and timeframe set forth in the annual HHS notice of benefit and payment parameters.

Subpart G—Health Insurance Issuer Standards Related to the Risk Adjustment Program

§ 153.600 [Reserved]

§ 153.610 Risk adjustment issuer requirements.

(a) *Data requirements.* An issuer that offers risk adjustment covered plans must submit or make accessible all required risk adjustment data for those risk adjustment covered plans in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State.

(b) *Risk adjustment data storage.* An issuer that offers risk adjustment covered plans must store all required risk adjustment data in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State.

(c) *Issuer contracts.* An issuer that offers risk adjustment covered plans may include in its contract with a provider, supplier, physician, or other practitioner, provisions that require such contractor's submission of complete and accurate risk adjustment data in the manner and timeframe established by the State, or HHS on behalf of the State. These provisions may include financial penalties for failure to submit complete, timely, or accurate data.

(d) *Assessment of charges.* An issuer that offers risk adjustment covered plans that has a net balance of risk adjustment charges payable, including adjustments made pursuant to §153.350(c), will be notified by the State, or by HHS on behalf of the State, of those net charges, and must remit those risk adjustment charges to the State, or to HHS on behalf of the State, as applicable.

(e) *Charge submission deadline.* An issuer must remit net charges to the State, or HHS on behalf of the State, within 30 days of notification of net charges payable by the State, or HHS on behalf of the State.

§ 153.620 Compliance with risk adjustment standards.

(a) *Issuer support of data validation.* An issuer that offers risk adjustment covered plans must comply with any data validation requests by the State or HHS on behalf of the State.

(b) *Issuer records maintenance requirements.* An issuer that offers risk adjustment covered plans must retain any information requested to support risk adjustment data validation for a period of at least ten years after the date of the report.

PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

Subpart A—General Provisions

Sec.

Subpart B—Disclosure and Review Provisions

Subpart C—Effective Rate Review Programs

AUTHORITY: Section 2794 of the Public Health Service Act (42 USC 300gg–94).

SOURCE: 76 FR 29985, May 23, 2011, unless otherwise noted.

Subpart A—General Provisions

§ 154.101 Basis and scope.

(a) *Basis.* This part implements section 2794 of the Public Health Service (PHS) Act.

(b) *Scope.* This part establishes the requirements for health insurance issuers offering health insurance coverage in the small group or individual markets to report information concerning unreasonable rate increases to the Centers for Medicare & Medicaid Services (CMS). This part further establishes the process by which it will be determined whether the rate increases are unreasonable rate increases as defined in this part.

§ 154.102 Definitions.

As used in this part:

CMS means the Centers for Medicare & Medicaid Services.

Effective Rate Review Program means a State program that CMS has determined meets the requirements set forth in §154.301(a) and (b) for the relevant market segment in the State.

Federal medical loss ratio standard means the applicable medical loss ratio standard for the State and market segment involved, determined under subpart B of 45 CFR part 158.

Health insurance coverage has the meaning given the term in section 2791(b)(1) of the PHS Act.

Health insurance issuer has the meaning given the term in section 2791(b)(2) of the PHS Act.

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.

Product means a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State.

Rate increase means any increase of the rates for a specific product offered in the individual or small group market.

Rate increase subject to review means a rate increase that meets the criteria set forth in §154.200.

Secretary means the Secretary of the Department of Health and Human Services.

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.

State has the meaning given the term in section 2791(d)(14) of the PHS Act.

Unreasonable rate increase means:

(1) When CMS is conducting the review required by this part, a rate increase that CMS determines under §154.205 is:

(i) An excessive rate increase;

(ii) An unjustified rate increase; or

(iii) An unfairly discriminatory rate increase.

(2) When CMS adopts the determination of a State that has an Effective Rate Review Program, a rate increase that the State determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable as provided under applicable State law.

[76 FR 29985, May 23, 2011, as amended at 76 FR 54976, Sept. 6, 2011]

§ 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.