or final dedicated distributed data environment report in accordance with paragraphs (d)(2) or (e)(2) of this section remains unresolved after the issuance of the notification of risk adjustment payments and charges or reinsurance payments under §153.310(e) or §153.240(b)(1)(ii), respectively, an issuer of a risk adjustment covered plan or reinsurance-eligible plan may make a request for reconsideration regarding such discrepancy under the process set forth in §156.1220(a) of this subchapter.

(g) *Risk corridors and MLR reporting.* (1) Notwithstanding any discrepancy report made under paragraph (d)(2) or (e)(2) of this section, or any request for reconsideration under §156.1220(a) of this subchapter with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees; reinsurance payment; cost-sharing reconciliation payment or charge; or risk corridors payment or charge, unless the dispute has been resolved, an issuer must report, for purposes of the risk corridors and MLR programs:

(i) The risk adjustment payment to be made or charge assessed, including an assessment of risk adjustment user fees, by HHS in the notification provided under §153.310(e);

(ii) The reinsurance payment to be made by HHS in the notification provided under §153.240(b)(1)(ii);

(iii) A cost-sharing reduction amount equal to the amount of the advance payments of cost-sharing reductions paid to the issuer by HHS for the benefit year; and

(iv) For medical loss ratio report only, the risk corridors payment to be made or charge assessed by HHS as reflected in the notification provided under §153.510(d).

(2) An issuer must report any adjustment made following any discrepancy report made under paragraph (d)(2) or (e)(2) of this section, or any request for reconsideration under §156.1220(a) of this subchapter with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees; reinsurance payment; cost-sharing reconciliation payment or charge; or risk corridors payment or charge; or following any audit, where such adjustment has not be accounted for in a prior risk corridors or medical loss ratio report, in the next following risk corridors or medical loss ratio report.

[78 FR 15531, Mar. 11, 2013, as amended at 79 FR 13837, Mar. 11, 2014]

§153.720 Establishment and usage of masked enrollee identification numbers.

(a) *Enrollee identification numbers.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must—

(1) Establish a unique masked enrollee identification number for each enrollee; and

(2) Maintain the same masked enrollee identification number for an enrollee across enrollments or plans within the issuer, within the State, during a benefit year.

(b) *Prohibition on personally identifiable information.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program on behalf of the State, as applicable, may not—

(1) Include enrollee's personally identifiable information in the masked enrollee identification number; or

(2) Use the same masked enrollee identification number for different enrollees enrolled with the issuer.

§153.730 Deadline for submission of data.

A risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must submit data to be considered for risk adjustment payments and charges and reinsurance payments for the applicable benefit year by April 30 of the year following the applicable benefit year.

§153.740 Failure to comply with HHS-operated risk adjustment and reinsurance data requirements.

(a) *Enforcement actions.* If an issuer of a risk adjustment covered plan or reinsurance-eligible plan fails to establish

a dedicated distributed data environment in a manner and timeframe specified by HHS; fails to provide HHS with access to the required data in such environment in accordance with §153.700(a) or otherwise fails to comply with the requirements of §§153.700 through 153.730; fails to adhere to the reinsurance data submission requirements set forth in §153.420; or fails to adhere to the risk adjustment data submission and data storage requirements set forth in §§153.610 through 153.630, HHS may impose civil money penalties in accordance with the procedures set forth in §156.805 of this subchapter. Civil monetary penalties will not be imposed for non-compliance with these requirements during 2014 pursuant to this paragraph (a) if the issuer has made good faith efforts to comply with these requirements.

(b) *Default risk adjustment charge.* If an issuer of a risk adjustment covered plan fails to establish a dedicated distributed data environment or fails to provide HHS with access to the required data in such environment in accordance with §153.610(a), §153.700, §153.710, or §153.730 such that HHS cannot apply the applicable Federally certified risk adjustment methodology to calculate the risk adjustment payment transfer amount for the risk adjustment covered plan in a timely fashion, HHS will assess a default risk adjustment charge.

[78 FR 65095, Oct. 30, 2013]

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: