

# CMS Final Rule regarding Rate Increase Disclosure & Review Regulation

## Implications for Exchange Enrollment & Viability

October 13, 2012

Joint Select Committee on Health Reform Implementation  
Office of Insurance Commissioner

# Today's Overview

1. Background: Association Health Plans (AHPs) in Washington state
2. HHS Regulations: Rate Increase Review & Disclosure
3. Implications for Exchange Enrollment & Viability

# Washington's Association Health Plan Market

- ❑ “Association coverage” means health insurance coverage offered to collections of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements, etc.
- ❑ WA State law allows associations to be formed solely for the purpose of purchasing insurance.
- ❑ AHPs are currently regulated as large group.

# Washington's Association Health Plan Market

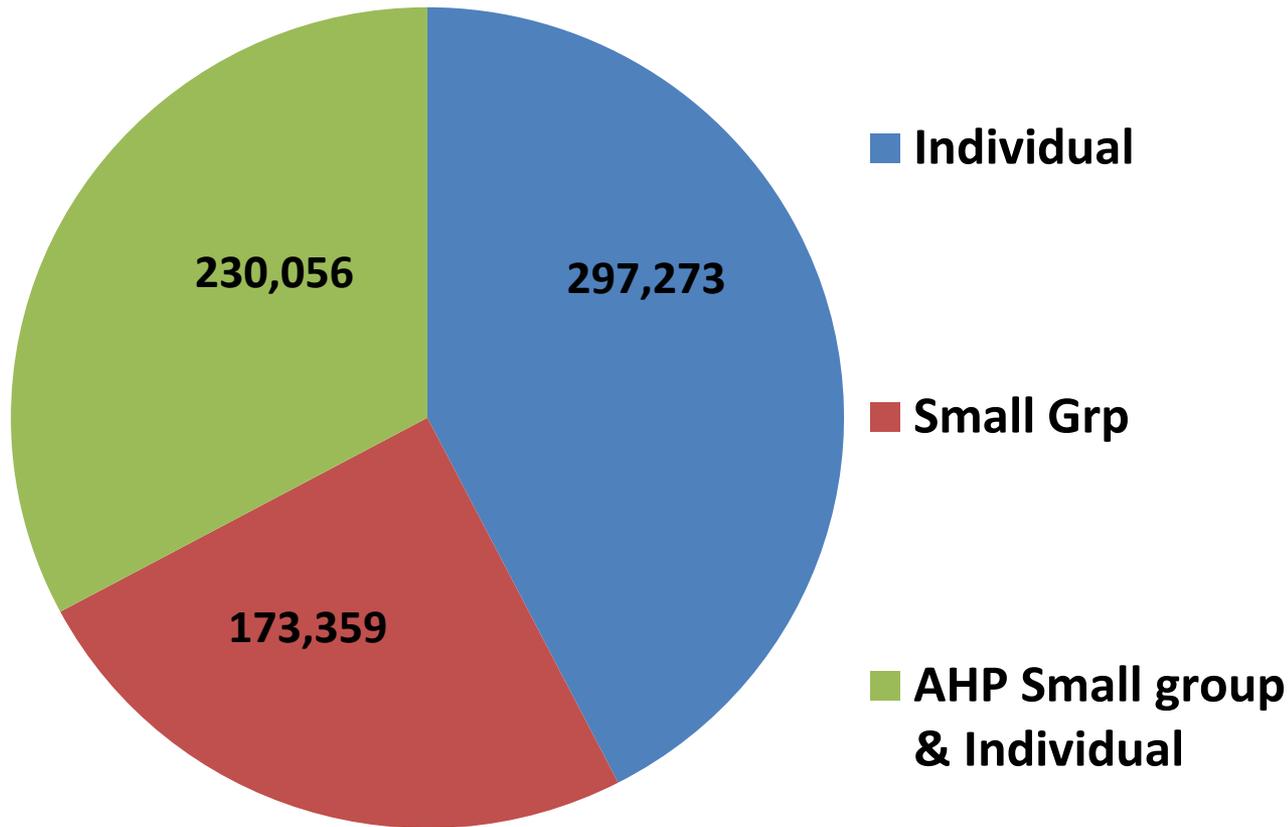
- ❑ AHPs are specifically exempted from small group community rating provisions.
- ▶ RCW 48.44.024  
“(2) Employers purchasing health plans provided through association or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.44.005.”

# Washington's Association Health Plan Market

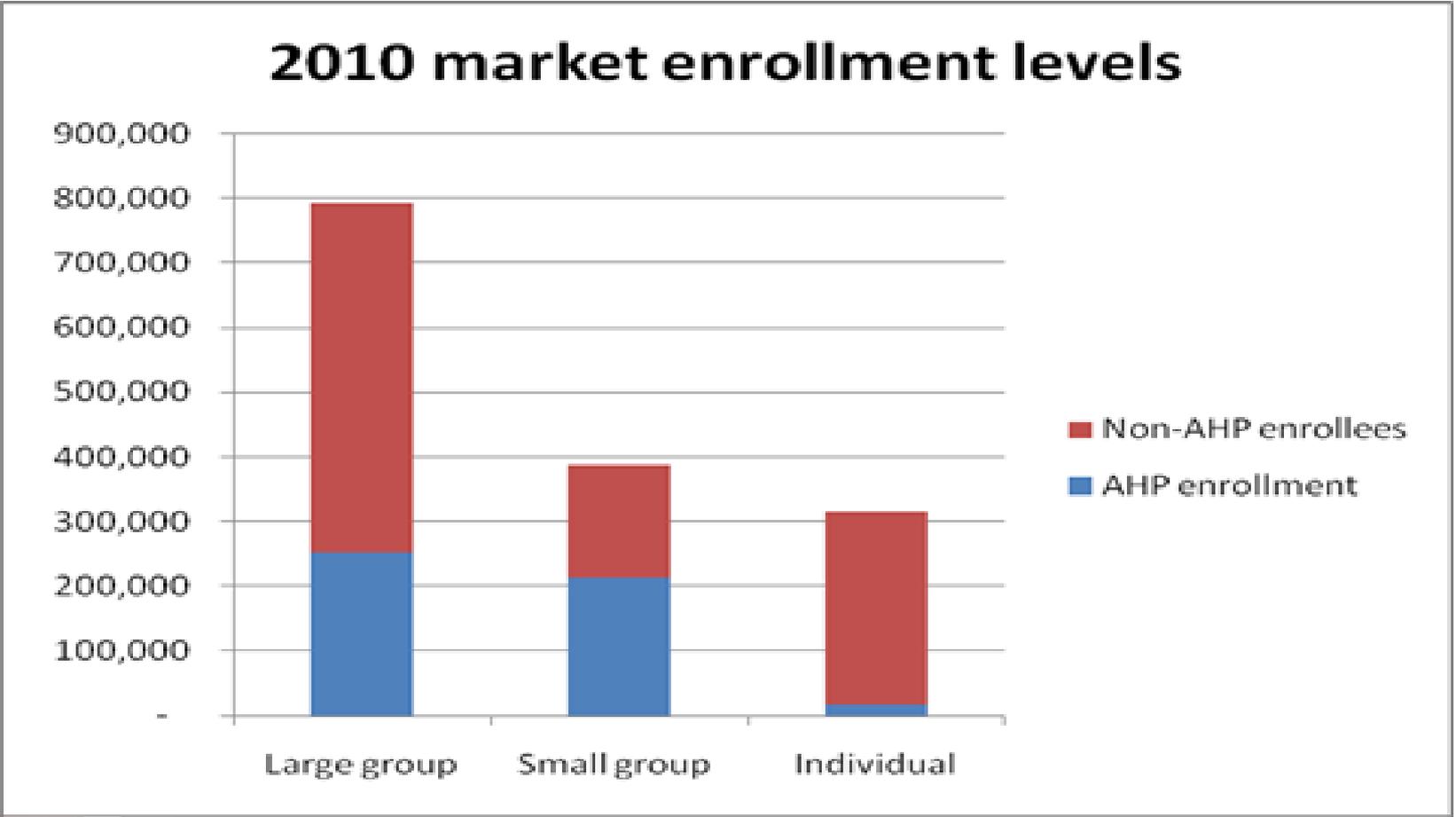
- ❑ Carriers can offer “experience rated” premiums to small employers in AHPs.
- ❑ Carriers may also use other rate factors such as gender & nonstandard age brackets for rate differentiation.
- ❑ There is substantial opportunity for carriers to select risk & isolate high-cost small groups in community-rated coverage.
- ❑ As a result, premiums in the community-rated small group market could be higher for the same benefit design.

# Enrollment by market 2010

## Individual, small group, AHP market (small group & individual)



# Washington's Association Health Plan Market



# Washington's Association Health Plan Market

Between 2008 and 2010:

- ❑ Average premiums increase by 6% in small group AHPs; community-rated small group increased by 21% in the same time period
- ❑ AHP premiums now 28% below community-rated small group

# CMS published amendment to the Rate Increase Disclosure and Review Regulation (45 CFR Part 154)

- ❑ Firmly sets forth the position that Association Health Plans are subject to Federal Health Care Reform
- ❑ Sets forth a process for filing of rates with CCIIO if the state is deemed to not be an effective rate review state for Association Health Plan Business
- ❑ Clarifies that small employers & individuals purchasing coverage through **non-bona fide associations** are considered to be small group and individual market products for FEDERAL rate review purposes

# What is a Bona Fide Association Health Plan?

Ultimate determination made by HHS but in general the criteria under the Public Health Service Act:

1. Has been actively in existence for five years;
2. Has been formed & maintained in good faith for purposes other than obtaining insurance;
3. Does not condition membership in the association on health status-related factors;
4. Makes coverage available to all members regardless of any health status-related factor;
5. Does not make coverage available other than in connection with members.

# What is a Bona Fide AHP? (continued)

A Bona Fide Assoc. must satisfy criteria to bring it within the ERISA definition of “employer.” The federal Department of Labor (DOL) will make that determination. Among the factors considered by the DOL to determine whether there is a bona fide employer group or association:

- ✓ How members are solicited;
- ✓ Who is entitled to participate & who actually participates in the association;
- ✓ The process by which the association was formed,
- ✓ The purposes for which it was formed, and

# What is a Bona Fide AHP? (continued)

- ✓ What, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; and
- ✓ Who actually controls and directs the activities and operations of the benefit program.

Further, as set forth in Program Memorandum 02-04 from CMS, dated September, 2002 (in packet), it appears that the use of health screening or claims experience to set rates at the employer level may result in the loss of Bona Fide Status

# Bona Fide vs. Non-Bona Fide Associations & why it matters

- ❑ Bona Fide Associations continue to be treated as large group by both state & federal regulators & contract continues to be held at the master Association level
- ❑ Non-Bona fide Associations continue to be exempt from State community rating laws but will now be made up of individual, small & large employer groups for Federal Rating purposes.
- ❑ Carriers will be required to file rate increase requests for non-bona fide AHPs in excess of 10% with CClIO beginning with filings received by the OIC on or after November 1, 2011.

# Bona Fide vs. Non-Bona Fide Associations & why it matters

- ❑ All Carriers -Domestic & Foreign will be required to segregate the experience for the non bona fide AHPs & report claims experience based on participating employer size
- ❑ Beginning in 2014 Non-Grandfathered small employers & individuals participating in a non bona fide AHP will be subject to the Federal Community Rating requirements –which will pre-empt the state exemption.

# How Non Bona Fide Association Health Plans will be reviewed by the OIC

- ✓ All state rate filing requirements remain **unchanged**
- ✓ Benefits offered will need to be revised if AHP is continuing to enroll new employers or individuals:
  - If they have not done so –Carriers and their AHPs will need to begin to differentiate between “grandfathered” and “non-grandfathered” employer groups or individuals
  - Employers or individuals joining the AHP on or after March 23, 2010 will be considered non-grandfathered unless they satisfy the transition rules -and will need to be issued “non-grandfathered” benefits

# What's Next

- ❑ OIC will not be pursuing legislation to repeal the state exemption to community rating
- ❑ 2014 the federal community rating requirement will apply to small group & individuals purchasing through a non bona fide AHP plans which are non-grandfathered.
- ❑ OIC will be asking carriers to work with the client AHPs to determine whether the AHP is bona fide or not & include this info in their filing documents
- ❑ If the OIC has reason to believe an AHP is non bona fide & the carrier has not filed non grandfathered benefit options –or the annual statements appear to be incorrect, we reserve our right to require clarification & correction of the filings

*This draft document is for discussion purposes only*

### Association Health Plan

Bona Fide AHP

Non-Bona Fide AHP

#### Rating

WA OIC continues to regulate as Large Group (community rating exemption still applies)  
  
CCIIO continues to recognize as "Large Group"  
Rate review rule does not apply

WA OIC Large Group rating still applies  
  
No preemptions of community rating exemption

CCIIO/HHS Federal Rate Review

Grandfathered no review

Non-Grandfathered Carriers file with HHS for Small Employer and Individual

#### Benefits

Grandfathered Master Contract "issued" before 3/23/10  
  
No changes made that triggered loss of Grandfathered status  
  
\*Issued as defined in 6/17/10 IFR, including transitional rules

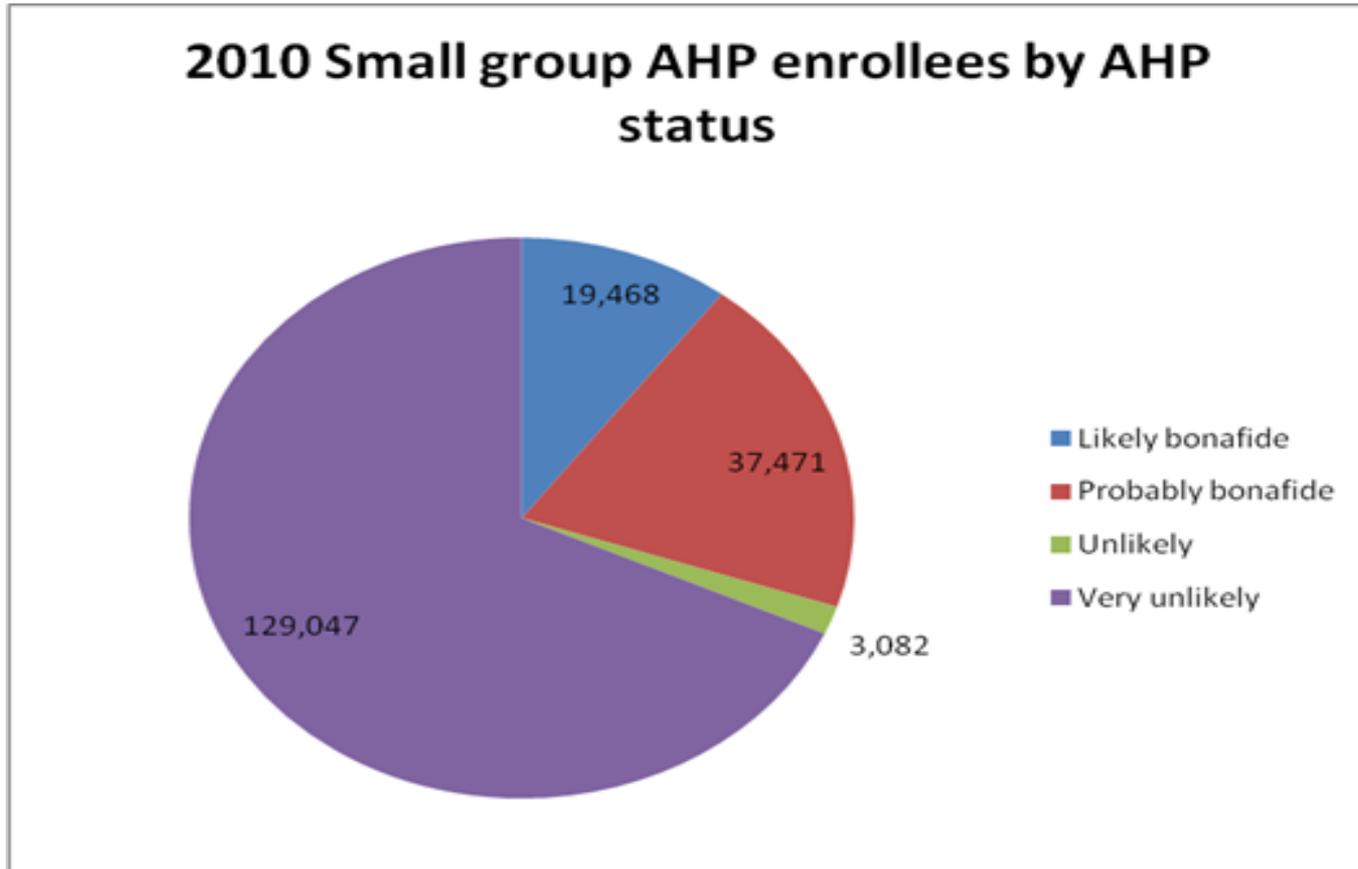
Non-Grandfathered Master Contract issued on or after 3/23/10 and did not meet test in 11/17/10 amended IFR

Grandfathered Large Employer, Small Employer or Individual joined AHP before 3/23/10 or met grandfathered test in 11/17/10 amended IFR

Non-Grandfathered Large Employer, Small Employer or Individual joined AHP on or after 3/23/10 and did not meet test in 11/17/10 amended IFR

Draft as of September 28, 2011

# Implications for Exchange enrollment & viability



- ▶ In 2014, non-bona fide associations comprised of individual & small groups will be subject to the ACA's federal community-rating provisions.

# Implications for Exchange enrollment & viability

- ▶ Greater latitude in exchange decisions due to:
  - ❑ 65%+ of current AHP small and medium market enrollees likely to be community rated
  - ❑ A potential 8–13% drop in average premium for the community-rated market
  - ❑ Little or no healthcare expense differential between small group and individual exchanges
  - ❑ 20–70,000 more Exchange enrollees in 2014 and 30–85,000 more in “ultimate” year

# Questions?

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