

(5) *Advance premium reserve* means premiums received by the insuring organization that are due after the valuation date.

(6) *Reserve for rate credits* means rate credits on a group policy that—

(i) Accrue by the valuation date of the policy; and

(ii) Are paid or credited after the valuation date.

**§ 403.256 Loss ratio supporting data.**

(a) For purposes of requesting CMS certification under § 403.232, the insuring organization must submit the following loss ratio data to CMS for review—

(1) A statement of why the policy is to be considered, for purposes of the loss ratio standards, an individual or a group policy.

(2) The earliest age at which policyholders can purchase the policy.

(3) The general marketing method and the underwriting criteria used for the selection of applicants to whom coverage is offered.

(4) What policies are to be included under the one policy form, by the dates the policies are issued.

(5) The loss ratio calculation period.

(6) The scale of premiums for the loss ratio calculation period.

(7) The expected level of earned premiums in the loss ratio calculation period.

(8) The expected level of incurred claims in the loss ratio calculation period.

(9) A description of how the following assumptions were used in calculating the loss ratio.

(i) Morbidity.

(ii) Mortality.

(iii) Lapse.

(iv) Assumed increases in the Medicare deductible.

(v) Impact of inflation on reimbursement per service.

(vi) Interest.

(vii) Expected distribution, by age and sex, of persons who will purchase the policy in the coming year.

(viii) Expected impact on morbidity by policy duration of—

(A) The process used to select insureds from among those that apply for a policy; and

(B) Pre-existing condition clauses in the policy.

(b) For purposes of requesting continued CMS certification under § 403.239(a), the insuring organization must submit the following to CMS—

(1) A description of all changes in the loss ratio data, specified in paragraph (a) of this section, that occurred since CMS last reviewed the policy.

(2) The past loss ratio experience for the policy, including the experience of all riders and endorsements issued under the policy. The loss ratio experience data must include earned premiums, incurred claims, and total policy reserves that the insuring organization calculates—

(i) For all years of issue combined; and

(ii) Separately for each calendar year since CMS first certified the policy.

**§ 403.258 Statement of actuarial opinion.**

(a) For purposes of certification requests submitted under § 403.232(b) and subsequent review as specified in § 403.239(a), *statement of actuarial opinion* means a signed declaration in which a qualified actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account actual policy experience, if any, and reasonable expectations.

(b) *Qualified actuary* means—

(1) A member in good standing of the American Academy of Actuaries; or

(2) A person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the Commissioner or Superintendent of Insurance of the domiciliary State of the insuring organization.

**Subpart C—Recognition of State Reimbursement Control Systems**

SOURCE: 51 FR 15492, Apr. 24, 1986, unless otherwise noted.

**§ 403.300 Basis and purpose.**

(a) *Basis.* This subpart implements section 1886(c) of the Act, which authorizes payment for Medicare inpatient hospital services in accordance with a State's reimbursement control system rather than under the Medicare

**§ 403.302**

**42 CFR Ch. IV (10–1–06 Edition)**

reimbursement principles as described in CMS's regulations and instructions.

(b) *Purpose.* Contained in this subpart are—

(1) The basic requirements that a State reimbursement control system must meet in order to be approved by CMS;

(2) A description of CMS's review and evaluation procedures; and

(3) The conditions that apply if the system is approved.

**§ 403.302 Definitions.**

For purposes of this subpart—

*Chief executive officer of a State* means the Governor of the State or the Governor's designee.

*Existing demonstration project* refers to demonstration projects approved by CMS under the authority of section 402(a) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b–1 (note)) and in effect on April 20, 1983 (the date of the enactment of Pub. L. 98–21 (Social Security Amendments of 1983)).

*Federal hospital* means a hospital that is administered by, or that is under exclusive contract with, the Department of Defense, the Veterans Administration, or the Indian Health Service.

*State system* or *system* refers to a State reimbursement control system that is approved by CMS under the authority of section 1866(c) of the Act and that satisfies the requirements described in this subpart.

**§ 403.304 Minimum requirements for State systems—discretionary approval.**

(a) *Discretionary approval by CMS.* CMS may approve Medicare payments under a State system, if CMS determines that the system meets the requirements in paragraphs (b) and (c) of this section and, if applicable paragraph (d) of this section.

(b) *Requirements for State system.* (1) An application for approval of the system must be submitted to CMS by the Chief Executive Officer of the State.

(2) The State system must apply to substantially all non-Federal acute care hospitals in the State.

(3) All hospitals covered by the system must have and maintain a utilization and quality control review agreement with a Quality Improvement Organization, as required under section 1866(a)(1)(F) of the Act and § 466.78(a) of this chapter.

(4) Federal hospitals must be excluded from the State system.

(5) Nonacute care or specialty hospital (such as rehabilitation, psychiatric, or children's hospitals) may, at the option of the State, be excluded from the State system.

(6) The State system must apply to at least 75 percent of all revenues or expenses—

(i) For inpatient hospital services in the State; and

(ii) For inpatient hospital services under the State's Medicaid plan.

(7) Under the system, HMOs and competitive medical plans (CMPs), as defined by section 1876(b) of the Act and part 417 of this chapter, must be allowed to negotiate payment rates with hospitals.

(8) The system must limit hospital charges for Medicare beneficiaries to deductibles, coinsurance or non-covered services.

(9) Unless a waiver is granted by CMS under § 489.23 of this chapter, the system must prohibit payment, as required under section 1862(a)(14) of the Act and § 405.310(m) of this chapter, for nonphysician services provided to hospital inpatients under Part B of Medicare.

(10) The system must require hospitals to submit Medicare cost reports or approved reports in lieu of Medicare cost reports as required.

(11) The system must require—

(i) Preparation, collection, or retention by the State of reports (such as financial, administrative, or statistical reports) that may be necessary, as determined by CMS, to review and monitor the State's assurances; and

(ii) Submission of the reports to CMS upon request.

(12) The system must provide hospitals an opportunity to appeal errors that they believe have been made in the determination of their payment rates. The system, if it is prospective may not permit providers to file administrative appeals that would result