§ 154.102 Definitions.

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Individual market has the meaning given the term under the applicable State’s rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(1)(A) of the PHS Act; and

(2) Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage.

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Small group market has the meaning given under the applicable State’s rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, “50” employees applies in place of “100” employees in the definition of “small employer” under section 2791(e)(4); and

(2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

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§ 154.103 Applicability.

(a) In general. The requirements of this part apply to health insurance issuers offering health insurance coverage in the individual market and small group market.

(b) Exceptions. The requirements of this part do not apply to grandfathered health plan coverage as defined in 45 CFR §147.140, or to excepted benefits as described in section 2791(c) of the PHS Act.


§ 154.200 Rate increases subject to review.

(a) A rate increase filed in a State on or after September 1, 2011, or effective on or after September 1, 2011, in a State that does not require a rate increase to be filed, is subject to review if:

(1) The rate increase is 10 percent or more, applicable to a 12-month period that begins on September 1, as calculated under paragraph (c) of this section; or

(2) The rate increase meets or exceeds a State-specific threshold applicable to a 12-month period that begins on September 1, as calculated under paragraph (c) of this section, determined by the Secretary. In establishing a State-specific threshold, the Secretary shall consult with the State and may consider relevant information provided by other interested parties. A State-specific threshold shall be based on factors impacting rate increases in a State to the extent that data relating to such State-specific factors is available.

(b) The Secretary will publish a notice no later than June 1 of each year concerning whether a threshold under paragraph (a)(1) or (2) of this section applies to a State; except that, with respect to the 12-month period that begins on September 1, 2011, the threshold under paragraph (a)(1) of this section applies.

(c) A rate increase meets or exceeds the applicable threshold set forth in paragraph (a) of this section if the average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold.

(d) If a rate increase that does not otherwise meet or exceed the threshold under paragraph (c) of this section meets or exceeds the threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the threshold and is subject to review under §154.210, and such review shall include a review of the aggregate rate increases during the applicable 12-month period.

§ 154.205 Unreasonable rate increases.

(a) When CMS reviews a rate increase subject to review under §154.210(a), CMS will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase.

(b) The rate increase is an excessive rate increase if the increase causes the
premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage. In determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, CMS will consider:

(1) Whether the rate increase results in a projected medical loss ratio below the Federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under Federal law;

(2) Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and

(3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

(c) The rate increase is an unjustified rate increase if the health insurance issuer provides data or documentation to CMS in connection with the increase that is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

(d) The rate increase is an unfairly discriminatory rate increase if the increase results in premium differences between insureds within similar risk categories that:

(1) Are not permissible under applicable State law; or

(2) In the absence of an applicable State law, do not reasonably correspond to differences in expected costs.

§ 154.210 Review of rate increases subject to review by CMS or by a State.

(a) Except as provided in paragraph (b) of this section, CMS will review a rate increase subject to review to determine whether it is unreasonable, as required by this part.

(b) CMS will adopt a State’s determination of whether a rate increase is an unreasonable rate increase, if the State:

(1) Has an Effective Rate Review Program as described in §154.301; and

(2) The State provides to CMS, on a form and in a manner prescribed by the Secretary, its final determination of whether a rate increase is unreasonable, which must include a brief explanation of how its analysis of the relevant factors set forth in §154.301(a)(3) caused it to arrive at that determination, within five business days following the State’s final determination.

(c) CMS will post and maintain on its Web site a list of the States with market segments that meet the requirements of paragraph (b) of this section.

§ 154.215 Submission of disclosure to CMS for rate increases subject to review.

(a) For each rate increase subject to review, a health insurance issuer must submit a Preliminary Justification for each product affected by the increase on a form and in the manner prescribed by the Secretary.

(b) The Preliminary Justification must consist of the following Parts:

(1) Rate increase summary (Part I), as described by paragraph (e) of this section;

(2) Written description justifying the rate increase (Part II), as described by paragraph (f) of this section; and

(3) When CMS is reviewing the rate increase under §154.210(a), rate filing documentation (Part III), as described by paragraph (g) of this section.

(c) A health insurance issuer must complete and submit Parts I and II of the Preliminary Justification described in paragraphs (b)(1) and (2) of this section to CMS and, as long as the applicable State accepts such submissions, to the applicable State for any rate increase subject to review. If a rate increase subject to review is for a product offered in the individual market or small group market and CMS is reviewing the rate increase under §154.210(a), then the health insurance issuer must also complete and submit Part III of the Preliminary Justification described in paragraph (b)(3) of this section to CMS only.

(d) The health insurance issuer may submit a single, combined Preliminary Justification for rate increases subject to review affecting multiple products, if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same across all products.