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.

(e) Content of rate increase summary (Part I): The rate increase summary must include the following as determined appropriate by the Secretary:

(1) Historical and projected claims experience;

(2) Trend projections related to utilization, and service or unit cost:

(3) Any claims assumptions related to benefit changes;

(4) Allocation of the overall rate increase to claims and non-claims costs;

(5) Per enrollee per month allocation of current and projected premium; and

(6) Three year history of rate increases for the product associated with the rate increase.

(f) Content of written description justifying the rate increase (Part II): The written description of the rate increase must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase and include the following:

(1) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary; and

(2) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

(g) Content of rate filing documentation (Part III): (1) The rate filing documentation must be sufficient for CMS to conduct an examination satisfying the requirements of §154.301(a)(3) and (4) and determine whether the rate increase is an unreasonable increase. Instructions concerning the requirements for the rate filing documentation will be provided in guidance issued by CMS.

(2) If the health insurance issuer is also required to submit a rate filing to a State in connection with the rate increase under State law, CMS will accept a copy of the filing provided that the filing includes all of the information described in paragraph (g)(1) of this section.

(h) If the level of detail provided by the issuer for the information under paragraph (g) of this section does not provide sufficient basis for CMS to determine whether the rate increase is an unreasonable rate increase, CMS will request the additional information necessary to make its determination. The health insurance issuer must provide the requested information to CMS within 10 business days following its receipt of the request.

(i) Posting of the disclosure on the CMS Web site: (1) CMS promptly will make available to the public on its Web site the information contained in Parts I and II of each Preliminary Justification.

(2) CMS will make available to the public on its Web site the information contained in Part III of each Preliminary Justification that is not a trade secret or confidential commercial or financial information as defined in CMS's Freedom of Information Act regulations, 45 CFR 5.65.

(3) CMS will include a disclaimer on its Web site with the information made available to the public that explains the purpose and role of the Preliminary Justification.

(j) CMS will include information on its Web site concerning how the public can submit comments on the proposed rate increases that CMS reviews.

§154.220 Timing of providing the Preliminary Justification.

A health insurance issuer must submit a Preliminary Justification for all rate increases subject to review that are 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 the rate increase subject to review to be filed, as follows:

(a) If a State requires that a proposed rate increase be filed with the State prior to the implementation of the rate, the health insurance issuer must submit to CMS and the applicable State the Preliminary Justification on the date on which the health insurance issuer submits the proposed rate increase to the State.

(b) For all other States, the health insurance issuer must submit to CMS and the State the Preliminary Justification prior to the implementation of the rate increase.

§154.225 Determination by CMS or a State of an unreasonable rate increase.

(a) When CMS receives a Preliminary Justification for a rate increase subject