



This document is scheduled to be published in the Federal Register on 02/27/2013 and available online at <http://federalregister.gov/a/2013-04335>, and on [FDsys.gov](http://FDsys.gov)

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### 45 CFR Parts 144, 147, 150, 154 and 156

[CMS-9972-F]

RIN 0938-AR40

### Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review

**AGENCY:** Department of Health and Human Services.

**ACTION:** Final rule.

**SUMMARY:** This final rule implements provisions related to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, and catastrophic plans, consistent with title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. The final rule clarifies the approach used to enforce the applicable requirements of the Affordable Care Act with respect to health insurance issuers and group health plans that are non-federal governmental plans. This final rule also amends the standards for health insurance issuers and states regarding reporting, utilization, and collection of data under the federal rate review program, and revises the timeline for states to propose state-specific thresholds for review and approval by the Centers for Medicare & Medicaid Services (CMS).

**DATES:** Effective Date. This rule is effective on [**OFR: INSERT DATE 60 DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER**], except 45 CFR 147.103 and the amendments to 45 CFR Part 154 are effective on [**OFR: INSERT DATE 30 DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER**].

Applicability Dates. The provisions of this final rule generally apply to health insurance coverage for plan or policy years beginning on or after January 1, 2014. The provisions of 45

CFR 147.103 apply on [**OFR: INSERT DATE 30 DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER**]. The amendments to 45 CFR Part 154 apply on April 1, 2013.

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Executive Summary: Beginning in 2014, health insurance issuers will be prohibited from denying coverage to any American because of a pre-existing condition, and from charging individuals and small employers higher premiums based on health status or gender. In addition, health insurance issuers will no longer be able to segment enrollees into separate rating pools in order to charge high-risk individuals more than low-risk individuals. These reforms, combined with other provisions in the Affordable Care Act, will improve the functioning of both the individual and small group markets and make health insurance affordable and accessible to millions of individuals and families who currently lack affordable coverage options.

The Department of Health and Human Services (HHS) published proposed standards to implement the 2014 market reform provisions of the Affordable Care Act and to amend the federal rate review program in a November 26, 2012 **Federal Register** proposed rule entitled “Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review” (77 FR 70584). These standards apply to health insurance issuers offering non-grandfathered health insurance coverage both inside and outside of the new competitive marketplaces called Affordable Insurance Exchanges, or “Exchanges.”

This final rule: (1) provides that health insurance issuers may vary the premium rate for health insurance coverage in the individual and small group markets only based on family size, geography, and age and tobacco use within limits; (2) directs health insurance issuers to offer

coverage to and accept every employer or individual who applies for coverage in the group and individual market, subject to certain exceptions; (3) directs health insurance issuers to renew or continue in force coverage in the group and individual market, subject to certain exceptions; (4) codifies the requirement that issuers maintain a single risk pool for the individual market and a single risk pool for the small group market (unless a state decides to merge the markets into a single risk pool); and (5) outlines standards for enrollment in catastrophic plans for young adults and people who cannot otherwise afford health insurance.

Finally, this rule amends the standards under the rate review program in 45 CFR part 154. The amendments revise the timeline for states to propose state-specific thresholds for review and approval by CMS. The amendments also direct health insurance issuers to submit data relating to proposed rate increases in a standardized format specified by the Secretary of HHS (the Secretary), and modify criteria and factors for states to have an effective rate review program. These changes are necessary to reflect the new market reform provisions discussed above and to fulfill the statutory requirement beginning in 2014 that the Secretary, in conjunction with the states, monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. The provisions are also designed to streamline data collection for issuers, states, Exchanges, and HHS.

The substantive authority for these final rules is generally sections 2701, 2702, 2703, 2723 and 2794 of the Public Health Service Act (PHS Act) and sections 1302(e), 1312(c), and 1560(c) of the Affordable Care Act. PHS Act section 2792 authorizes rulemaking as necessary or appropriate to carry out the provisions of title XXVII of the PHS Act, including sections 2701, 2702, 2703, 2723, and 2794. Section 1321(a) of the Affordable Care Act authorizes rulemaking

with respect to sections 1302(e), 1312(c), and 1560(c).

## **I. Background**

### A. Legislative Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was enacted on March 30, 2010. We refer to the two statutes collectively as the “Affordable Care Act” in this final rule.

Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to health insurance issuers in the group and individual markets and to group health plans that are non-federal governmental plans.<sup>1</sup> As relevant here, these PHS Act provisions include section 2701 (fair health insurance premiums), section 2702 (guaranteed availability of coverage), section 2703 (guaranteed renewability of coverage), and section 2794 (ensuring that consumers get value for their dollars). In addition, subtitle D of title I of the Affordable Care Act includes section 1302(e) (catastrophic plans) and section 1312(c) (single risk pool). These provisions will establish a federal floor that ensures individuals and employers in all states have certain basic protections with respect to the availability and affordability of health insurance coverage.

Section 2701(a)(1) of the PHS Act regarding fair health insurance premiums provides that the premium rate charged by a health insurance issuer for health insurance coverage offered

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<sup>1</sup> The Affordable Care Act also added section 715(a)(1) to the Employee Retirement Income Security Act of 1974 (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans other than non-federal governmental group health plans. The market reform provisions discussed in this final rule apply only to health insurance issuers offering health insurance coverage.

in the individual or small group market may vary with respect to a particular plan or coverage only based on the following factors: (1) whether the plan or coverage covers an individual or family; (2) rating area; (3) age (within a ratio of 3:1 for adults); and (4) tobacco use (within a ratio of 1.5:1). Section 2701(a)(2) directs each state to establish one or more rating areas and charges the Secretary with reviewing the adequacy of state-established rating areas. If the Secretary determines that a state's rating areas are not adequate, or that a state does not establish such areas, the statute authorizes the Secretary to establish rating areas for that state. Section 2701(a)(3) directs the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), to define permissible age bands for rating purposes. Section 2701(a)(4) provides that, for purposes of family coverage, any rating variation for age and tobacco use must be applied based on the portion of the premium attributable to each family member.

Section 2702 of the PHS Act directs a health insurance issuer offering health insurance coverage in the group or individual market in a state to accept every employer and individual in the state that applies for the coverage, subject to certain exceptions. These exceptions allow issuers to restrict enrollment in coverage: (1) to open and special enrollment periods as described in section 2702(b); (2) to employers with eligible individuals who live, work, or reside in the service area of a network plan as described in section 2702(c)(1)(A); and (3) in certain situations involving limited network capacity and limited financial capacity as described in section 2702(c)(1)(B) and (d).

Section 2703 of the PHS Act requires a health insurance issuer to renew or continue in force any coverage in the group or individual market at the option of the plan sponsor or the individual. Exceptions to this requirement described in section 2703(b) allow the issuer to

nonrenew or discontinue coverage for nonpayment of premiums, fraud, or violation of participation or contribution rules under state law. The law also permits an issuer to cease to offer either a particular type of product or all coverage in a particular market, to refuse to renew coverage if all of the plan's enrollees leave the service area of a network plan, or if group health plan coverage is provided through a bona fide association and the employer's association membership ends. Finally, an exception outlined in section 2703(d) permits a health insurance issuer, at the time of coverage renewal, to modify the coverage offered to a group health plan in the large group market, or in the small group market if, for coverage that is available in such market other than through one or more bona fide associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.<sup>2</sup>

Section 2701 applies to health insurance issuers offering health insurance coverage in the individual and small group markets, and in the large group market if a state, beginning in 2017, allows health insurance issuers in the large group market to offer qualified health plans (QHPs) in such market through an Exchange pursuant to section 1312(f)(2)(B) of the Affordable Care Act.<sup>3</sup> Sections 2702 and 2703 apply to issuers in the individual and group (small and large) markets. These provisions apply to health insurance coverage in the respective markets regardless of whether the coverage is a QHP offered on Exchanges. Section 1255 of the Affordable Care Act provides that sections 2701, 2702, and 2703 of the PHS Act are effective for plan years (in the individual market, policy years) beginning on or after January 1, 2014.<sup>4</sup>

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<sup>2</sup> Section 2742 of the PHS Act provides a corresponding exception for the uniform modification of coverage in the individual market.

<sup>3</sup> The applicable definitions for "individual market," "small group market," and "large group market" are found in PHS Act section 2791(e) and section 1304(a) of the Affordable Care Act.

<sup>4</sup> See 45 CFR 144.103 for definitions of "plan year" and "policy year." These terms are defined differently from

Section 1251(a)(2) of the Affordable Care Act provides that these PHS Act sections do not apply to grandfathered health insurance coverage.

Section 1302 of the Affordable Care Act specifies levels of coverage or “actuarial values” that health plans in the individual and small group markets, both inside and outside of an Exchange, will meet as part of the requirement to cover an essential health benefits (EHB) package beginning in 2014. These plans will provide a bronze, silver, gold, or platinum level of coverage as described in section 1302(d), or a catastrophic plan in the individual market as described in section 1302(e) for young adults and people who cannot otherwise afford health insurance.

Section 1312(c)(1) and (2) of the Affordable Care Act directs a health insurance issuer to consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer to be members of a single risk pool for a market (the individual market or small group market). Section 1312(c)(3) gives states the option to merge the individual and small group markets within the state into a single risk pool. Section 1312(c) applies to health plans offered both inside and outside of an Exchange for plan years (in the individual market, policy years) beginning on or after January 1, 2014. It does not apply to grandfathered health plans, and explicitly preempts state law requiring grandfathered health plans to be included in a single risk pool.

Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act, which directs the Secretary, in conjunction with the states, to establish a process for the annual review of “unreasonable increases in premiums for health insurance coverage.” The statute provides

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“plan year” and “benefit year” as defined in 45 CFR 155.20 with respect to QHPs.

that health insurance issuers must submit to the Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794(b)(2) also specifies that in plan years beginning in 2014, the Secretary, in conjunction with the states, shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. Section 2794 of the PHS Act does not, by its own terms, apply to grandfathered health insurance coverage or to self-funded plans. Regulations at 45 CFR 154.101(b) further limit the scope of review to small group and individual market coverage.

Section 1563 of the Affordable Care Act amended the Health Insurance Portability and Accountability Act of 1996 (HIPAA) enforcement provision that previously governed group health insurance coverage and non-federal governmental group health plans by expanding its scope to include individual health insurance coverage and by renumbering the provision as section 2723 of the PHS Act.

The preemption provisions of PHS Act section 2724(a)(1) apply so that the requirements of part A of title XXVII of the PHS Act are not to be “construed to supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of part A of title XXVII of the PHS Act. Section 1321(d) of the Affordable Care Act applies the same preemption principle to the requirements of title I of the Affordable Care Act.<sup>5</sup>

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<sup>5</sup> In addition, section 1252 of the Affordable Care Act provides that any standard or requirement adopted by a state pursuant to title I of the Affordable Care Act (or an amendment made by title I) must be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. Sections 1302(e) and 1312(c)

## B. Structure of the Final Rule

The regulations outlined in this final rule are codified in 45 CFR parts 144, 147, 150, 154, and 156. Part 144 outlines standards regarding the basis, scope, and applicability of 45 CFR Parts 144 through 148. Part 147 outlines standards for health insurance issuers in the group and individuals markets related to health insurance reforms. Part 150 outlines standards regarding enforcement. Part 154 outlines standards for health insurance issuers in the small group and individual markets with respect to rate increase disclosure and review. Part 156 outlines standards for issuers of QHPs, including with respect to participation in an Exchange.

## **II. Provisions of the Proposed Rule and Analysis and Responses to Comments**

HHS published standards under the statutory provisions discussed in section I.A. of the preamble in a November 26, 2012 **Federal Register** proposed rule entitled “Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review” (77 FR 70584). HHS received approximately 500 comment letters in response to the November 26, 2012 proposed rule. Commenters represented a wide variety of stakeholders, including states, tribal organizations, consumers, health insurance issuers, health care providers, employers, members of the public, and others. Additionally, HHS consulted with the NAIC through its Health Care Reform Actuarial (B) Working Group to define permissible age bands and consulted with and requested formal, written comments from tribal leaders and representatives about the provisions of this rule that impact tribes.

This section summarizes the provisions of the November 26, 2012 proposed rule and discusses and provides responses to the comments.

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of the Affordable Care Act and the amendments to PHS Act sections 2701, 2702, and 2703 are all found in title I of the Affordable Care Act.

## A. Part 144 – Requirements Relating to Health Insurance Coverage

### 1. Subpart A – General Provisions (§144.101 and §144.102)

HHS proposed technical changes in §144.101 and §144.102 to clarify enforcement of the health insurance reform requirements added by the Affordable Care Act and implemented in 45 CFR Part 147. In §144.102(c), HHS also proposed to clarify how to determine whether insurance coverage sold through associations is group or individual coverage under the PHS Act.

Comments received regarding HHS's enforcement processes and regarding bona fide associations are addressed in other sections of the preamble that we deemed to be more relevant to the substance of the comments.

Comment: Several commenters supported the clarifications proposed in Part 144. In particular, commenters supported the clarifications concerning coverage sold through associations, noting that they would ensure such coverage complies with the market reform protections of the Affordable Care Act.

Response: Based on the comments received, we are finalizing the proposed provisions in §144.101 and §144.102 of the proposed rule without modification.

Comment: A few commenters asked for clarification about how to determine whether a group policy should be treated as large group or small group coverage for purposes of applying the PHS Act requirements when employer group size fluctuates between the definition of large employer and small employer.

Response: We intend to issue future guidance on counting employees for determining market size of a group health plan.

B. Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Fair Health Insurance Premiums (§147.102)

Section 147.102 of this final rule implements section 2701 the PHS Act, which specifies that the only rating factors that may be used to vary premium rates for health insurance coverage in the individual and small group markets are (1) family size; (2) geographic rating area; (3) age (within a ratio of 3:1 for adults); and (4) tobacco use (within a ratio of 1.5:1).<sup>6 7</sup>

Comment: We received several comments requesting flexibility in the application of section 2701. For example, some commenters suggested that we allow states and issuers to phase in the premium rating rules, specifically the 3:1 age rating factor. One commenter recommended issuer flexibility to transition to the new per-member-rating methodology in states without community rating. Further, some commenters noted that small businesses in Massachusetts are permitted to form group health insurance purchasing cooperatives and receive premium discounts based on other factors that, while permitted by state law, were not explicitly included in the proposed rule.

Response: We do not have the legal authority to permit any rating factors in the final rule other than those explicitly permitted by section 2701 of the PHS Act. Further, we do not have

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<sup>6</sup> All non-grandfathered health insurance coverage offered through associations and through multiple employer welfare arrangements (MEWAs) is subject to the premium rating rules applicable to the appropriate market, as defined by PHS Act section 2791(e)(1), (3), and (5) (definitions of individual market, large group market, and small group market, respectively).

<sup>7</sup> The age, tobacco use, and geographic rating factors are multiplicative. For example, the maximum variation for age and tobacco use is 4.5:1 (3 times 1.5:1). The family rate calculation could be additive or multiplicative, depending on whether a per-member- or family-tier-rating methodology is used, as discussed later in this preamble.

the legal authority to provide for a phase-in of certain rating provisions such as the 3:1 age factor or the per-member-rating methodology.

a. Family Rating

In §147.102(c)(1), we proposed that issuers develop premiums for family coverage by adding up the rate of each covered family member.<sup>8</sup> Under this proposal, the rates of no more than the three oldest family members under age 21 would be taken into account in computing the family premium. There would be no cap on the number of family members age 21 and older whose per-member rates would be added into the family premium. We solicited comment on the number of family members that should be included in this rating cap, as well as the appropriate age limit for the cap.

We noted that rating based on specified family tiers, and other family rating practices that fail to apply the age and tobacco use factors proportionately to individual family members, would generally be impermissible pursuant to PHS Act section 2701(a)(4), which requires that any rating variation for age and tobacco use be apportioned to each family member's premium. However, in §147.102(c)(2), we proposed flexibility for community rated states that do not permit rating based on age or tobacco use to require issuers to use a standard family-tier methodology with corresponding multipliers. We solicited comment on whether instead of permitting such flexibility, states with pure community rating should also use the per-member approach that would be used in states that allow rating for age and tobacco use.

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<sup>8</sup> Under this approach, the issuer would charge the same per-member premium for all family members of the same age and tobacco use status. The issuer could not charge different rates for family members of the same age and tobacco use status based on their status, for example, as the policyholder, spouse, or dependent.

We noted that health insurance issuers currently have flexibility in determining how to set rates for family policies and in defining which family members may be on the same policy, subject to federal and state laws requiring coverage of certain individuals. We solicited comment on whether to set standards governing the minimum categories of family members that issuers must include in setting rates for family policies or to defer to states and issuers to make this determination. We also solicited comment on the types of individuals who are typically included under family coverage, including types of covered individuals who would not meet the classification of tax dependents under the Code.

Comment: Many commenters remarked on the proposed three-person rating cap for family members under age 21. Several commenters supported the cap, while some commenters expressed concern that it would increase rates for individuals and smaller families. Other commenters believed the cap would increase rates for larger families and requested that no more than two children under age 21 be rated for family coverage. Several commenters recommended clarifying that only the three oldest “dependent children” under age 21 would be taken into account in computing the family premium, so that policyholders and spousal dependents under age 21 would not be counted toward the three-person cap. Other commenters suggested raising the age limit for the cap to age 26, to better align with the rules regarding extension of dependent coverage under section 2714 of the PHS Act.

Response: The final rule maintains the cap at three persons, but clarifies that the cap applies only to the rates of no more than the three oldest “covered children” under age 21. This will mitigate premium increases for larger families accustomed to family tier rating structures and allow for more accurate rating of families with spouses under the age of 21. We maintain

age 21 as the age limit for the cap given that the medical risk associated with individuals between age 21 and 26 is higher than the risk associated with individuals under the age of 21. Further, this approach maintains consistency with our approach to child and adult rates for purposes of applying the age rating factor.

Comment: Many commenters supported the proposed per-member-rating methodology and the flexibility for states with community rating to require health insurance issuers to use a standard family-tier methodology with corresponding multipliers. Some commenters suggested that all states should have the option to use a family-tier structure, while other commenters supported applying per-member rating uniformly across all states, including those with community rating. A few commenters requested clarification of whether there is a limit on the number of family-tier categories permitted in community rated states.

Response: PHS Act section 2701(a)(4) compels per-member rating because the age and tobacco use factors must be attributable to individuals. Thus, only community rated states, which do not allow rating based on age or tobacco use, are able to implement family-tier-rating structures consistent with PHS Act section 2701(a)(4). Those states may require all health insurance issuers in the individual and small group markets to use a standard family-tier methodology with corresponding multipliers and will have the discretion to set the number of tiers in the family-tier structure. If a state has community rating but does not adopt a uniform family-tier structure (with corresponding multipliers), per-member rating will apply in that state.

Comment: Numerous commenters recommended that the final rule defer to the states (and to issuers if permitted by state law) on the categories of family members that must be included on a family policy, noting that state law typically provides the basis for defining

familial status. Other commenters urged that HHS adopt a broad definition of family coverage that accounts for all family compositions, including opposite sex and same sex domestic partners; biological, adoptive, step, foster, and grandchildren (if under the care of a grandparent); children under guardianship arrangements; and any other child who would be considered a tax dependent under the Code.

Response: The final rule does not specify the minimum categories of family members that must be rated together on a family policy. We recognize that state laws differ with respect to marriage, adoption, and custody and believe that states are best positioned to make decisions regarding family coverage practices. Accordingly, states have the flexibility to require issuers to include specific types of individuals on a family policy and nothing in these final rules precludes this ability. We note that if an individual is not eligible for family coverage, he or she will be able to purchase individual coverage on a guaranteed availability basis.

#### b. Small Group Rating

In §147.102(c)(3), we proposed that issuers in the small group market calculate rates for employee and dependent coverage on a per-member basis, and calculate the group premium by totaling the premiums attributable to each covered individual. States may require issuers to base small group premiums on an average amount for each employee in the group, provided that the total group premium equals the premium that would be derived through the per-member-rating approach. Furthermore, employers would retain flexibility to decide how to allocate employer contributions to health coverage.

Comments: Many commenters supported applying per-member rating in the small group market, especially in the Small Business Health Options Program (SHOP) where an “employee

choice” model would make composite rating difficult to administer. However, some commenters recommended allowing composite rating in the small group market outside the SHOP, and for “employer choice” coverage inside the SHOP where permitted, to minimize disruption in current issuer rating practices. Other comments raised concern that moving to per-member rating may increase premiums for older workers.

Response: The final rule directs that issuers use the per-member-rating methodology in the small group market. As discussed in the November 26, 2012 proposed rule, per-member rating assures compliance with the requirement that age and tobacco rating only be apportioned to an individual family member’s premium, enhances employee choice inside the SHOP, and promotes the accuracy of the risk adjustment methodology. Nothing in these final rules precludes a state from requiring issuers to offer (or a small employer from electing to offer) premiums based on average employee amounts where every employee in the group is charged the same premium. We note that the age bands, as implemented by the per-member-rating methodology, are only generally applicable to health insurance coverage in the individual and small group markets and are consistent with the Age Discrimination in Employment Act of 1967, 29 U.S.C. §621.

#### c. Geographic Rating

In §147.102(b), we proposed that each state establish rating areas, which would be presumed adequate if they meet one of the following options: one rating area for the entire state, or no more than seven rating areas based on counties, three-digit zip codes (that is, areas in which all zip codes share the same first three digits), or metropolitan statistical areas (MSAs) and

non-MSA geographic divisions.<sup>9</sup> We proposed that states would also be permitted to use other actuarially justified geographic divisions, or a number of rating areas greater than seven, with approval from HHS to ensure adequacy. In the event that states do not exercise the option to establish rating areas (or a state's rating areas were determined to be inadequate), we proposed that the default would be a single rating area for the entire state or one of the other proposed geographic standards as determined by HHS in consultation with the state, local issuers, and other interested stakeholders.

The November 26, 2012 proposed rule requested comment on various aspects concerning the proposed geographic rating area standards, namely comments concerning the use of other geographic divisions or factors; the maximum number of rating areas within a state that would be presumed adequate; whether states with existing rating areas would have to make changes to conform to the proposed standards; whether to establish minimum geographic size and population requirements; and the appropriate schedules and procedures for states to modify their rating areas in the future.

Comment: While some commenters supported the proposed rating area standards, many expressed concern that HHS would not extend a presumption of adequacy if a state established more than seven rating areas. Commenters asserted that the threshold of seven rating areas may not be high enough to reflect actuarially justified differences in health care costs and utilization patterns, particularly in states with large and diverse health care markets, and noted that issuers today use more than seven rating areas in some states. These commenters recommended that

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<sup>9</sup> MSAs encompass at least one urban core with a population of at least 50,000 people, plus adjacent territory that has a high degree of social and economic integration with the core. MSAs are always established along county boundaries, but may include counties from more than one state. The 367 MSAs in the United States include approximately one-third of the counties and 83 percent of the population of the United States.

states have flexibility to establish rating areas that reflect local market conditions and that minimize disruption. Others commenters were concerned about discrimination against rural, underserved, or high-cost populations.

Response: Following review of the comments submitted on this issue, we have determined that it is appropriate to modify the standards in §147.102(b) to provide states with additional flexibility to establish rating areas under section 2701 of the PHS Act. The revised standards recognize that in many cases, states established rating areas after an open and transparent dialogue with stakeholders. Further, the revised standards are intended to provide sufficient flexibility to states to establish rating areas that are responsive to local market conditions, while protecting consumers from potentially discriminatory rating practices.

Section 147.102(b)(3) of this final rule provides that a state's rating areas must be based on one of the following geographic divisions: counties, three-digit zip codes, or MSAs and non-MSAs, and will be presumed adequate if they meet either of the following conditions: (1) As of January 1, 2013, the state had established by law, rule, regulation, bulletin, or other executive action uniform geographic rating areas for the entire state; or (2) After January 1, 2013, the state establishes by law, rule, regulation, bulletin, or other executive action for the entire state no more geographic rating areas than the number of MSAs in the state plus one. Under these standards, geographic rating areas may be noncontiguous, but the area encompassed by a geographic rating area must be separate and distinct from areas encompassed by other geographic rating areas. As mentioned, rating areas must be based on counties, three-digit zip codes, or MSAs/non-MSAs. While we proposed the possibility that HHS might approve rating areas based on other existing geographic divisions, we have determined that these are the only geographic boundaries that

would be feasible for purposes of implementing the premium tax credit under Code section 36B. We note that if a state had established geographic rating areas on or before January 1, 2013 that did not follow these geographic boundaries, the state would have an opportunity to adjust their proposed rating areas before the default rating area is applied.

We recognize that a greater number of rating areas than the number of MSAs in the state plus one may in some cases be actuarially justified. Therefore, states have the option pursuant to §147.102(b)(4) of this final rule to seek approval from HHS of a greater number of rating areas as long as the areas are based on counties, three-digit zip codes, or MSAs and non-MSAs. We will review such state proposals to ensure they are actuarially justified and non-discriminatory as discussed below.

Comment: A few commenters requested that HHS specify the criteria it will use to assess the adequacy of state rating area proposals.

Response: As mentioned above, states may seek approval from HHS of a number of geographic rating areas that is greater than the number of MSAs in the state plus one, provided they are based on counties, three-digit zip codes, or MSAs/non-MSAs. HHS will review the state proposals pursuant to the criteria described in §147.102(b)(5) of this final rule. We will determine that a state's rating areas are adequate if they: (1) are actuarially justified; (2) are not unfairly discriminatory; (3) reflect significant differences in health care unit costs by rating area; (4) lead to stability in rates over time; (5) apply uniformly to all health insurance issuers in a market; and (6) are based on one of the geographic boundaries described above. We believe these are the appropriate criteria to ensure state rating areas are adequate and not designed to isolate high-cost populations of the state.

Comment: One commenter requested clarification as to whether PHS Act section 2701 prevents a state from setting limits on the permissible variation in a rating area factor.

Response: Section 2701 of the PHS Act does not limit the amount by which rates may vary based on geography. Therefore, states and issuers may determine the appropriate variation for the geographic rating area factor. We note, however, that a rating area factor should be actuarially justified to ensure that individuals and employers are not charged excessively high premiums that render meaningless the guaranteed availability protections of section 2702 of the PHS Act.

Comment: A few commenters requested clarification of whether states must apply geographic rating areas uniformly across the individual and small group markets in a state. Other commenters asked whether rating areas may vary by product, noting that provider contracting varies geographically between Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) plans, and also between broad and narrow networks.

Response: PHS Act section 2701 does not prevent a state from establishing different rating areas for the individual or small group markets. However, to preserve the integrity of the single risk pool requirement, rating areas must apply uniformly within each market and may not vary by product. If a state merges its individual and small group markets pursuant to section 1312(c) of the Affordable Care Act, rating areas will apply uniformly to both the individual and small group markets in the state.

Comment: Several commenters suggested that HHS should not establish minimum geographic size and population standards for rating areas. Commenters noted that geographic differences in health care costs are based on factors such as price, provider agreements,

utilization patterns, and access to care and technology—not based on size or population. By contrast, a few commenters argued minimum geographic size and population requirements were necessary to ensure that rating areas are not excessive in small or sparsely populated states.

Response: This final rule does not establish minimum geographic size or population requirements. We believe the geographic standards and criteria set forth in this final rule provide the appropriate basis for ensuring that state rating areas are actuarially justified and non-discriminatory.

Comment: A few commenters argued that states should have the flexibility to align rating areas with service areas to prevent issuer “cherry-picking” of service areas. Commenters expressed concern that if issuers are able to choose to write business in only the lower cost areas within geographic rating areas, there could be reduced competition and consumer access issues.

Response: While the final rule does not require that geographic rating areas be aligned with service areas, we recommend that states consider aligning both rating and service areas. As we noted in the March 27, 2012 **Federal Register** final rule entitled “Patient Protection and Affordable Care Act; Establishment of Exchange and Qualified Health Plans; Exchange Standards for Employers” (77 FR 18309), herein referred to as the Exchange final rule, Exchanges have flexibility on several elements of the QHP certification process, including the contracting model, so that Exchanges can appropriately adjust to local market conditions and consumer needs. To the extent issuers operate within such uniform service areas or operate statewide, this policy would facilitate consumers’ ability to compare health insurance premiums, promoting competition within the market. Furthermore, aligning rating areas with QHP service areas in the Exchange may simplify consumer understanding and Exchange administration of

eligibility determinations for premium tax credits, which may be complex if QHP service areas are highly individualized.

Comment: Many commenters expressed concern that applying a single statewide rating area as the default standard would not be appropriate in many states. Commenters suggested various alternatives, such as defaulting to county, three-digit zip code, or MSA boundaries; defaulting to existing state or issuer rating areas; or defaulting to the rating areas of the state's EHB base benchmark plan.

Response: Although the November 26, 2012 proposed rule suggested flexibility in applying either a single statewide rating area or another geographic standard as the default, in response to comments, we are modifying §147.102(b)(2) to specify that if a state does not establish rating areas (or does not provide information to CMS about such rating areas in accordance with the state reporting requirements discussed in section II.B.2. of the preamble), or a state's rating areas are determined to be inadequate, the default will be one rating area for each MSA in the state and one rating area for all other non-MSA portions of the state, as defined by the Office of Management and Budget (<http://www.census.gov/population/metro/data/def.html>). We believe MSA/non-MSA designations will sufficiently reflect actuarially justified differences in health care unit costs by geography and ensure rating areas are established timely, providing certainty to issuers. We encourage states to establish rating areas as soon as possible but not later than 30 days following publication of this final rule.

Comment: With respect to the process for updating state-established rating areas, several commenters suggested that states have flexibility to periodically review and modify their geographic rating areas (including default rating areas) as necessary or appropriate. Some

commenters suggested that rating areas be reviewed on a regular basis, such as annually or biannually, while other commenters suggested less frequent reviews, subject to the discretion of the states. Several commenters noted that insurance products and rates are often developed a year or more in advance and emphasized that issuers must be given adequate time to incorporate any changes to rating areas into their pricing.

Response: As discussed in section II.B.2. of the preamble, §147.103 of this final rule provides for the Secretary to issue guidance that will establish a process and timeline for states to update their rating areas (including default rating areas). HHS anticipates this process will provide sufficient notice to health insurance issuers in advance of state rate filing deadlines.

#### d. Age Rating

In 147.102(a)(1)(iii), we proposed that the premium rate charged by a health insurance issuer for non-grandfathered health insurance coverage in the individual or small group market may vary by age, except that such rate may not vary by more than 3:1 for adults, as set forth by the statute. We proposed to define adults as individuals age 21 and older for purposes of this provision. For individuals under age 21, we proposed that rates must be actuarially justified based on a standard population. Further, we proposed that an enrollee's age for rating purposes be determined at the time of policy issuance and renewal and requested comment on whether other measurement points, such as birthdays, were appropriate.

After consulting with the NAIC, we proposed the following standard age bands for use in all states and markets subject to section 2701 of the PHS Act:

- Children: A single age band for children ages 0 through 20.
- Adults: One-year age bands for adults ages 21 through 63.

- Older adults: A single age band for adults ages 64 and older.

We solicited comment on the proposed age bands, including comment on whether single or multiple age bands for children were appropriate.

Finally, we proposed that health insurance issuers in a state and market use a uniform age rating curve established by the state, specifying the relative distribution of rates across all age bands. We proposed an HHS standard default age curve that would apply in both the individual and small group markets in states that do not exercise the option to establish their own age curve. We requested comment on the default age rating curve, including comment on the premium impact of the transition from the child age curve to the adult age curve.

Comment: Many commenters supported applying the maximum 3:1 age rating factor to adults defined as individuals age 21 and older. Some commenters, however, recommended defining the adult age as beginning at age 19 to better align with the definition of “pediatric services” in the November 26, 2012 **Federal Register** proposed rule entitled “Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation” (77 FR 70644), herein referred to as the EHB/AV/Accreditation proposed rule. Other commenters recommended that adult rating begin at age 26, consistent with the rules regarding dependent coverage of children to age 26 under section 2714 of the PHS Act.<sup>10</sup> Several commenters suggested we allow issuers to develop rates for individuals age 65 and older outside of the 3:1 age rating factor due to the higher health care costs associated with this population.

Response: We are finalizing the proposed requirement that the maximum 3:1 ratio for

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<sup>10</sup> 45 CFR 147.120.

age rating applies to adults age 21 and older. PHS Act section 2701(a)(1)(A)(iii) provides that age rating with respect to adults must be consistent with section 2707(c) relating to child-only plans available to individuals up to age 21. Accordingly, the 3:1 age rating factor applies to all individuals age 21 and older, including those who may be eligible for Medicare based on age. The 3:1 age factor ratio does not apply to individuals under age 21.

Comment: Nearly all commenters expressed support for the proposal to establish single-year age bands for adults age 21 through 63. However, some commenters suggested that multiple age bands for children were necessary to reflect the fact that claims costs for children vary by age, particularly children age 0 to 1, who have much higher health care costs than older children.

Response: The final rule maintains a single age band for children to keep rates level between ages 0 through 1 and ages 2 through 20. This will avoid higher premiums for newborns and provide for easier price comparisons between different plans. A single band for children also simplifies and promotes efficiency of the risk adjustment methodology.

Comment: Most commenters supported determining an enrollee's age for rating purposes once a year at the time of policy issuance or renewal. Commenters stated that such annual determination is generally consistent with current issuer rating practices, helps enrollees to understand and plan for rate increases, and promotes administrative efficiency for issuers. In instances where a family member is added to a family policy or an employee is added to a group health plan outside of policy issuance or renewal, a few commenters requested issuer flexibility to apply an age rating factor based on the new enrollee's age at the time of enrollment.

Response: Based on the comments received, we are finalizing the provision that for rating purposes an enrollee's age be determined at the time of policy issuance or renewal. We clarify that for individuals who are added to the plan or coverage other than on the date of policy issuance or renewal, the enrollee's age may be determined as of the date such individuals are added or enrolled in the coverage.

Comment: A few commenters requested state flexibility to use different age-band structures, such as five-year bands in the small group market. One commenter specifically recommended that states operating their own risk adjustment programs should have flexibility to establish age bands and to determine whether they must be standardized across a market. Other commenters urged HHS to apply the same age-band structure to both the individual and small group markets to align more closely with per-member rating, minimize rate disruption when individuals move between the two markets, and facilitate states' ability to merge the individual and small group markets into a single risk pool if they determine it appropriate.

Response: The uniform age bands in this final rule apply in all states and markets subject to section 2701 of the PHS Act: the individual and small group markets in all states, and the large group market in states that, beginning in 2017, permit health insurance issuers in the large group market to offer QHPs in such market through an Exchange. Applying age bands consistently nationwide simplifies identification of the second lowest cost silver plan for calculation of the premium tax credit under Code section 36B. As indicated below, states are welcome to establish their own age rating curve provided the curve incorporates the uniform age bands. A state may establish separate age curves for the individual and small group markets.

Comment: With respect to HHS's proposed default standard age curve, several

commenters recommended smoothing the age curve to avoid a significant premium differential between the child age curve at age 20 and the adult age curve at age 21, while another commenter recommended smoothing the age curve for older adults. One commenter suggested that issuers should have flexibility to set their own age curves. Another commenter supported the default age rating curve as proposed, suggesting that it will enhance the transparency, predictability, and accuracy of risk adjustment. A few commenters urged that HHS not make frequent changes to the default age curve and that issuers be provided sufficient time to respond to any updates.

Response: As we stated in the November 26, 2012 proposed rule, the 0.635 age rating factor for children age 0 through 20 is supported by HHS's analysis of data available through HealthCare.gov and an examination of the large group insurance market. Although the shift from the child age curve to the adult age curve could result in a premium differential that is not reflected in current issuer rating practices, we do not believe the differential will result in a significant financial burden on consumers, given the low premiums for individuals in these age groups, as well as the relative premium stability from ages 21 through 30.

HHS will establish in guidance a default age rating curve that will apply in both the individual and small group markets in states that do not exercise the option to establish their own age curve (or that do not provide information to CMS about their age curve in accordance with the state reporting requirements discussed in section II.B.2. of the preamble). We intend to adopt in guidance the default age curve as proposed in the November 26, 2012 proposed rule for states that allow a maximum 3:1 ratio for age rating. For states that adopt narrower ratios for age rating, the default age curve established by HHS would take into account the permissible rating

variation for age under state law. We intend to revise the default age curve periodically, but no more frequently than annually, to reflect market patterns in the individual and small group markets following implementation of the 2014 market reforms.

Comment: One commenter requested clarification of whether issuers may establish their own, actuarially justified child age factor based on a standard population, rather than using the 0.635 child age factor in the HHS default standard age curve.

Response: Health insurance issuers within a market and state must use the uniform age rating curve established by each state or the HHS default standard age curve in instances where a state does not establish a uniform age curve, specifying the relative distribution of rates for all age bands, including the child age band. As discussed in the November 26, 2012 proposed rule, the age factor associated with the child age band must be actuarially justified based on a standard population.

Comment: A few commenters asked HHS to clarify how age rating applies to child-only plans. For example, some commenters requested clarification that the child age band and age curve apply only to dependent children on family policies, not to children enrolled in child-only plans.

Response: The child age band and child age curve apply to child-only plans in the same manner that they apply to all other individual and small group market coverage. Thus, for example, a 10-year-old child would be charged the same rate based on age whether the child was a dependent on a family policy or enrolled in a child-only plan.

#### e. Tobacco Rating

In §147.102(a)(1)(iv), we proposed that the premium rate charged by a health insurance

issuer for non-grandfathered health insurance coverage offered in the individual or small group market may vary for tobacco use, except that such rate may not vary by more than 1.5:1, as set forth by the statute. States or issuers would have flexibility within these limits to determine the appropriate tobacco rating factor for different age groups (for example, younger enrollees could be charged a lower tobacco use factor than older enrollees provided the tobacco use factor does not exceed 1.5:1 for any age group).

Further, we proposed to coordinate application of the tobacco rating rules of PHS Act section 2701 with the nondiscrimination and wellness program rules of PHS Act section 2705. Specifically, we proposed that a health insurance issuer in the small group market would be required to offer a tobacco user the opportunity to avoid paying the full amount of the tobacco rating factor permitted under PHS Act section 2701 if he or she participates in a wellness program meeting the standards of section 2705 of the PHS Act and its implementing regulations.<sup>11</sup> We solicited comment on this proposal and on whether and how the same wellness incentives promoting tobacco cessation could apply in the individual market.

We proposed that the definition of “tobacco use” for purposes of section 2701 be consistent with the approach taken with respect to health-contingent wellness programs designed to prevent or reduce tobacco use under section 2705. We noted that a common definition of “tobacco use” does not currently exist among the states, resulting in wide variation in how health insurance issuers define and assess tobacco use in insurance applications. We solicited comment

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<sup>11</sup> The Departments of HHS, Labor, and the Treasury published proposed rules under PHS Act section 2705 entitled “Incentives for Nondiscriminatory Wellness Programs in Group Health Plans” in the November 26, 2012 **Federal Register** (77 FR 70620). The rules proposed that the additional increase in the size of the reward for wellness programs designed to prevent or reduce tobacco use would not be limited to the small group market, to provide consistency across markets and to provide large group, self-insured, and grandfathered employment-based plans the same additional flexibility to promote tobacco-free workforces as small, insured non-grandfathered health plans.

on how to define “tobacco use” for purposes of both section 2701 and section 2705 and suggested several possible approaches, such as reliance on self-reporting, a defined amount of tobacco use within a specified look-back period, regular tobacco use, or tobacco use of sufficient frequency so as to be addicted to nicotine. We also solicited comment on use of the single streamlined application under 45 CFR 155.405 to collect information on tobacco use.

Comments: Numerous commenters supported establishing a clear definition and standard application questions to determine tobacco use. Commenters stated that in defining tobacco use, it would be important for HHS to specify the types of tobacco products that would be included, establish a minimum frequency of usage, define the appropriate look-back period, and clarify permissible assessment methods. For example, some commenters recommended a broad definition that includes any form of tobacco use in the past 12 months, while other commenters suggested considering only the most common types of tobacco products used within a 30-day look-back period. Additionally, some commenters recommended relying on self-reporting, while other commenters sought flexibility for issuers to use additional methods to verify accuracy and prevent fraud, such as cotinine testing, attestations, health assessments, and physician affidavits. Several commenters urged HHS to consult with experts and use planned consumer testing of the single streamlined application to develop precise and narrow language and questions about tobacco use. A few commenters representing tribal organizations suggested that a uniform definition of tobacco use include an express exemption for religious and ceremonial uses. One commenter suggested that states have flexibility to determine what constitutes tobacco use.

Response: The National Health Interview Survey, administered by the Centers for

Disease Control and Prevention, asks survey respondents if they use tobacco products “every day, some days, or not at all?”<sup>12</sup> In this final rule, we establish a definition of “tobacco use” that is based on the National Health Interview Survey, while setting forth the meaning of “some days” to ensure clarity for issuers and consumers. Specifically, for purposes of this final rule, we define “tobacco use” as use of tobacco on average of four or more times per week within no longer than the past six months. Further, tobacco use must be defined in terms of when a tobacco product was last used. Tobacco includes all tobacco products. However, religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives) are specifically exempt under this final rule. This approach establishes a minimum standard to assure consistency in the individual and small group health insurance markets and simplifies administration of the tobacco rating factor. For example, an individual could be asked the following two questions about tobacco use: (1) Within the past six months, have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial uses)? (2) If yes, when was the last time you used tobacco regularly? Issuers will have flexibility within the federal definition and as permitted by applicable state law to shorten the applicable period of time from the last regular use of tobacco. Because “four or more” as well as “six months” are federal thresholds, states have the ability to define both the frequency of use per week and the look-back period in ways that are more consumer protective (that is, a frequency of more than four times per week and a look-back period of less than six months). This definition is transitional. We intend to consult with experts, use experience with the above definition, and study the interaction effects with the permanent risk adjustment program to develop a more

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<sup>12</sup> Centers for Disease Control and Prevention, Cigarette Smoking Among Adults – United States, 1992, and Changes in the Definition of Current Cigarette Smoking, MMWR Weekly 43(19); 342-346, May 20, 1994.

evidenced-based definition of tobacco use through future rulemaking or guidance. We also intend to conduct consumer testing of language and questions about tobacco use.

Comment: Several commenters requested additional consequences for individuals who fail to disclose tobacco use during the application process, such as allowing issuers to collect additional premiums or other penalties, to rescind the policy in the case of intentional misrepresentation or fraud, and to determine the individual to be ineligible for certain enrollment periods. In addition, commenters suggested there should be clear and prominent warnings to applicants about the consequences of failing to answer questions about tobacco use truthfully.

Response: If an enrollee is found to have reported false or incorrect information about their tobacco use, the issuer may retroactively apply the appropriate tobacco use rating factor to the enrollee's premium as if the correct information had been accurately reported from the beginning of the plan year. However, an issuer must not rescind the coverage on this basis. Tobacco use is not a material fact for which an issuer may rescind coverage if there is a misrepresentation because these regulations already provide the remedy of recouping the tobacco premium surcharge that should have been paid since the beginning of the plan or policy year. Accordingly, it is the view of the Department of HHS, Labor, and the Treasury (which share interpretative jurisdiction over section 2712 of the PHS Act) that this remedy of recoupment renders any misrepresentation with regard to tobacco use no longer a "material" fact for purposes of rescission under PHS Act section 2712 and its implementing regulations.<sup>13</sup> Additionally, under guaranteed availability of coverage rules, an issuer may not deny an enrollee or their covered dependents an enrollment period described in this final rule because an enrollee

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<sup>13</sup> 26 CFR 54.9815-2712T, 29 CFR 2590.715-2712, and 45 CFR 147.128.

provided false or incorrect information about their tobacco use.

Comments: Several commenters remarked on the proposed rules concerning tobacco rating and wellness programs in the small group market. Some commenters objected to the rules, arguing that participation in a tobacco cessation program does not necessarily result in an actual reduction in the specific financial risk associated with tobacco use, and that issuers need to be able to rate for the higher expected claims costs of tobacco users. Several other commenters supported the proposed link between tobacco rating and wellness programs, noting that tobacco cessation programs are more effective in addressing tobacco use than a premium surcharge, and suggesting that the rules should be expanded to include participation in a broader array of tobacco cessation programs offered outside of one's workplace, including in the individual market.

Response: We finalize our proposal that a health insurance issuer in the small group market may impose the tobacco rating factor under section 2701 only in connection with a wellness program meeting the requirements under section 2705, allowing a tobacco user the opportunity to avoid paying the full amount of the tobacco rating factor by participating in a wellness program meeting the standards of section 2705(j) and its implementing regulations. We note that wellness rules already apply in the group market. Additionally, the use of tobacco cessation programs may help alleviate underreporting of tobacco use. Pursuant to section 2701(a)(5) of the PHS Act, these rules will apply to coverage offered in the large group market in a state that, beginning in 2017, allows health insurance issuers to offer QHPs in such market through an Exchange.

Comment: Some commenters supported the proposal allowing issuers to vary tobacco

rating by age. Other commenters suggested that tobacco rating should apply only with respect to individuals age 18 and older, the age at which people can begin to legally use tobacco products in most states. Other commenters expressed concern that tobacco rating would disproportionately impact low-income populations and recommended that HHS prohibit tobacco rating altogether.

Response: PHS Act section 2701 permits rating for tobacco use within a ratio of 1.5:1. While we do not have authority to prohibit the imposition of the 1.5:1 tobacco rating factor, we agree that tobacco rating should be limited to legal use of tobacco products under federal and state law, which generally is limited to those 18 years and older. We clarify our interpretation in the final rule. Consistent with these rules and subject to applicable state law, issuers will have the flexibility to vary tobacco rating by age, provided the tobacco use factor does not exceed 1.5:1 for any age band.

Comment: Several commenters sought clarification that states may require a narrower ratio than 1.5:1 for tobacco use or prohibit tobacco rating altogether.

Response: Pursuant to section 2724(a)(1) of the PHS Act, a state law with respect to health insurance issuers is not preempted unless it prevents the application of a federal requirement. Section 2701 provides that the premium rate charged by a health insurance issuer in the individual or small group market cannot vary for tobacco use by more than 1.5:1. Therefore, a state law that prescribes a narrower ratio (for example, 1.25:1) or prohibits varying rates for tobacco use altogether would not be preempted, since such law would not prevent the application of section 2701. Because states may generally impose requirements on health insurance issuers that are more consumer protective than those imposed by federal law, the language in proposed §147.102(a)(1)(iv) providing that states may use narrower tobacco rating

factors is unnecessary, and we remove it from the final rule. (We make parallel revisions in proposed §147.102(a)(1)(iii) with respect to state laws that use narrower age rating factors).

## 2. State Reporting (§147.103)

In various provisions throughout proposed §147.102, we proposed that no later than 30 days after publication of the final rule, states submit certain rating information to CMS generally to support the accuracy of the risk adjustment methodology. This included information about the following, as applicable:

- The use of a narrower age rating ratio than 3:1 for adults age 21 and older.
- The use of a narrower tobacco rating ratio than 1.5:1 for individuals who use tobacco.
- State-established rating areas.
- State-established age rating curves.
- In states with community rating, the use of uniform family tiers and corresponding multipliers.
- A requirement that premiums be based on average enrollee amounts in the small group market.

In addition, in §156.80(c), we proposed that a state inform CMS of its decision to merge the individual and small group markets in a state into a single risk pool.

We received no comments about the proposed reporting process. Accordingly, we are finalizing the state reporting process as proposed. However, for organization and clarity, we are consolidating these reporting requirements in a new §147.103 of this final rule. Section 147.103(a) provides that for the 2014 plan or policy year, states will submit information no later than 30 days following publication of the final rule, in a form and manner specified by the

Secretary. Section 147.103(b) provides for the Secretary to issue future guidance that would establish a process and timeline for states to submit information for plan or policy years after 2014 (or for updating a state standard that applies in 2014). As described in §156.80(c), states will follow the same process with respect to a state decision to merge the individual and small group markets in a state into a single risk pool.

### 3. Guaranteed Availability of Coverage (§147.104)

In §147.104, we proposed that a health insurance issuer offering health insurance coverage in the individual or group market in a state must offer to any individual or employer in the state all of the issuer's products that are approved for sale in the applicable market, and accept any individual or employer that applies for those products.<sup>14</sup> Consistent with other consumer protection rules under the Affordable Care Act, we proposed that this requirement include non-grandfathered closed blocks of business and solicited comment on our proposal.

We also proposed that issuers establish enrollment periods during which they would allow individuals and employers to purchase health insurance coverage. We proposed to align the initial and annual open enrollment periods outside the Exchanges with those inside the Exchanges. Specifically, we proposed a continuous open enrollment period in the group market and a fixed open enrollment period in the individual market based on a calendar policy year, consistent with the Exchange and SHOP standards outlined in 45 CFR 155.410 and 155.725. Effective dates of coverage would also follow those in the Exchange and SHOP. We solicited comment on how to address the open enrollment needs of individual market enrollees whose

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<sup>14</sup> Other federal laws may restrict the health insurance coverage products available to certain individuals. For example, individuals must meet certain requirements related to residency, citizenship/immigration status, and non-incarceration in order to buy QHPs through an Exchange (45 CFR 155.305(a)).

coverage renews on a non-calendar year basis.

We proposed that issuers in the individual and group markets establish special enrollment periods for individuals and plan participants and beneficiaries to enroll in coverage outside of the annual open enrollment period as a result of qualifying events triggering eligibility for COBRA continuation coverage under section 603 of ERISA.<sup>15</sup> These special enrollment periods are in addition to those in section 2704(f) of the PHS Act and other federal law.

We proposed that a participant, beneficiary, or enrollee would have 30 calendar days from the date of a qualifying event (generally consistent with the HIPAA standard) to request special enrollment, but invited comment on whether to establish a longer election period, such as 60 calendar days (generally consistent with the Exchange standard). We proposed special enrollment period effective dates that followed the effective dates of coverage for QHP special enrollment periods in §155.420(b). We noted that a notice of special enrollment rights is currently required to be provided to group health plan participants and beneficiaries under HIPAA and solicited comment on whether issuers in the individual market should provide a similar notice to individual market enrollees.

Additionally, we proposed rules governing the circumstances under which issuers are permitted to deny coverage to individuals and employers. These rules would allow issuers to deny coverage to an employer whose eligible individuals do not live, work, or reside in the

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<sup>15</sup> For employees, COBRA events include a loss of coverage due to voluntary or involuntary termination of employment for reasons other than gross misconduct and reduction in the number of hours of employment. For spouses of covered employees, these events include a loss of coverage due to reasons that would make the employee eligible for COBRA, the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee. For children of covered employees, these events include a loss of coverage due to reasons that would make the employee eligible for COBRA, the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, death of the covered employee, and loss of dependent child status under plan rules.

service area of a network plan (or to an individual who does not live or reside in the service area of a network plan) and in certain situations involving limited network capacity and limited financial capacity.

We also proposed that issuers in the small group market would be permitted to require small employers to satisfy minimum contribution or group participation requirements, to the extent allowed by state law or, in the case of a QHP offered in the SHOP, as permitted by §156.285(c), and to decline to offer coverage if these standards were not met. This policy was intended to prevent adverse selection. Specifically, we were concerned that a small employer could take advantage of the continuous open enrollment opportunity under the proposed rule to wait to purchase a group policy.

We also addressed the issue of whether there could be an exception from the guaranteed availability requirements allowing coverage sold through bona fide associations to be limited to members of the association. We contrasted the existing provisions in section 2703(b) (which retained a guaranteed renewability exception permitting coverage to be limited to members of a bona fide association) with the provisions in section 2702 (where the exception had not been included in the statute), and proposed that there was no basis for an exception from the guaranteed availability requirement for coverage sold through bona fide associations. We invited comment, however, on whether and how a transition or exception process for bona fide association coverage could be structured to minimize disruption.

To ensure consistency in the marketing of health plans inside and outside of the Exchange and to minimize adverse selection, we proposed to extend to the entire health insurance market the Exchange marketing standard applicable to QHPs under §156.225. This

standard requires that an issuer comply with state marking standards and not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage.

Finally, we solicited comment about how to prevent potential gaming of guaranteed availability rights and about strategies to minimize the risk of adverse selection.

Comment: Several commenters asked that the term “offer” in section 2702 be interpreted to mean “actively marketed,” so that issuers would not be required to reopen closed blocks of business. Commenters expressed concern about having to develop enrollment materials for closed products. In addition, some commenters were concerned that this requirement would make it difficult for issuers to bring existing products into compliance with the Affordable Care Act in a manner that minimizes consumer confusion, and ultimately prompt some issuers to terminate closed products. Some commenters argued that the requirement is not necessary because starting in 2014, individuals will have choices beyond closed blocks, alleviating many of the concerns about closed blocks in today’s market. Other commenters requested flexibility for states to determine the best policy for addressing closed blocks.

Response: Section 2702 provides that each health insurance issuer that offers health insurance coverage in the group or individual market in a state must accept every employer or individual in the state that applies for such coverage. We have interpreted the term “offer” as used throughout the title XXVII requirements of the PHS Act as added by the Affordable Care Act (which apply to “a health insurance issuer offering health insurance coverage”) to refer to an issuer offering both new as well as existing coverage. Accordingly, this final rule does not interpret the term “offer” in section 2702 to mean “actively marketing.” We note that while this

provision requires an issuer to accept any individual or employer that applies for coverage, it does not require closed blocks to be actively marketed. Furthermore, we clarify that only non-grandfathered plans are subject to guaranteed availability.

Comment: Several commenters remarked on the application of the guaranteed availability requirements to coverage sold through bona fide associations.

Response: We refer readers to section II.F.2. of the preamble for discussion of this issue.

Comment: We received a few comments about the proposal that issuers would be allowed to decline to offer coverage to small employers for failure to satisfy minimum contribution or group participation requirements under state law or the SHOP standards. Several commenters expressed support for the policy and recommended extending it to the large group market. One commenter emphasized that minimum participation and contribution standards must be reasonable and not burdensome to the point that small employers are discouraged from offering coverage.

Response: Upon further consideration of this issue, we have determined that small employers cannot be denied guaranteed availability of coverage for failure to satisfy minimum participation or contribution requirements. As in the case of the bona fide association exception discussed above, while Congress left in place an exception for failure to meet contribution or participation requirements under the guaranteed renewability requirement in section 2703(b), it provided no such exception from the guaranteed availability requirement in section 2702. To the contrary, language in the guaranteed availability provision for group health plans that was in place before the Affordable Care Act was not included in section 2702. Accordingly, the proposed approach would conflict with the guaranteed availability provisions in section 2702 of

the PHS Act. Moreover, permitting issuers to deny coverage altogether to a small employer with between 50 and 100 employees based on a failure to meet minimum participation or contribution requirements could subject such employer to a shared responsibility payment under section 4980H of the Code for a failure to offer coverage to its employees.

While section 2702 contains no exception to guaranteed availability based on a failure to meet contribution or minimum participation requirements, section 2702(b)(1) permits an issuer to limit enrollment in coverage to open and special enrollment periods. Under our authority in section 2702(b)(3) to define “open enrollment periods,” we are providing in this final rule that, in the case of a small employer that fails to meet contribution or minimum participation requirements, an issuer may limit its offering of coverage to an annual open enrollment period, which we set forth in this final rule as the period beginning November 15 and extending through December 15 of each year. As such, the group market will have continuous open enrollment, except for small employers that fail to meet contribution or minimum participation requirements, for which the enrollment period may be limited to the annual enrollment period described above, from November 15 through December 15. This approach addresses concerns about adverse selection in a manner that is consistent with the statutory provisions. We do not extend this provision to the large group market because large employers generally do not present the same adverse selection risk as small employers.

Comment: Several commenters voiced concerns about the potential for individuals with histories of non-payment to game guaranteed availability. Some commenters suggested that we take action to both prevent individuals with histories of non-payment from taking advantage of guaranteed availability and to prevent individuals from dropping in and out of coverage based on

medical need. Other commenters, including the NAIC, recommended that states have the flexibility to develop an environment that will discourage adverse selection and suggested that there are a number of tools available to states to limit adverse selection. Some of the tools identified by commenters included: (1) allowing issuers to require pre-payment of premiums each month; (2) allowing issuers to require payment of all outstanding premiums before enrollees can re-enroll in coverage after termination due to non-payment of premiums; (3) allowing late enrollment penalties or surcharges (similar to those in Medicare Parts B and D); (4) allowing issuers to establish waiting periods or delayed effective dates of coverage; (5) allowing issuers to offset claims payments by the amount of any owed premiums; (6) allowing issuers to prohibit individuals who have canceled coverage or failed to renew from enrolling until the second open enrollment period after their coverage ceased (unless they replace coverage with other creditable coverage); (7) restricting product availability (for example, to a catastrophic, bronze, or silver level plan) outside of enrollment periods to prevent high-risk individuals from enrolling in more generous coverage when medical needs arise; and (8) allowing individuals to move up one metal level each year through the Exchange shopping portal.

Response: We appreciate the various strategies suggested by commenters and agree that states have flexibility to implement policies to address adverse selection. We encourage states to consider approaches to discourage adverse selection while ensuring consumers' guaranteed availability rights are protected since state policies that limit guaranteed availability are preempted by this law. We intend to address permissible strategies to limit adverse selection in future guidance.

Comment: Several commenters suggested that the language in proposed §147.104(e),

which prohibits marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage, be broadened to apply to all forms of discrimination prohibited by the March 27, 2012 Exchange final rule and section 1557 of the Affordable Care Act, such as discrimination based on age, disability, race, ethnicity, gender, and sexual orientation, not just discrimination against individuals with significant or high cost health care needs. One commenter urged HHS to provide guidance about marketing practices and benefit designs that would be considered discriminatory under this standard. Another commenter asked HHS to remind states of their responsibility to monitor issuer marketing practices.

Response: As noted in the November 26, 2012 proposed rule, discriminatory marketing practices or benefit designs represent a failure by issuers to comply with the guaranteed availability requirements. In response to comments, we revise §147.104(e) of this final rule to make clear that a health insurance issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals in health insurance coverage based on these factors. This standard will ensure consistency with the prohibition on discrimination with respect to EHB in §156.125, the non-discrimination standards applicable to QHPs under §156.200(e), and the marketing standards in §156.225.

Comment: Numerous commenters expressed support for aligning open enrollment periods inside and outside of the Exchange to promote consistency between markets and minimize the potential for adverse selection. However, some commenters were concerned that establishing open enrollment periods and effective dates of coverage in the individual market

based on a calendar policy year would not align with many individual policies, which are currently offered on a non-calendar-year basis. Commenters suggested various approaches to resolving the transition, such as providing to individuals whose coverage renews mid-2014 a one-time special enrollment period to purchase coverage that complies with 2014 market reform provisions; requiring individuals whose coverage begins on a date other than January 1 to re-enroll during the next open enrollment period; and allowing a rating adjustment for individual health insurance policies covering less than a full year to reflect that fact that enrollees will have less than 12 months to reach the annual deductible. Other commenters recommended that states have flexibility to set their open enrollment periods and effective dates.

Response: We maintain the proposed open enrollment periods in §147.104(b)(1) of this final rule. We believe that consistent open enrollment periods will help minimize adverse selection between the Exchanges and the outside market, reduce consumer confusion, and allow issuer marketing to be focused on a single enrollment campaign. Rolling open enrollment periods with individual-specific dates, by contrast, would add complexity for families and increase risk selection. We agree with commenters that a one-time open enrollment period will allow individuals with non-calendar year plans to transition to a calendar-year plan upon their renewal date in 2014 and provide for such enrollment opportunity as discussed below. States may wish to consider other strategies to ease the transition, such as directing issuers to pro-rate premiums for policies covering less than a full year, among other transitional measures.

Comment: One commenter noted that his state currently allows individuals to purchase individual health insurance coverage on a guarantee-issue basis at any time during the year and requested clarification as to whether state standards would be preempted by the federal

standards. Another commenter urged HHS to ensure that issuers apply consistent rules when offering coverage outside of open enrollment. The commenter expressed concern that some issuers would attempt to employ selective marketing practices designed to attract low-risk individuals (for example, for enrollment in catastrophic plans).

Response: Section 2724(a)(1) of the PHS Act provides that nothing in part A or part C of title XXVII of the PHS Act should be construed to preempt any state law that does not prevent the application of a federal requirement. Therefore, these final rules do not preclude the application of stronger consumer protections provided by state law including, for example, open enrollment periods that allow individuals to purchase coverage more frequently than the federal standards. We note that if a health insurance issuer in the individual market allows for enrollment outside of an open or special enrollment period, the issuer must still comply with all of the individual market provisions of the PHS Act, including the prohibition against pre-existing condition exclusions and the prohibition against discrimination based on health status. An issuer cannot selectively offer enrollment in a plan to individuals outside of open or special enrollment periods in a manner that discriminates among individuals based on a pre-existing medical condition or health status.

Comment: A number of commenters recommended providing additional special enrollment periods to those described in proposed §147.104(b)(2), which incorporated the special enrollment periods for COBRA qualifying events under section 603 of ERISA. Specifically, several commenters recommended adding the guaranteed renewability exceptions in §147.106(b) through (d), for which an enrollee experiences a loss in coverage through no fault of their own, as explicit triggers permitting special enrollment. A few commenters

recommended including special enrollment periods for pregnancy. One commenter suggested providing a special enrollment period when individuals permanently move into the issuer's service area, consistent with the Exchange standard.

Response: We agree that it is appropriate to provide additional enrollment opportunities for individuals experiencing certain significant life changes, including several of those suggested by commenters. To provide consistency across the individual market, we believe these events should follow the special enrollment periods for individuals seeking coverage through the Exchanges, as described in the March 27, 2012 Exchange final rule. Because PHS Act section 2702 provides for "special" enrollment periods for "qualifying events" under ERISA, we are providing for additional "limited" open enrollment periods in the individual market under our authority in PHS Act section 2702(b)(3) to promulgate regulations with respect to open enrollment periods. These limited open enrollment periods are equivalent to special enrollment periods in terms of the limited scope and nature of their applicability, and coverage obtained during such limited open enrollment period will become effective consistent with the dates described in §155.420(b).

Accordingly, in §147.104(b)(2) of this final rule, we cross-reference the enrollment periods in §155.420(d) of the March 27, 2012 Exchange final rule (except as discussed below). Thus, under §147.104(b)(2), limited open enrollment periods are triggered in the individual market by the following events:

- An individual and any dependents losing minimum essential coverage.
- An individual gaining or becoming a dependent through marriage, birth, adoption, or placement for adoption.

- An individual experiencing an error in enrollment.
- An individual adequately demonstrating that the plan or issuer substantially violated a material provision of the contract in which he or she is enrolled.
- An individual becoming newly eligible or newly ineligible for advance payments of the premium tax credit or experiencing a change in eligibility for cost-sharing reductions.
- New coverage becoming available to an individual or enrollee as a result of a permanent move.

Additionally, the final rule provides that an individual enrolled in a non-calendar year plan is entitled to a limited open enrollment period beginning 30 calendar days prior to the individual's policy renewal date outside the open enrollment period for 2014. This one-time limited open enrollment period will allow individuals with non-calendar year policies in the individual market to transition to a calendar year policy that complies with 2014 market reform requirements of the Affordable Care Act.

We clarify that loss of minimum essential coverage triggering a limited open enrollment period does not include failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or situations allowing for a rescission as specified in 45 CFR 147.128.

We also note that these limited open enrollment periods do not include the events described in paragraphs (d)(3), (d)(8), or (d)(9) of §155.420 of the March 27, 2012 Exchange final rule (concerning citizenship status, Indians, and exceptional circumstances). The enrollment periods for events described in paragraphs (d)(3) and (d)(8) are related to specific Exchange eligibility criteria and therefore are not appropriate for the broader market. The

enrollment periods in paragraph (d)(9) arising from exceptional circumstances are not similar enough to those discussed in the November 26, 2012 proposed rule for HHS to include in the final rule. We would initiate future rulemaking if we were to establish a limited open enrollment period based on the triggering event in paragraph (d)(9) of §155.420. With the exception of these triggering events, limited open enrollment periods are the same inside and outside the Exchange in the individual and the small group market. We note that states may create special enrollment periods or limited open enrollment periods in addition to those established by this final rule.

Comment: Many commenters supported establishing 60-day special enrollment periods, consistent with those in the Exchange, to reduce consumer confusion, facilitate orderly enrollment, and ease the administrative burden on states and issuers. One commenter recommended 30-day special enrollment periods, consistent with the HIPAA standard. A few commenters recommended a 63-day election period. Other commenters recommended that individuals be permitted to begin the special enrollment process 30 days prior to a known qualifying event.

Response: We agree that 60-day enrollment periods will promote consistency with the Exchanges and will give consumers the time they need to explore coverage options following a change in life circumstances. Therefore, we provide a 60-day election period for the special and limited open enrollment periods in the individual market. However, to avoid inconsistency with the statutory requirement in PHS Act section 2704(f)(1) that individuals losing group health coverage must request special enrollment not later than 30 days after the loss of coverage, we maintain 30-day special enrollment periods for the group market. We note that the March 27,

2012 Exchange final rule (§155.725(a)(3)) currently provides for 60-day special enrollment periods with respect to the SHOP. We intend to revise the SHOP special enrollment periods to be consistent with the election period in group market under PHS Act section 2704(f)(1) and this final rule. We also note that we will monitor the effects the 60-day election period has on the individual market and whether or not is necessary to move to a 30-day election period to be consistent with the group market.

Comment: In response to our request for comment, many commenters supported a requirement that issuers in the individual market provide a notice of special enrollment rights to individual market enrollees, similar to what is provided to group health plan participants and beneficiaries under HIPAA.

Response: Following review of the comments submitted on this issue and further consideration of the additional burden that would be imposed on QHP issuers, we do not in this final rule require a notice of special enrollment in the individual market. QHP issuers are already subject to various notice requirements through the Exchange which will allow enrollees to make timely and informed coverage decisions. Furthermore, to ensure consistency with Exchanges and to avoid confusion, we do not extend a notice requirement to the broader individual market.

Comment: One commenter recommended that special enrollment periods not apply to individual family members who do not otherwise qualify for special enrollment. The commenter stated, for example, that an individual who loses minimum essential coverage should be allowed to obtain new coverage, but should not be allowed to obtain coverage for other dependents that were not covered on the previous policy.

Response: If an individual experiences an event that triggers a limited open or special enrollment right pursuant to §147.104(b)(2) or (b)(3) of this final rule, the individual has the option to choose any family coverage offered in the individual market to cover members of his or her family. Pursuant to existing HIPAA regulations at §146.117, this right already exists in the group market.

Comment: Some commenters recommended that issuers offering individual health insurance coverage be required to offer family coverage, while one commenter recommended clarifying that offering family coverage is not required under the guaranteed availability provisions.

Response: The final rule does not require an issuer to offer family coverage. While issuers are required to offer all products that are approved for sale in a market, an issuer is not required to offer a family coverage option with every policy form.

#### 4. Guaranteed Renewability of Coverage (§147.106)

In §147.106, we proposed to implement the guaranteed renewability provisions of section 2703 of the PHS Act. We proposed that an issuer offering health insurance coverage in the group or individual market must renew or continue in force such coverage at the option of the plan sponsor or individual. The exceptions to this requirement include: (1) nonpayment of premiums; (2) fraud; (3) violation of minimum employer participation or contribution rules, as permitted under applicable state law; (4) termination of a particular type of product or all coverage in a market; (5) enrollees' movement outside the service area of a network plan; and (6) for coverage provided through a bona fide association, an employer's loss of membership in the

association.<sup>16</sup> We noted that under the March 27, 2012 Exchange final rule at §155.430, QHP issuers are permitted to terminate coverage in additional circumstances (for example, decertification of the QHP in the Exchange) and requested comment on whether issuers in such circumstances should be required to renew coverage on a non-QHP basis outside the Exchange.

We also proposed standards governing the discontinuance of a particular product or all health insurance coverage in the group or individual market, consistent with the statute.

Finally, we proposed that issuers in the group market may uniformly modify coverage at the time of coverage renewal and noted that parallel provisions in section 2742 of the PHS Act allow for the uniform modification of coverage in the individual market. We stated that the uniform modification of coverage provisions would allow issuers to make cost-sharing adjustments and benefit design changes to come into compliance with the requirements of the Affordable Care Act that become effective in 2014 and requested comment on whether such interpretation should be incorporated explicitly into regulation text.

Comment: Many commenters supported allowing enrollees in a QHP that terminates or is decertified in the Exchange to elect to renew coverage on a non-QHP basis outside the Exchange. Some commenters supported applying such standard with respect to all QHP termination events. Other commenters suggested enrollees should be notified in such instances that continuing coverage outside of the Exchange will affect their eligibility for advance payments of the premium tax credit and cost-sharing reductions. One commenter asserted that renewing coverage on a non-QHP basis may be unnecessary, since an enrollee's loss of coverage in a QHP will in most instances trigger a special enrollment right, and argued that decisions

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<sup>16</sup> Section 2742(b)(5) of the PHS Act provides an exception to guaranteed renewability for an individual market enrollee's loss of membership in a bona fide association.

about coverage renewal are best left to the states.

Response: As discussed above, if an individual loses minimum essential coverage because, for example, a QHP is decertified, individuals enrolled in the QHP will have a limited open enrollment right for any policy in the individual market, including any product being offered by the same issuer that offered the QHP.

Comment: A few commenters recommended clarifying that coverage may be non-renewed for loss of eligibility. For example, commenters suggested that for consistency with §156.155 regarding catastrophic plans, a non-renewal provision would apply at the end of the policy year in which the person was no longer eligible for coverage.

Response: Individuals may only qualify for enrollment in some plans (for example, catastrophic plans or QHPs in the Exchange) if they meet certain eligibility criteria. While we do not include this clarification explicitly in §147.106 of the final rule, we note that issuers are not required to renew coverage if an individual is not otherwise eligible for such coverage.

Comment: One commenter recommended that issuers be permitted to non-renew coverage when an enrollee becomes covered by other minimum essential coverage to prevent individuals from over-insuring.

Response: Consistent with PHS Act section 2703, the final rule does not include enrollment in other coverage as an exception for guaranteed renewability. We note that state coordination of benefit laws may apply in instances where individuals are enrolled in more than one type of coverage.

Comment: With respect to the discontinuation of coverage provisions in §147.106(d)(1), one commenter suggested that HHS recognize the large group and small group segments of the

group market so that an issuer is not required to exit both segments of the group market when exercising the option to discontinue all coverage in a market.

Response: PHS Act section 2703(c)(2)(A) permits an issuer to non-renew or discontinue coverage if the issuer discontinues offering all health insurance coverage in the “group market.” Thus, the issuer must withdraw from the entire group market in order to satisfy this exception to guaranteed renewability. The final rule implements the statute without modification.

Comment: Several commenters noted that the guaranteed renewability laws in some states would prevent issuers from making plan design changes and cost-sharing adjustments necessary to bring existing, non-grandfathered coverage into compliance with the requirements of the Affordable Care Act that become effective in 2014. Commenters urged HHS to incorporate language into regulation text explicitly permitting issuers to discontinue or uniformly modify coverage at renewal, even if such discontinuance or modification is not permitted under applicable state law.

Response: State laws that prevent issuers from uniformly modifying coverage, as permitted by sections 2703 and 2742 of the PHS Act, to comply with federal standards in title XXVII of the PHS Act would, in effect, prevent the application of such standards and, therefore, be preempted under section 2724(a)(1) of the PHS Act.

### C. Part 150 – CMS Enforcement in Group and Individual Insurance Market

We proposed technical changes in 45 CFR part 150 to reflect that the HIPAA enforcement standard, as originally codified in PHS Act section 2722 and redesignated as section 2723 by the Affordable Care Act, applies to the market reform provisions of the PHS Act created by the Affordable Care Act. Pursuant to section 2723, states have the primary enforcement

authority with respect to health insurance issuers in the group and individual markets. HHS has secondary enforcement authority and will enforce a provision in a state only if the state advises us that it does not have authority to enforce the provision or if the state fails to substantially enforce a provision.

Comment: Several commenters requested a safe harbor from enforcement, at least for the first year of implementation, as long as issuers are making good faith efforts to comply and implement the new requirements. Special concern was raised in the instance where state law conflicts with federal law.

Response: As stated in previous Affordable Care Act guidance, our approach to implementation is marked by an emphasis on assisting (rather than imposing penalties on) issuers and others that are working diligently and in good faith to understand and comply with the law.<sup>17</sup> While the final rule does not provide an enforcement safe harbor for the market reform provisions, HHS will continue to work closely with issuers and states in the implementation of these provisions.

Comment: One commenter questioned HHS's authority to extend this enforcement standard to the provisions of the Affordable Care Act including the market reform provisions.

Response: Title I of the Affordable Care Act amends title XXVII of the PHS Act. Specifically, the market reform provisions are enumerated in sections 2701, 2702, and 2703 of title XXVII of the PHS Act, which are subject to the enforcement provisions of PHS Act section 2723.

Comment: One commenter requested clarification regarding the process HHS uses to

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<sup>17</sup> See, for example, Affordable Care Act Implementation FAQs – Set 1 Q1, available at [http://cciio.cms.gov/resources/factsheets/aca\\_implementation\\_faqs.html](http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs.html).

determine that a state is not substantially enforcing a provision of title XXVII of the PHS Act.

Response: We refer readers to 45 CFR 150.203, *et. seq.* for regulations describing HHS's enforcement processes.

#### D. Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review

##### 1. Subpart B – Disclosure and Review Provisions

###### a. State-specific Thresholds (§154.200)

In §154.200(a)(2) and (b), we proposed that states seeking state-specific thresholds submit proposals to CMS by August 1 of each year. The Secretary would publish a **Federal Register** notice not later than September 1 of each year concerning whether a state-specific threshold applies in a state. If approved, a state-specific threshold would become effective on January 1 of the year following the Secretary's notice.

Comment: A few commenters were concerned that proposed timeline would not give issuers sufficient time to file rates before January 1.

Response: We are finalizing the revised timeline in §154.200(a)(2) and (b) as proposed because the new dates increase consistency inside and outside of the Exchange. We are working to align the market with the QHP submission schedule and with the 2014 market reforms. Since QHP filings are due April 30 of each year, moving the state-specific threshold application date to August 1 will give states the appropriate amount of time to analyze the QHP information they receive and to request a state-specific threshold if they believe one is necessary. We will be moving the state-specific threshold determination deadline from June 1 to September 1, with any potential state-specific threshold going into effect January 1 of the following year. Under the May 23, 2011 rate review final rule (76 FR 29964), the Secretary was to publish a notice about

state-specific thresholds by June 1, and the effective date of any state-specific threshold was September 1 of the same year. Under this final rule, issuers will still have three months to prepare to file rates under any potential state-specific threshold. Therefore, we are shifting the entire timeline forward three months to enable states to have enough information to assess their markets appropriately. We note that the January 1 effective date for state-specific thresholds only means that rate filings submitted on or after January 1 will be subject to any potential state-specific threshold and not necessarily rate increases that are effective January 1.

b. Submission of Rate Filing Justification (§154.215)

Section 2794(b)(2)(A) of the PHS Act directs that beginning in 2014, the Secretary, in conjunction with the states, shall monitor premium increases of health insurance coverage offered through an Exchange and outside an Exchange. To enable the Secretary to carry out this new monitoring function and to streamline data collection for programs beginning in 2014, we proposed revisions in §154.215 that would direct health insurance issuers to submit data and documentation regarding rate increases on a standardized form determined by the Secretary. We also proposed that the rate review standards be modified by extending the requirement that health insurance issuers report information about rate increases to all rate increases, not just those above the review threshold. States would continue to have the authority to collect additional information above this baseline to conduct more thorough reviews or rate monitoring. Furthermore, the review threshold in §154.200 would continue to be used to determine which rates must be reviewed rather than just reported.

Under the Paperwork Reduction Act of 1995 (PRA) process (44 U.S.C. chapter 35), we proposed a “unified rate review” template for health insurance issuers to use for submitting data

for rate increases. In this final rule, we have revised the text of §154.215 to reflect the “unified rate review” terminology. We also have added language explicitly reflecting the fact that the premium rates subject to rate review reporting are shaped by the premium rating standards implemented under the single risk pool requirement and the applicability of the guaranteed availability and renewability requirements. We clarify that states are not specifically required to use the unified rate review template in order to have an effective rate review program.

Comment: Several commenters remarked on the proposal to expand reporting of all rate increases using the unified rate review template. Some commenters supported the expanded reporting requirement, while other commenters were concerned about the administrative burden on issuers. One commenter suggested that the proposal would allow both CMS and states to monitor rate trends and identify patterns that could indicate market disruption.

Response: Section 2794(b)(2)(A) of the PHS Act, as added by the Affordable Care Act, requires the Secretary to monitor premium increases of health insurance coverage offered both inside and outside an Exchange, for plan years beginning in 2014. Accordingly, we proposed that issuers offering health insurance coverage in the small group or individual markets report information about all rate increases. We believe that standardizing the reporting process will reduce administrative burden and duplication over time and enable both states and CMS to evaluate information about the single risk pool, actuarial value, essential health benefits, and other market reforms beginning in 2014. This reporting will also assist states and CMS in monitoring the market inside and outside the Exchange for adverse selection. Therefore, we are finalizing the requirement to report all rate increases in §154.215 as proposed. We note that when new business is included in the unified rate review template, the issuer must demonstrate

all premium and claims projections for the new products and plans as provided in guidance. Historical experience is only required for existing product/plan combinations represented on the unified rate review template. We also note that, in response to comments received through the PRA process, we have made changes to the uniform rate review template to both remove data elements and to make some optional in the first two years of applicability. As discussed in more detail in section V. of the preamble, we estimate that these changes reduce the number of required data elements by approximately 45 percent.

Comment: Several commenters remarked on the content of the proposed unified rate review template.

Response: We address these comments in section V. of the preamble regarding collection of information requirements. As mentioned above, we have made changes to the template in response to comments to ensure streamlined and efficient data collection.

## 2. Subpart C – Effective Rate Review Programs

### a. Determination of Effective Rate Review Programs (§154.301)

To account for the market reform changes in 2014, we proposed to modify the standards in §154.301(a)(3) for states to have an effective rate review program with respect to rate filings subject to review. Specifically, we proposed that a state with an effective rate review program review the following additional elements as part of its rate review process: (1) the reasonableness of assumptions used by an issuer to estimate the rate impact of the reinsurance and risk adjustment programs; and (2) issuer data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values, and other market reform provisions of the Affordable Care Act. We did not propose to modify the 10 percent subject to

review threshold as finalized in §154.200.

We also proposed to revise §154.301(a)(4) by adding additional factors that states would take into consideration when conducting their examinations, including (1) in reviewing the impact of cost-sharing changes, the impact on the actuarial value of the health plan in light of the requirement under section 1302(d) of the Affordable Care Act that a plan meet one of the AV levels; and (2) in reviewing benefit changes to a plan, the impact of the changes on the plan's essential health benefits and non-essential health benefits.

Additionally, we proposed that states take into account, to the extent possible, the following additional factors when conducting an examination of a rate review filing:

- Other standardized ratio tests (in addition to the medical loss ratio) recommended or required by statute, regulation, or best practices;
- The impact of geographic factors and variations;
- The impact of changes within a single risk pool to all products or plans within the risk pool; and
- The impact of reinsurance and risk adjustment payments and charges.

Finally, we proposed revisions in §154.301(b) to ensure that a state with an effective rate review program make available on its Web site, at a minimum, the same amount of information in Parts I, II, and III of each Rate Filing Justification that CMS makes available on its Web site. We proposed that a state may, instead of providing access to the information contained in Parts I, II, and III of each Rate Filing Justification, provide a link to CMS's Web site where consumers can find such information.

Comment: Several commenters remarked on the proposed additional criteria for states to

have an effective rate review program. Some commenters supported the additional criteria, while others suggested that states with effective rate review programs should have flexibility to use either the unified rate review template or their own templates and formats for collecting information from issuers. One commenter suggested that CMS should accept state regulators' attestations that they are reviewing the required information, but not necessarily require that states incorporate the unified rate review template into their review process.

Response: We finalize the proposed amendments in §154.301 except that, in order to limit additional factors to only those that reflect the 2014 market reforms, we do not require states to consider "other standardized ratio tests recommended or required by statute, regulation, or best practices" to have an effective rate review program. Although states will likely consider these ratio tests as part of their review processes, we intend to minimize the criteria and factors for states to have an effective rate review program in order to give states the maximum flexibility to conduct reviews. Further, this final rule does not require states to incorporate the unified rate review template into their review process. States will retain the flexibility to use other collection tools, provided they collect the information necessary to conduct effective reviews. States cannot rely on issuer attestation alone in conducting these reviews. Issuers in all states, including those with effective rate review programs, must still under this final rule submit information to CMS using the unified rate review template. We note that states and issuers will have an incentive to use the collection tools provided by CMS to ensure streamlined and efficient data collection.

This approach strikes the appropriate balance between maintaining state flexibility and allowing CMS to carry out functions related to: (1) the monitoring of premium increases of

health insurance coverage offered through an Exchange and outside an Exchange as required by section 2794(b)(2)(A) of the PHS Act; (2) Exchanges such as QHP certification and premium tax credit and cost-sharing reduction verification; and (3) the risk adjustment and reinsurance programs. We note that even without the administrative efficiencies associated with using the information collected through rate review authority for the second and third functions listed above, the same data would be needed and collected to carry out the first function by itself. We also clarify that we will use the information collected only for these specified purposes and will initiate future rulemaking if we intend to use the data for any other purpose.

Comment: Some commenters expressed concern about the public release of information. Commenters recommended disclosing only a minimal amount of information and that such disclosure not include confidential or proprietary information.

Response: As mentioned in the preamble of the November 26, 2012 proposed rule, we will release only information collected that is determined not to include trade secrets and is approved for release under the Freedom of Information Act (FOIA). In general, all information collected by HHS is subject to FOIA. In accordance with the HHS's FOIA implementing regulations at 45 CFR 5.65(c), health insurance issuers may designate part or all of the information submitted as exempt from disclosure under Exemption 4 of the FOIA if the issuer believes the information is commercial or financial information that is confidential or privileged. If there is a FOIA request, we will follow the pre-disclosure notification procedures found at 45 CFR 5.65(d) through (e) to seek issuer input on the applicability of Exemption 4 before disclosure is made. If the information has previously been published or made generally available to the public, it will not be considered confidential or privileged for purposes of Exemption 4. In

addition, as discussed in section II.E.1.a. of the preamble, issuers will set their index rates and plan-specific pricing once per year upon filing their rates with state insurance departments, and information would only be released after the QHP submission process is concluded.

Accordingly, we believe that public disclosure of certain rate review information will not undermine competitive market dynamics.

b. Rate Filing Justification (§154.225 and §154.330)

We proposed to amend §154.225 and §154.330 by replacing the term “Preliminary Justification” with the term “Rate Filing Justification,” to reflect more appropriately the rate filing information that would be reported. We received no comments regarding this proposed change. Accordingly, we are finalizing proposed §154.225 and §154.330 without modification.

E. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Subpart A – General Provisions

a. Single Risk Pool (§156.80)

In §156.80, we proposed standards to implement the requirement in section 1312(c) of the Affordable Care Act that an issuer use a single risk pool for a market (the individual market, small group market, or merged market) when developing rates and premiums for coverage effective beginning in 2014.

We proposed that an issuer develop a market-wide index rate (average rate) based on the total combined EHB claims experience of all enrollees in all non-grandfathered plans in the risk pool. After setting the index rate, the issuer would make a market-wide adjustment based on the expected aggregated payments and charges under the risk adjustment and reinsurance programs

in a state. The premium rate for any given plan could not vary from the resulting adjusted market-wide index rate, except for the following factors: the actuarial value and cost-sharing structure of the plan; the plan's provider network, delivery system characteristics, and utilization management practices; plan benefits in addition to EHB; and with respect to catastrophic plans, the expected impact of specific eligibility categories for those plans. The index rate, the market-wide adjustment to the index rate, and the plan-specific adjustments would have to be actuarially justified and implemented transparently, consistent with federal and state rate review processes.

We invited comment on the set of allowable plan-specific adjustments and whether to allow flexibility in product pricing in 2016 after issuers had gained sufficient experience with the reformed market. Additionally, in the "HHS Notice of Benefit and Payment Parameters for 2014" proposed rule (77 FR 73118), we solicited comment on whether Exchange user fees or other administrative costs should be spread across all plans in a market as a market-wide adjustment to the index rate.

Comment: Several commenters suggested that issuers should be allowed to reflect distribution costs and other administrative costs associated with different products in their premiums to promote administrative efficiency. One commenter recommended allowing a market-wide adjustment to the index rate for Exchange user fees, as well as distribution costs, agent and broker commissions, and all administrative costs, to spread these costs evenly across the market and protect against adverse selection. Other commenters urged that any flexibility in product pricing not result in de facto experience rating based on health status. A few commenters opposed our proposal to pool Exchange user fees across all plans in a market within a state because they believed that this would unfairly increase costs for members that are not

enrolled in the Exchange. Other commenters supported the proposal to pool Exchange user fees across all of an issuer's plans in a relevant market within a state.

Response: We agree with commenters urging the pooling of Exchange user fees across the market as these costs are not related to the unique efficiencies or designs of a particular plan. Accordingly, the final rule directs issuers to make a market-wide adjustment to the index rate for Exchange user fees. This will ensure that Exchange user fees are spread evenly across the market, creating a level playing field inside and outside the Exchange, and further protecting against adverse selection. Further, this policy is consistent with the treatment of Exchange user fees for medical loss ratio (MLR) and rebate calculations under 45 CFR 158.161(a).<sup>18</sup>

As for distribution costs and other administrative costs (other than Exchange user fees), we believe that issuers should be allowed to make actuarially justified adjustments to the market-wide index rate at the individual plan level for those costs. This will allow pricing to vary among individual plans by administrative costs reasonably allocable to those plans, ensuring that administrative efficiencies are priced accurately and promoting market competition. The final rule therefore includes administrative costs (other than Exchange user fees) as an additional factor that issuers may use to modify the market-wide index rate at the individual plan level.

Comment: Several commenters requested issuer flexibility in product pricing to adequately adjust for the risk of their enrollees. Commenters opposed any restriction to making actuarially justified adjustments to the index rate for new and renewing businesses during the course of the year. Other commenters suggested issuers adjust the index rate on a consistent, annual basis.

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<sup>18</sup> CCIIO Technical Guidance (CCIIO 2012—002): Questions and Answers Regarding the Medical Loss Ratio Regulation, Q&A #34 (Apr. 20, 2012), available at <http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf>.

Response: Issuers in the individual or combined markets (in states that have merged the individual and small group markets) should set their index rates and plan-specific pricing once per year, upon filing their rates with the state's department of insurance. Permitting changes in these markets to the index rate throughout the year could effectively lead to premium pricing in violation of the rules described above. We believe that these rates should apply to new and renewing enrollees during the course of the year.

Comment: Several commenters requested clarification on whether adjustments to the index rate could reflect differences in health status. Some commenters also requested that issuers be permitted to make an adjustment to the index rate to account for induced utilization. Other commenters requested that HHS enforce the single risk pool requirement so that the index rate and plan-specific rates set by issuers do not reflect differences in enrollee health status.

Response: As indicated in the preamble of the November 26, 2012 proposed rule, we believe that the purpose of the single risk pool is to prevent issuers from segregating enrollees into separate rating pools based on health status. In this final rule, we confirm that plan-specific adjustments to the market-wide index rate must not reflect differences in health status or risk selection. In addition, we exclude induced demand from the index rate adjustments because of the actuarial difficulty of measuring whether differences in total plan expenditures are due to risk selection or induced demand.

Comment: Several commenters requested clarification on whether the term "actuarial value" for the purpose of the individual plan adjustment to the index rate has the same meaning as the term "actuarial value" in the Actuarial Value (AV) calculator in the November 26, 2012 EHB/AV/Accreditation proposed rule. Several commenters also requested clarification on the

method for applying plan-specific premium factors, particularly whether issuers may adjust the index rate for anticipated difference in utilization, risk adjustment payments and reinsurance payments through plan design, and the allowable adjustment for catastrophic plans.

Response: The calculation of the actuarial value through the AV calculator is based on data sets provided by HHS reflecting a standard population, utilization, and unit prices. For the purpose of developing an adjustment to the market-wide index rate for individual plans, we would expect health insurance issuers to utilize pooled allowable claims data as a basis for calculating the plan-specific actuarial value. By using the claims data of their pooled population, issuers can develop more accurate adjustments to the index rate for individual plans. In the absence of data, issuers of new plans would have the option of calculating pooled allowable claims using actuarially reasonable projections.

Additionally, we would expect issuers to proportionally allocate anticipated reinsurance and risk adjustment payments and charges based on plan premium by applying the risk adjustment/reinsurance adjustment factor as a constant multiplicative factor across plans. We believe that this modification would prevent issuers from differentially allocating risk adjustment and reinsurance payments and charges across plans in a manner that would reintroduce risk selection differences into plan premiums.

Finally, with respect to catastrophic plans, we clarify that issuers may make a plan-specific adjustment to the market-wide index rate that accounts for differences between catastrophic and non-catastrophic plans in expected average enrollee gross spending and expected average risk adjustment payment transfers. This plan-specific adjustment would be uniform across all of an issuer's catastrophic plans (that is, risk across all catastrophic plans must

be pooled). This adjustment for catastrophic plans should not include plan liability differences due to actuarial value, because actuarial value differences should be accounted for in the actuarial value adjustment.

Comment: A few commenters requested flexibility in the claims data that could be used to determine the index rate for the initial years of Exchange operation. One commenter specifically recommended that issuers be permitted to use the claims experience from grandfathered books of business when developing initial rates.

Response: We recognize that lack of robust EHB claims experience may create challenges for issuers in setting rates in the initial years of implementation. We clarify that in the absence of applicable claims data, an issuer may use any reasonable source of claims data, including claims experience from grandfathered books of business or claims data from actuarial rate manuals (to the extent available), to establish its index rate, as long as those data are used to actuarially estimate the portion of claims data associated with providing coverage for EHB as required to establish the index rate.

Comment: A few commenters expressed concern that merging the individual and small group markets could cause market disruption and affect the rating methodology. Other commenters requested clarification about how the single risk pool would apply if a state elected to merge its individual and small group markets.

Response: If a state exercises the option to merge its individual and small group markets, an issuer must, in accordance with §156.80(d) of this final rule, calculate the market-wide index rate and plan-specific adjustments based on the merged market. As only non-grandfathered individual market plans are eligible for payments under the transitional reinsurance program, in a

merged market, the pooled reinsurance adjustment should be based only on the portion of the issuer's individual market business eligible for reinsurance payments.

Comment: Numerous commenters requested clarification of whether the single risk pool is to be maintained at the holding company level or at the individual licensee level.

Response: Section 1312(c) of the Affordable Care Act requires a health insurance issuer to maintain a single risk pool in the individual market and a single risk pool in the small group market (unless a state requires both pools to be merged). Section 1301(b)(2) of the Affordable Care Act provides that the term "health insurance issuer" has the meaning given the term in section 2791(b) of the PHS Act, which defines a health insurance issuer as an entity that is licensed to conduct the business of insurance in a state. Accordingly, the single risk pool is to be maintained at the licensed entity level.

## 2. Subpart B – Standards for Essential Health Benefits, Actuarial Value, and Cost Sharing

### a. Enrollment in Catastrophic Plans (§156.155)

In §156.155, we proposed standards for catastrophic plans offered in the individual market, consistent with section 1302(e) of the Affordable Care Act. Specifically, we proposed that a health plan is a catastrophic plan if it: (1) meets all applicable requirements for health insurance coverage in the individual market; (2) does not offer coverage at the bronze, silver, gold, or platinum levels of coverage described in section 1302(d) of the Affordable Care Act; (3) does not provide coverage of essential health benefits until the enrolled individual reaches the annual limitation in cost sharing in section 1302(c)(1) of the Affordable Care Act; and (4) covers at least three primary care visits per year before reaching the deductible. Further, we proposed that a catastrophic plan may not impose any cost-sharing requirements for preventive services

identified in section 2713 of the PHS Act.

We also proposed to codify the statutory criteria identified in section 1302(e)(2) of the Affordable Care Act listing the two categories of individuals eligible to enroll in a catastrophic plan. The first category includes individuals who are younger than age 30 before the beginning of the plan year. The second category includes individuals who have been certified as exempt from the individual responsibility payment because they cannot afford minimum essential coverage or because they are eligible for a hardship exemption. Finally, we proposed that if a catastrophic plan covers more than one person (such as a catastrophic family plan), each individual enrolled must satisfy at least one of these two eligibility criteria.

Comment: A few commenters requested clarification as to whether the provisions regarding catastrophic plans apply only to coverage offered through an Exchange.

Response: Section 1301(a)(1)(B) of the Affordable Care Act directs a QHP to provide the EHB package described in section 1302(a) that, subject to section 1302(e), meets the actuarial value (AV) levels described in section 1302(d) (bronze, silver, gold, or platinum levels of coverage). Section 1302(e) describes an exception to the AV requirements for catastrophic plans. These provisions are incorporated by reference in section 2707(a) of the PHS Act, which extends coverage of the EHB package required under section 1302(a) to health insurance issuers offering non-grandfathered coverage in the individual and small group markets. Accordingly, the provisions regarding catastrophic plans apply to coverage offered both inside and outside of an Exchange.

Comment: One commenter recommended clarifying that individuals are eligible for enrollment in a catastrophic plan (offered through or outside the Exchange) if they have obtained

from the Exchange a hardship exemption based on inability to afford or obtain coverage.

Response: As discussed in the February 1, 2013 **Federal Register** proposed rule entitled “Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions” (78 FR 7348), herein referred to as the Minimum Essential Coverage proposed rule, only the Exchange may issue certificates of exemption based on hardship. Under the Minimum Essential Coverage proposed rule, there are several situations where an Exchange would grant a certificate of exemption for hardship based on an inability to afford or obtain coverage. One category of the hardship exemption is based on the Exchange determining that an applicant, or another individual in the applicant’s family, is unable to afford coverage for a calendar year based on the applicant’s projected household income. This specific category would allow individuals to receive a hardship exemption in lieu of the statutory unaffordability exemption based on the individual’s actual household income. We agree that, consistent with the above discussion of section 2707(a) of the PHS Act, individuals granted a certificate of exemption from the Exchange based on hardship may use such exemption determination to establish eligibility to purchase a catastrophic plan outside of the Exchange.

Comment: One commenter stated that with respect to a catastrophic family plan, only one member of a family should have to meet the eligibility criteria rather than all family members.

Response: Section 1302(e)(1)(A) of the Affordable Care Act provides that the only individuals who are eligible to enroll in a catastrophic plan are those individuals who meet specific eligibility criteria described in section 1302(e)(2). Therefore, we do not accept the

commenter's suggestion that all members of a family may enroll in a catastrophic plan if only one family member is eligible to enroll.

Comment: We received several comments about the requirement that catastrophic plans must provide coverage for at least three primary care visits before reaching the annual deductible. Some commenters recommended clarifying that issuers must cover at least three primary care visits in addition to the preventive services required to be covered without cost sharing under section 2713 of the PHS Act, and that issuers may not impose any cost-sharing requirements for these visits. Other commenters recommended clarifying that primary care visits include visits to obstetrical or gynecological providers.

Response: Health insurance issuers providing catastrophic coverage must fully comply with PHS Act section 2713 and its implementing regulations in addition to providing coverage for at least three primary care visits. The classification of who is a primary care provider for the purpose of the primary care visits is determined by the terms of the health plan or by state law.

#### F. Applicability to Special Plan Types

##### 1. Student Health Insurance Coverage (§147.145)

Section 1560(c) of the Affordable Care Act provides that nothing in title I of the Affordable Care Act, or an amendment made by title I, "shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable federal, state, or local law." HHS has interpreted section 1560(c) to mean that if particular requirements of the Affordable Care Act would have, as a practical matter, the effect of prohibiting an institution of higher education from offering a

student health plan otherwise permitted under federal, state, or local law, these requirements would be inapplicable pursuant to section 1560(c).

HHS published a final rule in the March 21, 2012 **Federal Register** entitled “Student Health Insurance Coverage” (77 FR 16453), which clarified that for purposes of federal law, student health insurance coverage is defined as a type of individual health insurance coverage and therefore generally subject to the individual market requirements of title XXVII of the PHS Act and title I of the Affordable Care Act. However, pursuant to section 1560(c) of the Affordable Care Act, the March 21, 2012 final rule exempted student health insurance coverage from the guaranteed availability and guaranteed renewability requirements of PHS Act sections 2741(e)(1) and 2742(b)(5) added by HIPAA.

Consistent with that policy, the November 26, 2012 proposed rule outlined similar exemptions for student health insurance coverage from the guaranteed availability and guaranteed renewability requirements of PHS Act sections 2702 and 2703 added by the Affordable Care Act to ensure that enrollment in student health insurance plans may be limited only to students and their dependents. Further, we solicited comment on whether issuers should be permitted to maintain a separate risk pool for student health insurance coverage and whether different premium rating rules should apply.

Comment: While some commenters recommended including student health insurance coverage in the general individual market risk pool, many commenters urged HHS to recognize the unique characteristics of student health insurance plans by allowing separate risk pooling of such coverage. Commenters expressed concern that pooling the risk of student enrollees with other individual market enrollees could increase student health insurance premiums and

potentially discourage some universities from offering student health insurance plans.

Commenters also noted that student health insurance issuers typically do not underwrite students on an individual basis, but rather offer coverage to institutions of higher education at a group community rate. These commenters requested flexibility with respect to the premium rating rules of PHS Act section 2701 so that issuers may continue to consider characteristics such as the educational institution's claims experience, enrollment method, demographics, and availability of on-campus services when developing rates and premiums for student health insurance coverage.

Response: We recognize that student health insurance coverage generally is rated and administered differently than other forms of individual health insurance coverage. Issuers of student health insurance coverage typically contract with a college or university to issue a "blanket" health insurance policy, from which students can buy coverage, and the policy is generally rated on a group basis based on the total expected claims experience of the college's or university's students enrolled in the plan. Accordingly, under HHS's authority in section 1560(c) of the Affordable Care Act to ensure that the law's requirements would not effectively prohibit the offering of a student health insurance plan otherwise permitted under federal, state, or local law, and to minimize market disruption in the initial transition to the reformed market, this final rule provides that non-grandfathered student health insurance coverage is not subject to the single risk pool requirement of section 1312(c) of the Affordable Care Act.

Student health insurance is subject under these final rules to the premium rating requirements of section 2701 of the PHS Act. We note, however, that given the exemption from single risk pool requirement, the premium rate charged by an issuer offering student health

insurance coverage may be based on a school-specific group community rate if, consistent with section 2701, the issuer offers the coverage without rating for age or tobacco use. This provides flexibility to student health insurance issuers with respect to the per-member-rating provisions of PHS Act section 2701(a)(4) and §147.102(c)(1), while ensuring that student enrollees and their dependents are not charge more based on their health status or gender.

The treatment of student health insurance coverage under these final rules will serve as a transitional policy. We intend to monitor student health insurance coverage as the insurance market transitions to the 2014 market reforms and revisit this policy in the future.

Comment: Several commenters supported the proposal to exempt student health insurance coverage from the guaranteed availability and renewability requirements of the Affordable Care Act. One commenter specifically recommended with respect to the guaranteed availability provisions of the November 26, 2012 proposed rule that open enrollment periods for student health insurance plans be permitted to coincide with college and university enrollment periods.

Response: In this final rule, we finalize our proposal to exempt student health insurance coverage from the guaranteed availability requirements under PHS Act section 2702 and the guaranteed renewability requirements under PHS Act section 2703. Therefore, the special and open enrollment periods under section 2702 do not apply to issuers of student health insurance coverage. Student health insurance issuers may work with colleges and universities to determine appropriate enrollment periods for student enrollees and their dependents.

## 2. Bona Fide Association Coverage

As mentioned above, we proposed, consistent with PHS Act section 2702, that non-

grandfathered health insurance coverage made available in the individual or group market through a bona fide association must be guaranteed available to all individuals or employers in a state and market. These proposed rules represented a change from existing law permitting coverage sold through bona fide associations to be limited only to association members; therefore, we invited comment on whether and how a transition or exception process for bona fide association coverage could be structured to minimize disruption.

Comment: Several commenters noted that the Affordable Care Act preserved an exception for coverage sold through bona fide associations from the guaranteed renewability provisions of sections 2703 and 2742 of the PHS Act and urged HHS to recognize a similar exception for bona fide associations from the guaranteed availability provisions of section 2702. Some commenters recommended providing a transition period during which issuers could close association coverage to new enrollment, while other commenters cautioned that as long as issuers offering coverage through bona fide associations are able to limit coverage to association members, they effectively will be able to select healthy applicants and refuse applicants with high health care costs.

Response: Section 1563 of the Affordable Care Act deleted the exception contained in section 2711(f) of the PHS Act that existed prior to the amendments made by the Affordable Act, which exempted small group coverage sold through bona fide associations from having to guarantee issue policies to anyone other than members of the association. Therefore, the final rule implements the Affordable Care Act, which does not recognize an exception from guaranteed availability for bona fide association coverage. We note that while starting in 2014, health insurance issuers may not limit coverage sold through associations only to association

members, nothing prevents an issuer from renewing existing association coverage. Furthermore, as discussed in the November 26, 2012 proposed rule, the exception for limited network capacity could provide a basis for limiting enrollment in certain products to bona fide association members.

### 3. Expatriate Plans

Comment: A few commenters urged HHS to exempt expatriate coverage from the market reform provisions of the Affordable Care Act, including the guaranteed availability, guaranteed renewability, premium rating, and rate review provisions, arguing that expatriate plans face special circumstances and considerations in complying with these provisions of federal law. For example, commenters stated that expatriate policies are designed to meet the unique coverage needs of employees while working outside of the United States (and their dependents). Commenters also noted that the rates for expatriate policies must accommodate the regulatory requirements and health care costs of other countries; reflect benefits that are particularly important to expatriates (such as medical evacuation coverage, war risk coverage, and currency fluctuation); and maintain global competitiveness with non-U.S. issuers offering expatriate coverage. Accordingly, commenters recommended that enrollment in expatriate policies be limited to expatriate employees and their dependents, and that the rules reflect the unique rating requirements faced by expatriate plans.

Response: We plan to issue future guidance on the applicability of the market reform provisions of the Affordable Care Act, including these final rules, to expatriate policies.

### 4. State High Risk Pools

Comment: We received several comments as to whether states may continue their high risk pools beyond 2014. Many commenters supported state flexibility to transition high risk pools as a means of minimizing premium disruption and promoting continuity of care. A few commenters noted that high risk pool enrollees will have a right to guaranteed availability and stated such individuals must not be prohibited from enrolling in other coverage offered in the individual market, particularly through the Exchange. Some commenters suggested that enrollees who maintain high risk pool coverage should be eligible for premium tax credits and cost-sharing reductions and notified about new coverage options. Other commenters requested clarification about whether state high risk pools are subject to the market reform provisions of the Affordable Care Act.

Response: Many states currently have high risk insurance pools as their state alternative mechanism to provide insurance coverage for individuals who meet enrollment criteria and who do not otherwise have access to group or individual health insurance coverage. Since state high risk pool coverage is not provided through insurance and is not group health plan coverage, state high risk pool coverage is not subject to title XXVII of the PHS Act. However, some states, as their state alternative mechanism, require issuers (or certain issuers of last resort) to guarantee the availability of a product or specific benefit design. If the state alternative mechanism is individual market insurance coverage, it is subject to title XXVII of the PHS Act. Individuals enrolled in state high risk pools will have the same rights as others to guaranteed availability for any products offered inside and outside of the state Exchange, and states may not prevent individuals from moving to other products or to a state's Exchange. States will continue to have the discretion to determine whether each state continues to have a high risk pool in order to ease

the transition of enrollees to other products, consistent with the February 1, 2013 Minimum Essential Coverage proposed rule, which proposed to designate state high risk pools as minimum essential coverage for a period of time to be determined by the Secretary.<sup>19</sup>

### **III. Modification of Effective Date for Certain Provisions**

The Congressional Review Act, 5 U.S.C. 801(a)(3), ordinarily requires that the effective date of a “major rule” such as this final rule be at least 60 days from the date of publication. However, 5 U.S.C. 808(2) permits the federal agency promulgating the rule to determine an effective date, notwithstanding this otherwise applicable 60-day requirement, when an agency “for good cause finds (and incorporates the finding and a brief statement of reasons therefore in the rule issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.” While this final rule is generally effective 60 days from the date of publication, we have determined for 45 CFR 147.103, which specifies the timing for state reporting of rating factors, and the amendments to 45 CFR Part 154 governing rate review, an effective date 30 days from the date of publication of this rule.

Section 147.103 directs states to report to HHS within 30 days after publication of this rule certain rating factors required by §147.102, including but not limited to: the age rating ratio if a state adopts a ratio narrower than 3:1 for adults; the tobacco rating ratio if a state adopts a ratio narrower than 1.5 to 1; a uniform age rating curve if a state adopts any; and geographical rating areas if the state establishes any. It is imperative that HHS receive these data from the states within 30 days of publication of this final rule in order to implement timely the risk adjustment methodology set forth in section 1343 of the Affordable Care Act and its

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<sup>19</sup> 78 FR 7348

implementing regulations. Should these data not be received within 30 days of publication of this final rule, HHS's risk adjustment scores for use on January 1, 2014 would have to be calculated using assumed rating factors based on the limitations set forth in this final rule, which could result in inaccurate risk adjustment payments to health insurance issuers in states that have developed different rating factors. This may in turn lead to imbalance in the insurance markets in those states with different rating factors. Furthermore, health insurance issuers are required to submit their applications by April 30, 2013 to the Exchanges to be certified as QHPs in 2014. In order to submit accurate information on their applications, the issuers will need to know what rating factors in a state will be effective starting January 1, 2014.

The amendments to 45 CFR Part 154 revise the timeline for states to propose state-specific thresholds for review and approval by HHS. The amendments also direct health insurance issuers to submit data relating to proposed rate increases in a standardized format specified by the Secretary of HHS, and modify criteria and factors for states to have an effective rate review program. These changes are necessary to reflect the new market reform provisions and to fulfill the statutory requirement beginning in 2014 that the Secretary, in conjunction with the states, monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. The provisions are also designed to streamline data collection for issuers, states, Exchanges, and HHS. Since health insurance issuers will be submitting their 2014 rate filings in states starting April 1, 2013, these amendments must be effective at that point for consumers to experience the full benefits in 2014 of the rate review process both inside and outside the Exchanges.

Furthermore, HHS and the states must have the ability to collect, beginning April 1,

2013, rate data from health insurance issuers relating to the 2014 market reforms to ensure effective implementation of the market reforms starting January 1, 2014. For example, if the data submission requirement for all rate increases is not in place by April 1, 2013, states and HHS will have very little ability to gauge whether issuers have combined all of their products into a single risk pool in either the individual or small group markets. Issuers could, therefore, implement different index rates and allowable modifiers without fear of being observed by a regulator for some time, which would have the potential effect of issuers continuing to rate for health status in 2014.

Accordingly, for the reasons stated above, 45 CFR 147.103 of this final rule and the amendments to 45 CFR part 154 are effective 30 days after publication of this final rule.

#### **IV. Provisions of the Final Regulations**

For the most part, this final rule incorporates the provisions of the proposed rule. Those provisions of this final rule that differ from the proposed rule are as follows:

##### Changes to §147.102 (Fair health insurance premiums)

- Clarifies that tobacco use means use of tobacco on average four or more times per week within no longer than the past six months, including all tobacco products but excluding religious and ceremonial uses of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used. Additionally, clarifies that issuers may vary rates for tobacco use only with respect to individuals who may legally use tobacco under federal and state law.
- Gives states additional flexibility to establish geographic rating areas that would be presumed adequate.

- Modifies the default rating area standard such that there would be one rating area for each metropolitan statistical area and one rating area comprising all non-metropolitan statistical areas in the state.
- Clarifies the criteria that HHS will use to determine whether proposed state rating areas are adequate.
- Clarifies that the cap on the number of individuals under age 21 taken into account when computing the family premium applies to the three oldest “covered children” under age 21.
- Deletes language in paragraphs (a)(1)(iii) and (a)(1)(iv) providing that states may use narrower age and tobacco use factors to avoid confusion.
- Consolidates state reporting requirements in a new §147.103.

Changes to §147.104 (Guaranteed availability of coverage)

- Adds events triggering limited open enrollment periods in the individual market, consistent with Exchange special enrollment periods, as well as a one-time limited open enrollment period for the 2014 calendar year for individuals with non-calendar year individual policies.
- Establishes 60-day special and limited open enrollment periods in the individual market; maintains 30-day special enrollment periods in the group market.
- Ensures consistency of the prohibition against employing discriminatory marketing practices and benefit designs with the prohibition on discrimination with respect to EHB in §156.125 and the non-discrimination standards applicable to QHPs under §156.200(e).

Changes to §147.145 (Student health insurance coverage)

- Exempts student health insurance coverage from the single risk pool requirements of Affordable Care Act section 1312(c).

Changes to §154.215 (Submission of Rate Filing Justification)

- Clarifies that if any product is subject to a rate increase, an issuer must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products.
- Replaces the term “standardized data template” with “unified rate review template” each place it appears.

Changes to §156.80 (Single risk pool)

- Clarifies that the index rate for the single risk pool must be adjusted on a market-wide basis for Exchange user fees and may be adjusted at the plan-level for distribution costs and other administrative costs.

Changes to §156.155 (Enrollment in catastrophic plans)

- Makes a technical correction in paragraph (c) of this section that each enrolled individual in the case of a catastrophic plan covering multiple individuals must meet the eligibility criteria outlined in paragraph “(a)(5)” of this section.

## **V. Collection of Information Requirements**

In the November 26, 2012 proposed rule (77 FR 70584), we solicited public comments on each of the sections identified as containing information collection requirements (ICRs). In this final rule, we are restating our summary of the information collection requirements and providing summaries of the comments received and our responses to those comments.

Regarding wage data, we generally used data from the Bureau of Labor Statistics to derive average labor costs (including fringe benefits) for estimating the burden associated with the ICRs.

### A. ICRs Regarding State Disclosures (§147.102(b), §147.102(e), §147.103, §156.80(c))

The final rule directs states to submit to CMS certain information as applicable about their rating and risk pooling requirements. A state will inform CMS if it adopts a narrower age rating ratio than 3:1 or adopts a narrower rating ratio for tobacco use than 1.5:1. A state will also submit information to CMS regarding state-established geographic rating areas and state-established uniform age rating curves. A state with pure community rating will submit information to CMS about its uniform family tiers and corresponding multipliers, if any. A state will also inform CMS if it requires premiums to be based on average enrollee amounts in the small group market (§147.103). Finally, a state will inform CMS if it elects to merge its individual and small group market risk pools (§156.80(c)). Because we do not know how many states will choose to establish their own geographical rating areas, age rating curves, and family tier structures; adopt narrower age or tobacco rating factors; require premiums to be based on

average enrollee amounts in the small group market; or merge their individual and small group market risk pools, we have estimated the burden for one state.

The burden associated with this requirement is the time involved for states to provide to CMS information on the rating factors and requirements applicable to their small group and individual markets. If a state adopts narrower rating ratios for age or tobacco use, or chooses to merge their individual and small group market risk pools, the state will inform CMS. We estimate that it will take 20 minutes for a state to prepare and submit a report to CMS for each of these disclosures, for a total burden of one hour and a cost of approximately \$31 for all three reports combined.

This final rule provides that a state's rating areas must be based on the geographic divisions of counties, three-digit zip codes, or MSAs and non-MSAs and will be presumed adequate if either of the following conditions are met: (1) As of January 1, 2013, the state had established by law, rule, regulation, bulletin, or other executive action uniform geographic rating areas for the entire state; or (2) After January 1, 2013, the state establishes by law, rule, regulation, bulletin, or other executive action for the entire state no more geographic rating areas than the number of MSAs in the state plus one. We anticipate that states that currently have geographical rating areas will retain them. For states that establish rating areas, we estimate that it will take one hour for a state to prepare and submit a report to CMS on its geographical rating areas, for a burden of one hour and a cost of approximately \$31.

If a state develops an age rating curve, the state will report the state's age rating curve to CMS. We anticipate that HHS's default standard age rating curve will apply in most states. Only one state commented that it would establish its own age rating curve. For states that

designate their own curve, we estimate that it will take three hours for each state to prepare and submit a report on its age rating curve, for a burden of three hours and a cost of \$93.

If a state is community rated and designates a uniform family tier structure with corresponding multipliers, the state will report family tier structure information to CMS. We estimate that very few states will designate family tier structures and that it will take one hour to prepare and submit a report to CMS. The burden for reporting family tier structure information is estimated to be one hour, and a cost of approximately \$31.

If a state requires premiums in the small group market to be based on average enrollee amounts, it will submit that information to CMS. We estimate that it will take one hour for a state to prepare and submit the report on small group market premiums to CMS, for a burden of one hour and a cost of approximately \$31.

We assume that each report will be prepared by clerical staff (at a cost of approximately \$31 per hour) and will be reviewed by a senior manager (using 1 hour of labor at approximately \$65 per hour) prior to submission to CMS. The total burden for all disclosures is eight hours (seven by clerical staff and one by a senior manager) and approximately \$279 per state, if a state needs to prepare and submit a report in all of these areas.

We expect that states that already have established a narrower age or tobacco rating ratio, family tier structure and requirements for small group market premiums to be based on average enrollee amounts, will retain them and simply incur the burden of reporting them. Based on our interactions with state officials and review of publicly available studies prepared by actuarial firms on the impact of the Affordable Care Act on the health insurance market in various states, we believe that many states have already studied the issue of merging their individual and small

group market risk pools and would only incur the burden of reporting. We anticipate that few states will choose to establish their own age rating curve or establish new geographical rating areas and incur related administrative costs. If a state chooses to establish its own age rating curve (§147.102(e)), it is likely to engage an actuarial consultant. We estimate that it will require approximately 100 hours of effort by an actuary (at a cost of \$225 per hour) and 23 hours of combined labor by state actuaries (10 hours at a cost of approximately \$50 per hour) and senior management (13 hours at a cost of approximately \$65 an hour) to establish an age curve. The total burden will be 123 hours and approximately \$24,000. If a state chooses to establish geographical rating areas (§147.102(b)), if they haven't already done so, staff actuaries are likely to conduct an analysis and prepare a report for management (30 hours at a cost of approximately \$50 per hour) and senior management will review the reports and make a decision (2 hours at a cost of approximately \$65 an hour). The total burden would be 32 hours and approximately \$1,600.

#### B. ICRs Regarding Rate Increase Disclosure and Review (§154.215, §154.301)

This final rule directs that health insurance issuers use a unified rate review template, as specified by the Secretary, to report information about a proposed rate increase to CMS. States with effective rate review programs have the option to incorporate this template into their rate review process. The existing information collection requirement (OMB Control Number 0938-1141) includes a standardized template that is currently used by issuers seeking rate increases to submit data to CMS. CMS published an updated rate review template for public comment, in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35).

Health insurance issuers seeking rate increases will submit data using the unified rate

review template and will incur administrative costs to prepare and submit the data. Based on CMS's experience with the 2011 MLR reporting year, there are 2,010 health insurance issuers (company/state combinations, including territories) offering coverage in the individual market in all states and 1,050 issuers offering coverage in the small group market in all states, while there are 2,294 unique issuers offering products in one or both markets. Most issuers already have to provide this information to their respective states. We anticipate a total of 7,650 submissions for rate review increases annually in both markets. Based on past experience, we anticipate that approximately 1,200 of these submissions will be for rate increases at or above the subject to review threshold and the remaining 6,450 submissions will be for rate increases below the review threshold. We assume that each submission will require 11 hours of work by an actuary (at a cost of \$225 per hour), including minimal time required for recordkeeping. The total cost for all submissions will be approximately \$19 million. Therefore, the increase in administrative costs for all issuers seeking rate increases below the review threshold will be approximately \$16 million, with an average of \$7,000 per issuer. It should be noted that there are administrative efficiencies gained by helping issuers to avoid significant duplication of effort for filings subject to review by using the same standardized template for all issuers offering health insurance coverage in the small group or individual markets across all states, and because the vast majority of states currently require all rate increases to be filed. These efficiencies are not quantified in this rule.

A few commenters remarked that the costs related to rate review template submission have been underestimated. An industry group also provided estimates of the number of submissions and related costs. According to industry feedback received by CMS, the current rate

review template being used requires only one to four hours of actuarial labor to complete. The unified rate review template includes more data and we estimate that it would take an actuary 11 hours, on average, to complete. Issuers will have to submit only one consolidated report for all their products in a market, unlike the current template in use which requires a separate submission for each product.

Additionally, issuers seeking rate increases may need to adjust their systems to provide the data required in the unified rate review template and incur one-time costs. One commenter provided a range of anticipated costs obtained from an industry survey. However, we do not expect many issuers to undertake major systems changes to prepare the rate review submissions. Most of the data elements specified in the new template are currently captured by issuers and most of the changes will involve categorizing the data into new categories and aggregating the information to the market level. We estimate that an issuer would need, on average, 40 hours of work by a programmer (at a cost of approximately \$50 per hour) to develop a program that will extract the necessary data from its systems. The total one-time cost to all issuers for developing a program to extract the necessary data will be approximately \$4.6 million, with an average cost of approximately \$2,000 per issuer.

For filings subject to review, states with effective rate review programs may use the data submissions in their reviews; however, this is not expected to increase review costs.

Based on comments received and discussions with issuers and states, we have made changes to the proposed template to address concerns that have been raised. We have both removed data elements from the uniform rate review template and identified information that will be optional in the first two years of applicability. We estimate that through these changes

we have reduced the number of required data elements by approximately 45 percent. States may collect additional information above this baseline. We expect that the unified rate review template will not significantly increase the burden on states or industry; rather, the data requested in the template will assist states and industry in complying with the market rules.

In addition, the final rule gives states with effective rate review programs the discretion to choose whether to incorporate the unified rate review template in their rate review processes or whether to use their own rate review templates. Issuers in states with effective rate review programs that do not require the federal template will still be required to submit information about all rate increases to CMS on the template.

**Table V.1: Annual Reporting, Recordkeeping and Disclosure Burden\***

Regulation Section(s)	Number of respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting (\$)	Total Labor Cost of Reporting (\$)	Total Capital / Maintenance Costs (\$)	Total Cost (\$)
Age Ratio, Tobacco Ratio, Rating areas, Family Tier, Small Group Market Premium, Age rating curve: §147.103; Risk Pool Merger: §156.80 (c)	1	8	1	8	\$35	\$279	0	\$279
Age curve (§147.102(e))	1	1	123	123	\$194	\$24,000	0	\$24,000
Geographical Rating Area (§147.102(b))	1	1	32	32	\$51	\$1,600	0	\$1,600
Rate Increase Disclosure and Review (§154.215, §154.301)**	2,294	7,650	11	84,150	\$225	\$19,000,000	0	\$19,000,000
<b>Total</b>				<b>84,313</b>		<b>\$19,025,879</b>		<b>\$19,025,879</b>

\* Not included in this table is a \$4.6 million upfront burden related to rate increase disclosures.

\*\* Of the \$19 million labor cost of reporting, only \$16.3 million is attributable to this rule.

We have submitted an information collection request to OMB for review and approval of the ICRs contained in this final rule. The requirements are not effective until approved by OMB and assigned a valid OMB control number.

**VI. Regulatory Impact Analysis**

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

#### A. Summary

As stated earlier in this preamble, this final rule implements the Affordable Care Act's requirements on health insurance coverage related to fair health insurance premiums, guaranteed availability, guaranteed renewability, single risk pools, and catastrophic plans. These provisions are generally effective for plan or policy years beginning on or after January 1, 2014. In addition, this final rule amends the standards for health insurance issuers and states regarding reporting, utilization, and collection of data under the rate review program.

CMS has crafted this final rule to implement the protections intended by Congress in an economically efficient manner. We have examined the effects of this final rule as required by Executive Order 13563 (76 FR 3821, January 21, 2011), Executive Order 12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). In accordance with OMB Circular A-4, CMS has quantified the benefits, costs, and transfers where possible, and has also provided a qualitative discussion of the benefits, costs, and transfers that may stem from this final rule.

#### B. Executive Orders 13563 and 12866

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and

safety effects; distributive impacts; and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a final rule -- (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (for example, \$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the OMB. OMB has designated this final rule as a “significant regulatory action.” Even though it is uncertain whether it is likely to have economic impacts of \$100 million or more in any one year, CMS has provided an assessment of the potential costs, benefits, and transfers associated with this final regulation.

#### 1. Need for Regulatory Action

Sections 1302(e) and 1312(c) of the Patient Protection and Affordable Care Act (Affordable Care Act), and sections 2701, 2702, and 2703 of the Public Health Service Act (PHS Act), as added and amended by the Affordable Care Act, create certain standards related to fair

health insurance premiums, guaranteed availability, guaranteed renewability, risk pools, and catastrophic plans applicable to non-grandfathered health insurance coverage starting in 2014. These final regulations provide the necessary guidance to implement these important consumer protections. The current individual and small group health insurance markets generally are viewed as dysfunctional, placing consumers at a disadvantage due to the high cost of health insurance coverage, resulting from factors such as lack of competition, adverse selection, and limited transparency. In addition to affordability concerns, many people have difficulty finding and enrolling in coverage options. If employer-based coverage is not available, a person may find that affordable individual market coverage is not available due to medical underwriting. The provisions of this final rule, combined with other provisions in the Affordable Care Act, will improve the functioning of both the individual and the small group markets and make insurance affordable and accessible to millions of Americans who currently do not have affordable options available to them. In addition, this final rule would amend the existing rate review standards to reflect the new market conditions in 2014.

## 2. Summary of Impacts

In accordance with OMB Circular A-4, Table VI.1 below depicts an accounting statement summarizing CMS's assessment of the benefits, costs, and transfers associated with this regulatory action. The period covered by the RIA is 2013–2017.

CMS anticipates that the provisions of these final regulations would ensure increased access and improve affordability of health insurance coverage in the individual and small group markets. Individuals who are currently unable to obtain affordable coverage because of their medical history, health status, gender, or age will be able to obtain such coverage under these

final rules, along with other provisions of the Affordable Care Act, leading to an increase in the number of people with health insurance. Newly insured individuals and individuals with expanded coverage will have increased access to health care, improving utilization of preventive care and health outcomes and protection from the risk of catastrophic medical expenditures, leading to financial security. In addition, an issuer seeking a rate increase will submit data and documentation about the rate increase using a unified rate review template, which will provide CMS the data necessary for monitoring rate increases. In accordance with Executive Order 12866, CMS expects that the benefits of this final regulatory action justify the costs.

**Table VI.1: Accounting Table**

<b>Benefits:</b>				
Qualitative:				
* Increase in enrollment in the individual and small group market leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures				
* A common marketing standard covering the entire insurance market, reducing adverse selection, improving market oversight and competition and reducing search costs for consumers				
* Decrease in administrative costs for issuers due to elimination of medical underwriting and coverage exclusions				
* Prevent duplication of effort for rate review filings subject to review by setting forth a unified rate review template for all issuers offering health insurance coverage in the small group or individual markets				
* Provide state departments of insurance with more capacity to conduct meaningful rate review and approval of products sold inside and outside an Exchange by using a unified rate review template				
* Extend the availability and affordability of student health coverage as a transitional policy				
<b>Costs:</b>	Estimate	Year Dollar	Discount Rate	Period Covered
<b>Annualized Monetized (\$/year)</b>	\$ 17.3 million	2012	7%	2013-2017
	\$17.3 million	2012	3%	2013-2017
Administrative costs related to submission of data by issuers seeking rate increases below the rate review threshold, one-time fixed costs to issuers related to rate review data extraction, disclosure of state rating requirements and costs incurred by states choosing to establish rating areas and age rating curves				
Qualitative:				
* Additional costs incurred by issuers to comply with provisions in the final rule				
* Costs related to possible increases in utilization of health care for the newly insured				
* Costs incurred by states for disclosure of rate increases, if applicable				
<b>Transfers:</b>				
Qualitative:				
* Lower rates for individuals in the individual and small group market who are older and/or in relatively poor health, and women; and potentially higher rates for some young men which will be mitigated by				

provisions such as premium tax credits, risk stabilization programs, access to catastrophic plans, and the minimum essential coverage provision

- \* Reduction in uncompensated care for providers who treat the uninsured and increase in payments from issuers
- \* Decrease in out-of-pocket expenditures by the newly insured and increase in health care spending by issuers, which may be more than offset by an increase in premium revenue

### 3. Anticipated Benefits, Costs and Transfers

In developing this final rule, CMS carefully considered its potential effects including both costs and benefits. One commenter suggested providing additional quantitative estimates of benefits, costs and transfers. Because of data limitations, CMS did not attempt to quantify all of the benefits, costs, and transfers resulting from this final rule. Nonetheless, CMS was able to identify several potential impacts which are discussed qualitatively below.

There are diverse state laws and industry practices currently in place that result in wide variation in premium rates (henceforth referred to as “rates”) and coverage for individual and group health insurance markets. Regarding the individual market, only five states have both guaranteed availability for at least some products and modified or pure community rating requirements, while in other states, issuers can deny health insurance coverage or charge higher premiums to people with medical conditions.<sup>20</sup> Currently, 11 states and the District of Columbia have rate bands, which allow issuers to vary rates only within a certain range of the average rate, two states prohibit rating based on age, and five states prohibit rating based on tobacco use in the individual market.<sup>21</sup> In the small group market, 36 states and the District of Columbia have rate bands, 12 states have community rating requirements, two states do not allow rating based on

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<sup>20</sup> GAO, Private Health Insurance: Estimates of Individuals with Preexisting Conditions Range from 36 Million to 122 Million, GAO-12-439, March 2012.

<sup>21</sup> Kaiser Family Foundation, Focus on Health Reform: Health Insurance Market Reforms: Rate Restrictions, June 2012.

age and 16 do not allow rating based on tobacco use. In many states, women are charged higher premiums than men: only 14 states prohibit gender rating in the individual market while 15 states do not allow gender rating in the small group market. Of the states that prohibit gender rating in the individual market, only three of those states require maternity coverage in all policies, meaning that women in the other states can be charged additional premiums for maternity coverage.

Currently, only five states have guaranteed availability in the individual market. Studies show that 48 states require guaranteed renewability in the small group market while all 50 states provide some level of guaranteed renewability in the individual market. In addition, HIPAA already provides guaranteed renewability of coverage to individuals and employers, irrespective of state law. Therefore, this provision is not expected to have any significant effect in that regard.

Starting in 2014, issuers in the individual and small group markets will only be allowed to vary rates based on age and tobacco use within specified ranges, family size, and geography (the fair health insurance premium requirement). Issuers generally will accept every individual and employer that applies for health insurance coverage (the guaranteed availability requirement), and, subject to certain exceptions, must also renew or continue health insurance coverage at the option of the plan sponsor or individual (the guaranteed renewability requirement). In addition, issuers must have single risk pools for each of the individual and small group markets, or a single merged risk pool, if a state so elects, which will include all individuals enrolled in non-grandfathered plans in the applicable market (the single risk pool requirement).

The provisions of the final rule will affect the characteristics of enrollees, enrollment, and premium rates in the individual and small group markets. In addition, several other related provisions of the Affordable Care Act that will be effective in 2014, such as establishment of the Exchanges, premium tax credits, and the minimum essential coverage provision, will improve access to and affordability of health insurance coverage. The Congressional Budget Office (CBO) estimates that, by 2017, the number of uninsured will be reduced by 27 million.<sup>22</sup> Therefore, it is appropriate to take into consideration the effect of all these provisions in this analysis, even though not all of them are the focus of this final rule. It should be noted that the impact of these provisions may vary between states, because of the differences in current regulatory frameworks.

A few commenters referred to actuarial studies that include estimates of premium changes in different states and markets.<sup>23</sup> Actuarial studies that conclude that premiums will increase for certain markets or age groups generally do not take into account all the provisions of the Affordable Care Act and factors that would affect premiums and also assume that the risk pool will worsen as a result of these provisions. However, we, along with CBO, anticipate that the risk pool will improve. Different provisions of the Affordable Care Act can have opposing effects on premiums. Some of the other provisions, in addition to the ones mentioned above, that will also affect premiums are essential health benefits, medical loss ratio requirements, risk adjustment, temporary risk corridors and the transitional reinsurance programs. There are also

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<sup>22</sup> “CBO’s February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance,” Congressional Budget Office, February 2013.

<sup>23</sup> For example, studies on the Alaska Individual Market by Lewis & Ellis, Indiana Individual Market by Milliman, Maine Small Group Market by Jonathan Gruber & Gorman Actuarial, LLC and Wisconsin Small Group Market by Jonathan Gruber & Gorman Actuarial, LLC.

factors such as benefit improvements; competition among issuers in the Exchanges to be the second lowest cost silver plan; migration of current membership to more efficient, lower premium plans due to increased transparency; new plan design offerings such as Accountable Care Organizations and issuers re-contracting with providers to obtain lower unit prices due to reduction in uncompensated or charity care. In addition, studies that focus on premiums do not take into account the decrease in out-of-pocket costs for consumers. According to a study, in 2010, 49 million working-age adults spent at least 10 percent of their income on health insurance premiums and out-of-pocket costs and 20 million working-age adults' out-of-pocket costs were so high compared to their income that they were effectively underinsured.<sup>24</sup> Increased access will lead to a decrease in out-of-pocket costs for these individuals.

This final rule directs that health insurance issuers use a unified rate review template, as specified by the Secretary, to report information about a proposed rate increase to CMS. States will continue to have the authority to collect additional information above this baseline to conduct more thorough reviews or rate monitoring.

a. Benefits

In 2011, 48.6 million people in the United States were uninsured.<sup>25</sup> In addition, an estimated 29 million adults were underinsured in 2010.<sup>26</sup> Studies have shown that people without health insurance have reduced access to health care, higher out-of-pocket costs, higher

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<sup>24</sup> Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011.

<sup>25</sup> Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement, Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2011.

<sup>26</sup> Cathy Schoen Michelle M. Doty, Ruth H. Robertson and Sara R. Collins, Affordable Care Act Reforms Could Reduce The Number Of Underinsured US Adults by 70 Percent, Health Affairs, 30, no.9 (2011):1762-1771.

mortality rates and receive less preventive care.<sup>27</sup> Uninsured and underinsured people are also more likely to be unable to pay their medical bills, have medical debt, and experience financial difficulties.

The provisions of this final rule and other changes implemented by the Affordable Care Act will increase enrollment in the individual and small group markets. According to CBO, there will be approximately 26 million enrollees in Exchange coverage by 2017. CBO estimates that, by 2017, the number of uninsured will be reduced by 27 million.<sup>28</sup> Access to catastrophic plans is likely to further increase the number of insured. The provisions of this final rule will also preserve affordability and availability of student health insurance coverage. Newly insured individuals and individuals with expanded coverage will have access to better health care and experience a reduction in out-of-pocket costs. Ample research demonstrates that access to insurance coverage improves utilization of preventive care, improves health outcomes, and creates less financial debt, which would lead to better financial security.<sup>29</sup> The State of

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<sup>27</sup> The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance*, Washington, D.C., 2011, citing a number of studies on the effects of being uninsured; ASPE, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills*, 2011 (<http://aspe.hhs.gov/health/reports/2011/valueofinsurance/rb.shtml>); Sara R. Collins, Ruth Robertson, Tracy Garber, and Michelle M. Doty, *The Income Divide in Health Care: How the Affordable Care Act Will Help Restore Fairness to the U.S. Health System*, The Commonwealth Fund, February 2012 ; J. Doyle, *Health Insurance, Treatment and Outcomes: Using Auto Accidents as Health Shocks*, *Review of Economics and Statistics*, 87(2): 256-270, 2005 ; S. Dorn, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*, Urban Institute , 2008; Cathy Schoen, Michelle M. Doty, Ruth H. Robertson and Sara R. Collins, *Affordable Care Act Reforms Could Reduce The Number Of Underinsured US Adults by 70 Percent*, *Health Affairs*, 30, no.9 (2011):1762-1771.

<sup>28</sup> “CBO’s February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage,” Congressional Budget Office, February 2013.

<sup>29</sup> T. Gross and Notowidigdo, *Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid*, *Journal of Public Economics*, 95(7-8):767-778, 2011; J. Doyle, *Health Insurance, Treatment and Outcomes: Using Auto Accidents as Health Shocks*, *Review of Economics and Statistics*, 87(2): 256-270, 2005; Amy Finkelstein, et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, National Bureau of Economic Research Working Paper No. 17190, July 2011; Institute of Medicine, *Care without coverage: too little, too late*, National Academies Press, 2002; J. Ayanian et al., *Unmet Health Needs of Uninsured Adults in the United States*, *JAMA* 284(16):2061-9, 2000; Andrew P. Wilper, et al., *Health Insurance and Mortality in US Adults*.

Massachusetts passed similar health reforms in 2006, and now has the lowest uninsured rate in the country. In 2011, only 3.4 percent of Massachusetts residents were uninsured.<sup>30</sup> This has resulted in increased access to health care, including preventive care and fewer individuals with high out-of-pocket spending.<sup>31</sup>

Research shows that individuals in relatively poor health experience difficulty obtaining health insurance coverage. This results in lack of adequate access to health care and higher out-of-pocket expenses for these individuals. According to a recent study by U.S. Government Accountability Office (GAO), between 36 million and 122 million adults age 19 to 64 years old (or between 20 and 66 percent of the adult population) have medical conditions that could result in issuers denying them coverage or charging higher premiums.<sup>32</sup> Of these, an estimated 88 to 89 percent live in states that do not have insurance protections provided by the fair health insurance premium and guaranteed availability provisions of the Affordable Care Act. The GAO study estimated that health care expenditures for adults with medical conditions are, on average, between \$1,504 and \$4,844 more per year than for other adults. Similarly, a study by HHS found that there are between 50 million and 129 million non-elderly individuals with a medical condition, including between 4 and 17 million children under age 18, and up to 25 million of

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American Journal of Public Health, 99(12) 2289-2295, 2009; S. Dorn, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality, Urban Institute, 2008; Jack Hadley, Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition, JAMA. 2007;297(10):1073-1084. doi: 10.1001/jama.297.10.1073; K. Cook et al., Does major illness cause financial catastrophe?, Health Services Research 45, no. 2, 2010.

<sup>30</sup> Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement, Table HI06. Health Insurance Coverage Status by State for All People: 2011.

<sup>31</sup> Kaiser Family Foundation, Focus on Health Reform: Massachusetts Health Care Reform: Six Years Later, June 2012.

<sup>32</sup> GAO, Private Health Insurance: Estimates of Individuals with Preexisting Conditions Range from 36 Million to 122 Million, GAO-12-439, March 2012.

these adults and children are uninsured.<sup>33</sup> A study found that, in 2010, 35 percent of nonelderly adults who shopped for health insurance coverage in the individual market were denied coverage or received coverage exclusions for medical conditions.<sup>34</sup> The Affordable Care Act's provision on guaranteed availability will prohibit issuers from denying coverage to individuals based on their health status or any other factor, and the provision on fair insurance premiums will prevent issuers from charging a higher premium to individuals based on health status. The final rule will ensure that individuals who would have been denied coverage or charged excessively high premium rates, for reasons such as medical conditions or high expected medical costs, will now be able to obtain health insurance at an affordable cost. In addition, young adults and people for whom coverage would otherwise be unaffordable will have access to a catastrophic plan that will have a lower premium, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing.

The provisions of this final rule and other changes implemented by the Affordable Care Act will increase enrollment in the individual market. An analysis by CBO and the staff of the Joint Committee on Taxation (JCT)<sup>35</sup> estimated that the characteristics of enrollees in the individual market will be significantly different, especially due to the addition of people who would have been uninsured in the absence of the Affordable Care Act. CBO and JCT estimated that relatively more new enrollees in the individual market would be younger and healthier and

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<sup>33</sup> ASPE, *At Risk: Preexisting Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, November 2011.

<sup>34</sup> Sara R. Collins, *Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance*, The Commonwealth Fund, October 27, 2011.

<sup>35</sup> Congressional Budget Office, *Letter to Honorable Evan Bayh, providing an Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, November 30, 2009.

likely to use less medical care, and the addition of new enrollees would result in average premium rates in the market being 7 to 10 percent lower in 2016 compared to what they would have been in the absence of the Affordable Care Act, all else held constant. According to CBO and JCT, the characteristics of people in the small group market would change slightly, and projected premium rate changes could decrease up to 1 percent.

Currently, health insurance issuers may maintain several blocks of business, or “pools,” for their individual and small group market business. Most states place some restrictions on the number of small group blocks of business. However, the individual market generally has not been subject to similar restrictions. In the past, some issuers used separate pools to segment risks, resulting in large rate increases for less-healthy enrollees. A single risk pool will tend to lower rates for relatively unhealthy participants in the individual market by including younger, healthier individuals in the pool and ensuring that newer and more long-term policyholders are pooled together. In the small group market, a single risk pool will stabilize rates.

The guaranteed availability provision may result in some adverse selection -- individuals with poor health who would have been denied coverage before in some states will now be able to obtain health insurance. However, according to CBO and JCT,<sup>36</sup> adverse selection will be mitigated principally by the minimum essential coverage provision and the availability of premium tax credits, which will make insurance affordable for millions of Americans for whom it is currently unaffordable. Other factors such as fixed open enrollment periods will also help to mitigate adverse selection. The Affordable Care Act also establishes a transitional reinsurance program, a temporary risk corridor program, and a permanent risk adjustment program, which

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<sup>36</sup> Congressional Budget Office, Letter to Honorable Evan Bayh providing An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, November 30, 2009.

will provide payments to issuers providing coverage to high-risk individuals, to mitigate the potential effects of adverse selection. These programs will provide payment stability to issuers and reduce uncertainty in insurance risk in the individual market and in the small group market, in the case of the permanent risk adjustment program.

Administrative costs for issuers will be lowered because of the elimination of medical underwriting and the ban on coverage exclusions. Costs should decrease for processing new applications for coverage and implementing the coverage exclusions in the individual and small group markets. This, in turn, could contribute to lower premium rates.

The final rule also requires all health insurance issuers marketing group or individual health insurance coverage to comply with the same marketing standards as issuers offering QHPs within the Exchanges. This minimizes the potential for the adverse selection that could result if plans sold through Exchanges were subject to different marketing standards from plans sold outside of the Exchanges. A common standard covering the entire insurance market will also ensure consistency in market oversight, increase competition, and reduce search costs for consumers.<sup>37</sup>

The amendments to the rate review standards will help avoid significant issuer duplication of effort for filings subject to review by using the same standardized template for all issuers offering health insurance coverage in the small group or individual markets.

Additionally, the use of the unified rate review template will provide the necessary information to conduct the review and approval of products sold inside and outside an Exchange, monitor rates to detect patterns that could signal market disruption, and oversee the market-wide rules.

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<sup>37</sup> R. Cebul et al., *Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance*, *American Economic Review* 101(5): 1842-1847, 2011.

b. Costs

Under the final rule, issuers will likely incur some one-time, fixed costs in order to comply with the provisions of this final rule, including administrative expenditures for systems and software updates and changes in marketing. In addition, states may incur costs in order to establish geographic rating areas and uniform age rating curves. We do not anticipate that many states will establish their own age curve: only one state has indicated that it would establish its own age rating curve. As discussed in section V. of the preamble, we estimate that a state would incur approximately \$24,000 in costs to establish its own age curve. The final rule provides that a state's rating areas must be based on the geographic divisions of counties, three-digit zip codes, or MSAs and non-MSAs and will be presumed adequate if either of the following conditions are met: (1) As of January 1, 2013, the state had established by law, rule, regulation, bulletin, or other executive action uniform geographic rating areas for the entire state; or (2) After January 1, 2013, the state establishes by law, rule, regulation, bulletin, or other executive action for the entire state no more geographic rating areas than the number of MSAs in the state plus one. States have the option to seek approval from CMS of a greater number of rating areas as long as the areas are based on counties, three-digit zip codes, or MSAs and non-MSAs. We anticipate that few states will incur costs related to establishing rating areas and estimate that related costs will be approximately \$1,600 each for those that do.

In addition to these administrative costs, insurance coverage can lead to increased utilization of health services for individuals who become newly insured. While a portion of this increased utilization may be economically inefficient, studies that estimated the effects of Medicare found that the cost of this inefficiency is likely more than offset by the benefit of risk

reduction.<sup>38 39</sup>

The final rule also directs states to provide information to CMS about their rating and risk pooling practices in several key areas, as applicable. They include: age and tobacco rating factors, age rating curves, family tier structure, composite rating in the small group market, geographical rating areas, and combined individual and small group market risk pools. As discussed in section V. of the preamble, we estimate a total burden of approximately \$279 for a state to submit information in all seven areas. This estimate does not include the costs of establishing age curves and geographical rating areas, which are discussed above.

Health insurance issuers seeking rate increases below the subject to review threshold will submit data using the unified rate review template and incur administrative costs to prepare and submit the data. As discussed in section V. of the preamble, we estimate that the increase in administrative costs for all issuers seeking rate increases below the review threshold will be approximately \$16 million, with an average of \$7,000 per issuer. It should be noted that the vast majority of states currently require all rate increases to be filed and that administrative efficiencies can be gained by avoiding significant issuer duplication of effort for filings subject to review by using the same standardized template for all issuers offering health insurance coverage in the small group or individual markets across all states, and because the vast majority of states currently require all rate increases to be filed. These efficiencies are not quantified in this rule.

Additionally, issuers seeking rate increases may need to adjust their systems to provide

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<sup>38</sup> Finkelstein, A, McKnight R: "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out Of Pocket Medical Spending " *Journal of Public Economics* 2008, 92:1644-1668.

<sup>39</sup> Finkelstein, A., "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," National Bureau of Economic Research. Working Paper No. 11619, Sept, 2005.

the data required in the standardized template format. The total one-time cost to all issuers for developing a program to extract the necessary data from their systems is estimated at approximately \$4.6 million, with an average cost of approximately \$2,000 per issuer.

For filings subject to review, states with effective rate review programs may use the data submissions in their reviews; however, it is not expected to increase review costs.

c. Transfers

As discussed elsewhere in the preamble, most aspects of rating methodologies today are left to the discretion of health insurance issuers, subject to oversight by the states. In most states, issuers may vary premium rates based on a number of factors such as age, health status, and gender. In 2010, 60 percent of non-elderly adults who shopped for insurance coverage in the individual market had difficulty finding affordable coverage.<sup>40</sup> Also, as a result of current gender rating, premium rates for women are significantly higher than those for men. According to a study by the National Women's Law Center, 92 percent of best-selling plans currently practice gender rating.<sup>41</sup> The provision of fair premiums will allow issuers to vary rates based on only a limited number of factors and within specified ranges. Since rating based on gender and health will no longer be allowed, rates for some older, less healthy adults and women may decrease. While these rules could increase rates for younger, healthier adults and for some men, other factors will mitigate the effects of reformed rating practices, such as choices of and competition among plans on Exchanges, greater pooling of risks through the Exchanges,

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<sup>40</sup> Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011.

<sup>41</sup> National Women's Law Center, Turning to Fairness: Insurance discrimination against women today and the Affordable Care Act, Washington, D.C., March 2012.

premium tax credits, the risk stabilization programs, access to catastrophic plans, and the minimum essential coverage provision.

As people who were previously uninsured obtain coverage, their out-of-pocket expenses are expected to decrease while the issuers' spending will increase, which is expected to be mitigated by an increase in premium collections. Expansion in health insurance coverage will also reduce the amount of uncompensated care for providers that treat the uninsured. Millions of people without health insurance now use health care services for which they do not fully pay, shifting the uncompensated cost of their care to health care providers, people who do have insurance (in the form of higher premiums), and state and local governments.<sup>42</sup> Providers of uncompensated care try to recover the money by increasing the amounts charged to insurance companies, which results in higher premiums for individuals with private insurance. The cost of uncompensated care for the previously uninsured will be transferred from the providers (for example, hospitals and physicians), governmental programs and charitable organizations to the individuals and issuers of their health insurance coverage. Reduction in the number of uninsured would reduce the amount of uncompensated care and could lead, all else held equal, to a decrease in private health insurance rates.

### C. Regulatory Alternatives

Under Executive Order 12866, CMS is required to consider alternatives to issuing rules and alternative regulatory approaches.

Under the final rule, all issuers in a state and market will use a uniform age rating curve.

CMS considered the alternative of allowing issuers to set their own rating curve. Under the

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<sup>42</sup> Families USA, Hidden Health Tax: Americans Pay a Premium (Washington, DC: Families USA, 2009) (<http://familiesusa2.org/assets/pdfs/hidden-health-tax.pdf>).

alternative, issuers would have more flexibility and might incur lower upfront, fixed costs (for example, systems and software updates) to comply with the final rule. A uniform age rating curve, however, improves the accuracy of risk adjustment, provides for easier price comparisons between different plans, and simplifies identification of the second lowest cost silver plan for purposes of determining premium tax credits.

CMS also considered the alternatives of including a tobacco component for the rating curve and keeping the rating factor for tobacco use separate from the wellness program rules. These alternatives would reduce flexibility for the issuers with respect to rating for tobacco use and would provide no alternative to the tobacco surcharge which could discourage disclosure of tobacco use. Under the final rule, a health insurance issuer in the small group market may implement the tobacco use surcharge only in connection with a wellness program that effectively allows tobacco users to reduce their premiums to the level of non-tobacco users by participating in a tobacco cessation program or satisfying another reasonable alternative. This provision will help to alleviate underreporting of tobacco use and promote tobacco cessation strategies that improve health and reduce health care costs.

CMS believes that the provisions of this final rule strike the best balance of extending protections of the Affordable Care Act to consumers while preserving the availability of such coverage and minimizing market disruptions to the extent possible.

#### D. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a “small entity” as -- (1) a proprietary firm

meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000 (states and individuals are not included in the definition of “small entity”). CMS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed in the Web Portal final rule published on May 5, 2010 (75 FR 24481), CMS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the final rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for “small” business established by the SBA (currently \$7 million in annual receipts for health issuers).<sup>43</sup>

In addition, CMS used the data from Medical Loss Ratio (MLR) annual report submissions for the 2011 MLR reporting year to develop an estimate of the number of small entities that offer comprehensive major medical coverage. These estimates may overstate the actual number of small health insurance issuers that would be affected, since they do not include receipts from these companies’ other lines of business. It is estimated that there are 22 small entities each with less than \$7 million in earned premiums that offer individual or group health insurance coverage and would therefore be subject to the requirements of this final regulation. These small entities account for less than five percent of the estimated 466 companies offering health insurance coverage in the individual or group markets in different states that would be

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<sup>43</sup> Table of Small Business Size Standards Matched to North American Industry Classification System Codes, effective March 26, 2012, U.S. Small Business Administration, available at [www.sba.gov](http://www.sba.gov).

affected by the provisions of this rule. Thirty six percent of these small entities belong to holding groups, and many if not all of these small entities are likely to have other lines of business that would result in their revenues exceeding \$7 million. For these reasons, CMS expects that this final rule will not affect small issuers.

The requirements in this final rule may affect health insurance premiums in the small group market. We expect that many employers that purchase health insurance coverage in the small group market would meet the SBA standard for small entities. As mentioned earlier in the impact analysis, the impact on premiums is likely to be small and may even lead to lower rates in the small group market. CMS will monitor premium changes in the small group market through the rate review program.

#### E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a federal mandate that could result in any expenditure in any one year by state, local or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In early 2013, that threshold level is approximately \$139 million.

UMRA does not address the total cost of a final rule. Rather, it focuses on certain categories of cost, mainly those “federal mandate” costs resulting from--(1) imposing enforceable duties on state, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs.

This final rule gives state governments the option to establish rating areas within the state

and uniform age rating curves. There are no mandates on local or tribal governments. State governments may incur administrative cost related to the option of establishing rating areas and uniform age rating curves. However, if the state government does not act, CMS will establish the rating areas and uniform age rating curve in that state. State governments will also incur administrative costs related to disclosure of rating and pooling requirements to CMS, which are estimated to be \$279 per state. The private sector (for example, health insurance issuers) will incur administrative costs related to the implementation of the provisions in this final rule. This final rule does not impose an unfunded mandate on local or tribal governments. However, consistent with policy embodied in UMRA, this final rule has been designed to be low-burden alternative for state, local and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

#### F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications.

As discussed earlier in the preamble, states are the primary regulators of health insurance coverage. States will continue to apply state laws regarding health insurance coverage. However, if any state law or requirement prevents the application of a federal standard, then that particular state law or requirement would be preempted. If CMS determines that a state does not meet the criteria for an effective rate review program, then CMS will review a rate increase subject to review to determine whether it is unreasonable. If a state does meet the criteria, then CMS will adopt that state's determination of whether a rate increase is unreasonable. States will

continue to apply state law requirements regarding rate and policy filings. State requirements that are more stringent than the federal requirements would be not be preempted by this final rule. Accordingly, states have significant latitude to impose requirements with respect to health insurance coverage that are more restrictive than the federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policymaking discretion of the states, CMS has engaged in efforts to consult with and work cooperatively with affected states, including consulting with National Association of Insurance Commissioners.

Throughout the process of developing this final rule, CMS has attempted to balance the states' interests in regulating health insurance issuers and Congress's intent to provide uniform protections to consumers in every state. By doing so, it is CMS's view that it has complied with the requirements of Executive Order 13132. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this rule, HHS certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 for the attached final rule in a meaningful and timely manner.

#### G. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

**List of Subjects**45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

45 CFR Part 150

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 147, 150, 154, and 156 as set forth below:

**PART 144 – REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE**

1. The authority citation for part 144 continues to read as follows:

**Authority:** Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

2. Amend §144.101 by revising paragraphs (d)(1) and (d)(2) to read as follows:

**§144.101 Basis and Purpose.**

\* \* \* \* \*

(d) \* \* \*

(1) States that fail to substantially enforce one or more provisions of part 146 concerning group health insurance, one or more provisions of part 147 concerning group or individual health insurance, or the requirements of part 148 of this subchapter concerning individual health insurance.

(2) Insurance issuers in States described in paragraph (d)(1) of this section.

\* \* \* \* \*

3. Revise §144.102 to read as follows:

**§144.102 Scope and applicability.**

(a) For purposes of 45 CFR parts 144 through 148, all health insurance coverage is generally divided into two markets – the group market and the individual market. The group market is further divided into the large group market and the small group market.

(b) The protections afforded under 45 CFR parts 144 through 148 to individuals and employers (and other sponsors of health insurance offered in connection with a group health plan) are determined by whether the coverage involved is obtained in the small group market, the large group market, or the individual market.

(c) Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage under 45 CFR parts 144 through 148. If the coverage is offered to an association member other than in connection with a group health plan, or is offered to an association's employer-member that is maintaining a group health plan that has fewer than two participants who are current employees on the first day of the plan year, the coverage is considered individual health insurance coverage for purposes of 45 CFR parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law. If the health insurance coverage is offered in connection with a group health plan as defined at 45 CFR 144.103, it is considered group health insurance coverage for purposes of 45 CFR parts 144 through 148.

(d) Provisions relating to CMS enforcement of parts 146, 147, and 148 are contained in part 150 of this subchapter.

#### **PART 147 – HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS**

4. The authority citation for part 147 continues to read as follows:

**Authority:** Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

5. A new §147.102 is added to part 147 to read as follows:

**§147.102 Fair health insurance premiums.**

(a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(1) The rate may vary with respect to the particular plan or coverage involved only by determining the following:

(i) Whether the plan or coverage covers an individual or family.

(ii) Rating area, as established in accordance with paragraph (b) of this section.

(iii) Age, except that the rate may not vary by more than 3:1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under paragraph (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph and the age band under paragraph (d) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

(iv) Subject to section 2705 of the Public Health Service Act and its implementing regulations (related to prohibiting discrimination based on health status and programs of health promotion or disease prevention) as applicable, tobacco use, except that such rate may not vary by more than 1.5:1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

(2) The rate must not vary with respect to the particular plan or coverage involved by any other factor not described in paragraph (a)(1) of this section.

(b) Rating area. (1) A state may establish one or more rating areas within that state, as provided in paragraphs (b)(3) and (b)(4) of this section, for purposes of applying this section and the requirements of title XXVII the Public Health Service Act and title I of the Patient Protection and Affordable Care Act.

(2) If a state does not establish rating areas as provided in paragraphs (b)(3) and (b)(4) of this section or provide information on such rating areas in accordance with §147.103, or CMS determines in accordance with paragraph (b)(5) of this section that a state's rating areas under paragraph (b)(4) of this section are not adequate, the default will be one rating area for each metropolitan statistical area in the state and one rating area comprising all non-metropolitan statistical areas in the state, as defined by the Office of Management and Budget.

(3) A state's rating areas must be based on the following geographic boundaries: counties, three-digit zip codes, or metropolitan statistical areas and non-metropolitan statistical areas, as defined by the Office of Management and Budget, and will be presumed adequate if either of the following conditions are satisfied:

(i) The state established by law, rule, regulation, bulletin, or other executive action uniform rating areas for the entire state as of January 1, 2013.

(ii) The state establishes by law, rule, regulation, bulletin, or other executive action after January 1, 2013 uniform rating areas for the entire state that are no greater in number than the number of metropolitan statistical areas in the state plus one.

(4) Notwithstanding paragraph (b)(3) of this section, a state may propose to CMS for approval a number of rating areas that is greater than the number described in paragraph (b)(3)(ii) of this section, provided such rating areas are based on the geographic boundaries specified in paragraph (b)(3) of this section.

(5) In determining whether the rating areas established by each state under paragraph (b)(4) of this section are adequate, CMS will consider whether the state's rating areas are actuarially justified, are not unfairly discriminatory, reflect significant differences in health care unit costs, lead to stability in rates over time, apply uniformly to all issuers in a market, and are based on the geographic boundaries of counties, three-digit zip codes, or metropolitan statistical areas and non-metropolitan statistical areas.

(c) Application of variations based on age or tobacco use. With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(1)(iii) and (a)(1)(iv) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage.

(1) Per-member rating. The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.

(2) Family tiers under community rating. If a state does not permit any rating variation for the factors described in paragraphs (a)(1)(iii) and (a)(1)(iv) of this section, the state may require that premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers established by the state. If a state does not establish uniform family

tiers and the corresponding multipliers, the per-member-rating methodology under paragraph (c)(1) of this section will apply in that state.

(3) Application to small group market. In the case of the small group market, the total premium charged to the group is determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable. Nothing in this section precludes a state from requiring issuers to offer, or an issuer from voluntarily offering, to a group premiums that are based on average enrollee amounts, provided that the total group premium is the same total amount derived in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable.

(d) Uniform age bands. The following uniform age bands apply for rating purposes under paragraph (a)(1)(iii) of this section:

(1) Child age bands. A single age band for individuals age 0 through 20.

(2) Adult age bands. One-year age bands for individuals age 21 through 63.

(3) Older adult age bands. A single age band for individuals age 64 and older.

(e) Uniform age rating curves. Each state may establish a uniform age rating curve in the individual or small group market, or both markets, for rating purposes under paragraph (a)(1)(iii) of this section. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

(f) Special rule for large group market. If a state permits health insurance issuers that offer coverage in the large group market in the state to offer such coverage through an Exchange

starting in 2017, the provisions of this section applicable to coverage in the small group market apply to all coverage offered in the large group market in the state.

(g) Applicability date. The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(h) Grandfathered health plans. This section does not apply to grandfathered health plans in accordance with §147.140.

6. A new §147.103 is added to part 147 to read as follows:

**§147.103 State reporting.**

(a) 2014. If a state has adopted or intends to adopt for the 2014 plan or policy year a standard or requirement described in this paragraph, the state must submit to CMS information about such standard or requirement in a form and manner specified in guidance by the Secretary no later than [OFR—INSERT DATE 30 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER]. A state standard or requirement is described in this paragraph if it includes any of the following:

(1) A ratio narrower than 3:1 in connection with establishing rates for individuals who are age 21 and older, pursuant to §147.102(a)(1)(iii).

(2) A ratio narrower than 1.5:1 in connection with establishing rates for individuals who use tobacco legally, pursuant to §147.102(a)(1)(iv).

(3) Geographic rating areas, pursuant to §147.102(b).

(4) In states that do not permit rating based on age or tobacco use, uniform family tiers and corresponding multipliers, pursuant to §147.102(c)(2).

(5) A requirement that that issuers in the small group market offer to a group premiums that are based on average enrollee amounts, pursuant to paragraph §147.102(c)(3).

(6) A uniform age rating curve, pursuant to §147.102(e).

(b) Updates. If a state adopts a standard or requirement described in paragraph (a) of this section for any plan or policy year beginning after the 2014 plan or policy year (or updates a standard or requirement that applies for the 2014 plan or policy year), the state must submit to CMS information about such standard in a form and manner specified in guidance by the Secretary.

(c) Applicability date. The provisions of this section apply on [OFR—INSERT DATE 30 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER].

7. A new §147.104 is added to part 147 to read as follows:

**§147.104 Guaranteed availability of coverage.**

(a) Guaranteed availability of coverage in the individual and group market. Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual or group market in a state must offer to any individual or employer in the state all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.

(b) Enrollment periods. A health insurance issuer may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) Open enrollment periods —(i) Group market. A health insurance issuer in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group

market, a health insurance issuer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules as defined in §147.106(b)(3), pursuant to applicable state law and, in the case of a QHP offered in the SHOP, as permitted by §156.285(c) of this subchapter. With respect to coverage in the small group market, and in the large group market if such coverage is offered in a Small Business Health Options Program (SHOP) in a state, coverage must become effective consistent with the dates described in §155.725(h) of this subchapter.

(ii) Individual market A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods described in §155.410(b) and (e) of this subchapter. Coverage must become effective consistent with the dates described in §155.410(c) and (f) of this subchapter.

(2) Limited open enrollment periods. A health insurance issuer in the individual market must provide a limited open enrollment period for the events described in §155.420(d) of this subchapter, excluding paragraphs (d)(3) (concerning citizenship status), (d)(8) (concerning Indians), and (d)(9) (concerning exceptional circumstances). In addition, a health insurance issuer in the individual market must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(3) Special enrollment periods. A health insurance issuer in the group and individual market must establish special enrollment periods for qualifying events as defined under section

603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(4) Length of enrollment periods. With respect to the group market, enrollees must be provided 30 calendar days after the date of the qualifying event described in paragraph (b)(3) of this section to elect coverage. With respect to the individual market, enrollees must be provided 60 calendar days after the date of an event described in paragraph (b)(2) and (b)(3) of this section to elect coverage.

(5) Effective date of coverage for limited open and special enrollment periods. With respect to an election made under paragraph (b)(2) or (b)(3) of this section, coverage must become effective consistent with the dates described in §155.420(b) of this subchapter.

(c) Special rules for network plans. (1) In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may do the following:

(i) Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work, or reside in the service area for the network plan, and limit the individuals who may apply for the coverage in the individual market to those who live or reside in the service area for the network plan.

(ii) Within the service area of the plan, deny coverage to employers and individuals if the issuer has demonstrated to the applicable state authority (if required by the state authority) the following:

(A) It will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees.

(B) It is applying paragraph (c)(1) of this section uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees, and dependents.

(2) An issuer that denies health insurance coverage to an individual or an employer in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer coverage in the individual or group market, as applicable, within the service area to any individual or employer, as applicable, for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) Application of financial capacity limits. (1) A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated to the applicable state authority (if required by the state authority) the following:

(i) It does not have the financial reserves necessary to offer additional coverage.

(ii) It is applying this paragraph (d)(1) uniformly to all employers or individuals in the group or individual market, as applicable, in the state consistent with applicable state law and without regard to the claims experience of those individuals, employers and their employees (and

their dependents) or any health status-related factor relating to such individuals, employees, and dependents.

(2) An issuer that denies health insurance coverage to any employer or individual in a state under paragraph (d)(1) of this section may not offer coverage in the group or individual market, as applicable, in the state before the later of either of the following dates:

(i) The 181st day after the date the issuer denies coverage.

(ii) The date the issuer demonstrates to the applicable state authority, if required under applicable state law, that the issuer has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (d)(2) of this section does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section is subject to the requirements of this section.

(5) An applicable state authority may provide for the application of this paragraph (d) on a service-area-specific basis.

(e) Marketing. A health insurance issuer and its officials, employees, agents and representatives must comply with any applicable state laws and regulations regarding marketing by health insurance issuers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(f) Applicability date. The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(g) Grandfathered health plans. This section does not apply to grandfathered health plans in accordance with §147.140.

8. A new §147.106 is added to part 147 to read as follows:

**§147.106 Guaranteed renewability of coverage.**

(a) General rule. Subject to paragraphs (b) through (d) of this section, a health insurance issuer offering health insurance coverage in the individual or group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable.

(b) Exceptions. An issuer may nonrenew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums. The plan sponsor or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) Fraud. The plan sponsor or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.

(3) Violation of participation or contribution rules. In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law. For purposes of this paragraph the following apply:

(i) The term “employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(ii) The term “group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(4) Termination of plan. The issuer is ceasing to offer coverage in the market in accordance with paragraph (c) or (d) of this section and applicable state law.

(5) Enrollees' movement outside service area. For network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under §147.104(c)(1)(i).

(6) Association membership ceases. For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(c) Discontinuing a particular product. In any case in which an issuer decides to discontinue offering a particular product offered in the group or individual market, that product may be discontinued by the issuer in accordance with applicable state law in the applicable market only if the following occurs:

(1) The issuer provides notice in writing to each plan sponsor or individual, as applicable, provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 calendar days before the date the coverage will be discontinued.

(2) The issuer offers to each plan sponsor or individual, as applicable, provided that particular product the option, on a guaranteed availability basis, to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in that market.

(3) In exercising the option to discontinue that product and in offering the option of coverage under paragraph (c)(2) of this section, the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(d) Discontinuing all coverage. (1) An issuer may elect to discontinue offering all health insurance coverage in the individual or group market, or all markets, in a state in accordance with applicable state law only if—

(i) The issuer provides notice in writing to the applicable state authority and to each plan sponsor or individual, as applicable, (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued; and

(ii) All health insurance policies issued or delivered for issuance in the state in the applicable market (or markets) are discontinued and not renewed.

(2) An issuer that elects to discontinue offering all health insurance coverage in a market (or markets) in a state as described in this paragraph (d) may not issue coverage in the applicable market (or markets) and state involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(e) Exception for uniform modification of coverage. Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the following:

(1) Large group market.

(2) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with state law and is effective uniformly among group health plans with that product.

(f) Application to coverage offered only through associations. In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, the reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

(g) Applicability date. The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(h) Grandfathered health plans. This section does not apply to grandfathered health plans in accordance with §147.140.

9. Amend §147.145 by revising paragraph (b)(1) and adding paragraph (b)(3) to read as follows:

**§147.145 Student health insurance coverage.**

\* \* \* \* \*

(b) Exemptions from the Public Health Service Act and the Affordable Care Act —(1) Guaranteed availability and guaranteed renewability —(i) For purposes of sections 2741(e)(1) and 2742(b)(5) of the Public Health Service Act, student health insurance coverage is deemed to be available only through a bona fide association.

(ii) For purposes of section 2702(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage.

(iii) For purposes of section 2703(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students.

\* \* \* \* \*

(3) Single risk pool. Student health insurance coverage is not subject to the requirements of section 1312(c) of the Affordable Care Act.

\* \* \* \* \*

**PART 150 – CMS ENFORCEMENT IN GROUP AND INDIVIDUAL INSURANCE MARKETS**

10. The authority citation for part 150 continues to read as follows:

**Authority:** Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

11. Amend §150.101 by revising paragraphs (a) and (b)(2) to read as follows:

**§150.101 Basis and scope.**

(a) Basis. CMS's enforcement authority under sections 2723 and 2761 of the PHS Act and its rulemaking authority under section 2792 of the PHS Act provide the basis for issuing regulations under this part 150.

(b) \* \* \*

(2) Enforcement with respect to health insurance issuers. The states have primary enforcement authority with respect to the requirements of title XXVII of the PHS Act that apply to health insurance issuers offering coverage in the group or individual health insurance market. If CMS determines under subpart B of this part that a state is not substantially enforcing title XXVII of the PHS Act, including the implementing regulations in parts 146, 147, and 148 of this subchapter, CMS enforces them under subpart C of this part.

12. Amend §150.103 as follows:

- a. Remove the definition of "HIPAA requirements;"
- b. Revise the definition of "Individual health insurance policy or individual policy;" and
- c. Add the definition of "PHS Act requirements" in alphabetical order.

The revision and addition read as follows:

**§150.103 Definitions.**

\* \* \* \* \*

Individual health insurance policy or individual policy means the legal document or contract issued by the issuer to an individual that contains the conditions and terms of the insurance. Any association or trust arrangement that is not a group health plan as defined in

§144.103 of this subchapter or does not provide coverage in connection with one or more group health plans is individual coverage subject to the requirements of parts 147 and 148 of this subchapter. The term “individual health insurance policy” includes a policy that is –

(1) Issued to an association that makes coverage available to individuals other than in connection with one or more group health plans; or

(2) Administered, or placed in a trust, and is not sold in connection with a group health plan subject to the provisions of parts 146 and 147 of this subchapter.

PHS Act requirements means the requirements of title XXVII of the PHS Act and its implementing regulations in parts 146, 147, and 148 of this subchapter.

\* \* \* \* \*

13. In part 150, remove the words “HIPAA requirement” or “HIPAA requirements,” and add in their place “PHS Act requirement” or “PHS Act requirements,” respectively, wherever they appear in the following places:

- a. Section 150.103, in the definition of “Complaint”.
- b. In the heading of subpart B of part 150.
- c. Section 150.201.
- d. Section 150.203, in the introductory text and paragraphs (a) and (b).
- e. Section 150.205(d) and (e)(1).
- f. Section 150.207, in the section heading and text.
- g. Section 150.209.
- h. Section 150.211, in the introductory text.
- i. Section 150.213(b) and (c).

- j. Section 150.217, in the introductory text.
- k. Section 150.219(a).
- l. Section 150.221(a).
- m. Section 150.301.
- n. Section 150.303(a) introductory text, (a)(3), and (b).
- o. Section 150.305(a)(1), (b)(2), and (c)(2).
- p. Section 150.309.
- q. Section 150.311, in the introductory text and paragraphs (d), (f) introductory text, (f)(3), and (g).
- r. Section 150.313(a) and (e)(3)(iv).
- s. Section 150.317(a)(1) and (a)(3).
- t. Section 150.319(b)(1) introductory text, (b)(1)(ii), and (b)(1)(iii).
- u. Section 150.343(a).
- v. Section 150.465(c).

## **PART 154 – HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS**

14. The authority citation for part 154 continues to read as follows:

**Authority:** Section 2794 of the Public Health Service Act (42 U.S.C. 300gg-94).

15. In §154.200, revise the third sentence and add a fourth sentence to paragraph (a)(2) and paragraph (b) to read as follows:

### **§154.200 Rate increases subject to review.**

(a) \* \* \*

(2) \* \* \* A state-specific threshold shall be based on factors impacting rate increases in a state to the extent that the data relating to such state-specific factors is available by August 1. States interested in proposing a state-specific threshold for approval are required to submit a proposal to the Secretary by August 1.

(b) The Secretary will publish a notice no later than September 1 of each year, to be effective on January 1 of the following year, concerning whether a threshold under paragraph (a)(1) or (a)(2) of this section applies to the state; except that, with respect to the 12-month period that begins on September 1, 2011, the threshold under paragraph (a)(1) of this section applies.

\* \* \* \* \*

16. Revise §154.215 to read as follows:

**§154.215 Submission of rate filing justification.**

(a) If any product is subject to a rate increase, a health insurance issuer must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products, on a form and in a manner prescribed by the Secretary.

(b) The Rate Filing Justification must consist of the following Parts:

(1) Unified rate review template (Part I), as described in paragraph (d) of this section.

(2) Written description justifying the rate increase (Part II), as described in paragraph (e) of this section.

(3) Rating filing documentation (Part III), as described in paragraph (f) of this section.

(c) A health insurance issuer must complete and submit Parts I and III of the Rate Filing Justification described in paragraphs (b)(1) and (b)(3) of this section to CMS and, as long as the

applicable state accepts such submissions, to the applicable state. If a rate increase is subject to review, then the health insurance issuer must also complete and submit to CMS and, if applicable, the state Part II of the Rate Filing Justification described in paragraph (b)(2) of this section.

(d) Content of unified rate review template (Part I): The unified rate review template must include the following as determined appropriate by the Secretary:

- (1) Historical and projected claims experience.
- (2) Trend projections related to utilization, and service or unit cost.
- (3) Any claims assumptions related to benefit changes.
- (4) Allocation of the overall rate increase to claims and non-claims costs.
- (5) Per enrollee per month allocation of current and projected premium.
- (6) Three year history of rate increases for the product associated with the rate increase.

(e) Content of written description justifying the rate increase (Part II): The written description of the rate increase must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase and including the following:

(1) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary.

(2) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

(f) Content of rate filing documentation (Part III): The rate filing documentation must include an actuarial memorandum that contains the reasoning and assumptions supporting the

data contained in Part I of the Rate Filing Justification. Parts I and III must be sufficient to conduct an examination satisfying the requirements of §154.301(a)(3) and (4) and determine whether the rate increase is an unreasonable increase. Instructions concerning the requirements for the rate filing documentation will be provided in guidance issued by CMS.

(g) If the level of detail provided by the issuer for the information under paragraphs (d) and (f) of this section does not provide sufficient basis for CMS to determine whether the rate increase is an unreasonable rate increase when CMS reviews a rate increase subject to review under §154.210(a), CMS will request the additional information necessary to make its determination. The health insurance issuer must provide the requested information to CMS within 10 business days following its receipt of the request.

(h) Posting of the disclosure on the CMS Web site:

(1) CMS promptly will make available to the public on its Web site the information contained in Part II of each Rate Filing Justification.

(2) CMS will make available to the public on its Web site the information contained in Parts I and III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act regulations, 45 CFR 5.65.

(3) CMS will include a disclaimer on its Web site with the information made available to the public that explains the purpose and role of the Rate Filing Justification.

(4) CMS will include information on its Web site concerning how the public can submit comments on the proposed rate increases that CMS reviews.

17. Revise §154.220 to read as follows:

**§154.220 Timing of providing the rate filing justification**

A health insurance issuer must submit a Rate Filing Justification for all rate increases that are filed in a state on or after April 1, 2013, or effective on or after January 1, 2014 in a state that does not require the rate increase to be filed, as follows:

(a) If a state requires that a proposed rate increase be filed with the state prior to the implementation of the rate, the health insurance issuer must submit to CMS and the applicable state the Rate Filing Justification on the date on which the health insurance issuer submits the proposed rate increase to the state.

(b) For all other states, the health insurance issuer must submit to CMS and the state the Rate Filing Justification prior to the implementation of the rate increase.

**§154.225 [Amended]**

18a. In §154.225(a), introductory text, remove the words “Preliminary Justification” and add in their place “Rate Filing Justification.”

**§154.230 [Amended]**

18b. In §154.230(b) and (c)(1), remove the words “Preliminary Justification” and add in their place “Rate Filing Justification.”

19. Amend §154.301 as follows:

a. Amend paragraphs (a)(3)(i) and (a)(3)(xi) by removing “; and” and adding in its place a period.

b. Amend paragraphs (a)(4)(i), (a)(4)(ii), and (a)(4)(vi) through (a)(4)(x) by removing the semicolons and replacing them with periods.

c. Revise paragraphs (a)(4)(iii) through (a)(4)(v), and (b).

d. Add new paragraphs (a)(3)(iii), (a)(3)(iv), and (a)(4)(xiii) through (a)(4)(xv).

The revisions and additions read as follows:

**§154.301 CMS’s determinations of effective rate review programs.**

(a) \* \* \*

(3) \* \* \*

(iii) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.

(iv) The health insurance issuer’s data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.

(4) \* \* \*

(iii) The impact of cost-sharing changes by major service categories, including actuarial values.

(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.

(v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.

\* \* \* \* \*

(xiii) The impacts of geographic factors and variations.

(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.

(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

\* \* \* \* \*

(b) Public disclosure and input. In addition to satisfying the provisions in paragraph (a) of this section, a state with an effective rate review program must provide, for the rate increases it reviews, access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS’s Web address for such information) and have a mechanism for receiving public comments on those proposed rate increases.

\* \* \* \* \*

**PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

20. The authority citation for part 156 continues to read as follows:

**Authority:** Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321, 1322, 1324, 1334, 1342–1343, and 1401–1402, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18042).

21. A new §156.80 is added to subpart A to read as follows:

**§156.80 Single risk pool.**

(a) Individual market. A health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of

the Public Health Service Act and offered by such issuer in the individual market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(b) Small group market. A health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the small group market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(c) Merger of the individual and small group markets. A state may require the individual and small group insurance markets within a state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in §147.103 of this subchapter.

(d) Index rate —(1) In general. Each plan year or policy year, as applicable, a health insurance issuer must establish an index rate for a state market described in paragraphs (a) through (c) of this section based on the total combined claims costs for providing essential health benefits within the single risk pool of that state market. The index rate must be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the state and Exchange user fees. The premium rate for all of the health insurance issuer's plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to the plan-level adjustments permitted in paragraph (d)(2) of this section.

(2) Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(i) The actuarial value and cost-sharing design of the plan.

(ii) The plan's provider network, delivery system characteristics, and utilization management practices.

(iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(iv) Administrative costs, excluding Exchange user fees.

(v) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

(e) Grandfathered health plans in the individual and small group market. A state law requiring grandfathered health plans described in §147.140 of this subchapter to be included in a single risk pool described in paragraphs (a) through (c) of this section does not apply.

(f) Applicability date. The provisions of this section apply for plan years (as that term is defined in §144.103 of this subchapter) in the group market, and for policy years (as that term is defined in §144.103 of this subchapter) in the individual market, beginning on or after January 1, 2014.

22. A new §156.155 is added to subpart B to read as follows:

**§156.155 Enrollment in catastrophic plans.**

(a) General rule. A health plan is a catastrophic plan if it meets the following conditions:

(1) Meets all applicable requirements for health insurance coverage in the individual market (including but not limited to those requirements described in parts 147 and 148 of this subchapter), and is offered only in the individual market.

(2) Does not provide a bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the Affordable Care Act.

(3) Provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act once the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act is reached.

(4) Provides coverage for at least three primary care visits per year before reaching the deductible.

(5) Covers only individuals who meet either of the following conditions:

(i) Have not attained the age of 30 prior to the first day of the plan or policy year.

(ii) Have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of the Affordable Care Act.

(b) Coverage of preventive health services. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services, in accordance with section 2713 of the Public Health Service Act.

(c) Application for family coverage. For other than self-only coverage, each individual enrolled must meet the requirements of paragraph (a)(5) of this section.

**CMS-9972-F**

Dated: February 15, 2013

**Marilyn Tavenner,**

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: February 20, 2013

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**Kathleen Sebelius,**

Secretary,

Department of Health and Human Services.

**BILLING CODE 4120-01-P**

[FR Doc. 2013-04335 Filed 02/22/2013 at 11:15 am; Publication Date: 02/27/2013]