

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(10) Provider credentialing;

(11) Marketing expenses;

(12) Costs associated with calculating and administering individual enrollee or employee incentives;

(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

(14) Any function or activity not expressly included in paragraph (a) or (b) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

[75 FR 74921, Dec. 1, 2010, as amended at 76 FR 76592, Dec. 7, 2011; 77 FR 28790, May 16, 2012; 79 FR 30352, May 27, 2014; 85 FR 29262, May 14, 2020; 87 FR 27393, May 6, 2022]

§ 158.151 Expenditures related to Health Information Technology and meaningful use requirements.

(a) *General requirements.* An issuer may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in §158.150 of this subpart and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in re-

imbursement for clinical services as defined in §158.140 of this subpart;

(2) Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.

(6) Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.

(7) Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

(b) [Reserved]

§ 158.160 Other non-claims costs.

(a) *General requirements.* The report required in §158.110 of this subpart must include non-claims costs described in paragraph (b) of this section

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and must provide an explanation of how premium revenue is used, other than to provide reimbursement for clinical services covered by the benefit plan, expenditures for activities that improve health care quality, and Federal and State taxes and licensing or regulatory fees as specified in this part.

(b) *Non-claims costs other than taxes and regulatory fees.* (1) The report required in §158.110 of this subpart must include any expenses for administrative services that do not constitute adjustments to premium revenue as provided in §158.130 of this subpart, reimbursement for clinical services to enrollees as defined in §158.140 of this subpart, or expenditures on quality improvement activities as defined in §§158.150 and 158.151 of this subpart.

(2) Expenses for administrative services include the following:

(i) Cost-containment expenses not included as an expenditure related to an activity at §158.150 of this subpart.

(ii) Loss adjustment expenses not classified as a cost containment expense.

(iii) Direct sales salaries, workforce salaries and benefits.

(iv) Agents and brokers fees and commissions.

(v) General and administrative expenses.

(vi) Community benefit expenditures.

(vii) Beginning with the 2022 MLR reporting year, prescription drug rebates and other price concessions that are received and retained by an entity providing pharmacy benefit management services to the issuer and are associated with administering the issuer's prescription drug benefits.

[75 FR 74921, Dec. 1, 2010, as amended at 85 FR 29262, May 14, 2020]

§ 158.161 Reporting of Federal and State licensing and regulatory fees.

(a) *Licensing and regulatory fees included.* The report required in §158.110 must include statutory assessments to defray operating expenses of any State or Federal department, transitional reinsurance contributions assessed under section 1341 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, and examination fees in lieu of

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premium taxes as specified by State law.

(b) *Licensing and regulatory fees excluded.* The report required in §158.110 must include fines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments other than as specified in §158.161(a) as other non-claims costs, but not as an adjustment to premium revenue.”

[75 FR 82279, Dec. 30, 2010, as amended at 78 FR 15539, Mar. 11, 2013]

§ 158.162 Reporting of Federal and State taxes.

(a) *Federal taxes.* The report required in §158.110 of this subpart must separately report:

(1) Federal taxes excluded from premium under subpart B which include all Federal taxes and assessments allocated to health insurance coverage reported under section 2718 of the PHS Act.

(2) Federal taxes not excluded from premium under subpart B of this part which include Federal income taxes on investment income and capital gains, as well as Federal employment taxes, as other non-claims costs.

(b) *State taxes and assessments.* The report required in §158.110 of this subpart must separately report:

(1) State taxes and assessments excluded from premium under subpart B which include:

(i) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State.

(ii) Guaranty fund assessments.

(iii) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(iv) Advertising required by law, regulation or ruling, except advertising associated with investments.

(v) State income, excise, and business taxes other than premium taxes.

(vi) State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes.