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.[1] 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

[1] 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.[2]

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.[3] 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.[4]

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[2] Section 2742 of the PHS Act provides a corresponding exception for the uniform modification of coverage in the individual market.

[3] 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.

[4] 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.[5]

[5] 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.

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).[6] [7]

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

[6] 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).

[7] 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.

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.[11] 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

[11] 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?"[12] 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

[12] 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.[13] 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

[13] 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 disproportionally 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

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

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)

(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