(b) *Limitation on administrative expenses*. No more than 10 percent of available funds shall be used for administrative expenses over the life of the contract with the PCIP, absent approval from HHS.

§ 152.33 Initial allocation of funds.

HHS will establish an initial ceiling for the amount of the $5 billion in Federal funds allocated for PCIPs in each State using a methodology consistent with that used to established allocations under the Children's Health Insurance Program, as set forth under 42 CFR Part 457, Subpart F, Payment to States.

§ 152.34 Reallocation of funds.

If HHS determines, based on actual and projected enrollment and claims experience, that the PCIP in a given State will not make use of the total estimated funding allocated to that State, HHS may reallocate unused funds to other States, as needed.

§ 152.35 Insufficient funds.

(a) *Adjustments by a PCIP to eliminate a deficit*. In the event that a PCIP determines, based on actual and projected enrollment and claims data, that its allocated funds are insufficient to cover projected PCIP expenses, the PCIP shall report such insufficiency to HHS, and identify and implement necessary adjustments to eliminate such deficit, subject to HHS approval.

(b) *Adjustment by the Secretary*. If the Secretary estimates that aggregate amounts available for PCIP expenses will be less than the actual amount of expenses, HHS reserves the right to make such adjustments as are necessary to eliminate such deficit.

Subpart G—Relationship to Existing Laws and Programs

§ 152.39 Maintenance of effort.

(a) *General*. A State that enters into a contract with HHS under this part must demonstrate, subject to approval by HHS, that it will continue to provide funding of any existing high risk pool in the State at a level that is not reduced from the amount provided for in the year prior to the year in which the contract is entered.

(b) *Failure to maintain efforts*. In situations where a State enters into a contract with HHS under this part, HHS shall take appropriate action, such as terminating the PCIP contract, against any State that fails to maintain funding levels for existing State high risk pools as required, and approved by HHS, under paragraph (a) of this section.

§ 152.40 Relation to State laws.

The standards established under this section shall supersede any State law or regulation, other than State licensing laws or State laws relating to plan solvency, with respect to PCIPs which are established in accordance with this section.

Subpart H—Transition to Exchanges

§ 152.44 End of PCIP program coverage.

Effective January 1, 2014, coverage under the PCIP program (45 CFR part 152) will end.

§ 152.45 Transition to the exchanges.

Prior to termination of the PCIP program, HHS will develop procedures to transition PCIP enrollees to the Exchanges, established under sections 1311 or 1321 of the Affordable Care Act, to ensure that there are no lapses in health coverage for those individuals.

PARTS 152–158 [RESERVED]

PART 159—HEALTH CARE REFORM INSURANCE WEB PORTAL

Sec.

AUTHORITY: Section 1103 of the Patient Protection and Affordable Care Act (Pub. L. 111–148).

SOURCE: 75 FR 24482, May 5, 2010, unless otherwise noted.

§ 159.100 Basis and scope.

This part establishes provisions governing a Web portal that will provide information on health insurance coverage options in each of the 50 States and the District of Columbia. It sets forth data submission requirements for health insurance issuers. It covers the individual market and the small group market.

§ 159.110 Definitions.

For purposes of part 159, the following definitions apply unless otherwise provided:

Health Insurance Coverage: We adopt the Public Health Service Act (PHSA) definition of ''health insurance coverage'' found at section 2791(b)(1) of the Public Health Service Act (PHSA).

Health Insurance Issuer: We adopt the PHSA definition of ''health insurance issuer'' found at section 2791(b)(2) of the PHSA.

Health Insurance Product: Means a package of benefits that an issuer offers that is reported to State regulators in an insurance filing.

Individual Health Insurance Coverage: We adopt the PHSA definition of ''individual health insurance coverage'' found at section 2791(b)(5) of the PHSA.

Individual Market: We adopt the Affordable Care Act definition of ''individual market'' found at section 1304(a)(2) of the Affordable Care Act and 2791(e)(1)(A) of the PHSA.

Portal Plan: Means the discrete pairing of a package of benefits and a particular cost sharing option (not including premium rates or premium quotes).

Section 1101 High Risk Pools: We define section 1101 high risk pools as any entity described in regulations implementing section 1101 of the Affordable Care Act.

Small Employer: We adopt the Affordable Care Act definition of ''small employer'' found at section 1304(b)(2) and (3).

Small Group Coverage: Means health insurance coverage offered to employees of small employers in the small group market.

Small Group Market: We adopt the Affordable Care Act definition of ''small group market'' found at section 1304(a)(3).

State Health Benefits High Risk Pools: Means nonprofit organizations created by State law to offer comprehensive health insurance to individuals who otherwise would be unable to secure such coverage because of their health status.

§ 159.120 Data submission for the individual and small group markets.

(a) Health insurance issuers (hereinafter referred to as issuers) must, in accordance with guidance issued by the Secretary, submit corporate and contact information; administrative information; enrollment data by health insurance product; product names and types; whether enrollment is currently open for each health insurance product; geographic availability information; customer service phone numbers; and Web site links to the issuer Web site, brochure documents, and provider networks; and financial ratings on or before May 21, 2010, and annually thereafter.

(b) Issuers must, as determined by the Secretary, submit pricing and benefit information for their portal plans on or before September 3, 2010, and annually thereafter.

(c) Issuers must submit updated pricing and benefit data for their portal plans whenever they change premiums, cost-sharing, types of services covered, coverage limitations, or exclusions for one or more of their individual or small group portal plans.

(d) Issuers must submit pricing and benefit data for portal plans associated with products that are newly open or newly reopened for enrollment within 30 days of opening for enrollment.

(e) Issuers must annually verify the data submitted under paragraphs (a) through (d) of this section, and make corrections to any errors that are found.

(f) Issuers must submit administrative data on products and portal plans, and these performance ratings, percent of individual market and small group market policies that are rescinded; the percent of individual market policies sold at the manual rate; the percent of claims that are denied under individual market and small group market policies; and the number and disposition of appeals on denials to insure, pay

claims and provide required preauthorizations, for future releases of the Web portal in accordance with guidance issued by the Secretary.

(g) The issuer's CEO or CFO must electronically certify to the completeness and accuracy of all data submitted for the October 1, 2010, release of the Web portal and for any future updates to these requirements.