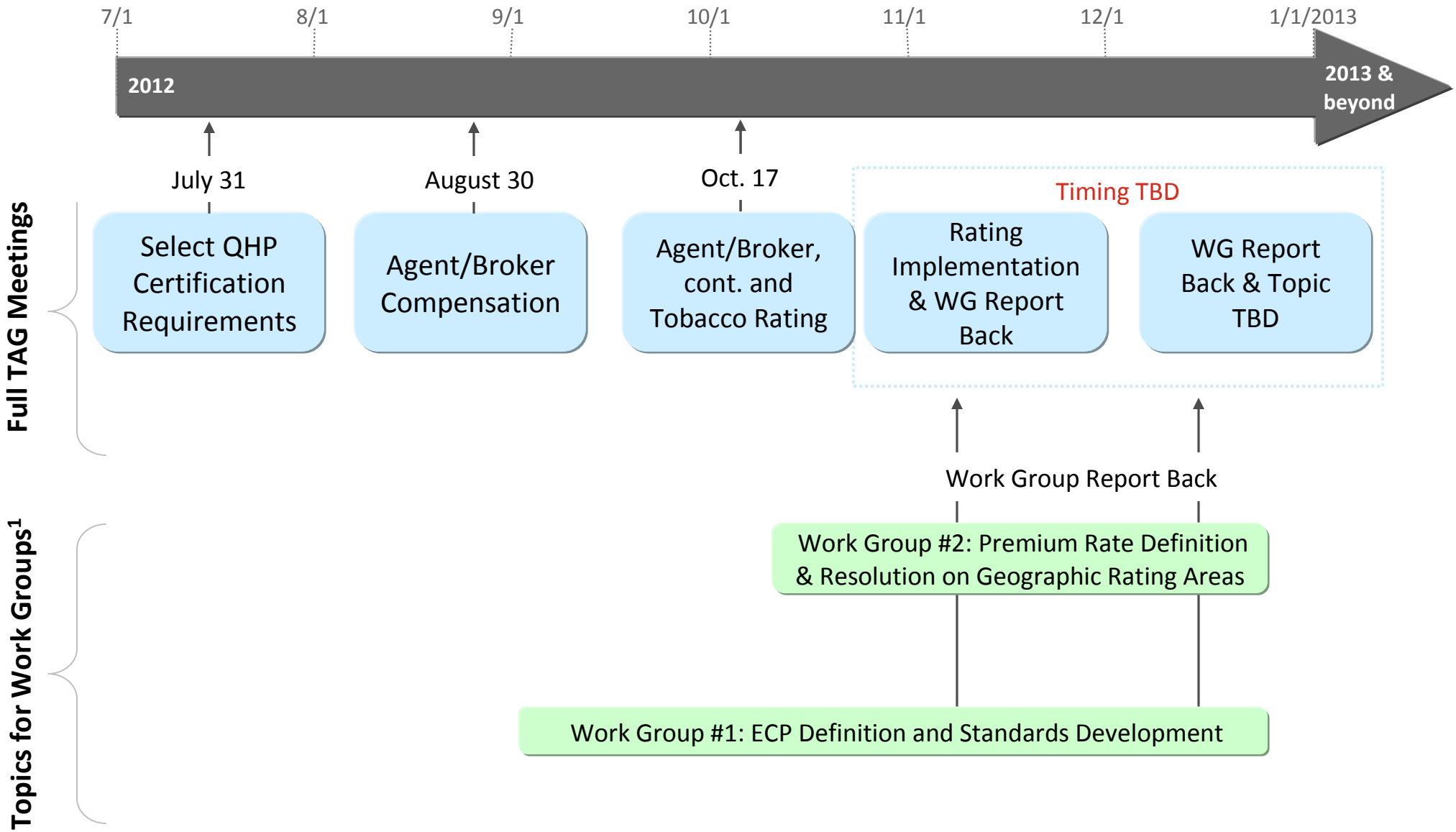
Draft Blueprint for SBEs and Partnerships; Guidance on FFEs (May 2012)

EHB Data Collection Standards and QHP Accreditation Final Rule (July 2012)

Current Project and Regulatory Timeline



Tentative 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 approaches 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 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 development 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 can also take into account a gradual process, if needed (e.g., Year One options versus options to be considered in later years)*

Role and Expectations of the Rating Implementation Work Group

- The purpose of the work group is to provide technical expertise and stakeholder input to support TAG discussion.
  - Participants invited because of expertise and experience in the topic under discussion
  - Anticipated that group will meet several times to work through issues prior to TAG discussion; frequency will be determined by regulations
- Work group will identify policy options/considerations for the TAG; the TAG, in turn, will recommend preferred options to the NC DOI, who will develop recommendations, as applicable, to the NCGA
  - Focus is on OPTIONS DEVELOPMENT and identification of pros/cons of certain options will be noted and shared with TAG as needed
- Understand that insurance market reform rules are not released
  - Work group may spend time discussing options and considerations which will not be possible to implement once the rules are available

Role and Expectations of Work Group Participants

- Work Group members will:
  - Be a consistent presence
  - Meet timelines
  - Contribute expertise
  - Consider perspectives from diverse stakeholder groups
  - Be solution-oriented
  - Respect the opinions and input of others
  - Work toward options development

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 Federal Laws and Regulations – Insurance Rating Rules

Rating rules are primarily addressed in federal statute, with minimal guidance currently available for how to implement reforms.

- Premiums offered by non-grandfathered plans in the individual and small group markets shall vary with respect to the particular plan or coverage involved only by:
  - (i) whether such plan or coverage covers an individual or family;
  - (ii) rating area, as established in accordance with paragraph (2);
  - (iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c))[1]; and
  - (iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1

  --(ACA Section 2701(a)(1)(A))

[1] *2702(c) refers to child only plans: "If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the PPACA, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21." Thus, children are not part of the 3:1 limitation.*

Relevant Laws and Regulations- Geographic Rating Areas

ACA and Federal Guidance:

- Each State shall establish 1 or more rating areas within that State. The Secretary shall review the rating areas to ensure the adequacy of such areas. *(PPACA Section 2701(a)(2))*
  - The Secretary will address the process for States requesting approval of rating areas in future rulemaking. *(Exchange Establishment NPRM §156.255(b)(2))*
  - Rating areas apply to the non-grandfathered fully-insured small group and individual plans. Fully insured large group plans are only subject to rating areas, and other rating requirements, in states that allow large groups to purchase through the exchange. *(PPACA Section 2701(a)(1) and (a)(5)*
- Rating areas will be applied consistently inside and outside of the Exchange *(Exchange Establishment NPRM §155.140(b)(2))*

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

How Rating Areas Are Currently Defined in NC

- Most insurers use counties to group the state into broader regions
- Many insurers offer separate regions by market type (e.g. small group has a separate rating region than the individual or large group market)
- Few insurers offer separate regions by product type (e.g. HMO small group has separate rating areas than non-HMO small group)
- Most insurers group counties into regions in the individual market, with the number of regions ranging between 4 and 8
- Most insurers do not group counties into rating regions for the small group market
- Factors range from 1.4 to 1 in the individual market and from 1.5 to 1 in the small group market

The rate development process usually begins 6 to 12 months out from the time the product goes to market, making timing of the essence to determine rates for October 2013 open enrollment.

Rating Variances in the Individual Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E	Insurer F
Product(s)	All	All	All	All	All	All
Use of County or Zip Code	County	County	County	County	3-Level Zip Code	Unknown
Use of Regions	Yes	Yes	Yes	Yes	No	Yes
If so, how many	7	7	4	8	N/A (2 different rate factors)	8
Lowest Factor Used	0.93	0.93	0.90	0.84	0.99	0.90
Highest Factor Used	1.20	1.09	1.15	1.16	1.08	1.04
Ratio between Highest and Lowest	1.3:1	1.2:1	1.3:1	1.4:1	1.1:1	1.2:1

Sample of most insurers having greater than 5000 lives; Carrier "A" in the individual market is not the same as Carrier "A" in the small group market

Rating Variances in the Small Group Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E	Insurer F
Product(s)	All	All	All	All	All	All
Use of County or Zip Code	County	County	County	County	County	County
Use of Regions	No	No	Yes	Yes	No	Yes
If so, how many	N/A (23 different rate factors)	N/A (14 different rate factors)	13	13 (9 different rate factors)	N/A (22 different rate factors)	10 (9 different rate factors)
Lowest Factor Used	0.84	0.80	0.90	0.90	0.83	0.90
Highest Factor Used	1.25	1.15	1.04	1.15	1.25	1.15
Ratio between Highest and Lowest	1.5:1	1.4:1	1.2:1	1.3:1	1.5:1	1.3:1

Sample of most insurers having greater than 5000 lives; Carrier "A" in the individual market is not the same as Carrier "A" in the small group market

Initial TAG Recommendations & NC DOI Response

The TAG discussed geographic rating areas and requested that they be set by the NCDOI after a study. NC DOI supported this recommendation in their report to the NCGA.

The TAG recommends that the NC DOI, in consultation with insurers, be responsible for the establishment of geographic rating areas for the North Carolina individual and small group markets pursuant to the ACA. The NC DOI should commission a study analyzing the impact of different rating area options on premiums and risk distribution in the individual and small group markets. At the conclusion of the study, the NC DOI should establish rating areas. Rating areas should be set by December 31, 2012 and reassessed by the NC DOI on an as-needed basis.

In general, the TAG prefers more segmented geographic rating areas, as is the current practice of most major insurers in the State, but it also believes that additional analysis on the impact of different rating regions on premium costs and access is needed before rating areas are configured.

TAG Statement pulled from Issue Brief #2, available at: http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/Issue%20Brief%202%20-%20Rating%20Areas%20and%20Leveling%20the%20Playing%20Field%20Issues.pdf
NCDOI Report to the NCGA, available at: http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/NC%20DOI%20Session%20Law%202011-391%20Study%20Report.pdf

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

Metropolitan Statistical Areas (MSAs) could be considered as a baseline for states that do not currently use a regional approach

- In the 1940's Federal agencies began to develop a single set of geographic guidelines to enhance data production for the largest population centers in the United States.
- The term "metropolitan areas" is used to generally describe an area containing a large population center and adjacent communities that have a high degree of integration with that population center.
- OMB's metropolitan area standards establish consistent definitions for collecting, tabulating and publishing Federal data for metro areas.
- An MSA is a metropolitan area made up of central counties, that include the MSAs central cities, and outlying counties that meet OBM requirements
  - Population size requirements - A city of 50,000 or more population *or* a U.S. Census Bureau defined urbanized areas of 50,000 or more population and smaller urban clusters of 10,000 to 49,999 population.
  - Central cities - City with the largest population in the MSA.
  - Central counties - Those counties that include a central city of the MSA, or at least 50 percent of the population of such a city, provided the city is located in a qualifier area; and those counties in which at least 50 percent of the population lives in the qualifier urbanized area.

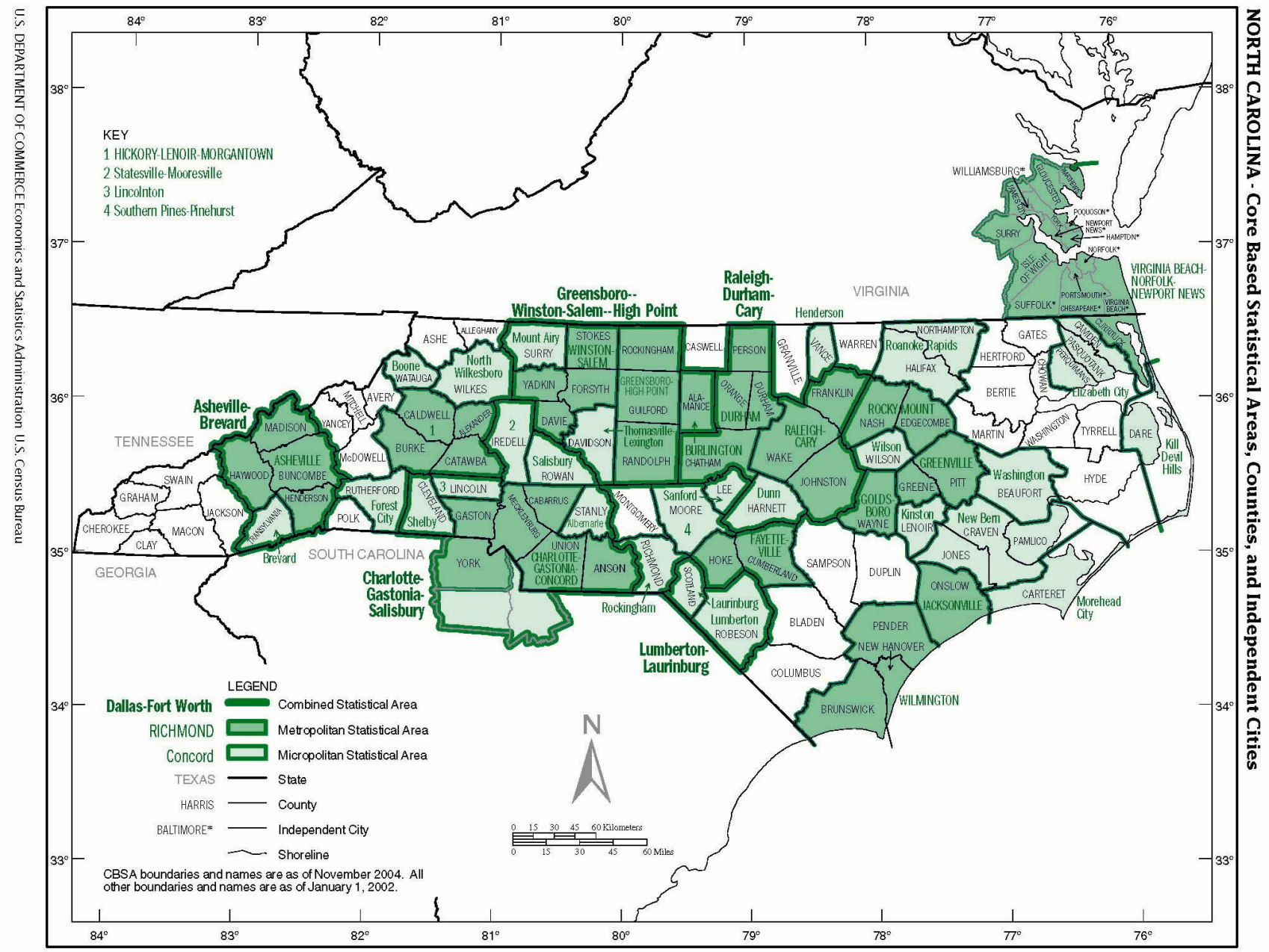
North Carolina Metropolitan Areas

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://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/msa.shtm

Metropolitan Aras Source: http://proximityone.com/metro_healthinsurance.htm

Metropolitan Statistical Area Map



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

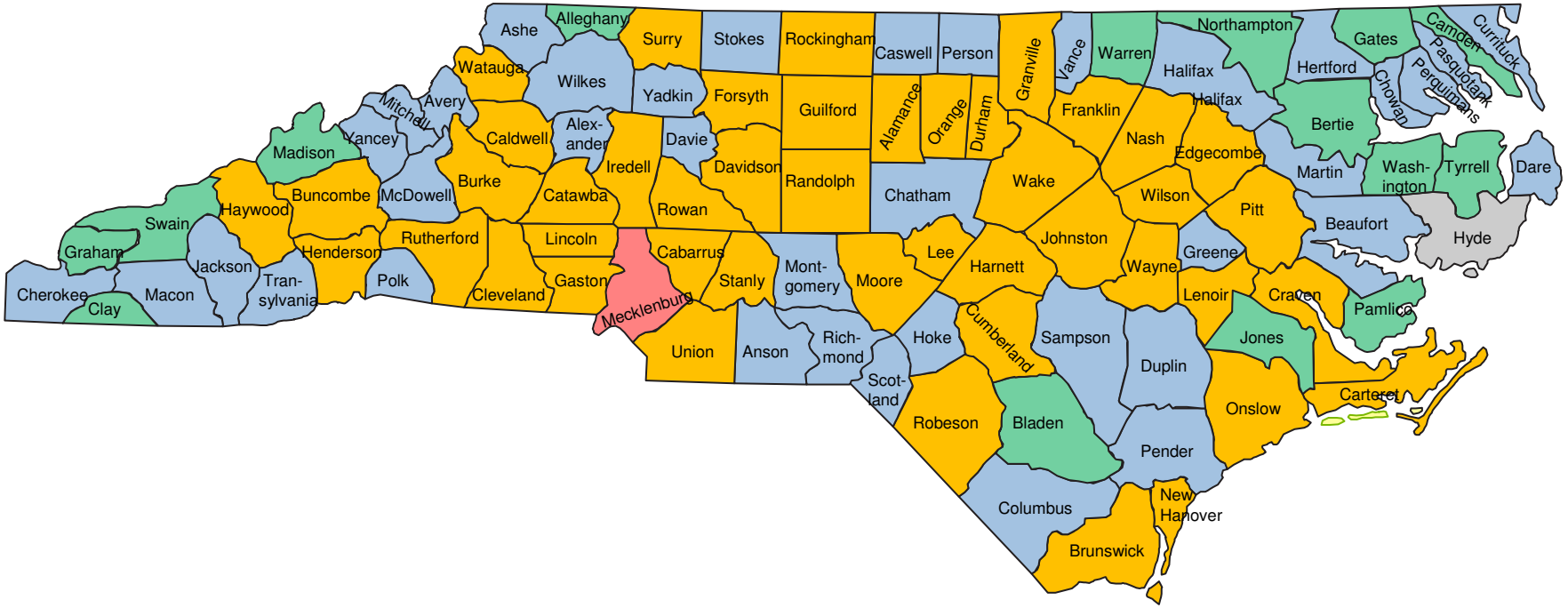
CMS has Network Adequacy Standards that Categorize Counties Which Could be Used as a Basis for Regional Groupings

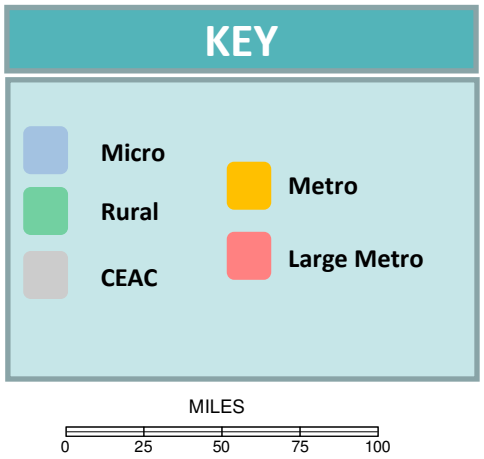
- Designations used as a part of CMS' Network Adequacy requirements for new applications for Medicare Advantage plans
- Due to variations in the patterns of care and access to health services across the counties within a given core based statistical area, CMS applies a designation methodology that is based upon the population size and density parameters of individual counties.
- A county must meet both the population and density thresholds for inclusion in a given designation.
- Any of the population-density combinations listed for a given county type may be met for inclusion within that county type.

	Populations	Density
Large Metro	≥ 1,000,000	≥ 1,000/mi2
	≥ 500,000 – 999,999	≥ 1,500/mi2
	Any	≥ 5,000/mi2
Metro	≥ 1,000,000	10 – 999.9/mi2
	500,000 – 999,999	10 – 1,499.9/mi2
	200,000 – 499,999	10 – 4,999.9/mi2
	50,000 – 199,999	100 – 4,999.9/mi2
	10,000 – 49,999	1000 – 4,999.9/mi2
Micro	50,000 – 199,999	10 – 99.9 /mi2
	10,000 – 49,999	50 – 999.9/mi2
Rural	10,000 – 49,999	10 – 49.9/mi2
	<10,000	10 – 4,999.9/mi2
CEAC	Any	<10/mi2

Source: http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2013_HSD_Provider_Facility_Specialties_Criteria_Guidance_111011.pdf

CMS Medicare Advantage Map for North Carolina





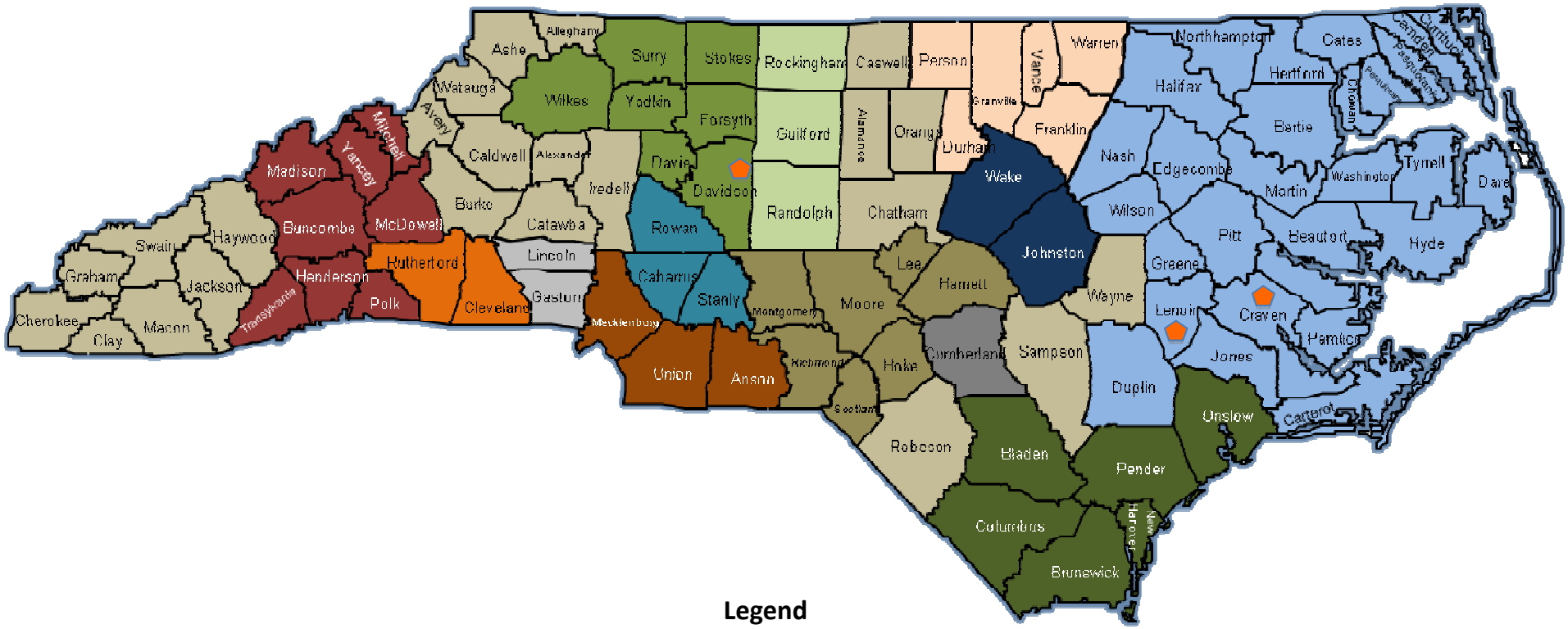
- Could use designation as a non-contiguous grouping
- Could also use in conjunction with MSAs to identify regions outside of MSAs

Community Care of North Carolina

- CCNC brings together regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organization to provide cooperative, coordinated care through the Medical Home model
- CCNC works with over 5,000 providers and serves over 1.2 million patients
- CCNC uses a community based infrastructure of 14 networks
  - With the exception of requiring an enrollee minimum (30,000) and requiring that networks comprise contiguous counties, program sponsors did not attempt to influence the way networks came together
  - These decisions were left to the key providers in each county — the group responsible for forming a network or choosing a network to join
  - Network formation has generally followed traditional care delivery and service patterns
    - All but two networks were built around urban medical centers and included neighboring suburban and rural counties
    - Network formation became difficult or drawn out only in a handful of counties — regions in which provider relationships were divided between competing regional health care systems
    - Steering committees in all but one county agreed unanimously on the networks they would join
- Most network serve a contiguous, multi-county region
  - AccessCare is an exception that serves 23 counties in disparate regions of the state

Source: https://www.communitycarenc.org/our-networks/; http://commonwealth.communitycarenc.org/toolkit/4/default.aspx#1

CCNC Regional Areas Map



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Community Care
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Source: CCNC September 2012

Considerations for Setting Areas

Rating Area Considerations	
County Level Designations	▪ Unclear if county-level designations will be permitted
Zip Code	▪ Unlikely that zip code delineation will be allowed
Maximum Regions	▪ CCIIO may consider up to a maximum number of regions in a state
Contiguous Areas	▪ Unclear if rating areas are required to be contiguous, although non-contiguous groupings could have the potential for rating to be based on health status rather than costs of care.
Morbidity	▪ Morbidity should not be considered in rating areas
Service Area vs. Rating Area	▪ In the preamble of the Exchange final rule, CCIIO recommends that Exchanges consider aligning QHP service areas with rating areas established by the State, but it is not a regulatory requirement to do so
Individual vs. Small Groups	▪ Unclear if geographic rating areas will be required to be the same, by market

Federal market reform rules will inform rating areas considerations.

How Should North Carolina Establish Geographic Rating Areas?

Question: If Federal Guidance/Regulations allow states to set geographic rating areas by county, should North Carolina exercise that option in 2014 and 2015?

Options	Description
Yes	• North Carolina should set rates at the county level
Yes, for 2014 & 2015	• North Carolina could elect to use counties in 2014 & 2015 only, with plans for developing another strategy for the long term (see next question)
No	• North Carolina should not set rates by county, but should define broader regions (see next question)
Other	• Other?

How Should North Carolina Establish Geographic Rating Areas?

Question: If Federal Guidance/Regulations indicate that geographic rating areas by county are too narrow, or if North Carolina does not prefer the county-level, how should regions be defined for 2014 and 2015?

Options	Considerations for Implementation
Establish New Grouping Methodology for North Carolina based on Studies/Analysis	• North Carolina could consider an economic impact analysis, which could set market regions for where prices are the same/similar • North Carolina could do a study based on hospital/provider locations and cost of care • Other?
Rely on Existing Groupings/Definitions	• North Carolina could consider using MSAs, CCNC Regions or CMS Network Adequacy as a baseline for grouping • North Carolina could consider using the regions set by the largest statewide insurer in the individual and small group market • North Carolina could base regions off of another state program (if applicable) • Other?
Rely on Federal Minimums	• North Carolina could defer to the federal minimums (if applicable) to set rating areas for 2014 and 2015 and target another approach for a later year (e.g. 2016 & beyond) • Other?
Other?	• Other?

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Relevant Laws and Regulations- Age Bands and Factors

ACA and Federal Guidance on Age, only:

- Premiums offered by non-grandfathered plans in the individual and small group markets can vary by age, except that such rate shall not vary by more than 3 to 1 for adults *--(ACA Section 2701(a)(1)(A))*

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)*

How Age Bands and Factors Are Currently Defined in NC

Almost all insurers will need to compress adult age factors to stay within the 3:1 ACA-mandated requirement.

- All insurers conform to required age bands under NC §58-50-130 for small group products
- Most insurers use single year age bands starting at or before age 21 for individual products
- Individual Product Spread
  - The average factor spread ranges from 3.77 to 5.58 – indicating that all insurers will need to also make adjustments to stay within the ACA requirement of 3:1
- Small Group Product Spread
  - The average factor spread ranges from 2.54 to 4.48 – indicating that almost all insurers will need to make adjustments to stay within the ACA requirement of 3:1

Average factor: Average of male and female

Age Band and Factor Variances in the Adult Individual Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E
Use of Bands over Age 21	No	Yes	No	No	No
If so, how many	NA	10	NA	NA	NA
Oldest Age Used	65+	66+	65	70	64
Male Spread: 21 – Oldest Age	4.9	5.19	6.09	5.03	4.57
Female Spread: 21 – Oldest Age	2.92	3.38	3.68	3.86	3.21
Average Spread: 21 – Oldest Age	3.84	4.11	5.58	4.39	3.77

Age Band and Factor Variances in the Small Group Market

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E
Uses Age Bands Consistent with NC Age Bands (§ 58-50-130)	Yes	Yes	Yes	Yes	Yes
Provides Medicare Primary & Secondary Factors	Yes	Yes	No	No	Yes*
Male Medicare Secondary: Spread 25 – 65+	6.05	6.82	7.35*	8.44*	8.18
Female Medicare Secondary: Spread 25 – 65+	2.66	2.85	2.88*	2.83*	2.56
Medicare Secondary: Average Spread 25 – 65+	3.76	4.06	4.24*	4.48*	2.54

*Carrier did not discern between Medicare Primary and Secondary

Responses from Other States

Other States' Approaches to Age Bands/Factors Implementation:

- CA- No more than the following age categories may be used in determining premium rates: Under 30; 30–39; 40–49; 50–54; 55–59; 60–64; 65 and over. However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).[1]
- DC- The law includes early adoption of the 3:1 requirements that are present in the ACA. They also include a restriction that the age factors for any age may not be more than 4% greater than the prior age. "a plan of individual or small group health insurance rates shall not include a standard rate for any age that is more than 300% of the standard rate for the age with the lowest rate in the same plan and the standard rate for any age shall not be more than 104% of the standard rate for the previous age." (DC ST § 31-3311.02)[2]
- NJ- insurers currently offering standard plans in New Jersey's individual market may consider age in establishing different premiums, with classifications set at minimum in five-year increments... eleven age factor categories: 19 and under; 20-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; and 65 and over... Premiums may differ from the lowest to the highest based on age by no more than 350 percent. (note: considering changes needed under ACA).[3]

[1]http://info.sen.ca.gov/pub/11-12/bill/asm/ab_1051-1100/ab_1083_bill_20120911_enrolled.pdf
[2]http://weblinks.westlaw.com/result/default.aspx?cite=UUID%28N46AFA25075%2D6F11E0A026D%2DCE73F53D307%29&db=1000869&findtype=VQ&fn=%5Ftop&pbc=DA010192&rlt=CLID%5FFQRLT5775649419410&rp=%2FSearch%2Fdefault%2Ewl&rs=WEBL12%2E07&service=Find&spa=DCC%2D1000&sr=TC&vr=2%2E0
[3]http://www.cshp.rutgers.edu/Downloads/9490.pdf

Considerations for Establishing Age Factors/Bands

The 3:1 statutory requirement will raise premiums for younger populations and lower them for older populations.

Considerations for Implementation	
Age Bands	▪ Unclear if feds will set default age bands, nationally, or what flexibility will be given to states ▪ Setting parameters around age bands, or standardization of age bands across insurers, may be a part of federal requirements (assumes age bands could be separate in the individual market versus the small group market) ▪ In North Carolina, currently regulated in the small group market only
Age Factors	▪ Unclear if feds will set default age factors, nationally, or what flexibility will be given to states ▪ Setting parameters around age factors may be a part of federal requirements ▪ Unclear if standardization of age factors across insurers will be required as part of federal regulations, or if individual insurers will be responsible for setting own factors within 3:1 requirement (assumes age factors could be separate in the individual market versus the small group market) ▪ In North Carolina, not currently regulated

Federal market reform rules will inform accuracy of considerations.

Options for Changing Age Bands/Factors In North Carolina

Options	Additional Details
Establish standardized age bands in the individual market	• Consider standardizing age bands in the individual market
Set age band parameters in the individual market	• North Carolina could consider establishing parameters around how ages could be grouped for pricing in the individual market (e.g. no more than 3 years factored together)
Establish standardized age factors in both markets	• Standardize age factors for the individual and small group markets (separately by market) to apply across all insurers
Set maximum allowable increases between ages across both markets	• Similar to DC, set a maximum amount that premiums can increase based solely on age between distinct ages or age bands (e.g. 4%)
Other?	• ?

Considerations for Additional Requirements on Age Factors

Implementing additional parameters on age factors could help smooth premium increases due solely to age for consumers over time, but also creates additional market disruption in the short term and reflects change from current business practices.

Pros from setting parameters around age bands?	Cons from setting parameters around age bands?
▪ Minimizes rating differences to consumers ▪ Over long term, could stabilize market ▪ Others?	▪ Reflects a shift from the way the market currently operates ▪ In short term, could cause market disruption ▪ Others?

Question for Discussion- Age Factors

Question: Should additional parameters be placed on age factors to mitigate rating "cliffs" that consumers face as they age in 2014 and 2015?

Options	
No	• No additional parameters should be placed on age factors for 2014 and 2015
Yes	• North Carolina should consider additional parameters on age factors in the short term for 2014 and 2015 *(see next slide)*
Yes, in Long Term only	• North Carolina should consider additional parameters on age factors in the long term, starting in 2016 *(see next slide)*
Other	• ?

Options for Discussion- Age Factors

Question: What additional options should be considered in North Carolina?*

Options	Next Steps
Establish standardized age bands in the individual market	• Determine a process by which the standardized age bands would be considered
Set age band parameters in the individual market	• Determine a process to set age band parameters
Establish standardized age factors in both markets	• Determine a process to identify/set factors
Set maximum allowable increases between ages across both markets	• Set maximum allowable increase between ages
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.

Age Bands in the Individual Market- Children

	Insurer A	Insurer B	Insurer C	Insurer D	Insurer E
Use of Bands under Age 21	No	Yes	Yes	Yes	Yes
If so, how many	NA	5	5	6	8
Age Bands	NA	0-01, 02-12, 13-16, 17-18, 19-20	Primary 0-17, Dependent 0-26, 18, 19, 20	0-1, 2-16, 17, 18, 19, 20	<1, 1-4, 5-15, 16, 17, 18, 19, 20

Question for Discussion- Age Factors

Question: Should standardized age bands for children be established in the individual market?

Options	
No	• No age bands should not be standardized for 2014 and 2015
Yes	• North Carolina should consider standard age bands in the short term for 2014 and 2015
Yes, in Long Term only	• North Carolina should consider standard age bands in the long term, starting in 2016
Other	• ?

Agenda

2:00 – 2:15	Welcome and Introductions
2:15 – 2:45	Goals/Objectives of Work Group and Today's Discussion
2:45 – 3:45	Items for Discussion in Work Group • Geographic Rating Areas
3:45 – 4:00	*Break*
4:00 – 4:50	Items for Discussion in Work Group, continued: • Age Composition- Adult and Children
4:50 – 5:00	Wrap Up and Next Steps

Next Steps

- **Review market reform regulations, once released**
- **Gather again to discuss options**
  - Focus will be on reacting to the regulations and feedback from this meeting to further develop options for TAG consideration

Questions?

National Dialogue on Rating Reform Issues

National Association of Insurance Commissioners (NAIC)

Comments on Market Reform

NAIC has determined that premium variations up to 5 to 1 based on age and up to 15 percent based on industry are reasonable in the small group market. August 2011 overview of individual market rating rules in selected states:

Rating Bands (Health status may be used, but within limits)

- Kentucky: Rate band on health: 2.08:1. Composite rate band for age, gender, industry and occupation: 5:1.
- Nevada: Variation due to health status may not exceed 1.75:1. Age, sex, occupation, geography and family composition may also be used.
- New Hampshire: The use of health status is limited to 1.5:1. The use of age is limited to 4:1. The use of tobacco use is limited to 1.5:1. Rating for health status may not be changed after issuance of policy
- New Mexico: Within any age group, health status may be used to set premiums within a 250% composite rate band that also includes a maximum variation of 20% due to gender.
- Rhode Island: Rhode Island has one carrier in the non-group market, which may use health status, age, and gender to vary premiums. Limits on these factors are negotiated between the carrier and the Health Insurance Commissioner.
- Utah: Premiums may not be increased from the index rate by more than 30% due to health status. There is no restriction on reductions from the index rate due to health status. Any adjustment for health status at renewal may not exceed 15% applied to an entire class of business.

Adjusted Community Rate (No health status rating – other factors allowed)

- Maine: Premiums may vary by age and geography. All premiums must be within 20% of the community rate, meaning the limit on variation is 1½ :1. Legislation was enacted to allow age-based discounts up to a maximum 2½:1 variation, effective 7/1/2009, but was never implemented because the discounts were to be supported by a reinsurance pool and the funding mechanism for the reinsurance pool was repealed.
- Massachusetts: Non-group market has been merged with small group market. Composite rate band of 2:1 for age and geography. Additional adjustment of .95:1.10 for group size. Adjustments for smoking and wellness program participation are allowed, but are not used by any carriers.
- Washington: No health status allowed. Age, geography, tenure discounts, and wellness activity discounts may be used to set rates. Age is restricted to 3.75:1.

Community Rate (No variation besides geography) in New York and Michigan: Blues Plan only, other carriers may use rating factors

http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf

National Dialogue on Rating Reform Issues

America's Health Insurance Plans (AHIP)
Comments on Market Reform
Starting January 1, 2014, the law limits the age rating band to 3:1, causing an overnight increase in premiums for younger individuals (ages 18-49) that live in states that currently have higher age bands. This increases the likelihood that younger, healthier people will choose to pay the penalty and wait to purchase health insurance until after they get sick or injured, thus driving up costs for everyone else. As Robert Samuelson noted in his op-ed for the Washington Post, "the ACA discriminates against the young in favor of the old. Government policy already does this through payroll taxes that have young workers subsidizing Social Security and Medicare benefits. The ACA compounds the effect by forcing some young Americans to buy insurance at artificially high premiums that would pay for the care of a sicker, older population." Timothy Jost has noted that age rating compression "is going to force younger people to pay more in the individual market as older individuals pay less." Avik Roy highlighted in a recent Forbes article that a "government policy aimed at forcing young people to subsidize premiums for the elderly ends up driving up costs for everybody, including the very elderly people it was designed to help." Roy outlines the pitfalls of adjusting the age rating bands to 3:1 given that "the oldest individuals in the private market (those younger than 65), on average, spend six times more on health care as the youngest ones do (those older than 18). Hence, 3:1 community ratings forces the youngest people to pay 75 percent more for insurance, so that the oldest people can pay 13 percent less." http://www.ahip.org/ACA-Toolbox/Documents/Communications-Toolkit/Age-Rating--What-You-Need-to-Know.aspx