

Dept. of Health and Human Services

§ 147.102

147.211 Transparency in coverage—required disclosures to participants, beneficiaries, or enrollees.

147.212 Transparency in coverage—requirements for public disclosure.

AUTHORITY: 42 U.S.C. 300gg through 300gg-63, 300gg-91, 300gg-92, and 300gg-111 through 300gg-139, as amended, and section 3203, Pub. L. 116-136, 134 Stat. 281.

SOURCE: 75 FR 27138, May 13, 2010, unless otherwise noted.

§ 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 (a), rating area is determined—

(A) In the individual market, using the primary policyholder's address.

(B) In the small group market, using the group policyholder's principal business address. For purposes of this paragraph (a)(1)(ii)(B), principal business address means the principal business address registered with the State or, if a principal business address is not registered with the State, or is registered solely for purposes of service of process and is not a substantial worksite for the policyholder's business, the business address within the State where the greatest number of employees of such policyholder works. If, for a network plan, the group policyholder's principal business address is not within the service area of such plan, and the policyholder has employees who live, reside, or work within the service area,

the principal business address for purposes of the network plan is the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such business address, the rating area for purposes of the network plan is the rating area that reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

(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

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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

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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—*
(i) In the case of the small group market, the total premium charged to a group health plan is determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (c)(1) or (2) of this section, as applicable.

(ii) Subject to paragraph (c)(3)(iii) of this section, nothing in this section prevents a state from requiring issuers to offer to a group health plan, or an issuer from voluntarily offering to a group health plan, premiums that are based on average enrollee premium amounts, provided that the total group premium established at the time of applicable enrollment at the beginning of the plan year is the same total amount derived in accordance with paragraph (c)(1) or (2) of this section, as applicable.

(iii) Effective for plan years beginning on or after January 1, 2015, an issuer that, in connection with a group

health plan in the small group market, offers premiums that are based on average enrollee premium amounts under paragraph (c)(3)(ii) of this section must—

(A) Ensure an average enrollee premium amount calculated based on applicable enrollment of participants and beneficiaries at the beginning of the plan year does not vary during the plan year.

(B) Unless a state establishes and CMS approves an alternate rating methodology, calculate an average enrollee premium amount for covered individuals age 21 and older, and calculate an average enrollee premium amount for covered individuals under age 21. The premium for a given family composition is determined by summing the average enrollee premium amount applicable to each family member covered under the plan, taking into account no more than three covered children under age 21.

(C) Pursuant to applicable state law, ensure that the average enrollee premium amount calculated for any individual covered under the plan does not include any rating variation for tobacco use permitted under paragraph (a)(1)(iv) of this section. The rating variation for tobacco use permitted under paragraph (a)(1)(iv) of this section is determined based on the premium rate that would be applied on a per-member basis with respect to an individual who uses tobacco and then included in the premium charged for that individual.

(D) To the extent permitted by applicable State law and, in the case of coverage offered through a SHOP, as permitted by the SHOP, apply this paragraph (c)(3)(iii) uniformly among group health plans enrolling in that product, giving those group health plans the option to pay premiums based on average enrollee premium amounts.

(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.* (i) For plan years or policy years beginning before January 1, 2018, a single age band for individuals age 0 through 20.

(ii) For plan years or policy years beginning on or after January 1, 2018:

(A) A single age band for individuals age 0 through 14.

(B) One-year age bands for individuals age 15 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 to reflect market patterns in the individual and small group markets will apply in that State that 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.

[78 FR 13436, Feb. 27, 2013, as amended at 78 FR 54133, Aug. 30, 2013; 79 FR 13834, Mar. 11, 2014; 81 FR 12334, Mar. 8, 2016; 81 FR 94173, Dec. 22, 2016; 83 FR 17058, Apr. 17, 2018]

§ 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 March 29, 2013. A state standard or requirement is described in this paragraph if it includes any of the following: