to review and CMS reviews the rate increase under §154.210(a). CMS will make a timely determination whether the rate increase is an unreasonable rate increase.

(1) CMS will post on its Web site its final determination and a brief explanation of its analysis, consistent with the form and manner prescribed by the Secretary under §154.210(b)(2), within five business days following its final determination.

(2) If CMS determines that the rate increase is an unreasonable rate increase, CMS will also provide its final determination and brief explanation to the health insurance issuer within five business days following its final determination.

(b) If a State conducts a review under §154.210(b), CMS will adopt the State’s determination of whether a rate increase is unreasonable and post on the CMS Web site the State’s final determination described in §154.210(b)(2).

(c) If a State determines that the rate increase is an unreasonable rate increase and the health insurance issuer is legally permitted to implement the unreasonable rate increase under applicable State law, CMS will provide the State’s final determination and brief explanation to the health insurance issuer within five business days following CMS’s receipt thereof.

§154.230 Submission and posting of Final Justifications for unreasonable rate increases.

(a) If a health insurance issuer receives from CMS a final determination by CMS or a State that a rate increase is an unreasonable rate increase, and the health insurance issuer declines to implement the rate increase or chooses to implement a lower increase, the health insurance issuer must submit to CMS timely notice that it will not implement the rate increase or that it will implement a lower increase on a form and in the manner prescribed by the Secretary.

(b) If a health insurance issuer implements a lower increase as described in paragraph (a) of this section and the lower increase does not meet or exceed the applicable threshold under §154.200, such lower increase is not subject to this part. If the lower increase meets or exceeds the applicable threshold, the health insurance issuer must submit a new Preliminary Justification under this part.

(c) If a health insurance issuer implements a rate increase determined by CMS or a State to be unreasonable, within the later of 10 business days after the implementation of such increase or the health insurance issuer’s receipt of CMS’s final determination that a rate increase is an unreasonable rate increase, the health insurance issuer must:

(1) Submit to CMS a Final Justification in response to CMS’s or the State’s final determination, as applicable. The information in the Final Justification must be consistent with the information submitted in the Preliminary Justification supporting the rate increase; and

(2) Prominently post on its Web site the following information on a form and in the manner prescribed by the Secretary:

(i) The information made available to the public by CMS and described in §154.215(i);
(ii) CMS’s or the State’s final determination and brief explanation described in §154.225(a) and §154.210(b)(2), as applicable; and
(iii) The health insurance issuer’s Final Justification for implementing an increase that has been determined to be unreasonable by CMS or the State, as applicable.

(3) The health insurance issuer must continue to make this information available to the public on its Web site for at least three years.

(d) CMS will post all Final Justifications on the CMS Web site. This information will remain available to the public on the CMS Web site for three years.

Subpart C—Effective Rate Review Programs

§154.301 CMS’s determinations of Effective Rate Review Programs.

(a) Effective Rate Review Program. In evaluating whether a State has an Effective Rate Review Program, CMS will apply the following criteria for the review of rates for the small group market and the individual market, and
also, as applicable depending on State law, the review of rates for different types of products within those markets:

(1) The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3) of this section.

(2) The State conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase.

(3) The State’s rate review process includes an examination of:
   (i) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions; and
   (ii) The health insurance issuer’s data related to past projections and actual experience.

(4) The examination must take into consideration the following factors to the extent applicable to the filing under review:
   (i) The impact of medical trend changes by major service categories;
   (ii) The impact of utilization changes by major service categories;
   (iii) The impact of cost-sharing changes by major service categories;
   (iv) The impact of benefit changes;
   (v) The impact of changes in enrollee risk profile;
   (vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
   (vii) The impact of changes in reserve needs;
   (viii) The impact of changes in administrative costs related to programs that improve health care quality;
   (ix) The impact of changes in other administrative costs;
   (x) The impact of changes in applicable taxes, licensing or regulatory fees;
   (xi) Medical loss ratio; and
   (xii) The health insurance issuer’s capital and surplus.

(5) The State’s determination of whether a rate increase is unreasonable is made under a standard that is set forth in State statute or regulation.

(b) Public disclosure and input. In addition to satisfying the provisions in paragraph (a) of this section, a State with an Effective Rate Review Program must provide access from its Web site to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

(c) CMS will determine whether a State has an Effective Rate Review Program for each market based on information available to CMS that a rate review program meets the criteria described in paragraphs (a) and (b) of this section.

(d) CMS reserves the right to evaluate from time to time whether, and to what extent, a State’s circumstances have changed such that it has begun to or has ceased to satisfy the criteria set forth in paragraphs (a) and (b) of this section.

PARTS 155–157 [RESERVED]

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

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158.101 Basis and scope.
158.102 Applicability.
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Subpart A—Disclosure and Reporting

158.110 Reporting requirements related to premiums and expenditures.
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158.121 Newer experience.
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Subpart B—Calculating and Providing the Rebate

158.210 Minimum medical loss ratio.
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