§ 147.100 Basis and scope.

Part 147 of this subchapter implements the requirements of the Patient Protection and Affordable Care Act that apply to group health plans and health insurance issuers in the Group and Individual markets.

§ 147.102 Fair health insurance premiums.

(a) In general. With respect to the premium rate charged by a health insurance issuer in accordance with §156.80 of this subchapter 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. For purposes of this paragraph, rating area is determined in the small group market using the group policyholder's principal business address and in the individual market using the primary policyholder's address. For plans (other than qualified health plans offered through the Federally-facilitated Small Business Health Options Program) for which an issuer can demonstrate that it relied in good faith on guidance from an applicable State authority issued before August 28, 2013, that differs from this paragraph (a)(1)(ii), the preceding sentence will not apply until the first plan year beginning on or after January 1, 2015 with respect to coverage in the small group market.

(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.

(i) Per-member rating. The total premium for family coverage must be determined by summing the premiums for each individual family member.

(ii) 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...
§ 147.103

in 2017, the provisions of this section applicable to coverage in the small
group market apply to all coverage of-
fered 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.

[78 FR 13436, Feb. 27, 2013, as amended at 78
FR 54133, Aug. 30, 2013]

§ 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 indi-
vidual 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 em-
ployer 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 in-
surance issuer may limit the avail-
ability of coverage to an annual enroll-
ment 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 mate-
rial plan provision relating to em-
ployer contribution or group participa-
tion 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 chapter. With respect to cov-
erage in the small group market, and
in the large group market if such cov-
erage 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(b) of this chapter.

(ii) Individual market. A health insur-
ance issuer in the individual market
must allow an individual to purchase
health insurance coverage during the
initial and annual open enrollment pe-
riods described in §155.410(b) and (e) of
this chapter. Coverage must become