

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

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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: