



Evaluating Federal and New Jersey Regulation of Rating Factors and Rate Bands

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Executive Summary

Absent regulation, insurers tend to differentiate premiums for health insurance using various factors associated with or predictive of higher costs for medical care, such as an individual or group's health status or claims experience, age, gender, geographic region, tobacco use, or occupation. As a result of basing premium variations on these factors, individuals and groups with the anticipated highest costs face much higher premiums than those with anticipated lower costs for the same coverage. These higher premiums often serve as barriers to coverage for populations most in need of insurance. Thus, to increase access to health care coverage, insurance law often regulates insurers' use of rating factors through rate banding to preserve "the pooling of risk between low-cost and high-cost individuals, [which is] the core function of insurance."¹ Rate bands are boundaries on the degree to which insurers may vary premiums for the same coverage based on rating factors. For example, a 200 percent or 2 to 1 rate band would mean that the highest premium an insurer may charge for a policy may not exceed 200 percent of the lowest rate it charges for the same policy.²

Recognizing this need to regulate insurers' use of rating factors, Congress, in the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) ("ACA" or "Affordable Care Act"), established uniform rating factors and bands throughout the country as a means of curbing premium variations. These standards, which go into effect on January 1, 2014, identify the limited range of considerations on which insurance companies offering coverage in other than grandfathered plans³ in the individual and small group markets may base rate variations and

¹ National Assoc'n of Ins. Comm'rs & The Center for Ins. Policy and Research, *Rate Regulation*, at 1, available at http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf (last visited Oct. 10, 2011) [hereinafter NAIC & CIPR, *Rate Regulation*].

² Kaiser Family Foundation, *How Private Health Coverage Works: A Primer: 2008 Update*, 11 (April 2008), <http://www.kff.org/insurance/upload/7766.pdf> [hereinafter KFF, *How Private Health Coverage Works*].

³ The ACA exempts or "grandfathers" plans that existed on March 23, 2010, when the statute was signed, from many of its provisions, including rate banding. See 42 U.S.C.A. § 18011; Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538-70 (June 17, 2010) (to be codified at 26 C.F.R. pts. 54 and 602, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 147) [hereinafter Grandfathered Plans IFR, 75 Fed. Reg. at X]; see generally Mark Merlis, *Health Policy Brief: 'Grandfathered' Health Plans*, HEALTH AFFAIRS (Oct. 29, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=29 (last visited Oct. 10, 2011).

also establish the maximum range of such variations. Insurers bound by the ACA's rating provisions⁴ will not be able to base premium variations on health status or claims experience. Instead, they may only vary premiums using four factors: age; whether the plan covers an individual or family; rating area; and tobacco use. Federal law also established rate bands for two of these factors, permitting premium variations up to a maximum of 3 to 1 based on age and 1.5 to 1 based on tobacco use.

This Issue Brief examines these Federal rating provisions and how they interrelate with restrictions on rating factors and rate bands that New Jersey implemented first in 1992 and amended most recently in 2008. It first crystallizes the ways in which the ACA rating provisions are similar to and different from New Jersey's and then assesses the degree to which Federal law preempts New Jersey's existing laws. Although concluding that some provisions of New Jersey's regulatory regime are preempted by the new Federal requirements, such as carriers' ability to vary rates based on gender for small group and individual group basic and essential health plans, the Brief also highlights various ways in which New Jersey retains discretion to regulate rating factors and rate bands within the boundaries established by the ACA. Importantly, the Federal law does not require that New Jersey insurance law employ all four ACA rating factors. Rather, New Jersey may choose which of the four factors, if any, it wishes to authorize insurers to use in varying premiums. If it chooses to permit carriers to vary premiums based on age or tobacco use, it then must be sure that any premium variation based on each factor does not exceed the cap imposed by the ACA, although it may choose to impose a narrower rate band than the ACA permits.

The Brief also identifies important policy issues that New Jersey must consider in implementing the Federal rating provisions, including that large group plans would become subject to the Federal rating restrictions if New Jersey elects to offer large group plans through the Exchange; whether to conform New Jersey's definition of the small and large group markets to the Federal; and whether to regulate grandfathered plans, which are exempt from the Federal restrictions on rating factors and rate bands. The Federal government is expected to issue regulatory guidance before the Federal rating provisions go into effect in 2014, which should clarify the issues New Jersey faces in implementing these reforms.

⁴ This brief uses terms such as "rating provisions," "rating restrictions," "rating limitations," and "rating reforms" to refer to Federal and State restrictions on issuers' ability to vary premiums based on various rating factors, including rate banding. These terms do not reference other examples of rating regulation, such as lifetime limits and essential health benefits.

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I. Introduction

Insurers often rely on different rating factors to justify premium differentials for the same coverage. To illustrate, some insurers charge a different premium for the same coverage offered, for example, to an individual diagnosed with a chronic illness and another without, to a twenty-one year old and a seventy year-old, for a man or woman, or to people from different geographic regions, ostensibly to reflect the different costs typically associated with these factors or characteristics.⁵ “These risk classification strategies allow insurers to provide lower premiums to healthier individuals and groups, while effectively excluding those with higher expected health care needs or charging them significantly more for coverage.”⁶

At first blush, it might seem fair that individuals with higher expected or actual claims pay more for insurance than those with lower costs. But differential pricing reduces “the pooling of risk between low-cost and high-cost individuals, [which is] the core function of insurance.”⁷ Thus, it is important to regulate insurers’ use of rating factors to ensure the practice does not undermine insurance markets and result in premiums that unhealthy or older individuals simply cannot reasonably afford.⁸

⁵ But see Robert Pear, *Gender Gap Persists as Health Insurers Resist Adopting Law Early*, THE NEW YORK TIMES, at A8 (Mar. 19, 2012) (reporting that Marcia D. Greenberger, president of the National Women’s Law Center finds insurers’ claim that they charge women more than men for health insurance because women ages 19 to 55 tend to use more health services “‘highly questionable’ because the disparities [in premiums] varied greatly from one insurer to another,” citing Arkansas as an example, where one insurer charged a 25 year-old woman 81 percent more than a man whereas a similar plan charged women only 10 percent more).

⁶ Linda J. Blumberg, *Much Variation: How Will the PPACA Impact Individual and Small Group Premiums in the Short and Long Term?*, WJ/URBAN INSTITUTE, at 3 (July 2010) [hereinafter “Blumberg, *Much Variation*].

⁷ NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 1.

⁸ By helping to control the premiums for more at-risk populations, regulating rate banding tends to increase the premiums for healthier populations. These higher premiums could then prompt healthier populations to opt out of health insurance coverage, which also would undermine the insurance markets and lead to higher premiums for the at-risk populations. See, e.g., Leigh Wachenheim, FSA, MAAA & Hans Leida, FSA, MAAA, Ph.D., *The Impact of Guaranteed Issue and Community Rating Reforms on States’ Individual Insurance Markets*, prepared for America’s Health Insurance Plans by MILLIMAN, at 2 (March 2012), available at http://www.statecoverage.org/files/Updated-Milliman-Report_GI_and_Comm_Rating_March_2012.pdf (finding that individual health insurance markets generally deteriorated in states that implemented guaranteed issue and community rating reforms in the 1990s). This is a primary reason the Obama Administration has taken the position that the mandatory coverage provision

One means of regulation is to prohibit insurers from basing premium variations on a particular rating factor, such as health status or gender, a series of factors, or any factor at all. As an adjunct or as an alternative to these prohibitions, regulators also can establish rate bands, which are boundaries on the degree to which insurers may vary premiums for the same coverage based on rating factors.⁹ For example, a 200 percent or 2 to 1 rate band would mean that the highest premium an insurer may charge for a policy may not exceed 200 percent of the lowest rate it charges for the same policy. “The rate bands may limit all factors by which rates vary (e.g., age, gender), or may apply only to specified factors, such as health status or claims experience.”¹⁰

Most, but not all, states have established boundaries for rate variation for policies sold within their boundaries, although much variation exists as to the factors that justify variations and the extent to which premiums may differ based on these factors in different States.¹¹ Some States have adopted experience rating, which permits insurers to differentiate pricing based on health status.¹² Others have adopted versions of community rating, which prohibit insurers from basing premium variations on health status or claims experience but may permit regulated adjustments to premiums for certain demographic or lifestyle factors, as established by each State.¹³ Some States, for example, permit variations based on several factors, including age, gender, geography, industry, and family structure, while others permit premiums to vary only based on family size.

Against this backdrop of divergent State regulation, the ACA established uniform boundaries for rating restrictions throughout the country as a means of curbing premium variations. These standards, which go into effect on January 1, 2014, identify the limited range

in the Affordable Care Act cannot be severed from the market reform provisions in the ACA, including rating reforms.

⁹ See Mila Kaufman & Karen Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*, HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY, at 2-3 (Apr. 2006), <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf>.

¹⁰ KFF, *How Private Health Coverage Works*, *supra* note 2, at 11.

¹¹ See Kaiser Family Foundation, *Small Group Health Insurance Market Rate Restrictions, 2011*, <http://www.statehealthfacts.org/comparetable.jsp?cat=7&ind=351> (last visited Nov. 18, 2011) [hereinafter Kaiser Family Foundation, *Small Group*]; Kaiser Family Foundation, *Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals), 2011*, <http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7> (last visited Nov. 18, 2011) [hereinafter Kaiser Family Foundation, *Individual Group*].

¹² See Office of Health Policy, Office of the Assistant Secretary for Planning & Evaluation, U.S. Department of Health & Human Services, *The Regulation of the Individual Health Insurance Market*, at 8 (Winter 2008) <http://aspe.hhs.gov/health/reports/08/reginsure/report.pdf> (last visited Nov. 18, 2011); see generally Janet L. Kaminski Leduc, *Community Versus Experience Rating Health Insurance*, OLR RESEARCH REPORT, at 1 (Jul. 3, 2008) (“[A]n insurer uses ‘experience rating’ when it predicts a group’s future medical costs based on its past experience (i.e., the actual cost of providing health care coverage to the group during a given period of time; the group’s claim history). Thus, the insurer calculates the group’s insurance premium based on its own, not the overall community’s, experience.”).

¹³ See Wachenheim & Leida, *supra* note 8, at 1 & A-1.

of considerations on which insurance companies offering coverage in other than grandfathered plans¹⁴ in the individual and small group markets may base rate variations and also establish the maximum range of variations based on certain criteria.

This Issue Brief analyzes the new Federal restrictions on rating factors and rate bands, including whether Federal law preempts existing New Jersey laws and regulations and what policy choices New Jersey has regarding regulating rating factors and bands in its markets.

II. Policy and Legal Context

A. Overview of Rating Factor Regulation in the States before the ACA

Insurers have used a variety of factors to vary premiums to reflect the actual and anticipated increased costs associated with certain characteristics. For example, some have based premiums on an individual's specific health status as determined during the underwriting process or actual claims experience, as reviewed in a renewal context.¹⁵

Insurers also look at factors that tend to indicate or predict increased health costs. One of the most common factors used to justify premium variation is the age of the insured, since typically health costs increase as health deteriorates with age.¹⁶ Some insurers also seek to vary premiums based on gender, arguing that women tend to incur greater than forty-five percent higher medical costs during childbearing years whereas men tend to incur higher costs later in life.¹⁷ Insurers also vary premiums to reflect the different costs to provide medical care in different geographical locations.¹⁸ Others have varied rates based on the industry at issue in the small group market or the occupation of the insured in the individual market.¹⁹ As a result of these practices, as a general matter prior to the ACA in most states, individual and small group premiums varied "significantly by health status and claims experience of individuals in the small group, by gender composition, by age composition, and by industry."²⁰

Most states in the small group market and fewer than half of the States in the individual market have taken legislative and regulatory steps to curb these variations so that premiums would be affordable for populations with greater actual or anticipated healthcare costs.²¹ But

¹⁴ The ACA exempts or "grandfathers" plans that existed on March 23, 2010, when the statute was signed, from many of its provisions, including its regulation of rating factors and rate banding. *See* 42 U.S.C. § 18011; Grandfathered Plans IFR, 75 Fed. Reg. at 34,538-70 *supra* note 3; *see generally* Merlis, *supra* note 3.

¹⁵ NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 2.

¹⁶ *Id.*

¹⁷ *Id.* But *see* Pear, *supra* note 5 ("Differences in rates for men and women are not explained by the cost of maternity care. In the individual insurance market, such care is usually not part of the standard package of benefits. Maternity coverage may be offered as an optional benefit, or rider, for a hefty additional premium.").

¹⁸ NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 2.

¹⁹ *Id.*

²⁰ Blumberg, *Much Variation*, *supra* note 6, at 3.

²¹ NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 3-5.

lowering premiums for these higher cost populations usually means increasing premiums for younger and healthier populations. States must be careful to balance their laudable goal of making insurance affordable for higher cost populations “with the need to avoid the adverse selection that can arise when low-cost individuals decide that the higher premiums they pay are not worthwhile given their expected needs and drop out of the market, resulting in a sicker risk pool and higher premiums.”²² This risk of adverse selection is increased in the individual market where employer contributions do not help defray the cost of high premiums and individual characteristics are not averaged across an employer’s workforce.²³

Prior to the ACA, States enacted divergent regulatory models in their attempt to strike the right balance. According to the National Association of Insurance Commissioners (“NAIC”), eleven states including Kentucky, Nevada, New Hampshire, and New Mexico permit insurers in the individual market to vary premiums based on health status,²⁴ which is referred to as experience rating.²⁵

Other States, in contrast, adopted community rating systems that prohibit insurers from basing premium variations on health status or claims experience.²⁶ Instead, insurers in community rating states charge each policyholder an average or community rate with regulated adjustments permitted for certain demographic or lifestyle factors, as established by each State.²⁷

Although no State with community rating permits insurers to base premium differences on health status or claims experience, states differ regarding what factors may justify different premiums and to what extent premiums may differ based on these factors. New York, for example, has implemented pure community rating standards in both its individual and small group markets, which means that insurers may not vary rates for the same coverage based on health status or other factors including age, sex, or occupation, although they may vary rates based on family composition and reasonable geographic regions.²⁸

²² *Id.* at 1.

²³ *Id.* at 4.

²⁴ *Id.* at 2 & 5.

²⁵ See Office of Health Policy, *supra* note 12, at 8; see generally Leduc, *supra* note 12, at 1 (“[A]n insurer uses ‘experience rating’ when it predicts a group’s future medical costs based on its past experience (i.e., the actual cost of providing health care coverage to the group during a given period of time; the group’s claim history). Thus, the insurer calculates the group’s insurance premium based on its own, not the overall community’s, experience.”).

²⁶ See Wachenheim & Leida, *supra* note 8, at 1 & A-1.

²⁷ *Id.* at A-1.

²⁸ See N.Y. INS. LAW § 3231; Kaiser Family Foundation, *New York: Protections in Small Group Market*, <http://www.statehealthfacts.org/profileind.jsp?ind=354&cat=7&rgn=34> (last visited Nov. 18, 2011); Kaiser Family Foundation, *New York: Individual Market Rate Restrictions (Not Applicable to HIPAA-Eligible Individuals)*, 2011, <http://www.statehealthfacts.org/profileind.jsp?cat=7&sub=86&rgn=34> (last visited Nov. 18, 2011); see generally Leduc, *Community Versus Experience Rating Health Insurance*, *supra* note 12, at 1 (“Under ‘community rating,’ an insurer charges all people covered by the same type of health insurance policy the same premium without regard to age, gender, health status, occupation, or other factors. The insurer determines the premium based on the

Other states have adopted adjusted or modified community rating systems that similarly prohibit insurers from basing premium variations on health status but permit variations based on more factors than pure community rating systems would permit, such as gender or age.²⁹ New Jersey, for example, as discussed in more detail in Section C below, has implemented a modified community rating system that prohibits insurers in its individual or small group markets from basing rate variations on health status but permits insurance companies in some of its markets to charge different premiums for the same coverage based on the different ages, genders, geographic locations, and family compositions of subscribers.³⁰

States also have enacted different limits on the degree of permissible variation in premium. For example, New York has not imposed a specific limit on “the use of separate community rates for reasonable geographic regions” in its individual and small group markets.³¹ Florida, in contrast, has established a rating band of 1.9 to 1, which means that the highest rating factor may be no more than 1.9 times the lowest rating factor for geography in Florida’s small group market.³² According to the NAIC, “[m]ost states that allow health status to be used for rating purposes in the small group market limit it using rating bands that vary from +/-10% to +/-60%.”³³ The 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.³⁴ Some states also have established “composite rating bands that place limits on the combined effects of multiple case characteristics”³⁵ In Kentucky’s individual market, for example, the composite rate band for age, gender, industry or occupation, and geographic area in the aggregate is limited to 5 to 1.³⁶

Through the ACA, the Federal government sought to protect consumers throughout the country by limiting the bases on and the extent to which insurers may vary premium rates. New Jersey already has requirements concerning permissible rating factors and bands, which now must be harmonized with the new Federal requirements.

B. Federal Regulation of Rating Factors and Bands

Section 2701(a) of the Public Health Services Act, which was added by Section 1201 of the ACA, sought to limit variation in premiums by establishing a national standard for premium rate

health and demographic profile of the geographic region or the total population covered under a particular policy that it insures.”).

²⁹ Wachenheim & Leida, *supra* note 8, at A-1.

³⁰ See Section I.C., *infra*.

³¹ See N.Y. INS. LAW § 3231(c).

³² NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 2.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ KRS § 304.17A-0952(6); NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 5.

variations in the individual and small group markets³⁷ beginning on January 1, 2014. As set forth in this statute, premiums charged by health insurance issuers in these markets “shall vary with respect to the particular plan or coverage involved only by”:

- i. whether the plan covers an individual or family;
- ii. the rating area;
- iii. age; and
- iv. tobacco use.³⁸

Importantly, insurers in the individual and small group markets may not vary premiums “by any other factor not described in [2701(a)].”³⁹ Thus, the Federal law enacts an adjusted community rating system pursuant to which premiums in these markets may not vary based on the particular health status or claims experience of the insured or any other unenumerated factor.

The United States Department of Health and Human Services (“HHS”) has explained that “[p]ermitting premium variation by geographic rating area enables health insurance issuers to account for regional variation in health care costs”⁴⁰ by establishing “1 or more rating areas within that State”⁴¹ The Secretary then must review each State’s rating areas “to ensure

³⁷ The small group market includes group plans offered to individuals by small employers, which are defined as employers “who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employ[] at least 1 employee on the first day of the plan year.” 42 U.S.C. § 18024(a)(3) & (b)(2). Recognizing that some states defined small employer as having no more than an average of fifty employees in a given year, Congress authorized States to substitute “51 employees” for “101 employees” in the definition of large employer and “50 employees” for “100 employees” in the definition of small employer for plan years beginning prior to January 1, 2016. *See id.* § 18024(b)(3). For medical loss ratio calculations, to which the same relevant definitions apply, CMS has clarified that “employee” includes full-time, part-time, and seasonal employees. *CCIIO Technical Guidance (CCIIO 2011-004): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule*, Question and Answer #18 (July 18, 2011), http://cciio.cms.gov/resources/files/20110718_mlr_guidance.pdf.

³⁸ *See* 42 U.S.C. § 300gg(a)(1)(A).

³⁹ *See id.* § 300gg(a)(1)(B).

⁴⁰ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule, 76 Fed. Reg. 41,866, 41,901 (July 15, 2011) (to be codified at 45 C.F.R. pts. 155 and 156) [hereinafter “Exchange Proposed Rule, 76 Fed. Reg. at X”].

⁴¹ *See* 42 U.S.C. § 300gg(a)(3); *see also* 45 C.F.R. § 156.255 (codifying ACA Section 1301(a)(4), which allows issuers of qualified health plans (“QHPs”), including an issuer of a multi-State plan, to “vary premiums by the geographic rating area established under section 2701(a)(2) of the PHS,” and ACA Section 1301(a)(1)(C)(iii), which requires QHPs to “charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent”); 45 C.F.R. § 155.140(b)(1)-(2) (permitting a State to “establish one or more subsidiary Exchanges within the State if: (1) Each such Exchange serves a geographically distinct area; and (2) The area served by each subsidiary Exchange is at least as large as a rating area described in section 2701(a) of the PHS Act”); *see generally* Exchange Proposed Rule, 76 Fed. Reg. at 41,874, *supra* note 40 (explaining that 45 C.F.R. § 156.255(b) means that premiums for QHPs may “vary only by the rating factors listed in 2701(a) of the PHS Act”); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule, Interim Final Rule, 77 Fed. Reg. 18,310, 18,316 (Mar. 27, 2012) (maintaining its position that “only one Exchange may operate in each geographically distinct area and that a subsidiary Exchange must be at least as large as a rating area” and opining that the final

[their] adequacy.”⁴² The statute is silent, however, regarding how the Secretary will establish adequacy. The Center for Medicare & Medicaid Services (“CMS”) within HHS has indicated that it will provide guidance in a future rulemaking to the States as to what factors will distinguish adequate from inadequate rating areas and address the process for States to request approval of rating areas.⁴³ The Secretary has discretion to establish rating areas for any State that does not establish its own or that the Secretary finds inadequate.⁴⁴

The ACA also permits issuers in the individual and small group markets to vary rates for adults⁴⁵ based on age, although it puts a limit on how much premiums may differ based on this factor. While the NAIC has blessed,⁴⁶ and many States permit,⁴⁷ a 5 to 1 premium differential based on age, the ACA limits the ratio between the highest and lowest rate charged to adults based on age to 3 to 1. Thus, a plan may charge its oldest adult insured no more than three times what it charges its youngest adult insured for the same benefits.⁴⁸ The ACA does not define, however, at what particular adult ages insurers may differentiate premiums. Rather, it directs the Secretary to consult with NAIC to “define the permissible age bands for rating purposes”⁴⁹ As of March 2, 2012, an NAIC working group is working with HHS to develop these standards.⁵⁰

Similarly, the ACA permits a ratio between premiums for tobacco and non-tobacco users to be no more than 1.5 to 1.⁵¹ Thus, the premium charged to a person using tobacco may be up to fifty percent higher than that charged to a non-tobacco user for the same plan. HHS has not yet defined what will constitute tobacco usage for purposes of this rating factor.

To date, HHS has not adopted regulations explaining how insurers may vary premiums based on whether the plan covers an individual or family. In the preamble to its proposed Exchange Regulation, HHS recognized that “the rating factor related to family size has significant implications for Exchanges.”⁵² In an effort to “maximize competition between health plans based on price and quality” by offering uniform family rating categories, it proposed to

Exchange rule “provides States with discretion to ensure that subsidiary Exchange service areas are consistent with rating areas”) [hereinafter “Exchange FR/IFR, 76 Fed. Reg. at X].

⁴² See 42 U.S.C. § 300gg(a)(2)(B).

⁴³ See Exchange Proposed Rule, 76 Fed. Reg. at 41,874, *supra* note 40.

⁴⁴ See 42 U.S.C. § 300gg(a)(2)(B).

⁴⁵ Center for Consumer Information & Ins. Oversight, *Risk Adjustment Implementation Issues (Draft)*, at 18 n.3 (Sept. 12, 2011) (noting that “Section 2701 does not specify the rating factors applicable to children”).

⁴⁶ NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 2.

⁴⁷ See Jason Grau & Kurt Giesa, *Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets*, OLIVER WYMAN, at 3 (Dec. 1, 2009) (noting that a premium variation ratio of 5 to 1 based on age is “common in many states today”), http://www.oliverwyman.com/media/YBS009-11-28_PPACA120309.pdf.

⁴⁸ Blumberg, *Much Variation*, *supra* note 6.

⁴⁹ See 42 U.S.C. § 300gg(a)(2)(B).

⁵⁰ NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 3.

⁵¹ See 42 U.S.C. § 300gg(a)(1)(A).

⁵² Exchange Proposed Rule, 76 Fed. Reg. at 41,901, *supra* note 40.

permit issuers of qualified health plans (“QHPs”) offered in the Exchange to vary premiums based on up to four types of family composition that issuers currently use, individuals, two adult families, one adult families with a child or children, and all other families.⁵³ Although QHP issuers would have had to cover all four family categories, HHS proposed to permit them to combine some of the categories. For example, a QHP issuer might have combined two adult families with one adult with child(ren) families to “limit premium variation within families of similar types.”⁵⁴

In doing so, however, HHS recognized several potentially complicating issues. For one, when family coverage is involved, the ACA provides that the rate bands permitted for age and tobacco “shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.”⁵⁵ As a result, issuers may not “calculate[] a family premium by determining the age and tobacco rated premium for one member of the family and apply[] a multiplier to set the rating factor for the entire family”⁵⁶ HHS thus sought comment on how to structure these family rating categories, given this statutory requirement.⁵⁷

In addition, HHS solicited comment on how risk adjustment would work with the four family categories.⁵⁸ It also sought input on whether it should require “QHP issuers to cover an enrollee’s tax household, including for purposes of applying individual and family rates” to ease

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ See 42 U.S.C. § 300gg(a)(4).

⁵⁶ Exchange Proposed Rule, 76 Fed. Reg. at 41,901, *supra* note 40.

⁵⁷ *Id.*; Nat’l Assoc’n of Ins. Commrs., *Health Insurance Exchanges: Plan Management Functions*, at 3 (March 2, 2012), http://www.naic.org/documents/committees_b_exchanges_1203_issue_brief.pdf.

⁵⁸ Exchange Proposed Rule, 76 Fed. Reg. at 41,901, *supra* note 40. HHS’s concern about risk adjustment coordination is not limited to family composition factors. For example, in the preamble to the proposed Risk Adjustment Regulations, HHS solicited comments regarding how to be sure the risk adjustment methodology accounts for the variations in premium permitted for geography, age, family status, and tobacco “so that risk adjustment does not adjust for the actuarial risk that issuers have been allowed to incorporate into their premium rates.” Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Proposed Rule, 76 Fed. Reg. 41,930, 41,939 (July 15, 2011) (to be codified at 45 C.F.R. pt. 153); see also Center for Consumer Information & Ins. Oversight, *supra* note 45, at 5 & 17-22 (stating that “the risk adjustment methodology must take into account plans’ ability to make limited rating adjustments based on factors such as age and smoking status” and discussing why it is important and possible ways to remove permissible rating factors from the risk adjustment methodology). The preamble to the final Risk Adjustment Regulation again referenced the need to adjust the risk adjustment methodology to account for “premium rating variation.” Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Final Rule, 77 Fed. Reg. 17,220, 17,232 (Mar. 23, 2012) (to be codified at 45 C.F.R. pt. 153); see also 45 C.F.R. § 153.320(b)(2) (requiring the publication of a risk adjustment methodology in the annual notice of benefit and payment parameters to include “[a] complete description of the calculation of plan average actuarial risk”). In a draft policy document, CCIIO indicated that it expects to update its risk adjustment methodology with a draft notice in Fall 2012 and requested comment on this question: “If States have set rating limits that are lower than what is permitted in the Affordable Care Act, should state policies be addressed in the federally certified methodology? If so, how?”. Center for Consumer Information & Ins. Oversight, *supra* note 45, at 22.

potential problems administering the premium tax credit.⁵⁹ Given these complicated issues, CMS also sought suggestions for alternatives to the four proposed family composition categories “and how to balance the number of categories offered by QHP issuers in order to reduce potential consumer confusion, while maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market.”⁶⁰

After reviewing comments, CMS struck the paragraph that identified the four family composition categories from the Final Exchange regulation, choosing to wait to define rating categories for all issuers in the small group and individual markets rather than only for QHPs in the Exchange context.⁶¹ CMS has indicated that it will issue separate regulations to establish rating rules implementing section 2701.⁶²

The Federal rating provisions do not apply to individual or small group plans that have been grandfathered by the ACA.⁶³ In addition, the large group market⁶⁴ is not categorically included in the ACA’s rate banding provisions. But in States that permit issuers to offer qualified large group coverage through the State’s Exchange, which they may choose to do beginning in 2017,⁶⁵ the rate banding provisions of Section 2701 will apply to all but self-insured and grandfathered plans in the large group market in those States.⁶⁶

Although the ACA prohibits issuers in the individual and small group markets from basing premium variations on health status or claims experience, Federal law permits insurers to offer premium discounts to enrollees in the small and large group markets based on participation in certain wellness programs.⁶⁷ The reward for the wellness program may not exceed 30 percent of the cost of coverage, although the Secretaries of Labor, Health and Human Services, and the Treasury have discretion to increase the wellness reward up to 50

⁵⁹ Exchange Proposed Rule, 76 Fed. Reg. at 41,901, *supra* note 40.

⁶⁰ *Id.*

⁶¹ Exchange FR/IFR, 77 Fed. Reg. at 18,424-25, *supra* note 41.

⁶² Exchange Proposed Rule, 76 Fed. Reg. at 41,901, *supra* note 40; *see also* Center for Consumer Information & Ins. Oversight, *supra* note 45, at 17 n.2 (indicating that “CMS plans to issue guidance on section 2701 of the PHS Act in the future”).

⁶³ *See* 42 U.S.C. § 18011; *see also* National Assoc’n of Ins. Comm’rs & The Center for Ins. Policy and Research, *Patient Protection and Affordable Care Act Section-by-Section Analysis*, at 16, available at http://www.naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf; Phyllis A. Doran, FSA, MAAA, *Rating and Underwriting under the New Healthcare Reform Law: Provisions Affecting the Operations of Health Insurers in the Individual, Small Group, and Large Group Markets*, MILLIMAN, at 3 (May 2010).

⁶⁴ Under the ACA, the large group market means the health insurance market in which individuals obtain health insurance coverage through a group health plan maintained by a large employer, which is defined as “an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.” 42 U.S.C. § 18024(a)(3) & (b)(1).

⁶⁵ 42 U.S.C. § 18032(f)(2)(B).

⁶⁶ *See id.* § 300gg(a)(5); *see also* Doran, *supra* note 63, at 8.

⁶⁷ *See id.* § 300gg-4(b) and (j) (2011). If the carrier does not condition receiving the premium discount credit or rebate on satisfaction of a standard related to a health status factor, then the program need only make the discount or rebate available to all similarly situated individuals. *See id.* § 300gg-4(j)(1)(B) & (2).

percent of the cost of coverage.⁶⁸ Despite language in the statute requiring that any wellness program “be reasonably designed to promote health or prevent disease” and not be “a subterfuge for discriminating based on a health status factor,”⁶⁹ some still worry that, “in practice, [wellness programs] are likely to effectively constitute a degree of health status-related rating in the group market.”⁷⁰ Importantly, these requirements do not apply to a health promotion or disease prevention program that already was established and operating when the ACA was enacted.⁷¹

The Federal rating provisions will apply to plans offered both inside and outside of the Exchange.⁷² It is not clear, however, if States may establish different standards or bands inside and outside the Exchange as long as those standards are within the Federal requirements. CMS, for example, twice has taken the position that “rating areas will be applied consistently inside and outside of the Exchange.”⁷³ It declined a request to codify this standard in the Exchange regulations, however, explaining that such a provision was outside the scope of that final rule and suggesting it instead would be the subject of “future rulemaking on other Affordable Care Act provisions that apply to insurance markets generally.”⁷⁴ Similarly, an Exchange official in Tennessee, who participated in a lengthy conference call with HHS, reported that the agency was “unclear whether states could adopt different bands for products sold inside and outside of the exchange, and [it] did not know when [it] would be able to answer this question.”⁷⁵ Relatedly, one commenter on the proposed Exchange regulation suggested that the final regulation “establish a process whereby a State demonstrates that existing State laws related to rating outside of the Exchange will not undermine the Exchange.” CMS responded by deferring the issue, stating that it is “continuing to evaluate the relationship and interaction of State

⁶⁸ See *id.* § 300gg-4(j)(3)(A). The statute details, among other things, the requirements if dependents also participate in the program, how to calculate the cost of coverage, and to whom and how often participation must be made available. See *id.* § 300gg-4(j)(3)(A) & (B).

⁶⁹ See *id.* § 300gg-4(j)(3)(B).

⁷⁰ Blumberg, *Much Variation*, *supra* note 6, at 3; see also NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 2 (noting that it has been difficult to implement “premium discounts or other incentives to individuals participating in wellness programs . . . without allowing carriers a back-door way to use health status in setting premiums” and recommending “State flexibility and further study”).

⁷¹ See 42 U.S.C. § 300gg-4(k).

⁷² Nat’l Assoc’n of Ins. Commrs., *supra* note 57, at 3.

⁷³ Exchange Proposed Rule, 76 Fed. Reg. at 41,901, *supra* note 40; Exchange FR/IFR, 77 Fed. Reg. at 18,424, *supra* note 41.

⁷⁴ Exchange FR/IFR, 77 Fed. Reg. at 18,424, *supra* note 41.

⁷⁵ June 6, 2011 Memorandum from Brian Haile to Health Care Providers and Advocates (June 6, 2011), Appdx. A, June 1, 2011 Memorandum from Brian Haile to Stakeholders of the Insurance Exchange Planning Initiative, at 2, available at <http://www.tn.gov/nationalhealthreform/forms/roundtable6-6-11.pdf> [hereinafter “Haile Memo at X”]. Mr. Haile confirmed to the author via electronic mail on May 9, 2012 that CCIIO had not yet provided an answer to this question.

rating laws, the market reform provisions in section 2701 of the PHSA, and the provisions to implement the Exchange standards” and that it “may issue further guidance in the future.”⁷⁶

C. New Jersey Regulation of Rating Factors and Bands

New Jersey was among the states that had regulated rating factors and bands prior to the ACA. Initially, it adopted pure community rating in its individual market and modified community rating in its small group market⁷⁷ in 1992 as part of a larger set of reforms to increase access to health care coverage.⁷⁸ But the individual market nearly collapsed from an adverse selection death spiral, caused at least in part by pure community rating, in which enrollment greatly decreased, premiums soared, and carriers exited the market.⁷⁹ As a result, in 2009, it implemented modified community rating based on age and, in some instances, other factors, in its individual market, along with other market reforms.⁸⁰ Its rating restrictions vary, to some extent, on the particular market in which the policies were being offered, as discussed below.

Some of the rating rules in New Jersey’s individual market, for example, differ for carriers offering standard plans as compared to carriers offering the less comprehensive basic and essential health benefits plans.⁸¹ Modified community rating, for purposes of standard individual benefit plans, means that plans may not vary premiums for all persons covered under the same policy based on “sex, health status, occupation, geographical location or any other factor or characteristic of covered persons, other than age.”⁸² As a result, insurers 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.⁸³ The regulations specify eleven age factor categories: 19 and under; 20-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-

⁷⁶ Exchange FR/IFR, 77 Fed. Reg. at 18,424, *supra* note 41.

⁷⁷ The small group market in New Jersey includes carriers offering health benefit plans to eligible employees of employers “that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employed at least two employees on the first day of the plan year, and the majority of the employees are employed in New Jersey.” N.J. STAT. ANN. § 17B:27A-17; N.J. ADMIN. CODE § 11:21-1.2. Eligible employees means a full-time employee who works a minimum of twenty-five hours per week. N.J. STAT. ANN. § 17B:27A-17.

⁷⁸ See State of New Jersey, Dep’t of Banking & Ins., *What Is New Jersey Health Insurance Reform*, http://www.state.nj.us/dobi/division_insurance/ihcseh/ihc_seh.htm (last visited April 15, 2012).

⁷⁹ Wachenheim & Leida, *supra* note 8, at 30-31.

⁸⁰ *Id.* at 31.

⁸¹ New Jersey’s individual market includes standard health benefits plan that have been adopted by New Jersey’s Individual Health Coverage Program Board, see N.J. ADMIN. CODE § 11:20-1.2, and basic and essential health plans, which are limited benefits plans that all carriers offering individual health insurance in New Jersey must offer, see N.J. STAT. ANN. § 17B:27A-4.5(e). See generally N.J. Dep’t of Banking & Ins., *Individual Plans Summary Chart*, http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcguide/ihc_plansummary.pdf.

⁸² N.J. STAT. ANN. §§ 17B:27A-2 & 6(a); N.J. ADMIN. CODE §§ 11:20-1.2 & 11:20-6.5. “‘Health status-related factor’ means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.” N.J. STAT. ANN. § 17B:27A-2.

⁸³ See N.J. STAT. ANN. § 17B:27A-2.

59; 60-64; and 65 and over.⁸⁴ Premiums may differ from the lowest to the highest based on age by no more than 350 percent.⁸⁵ New Jersey law also permits a “reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or for different health benefits plans offered by the carrier.”⁸⁶ Carriers may use only four rating tiers to differentiate premiums based on family composition: single; two adults; adult and child(ren); and family.⁸⁷ Premiums may vary up to 350 percent based on age within each tier.

Carriers offering the less comprehensive basic and essential health services plans in the individual market, in addition to the same age increments and family tiers that are permitted for standard plans,⁸⁸ may vary rates based on gender and geography.⁸⁹ Specifically, the regulations identify six geographic territories divided among the following counties: Essex, Hudson, and Union; Bergen and Passaic; Monmouth, Morris, Sussex, and Warren; Hunterdon, Middlesex, and Somerset; Burlington, Camden, and Mercer; and Atlantic, Cape May, Ocean, Salem, Cumberland, and Gloucester.⁹⁰ The policyholder’s place of residence determines which of the six geographic categories applies.⁹¹ New Jersey also imposes a composite rate band for basic and essential plans such that premium variations based age, gender, and geography for the highest and lowest rated individuals may not exceed 350 percent in the aggregate within each family tier.⁹² Carriers offering basic and essential plans may not base premium variations on any other rating factor, such as health status.⁹³

New Jersey similarly permits carriers in its small group market (2-50 eligible employees)⁹⁴ to base premium differences for plans issued or renewed on or after September 11, 1994 on age, gender, and geography and prohibits reliance on any other factors, such as health status.⁹⁵ The Board of Directors of the Small Employer Health Benefits Program exercised its statutory authority to establish “up to six geographic territories, none of which is

⁸⁴ N.J. ADMIN. CODE §§ 11:20-1.2 & 11:20-6.5(a)(1).

⁸⁵ See N.J. STAT. ANN. § 17B:27A-2.

⁸⁶ *Id.*; N.J. ADMIN. CODE §§ 11:20-1.2 & 11:20-6.5(b).

⁸⁷ N.J. ADMIN. CODE § 11:20-6.5(b).

⁸⁸ N.J. STAT. ANN. § 17B:27A-4.5(c); N.J. ADMIN. CODE § 11:20-6.5(a)(1) & (b). Although carriers offering basic and essential plans may vary premiums using the same family tiers as standard plans, New Jersey does not expressly require variations of basic and essential health plan premiums based on family composition to be “reasonable,” even though it does for standard health plans.

⁸⁹ N.J. STAT. ANN. § 17B:27A-4.5(c); N.J. ADMIN. CODE §§ 11:20-22.2 & 11:20-6.5(a).

⁹⁰ N.J. ADMIN. CODE § 11:21-6.5(a)(2).

⁹¹ See *id.* § 11:21-6.5(a)(2).

⁹² N.J. STAT. ANN. § 17B:27A-4.5(c); N.J. ADMIN. CODE § 11:20-6.5(a)(1) & (b).

⁹³ N.J. STAT. ANN. § 17B:27A-4.5(c); see generally *id.* § 17B:27A-4.4(a) (noting that “ground-breaking health insurance reform in 1992 for the individual market” included “a prohibition against rating on the basis of health status”).

⁹⁴ See *supra* note 77.

⁹⁵ N.J. STAT. ANN. § 17B:27A-25(a)(3); N.J. ADMIN. CODE § 11:21-7.14; see generally N.J. STAT. ANN. § 17B:27A-4.4(a) (noting that “ground-breaking health insurance reform in 1992 for the individual market” included “a prohibition against rating on the basis of health status”).

smaller than a county; and age classifications which, at a minimum, shall be in five-year increments.”⁹⁶ Carriers in the small group market for health plans issued or renewed on or after September 11, 1994 may base rate differentials on the same six geographic territories that apply for Basic and Essential plans in the individual market.⁹⁷ The address of the small employer’s principal place of business determines the applicable territory for rating purposes.⁹⁸ When differences in rates are based on age, carriers may only employ eleven age increments, which differ slightly from those applicable in the individual market, namely 24 and under; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; and 70 and over.⁹⁹ The small group market, however, imposes a different composite rate band on carriers. Premiums for the same health benefits plan may not vary based on age, gender, and geography in the aggregate between the highest and lowest rated small groups by more than 200 percent.¹⁰⁰ Like the individual market, though, carriers may have different premium rates for individuals and families.¹⁰¹ In differentiating rates based on family structure, carriers in New Jersey’s small group market again may only use four rating tiers: employee only; employee and spouse; employee and child(ren); and family.¹⁰² The 200 percent composite rate band for age, gender, and geography applies within each family tier.

New Jersey does not regulate the rating factors or bands used by carriers in its large group market.

D. Comparing Federal and New Jersey Rating Provisions

While some of the Federal rating rules dovetail with existing rules in New Jersey, there are significant distinctions as well.

Both jurisdictions forbid rate variation based on health status in the individual and small group markets and permit plans to vary rates in at least some markets based on age, geography, and family status. Federal and New Jersey law also forbid insurers from taking unenumerated factors into account in setting premiums.

But each system identifies a factor that the other does not: Federal law permits insurers to vary rates based on tobacco use, which New Jersey law does not. And New Jersey law permits certain types of plans to base rate differentials on gender, which Federal law does not permit. Thus, because each prohibits consideration of unitemized factors, Federal law prohibits New Jersey from taking gender into account, and New Jersey law prohibits carriers in the State

⁹⁶ N.J. STAT. ANN. § 17B:27A-25(a)(6).

⁹⁷ N.J. ADMIN. CODE § 11:21-7.14(a)(2).

⁹⁸ *Id.*

⁹⁹ *Id.* § 11:21-7.14(a)(1).

¹⁰⁰ N.J. STAT. ANN. § 17B:27A-25(a)(3).

¹⁰¹ *Id.* § 17B:27A-25(e). Like with basic and essential plans and unlike standard plans, New Jersey law does not require that any differentials based on family status be “reasonable.”

¹⁰² N.J. ADMIN. CODE § 11:21-7.14(b).

from taking tobacco use into account in varying premiums. New Jersey law also prohibits carriers offering standard plans in its individual market from varying premiums based on geography while Federal law does not impose this restriction.

Although both Federal and New Jersey law permit insurers to vary premiums based on family composition, more guidance is needed from HHS to fully compare the treatment of this rating factor in each jurisdiction. The Federal statute merely permits rates to vary depending on if the plan covers an individual or family and does not identify four specific tiers as New Jersey law does. As discussed above, HHS considered establishing four family composition rating tiers in its proposed Exchange regulation that were analogous to New Jersey's tiers, but, for a variety of reasons, it decided to defer action until it issues guidance or regulations concerning all plans in the individual and small group markets and not just QHPs in the Exchange.¹⁰³

Similarly, although both Federal and New Jersey law permit plans in all markets to take age into account in setting premiums, it is premature to find that the two laws are consistent because Federal law has not yet defined with specificity the contours of this rating factor. HHS hypothetically could establish mandatory age intervals that conflict with New Jersey's five-year minimum interval requirements or with the specific age categories established by New Jersey regulations.

The same is true with respect to the role of geography in New Jersey's small group market or for basic and essential plans in its individual market. HHS has not articulated how it will evaluate the adequacy of State rating areas, and thus it is not known if New Jersey's six geographic areas will satisfy Federal law.

Federal and New Jersey law also vary with respect to the particular rate bands that limit premium differentiation based on the enumerated rating factors. Federal law caps premium variations based on age at 300 percent and on tobacco use at 150 percent. New Jersey, in contrast, permits variations based on age up to 350 percent for standard plans in its individual market. It then imposes a composite rate band for premium variations based on age, gender, and geography of 350 percent for basic and essential plans in its individual market and only 200 percent for small group health benefit plans.

Another distinction between the Federal and New Jersey systems concerns plans that are grandfathered for Federal purposes, and therefore are not required to comply with Federal rating limitations; these plans are, if they are licensed in New Jersey, subject to New Jersey's rating restrictions.¹⁰⁴ In addition, New Jersey does not regulate use of rating factors in its large group market. The Federal rating restrictions, in contrast, will apply in the large group market if States permit large group issuers to offer plans through the State's Exchange.

¹⁰³ See *supra* notes 52-62.

¹⁰⁴ New Jersey's restrictions on rating factors and bands do not apply to "individual health benefits plan issued on an open enrollment, modified community rated basis or community rated basis prior to August 1, 1993." See N.J. STAT. ANN. § 17B:27A-3(b).

Because different requirements apply to different markets in the two systems, it is important to appreciate the different ways each defines their insurance markets. Federal law defines the small group as including employers with an average of 1-100 employees, at least one of whom was employed on the first day of the plan year,¹⁰⁵ while New Jersey's small group employers have 2-50 eligible employees, at least two of whom must have been employed on the first day of the plan year.¹⁰⁶ Although Federal law permits states to substitute 50 for 100 in the small group definition, this discretion only applies only to plan years beginning prior to January 1, 2016,¹⁰⁷ and it does not reconcile the discrepancy between the bottom number of the range.¹⁰⁸

As a result, Federal law contemplates situations when a group of one will be deemed part of the small group market whereas New Jersey law does not.¹⁰⁹ Further, at least as of January 1, 2016, when New Jersey no longer may elect to substitute 50 for 100 in the Federal small group definition, New Jersey employers employing 51-100 employees will be deemed to be in the large group market under New Jersey law, and thus not subject to its rating restrictions, but in the small group market under Federal law, and thus bound by the Federal rating provisions.

¹⁰⁵ See 42 U.S.C. § 18024(b)(2).

¹⁰⁶ N.J. STAT. ANN. § 17B:27A-17.

¹⁰⁷ See 42 U.S.C. § 18024(b)(3). Guidance from CMS makes clear that a state will be deemed to elect to use fifty employees in its definition of a small employer for medical loss ratio ("MLR") purposes until 2016 if it does so for other purposes and does not indicate a different choice. See *CCIIO Technical Guidance (CCIIO 2011-002): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule*, at 2 (May 13, 2011), http://cciio.cms.gov/resources/files/2011_05_13_MLR_Q_and_A_Guidance.pdf.

¹⁰⁸ Federal and New Jersey law also differ regarding which employees are eligible to be included in this count. CMS recently clarified that "employee" under Federal law includes full-time, part-time, and seasonal employees. *CCIIO Technical Guidance (CCIIO 2011-004)*, *supra* note 37, Question and Answer #19 (relying on definitions that also apply to the ACA's regulation of rating factors and bands). But New Jersey law defines an eligible employee as a full-time employee who works a minimum of twenty-five hours per week. N.J. STAT. ANN. § 17B:27A-17. New Jersey also requires that the majority of the employees are employed in New Jersey. *Id.*; N.J. ADMIN. CODE § 11:21-1.2.

¹⁰⁹ CMS recently provided guidance regarding when a plan is considered a group of one, and thus reported with the small group market, and when is it reported with the individual market, for purposes of complying with the ACA's MLR provisions:

To be considered a group health plan, the health plan must have "employees" among its participants. For the purpose of determining whether a group health plan exists, Federal law does not classify an individual and his or her spouse as employees when the trade or business is wholly owned by the individual or by the individual and his or her spouse. Thus, where a sole proprietor and/or a spouse-employee are the only enrolled employees, the health plan would not be considered to be a group health plan. Thus its experience would be aggregated with the issuer's individual market experience and not with the issuer's small group market experience.

However, if a sole proprietor enrolls a non-spouse employee, the experience of that plan is part of the small group market for MLR purposes. Even if the only enrollee is an employee who is not an owner or spouse, the plan is part of the small group market for MLR purposes.

CCIIO Technical Guidance (CCIIO 2012-002), *supra* note 107, at 3. The MLR Guidance relies on definitions that also apply to the Federal restrictions on rating factors and bands. See 42 U.S.C. §§ 300gg-91, 18111, 18024.

Summary of Permissible Rating Factors and Bands under Federal and New Jersey Law

	NJ Individual Market: Standard Health Services Plan	NJ Individual Market: Basic and Essential Health Services Plan	NJ Small Group Market	NJ Large Group Market	Federal Individual and Small Group Markets (and Large, where applicable)¹¹⁰
Health Status	No	No	No	Not regulated	No
Age	Yes: minimum of 5 year increments; 11 intervals set forth in regulation	Yes: minimum of 5 year increments; 11 intervals set forth in regulation	Yes: minimum of 5 year increments; 11 intervals set forth in regulation	Not regulated	Yes: Secretary, with NAIC, to define permissible age bands
Gender	No	Yes	Yes	Not regulated	No ¹¹¹
Geography	No	Yes: 6 regions defined in regulation	Yes: 6 regions defined in regulation	Not regulated	Yes: State to establish 1 or more, and Secretary to review “for adequacy”

¹¹⁰ Beginning in 2017, plans offered in the large group market (other than grandfathered and self-insured plans) will be subject to the Federal rate restrictions if a State permits issuers to offer large group coverage through the State’s Exchange. *See* 42 U.S.C. § 300gg(a)(5).

¹¹¹ The rating provisions in the ACA do not mention gender, and thus insurance companies may not base rate differentials on gender. Statements in Congress during consideration of this legislation criticizing the disparity in cost for premiums between men and women suggest that this was a policy choice and not an oversight. *See, e.g.*, 156 Cong. Rec. H1637-01 (daily ed. March 18, 2010) (statement of Rep. Speier) (“Is a woman worth as much as a man? One would think so, unless, of course, one was considering our current health care system, a system where women pay higher health care costs than men. Now, believe it or not, in 60 percent of the most popular health care plans in this country, a 40-year-old woman who has never smoked will pay more for health insurance than a 40-year-old man who has smoked.”).

Summary of Permissible Rating Factors and Bands under Federal and New Jersey Law (cont.)

	NJ Individual Market: Standard Health Services Plan	NJ Individual Market: Basic and Essential Health Services Plan	NJ Small Group Market	NJ Large Group Market	Federal Individual and Small Group Markets (and Large, where applicable)
Family Status/ Structure	Yes: 4 tiers (1) single (2) two adults (3) adult and child(ren) (4) family	Yes: 4 tiers (1) single (2) two adults (3) adult and child(ren) (4) family	Yes; 4 tiers (1) employee only (2) employee and spouse (3) employee and child(ren) (4) family	Not regulated	Yes: individual or family
Tobacco Use	No	No	No	Not regulated	Yes
Maximum Premium Differential	-≤ 350% based on age -“reasonable differential” for family status	-≤ 350% composite for age, geography, and gender	≤ 200% composite for age, geography, and gender	Not regulated	-≤ 150% for tobacco -≤ 300% for age

III. Policy Choices for New Jersey

Some of the differences between Federal and New Jersey rate banding restrictions require New Jersey to revise its laws, but others simply provide options that New Jersey may consider adopting.

The Supremacy Clause in the Federal Constitution “invalidates laws that ‘interfere with, or are contrary to,’ federal law.”¹¹² Federal statutes as well as Federal regulations may preempt state laws and regulations.¹¹³ Conflict preemption blocks enforcement of state law “to the extent that it actually conflicts with federal law.”¹¹⁴ Courts have found that state law actually

¹¹² *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 712 (1985) (quoting *Gibbons v. Ogden*, 9 Wheat. 1, 211 (1824)).

¹¹³ *See id.* at 713.

¹¹⁴ *Id.* (quoting *Gibbons*, 9 Wheat. at 211).

conflicts with Federal law not only when “compliance with both federal and state regulations is a physical impossibility” (referred to as implied impossibility preemption), but also “when state law ‘stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress’” (referred to as implied obstacle preemption).¹¹⁵

The ACA preempts State rating provisions that “prevent the application” of the Federal rating provisions.¹¹⁶ Although the ACA does not define what “prevent the application of” its provisions means in the rating context, the Eleventh Circuit has interpreted this language, as it applies to establishing state-run health insurance exchanges, to mean that states enjoy “some flexibility in operations and enforcement, though states must either (1) directly adopt the federal requirements set forth by HHS, or (2) adopt state regulations that effectively implement the federal standards, as determined by HHS.”¹¹⁷

New Jersey law is preempted to the extent it prevents the application of Federal rating provisions. Federal law prohibits insurers from varying rates based on any factor not enumerated in the ACA, such as gender. Thus, New Jersey laws permitting carriers in its small group market and those offering basic and essential health benefit plans in its individual market to vary premiums based on gender prevent the application of this Federal law and thus are preempted.

But preemption principles do not require New Jersey to permit carriers to vary premiums based on all of the factors enumerated in the ACA. Congress’s intent in enacting the rating provisions, which is the “touchstone” in preemption analysis,¹¹⁸ was to limit variation in premiums. A State statute that chooses to permit insurers to vary premiums on fewer bases is not preempted, as such a scheme does not prevent the application of the ACA nor stand as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress in seeking to reduce premium variation. Rather, by permitting variation on fewer factors, the State would be more protective of consumers and further Congress’s intent. By providing that rates “shall vary . . . only by” four itemized factors, the ACA established a mandatory ceiling on permissible bases for rate variation but not a floor. States may permit variation by up to these four factors but may add no others and are not necessarily required to vary on any. For example, rather than compelling states to vary rates based on geography, Congress requires States to establish one or more rating areas, which HHS then will evaluate for adequacy.¹¹⁹ By

¹¹⁵ *Id.* (quoting *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963) and *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)).

¹¹⁶ See 42 U.S.C. § 300gg-23(a)(1); see also 42 U.S.C. § 18041(d) (providing that “[n]othing in [Title 1 of the ACA] shall be construed to preempt any State law that does not prevent the application of the provisions of this title”).

¹¹⁷ *Florida v. United States HHS*, Nos. 11-11021 & 11-11067, 2011 U.S. App. LEXIS 16806, at *58 (11th Cir. Aug. 12, 2011), *cert. granted sub nom.* *Nat’l Fed’n of Indep. Bus. v. Kathleen Sebelius*, No. 11-393, 181 L. Ed. 2d 420; 2011 U.S. LEXIS 8269 (Nov. 14, 2011) (grant of *certiorari* limited to issue of severability).

¹¹⁸ *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963)).

¹¹⁹ See 42 U.S.C. § 300gg(a)(2).

not requiring States to establish at least two rating areas, Congress gave each State the option not to vary rates by geography unless HHS determines that a single rating area is inadequate for that State.

The same is true with respect to the percentage limitations for premium variation based on age and tobacco use. Congress cabined issuers' ability to vary premiums based on age and tobacco by adding, "except that such rate shall not vary by more than 3 to 1 for adults" for age and 1.5 to 1 for tobacco use.¹²⁰ By using "shall," Congress established a mandatory ceiling on the extent of variations based on age and tobacco use. No issuer that relies on age may exceed 300 percent rate variations, and no issuer relying on tobacco use may vary premiums by more than 150 percent. But Congress did not establish a floor on ratio variation based on age or tobacco use. Instead, its language contemplates that rates may vary by less than these ratio amounts.¹²¹ A State law that limits rate variation to narrower rating bands than the maximums authorized by the ACA (that is, less than 300 percent for age and less than 150 percent for tobacco use) advances and does not "prevent the application of" the ACA's rate banding provisions and thus is not preempted.¹²²

Thus, New Jersey has discretion to decide whether to permit carriers to vary rates based on the four factors enumerated in the ACA. 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.

¹²⁰ *Id.* § 300gg(a)(1)(A)(iii)-(iv).

¹²¹ According to a Tennessee official reporting on the substance of a three-hour conference call on May 26, 2011 with agency officials, "CCIIO clarified that the 3:1 age bands and the 1:1.5 tobacco use bands were the maximum permitted under the [ACA], but states could elect to adopt narrower bands." Haile Memo at 2, *supra* note 75. See also Center for Consumer Information & Ins. Oversight, *supra* note 45, at 18 n.3 (noting that "[i]t is possible that some States could choose to require issuers to use ratios lower than 3:1 for adults").

¹²² In a draft document, NAIC seems to agree with this analysis:

[The ACA's preemption provision] . . . effectively allowing states to adopt and enforce laws and regulations that afford greater consumer protections while ensuring a basic level of protections across the country. In practice, this means that, beginning on the effective date for each provision, any state law that does not meet the federal minimum standards will be preempted, and the federal Department of Health and Human Services will assume regulatory authority for that provision of federal law. If a state already has a requirement that at least meets the federal standards, or adopts one in the future, then it would retain the authority to enforce it. For example, [the ACA] requires that insurers in all markets comply with adjusted community rating standards with a maximum variation for age of 3:1. Most states do permit the use of health status and allow greater variation for age than the federal standards allow, preventing the application of the federal requirements. States that adopt the new federal standards by 2014, when the federal rating rules take effect, will retain the ability to enforce their new rating rules, as would states that adopt more stringent standards, such as pure community rating.

Nat'l Assoc'n of Ins. Comm'rs, *Preemption and State Flexibility in PPACA (Draft)* (NAIC 2010), available at http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf.

New Jersey already permits carriers to consider age in setting premiums in its small group and individual markets, although it is preempted from permitting carriers to vary premiums based on age by more than 300 percent because doing so prevents application of the Federal cap on the age variation ratio. As long as New Jersey defines modified community rating for standard plans in its individual market to permit variations solely based on age, it may not retain the current 350 percent rate band and instead must amend its law to provide that such variations may not exceed 300 percent (or such lower percentage as New Jersey chooses to adopt). New Jersey may retain its composite rate band of 350 percent for basic and essential plans in its individual market, however, as long as it amends its law to specify that variations based on age may not represent more than 300 percent of this larger composite. New Jersey also may retain its current composite rate variation cap of 200 percent in the small group market because it is under the Federal ceiling.¹²³

New Jersey currently permits variation for family status, so it would not need to amend its statutes and regulations if it chooses to retain this factor.¹²⁴ Similarly, it already permits variation based on geography in its small group market and for basic and essential plans in its individual market. It has discretion to amend its law to permit standard plans in its individual market to vary premiums based on geography, as the ACA permits but does not require. New Jersey also may regulate the extent to which carriers may vary premiums based on family status and/or geography by adopting rate bands for these factors.

If forthcoming regulations or guidance from the Secretary regarding the age, geography, family status, and tobacco use rating factors create conflict between Federal and New Jersey law, New Jersey will need to take additional legislative or regulatory action to bring its law into compliance with Federal. For example, HHS has not yet clarified what will constitute permissible age rating bands. Once it does, New Jersey will need to compare its age bands to the parameters set by the Federal agency. HHS also intends to issue regulations or guidance regarding what constitutes adequate rating areas. New Jersey will need to seek Federal approval of its current six geographic regions to determine if HHS deems them to be adequate. The same is true regarding rating categories based on family composition. New Jersey will need to ensure its family tiers do not prevent application of Federal law regarding varying rates for individuals and families. HHS also has not yet defined what will qualify as tobacco use for purposes of rating. If New Jersey chooses to permit variation based on tobacco use, it must be sure its definition does not prevent the application of Federal law.

¹²³ New Jersey also may widen its small group age rate band up to the Federal maximum differential of 300 percent or, conversely, it may further narrow its band from its present 200 percent standard. It just may not adopt a rate band based on age that exceeds a 3 to 1 ratio.

¹²⁴ New Jersey could consider adding a “reasonable differential” requirement to its statutory or regulatory provisions concerning family structure for small group plans and basic and essential plans in its individual market, to mirror the existing “reasonable differential” requirement that governs variations based on family structure for standard plans in the individual market. See *supra* notes 86, 88, and 101 and accompanying text.

Some of New Jersey's rating policy choices are inextricably intertwined with other policy choices New Jersey must make as it implements the ACA. For example, if New Jersey permits large group issuers to offer plans through New Jersey's Exchange, all large group plans, except self-funded and grandfathered plans, will be subject to the Federal rating restrictions. New Jersey must assess the impact of imposing the Federal requirements in the large group market but also the broader question of whether large group plans should be offered through the Exchange. Relatedly, if HHS ultimately permits States to establish different rating restrictions for plans inside and outside of the Exchange, New Jersey will need to decide whether it wants to create these distinctions.

Even if New Jersey does not permit large group plans to be offered through the Exchange, group plans for employers employing 51-100 eligible employees, now classified as large group in New Jersey and thus not subject to the State's rating provisions, will be within the Federal definition of "small group" no later than 2016 and thus bound by the Federal rating provisions.¹²⁵ New Jersey should consider the advantages and disadvantages of conforming its market definitions to Federal law.

New Jersey also must choose how to regulate grandfathered plans, which are not bound by the Federal rating restrictions.¹²⁶ The State now regulates these plans in its small group and individual markets. Although Section 18011 of the ACA prohibits Federal rating laws from applying to grandfathered plans, there is no indication in this law that Congress intended to divest States of their existing power to regulate these plans.¹²⁷ Thus, New Jersey has to decide whether to continue to regulate these plans or to exempt them from its rating provisions like the Federal law.

In making these policy choices, New Jersey will have to weigh the impacts on premiums and its insurance markets from these choices.¹²⁸ The NAIC succinctly summarizes the competing concerns that New Jersey must balance in making these choices:

¹²⁵ See *supra* notes 105 to 108 and accompanying text.

¹²⁶ See generally Christine Eibner, *et al.*, *Grandfathering in the Small Group Market Under the Patient Protection and Affordable Care Act: Effects on Offer Rates, Premiums, and Coverage*, RAND, at 2 (2010) ("Since PPACA requires that all nongrandfathered plans be subject to risk equalization and adhere to 3:1 rate bands on age, it moves the nongrandfathered market to a situation similar to modified community rating. As a result, we expect that the effects of grandfathering will be stronger in states where there are less-restrictive rating regulations. That is, when there are less-restrictive rating regulations in the current market, firms with lower-cost enrollees have a greater incentive to stay in grandfathered plans."), *available at* http://www.rand.org/pubs/occasional_papers/2010/RAND_OP313.pdf.

¹²⁷ See 42 U.S.C.A. § 18011.

¹²⁸ See generally Chris L. Peterson & Thomas Gabe, CONG. RESEARCH SERV., R41137, *Health Insurance Premium Credits Under PPACA* (P.L. 111-148) 10-11 (Apr. 6, 2010) (providing illustrative examples from the Kaiser Family Foundation of the possible effects of premium variations based on age, geography, and plan type on health insurance premium affordability" based on 2009 plan costs), *available at* http://assets.opencrs.com/rpts/R41137_20100406.pdf.

In developing rate regulations, policymakers must be aware that any decisions regarding the variation of premiums will create winners and losers in the marketplace. Loose restrictions will be generally favorable to low-cost individuals and businesses, resulting in higher premiums for older, sicker individuals. Tighter restrictions, on the other hand, result in higher premiums for young, healthy individuals and businesses to offset lower premiums for older, sicker individuals and businesses.¹²⁹

New Jersey must narrow its age rate band to 300 percent for standard plans in the individual market, so it is likely that premiums will increase at least to some degree for younger individuals and groups. Similarly, the Federal prohibition on basing rate variations on gender may increase premiums for younger to middle-aged men and older women in individual market basic and essential plans and small group plans. These premium increases, however, will in some sense be balanced by the proportionate decrease in the rates of those in the highest-rated categories. In addition, individuals experiencing higher premiums may be eligible for premium subsidies under other provisions of the ACA.¹³⁰ New Jersey also should factor in that “any potential increase in premiums under the ACA should be moderated somewhat by the influx of more healthy and young people into the risk pool as a result of the individual mandate.”¹³¹

To the extent New Jersey adopts rating rules that vary from the Federal, it should consider whether the Federal risk adjustment methodology developed by HHS accounts for these variations and, if it does not, it should seek Federal certification of an alternative risk adjustment methodology, as permitted by 45 C.F.R. §§ 153.320 and 153.330, to ensure its risk adjustment methodology accounts for the particular way in which New Jersey’s rating rules

¹²⁹ NAIC & CIPR, *Rate Regulation*, *supra* note 1, at 1.; *see also* Sabrina Corlette, *New Federal Rating Rules*, CANCER ACTION NETWORK, at 3 (noting risk that not subjecting grandfathered plans, plans in the large group, and self-insured plans to rating rules “could result in adverse selection against plans subject to the new rating and other market rules,” and, “[i]f left unchecked, the resulting separation of healthier enrollees from sicker enrollees could cause unaffordable premium increases for people in the plans that are subject to the rating rules”), <http://www.acscan.org/pdf/healthcare/implementation/background/NewFederalRatingRules.pdf>; *see generally* Eibner et al., *supra* note 126 (reporting analysis suggesting that although “grandfathering may lead to slightly higher exchange premiums,” it also is “associated with higher [employer-sponsored insurance] enrollment and lower government spending”).

¹³⁰ *See* Blumberg, *Much Variation*, *supra* note 6, at 3; *see generally id.* (“Overall, very little change in premiums should be expected in either the small group or non-group markets in Massachusetts, where age rating is already limited to a tighter 2:1 band, guaranteed issue is already in place in both markets, and an individual requirement to have coverage has already been implemented for adults.”); Linda J. Blumberg et al., *Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens*, URBAN INSTITUTE (Oct. 2009) (evaluating impact on premiums and insurance coverage of different rate differentials based on age).

¹³¹ Corlette, *supra* note 129, at 2; *see also* Blumberg, *Much Variation*, *supra* note 6, at 4 (“The presence of higher-need individuals in these markets will tend to place upward pressure on average premiums, but this upward pressure will be offset at least in part by increased enrollment of the healthy resulting from both the provision of federal subsidies for the purchase of coverage and the individual coverage requirement.”)

already compensate for the increased risk from factors such as age, geography, and family status.¹³²

Conclusions

The Federal government and New Jersey agree that regulating rating factors and bands is a vital component of health reform. After twenty years of experience regulating rate variation, New Jersey now needs to work with the Federal government in what has been called an “unprecedented federal-state partnership” to implement the new Federal rating restrictions.¹³³ Although there are aspects of New Jersey’s law that must be changed to comply with the ACA’s rating provisions, New Jersey retains considerable discretion to regulate its carriers within the ceiling erected by Congress. Indeed, New Jersey already had implemented most of the centerpieces of the Federal rating reforms, including prohibiting carriers from basing premium variations on health status the individual and small group markets and adopting age bands narrower than what most states permit. New Jersey, in fact, presently requires carriers to abide by a narrower age rate band in its small group market than the ACA requires.

Despite being ahead of the pack in many ways, New Jersey still faces important questions in implementing the ACA’s rating provisions, including which of the four permissible rating factors to permit carriers to use; to what extent, within the Federal caps, to permit variation based on these factors; and whether to regulate rating in the large group market or for grandfathered plans. The threat of adverse selection looms behind many of New Jersey’s decisions, and thus policymakers must carefully exercise their discretion to further narrow permissible rating factors or bands. New Jersey also must monitor forthcoming Federal guidance to ensure, for example, that the State’s age bands are permissible, its rating areas are adequate, and its family tiers are consistent with and do not prevent the application of Federal law. The State retains a vital role in monitoring its markets to evaluate if the rating reforms achieve their intended goals of reducing pricing variations and improving access to health insurance coverage.

¹³² See 45 C.F.R. §§ 153.320(a)(2) & 153.330.

¹³³ Corlette, *supra* note 129, at 4.

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