prior year periods related to the rate increase.

(vii) The impact of changes in reserve needs;

(viii) The impact of changes in administrative costs related to programs that improve health care quality;

(ix) The impact of changes in other administrative costs;

(x) The impact of changes in applicable taxes, licensing or regulatory fees.

(xi) Medical loss ratio.

(xii) The health insurance issuer's capital and surplus.

(xiii) The impacts of geographic factors and variations.

(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.

(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

(5) The State's determination of whether a rate increase is unreasonable is made under a standard that is set forth in State statute or regulation.

(b) *Public disclosure and input.* (1) In addition to satisfying the provisions in paragraph (a) of this section, a State with an Effective Rate Review Program must provide:

(i) For proposed rate increases subject to review, access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS's Web address for such information), and have a mechanism for receiving public comments on those proposed rate increases, no later than the date specified in guidance by the Secretary.

(ii) Beginning with rates filed for coverage effective on or after January 1, 2016, for all final rate increases (including those not subject to review), access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification (as applicable) that CMS makes available on its Web site (or provide CMS's Web address for such information), no later than the first day of the annual open enrollment period in the individual market for the applicable calendar year.

(2) If a State intends to make the information in paragraph (b)(1)(i) of this section available to the public prior to the date specified by the Secretary, or if it intends to make the information in paragraph (b)(1)(ii) of this section available to the public prior to the first day of the annual open enrollment period in the individual market for the applicable calendar year, the State must notify CMS in writing, no later than 30 days prior to the date it intends to make the information public, of its intent to do so and the date it intends to make the information public.

(3) A State with an Effective Rate Review Program must ensure the information in paragraphs (b)(1)(i) and (ii) of this section is made available to the public at a uniform time for all proposed and final rate increases, as applicable, in the relevant market segment and without regard to whether coverage is offered through or outside an Exchange.

(c) CMS will determine whether a State has an Effective Rate Review Program for each market based on information available to CMS that a rate review program meets the criteria described in paragraphs (a) and (b) of this section.

(d) CMS reserves the right to evaluate from time to time whether, and to what extent, a State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria set forth in paragraphs (a) and (b) of this section.

[76 FR 29985, May 23, 2011, as amended at 78 FR 13441, Feb. 27, 2013; 80 FR 10864, Feb. 27, 2015]

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

Subpart A—General Provisions

Sec.

Subpart B—General Standards Related to the Establishment of an Exchange

AUTHORITY: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083).

SOURCE: 77 FR 11718, Feb. 27, 2012, unless otherwise noted.

Subpart A—General Provisions.

SOURCE: 77 FR 18444, Mar. 27, 2012, unless otherwise noted.

§ 155.10 Basis and scope.

(a) *Basis.* This part is based on the following sections of title I of the Affordable Care Act:

(1) 1301. Qualified health plan defined

(2) 1302. Essential health benefits requirements

(3) 1303. Special rules

(4) 1304. Related definitions

(5) 1311. Affordable choices of health benefit plans.

(6) 1312. Consumer choice

(7) 1313. Financial integrity.

(8) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(9) 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(10) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(11) 1334. Multi-State plans.

(12) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(13) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(14) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(15) 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

(b) *Scope.* This part establishes minimum standards for the establishment of an Exchange, minimum Exchange functions, eligibility determinations, enrollment periods, minimum SHOP