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Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market

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Abstract The Affordable Care Act protects people from being charged more for insurance based on factors like medical history or gender and establishes new limits on how insurers can adjust premiums for age, tobacco use, and geography. This brief examines how states have implemented these federal reforms in their individual health insurance markets. We identify state rating standards for the first year of full implementation of reform and explore critical considerations weighed by policymakers as they determined how to adopt the law's requirements. Most states took the opportunity to customize at least some aspect of their rating standards. Interviews with state regulators reveal that many states pursued implementation strategies intended primarily to minimize market disruption and premium shock and therefore established standards as consistent as possible with existing rules or market practice. Meanwhile, some states used the transition period to strengthen consumer protections, particularly with respect to tobacco rating.

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OVERVIEW

Before the Affordable Care Act, insurance companies in most states were free to charge consumers a higher price for coverage based on many factors, including health status, gender, and occupation.[1] Relatively few states had legal standards that limited these rating practices in the individual (also known as "nongroup") insurance market, meaning that most people looking to buy an individual policy faced highly variable and often unaffordable premiums.[2]

The health law reforms rate-setting by limiting the factors that insurers can consider when pricing coverage. No longer may carriers charge more to a person with a preexisting condition. Instead, premiums must be the same for everyone community-wide, adjusted only for: 1) whether the plan covers an individual or family, 2) age, 3) tobacco use, and 4) where people live.[3]

These federal reforms apply nationwide and, in conjunction with other provisions of the law, aim to make health coverage more accessible and affordable.[4] At the same time, the states retain primary responsibility for regulating their health insurance markets and have significant flexibility when implementing the federal provisions.[5] Consequently, state officials continue to play an essential role in shaping the legal and regulatory landscape in which health coverage is bought and sold.[6]

This brief examines state rating standards in the first year of full implementation of reform. We identify the new federal rules governing age, tobacco, and geographic rating and analyze variation in state approaches to implementation of these factors. Drawing on interviews with state insurance regulators, we also explore some of the critical considerations weighed by policymakers as they determined how to implement the ACA's requirements for 2014.

FINDINGS

Age Rating

Federal Standard. The ACA permits insurers to adjust premiums according to an enrollee's age, but limits the overall magnitude of the variation.[7] To implement this requirement, federal regulations construct standard age brackets, also called bands, for children, adults, and older adults and an "age-rating curve" that specifies the annual rate at which premiums may rise as enrollees grow older (Exhibit 1).[8] States must use the federally defined age bands but may establish their own uniform age curve or a narrower rating ratio.[9]

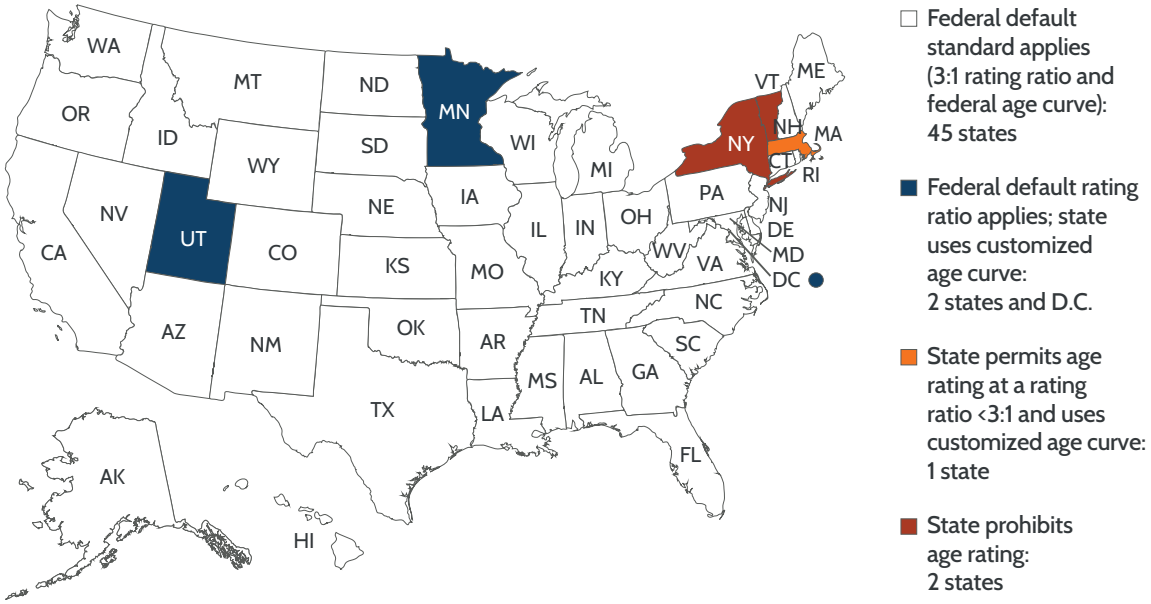
Exhibit 1. Federal Age-Rating Methodology

Age band category	Description
Children	A single band covers children ages 0 through 20. All children within the age band pay the same age-based premium rate.
Adults	Separate one-year age bands cover adults ages 21 through 63. All adults within a given age band (i.e., all 30-year-olds) pay the same age-based premium rate, but premiums may rise from one band to the next, according to a standard age curve (Appendix Table 1).[a] This variation is limited to a ratio of 3:1, meaning that an older adult, ages 64 and older, cannot be charged more than three times the age rate of a 21-year-old.
Older adults	A single age band covers adults ages 64 and older. All older adults within the age band pay the same age-based premium rate.

Note: An enrollee's age for purposes of applying a rating adjustment is determined at the time of policy issuance or renewal.
[a] The single-year adult age bands and uniform age curve are designed to mitigate premium disruption as enrollees age, as well as improve the accuracy of risk adjustment and make it easier for consumers to compare competing plans.
Source: 45 C.F.R. § 147.102(a)(1)(iii) & (d).

State Flexibility. Five states and the District of Columbia implemented state-specific age-rating standards. Massachusetts, New York, and Vermont further restricted age rating by reducing or eliminating the maximum rating ratio—meaning, for example, that New Yorkers cannot be charged different prices for coverage depending on their age—while the District of Columbia, Massachusetts, Minnesota, and Utah created unique age-rating curves that regulate, at the state level, the rate at which consumers' premiums may increase due to age each year. In the remaining 45 states, federal minimum requirements govern without modification (Exhibit 2).

Exhibit 2. State Standards for Age Rating in the Individual Market (2014)



Source: Authors' analysis.

Most states approached implementation of the age-rating ratio with the goal of minimizing market disruption. Before reform, only six states imposed a ratio equal to or narrower than the ACA's 3:1 maximum.[10] Thirty-eight had not established any explicit limitation on age rating in the individual market. Since, for most states, adopting the federal requirements created a substantial shift in rate regulation, policymakers in these jurisdictions were disinclined to require their markets to undergo still greater changes. One interviewee expressed concern that any further compression of the rating ratio might discourage younger, healthier individuals from enrolling, thereby undercutting efforts to expand coverage and producing an older, more expensive mix of enrollees in carriers' risk pools.

The few states that previously adopted strict age-based rate restrictions were similarly motivated to preserve market stability and thus tended to maintain their rules for 2014. New York and Vermont continued prohibitions on age rating and Massachusetts retained its 2:1 ratio, partly to avoid a potential rate spike for older individuals, which may have occurred had the state relaxed its ratio to match the federal minimum.[11]

Forty-seven states are using the federal age curve, with interviewees generally noting they lacked either the data to justify a deviation, or the time—during a tight implementation period—to explore state-specific alternatives. One of the exceptions, Utah, created a customized curve to reflect the health costs of its state population, which includes a comparatively high percentage of younger, larger families.[12]

Tobacco Rating

Federal Standard. The health law allows insurers to vary nongroup premiums based on whether an enrollee uses tobacco, up to a maximum ratio of 1.5:1.[13] Significantly, and in contrast to rate adjustments on the basis of age or geography, federal default rules require consumers who use tobacco to bear the full, unsubsidized cost of any tobacco-related surcharge (Exhibit 3).[14] Among other options, states may require insurers to calculate the surcharge based on the subsidized premium, reduce

the rating ratio, adopt a narrower definition of tobacco use, or implement a combination of these alternatives.[15]

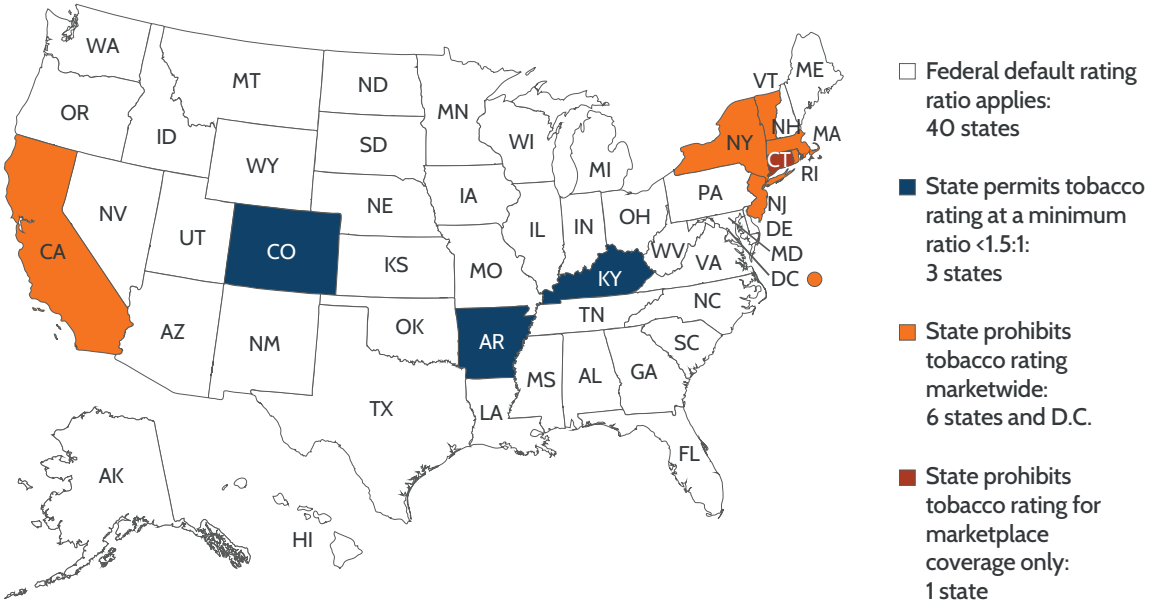
Exhibit 3. Impact of Tobacco Rating on Annual Premiums, After Tax Credits

Income[a]	Annual premium excluding tobacco rating		Annual premium including 50% tobacco surcharge	
	Premium	Premium as a percent of income	Premium	Premium as a percent of income[c]
150% FPL ($17,235)	$689	4.0%	$2,657	15.4%
250% FPL ($28,725)	$2,312	8.05%	$4,280	14.9%
350% FPL ($40,215)	$3,820	9.5%	$5,788	14.4%
444% FPL ($51,016)[b]	$3,936	7.7%	$5,904	11.6%

Notes: FPL refers to federal poverty level. Calculations based on an annual, unsubsidized premium of $3,936 for one enrollee. This value constitutes the weighted average annual premium of the second-lowest-cost silver plan offered in the marketplaces of 48 states during the open enrollment period for policy year 2014, as estimated by the Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy (ASPE). (Excluded from the ASPE estimate are the states of Hawaii, Kentucky, and Massachusetts, for which ASPE lacked premium data.) In general, premium tax credits are available on a sliding scale to individuals with incomes between 100 percent and 400 percent of the federal poverty level who purchase coverage through their insurance marketplace.
[a] Dollar values reflect federal poverty guideline data for 2013, the baseline used to calculate subsidy eligibility for the 2014 policy year.
[b] Income level equals the national median household income in 2012.
[c] Under the Affordable Care Act, an individual is deemed to lack access to "affordable" insurance if her required share of the premium for self-only coverage is greater than 8 percent of income. To the extent a consumer's coverage options (including those at metal tiers other than silver) exceed this threshold because of application of the tobacco surcharge, she would be exempt from the health law's coverage mandate tax penalty.
Source: Authors' analysis.

State Flexibility. Nine states and the District of Columbia chose to further limit the effect of tobacco rating by reducing or eliminating the 1.5:1 rating ratio marketwide, while Connecticut prohibited the use of the rating factor for coverage offered through the state's marketplace (Exhibit 4).[16] In addition, Maryland's marketplace, which is using Connecticut's technology platform in 2015, also adopted the restriction on tobacco rating for the coming year.[17]

Exhibit 4. State Standards for Tobacco Rating in the Individual Market (2014)



Source: Authors' analysis.

No state altered the federal definition of tobacco use, nor has any required the factor to be calculated from subsidized premiums—a step that would reduce the magnitude of the surcharge, especially for consumers with lower incomes (Exhibit 5).

Exhibit 5. Impact of Alternative Tobacco Rating Standards on Annual Premiums, After-Tax Credits

	Annual premium including 50% tobacco surcharge (default standard: surcharge applied to unsubsidized premium)		Annual premium including 50% tobacco surcharge (surcharge applied to subsidized premium)		Annual premium including 20% tobacco surcharge (surcharge applied to subsidized premium)	
Income[a]	Premium	Premium as a percent of income	Premium	Premium as a percent of income	Premium	Premium as a percent of income
150% FPL ($17,235)	$2,657	15.4%	$1,034	6.0%	$827	4.8%
250% FPL ($28,725)	$4,280	14.9%	$3,468	12.1%	$2,774	9.7%
350% FPL ($40,215)	$5,788	14.4%	$5,730	14.2%	$4,584	11.4%
444% FPL ($51,016)[b]	$5,904	11.6%	$5,904	11.6%	$4,723	9.3%

Notes: FPL refers to federal poverty level. Calculations based on an annual, unsubsidized premium of $3,936 for one enrollee. This value constitutes the weighted average annual premium of the second-lowest-cost silver plan offered in the marketplaces of 48 states during the open enrollment period for policy year 2014, as estimated by ASPE. (Excluded from the ASPE estimate are the states of Hawaii, Kentucky, and Massachusetts, for which ASPE lacked premium data.) In general, premium tax credits are available on a sliding scale to individuals with incomes between 100 percent and 400 percent of the federal poverty line who purchase coverage through their insurance marketplace. No state has adopted a rating standard whereby the tobacco adjustment is calculated based on an enrollee's subsidized premium. Three states permit tobacco rating at a ratio that is narrower than the federal default of 1.5:1, including Arkansas, which allows a 20 percent surcharge.
[a] Dollar values reflect federal poverty guideline data for 2013, the baseline used to calculate subsidy eligibility for the 2014 policy year.
[b] Income level equals the national median household income in 2012.
Source: Authors' analysis.

States considered a range of factors when implementing the tobacco rating provision, with a desire for market stability a high priority. Before reform, all but five states permitted individual market insurers to charge higher premiums for tobacco use.[18] For 2014, most states adhered to federal minimum requirements to allow carriers rating flexibility as consistent as possible with past practice. For similar reasons of continuity, four states that previously banned tobacco rating to broaden risk-sharing—New Jersey, New York, Rhode Island, and Vermont—maintained the prohibition, with interviewees noting little appetite for movement away from the existing consumer-protective framework.

In addition to their interest in maintaining stability, states grappled with competing views on the efficacy of tobacco rating. Officials recognized that tobacco use is a voluntary behavior associated with higher health costs but also acknowledged that it is highly addictive and difficult to influence. Policymakers thus debated how to allocate the risk of increased costs between tobacco users and the broader enrollee pool.[19] Kentucky, for example, imposed a tobacco rate restriction that is tighter than both the federal default and the state's requirements before reform. However, because regulators were concerned that completely phasing out the rating factor might negatively affect the premiums of nonusers, officials permitted a surcharge of 40 percent.[20] Wariness about imposing a potentially punitive charge on consumers with addiction weighed on policymakers in the District of Columbia, who chose to prohibit the rating practice in its entirety.[21] Meanwhile, several states considered

whether the tobacco surcharge would make coverage unaffordable for many consumers, particularly those with lower incomes.[22] These concerns—about whether the surcharge would ultimately increase the number of uninsured and encourage adverse selection against the marketplace—helped prompt California's legislature to eliminate the rating factor.[23]

Geographic Rating

Federal Standard. The ACA allows insurers to vary premiums based on where an individual lives within a state (Exhibit 6).[24] States have wide discretion to develop geographic rating areas and may also limit the magnitude of the premium variation between their highest- and lowest-cost regions.[25]

Exhibit 6. Geographic Rating Concepts

Key concept	Description
Rating area	States may establish one or more rating areas based on existing geographic divisions including counties, three-digit zip codes, or urban and rural regions. Within a rating area, all enrollees receive the same geographic rate, but insurers may adjust premiums based on geography from one area to the next.
Federal default approach	If a state declines to establish its own rating areas, federal rules specify that the state must have one rating area for each of its metropolitan statistical areas (MSAs) and one additional area combining all non-MSAs.
Rating band	In contrast to the ACA's rules for age and tobacco use, which do not allow rates to fluctuate beyond a maximum ratio, federal law does not limit the degree to which premiums may vary across geographic rating areas. States retain authority to impose such restrictions if they choose.

Source: 45 C.F.R. § 147.102(a)(1)(ii) & (b).

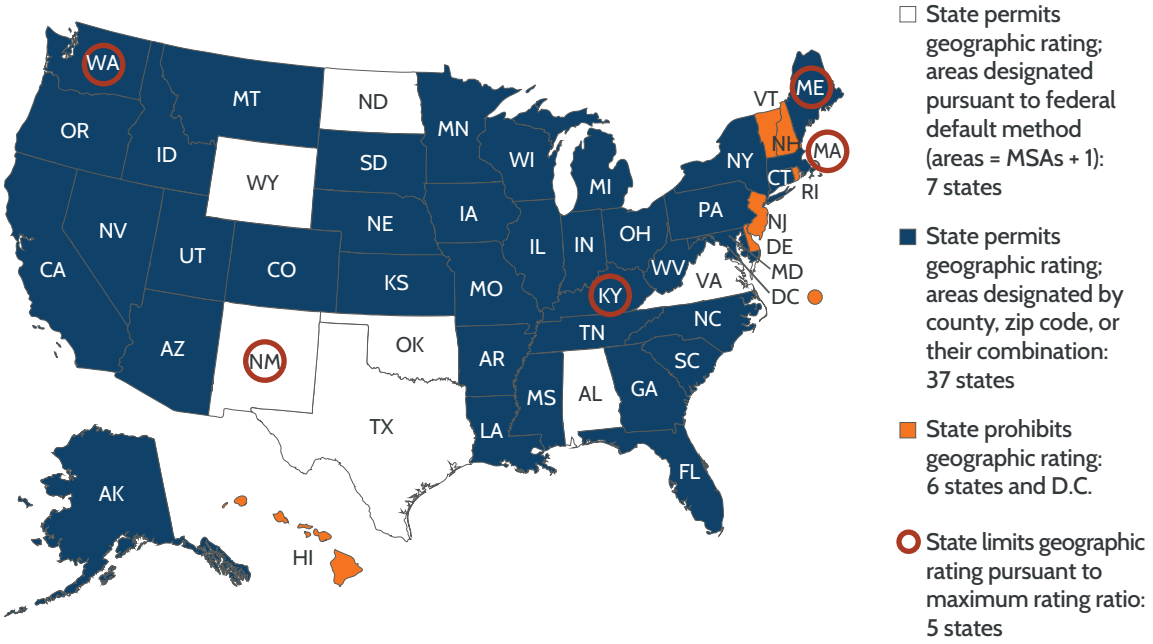
State Flexibility. All but seven states designated rating areas based on classifications that diverged from the federal default (Appendix Table 2).[26] Six states and the District of Columbia banned geographic rating by establishing a single rating area for the entire jurisdiction, while five states that permit the factor's use blunted its impact by limiting variation to a prescribed ratio (Exhibit 7).

States attempted to minimize disruption to their markets when implementing the geographic rating standards, frequently setting rating areas to align with existing regulatory requirements. New Jersey, for example, created a single rating area for its individual market pursuant to prevailing state law, while Florida and South Carolina adopted the largest number of rating areas nationwide (67 and 46, respectively), corresponding to the single-county areas each had established before reform.[27]

In some states, strict replication of past practice was either impossible, because that practice was not previously defined through state action, or undesirable, because additional analysis suggested alternatives. Policymakers in these states struggled to craft rating areas that reflected existing regional differences in health costs but that did not entrench pricing mechanisms that could systematically disadvantage particular subpopulations. One interviewee noted that his state did not adopt as many rating areas as allowed under federal rules in part because regulators did not want to segment the market too finely. Doing so, they worried, could make it easier for insurers to isolate communities with greater health needs and charge them higher rates, a practice that would undermine the federal law's protections against discrimination based on health status.

In general, however, regulators from states that perceived substantial geographic variation in the cost of care expressed caution about adopting relatively few rating areas, fearing that such

Exhibit 7. State Standards for Geographic Rating in the Individual Market (2014)



Notes: In Kentucky, state law establishes a combined maximum rating ratio for all "case characteristics" including geographic area and age. In New Mexico, state law imposes a similar requirement, and the state's insurance marketplace places additional limits on the differential between the highest and lowest rated areas.
Source: Authors' analysis.

limitations might lead to sharp increases in premiums for many residents.[28] Colorado officials, for example, worried that having too few rating areas might cause carriers to exit the market in expensive regions—depressing competition and raising prices there—while also producing significantly higher rates for low-cost areas that would now have to share risk more broadly.[29] These concerns led the state to design a framework with a greater number of rating areas than allowed by federal default rules to reflect the perceived regional differences in costs.[30] Colorado's method for delineating regions proved controversial, however, especially among residents of high-cost rating areas, where unsubsidized premiums were among the steepest in the country.[31] This backlash spurred the state to reassess its approach, leading to a decision to reduce the number of rating areas for 2015.[32]

Still other states sought to strike a balance between rating flexibility and risk-sharing by other means, including allowing geographic variation within prescribed bounds. Thus, Washington prohibited nongroup insurers from imposing a geographic adjustment of more than 15 percent, a limit that reflects the rating variation observed in the state's small-group market prior to reform.[33]

DISCUSSION

Prior to health reform, the individual market was marked by dysfunction, providing coverage that, for many, was difficult to access and hard to afford.[34] The ACA seeks to remedy these shortcomings, in part by placing limits on the factors that insurers can consider when setting premiums. The law's rating reforms require that everyone be charged the same price for the same coverage, adjusted only for an enrollee's family size, age, tobacco use, and geographic location.

Our findings reveal that—within the bounds set by the federal government— most states customized at least some aspect of their individual market rating requirements.[35] States varied in the standards they set, but most often were motivated by a common goal: to minimize market disruption.

In general, states pursued continuity to encourage carrier participation in as many service areas as possible and to reduce the risk of premium shocks for consumers.

For age and tobacco rating, most states chose to adhere to federal minimum requirements. Most interviewees viewed the default rules as the best option for facilitating a smooth transition from the pre-reform period—where restrictions on these rating factors were looser or nonexistent—to the present.[36] A few states, however, like Arkansas, California, and Connecticut, went further and reduced or eliminated tobacco rating in their nongroup markets to help ensure affordable coverage options for residents. Meanwhile, others left development of customized standards for the future and prioritized simpler approaches, given the significant time pressure to implement the new requirements.

For geographic rating, desire to prevent rate shock frequently led states to maximize carriers' flexibility to adjust rates across regions. Thus, most states established rating areas that corresponded to pre-reform rating patterns or that equaled the maximum number of areas allowed under federal regulations.[37] In a number of states, this market segmentation revealed significant differences in premiums from one rating area to the next. While these disparities often existed historically, several interviewees noted that the ACA's new rating framework and insurance marketplaces have made the variation more transparent. Increased awareness has already contributed to regulatory changes in Colorado, and seems likely to prompt fresh debates about the appropriate number of geographic areas and the possibility of establishing limits on geographic rating variation elsewhere.

As state officials continue to manage the transition and receive feedback from consumers and other stakeholders, states likely will diverge with increasing frequency from federal minimum requirements. This brief provides a baseline for evaluating future developments and suggests that continued monitoring of state action will be essential to understanding how the ACA is affecting the affordability of coverage.

Notes

[1] S. Corlette, J. Volk, and K. Lucia, *Real Stories, Real Reforms* (Princeton, N.J.: Robert Wood Johnson Foundation, Sept. 2013).

[2] See, for example, D. Goin and S. Long, *Prior Experience with the Nongroup Health Insurance Market: Implications for Enrollment under the Affordable Care Act* (Washington, D.C.: The Urban Institute, Jan. 2014); S. Collins, R. Robertson, T. Garber et al., *Gaps in Health Insurance: Why So Many Americans Experience Breaks in Coverage and How the Affordable Care Act Will Help* (New York, N.Y.: The Commonwealth Fund, April 2012); R. McDevitt, J. Gabel, R. Lore et al., "Group Insurance: A Better Deal for Most People than Individual Plans," *Health Affairs*, Jan. 2010 29:156-64; N. Turnbull and N. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market* (New York, N.Y.: The Commonwealth Fund, Feb. 2005).

[3] Public Health Service Act § 2701 (codified at 42 U.S.C. § 300gg).

[4] The ACA addresses shortcomings in the availability and affordability of individual market coverage through an interrelated and interdependent set of reforms. In addition to the rating protections discussed in this brief, the law requires insurers to provide guaranteed access to coverage and creates a tax penalty for Americans who can afford to get insurance but decline to do so. Public Health Service Act §§ 2702 (codified at 42 U.S.C. § 300gg-1); Pub. L. 111-148, 124 Stat. 782 (2010) § 1501(b) (codified at 26 U.S.C. § 5000A). The ACA also extends financial relief, in the form of premium tax credits and reduced exposure to out-of-pocket expenses, to defray the costs of coverage for low- and middle-income Americans. Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1401-02 (codified at 26 U.S.C. § 36B; 42 U.S.C. § 18071).

[5] See, generally, T. S. Jost, "The Regulation of Private Health Insurance" (Washington, D.C.: National Academy of Social Insurance, National Academy of Public Administration; Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2009).

[6] J. Giovannelli, K. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market* (New York, N.Y.: The Commonwealth Fund, July 2014); K. Keith and K. Lucia, *Implementing the Affordable Care Act: State of the States* (New York, N.Y.: The Commonwealth Fund, Jan. 2014).

[7] Public Health Service Act § 2701(a)(1)(A)(iii) (codified at 42 U.S.C. § 300gg(a)(1)(A)(iii)).

[8] 45 C.F.R. § 147.102(a)(1)(iii), (d) & (e).

[9] 45 C.F.R. § 147.103; Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule, 78 Fed. Reg. 13406, 13412 (Feb. 27, 2013) (the "ACA Market Reform Final Rule").

[10] The six states that maintained age-rating restrictions, prior to reform, that were at least as stringent as current ACA standards were Maine, Massachusetts, Minnesota, New Mexico, New York, and Vermont.

[11] N.Y. Ins. Law §§ 3231, 4317, 4328; Vt. Stat. Ann. tit. 33, § 1811; Mass. Gen. Laws Ann. ch. 176J, § 3.

[12] Utah Insurance Department, "Bulletin 2013-4: Health Benefit Plan Market Transition," March 28, 2013, https://insurance.utah.gov/health/documents/bulletin20134Signed.pdf.

[13] Public Health Service Act § 2701(a)(1)(A)(iv) (codified at 42 U.S.C. § 300gg(a)(1)(A)(iv)). Federal regulations define "tobacco use" as the use of any tobacco product on average four or more times per week within the last six months. 45 C.F.R. § 147.102(a)(1)(iv). This definition is described as "transitional" and federal regulators suggest a "more evidence-based definition" may be provided in future rulemaking. ACA Market Reform Final Rule 78 Fed. Reg. 13406, 13414 (Feb. 27, 2013). For purposes of the definition as it stands, "tobacco use" does not include the religious or ceremonial use of tobacco. 45 C.F.R. § 147.102(a)(1)(iv). Consumers must self-report whether they meet the definition of tobacco use when enrolling in coverage. An insurer may retroactively apply the appropriate tobacco rating surcharge to an individual who misrepresents her tobacco use on her application, but it may not rescind coverage on that basis. ACA Market Reform Final Rule, 78 Fed. Reg. 13406, 13414 (Feb. 27, 2013).

[14] See 26 C.F.R. § 1.36B-3(e) (stating that premium subsidy amounts are based on plan premiums calculated prior to the application of any tobacco rating factor).

[15] 45 C.F.R. § 147.103; ACA Market Reform Final Rule, 78 Fed. Reg. 13406, 13414 (Feb. 27, 2013).

[16] Connecticut Health Insurance Exchange, "Amendment to: Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges," http://www.ct.gov/hix/lib/hix/040613_FINAL_AMENDMENT_QHP_SOLICITATION_12_13_12.pdf.

[17] Maryland Health Benefit Exchange Board of Trustees, "April 15, 2014 Board Meeting Minutes," http://marylandhbe.com/wp-content/uploads/2014/05/MHBE-Board-Meeting-Minutes-04-15-14.pdf.

[18] The five states that prohibited tobacco rating prior to the ACA were: New Jersey, New York, Oregon, Rhode Island, and Vermont.

[19] Multiple interviewees—including one from a state that prohibits tobacco rating and several from states that do not—expressed doubt about whether the rating factor could be administered fairly or reliably, given that its application is based solely on the self-attestation of enrollees.

[20] Kentucky Department of Insurance, "Affordable Care Act Implementation Update, May 22, 2013," https://insurance.ky.gov/Documents/acaimpfaq2_052313.pdf; M. Burchett, "State health-insurance exchange plans to make smokers pay 40 percent more for coverage; varied interests, observers object," *Kentucky Health News*, Sept. 9, 2013, accessed April 10, 2014, http://kyhealth-news.blogspot.com/2013/09/state-health-insurance-exchange-plans.html.

[21] District of Columbia Health Benefit Exchange Authority, "Resolution: To prohibit tobacco use as a rating factor," http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/Resolution-ProhibitiononTobaccoUseRating.pdf; District of Columbia Health Benefit Exchange Authority, "Standing Advisory Board Meeting Minutes, March 27, 2013," http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/AdvisoryBoardMinutes3-27-13_0.pdf.

[22] District of Columbia Health Benefit Exchange Authority, "Tobacco Rating," March 20, 2013, http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/TobaccoRating.pdf; D. Dillon, "Report on Tobacco Rating Issues in Arkansas Under the Affordable Care Act," Lewis and Ellis, Inc., Feb. 2013, https://static.ark.org/eeuploads/hbe/Feb-2013-Tobacco-Plan.pdf; North Carolina Department of Insurance Market Reform Technical Advisory Group, "In-Person Meeting #9: Notes," Oct. 17, 2012, http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/TAG%209%20Meeting%20Notes.pdf; R. Curtis and E. Neuschler, "Tobacco Rating Issues and Options for California under the ACA," Institute for Health Policy Solutions, June 21, 2012, http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf.

[23] California State Assembly Committee on Health, "Bill Analysis: Senate Bill 2," http://leginfo.ca.gov/pub/13-14/bill/sen/sb_0001-0050/sbx1_2_cfa_20130308_164138_asm_comm.html. These same concerns also formed the basis for opposition to the tobacco use surcharge by consumer organizations like the American Cancer Society and the American Lung Association. American Cancer Society Cancer Action Network, "Insurance Market Reform Rule Comment Letter," Dec. 20, 2012, http://www.acscan.org/content/wp-content/uploads/2012/12/Ins-Mkt-Ref-comment-ltr-FINAL-Dec-20-2012.pdf; American Lung Association, "Tobacco Surcharges," 2013, http://www.lung.org/stop-smoking/tobacco-control-advocacy/reports-resources/2013/factsheet-tobacco-surcharges-v2.pdf.

[24] Public Health Service Act § 2701(a)(1)(A)(ii) (codified at 42 U.S.C. § 300gg(a)(1)(A)(ii)); 45 C.F.R. § 147.102(a)(1) (ii) & (b).

[25] State-selected rating areas that are uniform for the entire state and adhere to the geographic divisions described in Exhibit 6 are presumed by federal regulators to be adequate, provided: (1) they were established as of January 1, 2013; or (2) they are no greater in number than the total number of MSAs in the state plus one. If a state proposes rating areas that, in number, exceed the limit specified by this safe harbor, federal officials will review the state's plan to assess whether the proposed areas are actuarially justified, are not unfairly discriminatory, and reflect significant differences in health care unit costs, among other considerations. 45 C.F.R. § 147.102(b).

[26] Most interviewees expressed that it was important for states to retain primary control over rating area selection to manage their markets and seek premium stability for consumers. One interviewee in a state that set areas using counties saw value in the flexibility to deviate from the federal default approach, in particular. He noted that his state's rural regions displayed relatively substantial cost variation and would not have been well-served by a single, aggregated non-MSA rating area.

[27] N.J. Stat. Ann. §§ 17B:27A2 & A-6; Florida Office of Insurance Regulation, "State of Florida Geographical Rating Areas," Letter to the Honorable Kathleen Sebelius, March 21, 2013, http://www.floir.com/siteDocuments/FLGeoRatingAreas.pdf; South Carolina Department of Insurance, "Bulletin Number 2013-01: Rate Filing Procedures for Health Insurance Rate Change Requests, Rate Filing Procedures for New Products, and Other Rating Factors," April 5, 2013, http://www.doi.sc.gov/DocumentCenter/View/2699. Florida and South Carolina were two of only four states—the others, Colorado and Connecticut—to implement rating areas that were greater in number than the federal default maximum based on the number of MSAs in the state plus one. Connecticut also received approval to implement single-county areas (it established eight), while Colorado created 11 areas (reduced to nine beginning in 2015) consisting of a mix of MSAs and non-MSAs. See Department of Health and Human Services, "Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting," Feb. 25, 2013, http://www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf. ; 3 Code Colo. Regs. § 702-4-2-39.

[28] California and North Carolina are but two examples. California Department of Insurance, "SBX1-2 (Hernandez): Health Care Coverage—Oppose unless Amended," Letter to Senator Ed Hernandez, Feb. 13, 2013, http://www.insurance.ca.gov/0400-news/0100-press-releases/2013/upload/statement017HernandezLtr.pdf; North Carolina Department of Insurance, "State Rating Requirements Disclosure Form—Second Submission," Letter to the Honorable Kathleen Sebelius, March 28, 2013, http://www.ncdoi.com/HealthCareReform/Documents/HealthCareReform/Sebelius28March2013.pdf.

[29] Colorado Division of Insurance, "Fact Sheet: Colorado Geographic Rating Requirements in Mountain Resort Counties," Oct. 25, 2013.

[30] Ibid.

[31] K. McCrimmon, "Remote care, monopolies and pricey injuries hike resort, rural health costs," *Health News Colorado*, Jan. 29, 2014, accessed April 18, 2014, http://www.healthnewscolorado.org/2014/01/29/remote-care-monopolies-and-pricy-injuries-hike-resort-rural-health-costs/; J. Rau, "The 10 Most Expensive Insurance Markets In The U.S.," *Kaiser Health News*, Feb. 3, 2014, accessed April 18, 2014, http://www.kaiserhealthnews.org/Stories/2014/February/03/most-expensive-insurance-markets-obamacare.aspx.

[32] Colorado Division of Insurance, "U.S. Health & Human Services Approves Division of Insurance Shift on Geographic Rating Areas for 2015," May 19, 2014; see also M. Brown, G. Blobaum, and S. Loudon, "Colorado Total Health Cost and Geographic Study," Miller & Newberg Consulting Actuaries, May 2, 2014.

[33] Wash. Admin. Code 284-170-250.

[34] See, for example, D. Goin and S. Long, *Prior Experience with the Nongroup Health Insurance Market*, 2014; S. Collins, R. Robertson, T. Garber et al., *Gaps in Health Insurance*, 2012.

[35] Only six states—Alabama, North Dakota, Oklahoma, Texas, Virginia, and Wyoming—followed federal default rating standards in their individual markets.

[36] Similarly, pursuit of stability—and resistance to perceived backsliding on existing protections—prompted some states with already robust age or tobacco restrictions to maintain them.

[37] For 2014, 29 states established (or defaulted to) the maximum number of areas allowed under the federal safe harbor—a value equal to the number of MSAs in the state plus one. Compare The Center for Consumer Information & Insurance Oversight, "Market Rating Reforms: State Specific Geographic Rating Areas," http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html; with Department of Health and Human Services, "Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting," 2013.

Appendix Table 1. Federal Default Standard Age Curve (2014)

Age	Premium ratio	Age	Premium ratio	Age	Premium ratio
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.536	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and older	3.000

Source: The Center for Consumer Information and Insurance Oversight.

Appendix Table 2. State Geographic Rating Areas in the Individual Market (2014)

State	Number of rating areas (geographic division)	State	Number of rating areas (geographic division)
Alabama	13 (MSAs/non-MSAs)	Montana	4 (counties)
Alaska	3 (zip codes)	Nebraska	4 (zip codes)
Arizona	7 (counties)	Nevada	4 (counties)
Arkansas	7 (counties)	New Hampshire	1 (statewide)
California	19 (combination of zip codes and counties)	New Jersey	1 (statewide)
Colorado	11 (counties)*	New Mexico	5 (MSAs/non-MSAs)
Connecticut	8 (counties)	New York	8 (counties)
Delaware	1 (statewide)	North Carolina	16 (counties)
District of Columbia	1 (statewide)	North Dakota	4 (MSAs/non-MSAs)
Florida	67 (counties)	Ohio	17 (counties)
Georgia	16 (counties)	Oklahoma	5 (MSAs/non-MSAs)
Hawaii	1 (statewide)	Oregon	7 (counties)
Idaho	7 (zip codes)	Pennsylvania	9 (counties)
Illinois	13 (counties)	Rhode Island	1 (statewide)
Indiana	17 (counties)	South Carolina	46 (counties)
Iowa	7 (counties)	South Dakota	4 (counties)
Kansas	7 (counties)	Tennessee	8 (counties)
Kentucky	8 (counties)	Texas	26 (MSAs/non-MSAs)
Louisiana	8 (counties)	Utah	6 (counties)
Maine	4 (counties)	Vermont	1 (statewide)
Maryland	4 (counties)	Virginia	12 (MSAs/non-MSAs)
Massachusetts	7 (zip codes)	Washington	5 (counties)
Michigan	16 (counties)	West Virginia	11 (counties)
Minnesota	9 (counties)	Wisconsin	16 (counties)
Mississippi	6 (counties)	Wyoming	3 (MSAs/non-MSAs)
Missouri	10 (counties)		

Note: MSAs refers to metropolitan statistical areas.
* Colorado will have nine rating areas, based on counties, beginning in 2015.
Source: The Center for Consumer Information & Insurance Oversight.

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