

§ 158.103 Definitions.

For the purposes of this part, the following definitions apply unless specified otherwise.

*Blended rate* means a single rate charged for health insurance coverage provided to a single employer through two or more of an issuer's affiliated companies for employees in one or more States.

*Contract reserves* means reserves that are established by an issuer which, due to the gross premium pricing structure at issue, account for the value of the future benefits that at any time exceeds the value of any appropriate future valuation of net premiums at that time. Contract reserves must not include premium deficiency reserves. Contract reserves must not include reserves for expected MLR rebates.

*Direct paid claims* means claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this part.

*Enrollee* means an individual who is enrolled, within the meaning of § 144.103 of this title, in group health insurance coverage, or an individual who is covered by individual insurance coverage, at any time during an MLR reporting year.

*Experience rating refund* means the return of a portion of premiums pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium.

*Group conversion charges* means the portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance without providing evidence of insurability.

*Health Plan* means health insurance coverage offered through either individual coverage or a group health plan.

*Individual market* has the meaning given the term in section 2791(e)(1) of the PHS Act and section 1304(a)(2) of the Affordable Care Act.

*Large Employer* has the meaning given the term in § 144.103 of this subchapter.

*Large group market* has the meaning given the term in section 2791(e)(3) of the PHS Act and section 1304(a)(3) of the Affordable Care Act.

*MLR reporting year* means a calendar year during which group or individual health insurance coverage is provided by an issuer.

*Policyholder* means any entity that has entered into a contract with an issuer to receive health insurance coverage as defined in section 2791(b) of the PHS Act.

*Prescription drug rebates and other price concessions* means all remuneration received by or on behalf of an issuer, including remuneration received by and on behalf of entities providing

pharmacy benefit management services to the issuer, that decrease the costs of a prescription drug covered by the issuer, regardless from whom the remuneration is received (for example, pharmaceutical manufacturer, wholesaler, retail pharmacy, or vendor). Prescription drug rebates and other price concessions include discounts, charge backs or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits to the extent the value of these items reduce costs for the issuer, and excluding bona fide service fees. Prescription drug rebates and other price concessions exclude any remuneration, coupons, or price concessions for which the full value is passed on to the enrollee. Bona fide service fees mean fees paid by a drug manufacturer to an entity providing pharmacy benefit management services to the issuer that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes title to the drug.

*Qualifying issuer* means an issuer whose aggregate ratio of net payments related to the risk adjustment program under section 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18063, to earned premiums as defined in § 158.130, but prior to and excluding the adjustments in § 158.130(b)(5) that account for the net payments or receipts related to the risk adjustment, risk corridors, and reinsurance programs, based on three consecutive years of data in a relevant State and market, is greater than or equal to 50 percent.

*Situs of the contract* means the jurisdiction in which the contract is issued or delivered as stated in the contract.

*Small Employer* has the meaning given the term in § 144.103 of this subchapter.

*Small group market* has the meaning in section 2791(e)(5) of the PHS Act and section 1304(a)(3) of the Affordable Care Act.

*Student administrative health fee* has the meaning given the term in § 147.145 of this subchapter.

*Student health insurance coverage* has the meaning given the term in § 147.145 of this subchapter.

*Student market* means the market for student health insurance coverage.

*Subscriber* refers to both the group market and the individual market. In the group market, subscriber means the individual, generally the employee, whose eligibility is the basis for the enrollment in the group health plan and who is responsible for the payment of premiums. In the individual market, subscriber means the individual who purchases an individual policy and who is responsible for the payment of premiums.

*Unearned premium* means that portion of the premium paid in the MLR reporting year that is intended to provide coverage during a period which extends beyond the MLR reporting year.

*Unpaid Claim Reserves* means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year.

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