the following year, concerning whether a threshold under paragraph (a)(1) or (a)(2) of this section applies to the 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.

[76 FR 29985, May 23, 2011, as amended at 78 FR 13440, Feb. 27, 2013]

§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 rate filing justification.

(a) If any product is subject to a rate increase, a health insurance issuer

must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products, on a form and in a manner prescribed by the Secretary.

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

(1) Unified rate review template (Part I), as described in paragraph (d) of this section.

(2) Written description justifying the rate increase (Part II), as described in paragraph (e) of this section.

(3) Rating filing documentation (Part III), as described in paragraph (f) of this section.

(c) A health insurance issuer must complete and submit Parts I and III of the Rate Filing Justification described in paragraphs (b)(1) and (b)(3) of this section to CMS and, as long as the applicable state accepts such submissions, to the applicable state. If a rate increase is subject to review, then the health insurance issuer must also complete and submit to CMS and, if applicable, the state Part II of the Rate Filing Justification described in paragraph (b)(2) of this section.

(d) Content of unified rate review template (Part I): The unified rate review template 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.

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

(e) 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 including 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.

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

(f) Content of rate filing documentation (Part III): The rate filing documentation must include an actuarial memorandum that contains the reasoning and assumptions supporting the data contained in Part I of the Rate Filing Justification. Parts I and III must be sufficient 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.

(g) If the level of detail provided by the issuer for the information under paragraphs (d) and (f) of this section does not provide sufficient basis for CMS to determine whether the rate increase is an unreasonable rate increase when CMS reviews a rate increase subject to review under §154.210(a), 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.

(h) 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 Part II of each Rate Filing Justification.

(2) CMS will make available to the public on its Web site the information contained in Parts I and III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information as defined in HHS'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 Rate Filing Justification.

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

[78 FR 13440, Feb. 27, 2013]