§ 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.* A health insurance issuer must establish an index rate that is effective January 1 of each calendar year for a State market described in paragraphs (a) through (c) of this section.

(i) The index rate must be based on the total combined claims costs for providing essential health benefits within the single risk pool of that State market.

(ii) 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 program and Exchange user fees (expected to be remitted under § 156.50(b) or (c) and (d) as applicable, plus the dollar amount under § 156.50(d)(3)(i) and (ii) expected to be credited against user fees payable for that State market).

(iii) 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, including, if permitted by the applicable State authority (as defined in § 144.103 of this subchapter), accounting for cost-sharing reduction amounts provided to eligible enrollees under § 156.410, provided the issuer does not otherwise receive reimbursement for such amounts.

(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.

(3) *Calibration.* The issuer must calibrate the plan-adjusted index rate for its plans within the single risk pool to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0, in a manner specified by the Secretary in guidance, to ensure that any rating variation under § 147.102 of this subchapter may be accurately applied with respect to a particular plan or coverage. The calibration must be applied uniformly to all plans within the single risk pool of the State market and cannot vary by plan.

(4) *Frequency of index rate and plan-level adjustments.* (i) A health insurance issuer may not establish an index rate and make the market-wide adjustments pursuant to paragraph (d)(1) of this section, make the plan-level adjustments pursuant to paragraph (d)(2) of this section, or calibrate the plan-adjusted index rate for its plans pursuant to paragraph (d)(3) of this section more or less frequently than annually, except as provided in paragraph (d)(4)(ii) of this section.

(ii) A health insurance issuer in the small group market (not including a merged market) may establish index rates and make the marketwide adjustments under paragraph (d)(1) of this section, make the plan-level adjustments under paragraph (d)(2) of this section, and calibrate the plan-adjusted index rate for its plans pursuant to paragraph (d)(3) of this section, no more frequently than quarterly. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. Such rates may only apply to coverage issued or renewed on or after the rate effective date and will apply for the entire plan year of the group health plan.

(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.

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