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 for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs, and Exchange user fees (expected to be remitted under §156.50(b) or §156.50(c) and (d) of this subchapter as applicable plus the dollar amount under §156.50(d)(3)(i) and (ii) of this subchapter expected to be credited against user fees payable for that state market). 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.

[78 FR 13441, Feb. 27, 2013, as amended at 78 FR 39898, July 2, 2013]

Subpart B—Essential Health Benefits Package

SOURCE: 78 FR 12866, Feb. 25, 2013, unless otherwise noted.

§ 156.100 State selection of benchmark.

Each State may identify a single EHB-benchmark plan according to the selection criteria described below:

(a) State selection of base-benchmark plan. The options from which a base-benchmark plan may be selected by the State are the following:

(1) Small group market health plan. The largest health plan by enrollment

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§ 156.110 EHB-benchmark plan standards.

An EHB-benchmark plan must meet the following standards:

(a) EHB coverage. Provide coverage of at least the following categories of benefits:

(1) Ambulatory patient services.
(2) Emergency services.
(3) Hospitalization.
(4) Maternity and newborn care.

(b) Coverage in each benefit category. A base-benchmark plan not providing any coverage in one or more of the categories described in paragraph (a) of this section, must be supplemented as follows:

(1) General supplementation methodology. A base-benchmark plan lacking items or services within one or more of the categories described in paragraph (a) of this section must be supplemented by the addition of the entire category of benefits offered under any other benchmark plan option described in §156.100(a) of this subpart unless otherwise described in this subsection.

(2) Supplementing pediatric oral services. A base-benchmark plan lacking the category of pediatric oral services must be supplemented by the addition of these benefits from one of the following:

(i) The FEDVIP dental plan with the largest national enrollment that is offered to federal employees under 5 U.S.C. 8952; or

(ii) The benefits available under that State’s separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(3) Supplementing pediatric vision services. A base-benchmark plan lacking the category of pediatric vision services must be supplemented by the addition of these benefits from one of the following:

(i) The FEDVIP vision plan with the largest national enrollment that is offered to federal employees under 5 U.S.C. 8982; or

(ii) The benefits available under that State’s separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(4) Preventive and wellness services and chronic disease management.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.