**Section 2026.60 Determination of an Unreasonable Rate Increase or Inadequate Rate**

a) When the Director receives a Rate Filing Justification for a rate subject to review under Section 2026.30(a)(2) or (b) and the Director reviews the rate, the Director will make a timely determination whether:

1) for any rate increase subject to review under Section 2026.30(a)(2) or prior approval under Section 2026.30(b), the rate increase is an unreasonable rate increase in accordance with Section 2026.40, and submit that decision to CMMS within 5 business days following the final determination as required by 45 CFR 154.210(b)(2) (May 23, 2011) (no later editions or amendments); and

2) for rates described in Section 2026.30(b), the rate is an inadequate rate as defined in Section 2026.20.

b) If the Director determines that the rate increase is unreasonable or the rate is inadequate, then:

1) For rate increases described in Section 2026.30(a)(2) that the Director determines to be unreasonable, CMMS will provide the Director's final determination and brief explanation to the health insurance issuer within 5 business days following CMMS' receipt of the final determination as described in 45 CFR 154.225(c) (February 27, 2013) (no later editions or amendments).

2) For rates described in Section 2026.30(b), the Director will notify the health insurance issuer of the decision to disapprove or modify the rate as an unreasonable rate increase or inadequate rate within 60 days after the close of the public comment period described in Section 355(e) of the Code. If the Director does not notify the health insurance issuer within this 60-day period, the rates will automatically be deemed approved.

c) The Director's rate review process for unreasonable rate increases and inadequate rates includes an examination of the following as required by 45 CFR 154.301(a)(3):

1) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions;

2) The health insurance issuer's data related to past projections and actual experience;

3) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act (42 U.S.C. 18061 and 18063); and

4) The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the ACA.

d) As required by 45 CFR 154.301(a)(4) for unreasonable rate increases, the examination must take into consideration the following factors, to the extent applicable to the filing under review, which the Director also will apply to the review for inadequate rates:

1) The impact of medical trend changes by major service categories;

2) The impact of utilization changes by major service categories;

3) The impact of cost-sharing changes by major service categories, including actuarial values;

4) The impact of benefit changes, including essential health benefits and non-essential health benefits;

5) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under 42 U.S.C. 300gg;

6) The impact of any overestimate or underestimate of medical trends for prior year periods related to the rate increase;

7) The impact of changes in reserve needs;

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

9) The impact of changes in other administrative costs;

10) The impact of changes in applicable taxes, licensing or regulatory fees;

11) Medical loss ratio;

12) The health insurance issuer's capital and surplus;

13) The impacts of geographic factors and variations;

14) The impact of changes within a single risk pool to all products or plans within the risk pool; and

15) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the ACA (42 U.S.C. 18061 and 18063).

e) For rates described in Section 2026.30(a)(2) and (b), the Director will take into account information contained in public comments submitted under Section 355(e) of the Code, along with the actuarial justifications submitted by the health insurance issuer, for the purpose of determining whether the rate is an unreasonable rate increase or an inadequate rate as defined in this Part, including the examination described in subsections (c) and (d) of this Section.

(Source: Amended at 48 Ill. Reg. 7239, effective April 30, 2024)