DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 153, 155, 156, 157 and 158

[CMS-9964-P]

RIN 0938-AR51

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule provides further detail and parameters related to: the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for a Federally-facilitated Exchange; advance payments of the premium tax credit; a Federally-facilitated Small Business Health Option Program; and the medical loss ratio program. The cost-sharing reductions and advanced payments of the premium tax credit, combined with new insurance market reforms, will significantly increase the number of individuals with health insurance coverage, particularly in the individual market. The premium stabilization programs – risk adjustment, reinsurance, and risk corridors – will protect against adverse selection in the newly enrolled population. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue) protections and prohibiting the use of factors such as health status, medical history, gender, and industry of employment to set premium rates, will help to ensure that every American has access to high-quality, affordable health insurance.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR--insert date 30 days after the date of filing for public inspection at OFR.]

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Department of Health and Human Services,

Attention: CMS-9964-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

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Department of Health and Human Services,

Attention: CMS-9964-P,

Mail Stop C4-26-05,

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a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

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Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Sharon Arnold at (301) 492-4286, Laurie McWright at (301) 492-4311, or Jeff Wu at (301) 492-4305 for general information.

Adrianne Glasgow at (410) 786-0686 for matters related to reinsurance.

Michael Cohen at (301) 492-4277 for matters related to the methodology for determining the reinsurance contribution rate and payment parameters.

Grace Arnold at (301) 492-4272 for matters related to risk adjustment, the HHS risk adjustment methodology, or the distributed data collection approach for the HHS-operated risk adjustment and reinsurance programs.

Adam Shaw at (410) 786-1091 for matters related to risk corridors.

Johanna Lauer at (301) 492-4397 for matters related to cost-sharing reductions, advance payments of the premium tax credits, or user fees.

Rex Cowdry at (301) 492-4387 for matters related to the Small Business Health Options Program.

Carol Jimenez at (301) 492-4457 for matters related to the medical loss ratio program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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Acronyms

Affordable Care Act	The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act (Pub. L. 111–152))
APTC	Advance payment of the premium tax credit

AV	Actuarial Value
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
EHB	Essential Health Benefits
ERISA	Employee Retirement Income Security Act
ESI	Employer sponsored insurance
FFE	Federally-facilitated Exchange
FPL	Federal Poverty Level
GAAP	Generally accepted accounting principles
HCC	Hierarchical condition category
HHS	United States Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
IHS	Indian Health Service
IRS	Internal Revenue Service
MLR	Medical Loss Ratio
NAIC	National Association of Insurance Commissioners
OMB	Office of Management and Budget
OPM	United States Office of Personnel Management
PHS Act	Public Health Service Act
PRA	Paperwork Reduction Act of 1985
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
The Code	Internal Revenue Code of 1986

I. Executive Summary

A. Purpose

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through competitive marketplaces, called Affordable Insurance Exchanges, or "Exchanges." Individuals who enroll in health plans through Exchanges may receive premium tax credits to make health insurance more affordable, and financial assistance to cover cost sharing for health care services. The premium tax credits, combined with the new insurance reforms, will significantly increase the number of individuals with health insurance coverage, particularly in the individual market. Premium stabilization programs – risk adjustment, reinsurance, and risk corridors – protect against adverse selection in the newly enrolled population. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue) protections, prohibiting the use of factors such as health status, medical history, gender, and industry of employment to set premium rates, will help to ensure that every American has access to high-quality, affordable health insurance.

Premium stabilization programs: The Affordable Care Act establishes transitional reinsurance and temporary risk corridors programs, and a permanent risk adjustment program to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers.

The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The risk corridors program, which is a Federally administered program,

will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains. On an ongoing basis, the risk adjustment program is intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees. Under this program, funds are transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees.

In the Premium Stabilization Rule (77 FR 17220), we laid out a regulatory framework for these three programs. In that rule, we stated that the specific payment parameters for those programs would be published in this proposed rule. In this proposed rule, we expand upon these standards, and propose payment parameters for these programs.

Advanced payments of the premium tax credit and cost-sharing reductions: This proposed rule proposes standards for advanced payments of the premium tax credit and for cost-sharing reductions. These programs assist low- and moderate-income Americans in affording health insurance on an Exchange. Section 1401 of the Affordable Care Act amended the Internal Revenue Code (26 U.S.C.) to add section 36B, allowing an advance, refundable premium tax credit to help individuals and families afford health insurance coverage. Section 36B of the Code was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111–309) (124 Stat. 3285 (2010)); the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112–9) (125 Stat. 36 (2011)); and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112–10) (125 Stat. 38 (2011)). The section 36B credit is designed to make a qualified health plan affordable by reducing a taxpayer's out-of-pocket premium cost.

Under section 1411 of the Affordable Care Act, an Exchange makes an advance determination of tax credit eligibility for individuals enrolling in coverage through the Exchange and seeking financial assistance. Using information available at the time of enrollment, the Exchange determines: (1) whether the individual meets the income and other requirements for advance payments, and (2) the amount of the advance payments. Advance payments are made monthly under section 1412 of the Affordable Care Act to the issuer of the qualified health plan (QHP) in which the individual enrolls.

Section 1402 of the Affordable Care Act provides for the reduction of cost sharing for certain individuals enrolled in QHPs offered through the Exchanges and section 1412 of the Affordable Care Act provides for the advance payment of these reductions to issuers. This assistance will help low- and moderate-income qualified individuals and families afford the out-of-pocket spending associated with health care services provided through QHP coverage. The law directs issuers to reduce cost sharing for essential health benefits for individuals with household incomes between 100 and 400 percent of the Federal Poverty Level (FPL) who are enrolled in a silver level QHP through an individual market Exchange and are eligible for advance payment of premium tax credits. The statute also directs issuers to eliminate cost sharing for Indians (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income at or below 300 percent of the FPL who are enrolled in a QHP of any "metal" level (that is, bronze, silver, gold, or platinum) through the individual market in the Exchange, and prohibits issuers of QHPs from requiring cost sharing for Indians, regardless of household income, for items or services furnished directly by the Indian Health Service, an Indian Tribe, a Tribal Organization, or an Urban Indian Organization, or through referral under contracted health services.

HHS published a bulletin[1] outlining an intended regulatory approach to calculations of actuarial value and implementation of cost-sharing reductions on February 24, 2012 (the "AV/CSR Bulletin"). Specifically, HHS outlined an intended regulatory approach for the calculation of AV, de minimis variation standards, silver plan variations for individuals eligible for cost-sharing reductions, and advance payments of cost-sharing reductions to issuers, among other topics. In the Exchange Establishment Rule, we established eligibility standards for these cost-sharing reductions. In this proposed rule, we establish standards governing the administration of cost-sharing reductions and provide specific payment parameters for the program.

Federally-facilitated Exchange user fees: Section 1311(d)(5)(A) of the Affordable Care Act contemplates an Exchange charging assessments or user fees to participating issuers to generate funding to support its operations. As the operator of a Federally-facilitated Exchange, HHS has the authority, under this section of the statute, to collect and spend such user fees. In addition, 31 U.S.C. 9701 provides for an agency to establish a charge for a service provided by the agency. Office of Management and Budget Circular A-25 Revised ("Circular A-25R") establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. In this proposed rule, we establish a user fee for issuers participating in a Federally-facilitated Exchange.

Small Business Health Options Program: Section 1311(b)(1)(B) of the Affordable Care Act directs each State that chooses to operate an Exchange to establish a Small Business Health Options Program (SHOP) that provides health insurance options

[1] Available at: http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

for small businesses. The Exchange Establishment Rule sets forth standards for the administration of SHOP Exchanges. In this proposed rule, we clarify and expand upon the standards established in that final rule.

Medical loss ratio program: Public Health Service (PHS) Act section 2718 generally requires health insurance issuers to submit an annual MLR report to HHS and provide rebates to consumers if they do not achieve specified MLRs. On December 1, 2010, we published an interim final rule, entitled "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act," (75 FR 74864) that established standards for the MLR program. Since then, we have made several revisions and technical corrections to those rules. We propose in this proposed rule to amend the regulations to specify how issuers are to account for payments or receipts for risk adjustment, reinsurance, and risk corridors, and to change the timing of the annual MLR report and distribution of rebates required of issuers to allow for accounting of the premium stabilization programs. This proposed rule also proposes to amend the regulations to revise the treatment of community benefit expenditures in the MLR calculation for issuers exempt from Federal income tax.

B. Summary of the Major Provisions

This proposed rule fills in the framework established by the Premium Stabilization Rule by proposing provisions and parameters for the three premium stabilization programs — the permanent risk adjustment program, the transitional reinsurance program, and the temporary risk corridors program. It also proposes key provisions governing advance payments of the premium tax credit, cost-sharing reductions, and user fees for Federally-facilitated Exchanges. Finally, it proposes a number of amendments relating to the SHOP and the medical loss ratio program.

Risk Adjustment: The goal of the Affordable Care Act risk adjustment program is to mitigate the impacts of possible adverse selection and stabilize the premiums in the individual and small group markets as and after insurance market reforms are implemented. In this proposed rule, we propose a number of standards and parameters for implementing the risk adjustment program, including:

- Provisions governing a State operating a risk adjustment program;
- The risk adjustment methodology HHS will use when operating risk adjustment on behalf of a State, including the risk adjustment model, the payments and charges methodology, and the data collection approach; and
- An outline of the data validation process we propose to use when operating risk adjustment on behalf of a State.

Reinsurance: The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. In this proposed rule, we propose a number of standards and parameters for implementing the reinsurance program, including:

- Provisions excluding certain types of health coverage from reinsurance contributions;
- The national per capita contribution rate to be paid by health insurance issuers and self-insured group health plans along with the methodology to be used for calculating the contributions due from a health insurance issuer or self-insured group health plan;
- Provisions establishing eligibility for reinsurance payments;
- The national reinsurance payment parameters and the approach we propose to use to calculate and administer the reinsurance program; and
- The distributed data collection approach we propose to use to implement the reinsurance program.

Risk Corridors: The temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016. In this proposed rule, we propose to permit a QHP to include profits and taxes within its risk corridors calculations. We also propose an annual schedule for the program and standards for data submissions.

Advance Payments of the Premium Tax Credit: Sections 1401 and 1411 of the Affordable Care Act provide for advance payments of the premium tax credit for low- and moderate-income enrollees in QHPs on Exchanges. In this proposed rule, we propose a number of standards governing the administration of this program, including:

- Provisions governing the reduction of premiums by the amount of any advance payments of the premium tax credit; and
- Provisions governing the allocation of premiums to essential health benefits.

Cost-Sharing Reductions: Sections 1402 and 1412 of the Affordable Care Act provide for reductions in cost sharing on essential health benefits for low- and moderate-income enrollees in qualified silver level health plans in individual market Exchanges. It also provides for reductions in cost sharing for Indians enrolled in QHPs at any metal level. In this proposed rule, we propose a number of standards governing the cost-sharing reduction program, including:

- Provisions governing the design of variations of QHPs with cost-sharing structures for enrollees of various income levels and for Indians;
- The maximum out-of-pocket limits applicable to the various plan variations;
- Provisions governing the assignment and reassignment of enrollees to plan variations;
- Provisions governing issuer submissions of estimates of cost-sharing reductions, which are paid in advance to issuers by the Federal government; and

- Provisions governing reconciliation of these advance estimates against actual cost-sharing reductions provided.

User Fees: This proposed rule proposes a per billable member user fee applicable to issuers participating in a Federally-facilitated Exchange. This proposed rule also outlines HHS's approach to calculating the fee.

SHOP: Beginning in 2014, SHOP Exchanges will allow small employers to offer employees a variety of QHPs. In this proposed rule, we propose several standards and processes for implementing SHOP Exchanges, including:

- Standards governing the definitions and counting methods used to determine whether an employer is a small or large employer;
- A safe harbor method of employer contribution in a Federally-facilitated SHOP (FF-SHOP);
- The default minimum participation rate;
- QHP standards linking Exchange and FF-SHOP participation and ensuring broker commissions in FF-SHOP that are the same as those in the outside market; and
- Allowing Exchanges and SHOPs to selectively list only brokers registered with the Exchange or SHOP (and adopting that policy for FFEs and FF-SHOPs).

MLR: The MLR program requires issuers to rebate a portion of premiums if their MLRs fall short of the applicable MLR standard for the reporting year. MLR is calculated as a ratio of claims plus quality improvement activities to premium revenue, with adjustments for taxes, regulatory fees, and the premium stabilization programs. In this proposed rule, we propose a number of standards governing the MLR program, including:

- Provisions accounting for risk adjustment, reinsurance, and risk corridors in the MLR calculation;

- A revised timeline for MLR reporting and rebates; and
- Provisions modifying the treatment of community benefit expenditures.

C. Costs and Benefits

The provisions of this proposed rule, combined with other provisions in the Affordable Care Act, will improve the individual insurance market by making insurance more affordable and accessible to millions of Americans who currently do not have affordable options available to them. The shortcomings of the individual market today have been widely documented.[2]

These limitations of the individual market are made evident by how few people actually purchase coverage in the individual market. In 2011, approximately 48.6 million people were uninsured in the United States,[3] while only around 10.8 million were enrolled in the individual market.[4] The relatively small fraction of the target market that actually purchases coverage in the individual market in part reflects people's resources, how expensive the product is relative to its value, and how difficult it is for many people to access coverage.

The provisions of this proposed rule, combined with other provisions in the Affordable Care Act, will improve the functioning of both the individual and the small group markets while stabilizing premiums. The transitional reinsurance program will serve to stabilize premiums in the individual market. Reinsurance will attenuate individual market rate increases that might otherwise occur because of the immediate

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[2] Michelle M. Doty et al., Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2007, The Commonwealth Fund, July 2009; Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011.
[3] Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement, Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2011.
[4] Source: CMS analysis of June 2012 Medical Loss Ratio Annual Reporting data for 2011 MLR reporting year, available at http://cciio.cms.gov/resources/data/mlr.html.

enrollment of higher risk individuals, potentially including those currently in State high-risk pools. In 2014, it is anticipated that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent relative to expected premiums without reinsurance.

The risk corridors program will protect QHP issuers in the individual and small group market against inaccurate rate setting and will permit issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets.

The risk adjustment program protects against adverse selection by allowing issuers to set premiums according to the average actuarial risk in the individual and small group market without respect to the type of risk selection the issuer would otherwise expect to experience with a specific product offering in the market. This should lower the risk premium issuers would otherwise price into premiums in the expectation of enrolling individuals with unknown health status. In addition, it mitigates the incentive for health plans to avoid unhealthy members. The risk adjustment program also serves to level the playing field inside and outside of the Exchange, as payments and charges are applied to all non-grandfathered individual and small group plans.

Provisions addressing the advance payments of the premium tax credit and cost-sharing reductions will help provide for premium tax credits and the reduction or elimination of cost sharing for certain individuals enrolled in QHPs offered through the Exchanges. This assistance will help many low-and moderate-income individuals and families obtain health insurance. For many people, cost sharing is a barrier to obtaining

needed health care.[5] The availability of premium tax credits through Exchanges starting in 2014 will result in lower net premium rates for many people currently purchasing coverage in the individual market, and will encourage younger and healthier enrollees to enter the market, improving the risk pool and leading to reductions in premium rates for current policyholders.[6]

The provisions addressing SHOP Exchanges will reduce the burden and costs of enrolling employees in small group plans, and give small businesses many of the cost advantages and choices that large businesses already have. Additionally, SHOP Exchanges will allow for employers to preserve control over health plan choices while saving employers money by spreading insurers' administrative costs across more employers.

The provisions addressing the MLR program will result in a more accurate calculation of MLR and rebate amounts, since it will reflect issuers' claims-related expenditures, after adjusting for the premium stabilization programs.

We solicit comments on additional strategies consistent with the Affordable Care Act that HHS or States might deploy to help make rates affordable in the current market and encourage timely enrollment in coverage in 2014. Ensuring that premiums are affordable is a priority for HHS as well as States, consumers, and insurers, so we welcome suggestions for the proposed rule on ways to achieve this goal while implementing these essential consumer protections.

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[5] Brook, Robert H., John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patricia Camp and Joseph P. Newhouse. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment.* Santa Monica, CA: RAND Corporation, 1984. Available at: http://www.rand.org/pubs/reports/R3055.

[6] Congressional Budget Office, Letter to Honorable Evan Bayh, providing an Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, November 30, 2009; Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011; Fredric Blavin et al., The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State, Urban Institute, March 2012.

Issuers may incur some one-time fixed costs to comply with the provisions of the final rule, including administrative and hardware costs. However, issuer revenues and expenditures are also expected to increase substantially as a result of the expected increase in the number of people purchasing individual market coverage. That enrollment is projected to exceed current enrollment by 50 percent.[7] We are soliciting comments on the nature and magnitude of these costs and benefits to issuers, and the potential effect of the provisions of this rule on premium rates and financial performance.

In addition, States may incur administrative and operating costs if they choose to establish their own programs. We are also requesting information on such costs. In accordance with Executive Orders 12866 and 13563, we believe that the benefits of this regulatory action would justify the costs.

II. Background

Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges (Exchanges). The Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury are working in close coordination to release guidance related to Exchanges in several phases. The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act (Pub. L. 111-152) was enacted on March 30, 2010. We refer to the two statutes collectively as the Affordable Care Act in this proposed rule.

A. Premium Stabilization

[7] Congressional Budget Office, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf (Table 3).

A proposed regulation was published in the **Federal Register** on July 15, 2011 (76 FR 41930) to implement health insurance premium stabilization policies in the Affordable Care Act. A final rule implementing the health insurance premium stabilization programs (that is, risk adjustment, reinsurance, and risk corridors) (Premium Stabilization Rule) (77 FR 17220) was published in the **Federal Register** on March 23, 2012. We published a white paper on risk adjustment concepts on September 12, 2011 (Risk Adjustment White Paper). We published a bulletin on May 1, 2012, outlining our intended approach to implementing risk adjustment when we are operating risk adjustment on behalf of a State (Risk Adjustment Bulletin). On May 7-8, 2012, we hosted a public meeting in which we discussed that approach (Risk Adjustment Spring Meeting).

We published a bulletin on May 31, 2012, outlining our intended approach to making reinsurance payments to issuers when we are operating the reinsurance program on behalf of a State (Reinsurance Bulletin). The Department solicited comment on proposed operations for both reinsurance and risk adjustment when we are operating the program on behalf of a State.

B. Cost-Sharing Reductions

We published a bulletin outlining an intended regulatory approach to calculating actuarial value and implementing cost-sharing reductions on February 24, 2012 (AV/CSR Bulletin). In that bulletin, we outlined an intended regulatory approach for the design of plan variations for individuals eligible for cost-sharing reductions, and advance payments and reimbursement of cost-sharing reductions to issuers, among other topics. We reviewed and considered comments to the AV/CSR Bulletin in developing section III.E. of this proposed rule.

C. Advance Payments of the Premium Tax Credit

A proposed regulation relating to the health insurance premium tax credit was published by the Department of the Treasury in the **Federal Register** on August 17, 2011 (76 FR 50931). A final rule relating to the health insurance premium tax credit was published by the Department of the Treasury in the **Federal Register** on May 23, 2012 (26 CFR 1 and 602).

D. Exchanges

A Request for Comment relating to Exchanges was published in the **Federal Register** on August 3, 2010 (75 FR 45584). An Initial Guidance to States on Exchanges was issued on November 18, 2010. A proposed regulation was published in the **Federal Register** on July 15, 2011 (76 FR 41866) to implement components of the Exchange. A proposed regulation regarding Exchange functions in the individual market, eligibility determinations, and Exchange standards for employers was published in the **Federal Register** on August 17, 2011 (76 FR 51202). A final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges (Exchange Establishment Rule) was published in the **Federal Register** on March 27, 2012 (77 FR 18310).

E. Market Reform Rules

A notice of proposed rulemaking relating to market reforms and effective rate review was published in the **Federal Register** on November 26, 2012 (77 FR 70584) (proposed Market Reform Rule).

F. Essential Health Benefits and Actuarial Value

A notice of proposed rulemaking relating to essential health benefits and actuarial value was published in the **Federal Register** on November 26, 2012 (77 FR 70644) (proposed EHB/AV Rule).

G. Medical Loss Ratio

HHS published a request for comment on PHS Act section 2718 in the **Federal Register** on April 14, 2010 (75 FR 19297), and published an interim final rule with 60 day comment period relating to the medical loss ratio (MLR) program on December 1, 2010 (75 FR 74864). A final rule with 30 day comment period (MLR Final Rule) was published in the **Federal Register** on December 7, 2011 (76 FR 76574).

H. Tribal Consultations

This proposed rule may be of interest to, and affect, American Indians/Alaska Natives. Therefore, we plan to consult with Tribes during the comment period and prior to publishing a final rule.

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2014

A. Provisions for the State Notice of Benefit and Payment Parameters

In §153.100(c), we established a deadline of March 1 of the calendar year prior to the applicable benefit year for States to publish a State notice of benefit and payment parameters if the State wishes to modify the parameters for the reinsurance program or the risk adjustment methodology set forth in the applicable HHS notice of benefit and payment parameters. We recognize that, for this initial benefit year (that is, for benefit year 2014), it may be difficult for States to publish such a notice by the required deadline. We therefore propose to modify §153.100(c) to require that, for benefit year 2014 only, a State must publish a State notice by March 1, 2013, or by the 30th day following publication of the final HHS notice of benefit and payment parameters, whichever is later. If a State that chooses to operate reinsurance or risk adjustment does not publish the State notice within that timeframe, the State would: (1) adhere to the data requirements for health insurance issuers to receive reinsurance payments that are specified in the annual HHS notice of benefit and payment

parameters for the applicable benefit year; (2) forgo the collection of additional reinsurance contributions under §153.220(d) and the use of additional funds for reinsurance payments under §153.220(d)(3); (3) forgo the use of more than one applicable reinsurance entity; and (4) adhere to the risk adjustment methodology and data validation standards published in the annual HHS notice of benefit and payment parameters.

B. Provisions and Parameters for the Permanent Risk Adjustment Program

The risk adjustment program is a permanent program created by the Affordable Care Act that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside the Exchanges. In subparts D and G of the Premium Stabilization Rule, we established standards for the administration of the risk adjustment program. A State approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf.

In the Premium Stabilization Rule, we established that a risk adjustment program is operated using a risk adjustment methodology. States operating their own risk adjustment program may use a risk adjustment methodology developed by HHS, or may elect to submit an alternate methodology to HHS for approval. In the Premium Stabilization Rule, we also laid out standards for States and issuers with respect to the collection and validation of risk adjustment data.

In section III.B.1. of this proposed rule, we propose standards for HHS approval of a State-operated risk adjustment program (regardless of whether a State elects to use the HHS-developed methodology or an alternate, Federally certified risk adjustment methodology). This approval process would be distinct from the approval process for State-based Exchanges. In section III.B.2. of this proposed rule, we propose a fee to

support HHS operation of the risk adjustment program. This fee is a per-capita fee applied to issuers of risk adjustment covered plans in States where HHS is operating the risk adjustment program.

In section III.B.3. of this proposed rule, we describe the methodology that HHS would use when operating a risk adjustment program on behalf of a State. This methodology would be used to assign a plan average risk score based upon the relative average risk of a plan's enrollees, and to apply a payment transfer formula to determine risk adjustment payments and charges. We also describe the HHS-operated data collection approach, and the schedule for operating the HHS-operated risk adjustment program. States operating a risk adjustment program can use this methodology, or submit an alternate methodology, as described in section III.B.4. of this proposed rule.

Finally, in section III.B.5. of this proposed rule, we describe the data validation process we propose to use when operating a risk adjustment program on behalf of a State. We propose that issuers contract with independent auditors to conduct an initial validation audit of risk adjustment data, and that we conduct a second validation audit of a sample of risk adjustment data validated in the initial validation audit to verify the findings of the initial validation audit. We propose that this process be implemented over time, such that payment adjustments based on data validation findings would not be made in the initial years. We also describe a proposed framework for appeals of data validation findings.

1. Approval of State-Operated Risk Adjustment

a. Risk Adjustment Approval Process

In the Premium Stabilization Rule, we laid out minimum standards for States that choose to operate risk adjustment. In §153.310(a), we specified that a State that elects to operate an Exchange is eligible to establish a risk adjustment program. In §153.310(a)(2)

and (a)(3), we specified that HHS would carry out risk adjustment functions on behalf of the State if the State was not eligible to operate risk adjustment, or if the State deferred operation of risk adjustment to HHS. Under our authority in section 1321(a) of the Affordable Care Act on standards for operation of risk adjustment programs and section 1343(b) of the Affordable Care act on criteria and methods to be used in carrying out risk adjustment activities, we now propose to add §153.310(a)(4) such that, beginning in 2015, HHS would carry out the risk adjustment functions on behalf of a State if the State is not approved by HHS (that is, does not meet the standards proposed in §153.310(c)) to operate a risk adjustment program prior to State publication of its notice of benefit and payment parameters. We believe an approval process for State-operated risk adjustment programs will promote confidence in these programs so that they can effectively protect against the effects of adverse selection.

We propose that a new paragraph (c), entitled "State responsibilities for risk adjustment," set forth a State's responsibilities with regard to risk adjustment program operations. With this change, we also propose to redesignate paragraphs (c) and (d) to paragraphs (e) and (f) of §153.310. We note that the State must ensure that the entity it selects to operate risk adjustment complies with the standards established in §153.310(b).

In paragraph §153.310(c)(1), we propose that if a State is operating a risk adjustment program for a benefit year, the State administer the program through an entity that meets certain standards. These standards would ensure the entity has the capacity to operate the risk adjustment program throughout the benefit year, and is able to administer the risk adjustment methodology. We will work with States to ensure that entities are ready to operate a risk adjustment program by the beginning of the applicable benefit year.

As proposed in §153.310(c)(1)(i), the entity must be operationally ready to administer the applicable Federally certified risk adjustment methodology and process the resulting payments and charges. We believe that it is important for a State to demonstrate that its risk adjustment entity has the capacity to implement the applicable Federally certified risk adjustment methodology so that issuers may have confidence in the program, and so that the program can effectively mitigate the effects of potential adverse selection. To meet this standard, a State would demonstrate that the risk adjustment entity: (1) has systems in place to implement the data collection approach, to calculate individual risk scores, and calculate issuers' payments and charges in accordance with the applicable Federally certified risk adjustment methodology; and (2) has tested, or has plans to test, the functionality of the system that would be used for risk adjustment operations prior to the start of the applicable benefit year. States would also demonstrate that the entity has legal authority to carry out risk adjustment program operations, and has the resources to administer the applicable risk adjustment methodology in its entirety, including the ability to make risk adjustment payments and collect risk adjustment charges.

We propose in paragraph §153.310(c)(1)(ii) that the entity have relevant experience to operate a risk adjustment program. To meet this standard, a State would demonstrate that the entity has on staff, or has contracted with, individuals or firms with experience relevant to the implementation of a risk adjustment methodology. This standard is intended to ensure that the entity has the resources and staffing necessary to successfully operate the risk adjustment program.

We propose in paragraph §153.310(c)(2) that a State seeking to operate its own risk adjustment program ensure that the risk adjustment entity complies with all applicable provisions of subpart D of 45 CFR part 153 in the administration of the

applicable Federally certified risk adjustment methodology. In particular, the State would ensure that the entity complies with the privacy and security standards set forth in §153.340.

We propose in §153.310(c)(3) that the State conduct oversight and monitoring of risk adjustment activities in order for HHS to approve the State's risk adjustment program. Because the integrity of the risk adjustment program has important implications for issuers and enrollees, we propose to consider the State's plan to monitor the conduct of the entity. HHS would examine the State's requirements for data integrity and the maintenance of records, and the State's standards for issuers' use of risk adjustment payments. We will provide more detail about oversight in future rulemaking.

Finally, we propose in §153.310(d) that a State submit to HHS information that establishes that it and its risk adjustment entity meet the criteria set forth in §153.310(c). Under the proposed §153.310(a)(4), HHS would operate risk adjustment in the State, under the HHS-developed methodology, if the State does not receive approval prior to the March deadline for publication of the State notice of benefit and payment parameters. Thus, if a State wishes to operate risk adjustment for benefit year 2015, it would have to be approved prior to publication of the State notice of benefit and payment parameters for benefit year 2015 (publication of which must occur by March 1, 2014). We will issue future guidance on application dates, procedures, and standards.

We welcome comments on these proposed provisions.

b. Risk Adjustment Approval Process for Benefit Year 2014

For benefit year 2014, we recognize there are unique timing issues for approving a State-operated risk adjustment program. States would not know whether they are eligible to operate a risk adjustment program until they are approved or conditionally approved to operate an Exchange for the 2014 benefit year. In addition, the set of

Federally certified risk adjustment methodologies and the State-operated risk adjustment program approval process will not be finalized until the final Payment Notice is effective.

Given these timing constraints, we are proposing a transitional policy for benefit year 2014. We would not require that a State-operated risk adjustment program receive approval for benefit year 2014. Instead, we propose a transitional process shortly after the provisions of §153.310(a)(4), (c), and (d) become effective. We are requesting that States planning to operate risk adjustment in benefit year 2014 consult with HHS to determine the capacity of the State to operate risk adjustment. In these consultations, HHS would ask States to identify the entity they select to operate risk adjustment, and to describe its plans for risk adjustment operations in the State. This consultative process would apply for benefit year 2014; however, we intend that States obtain formal approval under the proposed process for benefit year 2015 and subsequent years.

For benefit year 2015 and subsequent benefit years, the proposed approval process would continue to involve ongoing consultations with States and their selected risk adjustment entities. In the course of these consultations, we would provide States and proposed entities with our ongoing views on whether they are adequately demonstrating the capacity of the entity to operate all risk adjustment functions. If the State does not produce the requested evidence or make the requested changes in the specified timeframe, HHS may determine that the relevant criteria were not met, and may decline to approve that State's risk adjustment program. We welcome comments on this proposal.

2. Risk Adjustment User Fees

If a State is not approved to operate or chooses to forgo operating its own risk adjustment program, HHS would operate risk adjustment on the State's behalf. We intend to collect a user fee to support the administration of HHS-operated risk

adjustment. This fee would apply to issuers of risk adjustment covered plans in States in which HHS is operating the risk adjustment program.

Circular No. A-25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. The risk adjustment program will provide special benefits as defined in section 6(a)(1)(b) of Circular No. A-25R to an issuer of a risk adjustment covered plan because it will mitigate the financial instability associated with risk selection as other market reforms go into effect. The risk adjustment program will also contribute to consumer confidence in the insurance industry by helping to stabilize premiums across the individual and small group health insurance markets.

We propose to determine HHS' total costs for administering risk adjustment programs on behalf of States by examining HHS's contract costs of operating the risk adjustment program. These contracts cover development of the model and methodology, collections, payments, account management, data collection, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. We do not propose to set the user fee to cover Federal personnel.

We would set the user fee rate as a national per capita rate, which would spread the cost of the program across issuers of risk adjustment covered plans based on enrollment. We would divide HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of enrollees in risk adjustment covered plans in HHS-operated risk adjustment programs.

An issuer of a risk adjustment covered plan in a State where HHS is operating risk adjustment would pay a risk adjustment user fee equal to the product of its annual enrollment in the risk adjustment covered plan multiplied by the annual per capita risk

adjustment user fee rate specified in the annual notice of benefit and payment parameters for the applicable benefit year. We would calculate the total user fee that would be charged to each issuer based on the issuer's monthly enrollment, as provided to HHS using the data collection approach for the risk adjustment program. This approach would ensure that user fees are appropriately tied to enrollment and spread across issuers. We expect that the use of existing data collection and submission methods would minimize burden on issuers, while promoting accuracy.

We anticipate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2014 would be less than $20 million, and that the per capita risk adjustment user fee would be no more than $1.00 per enrollee per year.

HHS would collect risk adjustment user fees from issuers of risk adjustment covered plans in June of the year after the applicable benefit year to align with payments and charges processing, to provide issuers the time to fully comply with the data collection and submission standards, and to permit HHS to perform the user fee calculations based on actual monthly enrollment counts from the benefit year.

We seek comment on this proposed assessment of user fees to support HHS-operated risk adjustment programs.

3. Overview of the risk adjustment methodology HHS would implement when operating risk adjustment on behalf of a State

The goal of the risk adjustment program is to stabilize the premiums in the individual and small group markets as and after insurance market reforms are implemented. The risk adjustment methodology proposed here, which HHS would use when operating risk adjustment on behalf of a State, is based on the premise that premiums should reflect the differences in plan benefits and plan efficiency, not the health status of the enrolled population.

Under §153.20, a risk adjustment methodology is made up of five elements:

- The risk adjustment model uses an individual's recorded diagnoses, demographic characteristics, and other variables to determine a risk score, which is a relative measure of how costly that individual is anticipated to be.
- The calculation of plan average actuarial risk and the calculation of payments and charges average all individual risk scores in a risk adjustment covered plan, make certain adjustments, and calculate the funds transferred between plans. In this proposed rule, these two elements of the methodology are presented together as the payment transfer formula.
- The data collection approach describes HHS' approach to obtaining data, using the distributed model described in section III.G. of this proposed rule that is required for the risk adjustment model and the payment transfer formula.
- The schedule for the risk adjustment program describes the timeframe for risk adjustment operations.

States approved to operate risk adjustment may utilize this risk adjustment methodology, or they may submit an alternate methodology as described in section III.B.4. of this proposed rule.

The risk adjustment methodology addresses three considerations: (1) the newly insured population; (2) plan metal levels and permissible rating variation; and (3) the need for inter-plan transfers that net to zero. Risk adjustment payments or charges would be calculated from the payment transfer formula described in section III.B.3.c. of this proposed rule. The key feature of the HHS risk adjustment methodology is that the risk score alone does not determine whether a plan is assessed charges or receives payments. Transfers depend not only on a plan's average risk score, but also on its plan-specific cost factors relative to the average of these factors within a risk pool within a State.

As discussed in greater detail below, the risk adjustment methodology developed by HHS:

- Is developed on commercial claims data for a population similar to the expected population to be risk adjusted;
- Uses the hierarchical condition categories ("HCC") grouping logic used in the Medicare population, with HCCs refined and selected to reflect the expected risk adjustment population;
- Calculates risk scores with a concurrent model (current year diagnoses predict current year costs);
- Establishes 15 risk adjustment models, one for each combination of metal level (platinum, gold, silver, bronze, catastrophic) and age group (adults, children, infants);
- Results in "balanced" payment transfers within a risk pool within a market within a State;
- Adjusts payment transfers for plan metal level, geographic rating area, induced demand, and age rating, so that transfers reflect health risk and not other cost differences; and
- Transfers funds between plans within a market within a State.

a. Risk Adjustment Applied to Plans in the Individual and Small Group Markets

Section 1343(c) of the Affordable Care Act stipulates that risk adjustment is to apply to non-grandfathered health insurance coverage offered in the individual and small group markets. We previously defined a "risk adjustment covered plan" in §153.20 as health insurance coverage offered in the individual or small group markets, excluding plans offering excepted benefits and certain other plans, including "any other plan determined not to be a risk adjustment covered plan in the annual HHS notice of benefit and payment parameters." We propose to amend this definition by replacing "and any

plan determined not to be a risk adjustment covered plan in the annual HHS notice of benefit and payment parameters" with "and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology." We note that, under this revised definition, we would describe any plans not determined to be risk adjustment covered plans under the HHS risk adjustment methodology in the annual notice of benefit and payment parameters, which is subject to notice and comment.

We describe below our proposed treatment of certain types of plans (specifically, plans not subject to market reforms, student health plans, and catastrophic plans), and our proposed approach to risk pooling for risk adjustment purposes when a State merges markets for the purposes of the single risk pool provision described in section 1312(c) of the Affordable Care Act. States may propose different approaches to these plans and to risk pooling in State alternate methodologies, subject to the requirements established at §153.330(b) in this proposed rule.

Plans not subject to market reforms: Certain types of plans offering non-grandfathered health insurance coverage in the individual and small group markets would not be subject to the insurance market reforms proposed in the Market Reform Rule and the EHB/AV proposed rule. In addition, plans providing benefits through policies that begin in 2013, with renewal dates in 2014, would not be subject to these requirements until renewal in 2014. The law specifies that the risk adjustment program is to assess charges on non-grandfathered health insurance coverage in the individual and small group markets with less than average actuarial risk and to make payments to non-grandfathered health insurance coverage in these markets with higher than average actuarial risk. We interpret actuarial risk to mean predictable risk that the issuer has not been able to compensate for through exclusion or pricing. In the current market, plans

are generally not subject to the insurance market reforms that begin in 2014 described at §147.102 (fair health insurance premiums), §147.104 (guaranteed availability of coverage, subject to the student health insurance provisions at §147.145), §147.106 (guaranteed renewability of coverage, subject to the student health insurance provisions at §147.145), §156.80 (single risk pool), and Subpart B 156 (essential health benefits package), and so are generally able to minimize actuarial risk by excluding certain conditions (for example, maternity coverage for women of child-bearing age), denying coverage to those with certain high-risk conditions, and by pricing individual premiums to cover the costs of providing coverage to an individual with those conditions.

We propose to use the authority in section 1343(b) of the Affordable Care Act to "establish criteria and methods to be used in carrying out … risk adjustment activities" to treat plans not subject to insurance market reforms at §147.102 (fair health insurance premiums), §147.104 (guaranteed availability of coverage, subject to the student health insurance provisions at §147.145), §147.106 (guaranteed renewability of coverage, subject to the student health insurance provisions at §147.145), §156.80 (single risk pool), and Subpart B 156 (essential health benefits package), as follows. Because we believe that plans not subject to these market reform rules are able to effectively minimize actuarial risk, we believe these plans would have uniform and virtually zero actuarial risk. We therefore propose to treat these plans separately, such that these plans would not be subject to risk adjustment charges and would not receive risk adjustment payments. Also, these plans would not be subject to the issuer requirements described in subparts G and H of part 153. We note that plans issued in 2013 and subject to these requirements upon renewal would become subject to risk adjustment upon renewal, and would comply with the requirements established in subparts G and H of part 153 at that time.

Student health plans: Only individuals attending a particular college or university are eligible to enroll in a student health plan (as described in §147.145) offered by that college or university. We believe that student health plans, because of their unique characteristics, will have relatively uniform actuarial risk. We therefore propose to use the authority in section 1343(b) of the Affordable Care Act to "establish criteria and methods to be used in carrying out … risk adjustment activities" to treat these plans as a separate group that would not be subject to risk adjustment charges and would not receive risk adjustment payments. Therefore, these plans would not be subject to the issuer requirements described in subparts G and H of part 153.

Catastrophic plans: Unlike metal level coverage, only individuals age 30 and under, or individuals for whom insurance is deemed to be unaffordable as specified in section 1302(e) of the Affordable Care Act, are eligible to enroll in catastrophic plans. Because of the unique characteristics of this population, we propose to use our authority to establish "criteria and methods" to risk adjust catastrophic plans in a separate risk pool from the general (metal level) risk pool. Catastrophic plans with less than average actuarial risk compared with other catastrophic plans would be assessed charges, while catastrophic plans with higher than average actuarial risk compared with other catastrophic plans would receive payments. The specific mechanisms for assessing risk, and calculating payments and charges, are described below. We are not, however, proposing to exempt these plans from the requirements in subparts G and H of part 153.

Merger of markets: Section 1312(c) of the Affordable Care Act directs issuers to use a single risk pool for a market – the individual or small group market – when developing rates and premiums. Section 1312(c)(3) gives States the option to merge the individual and small group market into a single risk pool. To align risk pools for the risk adjustment program and rate development, we would merge markets when operating risk

adjustment on behalf of a State if the State elects to do the same for single risk pool purposes. In such a case, rather than transferring funds between individual market plans only and between small group market plans only, we would transfer funds between all individual and small group market plans, considered as one market. When the individual and small group markets are merged, the State average premium, described in section III.B.3.c. below, would be the average premium of all applicable individual and small group market plans in the applicable risk pool, and normalization described in section III.B.3.c. below would occur across all plans in the applicable risk pool in the individual and small group market.

Risk adjustment in State of licensure: Risk adjustment is a State-based program in which funds are transferred within a State within a market, as described above. In general, a risk adjustment methodology will be linked to the rate and benefit requirements applicable under State and Federal law in a particular State. Such requirements may differ from State to State, and apply to policies filed and approved by the department of insurance in a State.[8] However, a plan licensed in a State (and therefore subject to that State's rate and benefit requirements) may enroll individuals in multiple States. To help ensure that policies in the small group market are subject to risk adjustment programs linked to the State rate and benefit requirements applicable to that policy, we propose in §153.360 that a risk adjustment covered plan be subject to risk adjustment in the State in which the policy is filed and approved. We welcome comments on these proposals.

b. Overview of the HHS Risk Adjustment Model

We developed the HHS risk adjustment model in consultation with States, providers, issuers, and consumers on methodological choices by soliciting comment on

[8] *State Jurisdictional and Extraterritorial Issues White Paper: States' Treatment of Regulatory Jurisdiction Over Single Employer Group Health Insurance* (unpublished white paper- available from NAIC Research Library or in NAIC Proceedings I, 2009) NAIC,3/17/09.

the choices in preamble to the proposed Premium Stabilization Rule and in the Risk Adjustment White Paper.[9] We also engaged in discussions with these stakeholders at the Risk Adjustment Spring Meeting and in user group calls with States.

Each HHS risk adjustment model predicts plan liability for an enrollee based on that person's age, sex, and diagnoses (risk factors), producing a risk score. We propose separate models for adults, children, and infants to account for cost differences in each of these age groups. The adult and child models are additive; that is, the relative costs assigned to an individual's age, sex, and diagnoses are added together to produce a risk score. Infant risk scores are determined by inclusion in one of 25 mutually exclusive groups based on the infant's maturity and the severity of its diagnoses. If applicable, the risk score is multiplied by a cost-sharing reduction adjustment.

The enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan within a geographic rating area are then input into the payment transfer formula, as described in section III.B.3.c. of this proposed rule, to determine an issuer's payment or charge for a particular plan.

Each HHS risk adjustment model predicts individual-level risk scores, but is designed to predict average group costs to account for risk across plans.[10] This method accords with the Actuarial Standard Board's Actuarial Standard of Practice for risk classification.[11]

(1) Data Used to Develop the HHS Risk Adjustment Model

Each HHS risk adjustment model was calibrated using de-identified data from the Truven Health Analytics 2010 MarketScan® Commercial Claims and Encounters

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[9] http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf
[10] American Academy of Actuaries: Risk Assessment and Risk Adjustment, Issue Brief. May 2010.
[11] Actuarial Standard of Practice No. 12: Risk Classification (for All Practice Areas). Actuarial Standards Board, Doc. No. 101. December 2005.

database (MarketScan) for individuals living in all States, aged 0-64, enrolled in commercial health insurance plans. The database contains enrollee-specific clinical utilization, expenditures, and enrollment across inpatient, outpatient, and prescription drug services from a selection of large employers and health plans. The database includes de-identified data from approximately 100 payers, and has more than 500 million claims from insured employees, their spouses, and dependents. Active employees, early retirees, individuals on COBRA continuation coverage, and their dependents are included in the database. The enrollment data files contain information for any person enrolled in one of the employer or individual health plans at any point during a year. Enrollees were classified as enrolled in fee-for-service ("FFS") plans or encounter-type plans, with most FFS plans being preferred provider organization ("PPO") plans, and the majority of encounter-type plans being health maintenance organization ("HMO") plans. An individual could have been enrolled for as few as one and as many as 365 days in a year, and could have been enrolled in one or more years. In operation, the same rules will be applied with respect to enrollment.

Diagnoses for model calibration were extracted from facility and professional claims. Facility claims were extracted only from bill types that were hospital inpatient, hospital outpatient, rural health clinic, federally qualified health center, or community mental health center. For professional and outpatient facility claims, diagnoses were generally extracted from claims where the procedure (CPT code) indicated a face-to-face visit with a qualified clinician. Diagnoses from procedures that did not meet these criteria (for example, durable medical equipment, pathology/laboratory, and diagnostic radiology) were not included. The concurrent modeling sample (approximately 20 million individuals) was generated using the following criteria: (1) the enrollee had to be

enrolled in a FFS plan[12]; (2) the enrollee must not have incurred any claims paid on a capitated basis[13]; and (3) the enrollee must have been enrolled in a plan with drug benefits and mental health and substance abuse coverage. The final database reflects our best approximation of the essential health benefits package under the Affordable Care Act, which also includes prescription drug and mental health and substance abuse coverage.

MarketScan expenditure data includes gross covered charges, which were defined as:

Gross covered charges = submitted charges – non-covered charges – pricing reductions

Inpatient, outpatient, and prescription drug expenditures for each enrollee were calculated by summing gross covered charges in, respectively, the inpatient, outpatient, and prescription drug services files. Total expenditures were defined as the sum of inpatient, outpatient, and prescription drug expenditures. Plan liability expenditures for a given plan type (platinum, gold, silver, bronze, catastrophic) were defined by applying the applicable standardized benefit design, as discussed in section III.B.3.b.10., to total expenditures. To more accurately reflect expected expenditures for 2014, the 2010 total expenditures were increased for projected cost growth.[14] Average monthly expenditures were defined as the enrollee's expenditures for the enrollment period divided by the number of enrollment months. Annualized expenditures (total or plan liability) were defined as average monthly expenditures multiplied by 12. Data for each individual was weighted by months of enrollment divided by 12.

(2) Concurrent Model

[12] We limited the modeling sample to enrollees in FFS plans because costs on non-FFS claims may not represent the full cost of care associated with a disease.
[13] In 2010 the MarketScan database, even FFS plan types can have carve-out services paid on a capitated basis, which are less reliable for predicted expenditure calculations.
[14] We used the same projected cost growth as was used in the development of the AV calculator.

The HHS risk adjustment model is a concurrent model. A concurrent model takes diagnoses from a given period to predict cost in that same period. This is in contrast to a prospective model, which would use data from a prior period to predict costs in a future period. We are proposing to use a concurrent model because 2013 diagnostic data will not be available for use in the model in 2014. In addition, we anticipate that enrollees may move between plans, or between programs. A concurrent model would be better able to handle changes in enrollment than a prospective model because individuals newly enrolling in health plans may not have prior data available that can be used in risk adjustment.

(3) Prescription Drugs

At this time, we have elected not to include prescription drug use as a predictor in each HHS risk adjustment model. While use of particular prescription drugs may be useful for predicting expenditures, we believe that inclusion of prescription drug information could create adverse incentives to modify discretionary prescribing. We seek comments on possible approaches for future versions of the model to include prescription drug information while avoiding adverse incentives.

(4) Principles of Risk Adjustment and the Hierarchical Condition Category (HCC) Classification System

A diagnostic classification system determines which diagnosis codes should be included, how the diagnosis codes should be grouped, and how the diagnostic groupings should interact for risk adjustment purposes. The ten principles that were used to develop the hierarchical condition category (HCC) classification system for the Medicare risk adjustment model guided the creation of the HHS risk adjustment model we propose to use when HHS operates risk adjustment on behalf of a State. Those principles are:

Principle 1—Diagnostic categories should be clinically meaningful. Each diagnostic category is a set of International Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9-CM") codes.[15] These codes should all relate to a reasonably well-specified disease or medical condition that defines the category.

Principle 2—Diagnostic categories should predict medical (including drug) expenditures. Diagnoses in the same HCC should be reasonably homogeneous with respect to their effect on both current (this year's) costs (concurrent risk adjustment) or future (next year's) costs (prospective risk adjustment).

Principle 3—Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures. Diagnostic categories used in establishing payments should have adequate sample sizes in available data sets.

Principle 4—In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate. Related conditions should be treated hierarchically, with more severe manifestations of a condition dominating (and zeroing out the effect of) less serious ones.

Principle 5—The diagnostic classification should encourage specific coding. Vague diagnostic codes should be grouped with less severe and lower-paying diagnostic categories to provide incentives for more specific diagnostic coding.

Principle 6—The diagnostic classification should not reward coding proliferation. The classification should not measure greater disease burden simply because more ICD-9-CM codes are present.

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[15] Please note that in future years we will update the calibration of the HHS risk adjustment model to account for the transition from ICD-9-CM codes to ICD-10-CM codes.

Principle 7—Providers should not be penalized for recording additional diagnoses (monotonicity). This principle has two consequences for modeling: (1) no HCC should carry a negative payment weight; and (2) a condition that is higher-ranked in a disease hierarchy (causing lower-rank diagnoses to be ignored) should have at least as large a payment weight as lower-ranked conditions in the same hierarchy. (There may be exceptions, as when a coded condition represents a radical change of treatment of a disease process.)

Principle 8—The classification system should be internally consistent (transitive). If diagnostic category A is higher-ranked than category B in a disease hierarchy, and category B is higher-ranked than category C, then category A should be higher-ranked than category C. Transitivity improves the internal consistency of the classification system and ensures that the assignment of diagnostic categories is independent of the order in which hierarchical exclusion rules are applied.

Principle 9—The diagnostic classification should assign all ICD-9-CM codes (exhaustive classification). Because each diagnostic code potentially contains relevant clinical information, the classification should categorize all ICD-9-CM codes.

Principle 10—Discretionary diagnostic categories should be excluded from payment models. Diagnoses that are particularly subject to intentional or unintentional discretionary coding variation or inappropriate coding by health plans/providers, or that are not clinically or empirically credible as cost predictors, should not increase cost predictions. Excluding these diagnoses reduces the sensitivity of the model to coding variation, coding proliferation, gaming, and upcoding.

(5) CMS HCC Diagnostic Classification System

The HCCs in the Medicare risk adjustment model are referred to as CMS HCCs. The HCCs in the HHS risk adjustment model are referred to as HHS HCCs. The CMS

HCC diagnostic classification provides the diagnostic framework for the classification and selection of HCCs for the HHS risk adjustment model. The CMS HCC risk adjustment model uses patient diagnoses and demographic information to prospectively predict medical spending for beneficiaries in Medicare Part C managed care plans. The CMS HCC classification system was reviewed and adapted to account for the different population to create the HHS HCC classification.

The CMS HCC diagnostic classification system begins by classifying over 14,000 ICD-9-CM diagnosis codes into diagnostic groups, or DXGs. Each ICD-9-CM code maps to exactly one DXG, which represents a well-specified medical condition or set of conditions. DXGs are further aggregated into Condition Categories, or CCs. CCs describe a broader set of similar diseases. Although they are not as homogeneous as DXGs, diseases within a CC are related clinically and with respect to cost. Hierarchies are imposed among related CCs, so that a person is coded for only the most severe manifestation among related diseases.

After imposing hierarchies, CCs become Hierarchical Condition Categories, or HCCs. Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate. For example, a female with rheumatoid arthritis and breast cancer has (at least) two separate HCCs coded, and her predicted cost would reflect increments for both conditions. The model's structure thus provides, and predicts from, a detailed comprehensive clinical profile for each individual.

Three major characteristics of the CMS HCC classification system required modification for use with the HHS risk adjustment model: (1) population; (2) type of spending; and (3) prediction year. The CMS HCCs were developed using data from the aged and/or disabled Medicare population. Although every ICD-9-CM diagnosis code is mapped and categorized into a diagnostic grouping, for some conditions (such as

pregnancy) the sample size in the Medicare population is quite low. With larger sample sizes in the commercial population, HCCs were re-examined for infant, child, and adult subpopulations. Additionally, the CMS HCCs are configured to predict medical spending, while HHS HCCs predict both medical and drug spending. Finally, the CMS HCC classification is primarily designed for use with a prospective risk adjustment model, using base year diagnoses and demographic information to predict the next year's spending. Each HHS risk adjustment model is concurrent, using current year diagnoses and demographics to predict the current year's spending. Medical conditions may predict current year costs that differ from future costs; HCC and DXG groupings should reflect those differences.

As such, HCCs and DXGs may not be the same between the Medicare and HHS risk adjustment models. For example, the newborn hierarchy was reconfigured in the HHS risk adjustment model to include new HCCs and DXGs to account for major cost differences in the youngest premature newborns and in neonatal disorders. Adjustments such as these resulted in 264 classification HCCs in the HHS risk adjustment model.

In designing the diagnostic classification for the HHS risk adjustment model, principles 7 (monotonicity), 8 (transitivity), and 9 (exhaustive classification) were prioritized. For example, if the expenditure weights for the models did not originally satisfy monotonicity, constraints were imposed to create models that did. However, tradeoffs were often required among other principles. For example, clinical meaningfulness is often best served by creating a very large number of detailed clinical groupings. However, a large number of groupings may not allow for adequate sample sizes for each category.

(6) Principles for HCC Selection

We selected 127 of the full classification of 264 HHS HCCs for inclusion in the HHS risk adjustment model. In determining which HCCs to include in the HHS risk adjustment model, HCCs that were more appropriate for a concurrent model or for the expected risk adjustment population (for example, low birth weight babies were included in the HHS risk adjustment model). We considered the basic criteria below to determine which HCCs should be included in the HHS risk adjustment model:

- Whether the HCC represents clinically significant medical conditions with significant costs for the target population;
- Whether there will be a sufficient sample size to ensure stable results for the HCC;
- Whether excluding the HCC would exclude (or limit the impact of) diagnoses particularly subject to discretionary coding;
- Whether the HCC identifies chronic or systematic conditions that represent insurance risk selection or risk segmentation, rather than random acute events;
- Do not represent poor quality of care; and
- Whether the HCC is applicable to the model age group.

Consistent with the risk adjustment principles described previously, each HHS risk adjustment model excludes HHS HCCs containing diagnoses that are vague or nonspecific (for example, symptoms), discretionary in medical treatment or coding (for example, osteoarthritis), or not medically significant (for example, muscle strain). Each HHS risk adjustment model also excludes HHS HCCs that do not add to costs.

(7) Grouping of HCCs

To balance the competing goals of improving predictive power and limiting coding variability to create a relatively simple risk adjustment model, a number of HHS HCCs were grouped into sets equivalent to a single HCC. HHS HCCs were grouped (1)

to reduce model complexity; (2) to avoid including HHS HCCs with small sample size; (3) to limit upcoding by severity within an HCC hierarchy; and (4) to reduce additivity within disease groups (but not across disease groups) to decrease the sensitivity of the model to coding proliferation. After grouping, the number of HHS HCCs included in the proposed HHS risk adjustment model was effectively reduced from 127 to 100.[16]

(8) Demographics

In addition to the HHS HCCs included in the HHS risk adjustment model, enrollee risk scores are calculated from demographic factors. There are 18 age/sex categories for adults, and 8 age/sex categories for children. As described below, age/sex categories for infants are not used. Adults are defined as ages 21+, children are ages 2-20, and infants are ages 0-1. The age categories for adult male and female are ages 21-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, and 60+. The age categories for children male and female are ages 2-4, 5-9, 10-14, and 15-20. This is consistent with the CMS HCC model, which also uses five year increments for age groups. In operation, age will be defined as age as of the enrollee's last day of enrollment in risk adjustment covered plans within an issuer in the applicable benefit year. For individuals who do not have any of the HHS HCCs included in the proposed HHS risk adjustment model, predicted expenditures are based solely on their demographic risk factors. In the calibration data set, 19 percent of adults, nine percent of children, and 45 percent of infants have HCCs included in the risk adjustment models.

(9) Separate Adult, Child and Infant Models

Due to the inherent clinical and cost differences in the adult (age 21+), child (age 2-20), and infant (age 0-1) populations, HHS developed separate risk adjustment models

[16] In addition, we imposed several additional constraints –HCC coefficient values were made equal if a lower-ranked HCC in a disease hierarchy had a higher coefficient than a higher-ranked HCC; the 10 principles of risk adjustment models described in section III.B.3.b.4. were generally followed.

for each age group. The models for adults and children generally have similar specifications, including demographic age/sex categories and HHS HCCs, but differ slightly due to clinical and cost differences. However, infants have certain costs related to hospitalization at birth and can have severe and expensive conditions that do not apply to adults or children, while having relatively low frequencies for most HHS HCCs included in the model compared to adults and children. Therefore, HHS proposes to use a separate infant model.

The infant model utilizes a mutually exclusive groups approach in which infants are assigned a maturity category (by gestation and birth weight) and a severity category. There are 5 maturity categories: Extremely Immature; Immature; Premature/Multiples; Term; and Age 1. For the maturity category, age 0 infants would be assigned to one of the first four categories and age 1 infants would be assigned to the Age 1 category. There are 5 severity categories based on the clinical severity and associated costs of the non-maturity HCCs: Severity Level 1 (Lowest Severity) to Severity Level 5 (Highest Severity). All infants (age 0 or 1) are assigned to a severity category based on the highest severity of their non-maturity HCCs. The 5 maturity categories and 5 severity categories would be used to create 25 mutually-exclusive interaction terms to which each infant is assigned. An infant who has HCCs in more than one severity category would be assigned to the highest of those severity categories. An infant who has no HCCs or only a newborn maturity HCC would be assigned to Severity Level 1 (Lowest). Finally, evidence suggests that male infants have higher costs than female infants due to increased morbidity and neonatal mortality.[17] To account for these differences by sex, there are 2

[17] Mathews, T.J., M.S. & Marian F. MacDormon, Ph.D., Division of Vital Statistics. Infant Mortality Statistics From the 2007 Period Linked Birth/Infant Death Data Set. National Vital Statistic Reports. Vol. 59. No. 6. (June 29, 2011). Available at: www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_06.pdf

male-age indicator variables: Age 0 Male and Age 1 Male. The male-age variable would be added to the interaction term to which the infant is assigned.

We understand that there may be cases in which there is no separate infant birth claim from which to gather diagnoses. For example, at an operational level mother and infant claims may be bundled such that infant diagnoses appear on the mother's record. Where newborn diagnoses appear on the mother's claims, HHS is exploring the feasibility of associating those codes with the appropriate infant. This assumes that the mother and infant enrollment records exist and can be matched, which may also pose operational problems in some cases. Alternatively, we are considering requiring issuers to provide separate mother and infant claims when they have received a combined claim. We seek comment on the operational feasibility of both of these approaches.

Tables 5 and 6 contain descriptions of how the severity and maturity are defined.

(10) Selection of plan liability model

We propose separate risk adjustment models for each metal level because plans at different metal levels would have different liability for enrollees with the same expenditure patterns.

We considered using a total expenditure approach to estimating the HHS risk adjustment model. A total expenditure risk adjustment model would use the demographic age/sex categories, HHS HCCs included in the model, and any other independent variables to predict all of the costs associated with an enrollee, whether those costs are incurred by the enrollee or the issuer. In a total expenditure model, two individuals of the same age with the same set of HCCs would have the same risk score regardless of the metal level plan type in which the individuals were enrolled. However, we do not believe that this approach would accurately capture plan liability levels due to the non-linear nature of liability for plans at different metal levels. In particular,

deductibles are anticipated to be highest in bronze plans and lowest in platinum plans. Plan liabilities for plan types (platinum, gold, silver, bronze, and catastrophic) were defined by applying standardized benefit design parameters for each given metal level to total expenditures. We estimated average plan liability for each of the plan types, and created an adult, child, and infant model for each plan type.

(11) Disease interactions

We propose that the HHS risk adjustment models for adults include interaction factors. Including interactions improves model performance for low- and high-cost individuals and better reflects plan liability across metal levels.

Disease interactions were created using the silver model by first creating a single severity illness indicator. We elected to use the silver model to create interaction terms because we expect enrollment to be highest in silver plans due to the availability of premium tax credits and cost-sharing reductions in those plans. The severity illness indicator variable was interacted with individual HCCs or HCC groups, and the predicted costs of the interaction variables were then grouped into three cost categories: low, medium and high. Interaction groups in the medium and high cost categories were included in the HHS risk adjustment model as shown at the bottom of Table 1 below. An individual is determined to have the severity indicator if they have one or more of the HCCs listed in Table 2.

An individual with at least one of the HCCs that comprises the severity illness indicator variable and at least one of the HCCs interacted with the severity illness indicator variable would be assigned a single interaction factor. A hierarchy is imposed on these interaction groups such that an individual with a high cost interaction is excluded from having a medium cost interaction. The high or the medium interaction factor would be added to demographic and diagnosis factors of the individual.

(12) List of factors to be employed in the model

The proposed HHS risk adjustment models predict annualized plan liability expenditures using age and sex categories and the HHS HCCs included in the HHS risk adjustment model. Dollar coefficients were estimated for these categories and HCCs using weighted least squares regression, where the weight was the fraction of the year enrolled.

For each model, the factors were the statistical regression dollar values for each category or HCC in the model divided by a weighted average plan liability for the full modeling sample. The factors represent the predicted relative incremental expenditures for each category or HCC. For a given enrollee, the sums of the factors for the enrollee's category and HCCs are the total relative predicted expenditures for that enrollee. Table 1 contains factors for each adult model, including the interactions. Table 3 contains the factors for each child model. Table 5 contains the factors for each infant model.

TABLE 1: Adult Risk Adjustment Model Factors

Factor	**Platinum**	**Gold**	**Silver**	**Bronze**	**Catastrophic**
		Demographic Factors			
Age 21-24, Male	0.258	0.208	0.141	0.078	0.062
Age 25-29, Male	0.278	0.223	0.150	0.081	0.064
Age 30-34, Male	0.338	0.274	0.187	0.101	0.079
Age 35-39, Male	0.413	0.339	0.240	0.140	0.113
Age 40-44, Male	0.487	0.404	0.293	0.176	0.145
Age 45-49, Male	0.581	0.487	0.365	0.231	0.195
Age 50-54, Male	0.737	0.626	0.484	0.316	0.269
Age 55-59, Male	0.863	0.736	0.580	0.393	0.339
Age 60-64, Male	1.028	0.880	0.704	0.487	0.424
Age 21-24, Female	0.433	0.350	0.221	0.101	0.072
Age 25-29, Female	0.548	0.448	0.301	0.156	0.120
Age 30-34, Female	0.656	0.546	0.396	0.243	0.203
Age 35-39, Female	0.760	0.641	0.490	0.334	0.293
Age 40-44, Female	0.839	0.713	0.554	0.384	0.338
Age 45-49, Female	0.878	0.747	0.583	0.402	0.352
Age 50-54, Female	1.013	0.869	0.695	0.486	0.427

Age 55-59, Female	1.054	0.905	0.726	0.507	0.443
Age 60-64, Female	1.156	0.990	0.798	0.559	0.489
			Diagnosis Factors		
HIV/AIDS	5.485	4.972	4.740	4.740	4.749
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	13.696	13.506	13.429	13.503	13.529
Central Nervous System Infections, Except Viral Meningitis	7.277	7.140	7.083	7.117	7.129
Viral or Unspecified Meningitis	4.996	4.730	4.621	4.562	4.550
Opportunistic Infections	9.672	9.549	9.501	9.508	9.511
Metastatic Cancer	25.175	24.627	24.376	24.491	24.526
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	11.791	11.377	11.191	11.224	11.235
Non-Hodgkin`s Lymphomas and Other Cancers and Tumors	6.432	6.150	6.018	5.983	5.970
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	5.961	5.679	5.544	5.500	5.483
Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	3.509	3.294	3.194	3.141	3.121
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.727	1.559	1.466	1.353	1.315
Pancreas Transplant Status/Complications	9.593	9.477	9.411	9.434	9.439
Diabetes with Acute Complications	1.331	1.199	1.120	1.000	0.957
Diabetes with Chronic Complications	1.331	1.199	1.120	1.000	0.957

Diabetes without Complication	1.331	1.199	1.120	1.000	0.957
Protein-Calorie Malnutrition	14.790	14.790	14.786	14.862	14.883
Mucopoly-saccharidosis	2.335	2.198	2.130	2.071	2.052
Lipidoses and Glycogenosis	2.335	2.198	2.130	2.071	2.052
Amyloidosis, Porphyria, and Other Metabolic Disorders	2.335	2.198	2.130	2.071	2.052
Adrenal, Pituitary, and Other Significant Endocrine Disorders	2.335	2.198	2.130	2.071	2.052
Liver Transplant Status/Complications	18.445	18.197	18.105	18.165	18.188
End-Stage Liver Disease	6.412	6.102	5.974	6.001	6.012
Cirrhosis of Liver	2.443	2.255	2.177	2.137	2.125
Chronic Hepatitis	1.372	1.228	1.152	1.071	1.046
Acute Liver Failure/Disease, Including Neonatal Hepatitis	4.824	4.634	4.548	4.547	4.550
Intestine Transplant Status/Complications	77.945	78.110	78.175	78.189	78.195
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	13.144	12.823	12.681	12.743	12.764
Intestinal Obstruction	7.257	6.922	6.789	6.842	6.864
Chronic Pancreatitis	6.682	6.385	6.269	6.309	6.329
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	3.614	3.380	3.281	3.245	3.234
Inflammatory Bowel Disease	2.894	2.640	2.517	2.398	2.355
Necrotizing Fasciitis	7.878	7.622	7.508	7.545	7.559
Bone/Joint/Muscle Infections/Necrosis	7.878	7.622	7.508	7.545	7.559
Rheumatoid Arthritis and Specified Autoimmune Disorders	3.414	3.135	3.009	2.987	2.982

Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.263	1.124	1.051	0.954	0.921
Osteogenesis Imperfecta and Other Osteodystrophies	3.524	3.300	3.184	3.126	3.107
Congenital/Developmental Skeletal and Connective Tissue Disorders	3.524	3.300	3.184	3.126	3.107
Cleft Lip/Cleft Palate	2.168	1.978	1.891	1.815	1.793
Hemophilia	49.823	49.496	49.321	49.330	49.329
Myelodysplastic Syndromes and Myelofibrosis	15.404	15.253	15.182	15.214	15.224
Aplastic Anemia	15.404	15.253	15.182	15.214	15.224
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	7.405	7.198	7.099	7.090	7.089
Sickle Cell Anemia (Hb-SS)	7.405	7.198	7.099	7.090	7.089
Thalassemia Major	7.405	7.198	7.099	7.090	7.089
Combined and Other Severe Immunodeficiencies	5.688	5.489	5.402	5.419	5.423
Disorders of the Immune Mechanism	5.688	5.489	5.402	5.419	5.423
Coagulation Defects and Other Specified Hematological Disorders	3.080	2.959	2.899	2.880	2.872
Drug Psychosis	3.776	3.517	3.389	3.302	3.274
Drug Dependence	3.776	3.517	3.389	3.302	3.274
Schizophrenia	3.122	2.854	2.732	2.647	2.624
Major Depressive and Bipolar Disorders	1.870	1.698	1.601	1.476	1.436
Reactive and Unspecified Psychosis, Delusional Disorders	1.870	1.698	1.601	1.476	1.436
Personality Disorders	1.187	1.065	0.974	0.836	0.790
Anorexia/Bulimia Nervosa	3.010	2.829	2.732	2.657	2.631

Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	5.387	5.219	5.141	5.101	5.091
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	1.264	1.171	1.099	1.015	0.985
Autistic Disorder	1.187	1.065	0.974	0.836	0.790
Pervasive Developmental Disorders, Except Autistic Disorder	1.187	1.065	0.974	0.836	0.790
Traumatic Complete Lesion Cervical Spinal Cord	11.728	11.537	11.444	11.448	11.449
Quadriplegia	11.728	11.537	11.444	11.448	11.449
Traumatic Complete Lesion Dorsal Spinal Cord	10.412	10.205	10.108	10.111	10.111
Paraplegia	10.412	10.205	10.108	10.111	10.111
Spinal Cord Disorders/Injuries	6.213	5.969	5.861	5.843	5.836
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	3.379	3.094	2.967	2.927	2.919
Quadriplegic Cerebral Palsy	2.057	1.810	1.681	1.610	1.589
Cerebral Palsy, Except Quadriplegic	0.729	0.596	0.521	0.437	0.408
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	0.727	0.590	0.522	0.467	0.449
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.174	4.999	4.921	4.900	4.891
Muscular Dystrophy	2.118	1.928	1.848	1.771	1.745
Multiple Sclerosis	7.441	6.971	6.764	6.830	6.850

Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	2.118	1.928	1.848	1.771	1.745
Seizure Disorders and Convulsions	1.578	1.411	1.321	1.229	1.199
Hydrocephalus	7.688	7.552	7.486	7.492	7.493
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	9.265	9.102	9.022	9.026	9.025
Respirator Dependence/Tracheo stomy Status	40.054	40.035	40.022	40.105	40.131
Respiratory Arrest	12.913	12.707	12.612	12.699	12.728
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	12.913	12.707	12.612	12.699	12.728
Heart Assistive Device/Artificial Heart	33.372	33.025	32.877	32.978	33.014
Heart Transplant	33.372	33.025	32.877	32.978	33.014
Congestive Heart Failure	3.790	3.648	3.587	3.591	3.594
Acute Myocardial Infarction	11.904	11.451	11.258	11.423	11.478
Unstable Angina and Other Acute Ischemic Heart Disease	6.369	6.001	5.861	5.912	5.935
Heart Infection/Inflammati on, Except Rheumatic	6.770	6.611	6.537	6.530	6.528
Specified Heart Arrhythmias	3.363	3.193	3.112	3.063	3.046
Intracranial Hemorrhage	10.420	10.062	9.907	9.943	9.959
Ischemic or Unspecified Stroke	4.548	4.304	4.215	4.242	4.256
Cerebral Aneurysm and Arteriovenous Malformation	5.263	5.000	4.890	4.867	4.859

Hemiplegia/ Hemiparesis	5.979	5.846	5.794	5.858	5.881
Monoplegia, Other Paralytic Syndromes	4.176	4.024	3.959	3.938	3.931
Atherosclerosis of the Extremities with Ulceration or Gangrene	11.941	11.801	11.745	11.844	11.876
Vascular Disease with Complications	8.228	7.996	7.896	7.922	7.932
Pulmonary Embolism and Deep Vein Thrombosis	4.853	4.642	4.549	4.539	4.537
Lung Transplant Status/Complications	31.457	31.161	31.030	31.131	31.161
Cystic Fibrosis	10.510	10.142	9.957	9.960	9.962
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	1.098	0.978	0.904	0.810	0.780
Asthma	1.098	0.978	0.904	0.810	0.780
Fibrosis of Lung and Other Lung Disorders	2.799	2.657	2.596	2.565	2.556
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	9.052	8.934	8.883	8.913	8.924
Kidney Transplant Status	10.944	10.576	10.432	10.463	10.482
End Stage Renal Disease	37.714	37.356	37.193	37.352	37.403
Chronic Kidney Disease, Stage 5	2.189	2.048	1.995	1.990	1.992
Chronic Kidney Disease, Severe (Stage 4)	2.189	2.048	1.995	1.990	1.992
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.377	1.219	1.120	0.912	0.828
Miscarriage with Complications	1.377	1.219	1.120	0.912	0.828
Miscarriage with No or Minor Complications	1.377	1.219	1.120	0.912	0.828

Completed Pregnancy With Major Complications	3.778	3.285	3.134	2.931	2.906
Completed Pregnancy With Complications	3.778	3.285	3.134	2.931	2.906
Completed Pregnancy with No or Minor Complications	3.778	3.285	3.134	2.931	2.906
Chronic Ulcer of Skin, Except Pressure	2.515	2.371	2.313	2.304	2.304
Hip Fractures and Pathological Vertebral or Humerus Fractures	9.788	9.570	9.480	9.521	9.536
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	1.927	1.805	1.735	1.648	1.620
Stem Cell, Including Bone Marrow, Transplant Status/Complications	30.944	30.908	30.893	30.917	30.928
Artificial Openings for Feeding or Elimination	11.093	10.939	10.872	10.943	10.965
Amputation Status, Lower Limb/Amputation Complications	7.277	7.087	7.009	7.056	7.073
Interaction Factors					
Severe illness x Opportunistic Infections	12.094	12.327	12.427	12.527	12.555
Severe illness x Metastatic Cancer	12.094	12.327	12.427	12.527	12.555
Severe illness x Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	12.094	12.327	12.427	12.527	12.555

Severe illness x Non-Hodgkin`s Lymphomas and Other Cancers and Tumors	12.094	12.327	12.427	12.527	12.555
Severe illness x Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	12.094	12.327	12.427	12.527	12.555
Severe illness x Heart Infection/Inflammation, Except Rheumatic	12.094	12.327	12.427	12.527	12.555
Severe illness x Intracranial Hemorrhage	12.094	12.327	12.427	12.527	12.555
Severe illness x HCC group G06 (HCC Group 6 includes Myelodysplastic Syndromes and Myelofibrosis, and Aplastic Anemia)	12.094	12.327	12.427	12.527	12.555
Severe illness x HCC group G08 (HCC Group 8 includes Combined and Other Severe Immunodeficiencies, and Disorders of the Immune Mechanism)	12.094	12.327	12.427	12.527	12.555
Severe illness x End-Stage Liver Disease	2.498	2.648	2.714	2.813	2.841
Severe illness x Acute Liver Failure/Disease, Including Neonatal Hepatitis	2.498	2.648	2.714	2.813	2.841
Severe illness x Atherosclerosis of the Extremities with Ulceration or Gangrene	2.498	2.648	2.714	2.813	2.841

Severe illness x Vascular Disease with Complications	2.498	2.648	2.714	2.813	2.841
Severe illness x Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	2.498	2.648	2.714	2.813	2.841
Severe illness x Artificial Openings for Feeding or Elimination	2.498	2.648	2.714	2.813	2.841
Severe illness x HCC group G03 (HCC Group 3 includes Necrotizing Fasciitis and Bone/Joint/Muscle Infections/Necrosis)	2.498	2.648	2.714	2.813	2.841

TABLE 2: HHS HCCs in the Severity Illness Indicator Variable

Description
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Peritonitis/Gastrointestinal Perforation/Necrotizing Enter colitis
Seizure Disorders and Convulsions
Non-Traumatic Coma, Brain Compression/Anoxic Damage
Respirator Dependence/Tracheostomy Status
Respiratory Arrest
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
Pulmonary Embolism and Deep Vein Thrombosis

TABLE 3: Child Risk Adjustment Model Factors

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Demographic Factors					
Age 2-4, Male	0.283	0.209	0.106	0.019	0.000
Age 5-9, Male	0.196	0.140	0.064	0.005	0.000
Age 10-14, Male	0.246	0.189	0.110	0.047	0.033
Age 15-20, Male	0.336	0.273	0.191	0.114	0.095
Age 2-4, Female	0.233	0.165	0.071	0.019	0.000
Age 5-9, Female	0.165	0.113	0.048	0.005	0.000
Age 10-14, Female	0.223	0.168	0.095	0.042	0.031
Age 15-20, Female	0.379	0.304	0.198	0.101	0.077

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Diagnosis Factors					
HIV/AIDS	2.956	2.613	2.421	2.228	2.166
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	17.309	17.142	17.061	17.081	17.088
Central Nervous System Infections, Except Viral Meningitis	12.636	12.409	12.296	12.313	12.319
Viral or Unspecified Meningitis	3.202	3.004	2.896	2.750	2.702
Opportunistic Infections	20.358	20.262	20.222	20.201	20.189
Metastatic Cancer	34.791	34.477	34.307	34.306	34.300
Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	11.939	11.618	11.436	11.358	11.334
Non-Hodgkin`s Lymphomas and Other Cancers and Tumors	9.354	9.071	8.908	8.806	8.774
Colorectal, Breast (Age < 50), Kidney, and Other Cancers	3.689	3.480	3.337	3.188	3.143
Benign/Uncertain Brain Tumors, and Other Cancers and Tumors[18]	3.308	3.084	2.954	2.814	2.769
Thyroid Cancer, Melanoma, Neurofibromatosis, and Other Cancers and Tumors	1.530	1.368	1.254	1.114	1.066
Pancreas Transplant Status/Complications	18.933	18.476	18.264	18.279	18.289
Diabetes with Acute Complications	2.629	2.354	2.198	1.904	1.799
Diabetes with Chronic Complications	2.629	2.354	2.198	1.904	1.799
Diabetes without Complication	2.629	2.354	2.198	1.904	1.799
Protein-Calorie Malnutrition	13.930	13.794	13.726	13.751	13.759
Mucopolysaccharidosis	6.177	5.867	5.696	5.642	5.625
Lipidoses and Glycogenosis	6.177	5.867	5.696	5.642	5.625

[18] This HCC also includes Breast (Age 50+) and Prostate Cancer.

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Congenital Metabolic Disorders, Not Elsewhere Classified	6.177	5.867	5.696	5.642	5.625
Amyloidosis, Porphyria, and Other Metabolic Disorders	6.177	5.867	5.696	5.642	5.625
Adrenal, Pituitary, and Other Significant Endocrine Disorders	6.177	5.867	5.696	5.642	5.625
Liver Transplant Status/Complications	18.322	18.048	17.922	17.898	17.888
End-Stage Liver Disease	12.960	12.754	12.650	12.622	12.614
Cirrhosis of Liver	1.177	1.027	0.920	0.871	0.833
Chronic Hepatitis	1.177	1.027	0.920	0.807	0.775
Acute Liver Failure/Disease, Including Neonatal Hepatitis	6.255	6.092	6.003	5.972	5.966
Intestine Transplant Status/Complications	106.169	106.704	106.991	107.180	107.222
Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	16.784	16.360	16.156	16.171	16.179
Intestinal Obstruction	5.715	5.451	5.307	5.210	5.178
Chronic Pancreatitis	16.692	16.315	16.148	16.163	16.166
Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	3.843	3.685	3.584	3.471	3.434
Inflammatory Bowel Disease	5.049	4.673	4.471	4.320	4.271
Necrotizing Fasciitis	5.829	5.551	5.398	5.318	5.292
Bone/Joint/Muscle Infections/Necrosis	5.829	5.551	5.398	5.318	5.292
Rheumatoid Arthritis and Specified Autoimmune Disorders	2.689	2.473	2.327	2.171	2.122
Systemic Lupus Erythematosus and Other Autoimmune Disorders	1.397	1.249	1.139	0.996	0.951
Osteogenesis Imperfecta and Other Osteodystrophies	1.536	1.410	1.311	1.211	1.183
Congenital/Developmental Skeletal and Connective Tissue Disorders	1.536	1.410	1.311	1.211	1.183
Cleft Lip/Cleft Palate	1.785	1.573	1.441	1.281	1.228
Hemophilia	46.388	45.839	45.551	45.541	45.535

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Myelodysplastic Syndromes and Myelofibrosis	29.387	29.168	29.063	29.075	29.078
Aplastic Anemia	29.387	29.168	29.063	29.075	29.078
Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn	7.791	7.476	7.308	7.229	7.203
Sickle Cell Anemia (Hb-SS)	7.791	7.476	7.308	7.229	7.203
Thalassemia Major	7.791	7.476	7.308	7.229	7.203
Combined and Other Severe Immunodeficiencies	5.690	5.455	5.339	5.270	5.247
Disorders of the Immune Mechanism	5.690	5.455	5.339	5.270	5.247
Coagulation Defects and Other Specified Hematological Disorders	4.909	4.754	4.650	4.543	4.511
Drug Psychosis	4.067	3.816	3.693	3.596	3.566
Drug Dependence	4.067	3.816	3.693	3.596	3.566
Schizophrenia	5.536	5.127	4.916	4.775	4.730
Major Depressive and Bipolar Disorders	1.779	1.591	1.453	1.252	1.188
Reactive and Unspecified Psychosis, Delusional Disorders	1.779	1.591	1.453	1.252	1.188
Personality Disorders	0.935	0.832	0.723	0.511	0.441
Anorexia/Bulimia Nervosa	2.565	2.372	2.252	2.146	2.111
Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes	3.606	3.347	3.239	3.201	3.189
Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	2.403	2.203	2.093	1.982	1.943
Autistic Disorder	1.673	1.500	1.372	1.177	1.112
Pervasive Developmental Disorders, Except Autistic Disorder	0.963	0.850	0.723	0.511	0.441
Traumatic Complete Lesion Cervical Spinal Cord	18.394	18.224	18.156	18.210	18.228
Quadriplegia	18.394	18.224	18.156	18.210	18.228

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Traumatic Complete Lesion Dorsal Spinal Cord	18.394	18.224	18.156	18.210	18.228
Paraplegia	18.394	18.224	18.156	18.210	18.228
Spinal Cord Disorders/Injuries	4.668	4.416	4.287	4.181	4.150
Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease	14.484	14.155	13.995	13.958	13.954
Quadriplegic Cerebral Palsy	5.717	5.367	5.223	5.251	5.262
Cerebral Palsy, Except Quadriplegic	1.899	1.672	1.557	1.447	1.412
Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies	0.943	0.785	0.686	0.592	0.562
Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	5.301	5.071	4.950	4.861	4.832
Muscular Dystrophy	3.122	2.915	2.800	2.698	2.669
Multiple Sclerosis	5.370	4.996	4.806	4.769	4.752
Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders	3.122	2.915	2.800	2.698	2.669
Seizure Disorders and Convulsions	2.188	2.012	1.882	1.702	1.644
Hydrocephalus	6.791	6.630	6.550	6.521	6.513
Non-Traumatic Coma, and Brain Compression/Anoxic Damage	9.073	8.882	8.788	8.753	8.735
Respirator Dependence/Tracheostomy Status	34.717	34.532	34.471	34.623	34.668
Respiratory Arrest	14.998	14.772	14.669	14.691	14.696

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	14.998	14.772	14.669	14.691	14.696
Heart Assistive Device/Artificial Heart	25.734	25.262	25.057	25.189	25.225
Heart Transplant	25.734	25.262	25.057	25.189	25.225
Congestive Heart Failure	6.292	6.159	6.073	6.013	5.992
Acute Myocardial Infarction	4.568	4.453	4.410	4.433	4.448
Unstable Angina and Other Acute Ischemic Heart Disease	4.568	4.453	4.410	4.433	4.448
Heart Infection/Inflammation, Except Rheumatic	12.842	12.655	12.573	12.590	12.597
Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders	7.019	6.823	6.668	6.528	6.480
Major Congenital Heart/Circulatory Disorders	2.257	2.143	2.018	1.870	1.828
Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	1.411	1.319	1.206	1.078	1.047
Specified Heart Arrhythmias	4.483	4.276	4.141	4.052	4.026
Intracranial Hemorrhage	21.057	20.757	20.616	20.617	20.618
Ischemic or Unspecified Stroke	8.498	8.373	8.324	8.360	8.363
Cerebral Aneurysm and Arteriovenous Malformation	4.704	4.464	4.344	4.280	4.250
Hemiplegia/Hemiparesis	5.561	5.404	5.334	5.315	5.310
Monoplegia, Other Paralytic Syndromes	5.561	5.404	5.334	5.315	5.310
Atherosclerosis of the Extremities with Ulceration or Gangrene	10.174	9.937	9.799	9.688	9.641
Vascular Disease with Complications	11.571	11.355	11.257	11.260	11.272
Pulmonary Embolism and Deep Vein Thrombosis	13.894	13.661	13.557	13.591	13.604

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Lung Transplant Status/Complications	100.413	100.393	100.412	100.660	100.749
Cystic Fibrosis	13.530	13.006	12.743	12.739	12.742
Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	0.521	0.458	0.354	0.215	0.175
Asthma	0.521	0.458	0.354	0.215	0.175
Fibrosis of Lung and Other Lung Disorders	5.812	5.657	5.555	5.472	5.450
Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	10.730	10.615	10.549	10.566	10.571
Kidney Transplant Status	18.933	18.476	18.264	18.279	18.289
End Stage Renal Disease	43.158	42.816	42.659	42.775	42.808
Chronic Kidney Disease, Stage 5	11.754	11.581	11.472	11.374	11.340
Chronic Kidney Disease, Severe (Stage 4)	11.754	11.581	11.472	11.374	11.340
Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism	1.191	1.042	0.917	0.674	0.590
Miscarriage with Complications	1.191	1.042	0.917	0.674	0.590
Miscarriage with No or Minor Complications	1.191	1.042	0.917	0.674	0.590
Completed Pregnancy With Major Complications	3.419	2.956	2.778	2.498	2.437
Completed Pregnancy With Complications	3.419	2.956	2.778	2.498	2.437
Completed Pregnancy with No or Minor Complications	3.419	2.956	2.778	2.498	2.437
Chronic Ulcer of Skin, Except Pressure	1.570	1.479	1.394	1.314	1.289
Hip Fractures and Pathological Vertebral or Humerus Fractures	7.389	7.174	7.022	6.882	6.842
Pathological Fractures, Except of Vertebrae, Hip, or Humerus	2.353	2.244	2.128	1.965	1.912
Stem Cell, Including Bone Marrow, Transplant Status/Complications	30.558	30.485	30.466	30.522	30.538

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Artificial Openings for Feeding or Elimination	14.410	14.247	14.197	14.340	14.383
Amputation Status, Lower Limb/Amputation Complications	10.174	9.937	9.799	9.688	9.641

TABLE 4: Infant Risk Adjustment Models Factors

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Extremely Immature * Severity Level 5 (Highest)	393.816	392.281	391.387	391.399	391.407
Extremely Immature * Severity Level 4	225.037	223.380	222.424	222.371	222.365
Extremely Immature * Severity Level 3	60.363	59.232	58.532	58.247	58.181
Extremely Immature * Severity Level 2	60.363	59.232	58.532	58.247	58.181
Extremely Immature * Severity Level 1 (Lowest)	60.363	59.232	58.532	58.247	58.181
Immature * Severity Level 5 (Highest)	207.274	205.589	204.615	204.629	204.644
Immature * Severity Level 4	89.694	88.105	87.188	87.169	87.178
Immature * Severity Level 3	45.715	44.305	43.503	43.394	43.379
Immature * Severity Level 2	33.585	32.247	31.449	31.221	31.163
Immature * Severity Level 1 (Lowest)	33.585	32.247	31.449	31.221	31.163
Premature/Multiples * Severity Level 5 (Highest)	173.696	172.095	171.169	171.111	171.108
Premature/Multiples * Severity Level 4	34.417	32.981	32.155	31.960	31.925
Premature/Multiples * Severity Level 3	18.502	17.382	16.694	16.311	16.200
Premature/Multiples * Severity Level 2	9.362	8.533	7.967	7.411	7.241
Premature/Multiples * Severity Level 1 (Lowest)	6.763	6.144	5.599	4.961	4.771
Term * Severity Level 5 (Highest)	132.588	131.294	130.511	130.346	130.292
Term * Severity Level 4	20.283	19.222	18.560	18.082	17.951
Term * Severity Level 3	6.915	6.286	5.765	5.092	4.866

Group	Platinum	Gold	Silver	Bronze	Catastrophic
Term * Severity Level 2	3.825	3.393	2.925	2.189	1.951
Term * Severity Level 1 (Lowest)	1.661	1.449	0.998	0.339	0.188
Age1 * Severity Level 5 (Highest)	62.385	61.657	61.217	61.130	61.108
Age1 * Severity Level 4	10.855	10.334	9.988	9.747	9.686
Age1 * Severity Level 3	3.633	3.299	3.007	2.692	2.608
Age1 * Severity Level 2	2.177	1.930	1.665	1.320	1.223
Age1 * Severity Level 1 (Lowest)	0.631	0.531	0.333	0.171	0.137
Age 0 Male	0.629	0.587	0.574	0.533	0.504
Age 1 Male	0.117	0.102	0.094	0.065	0.054

TABLE 5: HHS HCCS Included in Infant Model Maturity Categories

Maturity Category	HCC/Description
Extremely Immature	Extremely Immature Newborns, Birthweight < 500 Grams
Extremely Immature	Extremely Immature Newborns, Including Birthweight 500-749 Grams
Extremely Immature	Extremely Immature Newborns, Including Birthweight 750-999 Grams
Immature	Premature Newborns, Including Birthweight 1000-1499 Grams
Immature	Premature Newborns, Including Birthweight 1500-1999 Grams
Premature/Multiples	Premature Newborns, Including Birthweight 2000-2499 Grams
Premature/Multiples	Other Premature, Low Birthweight, Malnourished, or Multiple Birth Newborns
Term	Term or Post-Term Singleton Newborn, Normal or High Birthweight
Age 1	All age 1 infants

TABLE 6: HHS HCCS Included in Infant Model Severity Categories

Severity Category	HCC
Severity Level 5 (Highest)	Metastatic Cancer
Severity Level 5	Pancreas Transplant Status/Complications
Severity Level 5	Liver Transplant Status/Complications
Severity Level 5	End-Stage Liver Disease
Severity Level 5	Intestine Transplant Status/Complications
Severity Level 5	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis

Severity Category	HCC
Severity Level 5	Respirator Dependence/Tracheostomy Status
Severity Level 5	Heart Assistive Device/Artificial Heart
Severity Level 5	Heart Transplant
Severity Level 5	Congestive Heart Failure
Severity Level 5	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders
Severity Level 5	Lung Transplant Status/Complications
Severity Level 5	Kidney Transplant Status
Severity Level 5	End Stage Renal Disease
Severity Level 5	Stem Cell, Including Bone Marrow, Transplant Status/Complications
Severity Level 4	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Severity Level 4	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
Severity Level 4	Mucopolysaccharidosis
Severity Level 4	Major Congenital Anomalies of Diaphragm, Abdominal Wall, and Esophagus, Age < 2
Severity Level 4	Myelodysplastic Syndromes and Myelofibrosis
Severity Level 4	Aplastic Anemia
Severity Level 4	Combined and Other Severe Immunodeficiencies
Severity Level 4	Traumatic Complete Lesion Cervical Spinal Cord
Severity Level 4	Quadriplegia
Severity Level 4	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
Severity Level 4	Quadriplegic Cerebral Palsy
Severity Level 4	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
Severity Level 4	Non-Traumatic Coma, Brain Compression/Anoxic Damage
Severity Level 4	Respiratory Arrest
Severity Level 4	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
Severity Level 4	Acute Myocardial Infarction
Severity Level 4	Heart Infection/Inflammation, Except Rheumatic
Severity Level 4	Major Congenital Heart/Circulatory Disorders
Severity Level 4	Intracranial Hemorrhage
Severity Level 4	Ischemic or Unspecified Stroke
Severity Level 4	Vascular Disease with Complications
Severity Level 4	Pulmonary Embolism and Deep Vein Thrombosis
Severity Level 4	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections
Severity Level 4	Chronic Kidney Disease, Stage 5
Severity Level 4	Hip Fractures and Pathological Vertebral or Humerus Fractures
Severity Level 4	Artificial Openings for Feeding or Elimination
Severity Level 3	HIV/AIDS
Severity Level 3	Central Nervous System Infections, Except Viral Meningitis
Severity Level 3	Opportunistic Infections
Severity Level 3	Non-Hodgkin`s Lymphomas and Other Cancers and Tumors
Severity Level 3	Colorectal, Breast (Age < 50), Kidney and Other Cancers

Severity Category	HCC
Severity Level 3	Benign/Uncertain Brain Tumors, and Other Cancers and Tumors[19]
Severity Level 3	Lipidoses and Glycogenosis
Severity Level 3	Adrenal, Pituitary, and Other Significant Endocrine Disorders
Severity Level 3	Acute Liver Failure/Disease, Including Neonatal Hepatitis
Severity Level 3	Intestinal Obstruction
Severity Level 3	Necrotizing Fasciitis
Severity Level 3	Bone/Joint/Muscle Infections/Necrosis
Severity Level 3	Osteogenesis Imperfecta and Other Osteodystrophies
Severity Level 3	Cleft Lip/Cleft Palate
Severity Level 3	Hemophilia
Severity Level 3	Disorders of the Immune Mechanism
Severity Level 3	Coagulation Defects and Other Specified Hematological Disorders
Severity Level 3	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes
Severity Level 3	Traumatic Complete Lesion Dorsal Spinal Cord
Severity Level 3	Paraplegia
Severity Level 3	Spinal Cord Disorders/Injuries
Severity Level 3	Cerebral Palsy, Except Quadriplegic
Severity Level 3	Muscular Dystrophy
Severity Level 3	Parkinson`s, Huntington`s, and Spinocerebellar Disease, and Other Neurodegenerative Disorders
Severity Level 3	Hydrocephalus
Severity Level 3	Unstable Angina and Other Acute Ischemic Heart Disease
Severity Level 3	Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders
Severity Level 3	Specified Heart Arrhythmias
Severity Level 3	Cerebral Aneurysm and Arteriovenous Malformation
Severity Level 3	Hemiplegia/Hemiparesis
Severity Level 3	Cystic Fibrosis
Severity Level 3	Fibrosis of Lung and Other Lung Disorders
Severity Level 3	Pathological Fractures, Except of Vertebrae, Hip, or Humerus
Severity Level 2	Viral or Unspecified Meningitis
Severity Level 2	Thyroid, Melanoma, Neurofibromatosis, and Other Cancers and Tumors
Severity Level 2	Diabetes with Acute Complications
Severity Level 2	Diabetes with Chronic Complications
Severity Level 2	Diabetes without Complication
Severity Level 2	Protein-Calorie Malnutrition
Severity Level 2	Congenital Metabolic Disorders, Not Elsewhere Classified
Severity Level 2	Amyloidosis, Porphyria, and Other Metabolic Disorders
Severity Level 2	Cirrhosis of Liver
Severity Level 2	Chronic Pancreatitis
Severity Level 2	Inflammatory Bowel Disease
Severity Level 2	Rheumatoid Arthritis and Specified Autoimmune Disorders
Severity Level 2	Systemic Lupus Erythematosus and Other Autoimmune Disorders
Severity Level 2	Congenital/Developmental Skeletal and Connective Tissue Disorders

[19] This HCC also includes Breast (Age 50+) and Prostate Cancer.

Severity Category	HCC
Severity Level 2	Acquired Hemolytic Anemia, Including Hemolytic Disease of Newborn
Severity Level 2	Sickle Cell Anemia (Hb-SS)
Severity Level 2	Drug Psychosis
Severity Level 2	Drug Dependence
Severity Level 2	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes
Severity Level 2	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies
Severity Level 2	Seizure Disorders and Convulsions
Severity Level 2	Monoplegia, Other Paralytic Syndromes
Severity Level 2	Atherosclerosis of the Extremities with Ulceration or Gangrene
Severity Level 2	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis
Severity Level 2	Chronic Ulcer of Skin, Except Pressure
Severity Level 1 (Lowest)	Chronic Hepatitis
Severity Level 1	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption
Severity Level 1	Thalassemia Major
Severity Level 1	Autistic Disorder
Severity Level 1	Pervasive Developmental Disorders, Except Autistic Disorder
Severity Level 1	Multiple Sclerosis
Severity Level 1	Asthma
Severity Level 1	Chronic Kidney Disease, Severe (Stage 4)
Severity Level 1	Amputation Status, Lower Limb/Amputation Complications
Severity Level 1	No Severity HCCs

(13) Adjustments to Model discussed in the Risk Adjustment White Paper

We discussed the possibility of including adjustments to the HHS risk adjustment model to account for cost-sharing reductions and reinsurance payments in the Risk Adjustment White Paper, and sought comment. We propose to include an adjustment for the receipt of cost-sharing reductions in the model, but not to adjust for receipt of reinsurance payments in the model.

(i) Cost-sharing reductions adjustments

We propose an adjustment to the HHS risk adjustment models for individuals who receive cost-sharing reductions. The Affordable Care Act establishes cost-sharing reductions for enrollees in individual market plans in Exchanges based on their income and/or Indian status. Individuals who qualify for cost-sharing reductions may utilize

health care services at a higher rate than would be the case in the absence of cost-sharing reductions. This higher utilization (to the extent not covered by required cost sharing by the enrollees or cost-sharing reductions reimbursed by the Federal government) would neither be paid by cost sharing reductions nor built into premiums. This adjustment to the HHS risk adjustment models would be based on the adjustment for induced demand for advanced payment of cost-sharing reductions described in section III.E. of this proposed rule. The proposed adjustment factors are set forth in Table 7. These adjustments would be multiplicative, and applied after demographic, diagnosis, and interaction factors are summed.

We plan to evaluate this adjustment in the future, once data from the first few years of risk adjustment are available. We seek comment on this approach.

TABLE 7: Cost-Sharing Reduction Adjustment

Household Income	Plan AV	Induced Utilization Factor
Non-Indian CSR Recipients		
100-150% of FPL	Plan Variation 94%	1.12
150-200% of FPL	Plan Variation 87%	1.12
200-250% of FPL	Plan Variation 73%	1.00
>250% of FPL	Standard Plan 70%	1.00
Indian CSR Recipients		
<300% of FPL	Platinum (90%)	1.15
<300% of FPL	Gold (80%)	1.12
<300% of FPL	Silver (70%)	1.07
<300% of FPL	Bronze (60%)	1.00
>300% of FPL		1.00

(ii) Reinsurance Adjustments

Section 1341 of the Affordable Care Act establishes a three-year transitional reinsurance program in the individual market, raising the question of whether to account for these reinsurance payments when developing the HHS risk adjustment models. Some reinsurance payments would be made for low-risk individuals with unexpected high-cost expenditures (for example, due to an accident) that may not be accounted for in the risk

adjustment models. However, plans that receive risk adjustment payments for their higher-than-average risk enrollees may also be eligible to receive reinsurance payments for the same high-risk enrollees. Adjusting for reinsurance payments in the HHS risk adjustment model would address the concerns that reinsurance and risk adjustment could compensate twice for the same high-risk individuals.

Despite this potential, we propose not to adjust for reinsurance in the HHS risk adjustment model for a number for reasons. First, removing reinsurance payments from risk adjustment would reduce protections for issuers of reinsurance-eligible plans that enroll high-cost individuals. Second, it would be difficult to determine what portion of reinsurance payments were made for conditions included in each HHS risk adjustment model, and the appropriate model adjustment for these payments. Finally, because the size of the reinsurance pool declines over its three-year duration, the methodology to account for reinsurance payments would need to be modified each year for the HHS risk adjustment model.

(14) Model performance statistics

To evaluate model performance, we examined their R-squared and predictive ratios. The R-squared statistic, which calculates the percentage of individual variation explained by a model, measures the predictive accuracy of the model overall. The predictive ratios measure the predictive accuracy of a model for different validation groups or subpopulations. The predictive ratio for each of the HHS risk adjustment models is the ratio of the weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The predictive ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0. For each of the HHS risk adjustment models, the R-squared

statistic and the predictive ratio are in the range of published estimates for concurrent risk adjustment models.[20] The R-squared statistic for each model is shown in Table 8.

We welcome comment on these proposed risk adjustment models.

TABLE 8: R-Squared Statistic for HHS Risk Adjustment Models

Risk Adjustment Model	R-Squared Statistic
Platinum Adult	0.360
Platinum Child	0.307
Platinum Infant	0.292
Gold Adult	0.355
Gold Child	0.302
Gold Infant	0.289
Silver Adult	0.352
Silver Child	0.299
Silver Infant	0.288
Bronze Adult	0.351
Bronze Child	0.296
Bronze Infant	0.289
Catastrophic Adult	0.350
Catastrophic Child	0.295
Catastrophic Infant	0.289

c. Overview of the payment transfer formula

Plan average risk scores are calculated as the member month-weighted average of individual enrollee risk scores, as shown in section III.B.3.b. of this proposed rule. We defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. Here, we combine these concepts into a risk adjustment payment transfer formula. In this section, we refer to payments and charges generically as transfers. Under §153.310(e), as proposed to renumbered, HHS would invoice issuers of risk adjustment covered plans for transfers by June 30 of the year following the applicable benefit year.

[20] Winkleman, Ross and Syed Mehmud. "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment." Society of Actuaries. April 2007.

We propose to calculate risk adjustment transfers after the close of the applicable benefit year, following the completion of issuer risk adjustment data reporting. As discussed in detail below, the payment transfer formula includes a set of cost adjustment terms that require transfers to be calculated at the geographic rating area level for each plan (thus, HHS would calculate two separate transfer amounts for a plan that operates in two rating areas). Payment transfer amounts would be aggregated at the issuer level (that is, at the level of the entity licensed by the State) such that each issuer would receive an invoice and a report detailing the basis for the net payment that would be made or the charge that would be owed. The invoice would also include plan-level risk adjustment information that may be used in the issuer's risk corridors calculations.

The proposed payment transfer formula is designed to provide a per member per month (PMPM) transfer amount. The PMPM transfer amount derived from the payment transfer formula would be multiplied by each plan's total member months for the benefit year to determine the total payment due or charge owed by the issuer for that plan in a rating area.

(1) Rationales for a Transfer Methodology Based on State Average Premiums

Risk adjustment transfers are intended to reduce the impact of risk selection on premiums while preserving premium differences related to other cost factors, such as the actuarial value, local patterns of utilization and care delivery, local differences in the cost of doing business, and, within limits established by the Affordable Care Act, the age of the enrollee. Risk adjustment payments would be fully funded by the charges that are collected from plans with lower risk enrollees (that is, transfers within a State would net to zero).

In the Risk Adjustment White Paper, we presented several approaches for calculating risk adjustment transfers using the State average premium and plans' own

premiums. The approaches that used plans' own premiums resulted in unbalanced payment transfers, requiring a balancing adjustment to yield transfers that net to zero. These examples also demonstrated that the balancing adjustments could introduce differences in premiums across plans that were not consistent with features of the plan (for example, AV or differences in costs and utilization patterns across rating areas). A balancing adjustment would likely vary from year to year, and could add uncertainty to the rate development process (that is, plan actuaries would need to factor the uncertainty of the balancing adjustment into their transfer estimates).

Therefore, we propose a payment transfer formula that is based on the State average premium for the applicable market, as described in section III.B.3.a. of this proposed rule. The State average premium provides a straightforward and predictable benchmark for estimating transfers. As shown in the examples in the Risk Adjustment White Paper, transfers net to zero when the State average premium is used as the basis for calculating transfers.

Plan premiums differ from the State average premium due to a variety of factors, such as differences in cost-sharing structure or regional differences in utilization and unit costs. The proposed payment transfer formula applies a set of cost factor adjustments to the State average premium so that it will better reflect plan liability. These adjustments to the State average premium result in transfers that compensate plans for liability differences associated with risk selection, while preserving premium differences related to the other cost factors described above.

(2) Conceptual overview of the payment transfer formula

In this section, we provide a broad overview of the payment transfer formula that we propose to use when operating risk adjustment on behalf of a State. We discuss at a

conceptual level our proposal to use the State average premium as the basis of the formula and the components of the formula.

(i) Calculating transfers using the State average Premium

The payment transfer formula proposed for 2014 is based on the difference between two plan premium estimates: (1) a premium based on plan-specific risk selection; and (2) a premium without risk selection. Transfers are intended to bridge the gap between these two premium estimates:

Conceptually, the goal of payment transfers is to provide plans with payments to help cover their actual risk exposure beyond the premiums the plans would charge reflecting allowable rating and their applicable cost factors. In other words, payments would help cover excess actuarial risk due to risk selection.

Both of these premium estimates would be based on the State average premium. The State average premium is the average premium requirement for providing insurance to the applicable market population. The proposed payment transfer formula develops plan premium estimates by adjusting the State average premium to account for plan-specific characteristics such as benefit differences. This approach also assumes that all plans have premiums that can be decomposed into the State average premium and a set of adjustment factors, and that all plans would have the same premium if the adjustment factors were held constant across plans. Finally, the derivation of the payment transfers also assumes that plans “price to cost,” that is, that competition among plans for enrollees drives plans' premiums to their premium requirements. Therefore, we may consider

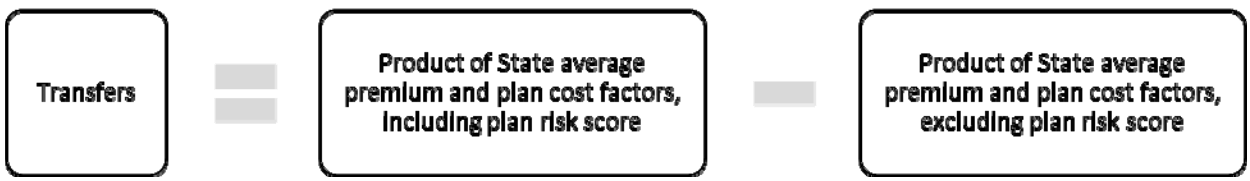
"premiums" to be "costs" or "premium requirements." The payment transfer formula includes the following premium adjustment terms:

- Plan average risk score: multiplying the plan average risk score by the State average premium shows how a plan's premium would differ from the State average premium based on the risk selection experienced by the plan.
- Actuarial value: a particular plan's premium may differ from the State average premium based on the plan's cost sharing structure, or actuarial value. An AV adjustment is applied to the State average premium to account for relative differences between a plan's AV and the market average AV.
- Permissible rating variation: plan rates may differ based on allowable age rating factors. The rating adjustment accounts for the impact of allowable rating factors on the premium that would be realized by the plan.
- Geographic cost differences: differences in unit costs and utilization may lead to differences in the average premium between intra-State rating areas, holding other cost factors (for example, benefit design) constant. The geographic cost adjustment accounts for cost differences across rating areas.
- Induced demand: enrollee spending patterns may vary based on the generosity of cost-sharing. The induced demand adjustment accounts for greater utilization of health care services induced by lower enrollee cost sharing in higher metal level plans.

The State average premium is multiplied by these factors to develop the plan premium estimates used in the payment transfer formula. The factors are relative measures that compare how plans differ from the market average with respect to the cost factors (that is to say, the product of the adjustments is normalized to the market average product of the cost factors).

In the absence of these adjustments, transfers would reflect liability differences attributed to cost factors other than risk selection. For example, in the absence of the AV adjustment, a low AV plan with lower-risk enrollees would be overcharged because the State average premium would not be scaled down to reflect the fact that the plan's AV is lower than the average AV of plans operating in the market in the State.

The figure below shows how the State average premium, the plan average risk score, and other plan-specific cost factors are used to develop the two plan premium estimates that are used to calculate payment transfers:



(ii) Estimating the Plan Premium With Risk Selection

The first premium term in the proposed payment transfer formula, the plan premium estimate reflecting risk selection, is calculated as the product of the State average premium and the normalized product of the plan average risk score, the plan geographic cost factor, and the plan induced demand factor.

The formula below shows how the plan premium estimate reflecting risk selection would be calculated:

$$\left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)}\right] \bar{P}_S$$

Where,
$\bar{P}_S$ = State average premium,

$PLRS_i$ = plan i's plan liability risk score,

IDF_i = plan i's induced demand factor,
GCF_i = plan i's geographic cost factor,
s_i = plan i's share of State enrollment,
and the denominator is summed across all plans in the risk pool in the market in the State.

The key factor in the premium reflecting risk selection is the plan average risk score, which would be calculated from the HHS risk adjustment models. The plan average risk score is a relative measure of plan liability based on the health status of a plan's enrollees. The State average premium is multiplied by the plan average risk score to estimate plan liability based on the risk selection present in its enrollee population. However, because the HHS risk adjustment models do not account for plan liability differences attributable to induced demand or geographic cost differences, those cost factors must be included in the estimate of the premium with risk selection.

The denominator of the adjustment term normalizes the product of the plan cost factors to the State average product of the cost factors. The normalized product of the plan cost factors provides an estimate of how a plan's liability differs from the market average due to underlying differences in its cost factors, including risk selection, induced demand and geographic cost differences.

The premium reflecting risk selection does not include an AV adjustment because the risk score reflects the plan's AV. Additionally, the premium estimate reflecting risk selection does not include the allowable rating factor adjustment. Thus, the difference between the premium estimates (that is, the premium with and the premium without risk selection) provides an estimate of plan liability attributed to risk selection that is not compensated for through allowable premium rating – our measure of actuarial risk.

(iii) Estimating the Plan Premium Without Risk Selection

The second premium term in the proposed payment transfer formula, the plan premium estimate not reflecting risk selection, would be calculated as the product of the State average premium and the normalized product of the plan AV, plan allowable rating factor, the induced demand factor, and a geographic cost factor. The formula below shows how this term would be calculated:

$$\left[\frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right]\bar{P}_s$$

Where,
$\bar{P}_s$ = State average premium,

AV_i= plan i's metal level AV,
$ARF_{i=}$ allowable rating factor
IDF_i = plan i's induced demand factor,
GCF_i = plan i's geographic cost factor,
s_i = plan i's share of State enrollment,
and the denominator is summed across all plans in the risk pool in the market in the State.

The normalized adjustment terms would account for how a plan's AV, allowed rating variation, induced demand, and geographic cost factors jointly vary from the State average product of these terms. The normalized product of the adjustment terms would be multiplied by the State average premium to estimate the extent to which the plan's premium requirement would differ from the premium requirement for the State average plan due to cost factors unrelated to risk selection.

(iv) Risk Adjustment Payment Transfer Formula

Transfers would be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection – the two premium estimates described above. Therefore, the proposed 2014 HHS risk adjustment payment transfer formula is:

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right]\bar{P}_s$$

Where,

$\bar{P}_S$ = State average premium,

$PLRS_i$ = plan *i*'s plan liability risk score,

AV_i= plan *i*'s metal level AV,
ARF_i= allowable rating factor
IDF_i = plan *i*'s allowable rating factor,
GCF_i = plan *i*'s geographic cost factor,
s_i = plan *i*'s share of State enrollment,
and the denominator is summed across all plans in the risk pool in the market in the State.

The difference between the two premium estimates in the payment transfer formula would determine whether a plan would pay a risk transfer charge or receive a risk transfer payment. Note that the value of the plan average risk score by itself does not determine whether a plan would be assessed a charge or receive a payment – even if the risk score is greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan may receive through its rating practices (as measured through the allowable rating factor) exceeds the plan's predicted liability associated with risk selection.

Plans with higher AV would, other things being equal, also have higher risk scores. This is due to the fact that the metal level-specific risk adjustment models that are used to predict plan liability assume different cost sharing and levels of plan liability. Thus, the risk score for two identical sets of enrollees would differ depending on the metal level model used. Thus, a bronze plan with an average risk score of 1.1 would likely have more adverse selection than a gold plan with an average risk score of 1.1 (because the bronze plan risk adjustment model assumes a lower level of plan liability than the gold plan model).

Risk adjustment transfers are calculated at the risk pool level. Each State will have a risk pool for all of its metal-level plans. Catastrophic plans will be treated as a separate risk pool for purposes of risk adjustment. Individual and small group market

plans will either be pooled together or treated as separate risk pools, as described in section III.B.3.a. of this proposed rule.

(v) Normalization and Budget Neutral Transfers

As discussed above, each of the two premium terms in the payment transfer formula would be divided by its average. This means that each "normalized" term would average to 1.0. Thus, the average of the difference between these terms would be zero. This is the fundamental property of the payment transfer formula that ensures that transfers across a risk pool would net to zero.

Note that the individual factors in the proposed payment transfer formula do not need to independently average to 1.0. For example, the average risk score for a State may not equal 1.0 due to the underlying differences in the health status of the State's population and the national sample used to calibrate the model. It is not necessary to separately renormalize plan average risk scores to the State average risk score because the payment transfer formula normalizes the product of the risk score, the induced demand factor and the geographic cost factor. The individual scales for PLRS, IDF, GCF, and ARF are not specified because the payment transfer formula applies to the plan-specific value relative to the State average.

(vi) Calculation of Transfer Formula Inputs

In this section, we describe each component of the proposed payment transfer formula, and explain how it is computed and how it affects transfers.

(A) Plan Average Risk Score

The plan average risk score represents the plan's overall risk exposure. The proposed plan average risk score calculation includes an adjustment to account for the family rating rules proposed in the Market Reform Rule, which caps the number of children that can count toward the build-up of family rates at three. If risk scores were

calculated as the member month-weighted average of all enrollee risk scores, plan average risk scores would tend to misrepresent the risk issuers take on for family policies that include children that do not count toward family rates. In general, children tend to have lower risk scores than adults, and without an adjustment the average risk score for family policies including more than three children would tend to be lower than the average risk score of family policies with three or fewer children, despite the fact that family policies with more than three children face more uncompensated risk.

The formula below shows the proposed plan average risk score calculation including the risk of all members on the policy, including those children not included in the premium.

$$PLRS_i = \frac{\sum_e M_e \cdot PLRS_e}{\sum_b M_b}$$

where
$PLRS_i$ is plan i's average plan liability risk score, the subscript e denotes each enrollee within the plan,
$PLRS_e$ is each enrollee's individual plan liability risk score,
M_e is the number of months during the risk adjustment period the enrollee e is enrolled in the plan, and
M_b is the number of months during the risk adjust period the billable member b is enrolled in the plan (billable members exclude children who do not count towards family rates).

The proposed payment transfer formula uses the plan average risk score to calculate transfers. The plan average risk scores would be calculated using the applicable risk adjustment model described in section III.B.3.b. of this proposed rule. The plan liability models would produce risk scores that reflect the health status of the plan's enrollees and the AV of the plan. The AV adjustment in the proposed payment transfer formula would help ensure that transfers do not compensate plans for differences in AV (for which the plans may charge an appropriate premium).

(B) Billable Members

With the exception of the plan average risk score calculation discussed above, all of the other calculations used in the proposed payment transfer formula are based on billable members (that is, children who do not count toward family policy premiums are excluded). Member months, the State average premium, the allowable rating factor, and the geographic cost factor are all calculated based on billable members.

(C) State Average Premium

As noted above, we propose to use the State average premium as the basis of calculating payment transfers. The average premium calculation would be based on the total premiums assessed to enrollees, including the portion of premiums that are attributable to administrative costs. The State average premium would be calculated as the enrollment-weighted mean of all plan average premiums of risk adjustment covered plans in the applicable risk pool in the applicable market in the State. The State average premium calculation is based on billable member months and excludes member months for children that do not count toward family policy rates. Plan average premiums would be calculated from the actual premiums charged to their enrollees, weighted by the number of months enrolled.

The proposed equations for these average premiums are:

$$P_s = \sum_i s_i^s P_i$$

and

$$P_i = \frac{\sum_s (M_s \cdot P_s)}{\sum_s M_s}$$

The first equation calculates the State average premium $\overline{P}_s$ as the average of individual plan averages, $\overline{P}_i$ weighted by each plan's share of statewide enrollment in the risk pool in the market, s_i^s (based on billable member months). The second equation shows how the plan averages are calculated. This is the weighted mean over all subscribers s of subscriber premiums P_s, with M_s representing the number of billable member months of enrollment under the policy of each subscriber s.

(D) Actuarial Value

The proposed AV adjustment in the payment transfer formula would account for relative differences in plan liability due to differences in actuarial value. The AV adjustment helps to achieve the goal of compensating plans for risk selection while allowing other determinants of premiums – including the generosity of plan benefits – to be reflected in premiums. If the payment transfer formula were to ignore actuarial value, it would effectively force low-AV plans to subsidize high-AV plans. This is because the State average premium is calculated from all plans at all metal levels in the risk pool in the market. As a result, in the absence of an actuarial value adjustment, a bronze plan with a low risk score would see its transfer charge increased based on a State average premium that includes plans with more generous benefits.

The AV adjustment would be based on the metal level actuarial value associated with each plan type (for example, all bronze health plans would be assigned an AV factor of .6 in the proposed payment transfer formula). Using the metal level actuarial value as the basis for this adjustment provides a simple and straightforward approach for estimating the impact of benefit design on plan liability. The standard metal level actuarial values approximate plan liability for the standard population (that is, plan liability in the absence of risk selection). Additionally, the adjustment should not be

based on a plan's actuarial value, including the de minimis range as computed by the AV calculator. The cost sharing assumptions in the HHS risk adjustment models correspond to the standard metal level actuarial values (for example, 0.6 a bronze plan), so the actuarial value adjustment in the payment transfer formula must also correspond to the standard metal level actuarial values.

Table 9 shows the AV adjustment that would be used for each category of metal level plans.

TABLE 9: Actuarial Value Adjustment Used for Each Metal Level in the Payment Transfer Formula

Metal Level	AV Adjustment
Catastrophic	0.57
Bronze	0.60
Silver	0.70
Gold	0.80
Platinum	0.90

(E) Allowable rating variation

PHS Act section 2701, as added by the Affordable Care Act, establishes standards for plan premium rating. Rates can vary based on three enrollee characteristics – age, family size, and tobacco use – and geographic area within each State. Furthermore, the law limits the amount by which premiums may vary by age; the most expensive age group's rating cannot be more than three times as high as the lowest (for adults age 21 or above), and rating based on tobacco use cannot exceed a 50 percent increment. Plans cannot base premiums on enrollee health status. In the proposed Market Reform Rule, we have issued proposed standards related to the rating rules under the Affordable Care Act. The proposed payment transfer formula discussed above assumes the rating standards of the proposed Market Reform Rule. The final payment transfer formula may require updating in the final Payment Notice to reflect any changes to the rating standards in the final Market Reform Rule.

The proposed Allowable Rating Factor (ARF) adjustment in the payment transfer formula would account only for age rating. Tobacco use, wellness discounts, and family rating requirements would not be included in the payment transfer formula for the reasons specified below. Geographic cost variation is treated as a separate adjustment in the payment transfer formula.

Age rating is permitted within limits to enable plans to be partially compensated for risk based on enrollee age. Under the proposed Market Reform Rule, each State would have a standard age curve that all issuers would be required to use. The 3:1 age rating restriction applies to the adults aged 21 and older. Age bands for individuals under 21 would not be subject to the 3:1 restriction, but their corresponding rating factors would still be specified in the standard age curves. Each plan's allowable rating factor would be calculated as the enrollment-weighted average of the age factor, based on the applicable standard age curve, across all of a plan's enrollees. In operation, for the age rating factor included in the payment transfer formula, age would be calculated as the enrollee's age at the time of enrollment, as outlined in the proposed Market Reform Rule.

Under the proposed Market Reform Rule, premiums for families with three or fewer children would be calculated as the sum of individual rates for each individual within the family. These individual rates would be based on each person's age, tobacco use, and geographic rating area. For families with more than three children, the family premium would be built up from the individual premiums of the parents plus the three oldest children. Additional children would not be reflected in the family premium. The proposed payment transfer formula does not include an explicit adjustment related to the family rating requirements, as rate setting would not include a family rating factor.

Tobacco rating and wellness discounts are also not included in the proposed allowable rating factor adjustment. These rating factors are discretionary. HHS proposes

not to include adjustments for these rating factors in the payment transfer formula to maintain issuer flexibility with respect to tobacco and wellness discount rating that is allowed by the Affordable Care Act.

Table 10 shows a simplified example of how the ARF values would be calculated for three plans.

TABLE 10: Example Allowable Rating Factor Calculation

Age Band	**State Age-Rating Curve**	**Plan A**	**Plan B**	**Plan C**	**State**
		Enrollment percentages (Share of member-months)			
21	1.000	33.30%	40.00%	10.00%	31.70%
*(*Age bands from 22-39 omitted*)*					
40	1.278	33.30%	40.00%	20.00%	33.30%
*(*Age bands from 41-63 omitted*)*					
64 and older	3.000	33.30%	20.00%	70.00%	35.00%
Total member-months		300,000	200,000	100,000	600,000
ARF		1.758	1.511	2.456	1.793

In Table 10, three plans constitute the entire risk pool in the market in the State. In practice, each State age rating curve would have 44 adult bands: one for each year from 21 to 63, plus a 64-and-older band. In this example, we simplify by considering only three bands: 21, 40, and 64 and older. The second column shows the relative premiums for each age band; note that these values conform to the 3:1 rating restriction.

Three plans are presented in the next three columns, followed by statewide totals. We assume Plan A's enrollment of 300,000 member-months is equally distributed among the three age bands. Enrollment in Plan B is weighted toward younger ages, while Plan C captures a disproportionately older population. Statewide, these enrollments add up to a 31.7 percent share in the age 21 band, 33.3 percent in 40 and older age band, and 35.0 percent in 64 and older age band.

Plan-specific ARF values are calculated similarly. For example, Plan C's ARF is the sum of three products: 1.000*0.10 + 1.278*0.20 + 3.000*0.70 = 2.456. This value indicates that within the 3:1 rating restriction, Plan C would be expected to collect premiums that are higher than the State average due to Plan C's enrollments skewing older. Plan A's enrollees are slightly younger than the State average, which is also reflected in its 1.758 ARF, and Plan B's enrollment is younger than Plan A.

(F) Induced Demand

Induced demand reflects differences in enrollee spending patterns attributable to differences in the generosity of plan benefits (as opposed to risk selection). Induced demand is a function of plan benefit design. We believe risk adjustment should not compensate a plan for differences in plan liability that are not attributed to the underlying health and demographic characteristics of the plan's enrollees. In the absence of an induced demand adjustment, relative differences in induced demand may not be reflected in a plan's post-transfer premiums. In other words, plans with relatively high AV and induced demand could receive larger transfers, allowing them to reduce the premium impact of induced demand. For example, a plan that experiences 10 percent higher utilization due to induced demand would have a post-transfer premium that is less than 10 percent above an otherwise identical plan without induced demand.

The expenditure data underlying the AV calculator includes an induced demand factor for each metal level. We propose to use the same induced demand factors in the payment transfer formula, shown in Table 11.

TABLE 11: Induced Demand Adjustment Used for Each Metal Level in the Payment Transfer Formula

Metal Level	Induced Demand Adjustment
Catastrophic	1.00
Bronze	1.00
Silver	1.03
Gold	1.08

Metal Level	Induced Demand Adjustment
Platinum	1.15

(G) Geographic Area Cost Variation

The proposed geographic cost factor (GCF) would be an adjustment in the payment transfer formula because there are some plan costs – such as input prices or utilization rates – that vary geographically and are likely to affect plan premiums. By including the adjustment, these costs would be reflected in premiums, rather than being offset by transfers.

Excluding this adjustment would cause transfers to subsidize high-risk plans in high-cost areas at the expense of low-risk plans in low-cost areas. In a low-cost area, for example, a plan with lower-than-average risk enrollees would face a charge scaled to State average costs, which would be larger than would be appropriate in an area where costs are low. At the same time, the payment received by higher-than-average risk plans would be larger than necessary to compensate for the plan's excess risk. This would disadvantage low-risk plans relative to high-risk plans in the low-cost area. The opposite would be true in high-cost areas.

GCFs would be calculated for each rating area. These factors would be calculated based on the observed average silver plan premiums in a geographic area relative to the Statewide average silver plan premium. Using only silver plans as the basis of the adjustment would help control for differences in premiums across rating areas due to differential enrollment patterns in the available plan types. Additionally, the silver plan premiums used to calculate the adjustment must be standardized for age to isolate geographic cost differences in premiums.

Calculation of the GCF would involve three steps. First, the average premium would be computed for each silver plan in each rating area (using the same formula that

is used to compute plan premiums in the State average premium calculation discussed above). The calculation would be:

$$\bar{P}_i = \frac{\sum_s (M_s \cdot P_s)}{\sum_s M_s}$$

Where,
$\bar{P}_i$, is the average premium for plan *i*
s indexes all subscribers enrolled in the plan
M_s is the number of billable member months for billable members under the policy of subscriber *s*
P_s is the premium for subscriber *s*.

The second step would be to generate a set of plan average premiums that standardizes the premiums for age rating. Plan premiums are standardized for age by dividing the average plan premium by the plan rating factor, the enrollment-weighted rating factor applied to all billable members (discussed above). This formula would be:

$$\bar{P}_i^{AS} = \bar{P}_i / (ARF_i)$$

Where, $\bar{P}_i^{AS}$ is plan *i*'s age standardized average premium,
$\bar{P}_i$, is the average premium for plan *i*, and
ARF_i is the allowable rating factor.

The third and final step would compute a GCF for each area and assign it to all plans in that area. This would be accomplished with the following calculation:

$$GCF_i = \left(\sum_{area} s_i^a \cdot \bar{P}_i^{AS}\right) \Big/ \left(\sum_{state} s_i^s \cdot \bar{P}_i^{AS}\right)$$

This equation divides the enrollment-weighted average of standardized silver-level plan premiums in a geographic area by the average of those premiums Statewide. The numerator's summation is over all silver-level plans within plan *i*'s geographic area,

so $\sum_{area} s_i^s = 1$. Similarly, the summation in the denominator is over all silver-level plans in the State, so $\sum_{state} s_i^s = 1$.

Using these formulas, the enrollment-weighted statewide average of plan GCF values would equal 1.0, so deviations from 1.0 can be interpreted as the percentage by which any geographic area's costs deviate from the State average. In other words, a GCF equal to 1.15 indicates that the plan operates in a geographic area where costs are, on average, 15 percent higher than the Statewide average.

(H) Calculation of the Plan Transfer Payments

The PMPM transfer payment calculated from the proposed payment transfer formula would be multiplied by the total number of plan member months for billable members to calculate the total plan level payment. As discussed above, transfers would be calculated at the plan level within rating areas (that is, a plan operating in two rating areas would be treated as two separate plans for the purposes of calculating transfers).

We welcome comment on this proposed payment transfer formula.

d. Overview of the data collection approach

In §153.20, we propose a technical correction to the definition of risk adjustment data collection approach. We propose to delete "and audited" so that the definition of risk adjustment data collection approach means "the specific procedures by which risk adjustment data is to be stored, collected, accessed, transmitted, validated and the applicable timeframes, data formats, and privacy and security standards." This technical correction clarifies that auditing of risk adjustment data is not part of the risk adjustment data collection approach. Risk adjustment data should be audited during the data validation process, which is not a part of the risk adjustment methodology or data collection approach.

We also propose to modify §153.340(b)(3) by adding the additional restriction that "Use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected (including for purposes of data validation)." This addition will further ensure the privacy and security of potentially sensitive data by limiting the use or disclosure of any personally identifiable information collected as a part of this program.

The data collection approach HHS proposes to use when operating risk adjustment on behalf of the State is described in the applicable sections of section III.G. of this proposed rule and in the new proposed §153.700 through §153.730.

We welcome comment on this proposed data collection approach.

e. Schedule for risk adjustment

Under §153.610(a), issuers of risk adjustment covered plans will provide HHS with risk adjustment data in the form and manner specified by HHS. Under the HHS-operated risk adjustment program, issuers will not send, but must make available to HHS, anonymized claims and enrollment data, as specified in section III.G. of this proposed rule, for benefit year 2014 beginning January 1, 2014. Enrollee risk scores will be calculated based on enrollee enrollment periods and claims dates of service that occur between January 1, 2014 and December 31, 2014. Enrollee risk scores for subsequent benefit years will be calculated based on claims and enrollment periods for that same benefit year.

As set forth in the proposed §153.730, claims to be used in the risk score calculation must be made available to HHS by April 30 of the year following the benefit year. We believe this date provides for ample claims runout to ensure that diagnoses for the benefit year are captured, while providing HHS sufficient time to run enrollee risk

score, plan average risk, and payments and charges calculations and meet the June 30 deadline described at the redesignated §153.310(e).

We welcome comment on this proposed schedule for risk adjustment.

4. State alternate methodology

a. Technical correction

The Premium Stabilization Rule established standards for States that establish their own risk adjustment programs. Under the proposed revision to §153.310, a State may establish a risk adjustment program if it elects to operate an Exchange and is approved to operate risk adjustment in the State. If a State does not meet the requirements to operate risk adjustment, HHS will carry out all functions of risk adjustment on behalf of the State. In §153.320(a), we established that Federally certified methodologies must be used in the operation of the risk adjustment program, and defined the process by which a methodology may become Federally certified. In this proposed rule, we modify §153.320(a)(1) and (a)(2) to clarify that these methodologies must be published in "the applicable annual" notice of benefit and payment parameters as opposed to "an annual" HHS notice of benefit and payment parameters. This proposed change makes clear that methodologies must be certified for use each year.

b. State alternate risk adjustment methodology evaluation criteria

The Premium Stabilization Rule specified the information that a State will need to provide to support its request for HHS to certify an alternate risk adjustment methodology. In §153.330(a), we specified the elements required to be included with the request to HHS for certification of an alternate risk adjustment methodology. Section 153.330(a)(1)(i) states that a request for certification for an alternate methodology must include the elements specified in §153.320(b), which includes a complete description of: (1) the risk adjustment model; (2) the calculation of plan average actuarial risk; (3) the

calculation of payments and charges; (4) the risk adjustment data collection approach; and (5) the schedule for the risk adjustment program. Section 153.330(a)(1)(ii) states that the alternate methodology request must also include the calibration methodology and frequency of calibration, and §153.330(a)(1)(iii) provides that the request must include statistical performance metrics specified by HHS. Section 153.330(a)(2) requires that the request also include certain descriptive and explanatory information relating to the alternate methodology.

Under our existing regulations, States wishing to submit an alternate risk adjustment methodology should do so by submitting the information described in this proposed rule to HHS at AlternateRAMethodology@cms.hhs.gov. As described in preamble to the Premium Stabilization Rule, at the Risk Adjustment Spring Meeting, and in technical assistance calls with States, requests for State alternate methodologies will be accepted up to 30 days after publication of this proposed rule. We will review a State's request for certification of its alternate methodology only if it has submitted an Exchange Blueprint application and has indicated on that application its intent to operate a risk adjustment program in the State (or, in later years, if it is operating or has been approved to operate an Exchange). We expect to work with States as they develop their alternate methodologies.

We noted in the Premium Stabilization Rule that we would provide greater detail about the process for receiving Federal certification of alternate risk adjustment methodologies in this proposed rule. We propose the following evaluation criteria to certify alternate risk adjustment methodologies. We propose to redesignate paragraph (b) of §153.330 to paragraph (c), and are proposing a new paragraph (b) that sets forth the evaluation criteria for alternate risk adjustment methodologies. In the new §153.330(b)(1), we propose to consider whether the alternate risk adjustment

methodology meets criteria that correspond to the elements of the alternate methodology request described in paragraph §153.330(a)(1) and (2). Specifically, we will be evaluating the extent to which an alternate risk adjustment methodology:

(i) Explains the variation in health care costs of a given population;

(ii) Links risk factors to daily clinical practices and is clinically meaningful to providers;

(iii) Encourages favorable behavior among providers and health plans and discourages unfavorable behavior;

(iv) Uses data that is complete, high in quality, and available in a timely fashion;

(v) Is easy for stakeholders to understand and implement;

(vi) Provides stable risk scores over time and across plans; and

(vii) Minimizes administrative costs.

For example, to determine the extent that an alternate methodology explains the variation in health care costs of a given populations, we would consider whether the risk adjustment model was calibrated from data reflecting the applicable market benefits, was calibrated on a sample that is reasonably representative of the anticipated risk adjustment population, and was calibrated using a sufficient sample to ensure stable weights across time and plans. In addition, in evaluating this criterion, we would consider whether the methodology has suitably categorized the types of plans subject or not subject to risk adjustment, given the overall approach taken by the methodology and the goal of the program to account for plan average actuarial risk. States must provide a rationale for the methodology's approach to the plans subject to risk adjustment. Under this proposed criteria, we would also evaluate the State's method for calculating payments and charges, as described in section III.B.4.c., below.

We also note that we would consider whether the alternate methodology discriminates against vulnerable populations or creates inappropriate incentives. Alternate methodologies must not discriminate against individuals because of age, disability, or expected length of life, and should take into account the health care needs of diverse segments of the risk adjustment population, including women, children, persons with disabilities, and other vulnerable groups.

In the proposed §153.330(b)(2), we would consider whether the alternate methodology complies with the requirements of subpart D, especially §153.310(e) (as proposed to be renumbered) and §153.340. Section 153.310(e) requires alternate methodologies to have a schedule that provides annual notification to issuers of risk adjustment covered plans of payments and charges by June 30 of the year following the benefit year. Section 153.340(b)(1) sets forth a number of minimum requirements for data collection under risk adjustment, including standards relating to data privacy and security. While the Federal approach will not directly collect data from insurers, but instead will use a distributed approach that will not include personally identifiable information, the Premium Stabilization Rule gave States the flexibility to design their own data collection approach, provided privacy and security standards are met. The privacy and security of enrollees' data is of paramount importance to HHS, and the data collection approach in an alternate methodology must protect personally identifiable information, if any, that is stored, transmitted, or analyzed, to be certified. The application for certification of the alternate methodology should identify which data elements contain personally identifiable information, and should specify how the State would meet these data and privacy security requirements.

In §153.330(b)(3), we propose to consider whether the alternate risk adjustment methodology accounts for payment transfers across metal levels. We believe that sharing

risk across metal levels is a critical part of a risk adjustment methodology as new market reforms are implemented because of the need to mitigate adverse selection across metal levels, as well as within metal levels. The proposed HHS risk adjustment methodology transfers funds between plans across metal levels, and under this proposal, State alternate methodologies must do so as well.

For reasons described previously, under the proposed HHS risk adjustment methodology, we propose to apply risk adjustment to catastrophic plans in their own risk pool – that is, we would transfer funds between catastrophic plans, but not between catastrophic plans and metal level plans. For a number of plans, such as student health plans and plans not subject to the market reform rules, we have proposed not to transfer payments under the HHS risk adjustment methodology. However, as discussed above, we believe that States should have the flexibility to submit a methodology that transfers funds between these types of plans (either in their own risk pool or with the other metal levels).

In §153.330(b)(4), we propose to consider whether the elements of the alternate methodology align with each other. For example, the data collected through the data collection approach should align with the data required by the risk adjustment model to calculate individual risk scores.

Alternate methodologies submitted by States that are approved as Federally certified risk adjustment methodologies for 2014 will be published in the final 2014 HHS notice of benefit and payment parameters. We envision working closely with States during the development of their alternate methodologies to ensure that they meet the criteria described above. We expect to have a number of meetings with any State proposing an alternate methodology during the certification process. During these meetings, we intend to provide input to States on whether their proposed alternate

methodologies meet the given criteria. States will then have the opportunity to modify their alternate methodologies and request further review. We are committed to working with States in a collaborative fashion on these matters.

c. Payment and Charges

In the preamble to the Premium Stabilization Rule, we noted that we plan to establish a national method for calculation of payments and charges. The goal of the proposed payment transfer formula is to reduce the impact of risk selection on premiums while ensuring that payments and charges net to zero. A national method for the calculation of payments and charges would ensure a degree of consistency in the risk adjustment program from State to State, while allowing States to vary other elements of the program. However, we recognize that a uniform national method could limit States' flexibility in developing their alternate risk adjustment methodologies.

The proposed payment transfer formula (regardless of whether for a plan liability or total expenditure approach, as described in section III.B.3.10. utilizes the plan average risk score and the State average premium. The proposed HHS payment transfer formula is based on a plan liability model. States can adapt this formula to a total expenditure model by replacing the plan liability risk score in the formula with the total expenditure risk score of a plan, and multiplying the total expenditure risk score by an adjustment for AV. We propose to provide States the flexibility to select the adjustments used for the calculation of payments and charges in their alternate methodologies. The proposed HHS payment transfer formula will make adjustments for AV, age rating factor, geographic cost differences, and induced demand. States have the option of including or excluding any of these adjustments. States may also include other adjustments in the calculation of payments and charges under their alternate methodologies. Adjustments can be added to or removed from the basic payment transfer formula as long as these factors are

normalized, so that transfers net to zero. We will work with States on a one-on-one basis in developing their payment transfer formulae for their alternate methodologies.

States may construct particular adjustment factors in different ways. For example, HHS would determine an adjustment for geographic cost differences by comparing the area premium to the State average premium. A State may elect to develop a different factor to adjust for geographic cost differences. As described above, we ask States to provide the adjustments, the associated factors or curves, and the rationale for the adjustments they plan to use for their alternate methodologies as part of their response to the criterion proposed in §153.330(b)(1). We believe this approach ensures a degree of consistency while allowing States flexibility for calculating payments and charges.

5. Risk Adjustment Data Validation

In §153.350, we specified standards applicable to States, or HHS on behalf of States, in validating risk adjustment data. Specifically, we required States operating risk adjustment programs and HHS to establish a process to appeal findings from data validation and allow the State, or HHS on behalf of the State, to adjust risk adjustment payments and charges based on data validation findings. The credibility of risk adjustment data, which results from a reliable data validation process, is important to establishing issuer confidence in the risk adjustment program. Moreover, as error rates derived from the results of data validation may be used to make adjustments to the plan average actuarial risk calculated for a risk adjustment covered plan, the data validation process will ensure that such transfers accurately reflect each plan's average enrollee risk. In this proposed rule, we build upon guidance released in the Risk Adjustment Bulletin and in discussions held with stakeholders at the Risk Adjustment Spring Meeting to define data validation standards applicable to issuers of risk adjustment covered plans when HHS operates risk adjustment on behalf of a State.

We propose that, beginning in 2014, HHS conduct a six-stage data validation program when operating risk adjustment on behalf of a State: (1) sample selection; (2) initial validation audit; (3) second validation audit; (4) error estimation; (5) appeals; and (6) payment adjustments. We discuss these concepts in greater detail below. We note States are not required to adopt this HHS data validation methodology.

a. Data Validation Standards When HHS Operates Risk Adjustment

We propose to add a new subsection, §153.630, which sets forth risk adjustment data validation standards applicable to all issuers of risk adjustment covered plans when HHS is operating risk adjustment. In §153.630(a), we propose a general standard that issuers of risk adjustment covered plans have an initial and second validation audit of risk adjustment data. These are the second and third stages of the six-stage data validation program described below.

b. Data Validation Process When HHS Operates Risk Adjustment

(1) Sample Selection

Under the Premium Stabilization Rule, HHS will validate a statistically valid sample from each issuer that submits data for risk adjustment every year. As described above, sample selection is the first stage of HHS' six-stage risk adjustment data validation process. HHS would select the sample for each issuer of a risk adjustment covered plan in accordance with standards discussed in this section. HHS would ensure that the data validation process reviews an adequate sample size of enrollees such that the estimated payment errors will be statistically sound and so that enrollee-level risk score distributions reflect enrollee characteristics for each issuer. The sample would cover applicable subpopulations for each issuer. For example, enrollees with and without risk adjustment diagnoses would be included in the sample. In determining the appropriate sample size for data validation, we recognize the need to strike a balance between

ensuring statistical soundness of the sample and minimizing the operational burden on issuers, providers, and HHS.

We expect that each issuer's initial validation audit sample within a State will consist of approximately 300 enrollees, with up to two-thirds of the sample consisting of enrollees with HCCs.

Note that any assumptions used by HHS that underlie the sample size determinations in the initial years of the program may be updated as we gain experience performing data validation for risk adjustment. Additionally, we will continue to evaluate population distributions to determine the sample subpopulations. We seek comment on this approach to sample selection, particularly on use of existing data validation program results that could be used to derive comparable estimates under this program.

(2) Initial Validation Audit

Once the audit samples are selected by HHS, issuers would conduct independent audits of the risk adjustment data for their initial validation audit sample enrollees, as set forth in §153.630(b). In §153.630(b)(1), we propose that issuers of risk adjustment covered plans engage one or more auditors to conduct these independent initial validation audits. We propose in §153.630(b)(2) through (4) that issuers ensure that initial validation auditors are reasonably capable of performing the audit, that the audit is completed, that the auditor is free from conflicts of interest, and that the auditor submits information regarding the initial validation audit to HHS in the manner and timeframe specified by HHS. These proposed requirements would ensure that the initial validation audit is conducted according to minimum audit standards, and that issuers or auditors transmit necessary information to HHS for use in the second validation audit.

For the enrollees included in the HHS-specified audit sample, issuers of risk adjustment covered plans would provide enrollment and medical record documentation to the initial validation auditor to validate the demographic and health status data of each enrollee, as described above.[21] We anticipate that issuers would have considerable autonomy in selecting their initial validation auditors. However, initial validation auditors must conduct data validation audits in accordance with audit standards established by HHS. We have identified three methods for establishing these standards:

- HHS or an HHS-designated entity could prospectively certify auditors for these audits;
- HHS could develop standards that issuers and initial validation auditors would follow, without any requirement of prior HHS certification or approval of auditors; or
- HHS could issue non-binding, "best practice" guidelines for issuers and auditors.

We request comment on these approaches and on any standards or best practices that should be applicable. Upon conclusion of the initial validation audit process, issuers of risk adjustment covered plans would be required to submit audit findings to HHS in accordance with the standards established by HHS.

(3) Second Validation Audit

We propose to retain an independent second validation auditor to verify the accuracy of the findings of the initial validation audit. We would select a sub-sample of initial validation audit sample enrollees for review by the second validation auditor. We would provide additional information pertaining to its approach for selecting the second validation audit sub-sample in future guidance. The second validation auditor would

[21] We note that issuers will need to link information on the dedicated distributed data environments with the information specified this proposed rule for data validation purposes.

only review enrollee information that was or was to be originally presented during the initial validation audit.

In §153.630(c), we establish standards for issuers of risk adjustment covered plans related to HHS' second validation audit of risk adjustment data. These requirements establish minimum standards for issuer compliance with the second validation audit. We propose that an issuer of a risk adjustment covered plan comply with, and ensure the initial validation auditor complies with, HHS and the second validation auditor in connection with the second validation audit. Specifically, issuers would submit (or ensure their initial validation auditor submits) data validation information, as specified by HHS, from their initial validation audit for each enrollee included in the second validation audit sub-sample. Issuers would also transmit all information to HHS or its second validation auditor in an electronic format to be determined by HHS. The second validation auditor would inform the issuers of error findings based on their review of enrollees in the second validation audit subsample.

(4) Error Estimation

We would estimate risk score error rates based on the findings from the data validation process. Risk adjustment errors may include any findings that result in a change to the demographic or health status components of an enrollee's risk score. This may include errors due to incorrect diagnosis coding, invalid documentation, missing or insufficient medical record documentation, or incorrect determination of enrollee demographic information. We are considering estimating changes in plan average actuarial risk for the issuer error rates calculated from data validation activities, with a suitable confidence interval. We plan to conduct analyses to determine the most effective methodology for adjusting plan risk scores for calculating risk adjustment payment transfers.

Upon completion of the second validation audit and error estimation stages of HHS's data validation process, we would provide each issuer with enrollee-level audit results and error estimates at the issuer level, based on the methodology described above.

We are requesting comments on the described error estimation concepts.

c. Appeals

In accordance with §153.350(d), we provide an administrative process to appeal findings with respect to data validation. We propose in §153.630(d) that issuers may appeal the findings of a second validation audit or the application of a risk score error rate to its risk adjustment payments and charge. We anticipate that appeals would be limited to instances in which the audit was not conducted in accordance with second validation audit standards established by HHS. We will provide further detail on this process in future guidance or regulation, as appropriate.

d. Payment Adjustments

In accordance with 153.350(b), HHS may adjust charges and payments to a risk adjustment covered plan based on the recalculation of plan average actuarial risk following the data validation process. We anticipate that HHS would use a prospective approach when making such payment adjustments. We believe a prospective approach is appropriate because we anticipate issuers' error estimates to be relatively stable from year to year. Further, we believe it is necessary to use a prospective approach to allow issuers and HHS sufficient time to complete the validation and appeals processes. Transfers for a given benefit year would likely be invoiced before the data validation process for that benefit year is completed. The prospective approach would ensure that issuers would not be subject to a second transfer for the benefit year. We would use an issuer's data validation error estimates from the prior year to adjust the issuer's average risk score in the current year for transfers. We request comments on this approach.

As described previously, because the risk adjustment program transfers funds between issuers in a zero sum manner, trust in the system is important for the success of the program. We have proposed the data validation process described here to ensure that issuers comply with risk adjustment standards and to promote confidence in the risk adjustment program. As such, we propose in paragraph §153.630(e) that HHS may adjust payments and charges for issuers that do not comply with the initial or second validation audit standards set forth in §153.630(b) and (c). We seek comment on the types of adjustments that may be assessed on issuers that do not comply with parameters set forth in this proposed rule.

e. Proposed HHS-Operated Data Validation Process for Benefit Years 2014 and 2015

We propose that issuers of risk adjustment covered plans adhere to the data validation process outlined above beginning with data for the 2014 benefit year. However, we recognize the complexity of the risk adjustment program and the data validation process, and the uncertainty in the market that will exist in 2014. In particular, we are concerned that adjusting payments and charges without first gathering information on the prevalence of error could lead to a costly and potentially ineffective audit program. Therefore, we are proposing that issuers conduct an initial validation audit and that we conduct a second validation audit for benefit year 2014 and 2015, but that we would not adjust payments and charges based on validation findings during these first two years of the program (that is, we would not adjust payments and charges based on validation results on data from the 2014 and 2015 benefit years). However, we would conduct all aspects of the data validation program other than adjusting payments and charges (though we would make adjustments under the proposed §153.630(e)) during the first two years of the program, including requiring the initial validation and second validation audits, and calculating error rates for each issuer. We believe that the data validation conducted

during the first two years of the program will serve an important educational purpose for issuers and providers. Although we are proposing not to adjust payments and charges as a correction based on error estimates discovered, we note that other remedies, such as prosecution under the False Claims Act, may be applicable to issuers not in compliance with the risk adjustment program requirements. We have tried to balance the need to provide assurance to issuers that all risk adjustment data is adequate and that calculations are appropriate with the desire to limit burden and uncertainty in the initial years of program operation.

This approach was taken with the Medicare Part C risk adjustment program – the data validation audit process was observed for several years before payment adjustments were made. We plan to work with issuers during the first two years of the data validation program, and will seek additional input on how to improve the process. We are requesting comments on this approach, particularly with respect to improvements to the data validation process generally, whether there are alternatives to forgoing changes to payments and charges that we should adopt, and what methods we should adopt to ensure data integrity in the first two years of the program.

As part of our effort to refine the data validation program during the first two years, we are considering publishing a report on the error rates discovered during these first two years, and propose to use these results to inform our audit program. For this report, we may conduct special studies of the second validation audits aimed at comparing the error rate results of the initial validation auditors and second validation audits. For example, the second validation audits may be used to assess the extent to which auditor error contributed to the initial validation audit risk score error rate findings, and to determine whether discrepancies between the results of the two audits may result

in adjustments to the estimated error rates calculated for the initial validation audit process.

The second validation audits could also be used to assess the accuracy of the initial audit error rates at either the auditor or issuer level. Conducting the second validation audits at the auditor level in future years would allow us to examine the accuracy of the initial validation audit without having to draw large initial validation audit record samples from each issuer that participates in risk adjustment. We anticipate that a small number of audit firms will perform the majority of initial audits. We seek comment on the approaches outlined here, as well as additional approaches to data validation for risk adjustment.

f. Data Security and Transmission

In §153.630(f), we establish data security and transmission requirements for issuers related to the HHS data validation process. These requirements establish the manner in which issuers and auditors must transmit audit information, and ensure that any enrollee information that is transmitted is protected. In §153.630(f)(1), we propose that issuers submit any risk adjustment data and source documentation specified by HHS for the initial and second validation audits to HHS in the manner and timeframe established by HHS. We propose in §153.630(f)(2) that, in connection with the initial validation audit, the second validation audit, and any appeals, an issuer must ensure that it and its initial validation auditor complies with the security standards described at §164.308, §164.310, and §164.312.

C. Provisions and Parameters for the Transitional Reinsurance Program

The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. The reinsurance program is designed to alleviate the need to

build into premiums the risk of enrolling individuals with significant unmet medical needs. By stabilizing premiums in the individual market equitably throughout the United States, the reinsurance program is intended to help millions of Americans purchase affordable health insurance, reduce unreimbursed usage of hospital and other medical facilities by the uninsured, and thereby lower medical expenses and premiums for all people with private health insurance.

We aim to administer the reinsurance program to provide reinsurance payments in an efficient, fair, and accurate manner, where they are needed most, to effectively stabilize premiums nationally. In addition, we intend to implement the reinsurance program in a manner that minimizes the administrative burden of collecting contributions and making reinsurance payments. For example, HHS intends to collect contributions from health insurance issuers and self-insured group health plans[22] in all States, including States that elect to operate their reinsurance programs. This would allow for a centralized and streamlined process for the collection of contributions, and would avoid inefficiencies related to using different processes in different States. This would also eliminate the need for States to send to HHS the contributions collected for the U.S. Treasury. Federal collections will also leverage economies of scale, reducing the overall administrative costs of the reinsurance program.

We also intend to simplify collections by using a national per capita uniform contribution rate. Collection based on a per capita rate is simpler and easier to implement than other methods. In addition, in the HHS-operated reinsurance program, we propose

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[22] As discussed in more detail below, Section 1341 of the Affordable Care Act provides that health insurance issuers and "third party administrators on behalf of group health plans" must make contributions to an applicable reinsurance entity. Although self-insured group health plans are ultimately liable for reinsurance contributions, a third-party administrator or administrative-services-only contractor may be utilized for transfer of the reinsurance contributions. For consistency, throughout this proposed rule, we will refer to these contributing entities as self-insured group health plans.

to calculate reinsurance payments using the same distributed approach for data collection that we propose for operating risk adjustment on behalf of States.[23] This will permit issuers to receive reinsurance payments using the same systems established for the risk adjustment program, resulting in less administrative burden and lower costs, while maintaining the security of identifiable health information.

In this proposed rule, we propose modifications and refinements to the reinsurance program standards for States and issuers. These modifications further reduce the administrative burden of collecting contributions and making reinsurance payments, and will more effectively stabilize premiums in the individual markets in all States across the country. In particular, we propose uniform reinsurance payment parameters to be used across all States. These payment parameters would be used to calculate reinsurance payments in all States, regardless of whether the State or HHS on behalf of the State operates the reinsurance program. We also propose that HHS will collect contributions from health insurance issuers and self-insured group health plans in all States, including States that elect to operate their own reinsurance programs. In addition, we propose a national, uniform calendar under which reinsurance contributions will be collected from all contributing entities, and reinsurance payments will be disbursed to issuers of non-grandfathered individual market plans. Furthermore, we propose to distribute reinsurance payments based on the need for reinsurance payments in each State. Because reinsurance contributions and reinsurance needs will vary significantly between States, we believe a policy of disbursing reinsurance payments solely in a State in which the contributions are collected would not meet the States' individual reinsurance needs, would not fulfill HHS's obligation to provide equitable allocation of these funds under section

[23] See our discussion of this distributed approach in section III.G. of this proposed rule.

1341(b)(2)(B) of the Affordable Care Act as well as would disbursing reinsurance payments in the manner proposed in this proposed rule.

We note that these proposals reflect changes from policies set forth in the Premium Stabilization Rule. The principal proposed changes from the policies in the Premium Stabilization Rule include:

- Uniform reinsurance payment parameters to be used by all States;
- A uniform reinsurance contribution collection and payment calendar;
- A one-time annual reinsurance contribution collection, instead of quarterly collections in a benefit year;
- Collection of reinsurance contributions by HHS under the national contribution rate from both health insurance issuers and self-insured group health plans;
- A limitation on States' ability to change reinsurance payment parameters from those that HHS establishes in the annual HHS notice of benefit and payment parameters — a State may only propose supplemental reinsurance payment parameters if the State elects to collect additional funds for reinsurance payments or use additional State funds for reinsurance payments; and
- A limitation on States that seek additional reinsurance funds for administrative expenses, such that the State must have its applicable reinsurance entity collect those additional funds.

These modifications are proposed in addition to other regulatory changes outlined below to ensure effective administration of the transitional reinsurance program.

1. State Standards Related to the Reinsurance Program

a. State notice of benefit and payment parameters

HHS intends to establish a reinsurance contribution and payment process and reinsurance payment parameters that will be applicable in all States, and proposes to

amend the requirements set forth in the Premium Stabilization Rule accordingly. First, instead of allowing a State establishing its own reinsurance program to modify, via a State notice of benefit and payment parameters, the data collection frequency for issuers to receive reinsurance payments from those specified in this proposed rule, we propose that all States be required to use the annual payment schedule set forth in this proposed rule. As such, we propose to amend §153.100(a)(1) to remove the reference to State modification of data collection frequency. Under this proposal, the frequency with which data must be submitted for reinsurance payments would follow a national schedule. Under §153.100(a)(1), HHS would continue to allow a State establishing a reinsurance program to modify the data requirements for health insurance issuers to receive reinsurance payments, provided that the State publishes a State notice of benefit and payment parameters and specifies these modifications in that notice.

We propose to also amend §153.100 by deleting subparagraph (a)(5), and to add §153.232 to direct a State that elects to collect additional reinsurance contributions for purposes of making additional reinsurance payments or to use additional funds for reinsurance payments under §153.220(d) to publish supplemental State reinsurance payment parameters in its State notice of benefit and payment parameters under proposed §153.100(a)(2).

The Premium Stabilization Rule stated that a State establishing a reinsurance program may either directly collect additional reinsurance contributions for administrative expenses and reinsurance payments when a State elects to collect from health insurance issuers, or may elect to have HHS collect contributions from health insurance issuers for administrative expenses. However, we now propose to change this policy such that a State operating its own reinsurance program will no longer be permitted to have HHS collect additional funds for administrative expenses. To create

the most effective reinsurance program, we are proposing to collect reinsurance contributions on behalf of all States from both health insurance issuers and self-insured group health plans in the aggregate, and we propose to disburse reinsurance payments based on a State's need for reinsurance payments, not based on where the contributions were collected. As a result, HHS will no longer be able to attribute additional funds for administrative expenses back to a State. We propose to amend §153.100(a)(3) to clarify that these additional contributions may only be collected by a State operating its own reinsurance program in that State.

We also propose to delete §153.110(d)(5) and §153.210(a)(2)(iii), because we propose to disburse reinsurance contributions in proportion to the need for reinsurance payments. Thus, a State's allocation of reinsurance contributions among applicable reinsurance entities is no longer necessary. Accordingly, we also propose to delete §153.110(d)(2), which requires that a State notice include an estimate of the number of enrollees in fully insured plans with the boundaries of each reinsurance entity.

We further propose that HHS collect all contributions under a national contribution rate from all health insurance issuers in all States. We therefore propose to delete all requirements regarding the State collection of reinsurance contributions from health insurance issuers under the national contribution rate, including §153.100(a)(2) and §153.110(b), removing the requirement that a State publish a State notice of benefit and payment parameters to announce its intention to collect reinsurance contributions from health insurance issuers. We also propose to delete §153.110(d)(4) which requires States to publish in their State notices an estimate of the reinsurance contributions that will be collected by each applicable reinsurance entity.

b. Reporting to HHS

We propose to amend §153.210 by adding paragraph (e), which directs a State that establishes a reinsurance program to provide information regarding all requests for reinsurance payments received from all reinsurance-eligible plans for each quarter during the benefit year. We propose to use this information to monitor requests for reinsurance payments and reinsurance contribution amounts throughout the benefit year, to ensure equitable reinsurance payments in all States.

To provide issuers in the individual market with information to assist in developing rates in subsequent benefit years, we propose in §153.240(b)(2) that a State, or HHS on behalf of the State, provide issuers of reinsurance-eligible plans with quarterly estimates of the expected requests for reinsurance payments for the reinsurance-eligible plan under both the national payment parameters and any State supplemental payments parameters set forth under §153.232, as determined by HHS or the State's reinsurance entity, as applicable. These quarterly estimates would provide issuers with the timely information that is needed to support the calculation of expected claims assumptions that are key to rate development and ultimately, premium stabilization. We expect that an issuer of a reinsurance-eligible plan will use this information to estimate total reinsurance payments to be received for future benefit years, and will use its best estimates of future payments to reduce premiums. It is our expectation that reinsurance payments will be used in the rate setting process to reduce premiums, fulfilling the goals of the reinsurance program.

The national reinsurance payment parameters are calculated to expend all reinsurance contributions collected under the national contribution rate. Similarly, the additional funds collected by the State for reinsurance payments or additional State funds are to be reasonably calculated, under proposed §153.232(a)(2), to cover all additional

reinsurance payments projected to be made under the State supplemental payment parameters. Because the national payment parameters and State supplemental payment parameters apply to two separate funds, we believe that it is important for a State to distinguish between reinsurance payments made under the two different sets of parameters so that reinsurance-eligible plans can understand how each reinsurance program will likely affect claims costs. HHS intends to collaborate with issuers and States to develop these early notifications. We therefore propose in §153.240(b) that each State, or HHS on behalf of the State, ensure that each applicable reinsurance entity provides to issuers the expected requests for reinsurance payments made under §153.410 and §152.232 for all reinsurance-eligible plans in the State within 60 days of the end of each quarter, with a final report for a benefit year sent to issuers no later than June 30 of the year following the applicable benefit year.

For efficient administration of the reinsurance program, HHS must ensure that reinsurance contributions are appropriately spent on reinsurance payments. To this end, we intend to obtain reports regarding reinsurance payments and administrative expenses from States that establish a reinsurance program. We intend to provide details of these reports in future regulation and guidance, along with similar standards for Exchanges, the risk adjustment program, and other Affordable Care Act programs.

c. Additional State Collections

Under the current §153.220(g) of the Premium Stabilization Rule (which we now propose to redesignate as paragraph (d)), a State operating its own reinsurance program may elect to collect more than the amounts based on the national contribution rate set forth in the annual HHS notice of benefit and payment parameters for administrative expenses of the applicable reinsurance entity or additional reinsurance payments. Under §153.220(h)(1) of the Premium Stabilization Rule (now proposed to be designated as

§153.220(d)(2)), a State must notify HHS within 30 days after publication of the draft annual HHS notice of benefit and payment parameters for the applicable benefit year of the additional contribution rate that it elects to collect.

We note that although the proposed §153.220(d) specifies that a State may elect to collect additional reinsurance contributions for administrative expenses or reinsurance payments, nothing in section 1341 of the Affordable Care Act or this proposed rule gives a State the authority to collect from self-insured group health plans covered by ERISA, and that Federal law generally preempts State law that relates to an ERISA-covered plan.

d. State Collections

We propose that HHS collect reinsurance contributions from all contributing entities regardless of whether a State elects to operate the reinsurance program or have HHS operate the reinsurance program on its behalf. As reinsurance payments will be calculated based on aggregate contributions collected and total requests for reinsurance payments nationally, we believe that a centralized collection process for all contributing entities will facilitate the allocation and disbursement of funds. This will also streamline the contribution submissions process for health insurance issuers who operate in multiple States.

We propose to amend §153.220(a) to set forth that if a State establishes a reinsurance program, HHS will collect all reinsurance contributions from all contributing entities for that State under the national contribution rate. We, therefore, propose to delete §153.220(a)(2), as we are no longer requiring a State to ensure that the applicable reinsurance entity accepts contributions for reinsurance contribution enrollees who reside in that State with respect to health insurance issuers from HHS. In accordance with the proposed change regarding State collections, we also propose to delete §153.220(b) of the Premium Stabilization Rule, which directs a State operating its own reinsurance program

to notify HHS of its intention to collect from its health insurance issuers for the 2014 benefit year by December 1, 2012. If finalized as proposed, we would consider any notification a State made to HHS pursuant to §153.220(b) of the Premium Stabilization Rule prior to the finalization of this proposed rule to be withdrawn. We propose to delete §153.220(f) of the Premium Stabilization Rule which includes requirements on the State collection of reinsurance contributions from health insurance issuers.

Section 153.220(e) of the Premium Stabilization Rule requires that reinsurance contributions are allocated as required in the annual HHS notice of benefit and payment parameters for the applicable benefit year such that contributions allocated for reinsurance payments within the State are only used for reinsurance payments, and contributions allocated for payments to the U.S. Treasury are paid in the timeframe and manner established by HHS. We also propose that any additional contributions collected under §153.220(d)(1)(ii) and allocated for reinsurance payments under the State supplemental reinsurance payment parameters must be used to make reinsurance payments. We also propose under §153.220(d)(3) that States may use additional funds, which were not collected as additional reinsurance contributions, to make reinsurance payments under the State supplemental reinsurance payment parameters. This would allow States to use other revenue sources, including funds collected for State high-risk pools as discussed below, for supplemental reinsurance payments, as determined by a State. This proposal ensures that additional State collections for reinsurance payments and other State funds, as applicable, may be used to reduce premiums.

e. High-Risk Pools

We are not proposing further requirements for State high-risk pools beyond those currently provided at §153.250. As stated in that section, a State must eliminate or modify its high-risk pool to the extent necessary to carry out the transitional reinsurance

program. However, any changes made to a State high-risk pool must comply with the terms and conditions of Grants to States for Operation of Qualified High-Risk Pools (CFDA 93.780), as applicable. Under §153.400(a)(2)(iii), State high-risk pools are excluded from making reinsurance contributions and cannot receive reinsurance payments. Because State high-risk pools and the transitional reinsurance program both target high-cost enrollees, high-risk pools can operate in parallel with the reinsurance program, serving a distinct subset of the target population. States have the flexibility to decide whether to maintain, phase out, or eliminate their high-risk pools.

The Affordable Care Act permits a State to coordinate its high-risk pool with the reinsurance program "to the extent not inconsistent" [24] with the statute. Thus, a State may coordinate the entry of the State's high-risk pool enrollees into the Exchange. HHS is examining ways in which a State could continue its program to complement Exchange coverage. We clarify that nothing in the Premium Stabilization Rule prevents a State that establishes its own reinsurance program from using State money designated for its own high-risk pool towards the reinsurance program. However, a State may not use funds collected for the reinsurance program for its high-risk pool. As indicated in the Premium Stabilization Rule, funds collected for the transitional reinsurance program can only be used for the purpose of making payments under the reinsurance program or for administering that program. Finally, a State could designate its high-risk pool as its applicable reinsurance entity, provided that the high-risk pool meets all applicable criteria for being an applicable reinsurance entity.

[24] See section 1341(d) of the Affordable Care Act.

2. Contributing Entities and Excluded Entities

Section 1341 of the Affordable Care Act provides that health insurance issuers and third party administrators on behalf of group health plans must make payments to an applicable reinsurance entity. Thus, with respect to insured coverage, issuers are liable for making reinsurance contributions. With respect to self-insured group health plans, the plan is liable, although a third-party administrator or administrative-services-only contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion. A self-insured, self-administered group health plan without a third-party administrator or administrative-services-only contractor would make its reinsurance contributions directly.[25]

Under section 1341(b)(3)(B)(i) of the Affordable Care Act, contribution amounts for reinsurance are to reflect, in part, an issuer's "fully insured commercial book of business for all major medical products." We interpret this statutory language to mean that an issuer will not be required to make reinsurance contributions for coverage that is non-commercial, or that is not "major medical coverage."[26] We believe it is implicit in the statute that contributions are not required for health insurance coverage that is not regulated by a State department of insurance and written on a policy form filed with and approved by a State department of insurance (but contributions are generally required for self-insured plans even though they are not regulated by a State department of insurance). We discuss below our intent to exclude certain types of plans.

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[25] In the Certain Preventive Services under the Affordable Care Act Advanced Notice of Proposed Rulemaking (77 FR 16501) published March 21, 2012, potential changes to the reinsurance contributions were contemplated with regard to a potential religious accommodation for contraception coverage for certain self-funded plans. If the rules regarding the religious accommodation include changes to the reinsurance contribution, this policy may be changed accordingly.

[26] We note that under the definition of reinsurance-eligible plan in §153.20, if a plan is excluded from making reinsurance contributions, the plan is excluded from the reinsurance program altogether, (that is, a plan excluded from making reinsurance contributions cannot receive reinsurance payments).

Major medical coverage: Section 1341(b)(3)(B)(i) of the Affordable Care Act refers to "major medical products," but does not define the term. For the purpose of the reinsurance program, our view is that coverage provided under a major medical product (which we refer to in Part 153 as "major medical coverage") is health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings, including inpatient, outpatient, and emergency room settings.[27] Thus, for purposes of the reinsurance program, we believe that coverage that is limited in scope (for example, dread disease coverage, hospital indemnity coverage, stand-alone vision coverage, or stand-alone dental coverage) or extent (for example, coverage that is not subject to the Public Health Service Act section 2711 and its implementing regulations) would not be major medical coverage.

In this proposed rule, we also propose to clarify that when an individual has both Medicare coverage and employer-provided group health coverage, Medicare Secondary Payer (MSP) rules under section 1862(b) of the Social Security Act would be applicable, and the group health coverage would be considered major medical coverage only if the group health coverage is the primary payer of medical expenses (and Medicare is the individual's secondary payer) under the MSP rules. For example, a working 68-year-old employee enrolled in a group health plan who, under the MSP rules, is a beneficiary for whom Medicare is the secondary payer would be counted for purposes of reinsurance contributions. However, a 68-year-old retiree enrolled in a group health plan who, under the MSP rules, is a beneficiary for whom Medicare is the primary payer would not be

[27] See Section 7F of the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act, (MDL-171) for a definition of major medical expense coverage. Available at: http://naic.org/committees_index_model_description_a_c.htm#accident_health.

counted for purposes of reinsurance contributions. Similarly, an individual covered under a group health plan with only Medicare Part A (hospitalization) benefits (where Medicare is the primary payer), would not be counted for purposes of reinsurance contributions because the group health coverage would not be considered major medical coverage. We also intend that individuals entitled to Medicare because of disability or end-stage renal disease that have other primary coverage under the MSP rules be treated consistently with the working aged, as outlined above. We seek comment on this proposal.

Commercial book of business: Section 1341(b)(3)(B)(i) of the Affordable Care Act refers to a "commercial book of business," which we interpret to refer to large and small employer group policies and individual market policies. For example, products offered by an issuer under Medicare Part C or D would be part of a "governmental" book of business, not a commercial book of business. Similarly, a plan or coverage offered by a Tribe to Tribal members and their spouses and dependents, and other persons of Indian descent closely affiliated with the Tribe in the capacity of the Tribal members as Tribal members (and not in their capacity as current or former employees of the Tribe or their dependents) would not be part of a commercial book of business, but a plan or coverage offered by the Federal government, a State government or a Tribe to employees (or retirees or dependents) because of a current or former employment relationship would be part of a commercial book of business. We seek comment on this interpretation.

Policy filed and approved in a State. We propose that a group or individual policy for health insurance coverage not filed and approved in a State be excluded from reinsurance contributions. To illustrate, if group coverage for employees substantially all of whom work outside the United States – "expatriate coverage" – is not written on a form filed with and approved by a State department of insurance, we propose to exclude

it from reinsurance contributions because that coverage is not within the jurisdiction of a State department of insurance and the Affordable Care Act generally does not apply. On the other hand, insured group "expatriate" coverage written on a form filed with and approved by a State department of insurance would be subject to the Affordable Care Act and required to make reinsurance contributions. Individual coverage for overseas travel would be similarly treated.

Therefore, we propose to amend §153.400(a)(1) to state that a contributing entity must make reinsurance contributions on behalf of its self-insured group health plans and health insurance coverage except to the extent that:

(1) The plan or coverage is not major medical coverage;

(2) In the case of health insurance coverage, the coverage is not considered to be part of an issuer's commercial book of business; or

(3) In the case of health insurance coverage, the coverage is not issued on a form filed and approved by a State insurance department.[28] We seek comment on this proposal.

Under the requirements proposed in §153.400(a)(1), and for clarity, we propose in §153.400(a)(2) to explicitly exclude the following types of plans and coverage from reinsurance contributions.

(a) Excepted benefits: We are not proposing a change in policy with respect to plans or health insurance coverage that consist solely of excepted benefits as defined by section 2791(c) of the PHS Act, as currently described in §153.400(a)(2) of the Premium Stabilization Rule.

[28]We note that contributions are generally required for self-insured plans even if not regulated by a State department of insurance because self-insured plans are not typically regulated by these entities.

(b) Private Medicare, Medicaid, CHIP, State high-risk pools, and basic health plans: Both Medicare and Medicaid have fee-for-service or traditional components, as well as managed care components, in which private health insurance issuers, under contract with HHS, deliver the requisite benefits. As discussed in the preamble to the Premium Stabilization Rule, these private Medicare or Medicaid plans are excluded from reinsurance contributions because they are not part of a commercial book of business. We also clarify that for purposes of reinsurance contributions, programs under the CHIP, Federal and State high-risk pools (including the Pre-Existing Condition Insurance Plan Program under section 1101 of the Affordable Care Act), and basic health plans described in section 1331 of the Affordable Care Act are similarly excluded from reinsurance contributions because they are not part of a commercial book of business.

(c) Health Reimbursement Arrangements (HRAs) integrated with a group health plan: HRAs are group health plans that are governed by IRS Notice 2002-45 (2002-2 CB 93) and subsequent guidance. An employer credits an amount to each eligible employee's HRA which the employees may use for allowable medical expenses. An HRA that is integrated with a group health plan is excluded from reinsurance contributions because it is integrated with major medical coverage.[29] We note that reinsurance contributions generally would be required for that group health plan.

(d) Health saving accounts (HSAs): Eligible individuals covered by a high deductible health plan may have the option of contributing to an HSA. An HSA is an individual arrangement governed by section 223(d) of the Code and subsequent guidance that consists of a tax-favored account held in trust to accumulate funds that can be used to pay qualified medical expenses of the beneficiary. An HSA is offered along with a high

[29] The preamble to interim final regulations under section 2711 of the PHS Act provides that an HRA satisfies the prohibition on annual and lifetime limits in section 2711 when it is integrated as part of a group health plan with other coverage that satisfies section 2711. See 75 FR 37190-37191.

deductible health plan. For purposes of reinsurance contributions, we believe that an HSA is not major medical coverage because it consists of a fixed amount of funds that are available for both medical and non-medical purposes, and would be excluded from reinsurance contributions. We note that reinsurance contributions generally would be required for the high deductible health plan because we believe that it would constitute major medical coverage.

(e) Health flexible spending arrangements (FSAs): Health FSAs are usually funded by an employee's voluntary salary reduction contributions under section 125 of the Code. Because section 9005 of the Affordable Care Act limits the annual amount that may be contributed by an employee to a health FSA to $2,500, we believe that a health FSA is not major medical coverage under this rule, and therefore would be excluded from reinsurance contributions.

(f) Employee assistance plans, disease management programs, and wellness programs: Employee assistance plans, disease management programs, and wellness programs typically provide ancillary benefits to employees that in many cases do not constitute major medical coverage. Employers, plan sponsors, and health insurance issuers have flexibility in designing these programs to provide services to provide additional benefits to employees, participants, and beneficiaries. If the program (whether self-insured or insured) does not provide major medical coverage, we propose to exclude it from reinsurance contributions. We also note that employers that provide one or more of these ancillary benefits often sponsor major medical plans, which will be subject to reinsurance contributions, absent other excluding circumstances.

(g) Stop-loss and indemnity reinsurance policies: For the purpose of reinsurance, we propose to exclude stop-loss insurance and indemnity reinsurance because they do not constitute major medical coverage for the applicable covered lives. Generally, a stop-loss

policy is an insurance policy that protects against health insurance claims that are catastrophic or unpredictable in nature and provides coverage to self-insured group health plans once a certain level of risk has been absorbed by the plan. Stop-loss insurance allows an employer to self-insure for a set amount of claims costs, with the stop-loss insurance covering most or all of the remainder of the claims costs that exceed the set amount. An indemnity reinsurance policy is an agreement between two or more insurance companies under which the reinsuring company agrees to accept and to indemnify the issuing company for all or part of the risk of loss under policies specified in the agreement and the issuing company retains its liability to, and its contractual relationship with, the applicable lives covered. We believe these types of policies were not intended to be subject to the reinsurance program. No inference is intended as to whether stop-loss or reinsurance policies constitute health insurance policies for purposes other than reinsurance contributions.

(h) Military Health Benefits: TRICARE is the component of the Military Health System that furnishes health care insurance to active duty and retired personnel of the uniformed services (and covered dependents) through private issuers under contract. Although TRICARE coverage is provided by private issuers, it is not part of a commercial book of business because the relationship between the uniformed services and service members differs from the traditional employer-employee relationship in certain important respects. For example, service members may not resign from duty during a period of obligated service, may not form unions, and may be subject to discipline for unexcused absences from duty. Consequently, our view is that such military health insurance is excluded from reinsurance contributions.

In addition to TRICARE, the Military Health System also includes health care services that doctors, dentists, and nurses provide to uniformed services members on

military bases and ships. The Veterans Health Administration within the U.S. Department of Veterans Affairs provides health care to qualifying veterans of the uniformed services at its outpatient clinics, hospitals, medical centers, and nursing homes. Similarly, because we do not consider these programs to be part of a commercial book of business, our view is that such military health programs are excluded from reinsurance contributions.

(i) Tribal coverage: As discussed above, we propose to exclude plans or coverage (whether fully insured or self-insured) offered by a Tribe to Tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the Tribe) in the capacity of the Tribal members as Tribal members (and not in their capacity as current or former employees of the Tribe or their dependents) as this would not be part of a commercial book of business. However, a plan or coverage offered by the Federal government, a State government or a Tribe to employees (or retirees or dependents) because of a current or former employment relationship would be part of a commercial book of business. Similarly, coverage provided to Indians through programs operated under the authority of the Indian Health Service (IHS), Tribes or Tribal organizations, or Urban Indian organizations, as defined in section 4 of the Indian Health Care Improvement Act would be excluded from reinsurance contributions because it is not part of a commercial book of business. We note, however, that a plan or coverage offered by a Tribe to its employees (or retirees or dependents) on account of a current or former employment relationship would not be excluded.

3. National Contribution Rate

a. 2014 Rate

As described in §153.220(c) (previously designated as §153.220(e)), we intend to publish in the annual HHS notice of benefit and payment parameters the national per

capita reinsurance contribution rate for the upcoming benefit year. We read section 1341 of the Affordable Care Act to specify the total contribution amounts to be collected from contributing entities (reinsurance pool) as $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. Additionally, we read sections 1341(b)(3)(B)(iv) and 1341(b)(4) of the Affordable Care Act to direct the collection of funds for contribution to the U.S. Treasury each year as $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016. These amounts, payable to the U.S. Treasury, total $5 billion, which we note is the same amount as that appropriated for the Early Retiree Reinsurance Program under section 1102 of the Affordable Care Act. It has been suggested that the collection of the $2 billion in funds payable to the U.S. Treasury for 2014 should be deferred until 2016, thereby lowering the contribution rate in 2014, while ensuring that the total amount specified by law is returned to the U.S. Treasury by the end of this temporary program. We seek comment on whether such a delayed collection would be consistent with the statutory requirements described above and whether there are other steps that could be taken to reduce the burden of these collections on contributing entities. Finally, section 1341(b)(3)(B)(ii) of the Affordable Care Act allows for the collection of additional amounts for administrative expenses. Taken together, these three components make up the total dollar amount to be collected from contributing entities for each of the three years of the reinsurance program under the national per capita contribution rate.

Each year, the national per capita contribution rate will be calculated by dividing the sum of the three amounts (the national reinsurance pool, the U.S. Treasury contribution, and administrative costs) by the estimated number of enrollees in plans that must make reinsurance contributions:

$$\text{National Per Capita Reinsurance Contribution Rate} = \frac{\text{National reinsurance pool} + \text{Treasury contribution} + \text{Administrative costs}}{\text{Estimate of enrollees in plans required to make reinsurance contributions}}$$

As an illustration, under the Affordable Care Act, the 2014 national reinsurance pool is $10 billion, and the contribution to the U.S. Treasury is $2 billion. The amount to be collected for administrative expenses for benefit year 2014 would be $20.3 million (or 0.2 percent of the $10 billion dispersed), discussed in greater detail below. The HHS estimate of the number of enrollees in plans that must make reinsurance contributions that total the $12.02 billion described above yields a per capita contribution rate of $5.25 per month in benefit year 2014. We seek comment on this calculation.

Section 153.220(c) (previously designated as §153.220(e)) provides that HHS will set in the annual HHS notice of benefit and payment parameters for the applicable benefit year the national contribution rate and the proportion of contributions collected under the national contribution rate to be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses. In Table 12 below, we specify these proportions (or amounts, as applicable):

TABLE 12: Proportion of Contributions Collected under the National Contribution Rate for Reinsurance Payments, Payments to U.S. Treasury and Administrative Expenses

Proportion or amount for:	If total contribution collections under the national contribution rate are less than or equal to $12.02 billion	If total contribution collections under the national contribution rate are more than $12.02 billion
Reinsurance payments	83.2 percent ($10 billion/$12.02 billion)	The difference between total national collections and those contributions allocated to the U.S. Treasury and administrative expenses
Payments to the U.S. Treasury	16.6 percent ($2 billion/$12.02 billion)	$2 billion
Administrative expenses	0.2 percent ($20.3	$20.3 million

	million/$12.02 billion)	

As shown in Table 12, if the total amount of contributions collected is less than equal to $12.02 billion, we propose to allocate approximately 83.2 percent of the reinsurance contributions collected to reinsurance payments, 16.6 percent of the reinsurance contributions collected to the U.S. Treasury and 0.2 percent of the reinsurance contributions collected to administrative expenses.

Section III.C.6. of this proposed rule provides details on the methodology we used to develop enrollment estimates for the national per capita contribution rate.

b. Federal Administrative Fees

As described in the Premium Stabilization Rule, HHS would collect reinsurance contributions from self-insured group health plans, even if a State is operating its own reinsurance program. As noted above, we propose that HHS also collect reinsurance contributions from health insurance issuers, even if a State is operating its own reinsurance program. In this proposed rule, we estimate the Federal administrative expenses of operating the reinsurance program in 2014 to be approximately $20.3 million, or approximately 0.2 percent of the $10 billion in reinsurance funds to be distributed in 2014. We believe this figure reflects the Federal government's significant economies of scale in operating the program, and estimate a national per capita contribution rate of $0.11 annually for HHS administrative expenses.

As shown in Table 13, we expect to apportion the annual per capita amount of $0.11 of administrative expenses as follows: $0.055 of the total amount collected per capita for administrative fees for the collection of contributions from health insurance issuers and self-insured group health plans; and $0.055 of the total amount collected per

capita for administrative fees for reinsurance payment activities, supporting the administration of payments to issuers of reinsurance-eligible plans.

TABLE 13: Breakdown of Administrative Expenses (annual, per capita)

Item	Estimated Cost
Collecting contributions from health insurance issuers and self-insured group health plans	$0.055
Payment activities	$0.055
Total annual per capita fee for HHS to perform all reinsurance functions	$0.11

If HHS operates the reinsurance program on behalf of a State, HHS would retain the annual per capita fee for HHS to perform all reinsurance functions, which would be $0.11. If a State operates its own reinsurance program, HHS would transfer $0.055 of the per capita administrative fee to the State for purposes of administrative expenses incurred in making reinsurance payments, and retain the remaining $0.055 to offset the costs of contribution collection. We note that the administrative expenses for reinsurance payments will be distributed in proportion to the State-by-State total requests for reinsurance payments made under the national payment parameters. We seek comment on this approach, and other reasonable, administratively simple approaches that may be used to calculate administrative costs.

4. Calculation and Collection of Reinsurance Contributions

a. Calculation of Reinsurance Contribution Amount and Timeframe for Collections

We intend to administer the reinsurance program in a manner that minimizes the administrative burden on health insurance issuers and self-insured group health plans, while ensuring that contributions are calculated accurately. Thus, we propose in §153.400(a) and §153.240(b)(1), respectively, to collect and pay out reinsurance funds annually to minimize the costs of administering the program and the burden on contributing entities. If we were to collect and make reinsurance payments throughout

the benefit year, we would likely be required to hold the disbursement of a large portion of the reinsurance payments until the end of the benefit year to ensure an equitable allocation of payments. This would deprive contributing entities of the use of those funds during the benefit year, and we believe that the proposed §153.400(a) and §153.240(b)(1) would address this issue. However, we note that this approach would delay the receipt of some reinsurance payments for individual market issuers, and solicit comment on the benefits and burdens for issuers, States, and other stakeholders of a more frequent collections and payment cycle.

Under the Premium Stabilization Rule, HHS would collect reinsurance contributions through a per capita assessment on contributing entities. To clarify how this assessment is made, we propose to add §153.405, which provides that the reinsurance contribution of a contributing entity be calculated by multiplying the average number of covered lives of reinsurance contribution enrollees during the benefit year for all of the contributing entity's plans and coverage that must pay reinsurance contributions, by the national contribution rate for the applicable benefit year.

$$\begin{aligned}&\textit{Required Reinsurance Contribution}\\&= \textit{Number of Covered Lives During the Benefit Year for All Contributing Entity's Pla}\\&\times \textit{National Contribution Rate for the Applicable Benefit Year}\end{aligned}$$

We also propose to amend §153.405(b) to require that, no later than November 15 of benefit year 2014, 2015, and 2016, as applicable, a contributing entity must submit to HHS an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees for each benefit year. The count must be determined as specified in proposed §153.405(d), (e), (f), or (g) as applicable. We propose to amend §153.400(a) so that each contributing entity makes reinsurance contributions at the national contribution rate annually and in a manner specified by HHS. We also propose to amend

§153.400(a) so that each contributing entity makes reinsurance contributions under any additional applicable State supplemental contribution rate, if a State elects to collect additional contributions for administrative expenses or reinsurance payments under §153.220(d), annually and in a manner specified by the State. We believe this annual collection schedule will ensure a more accurate count of a contributing entity's average covered lives, and would avoid the need for any initial estimates and subsequent reconciliation to account for fluctuations in enrollment during the course of the benefit year.

Under §153.405(c)(1), within 15 days of submission of the annual enrollment count or by December 15, whichever is later, HHS will notify each contributing entity of the reinsurance contribution amounts to be paid based on that annual enrollment count. We specify in §153.405(c)(2) that a contributing entity remit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year. The amount to be paid by the contributing entity must be based upon the notification received under §153.405(c)(1).

Counting Methods for Health Insurance Issuers: In §153.405(d), we propose a number of methods that a health insurance issuer may use to determine the average number of covered lives of reinsurance contribution enrollees under a health insurance plan for a benefit year for purposes of the annual enrollment count. These methods promote administrative efficiencies by building on the methods permitted for purposes of the fee to fund the Patient-Centered Outcomes Research Trust Fund (the PCORTF Rule), modified so that a health insurance issuer may determine an annual enrollment count

during the fourth quarter of the benefit year.[30] Thus, under each of these methods, the number of covered lives will be determined based on the first nine months of the benefit year.

(1) Actual Count Method: Under the PCORTF Rule, an issuer may use the "actual count method" to determine the number of lives covered under the plan for the plan year by calculating the sum of the lives covered for each day of the plan year and dividing that sum by the number of days in the plan year. We propose that, for reinsurance contributions purposes, a health insurance issuer would add the total number of lives covered for each day of the first nine months of the benefit year and divide that total by the number of days in those nine months.

(2) Snapshot Count Method: Under the PCORTF Rule, a health insurance issuer may use the "snapshot count method" generally by adding the total number of lives covered on a certain date during the same corresponding month in each quarter, or an equal number of dates for each quarter, and dividing the total by the number of dates on which a count was made. For reinsurance contributions purposes, an issuer would add the totals of lives covered on a date (or more dates if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year, (provided that the dates used for the second and third quarters must be within the same week of the quarter as the date used for the first quarter), and divide that total by the number of dates on which a count was made. For this purpose, the same months must be used for each quarter (for example, January, April and July).

(3) Member Months Method or State Form Method: Under the PCORTF Rule, a health insurance issuer may use the "Member Months Method" or "State Form Method"

[30] See the proposed rule published on April 17, 2012 (77 FR 22691). Once the PCORTF Rule is finalized, we may modify the methods of reporting contained in this rulemaking.

by using data from the NAIC Supplemental Health Exhibit or similar data from other State forms. However, data from these forms may be out of date at the time of the annual enrollment count submission, and we believe that it is important that health insurance issuers achieve an accurate count of covered lives, particularly for individual market plans. We expect that the individual market would be subject to large increases in enrollment between 2014 and 2016. Therefore, we propose a modified counting method based upon the ratio of covered lives per policy in the NAIC or State form. Specifically, we propose that health insurance issuers using this method multiply the average number of policies for the first nine months of the applicable benefit year by the ratio of covered lives per policy calculated from the NAIC Supplemental Health Care Exhibit (or from a form filed with the issuer's State of domicile for the most recent time period). Issuers would count the number of policies in the first nine months of the applicable benefit year by adding the total number of policies on one date in each quarter, or an equal number of dates for each quarter (or all dates for each quarter), and dividing the total by the number of dates on which a count was made.

For example, if a health insurance issuer indicated on the NAIC form for the most recent time period that it had 2,000 policies covering 4,500 covered lives, it would apply the ratio of 4,500 divided by 2,000, equaling 2.25 to the number of policies it had over the first three quarters of the applicable benefit year. If the issuer had an average of 2,300 policies in the three quarters of the applicable benefit year, it would report 2.25 multiplied by 2,300 as the number of covered lives for the purposes of reinsurance contributions.

Counting Methods for Self-Insured Group Health Plans: In §153.405(e), we propose a number of methods that a self-insured group health plan may use to determine the average number of covered lives for purposes of the annual enrollment count. These

methods mirror the methods permitted to sponsors of self-insured group health plans under the PCORTF Rule, modified slightly for timing, so that enrollment counts may be obtained on a more current basis.

(1) Actual Count Method or Snapshot Count Method: We propose that self-insured plans, like health insurance issuers, may use the actual count method or snapshot count method as described above.

(2) Snapshot Factor Method: Under the PCORTF Rule, a plan sponsor generally may use the "snapshot factor method" by adding the totals of lives covered on any date (or more dates if an equal number of dates are used for each quarter) during the same corresponding month in each quarter, and dividing that total by the number of dates on which a count was made, except that the number of lives covered on a date is calculated by adding the number of participants with self-only coverage on the date to the product of the number of participants with coverage other than self-only coverage on the date and a factor of 2.35.[31] For this purpose, the same months must be used for each quarter (for example, January, April, July, and October). For reinsurance contributions purposes, a self-insured group health plan would use this PCORTF counting method over the first three quarters of the benefit year, provided that for this purpose, the corresponding dates for the second and third quarters of the benefits year must be within the same week of the quarter as the date selected for the first quarter.

(3) Form 5500 Method: Under the PCORTF Rule, a plan sponsor may use the "Annual Return/Report of Employee Benefit Plan" filed with the Department of Labor (Form 5500) by using data from the Form 5500 for the last applicable plan year. We

[31] The preamble to the proposed PCORTF Rule explains that "the 2.35 dependency factor reflects that all participants with coverage other than self-only have coverage for themselves and some number of dependents. The Treasury Department and the IRS developed the factor, and other similar factors used in the regulations, in consultation with Treasury Department economists and in consultation with plan sponsors regarding the procedures they currently use for estimating the number of covered individuals."

propose that, for purposes of reinsurance contributions, a self-insured group health plan may also rely upon such data, even though the data may reflect enrollment in a previous benefit year. Our modeling of the 2014 health insurance marketplace, discussed in section III.C.6. of this proposed rule, suggests that enrollment in self-insured group health plans is less likely to fluctuate than enrollment in the individual market. Thus, we propose that a self-insured group plan may calculate the number of lives covered for a plan that offers only self-only coverage by adding the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500, and dividing by two. Additionally, a self-insured group plan that offers self-only coverage and coverage other than self-only coverage may calculate the number of lives covered by adding the total participants covered at the beginning and the end of the benefit year, as reported on the Form 5500.

Counting Methods for Plans with Self-insured and Insured Options: An employer may sponsor a group health plan that offers one or more coverage options that are self-insured and one or more other coverage options that are insured. In §153.405(f), we propose that to determine the number of covered lives of reinsurance contribution enrollees under a group health plan with both self-insured and insured options for a benefit year must use one of the methods specified in either §153.405(d)(1) or §153.405(d)(2) – the "actual count" method or "snapshot count" for health insurance issuers.

Aggregation of self-insured group health plans and health insurance plans: We propose in §153.405(g)(1) that if a plan sponsor maintains two or more group health plans or health insurance plans (or a group health plan with both insured and self-insured components) that collectively provide major medical coverage for the same covered lives, which we refer to as "multiple plans" for the purpose of the reinsurance program, then

these multiple plans must be treated as a single self-insured group health plan for purposes of calculating any reinsurance contribution amount due under paragraph (c) of this section. This approach would prevent the double counting of a covered life for major medical coverage offered across multiple plans, and prohibit plan sponsors that provide such major medical coverage from splitting the coverage into separate arrangements to avoid reinsurance contributions on the grounds that it does not offer major medical coverage.

For purposes of §153.405(g)(1), the plan sponsor is responsible for paying the applicable fee. We propose to define "plan sponsor" in proposed §153.405(g)(2) based on the definition of the term in the PCORTF Rule.[32] We propose to define "plan sponsor" as:

(A) The employer, in the case of a plan established or maintained by a single employer;

(B) The employee organization, in the case of a plan established or maintained by an employee organization;

(C) The joint board of trustees, in the case of a multi-employer plan (as defined in section 414(f) of the Code);

(D) The committee, in the case of a multiple employer welfare arrangement;

(E) The cooperative or association that establishes or maintains a plan established or maintained by a rural electric cooperative or rural cooperative association (as such terms are defined in section 3(40)(B) of ERISA);

(F) The trustee, in the case of a plan established or maintained by a voluntary employees' beneficiary association (meaning that the association is not merely serving as

[32] If the definition of "plan sponsor" is revised in the final PCORTF Rule, we intend to revise the definition proposed herein to maintain consistency.

a funding vehicle for a plan that is established or maintained by an employer or other person);

(G) In the case of a plan, the plan sponsor of which is not described in (A) through (F) above, the person identified or designated by the terms of the document under which the plan is operated as the plan sponsor, provided that designation is made and consented to, by no later than the date by which the count of covered lives for that benefit year is required to be provided. After that date, the designation for that benefit year may not be changed or revoked, and a person may be designated as the plan sponsor only if the person is one of the persons maintaining the plan (for example, one of the employers that is maintaining the plan with one or more other employers); or

(H) In the case of a plan the sponsor of which is not described in (A) through (F) above, and for which no identification or designation of a plan sponsor has been made pursuant (G), each employer or employee organization that maintains the plan (with respect to employees of that employer or employee organization), and each board of trustees, cooperative or association that maintains the plan.

Exceptions: We propose two exceptions to this aggregation rule, in §153.405(g)(3). First, if the benefits provided by any health insurance or self-insured group health plans are limited to excepted benefits within the meaning of section 2791(c) of the PHS Act (such as stand-alone dental or vision benefits), the excepted benefits coverage need not be aggregated with other plans for purposes of this section. Second, if benefits provided by any health insurance or self-insured group health plan are limited to prescription drug coverage, that prescription drug coverage need not be aggregated so as to reduce the burden on sponsors who have chosen to structure their coverage in that manner. As discussed in section III.C.2. of this proposed rule, coverage that consists solely of prescription drug or excepted benefits is not major medical coverage. If

enrollees have major medical coverage and separate coverage consisting of prescription drug or excepted benefits, reinsurance contributions only would be required with respect to the major medical coverage. Reinsurance contributions would not be required with respect to the same enrollees' prescription drug or excepted benefits coverage, and consequently, double counting of covered lives will not occur.

Multiple Plans: In §153.405(g)(4), we propose counting requirements for multiple plans in which at least one of the plans is an insured plan (covered in §153.405(g)(4)(i)), and multiple self-insured group health plans not including an insured plan (covered in §153.405(g)(4)(ii)). First, we anticipate that a plan sponsor will generate or obtain a list of the participants in each plan and then analyze the lists to identify those participants that have major medical coverage across all the plans collectively. To calculate the average number of covered lives of reinsurance contribution enrollees across multiple plans, we propose that a plan sponsor must use one of the methods applicable to health insurance plans or self-insured group health plans under §153.405(d) and §153.405(e), respectively, applied across the multiple plans as a whole. We also propose to require reporting to HHS or the applicable reinsurance entity concerning multiple plans, as discussed in §153.405(g)(4). Additionally, it is important to note that the reinsurance program operates on a benefit year basis as discussed in section III.C.5. of this proposed rule, which is defined at §153.20 of this part (by reference to §155.20) as the calendar year, and the applicable counting methods all apply on that basis, no matter the plan year applicable to particular plans.

Multiple Group Health Plans Including an Insured Plan: When one or more of the multiple group health plans is an insured plan, we propose that the actual count method for health insurance issuers in §153.405(d)(1) or the snapshot count method for health insurance issuers in §153.405(d)(2) must be used. We propose to prohibit the use of the

"Member Months Method" or "State Form Method" to count covered lives across multiple insured plans because those methods would not easily permit aggregate counting, since the identities of the covered lives are not available on the applicable forms. We propose that the plan sponsor must determine and report, in a timeframe and manner established by HHS, to HHS (or, the applicable reinsurance entity if the multiple plans all consist solely of health insurance plans and the applicable reinsurance entity of a State is collecting contributions from health insurance issuers in such State): (1) the average number of covered lives calculated; (2) the counting method used; and (3) the names of the multiple plans being treated as a single group health plan as determined by the plan sponsor and reported to HHS.

Multiple Self-Insured Group Health Plans Not Including an Insured Plan: We describe the counting provisions applicable to multiple self-insured group health plans (that is, when none of the plans is an insured plan) in proposed paragraph (g)(4)(ii) of this section. There are four counting methods available for self-insured plans which are set forth in proposed §153.405(e)(1) through §153.405(e)(4) of this section. Proposed §153.405(e)(1) permits a plan sponsor to use the actual count method under §153.405(d)(1) or the snapshot count method under §153.405(d)(2) that are also available for insured plans. Proposed paragraph (e)(2) permits an additional method (the snapshot factor method) for self-insured plans. We propose not to permit a plan sponsor to use the fourth method, the "Form 5500 Method" as described in proposed §153.405(e)(3) to count covered lives across multiple self-insured plans because that method would not easily permit aggregate counting, since the identities of the covered lives are not available on that form. Thus, we propose three possible methods for multiple self-insured plans under paragraph (g)(4)(ii). We further propose that the plan sponsor must report, in a timeframe and manner established by HHS, to HHS: (1) the average number of covered

lives calculated; (2) the counting method used; and (3) the names of the multiple plans being treated as a single group health plan as determined by the plan sponsor.

Consistency with PCORTF Rule Not Required: We intend to allow a contributing entity to use a different counting method for the annual enrollment count of covered lives for purposes of reinsurance contributions from that used for purposes of the return required in connection with the PCORTF Rule. Because time periods and counting methods may differ, we would not require that a contributing entity submit consistent estimates of its covered lives in the return required in connection with the PCORTF Rule and the annual enrollment count required for reinsurance contributions (although these counts should be performed in accordance with the rules of the counting method chosen). However, when calculating the average number of covered lives across two or more plans under proposed paragraph (g), the same counting method must be used across all of the multiple plans, because they would be treated as a single plan for counting purposes.

We welcome comments on this approach to counting covered lives for reinsurance contributions.

b. State Use of Contributions Attributed to Administrative Expenses

To achieve the purposes of the reinsurance program, reinsurance contributions collected must be appropriately spent on reinsurance payments, payments to the U.S. Treasury, and on reasonable expenses to administer the reinsurance program. Therefore, we provide guidance on three restrictions that we intend to propose on the use of reinsurance contributions for administrative expenses, to permit States that participate in the reinsurance program to accurately estimate the cost of administrative expenses. While we will provide details of those standards in future regulation and guidance, along with similar standards for Exchanges, the risk adjustment program, and other Affordable Care Act programs, we provide below an overview of our intentions.

First, we intend to apply the prohibition described in section 1311(d)(5)(B) of the Affordable Care Act to the reinsurance program so that reinsurance funds intended for administrative expenses cannot be used for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative or regulatory modifications. Second, we intend to propose that reinsurance funds intended for administrative expenses may not be used for any expense not necessary to the operation and administration of the reinsurance program. Third, we intend to propose that an applicable reinsurance entity must allocate any shared, indirect, or overhead costs between reinsurance-related and other State expenses based on generally accepted accounting principles, consistently applied. An applicable reinsurance entity would be required to provide HHS, in a timeframe and manner specified by HHS, a report setting forth and justifying its allocation of administrative costs. We welcome comments on these intended proposals.

5. Eligibility for Reinsurance Payments under Health Insurance Market Rules

We are proposing to add §153.234 to clarify that, under either the reinsurance national payment parameters or the State supplemental reinsurance payment parameters, if applicable, a reinsurance-eligible plan's covered claims costs for an enrollee incurred prior to the application of 2014 market reform rules – §147.102 (fair health insurance premiums), §147.104 (guaranteed availability of coverage, subject to the student health insurance provisions at §147.145), §147.106 (guaranteed renewability of coverage, subject to the student health insurance provisions at §147.145), §156.80 (single risk pool), and Subpart B 156 (essential health benefits package) – do not count toward either the national or State supplemental attachment points, reinsurance caps, or coinsurance rates. Unlike plans subject to the market reform rules under the Affordable Care Act, plans not subject to these 2014 market reforms rules may use several mechanisms to

avoid claims costs for newly insured, high-cost individuals by excluding certain conditions (for example, maternity coverage for women of child-bearing age), by denying coverage to those with certain high-risk conditions, and by pricing individual premiums to cover the costs of providing coverage to such individuals. (We note that student health plan eligibility would be subject to the modified guaranteed availability and guaranteed issue requirements only, to the extent that they apply, as set forth in §147.145, and we would require that the student health plans only meet those modified requirements to be eligible for reinsurance payments.) The market reform rules will be effective for the individual market for policy years[33] beginning on or after January 1, 2014, and as a result, policies that are issued in 2013 will be subject to these rules at the time of renewal in 2014, and therefore, become eligible for reinsurance payments at the time of renewal in 2014.

We believe that providing reinsurance payments only to those reinsurance-eligible plans that are subject to the 2014 market reform rules better reflects the reinsurance program's purpose of mitigating premium adjustments to account for risk from newly insured, high-cost individuals. We also propose that State-operated reinsurance programs similarly limit eligibility for reinsurance payments. We recognize that this policy contrasts with the approach proposed for State-operated risk adjustment programs, under which HHS is proposing to permit States to choose to risk adjust plans not subject to the 2014 market reform rules. Because some States may have enacted State-specific rating and market reforms that they believe would justify the inclusion of these plans in risk adjustment before these plans' renewal dates, permitting State flexibility on the

[33] As defined at 45 CFR 144.103, "policy year means in the individual health insurance market the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year."

applicability of risk adjustment to plans not subject to the 2014 market reform rules furthers the goals of the risk adjustment program. However, we believe that State flexibility for eligibility for reinsurance payments does not further the goal of the reinsurance program.

Also, we intend to operate the reinsurance program on a calendar year basis, which we believe makes the most sense from policy and administrative perspectives. First, we believe that there is ambiguity in section 1341 of the Affordable Care Act as to whether the reinsurance program is to be administered on a plan year or calendar year basis. Some provisions of section 1341 concerning contributions from and payments to issuers use the term "plan year." However, other provisions of section 1341—notably sections 1341(b)(4), 1341(b)(3)(B)(iv) and 1341(c)(1)(A)—contemplate that the transitional reinsurance program would run with the calendar year. Second, a calendar year based program would ensure adequate collections in the early part of the program and to preserve fairness in making reinsurance payments. Third, implementing the reinsurance program on a calendar year basis permits the reinsurance program schedule to coincide with the MLR and the temporary risk corridors program schedules, both of which operate on a calendar year basis. Finally, we believe that the purpose of the reinsurance program is to stabilize premiums beginning in 2014, when the Exchanges begin to operate. We believe that the statute reflects this intent in section 1341(c)(1)(A) of the Affordable Care Act, which states that the purpose of an applicable reinsurance entity is "to help stabilize premiums for coverage in the individual market in a State during the first three years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest."

We welcome comments on this proposal.

6. Reinsurance Payment Parameters

As described in the Premium Stabilization Rule, reinsurance payments to eligible issuers will be made for a portion of an enrollee's claims costs paid by the issuer that exceeds an attachment point, subject to a reinsurance cap. The coinsurance rate, attachment point, and reinsurance cap are the reinsurance "payment parameters." Section 1341(b)(2)(B) of the Affordable Care Act directs the Secretary, in establishing standards for the transitional reinsurance program to include a formula for determining the amount of reinsurance payments to be made to issuers for high-risk individuals that provides for the equitable allocation funds. Using the Secretary's authority under this provision, we propose to amend the policy described in the Premium Stabilization Rule by establishing uniform, "national" reinsurance payment parameters that will be applicable to the reinsurance program for each State, whether or not operated by a State. We believe that using uniform, national payment parameters would result in equitable access to the reinsurance funds across States, while furthering the goal of premium stabilization across all States by disbursing reinsurance contributions where they are most needed.

The primary purpose of the transitional reinsurance program is to stabilize premiums by setting the reinsurance payment parameters to achieve the greatest impact on rate setting, and therefore, premiums, through reductions in plan risk, while complementing the current commercial reinsurance market. In contrast to commercial reinsurance, which is used to protect against risk, the primary purpose of the reinsurance program is to stabilize premiums in the individual market from 2014 through 2016. The reinsurance program is designed to protect against issuers' potential perceived need to raise premiums due to the implementation of the 2014 market reform rules, specifically guaranteed availability. Even though HHS expects that any potential new high-cost claims from newly insured individuals would be balanced out by low-cost claims from

many newly insured individuals who enter the individual market as a result of the availability of premium tax credits, more affordable coverage, the minimum coverage provision, and greater transparency and competition in the market, the reinsurance program is designed to alleviate the concern of new high-cost claims from newly insured individuals.

Therefore, we propose that the 2014 national payment parameters be established at an attachment point of $60,000, when reinsurance payments would begin, a national reinsurance cap of $250,000, when the reinsurance program stops paying claims for a high-cost individual, and a uniform coinsurance rate of 80 percent, meant to reimburse a proportion of claims between the attachment point and reinsurance cap while giving issuers an incentive to contain costs. These three proposed payment parameters would help offset high-cost enrollees, without interfering with traditional commercial reinsurance, which typically has attachment points in the $250,000 range. We estimate that these national payment parameters will result in total requests for reinsurance payments of approximately $10 billion. With the coinsurance rate, reinsurance cap, and attachment point fixed uniformly across all States, we believe that the reinsurance program would have the greatest equitable impact on premiums across all States. We believe that these proposed national payment parameters best address the reinsurance program's goals to promote national premium stabilization and market stability while providing plans incentives to continue effective management of enrollee costs. We intend to continue to monitor individual market enrollment and claims patterns to appropriately disburse reinsurance payments throughout each of the benefit years.

To assist with the development of the payment parameters, HHS developed a model that estimates market enrollment incorporating the effects of State and Federal policy choices and accounting for the behavior of individuals and employers, the

Affordable Care Act Health Insurance Model (ACAHIM). The outputs of the ACAHIM, especially the estimated enrollment and expenditure distributions, were used to analyze a number of policy choices relating to benefit and payment parameters, including the national reinsurance contribution rate and national reinsurance payment parameters.

The ACAHIM generates a range of national and State-level outputs for 2014, including the level and composition of enrollment across markets given the eligible population in a State. The ACAHIM is described below in two sections: (1) the approach for estimating 2014 enrollment and (2) the approach for estimating 2014 expenditures. Because enrollment projections are key to estimating the reinsurance payment parameters for the reinsurance program, HHS paid much attention to the underlying data sources and assumptions for the ACAHIM. The ACAHIM uses recent Current Population Survey (CPS) data adjusted for small populations at the State level, exclusion of undocumented immigrants, and population growth to 2014, to assign individuals to the various coverage markets.

More specifically, the ACAHIM assigns each individual to a single health insurance market as their baseline (pre-Affordable Care Act) insurance status. In addition to assuming that individuals currently in Medicare, TRICARE, or Medicaid will remain in such coverage, the ACAHIM takes into account the probability that a firm will offer employment-based coverage based on the CPS distribution of coverage offers for firms of a similar size and industry. Generally, to determine the predicted insurance enrollment status for an individual or family (the "health insurance unit" or "HIU") in 2014, the ACAHIM calculates the probability that the firm will offer insurance, then models Medicaid eligibility, and finally models eligibility for advance payments of the premium tax credit and cost-sharing reductions under the Exchange. Whenever a transition to another coverage market is possible, the ACAHIM takes into account the

costs and benefits of the decision for the HIU and assigns a higher probability of transition to those with the greatest benefit. The ACAHIM also assumes that uninsured individuals will take up individual market coverage as informed by current take-up rates of insurance across States, varying by demographics and incomes and adjusting for post Affordable Care Act provisions, such as advance payments of the premium tax credit and cost-sharing reductions.

Estimated expenditure distributions from the ACAHIM are used to set the uniform, national reinsurance payment parameters so that estimated contributions align with estimated payments for eligible enrollees. The ACAHIM uses the Health Intelligence Company, LLC (HIC) database from calendar year 2010, with the claims data trended to 2014 to estimate total medical expenditures per enrollee by age, gender, and area of residence. The expenditure distributions are further adjusted to take into account plan benefit design, or, "metal" level (that is, "level of coverage," as defined in 156.20) of individual insurance coverage in an Exchange. To describe a State's coverage market, the ACAHIM computes the pattern of enrollment using the model's predicted number and composition of participants in a coverage market. These estimated expenditure distributions were the basis for the national reinsurance payment parameters.

7. Uniform Adjustment to Reinsurance Payments

We propose to amend §153.230 by specifying in subparagraph (d) that HHS will adjust reinsurance payments by a uniform, pro rata adjustment rate in the event that HHS determines that the amount of total requests for reinsurance payments under the national reinsurance payment parameters will exceed the amount of reinsurance contributions collected under the national contribution rate during a given benefit year. The total amount of contributions considered for this purpose would include any contributions

collected but unused under the national contribution rate during any previous benefit year.

For example, in 2014, if total requests for reinsurance payments under the national reinsurance payment parameters are $10.1 billion and only $10 billion is collected for reinsurance payments under the national contribution rate, then all requests for reinsurance payments would be reduced by approximately 1 percent. However, if HHS determines that the total reinsurance contributions collected under the national contribution rate for the applicable benefit year are equal to or more than the total requests for reinsurance payments calculated using the national reinsurance payment parameters, then no such adjustment will be applied, and all requests for reinsurance payments will be paid in full under the national payment parameters. Any unused reinsurance funds would be used for the next benefit year's reinsurance payments. This uniform pro rata adjustment would ensure that claims are paid at the same rate out of the national reinsurance fund, and promote equitable access to the national reinsurance fund across all States while furthering the goal of premium stabilization under the Affordable Care Act. We invite comment on this policy.

8. Supplemental State Reinsurance Parameters

While we propose uniform, national payment parameters applicable to all States as discussed above, we are also proposing to add §153.232(a), which specifies the manner in which States may modify the national reinsurance payment parameters established in the HHS notice of benefit and payment parameters. Specifically, we propose that a State that establishes its own reinsurance program may only modify the national reinsurance payment parameters by establishing State supplemental payment parameters that cover an issuer's claims costs beyond the national reinsurance payments parameters. Furthermore, reinsurance payments under these State supplemental

payments parameters may only be made with additional funds the State collects for reinsurance payments under §153.220(d)(1)(ii) or State funds applied to the reinsurance program under §153.220(d)(3). We believe that this approach would not prohibit States from collecting additional amounts for reinsurance payments, as provided for under section 1341(b)(3)(B) of the Affordable Care Act, while allowing nationwide access to the reinsurance payments from the contributions collected under the national reinsurance contribution rate.

We propose in §153.232(a) that a State may set State supplemental reinsurance payments parameters by adjusting the national reinsurance payment parameters in one or more of the following ways: (1) decreasing the national attachment point; (2) increasing the national reinsurance cap; or (3) increasing the national coinsurance rate. In other words, a State may not alter the national reinsurance payment parameters in a manner that could result in reduced reinsurance payments. We seek comment on this approach, including whether there should be any limitations as to how a State may supplement the national reinsurance payment parameters.

To provide issuers with greater certainty for premium rate setting purposes, we propose that a State ensure that any additional funds for reinsurance payments it collects under §153.220(d)(1)(ii) or State funds under §153.220(d)(3) as applicable are reasonably calculated to cover additional reinsurance payments that are projected to be made under the State's supplemental reinsurance payment parameters for a given benefit year. We believe that the State must also ensure that such parameters are applied to all reinsurance-eligible plans in that State in the same manner. We further propose in §153.232(b) that contributions collected under §153.220(d)(1)(ii) or additional funds collected under §153.220(d)(3), as applicable, must be applied toward requests for reinsurance payments

made under the State supplemental reinsurance payments parameters for each benefit year commencing in 2014 and ending in 2016.

We also propose in §153.232(c) that, as applicable, a health insurance issuer of a non-grandfathered individual market plan becomes eligible for reinsurance payments under a State's supplemental reinsurance parameters, if its incurred claims costs for an individual enrollee's covered benefits during a benefit year: (1) exceed the supplemental State attachment point; (2) exceed the national reinsurance cap; or (3) exceed the national attachment point, if the State has established a State supplemental coinsurance rate. This would allow reinsurance payments made under the State supplemental payment parameters to "wrap around" the national reinsurance payment parameters so that the State could apply any additional contributions it collects under proposed §153.220(d) towards reinsurance payments beyond the national reinsurance payment parameters. In this way, HHS can distribute funds under the national payments formula to where they are needed most, while allowing States that elect to run their own program the flexibility to supplement nationally calculated reinsurance payments. As mentioned previously, States would be required to separate in its reporting to issuers the reinsurance payments paid under the national reinsurance payment parameters and State supplemental reinsurance payment parameters.

To ensure that reinsurance payments under State supplemental payment parameters do not overlap with the national reinsurance payment parameters, we propose the method for calculating State supplemental reinsurance payments. Specifically, we propose in §153.232(d) that supplemental reinsurance payments with respect to a health insurance issuer's claims costs for an individual enrollee's covered benefits must be calculated by taking the sum of: (1) the product of such claims costs between the supplemental State attachment point and the national attachment point multiplied by the

national coinsurance rate (or applicable State supplemental coinsurance rate); (2) the product of such claims costs between the national reinsurance cap and the supplemental State reinsurance cap multiplied by the national coinsurance rate (or applicable State supplemental coinsurance rate); and (3) the product of such claims costs between the national attachment point and the national reinsurance cap multiplied by the difference between the State supplemental coinsurance rate and the national coinsurance rate.

For example, in 2014 a State may elect to establish supplemental State reinsurance payment parameters that modify all three national reinsurance payment parameters, by establishing a State supplemental attachment point of $50,000, a State supplemental coinsurance rate of 100 percent, and a State supplemental reinsurance cap of $300,000. Under these supplemental State reinsurance payment parameters, the State must use its additional contributions to pay up to $98,000 of the issuer costs under $300,000 or the sum of: $10,000 (100 percent of an issuer's costs between the State's 2014 supplemental attachment point of $50,000 and the 2014 national attachment point $60,000); and $50,000 (100 percent of an issuer's costs between the 2014 national reinsurance cap of $250,000 and the 2014 State supplemental reinsurance cap $300,000); and $38,000 (the product of an issuer's costs between $60,000 and $250,000 multiplied by the difference between the State's supplemental coinsurance rate (100 percent) and the national coinsurance rate (80 percent). Contributions collected under the national contribution rate would be applied to an issuer's claims costs above the 2014 national attachment point, subject to the national coinsurance rate and national reinsurance cap.

Alternatively, a second State may elect to establish a State supplemental attachment point of $40,000 in 2014, but elect not to establish a supplemental State coinsurance rate or reinsurance cap. That State would then use any additional contributions it collects to cover up to $16,000 or 80 percent (the 2014 national

coinsurance rate) of an issuer's claims costs between $40,000 (the 2014 supplemental State attachment point) and $60,000 (the 2014 national attachment point). As in the first example, contributions collected under the national contribution rate would be applied to an issuer's claims costs above the 2014 national attachment point, subject to the national coinsurance rate and national reinsurance cap.

Similar to payment calculations under the national reinsurance payments parameters, we propose in §153.232(e) that if all requested reinsurance payments under the State supplemental reinsurance parameters calculated in a State for a benefit year will exceed all the additional funds a State collects for reinsurance payments under §153.220(d)(1)(ii) or State funds under §153.220(d)(3) as applicable, the State must determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments in the State. Each applicable reinsurance entity in the State must reduce all such requests for reinsurance payments under the State supplemental reinsurance payment parameters for the applicable benefit year by that adjustment.

Finally, in §153.232(f), we propose that a State must ensure that reinsurance payments made to issuers under the State supplemental reinsurance payment parameters do not exceed the issuer's total paid amount for the reinsurance-eligible claim(s) and any remaining additional funds collected under §153.220(d)(1)(ii) must be used for reinsurance payments under the State supplemental parameters in subsequent benefit years. We seek comment on this proposal, including other areas of flexibility that could be provided to State-operated reinsurance programs.

9. Allocation and Distribution of Reinsurance Contributions

Section 153.220(d) of the Premium Stabilization Rule currently provides that HHS would distribute reinsurance contributions collected for reinsurance payments from a State to the applicable reinsurance entity for that State. We propose to replace this

section with proposed §153.235(a), which provides that HHS will allocate and distribute the reinsurance contributions collected under the national contribution rate based on the need for reinsurance payments, regardless of where the contribution was collected. As previously stated in this proposed rule, HHS will disburse all contributions collected under the national contribution rate from all States for the applicable benefit year, based on all available contributions and the aggregate requests for reinsurance payments, net of the pro rata adjustment, if any. We believe that this method of disbursing reinsurance contributions will allow the transitional reinsurance program to equitably stabilize premiums across the nation, and permit HHS to direct reinsurance funds based on the need for reinsurance payments. Consistent with this proposal, we propose to amend §153.220(a) to clarify that even if a State establishes a reinsurance program, HHS would directly collect from health insurance issuers, as well as self-insured group health plans, the reinsurance contributions for enrollees who reside in that State.

10. Reinsurance Data Collection Standards

a. Data Collection Standards for Reinsurance Payments

Section 153.240(a) directs a State's applicable reinsurance entity to collect data needed to determine reinsurance payments as described in §153.230. We propose to amend §153.240(a) by adding subparagraph (1) to direct a State to ensure that its applicable reinsurance entity either collect or be provided access to the data necessary to determine reinsurance payments from an issuer of a reinsurance-eligible plan. We note that this data would include data related to cost-sharing reductions because reinsurance payments are not based on a plan's paid claims amounts that are reimbursed by cost-sharing reduction amounts. The applicable reinsurance entity, therefore, must reduce a plan's paid claims amount considered for reinsurance payments attributable to cost-sharing reductions. When HHS operates a reinsurance program on behalf of a State,

HHS would utilize the same distributed data collection approach that we propose to use for risk adjustment, as described in section III.G. of this proposed rule. This proposed amendment would clarify that an applicable reinsurance entity may either use a distributed data collection approach for its reinsurance program or directly collect privacy-protected data from issuers to determine an issuer's reinsurance payments. The distributed data collection approach would not involve the direct collection of data; instead, HHS or the State would access data on plans' secure servers.

We also propose to amend §153.240(a) by adding subparagraph (3), directing States to provide a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims in the normal course of business (such as a capitated plan) may request reinsurance payments (or submit data to be considered for reinsurance payments) based on estimated costs of encounters for the plan in accordance with the requirements of §153.410. We propose to direct States to ensure that such requests (or a subset of such requests) are subject to (to the extent required by the State) a data validation program. A State would have the flexibility to design a data validation program that meets its adopted methodology and State-specific circumstances. This proposed amendment would enable certain reinsurance-eligible plans, such as staff-model health maintenance organizations, that do not generate claims with associated costs in the normal course of business to provide data to request and receive reinsurance payments.

When HHS operates a reinsurance program on behalf of a State, issuers of capitated plans would generate claims for encounters, and derive costs for those claims when submitting requests for reinsurance payments (or submitting data to be considered for reinsurance payments). It is our understanding that many capitated plans currently use some form of encounter data pricing methodology to derive claims, often by imputing an amount based upon the Medicare fee-for-service equivalent price or the usual,

customary, and reasonable equivalent that would have been paid for the service in the applicable market. A capitated plan should use its principal internal methodology for pricing encounters, such as the methodology in use for other State or Federal programs (for example, a methodology used for the Medicare Advantage market). If a plan has no such methodology, or has an incomplete methodology, it would be permitted to implement a methodology or supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific market that the plan is serving. Capitated plans, like all plans that submit reinsurance payment requests (or data to be considered for reinsurance payments) in the HHS-operated program, will be subject to validation and audit. Because capitated plans already use pricing methodologies, we believe this proposed policy would permit capitated plans to participate in the reinsurance program with a minimal increase in administrative burden. We welcome comments on this approach.

b. Notification of Reinsurance Payments

We propose to add §153.240(b)(1) which directs a State, or HHS on behalf of the State, to notify issuers of the total amount of reinsurance payments that will be made no later than June 30 of the year following the benefit year. This corresponds with the date on which a State or HHS must notify issuers of risk adjustment payments and charges. As such, by June 30 of the year following the applicable benefit year, issuers will be notified of reinsurance payments and risk adjustment payments and charges, allowing issuers to account for their total reinsurance payments and risk adjustment payments and charges when submitting data for the risk corridors and MLR programs. To provide issuers in the individual market with information to assist in development of premiums and rates in subsequent benefit years, we also propose in new §153.240(b)(2) that a State provide quarterly notifications of estimates to each reinsurance-eligible plan of the

expected requests for reinsurance payments for each quarter. HHS intends to collaborate with issuers and States to develop these early notifications. We welcome comments on this proposal.

c. Privacy and Security Standards

We propose to amend §153.240 by adding paragraph (d)(1), to require a State operating its own reinsurance program to ensure that the applicable reinsurance entity's collection of personally identifiable information is limited to information reasonably necessary for use in the calculation of reinsurance payments and that use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected (including for purposes of data validation). This proposal aligns with corresponding language for the risk adjustment program. The term "personally identifiable information" is a broadly used term across Federal agencies, and has been defined in the Office of Management and Budget Memorandum M-07-16 (May 22, 2007).[34] To reduce duplicative guidance or potentially conflicting regulatory language, we are not defining personally identifiable information in this proposed rule, and incorporate the aforementioned definition in to this proposed rule.

We also propose to amend §153.240 by adding paragraph (d)(2) to require that an applicable reinsurance entity implement specific privacy and security standards to ensure enrollee privacy, and to protect sensitive information. Specifically, this provision would require an applicable reinsurance entity to provide administrative, physical, and technical safeguards for personally identifiable information that may be used to request reinsurance payments. This provision is meant to ensure that an applicable reinsurance entity

[34] Available at: http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2007/m07-16.pdf.

complies with the same privacy and security standards that apply to issuers and providers, specifically the security standards described at §164.308, §164.310, and §164.312.

d. Data Collection

We propose to add new §153.420(a) to address data collection issues, including the distributed data collection approach that HHS intends to use when operating the reinsurance program on behalf of a State. We propose that issuers of plans eligible for and seeking reinsurance payments submit or make accessible data (including data on cost-sharing reductions to permit the calculation of enrollees' claims costs incurred by the issuer), in accordance with the reinsurance data collection approach established by the State, or HHS on behalf of the State.

In §153.420(b), we propose that an issuer of a reinsurance-eligible plan submit data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year. The April 30 deadline would apply to all issuers of reinsurance-eligible plans, regardless of whether HHS or the State is operating reinsurance. We welcome comments on this proposal.

D. Provisions for the Temporary Risk Corridors Program

1. Definitions

In the Premium Stabilization Rule, we stated in response to comments that we intended to propose that taxes and profits be accounted for in the risk corridors calculation, in a manner consistent with the MLR program. We, therefore, propose the following amendments and additions to the definitions in this section.

We propose to amend §153.500 by defining "taxes" with respect to a QHP as Federal and State licensing and regulatory fees paid with respect to the QHP as described in §158.161(a), and Federal and State taxes and assessments paid for the QHP as described in §158.162(a)(1) and §158.162(b)(1). This definition aligns with the fees and

taxes deductible from premiums in the MLR calculation. We use this definition to define "after tax premiums earned" which we propose to mean, with respect to a QHP, premiums earned minus taxes.

We propose to revise the definition of "administrative costs" in §153.500 to mean, with respect to a QHP, the total non-claims costs incurred by the QHP issuer for the QHP, including taxes. We note that under this broader definition, administrative costs may also include fees and assessments other than "taxes," as defined above.

Using the definitions above, we propose to amend §153.500 by defining "profits" with respect to a QHP to mean the greater of: (1) 3 percent of after-tax premiums earned; and (2) premiums earned by the QHP minus the sum of allowable costs and administrative costs of the QHP. Thus, we propose to define profits for a QHP through the use of the risk corridors equation; however, we provide for a minimum 3 percent profit margin so that the risk corridors program will protect a reasonable profit margin (subject to the 20 percent cap on allowable administrative costs as described below). We believe that permitting issuers of QHPs to retain a reasonable profit margin will afford them greater assurance of achieving reasonable financial results given the expected changes in the market in 2014 through 2016, and will encourage the issuers to reduce the risk premium built into their rates. Long-term industry trends suggest an average industry underwriting margin of approximately 2 percent.[35] However, our understanding is that the 2 percent margin includes many plans with significant, unexpected underwriting losses, and includes lines of business that typically have lower underwriting margins than those customarily earned in the individual and small group markets. MLR data from 2011 on 30 large issuers suggest an average underwriting margin of

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[35] Borsch, Matthew, CFA, and Wass, Sam, Equity Research Report, *Americas: Managed Care, Decline in Blue Cross Margins Shows the Industry-Wide Downturn*, Goldman Sachs Group, Inc. (August 28, 2012).

approximately 3 percent, once individual issuer negative results are removed. We believe that a calculation with significant negative margins removed better reflects reasonable issuer projections of underwriting profit. We welcome comments on the estimates, data sources, and appropriate profit margin to use in the risk corridor calculation.

Finally, using the definition of profits discussed above, we propose to revise the definition of "allowable administrative costs" in §153.500 so that it means, with respect to a QHP, the sum of administrative costs, other than taxes, and profits earned, which sum is limited to 20 percent of after-tax premiums earned (including any premium tax credit under any governmental program), plus taxes. This definition reflects the inclusion of profits and taxes discussed above, and clarifies that the 20 percent cap on allowable administrative costs applies to taxes, other than taxes deductible from premium revenue under the MLR rules, a result that is consistent with the way these taxes are accounted for by the MLR rules.

The following example illustrates the operation of the risk corridors calculation as proposed in this proposed rule:

- Premiums earned: Assume a QHP with premiums earned of $200.
- Allowable costs: Assume allowable costs of $140, including expenses for health care quality and health information technology, and other applicable adjustments. Risk adjustment and reinsurance payments are after-the-fact adjustments to allowable costs for purposes of determining risk corridors amounts, and allowable costs must be reduced by the amount of any cost-sharing reductions received from HHS.
- Non-Claims Costs: Assume that the QHP has non-claims costs of $50, of which $15 are properly allocable to licensing and regulatory fees and taxes and assessments described in §158.161(a), §158.162(a)(1), and §158.162(b)(1) (that is, "taxes").

The following calculations result:

- Taxes: Under the proposed definition of taxes, the QHP's taxes will be $15.
- Administrative costs are proposed to be defined as non-claims costs. In this case, those costs would be $50. Administrative costs other than taxes would be $35.
- After-tax premiums earned are proposed to be defined as premiums earned minus taxes, or in this case $200 - $15 = $185.
- Profits are proposed to be defined as the greater of: 3 percent of premiums earned, or 3 percent * $200 = $6; and premiums earned by the QHP minus the sum of allowable costs and administrative costs, or $200 – ($140 + $50) = $200 - $190 = $10. Therefore, profits for the QHP would be $10, which is greater than $6.
- Allowable administrative costs are proposed to be defined as the sum of administrative costs, other than taxes, plus profits earned by the QHP, which sum is limited to 20 percent of after-tax premiums earned by the QHP (including any premium tax credit under any governmental program), plus taxes.

= ($35 + $10), limited to 20 percent of $185, plus $15

= $45, limited to $37, plus $15

= $37, plus $15

= $52.

- The target amount is defined as premiums earned reduced by allowable administrative costs, or $200 - $52 = $148.
- The risk corridors ratio is the ratio of allowable costs to target amount, or the ratio of $140 to $148, or approximately 94.6 percent (rounded to the nearest one-tenth of one percent), meaning that the QHP issuer would be required to remit to HHS 50 percent of approximately (97 percent - 94.6 percent) = 50 percent of 2.4 percent, or

approximately 1.2 percent of the target amount, or approximately 0.012 * $148, or approximately $1.78.

We propose these amendments to account for taxes and profits in a manner broadly consistent with the MLR calculation. As described in the Premium Stabilization Rule, we seek alignment between the MLR and risk corridors program when practicable so that similar concepts in the two programs are handled in a similar manner, and similar policy goals are reflected. Otherwise, there would be the potential for the Federal government to subsidize MLR rebate payments, or for an issuer to make risk corridors payments even though no MLR rebates would have been required.

We welcome comments on these proposals.

2. Risk corridors establishment and payment methodology

We propose to add paragraph (d) to §153.510, which would specify the due date for QHP issuers to remit risk corridors charges to HHS. Under this provision, an issuer would be required to remit charges within 30 days after notification of the charges.

We propose a schedule for the risk corridors program, as follows. By June 30 of the year following an applicable benefit year, under the redesignated §153.310(e), issuers of QHPs will have been notified of risk adjustment payments and charges for the applicable benefit year. By that same date, under proposed §153.240(b)(1), QHP issuers also would have been notified of all reinsurance payments to be made for the applicable benefit year. As such, we propose in §153.530(d) that the due date for QHP issuers to submit all information required under §153.530 of the Premium Stabilization Rule is July 31 of the year following the applicable benefit year. We note that in section III.I. of this proposed rule, we are proposing that the MLR reporting deadline be revised to align with this schedule.

We welcome comments on these proposals.

3. Risk Corridors Data Requirements

In §153.530 of the Premium Stabilization Rule, we stated that to support the risk corridors program calculations, a QHP must submit data related to actual premium amounts collected, including premium amounts paid by parties other than the enrollee in a QHP, specifically advance premium tax credits. We further specified that risk adjustment and reinsurance payments be regarded as after-the-fact adjustments to allowable costs for purposes of determining risk corridors amounts, and allowable costs be reduced by the amount of any cost-sharing reductions received from HHS. For example, if a QHP incurred $200 in allowable costs for a benefit year, but received a risk adjustment payment of $25, made reinsurance contributions of $10, received reinsurance payments of $35, and received cost-sharing reduction payments of $15, its allowable costs would be $135 ($200 allowable costs - $25 risk adjustment payments received + $10 reinsurance contributions made - $35 reinsurance payments received – $15 cost-sharing reduction payments).

As noted in section III.E. of this proposed rule, we are proposing an approach to reimbursement of cost-sharing reductions that would add an additional reimbursement requirement for cost-sharing reductions by providers with whom the issuer has a fee-for-service compensation arrangement. As described in section III.E., we propose that issuers be reimbursed for, in the case of a benefit for which the issuer compensates the provider in whole or in part on a fee-for-service basis, the actual amount of cost-sharing reductions provided to the enrollee for the benefit and reimbursed to the provider by the issuer. However, cost-sharing reductions on benefits rendered by providers for which the issuer provides compensation other than on a fee-for-service arrangement (such as a capitated system) would not be held to this standard.

It is our understanding that, in most fee-for-service arrangements, cost-sharing reductions will be passed through to the fee-for-service provider, and as such a QHP's allowable costs should not include either enrollee cost sharing or cost-sharing reductions reimbursed by HHS. However, in contrast in capitated arrangements, cost-sharing reduction payments should be accounted for as a deduction from allowable costs because we assume in a competitive market that capitation payments (which are reflected directly in an issuer's allowable costs) will be raised to account for the reductions in providers' cost-sharing income, and that the issuer will retain the cost-sharing reduction payments.

Therefore, we are proposing to amend §153.530(b)(2)(iii) so that allowable costs are reduced by any cost-sharing reduction payments received by the issuer for the QHP to the extent not reimbursed to the provider furnishing the item or service.

4. Manner of Risk Corridor Data Collection

We also propose to amend §153.530(a),(b), and (c) to specify that we will address the manner of submitting required risk corridors data in future guidance rather than in this HHS notice of benefit and payment parameters.

E. Provisions for the Advance Payments of the Premium Tax Credit and Cost-Sharing Reduction Programs

1. Exchange Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

a. Special Rule for Family Policies

We propose to amend §155.305(g)(3), currently entitled "special rule for multiple tax households." Currently, this provision sets forth a rule for determining the cost-sharing reductions applicable to individuals who are, or who are expected to be, in different tax households but who enroll in the same QHP policy. This provision includes a hierarchy of cost-sharing eligibility categories. Our proposed amendment would

rename this paragraph "special rule for family policies," add a category for qualified individuals who are not eligible for any cost-sharing reductions, and add text to explicitly address situations in which Indians (as defined in §155.300(a)) and non-Indians enroll in a family policy. The proposed amendment would extend the current policy with respect to tax households such that individuals on a family policy would be eligible to be assigned to the most generous plan variation for which all members of the family are eligible. We note that nothing in this provision precludes qualified individuals with different levels of eligibility for cost-sharing reductions from purchasing separate policies to secure the highest cost-sharing reductions for which they are respectively eligible. We expect that Exchanges will assist consumers in understanding the relative costs and benefits of enrolling in a family policy versus several individual policies.

The following example demonstrates the applicability of this provision:

- Example: A and B are parent and child who live together, but are each in separate tax households. A and B purchase a silver level QHP family policy in the individual market on an Exchange. A has a household income of 245 percent of the FPL, while B has a household income of 180 percent of the FPL. Individually, A would be eligible for enrollment in the 73 percent AV silver plan variation (that is, with higher cost-sharing requirements), and B in the 87 percent AV silver plan variation (that is, with lower cost-sharing requirements). Under the proposed provision, A and B would collectively qualify for the 73 percent AV silver plan variation, but not the 87 percent AV silver plan variation.

HHS recognizes that this policy may limit the cost-sharing reductions that members of a family could receive if the family chooses to enroll in a family policy; however, section 1402 of the Affordable Care Act does not permit an individual to receive benefits under the Federal cost-sharing reductions program for which the

individual is ineligible. In addition, because deductibles and out-of-pocket limits are calculated at the policy level, as opposed to the individual level, it would be operationally difficult to establish separate cost-sharing requirements for different enrollees within the same policy. We discuss this policy further with regard to Indians in section III.E.4.i. of this proposed rule. We welcome comments on this proposal and its effect on families.

b. Recalculation of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

We propose to add paragraph (g) to §155.330, related to eligibility redeterminations during a benefit year, to clarify how changes during a benefit year in a tax filer's situation that are reported or identified in accordance with §155.330 affect eligibility for advance payments of the premium tax credit and cost-sharing reductions. As discussed in the Exchange Establishment Rule, an Exchange must redetermine a tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions either as a result of a self-reported change by an individual under §155.330(b) or as a result of periodic data matching as described in §155.330(d).

As described in 26 CFR 1.36B-4(a)(1), a tax filer whose premium tax credit for the taxable year exceeds the tax filer's advance payments may receive the excess as an income tax refund, and a tax filer whose advance payments for the taxable year exceed the tax filer's premium tax credit would owe the excess as additional income tax liability, subject to the limits specified in 26 CFR 1.36B-4(a)(3). Consequently, it is important when calculating advance payments that the Exchange act to minimize any projected discrepancies between the advance payments and the final premium tax credit amount, which would be determined by the IRS after the close of the tax year. Thus, we propose in §155.330(g)(1)(i) that when an Exchange is recalculating the amounts of advance payments of the premium tax credit available due to an eligibility redetermination made

during the benefit year, an Exchange must account for any advance payments already made on behalf of the tax filer in the benefit year for which information is available to the Exchange, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's projected premium tax credit for the benefit year, calculated in accordance with 26 CFR 1.36B-3. We propose in § 155.330(g)(1)(ii) to specify that the advance payment provided on the tax filer's behalf must be greater than or equal to zero, and must comply with 26 CFR 1.36B-3(d), which limits advance payments to the total premiums for the QHPs (and stand-alone dental plans, if applicable) selected.

The following example demonstrates the applicability of this provision:

- Tax filer A is determined eligible for enrollment in a QHP through the Exchange and for advance payments of the premium tax credit during open enrollment prior to 2014 based on an expected household income for the year 2014 of $33,510 (300 percent of the FPL). Tax filer A seeks to purchase coverage in a rating area where the premium for the second lowest cost silver plan is $300 per month. As such, the maximum amount of advance payments of the premium tax credit per month would be calculated as follows: 300 – ((1/12)*(9.5%*33,510)) = $35. During the month of June, the tax filer reports an expected decrease in annual household income such that tax filer A's projected household income for the year 2014 will now be $27,925 (250 percent of the FPL). Thus, the maximum amount of advance payments of the premium tax credit per month would be calculated as follows: 300 – ((1/12)*(8.05%*27,925)) = $113. However, the Exchange's recalculation of advance payments of the premium tax credit must take into account the advance payments already made on behalf of tax filer A. The Exchange must first multiply $113 by 12 months to calculate the expected tax credit for the entire year ($1,356), subtract the amount already paid for the first six months ($210),

and then divide the difference by the number of months remaining in the year (six), which results in a recalculated maximum advance payment for the remaining months of $191. In this example, we assume that the taxpayer has elected to have the maximum advance payment for which he or she is eligible to be paid to his or her selected QHP issuer.

If a tax filer is determined eligible for advance payments of the premium tax credit during the benefit year but did not previously receive advance payments of the premium tax credit, the Exchange would calculate the advance payments in accordance with the process described above, without subtracting any previous payments. We reiterate that the provision of all advance payments of the premium tax credit must be consistent with section 36B of the Code and its implementing regulations, including the requirement that premium tax credits (and advance payments) are available only for "coverage months" during which the individual is eligible and enrolled in a QHP through the Exchange. We also considered taking a different approach if an eligibility redetermination during the benefit year results in an increase in advance payments of the premium tax credit—we considered proposing that in such a situation, HHS would make retroactive payments to the QHP issuer for all prior months of the benefit year to reflect the increased advance payment amount, not to exceed the total premium for each month. This approach would permit us to pay out more of the full premium tax credit amount prior to the close of the tax year. Without retroactive payments, in the case of a redetermination late in the year, we would have a limited ability to pay out an increase because of the limitation that the premium tax credit – and thus the advance payments of the premium tax credit not exceed the total premium for the month. Following this alternative approach in the case of increases in advance payments of the premium tax credit during the benefit year could also help address any outstanding premium amounts

owed by an enrollee to a QHP issuer. We solicit comments regarding whether we should adopt this approach, and how QHP issuers should be required to provide the retroactive payments to enrollees.

In §155.330(g)(2), we propose that, when redetermining eligibility for cost-sharing reductions during the benefit year, an Exchange must determine an individual to be eligible for the category of cost-sharing reductions that corresponds to the individual's expected annual household income for the benefit year, as determined at redetermination. Section 1402(f)(3) of the Affordable Care Act provides that eligibility determinations for cost-sharing reductions are made on the basis of the expected annual household income for the same taxable year for which the advance payment determination is made under section 1412(b) of the Affordable Care Act. Therefore, if a mid-year change in income triggers use of a new annual household income figure for purposes of determining eligibility for advance payments of the premium tax credit, eligibility for cost-sharing reductions must also be redetermined using the new figure. However, unlike the premium tax credit, cost-sharing reductions are not reconciled at the end of the year by tax filers. As such, redeterminations of eligibility for cost-sharing reductions should not take into account the amount of cost-sharing reductions already provided on an individual's behalf.

The following example demonstrates the applicability of this provision:

- Tax filer B is determined eligible for enrollment in a QHP through the Exchange and for cost-sharing reductions during open enrollment prior to 2014 and enrolls in a silver plan QHP. Tax filer B is assigned to a plan variation in January 2014 based on an expected annual household income of 150 percent of the FPL. During the month of June, the tax filer self-reports an increase in expected household income such that tax filer B's expected annual household income will now be at 200 percent of the

FPL. The Exchange must redetermine the tax filer's eligibility for cost-sharing reductions for the remainder of the benefit year following the effective date of redetermination at 200 percent of the FPL, which is the tax filer's expected annual household income, and the tax filer should then be assigned to the plan variation designed to provide cost-sharing reductions for individuals with that expected annual household income.

c. Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

We propose to add two paragraphs to §155.340. First, we propose to add paragraph (e) to §155.340, which would provide that if one or more individuals in a tax household who are eligible for advance payments of the premium tax credit(s) collectively enroll in more than one policy through the Exchange (whether by enrolling in more than one policy under a QHP, enrolling in more than one QHP, or enrolling in one or more QHPs and one or more stand-alone dental plans) for any month in a benefit year, the Exchange must allocate the advance payment of the premium tax credit(s) in accordance with the methodology proposed in §155.340(e)(1) and (2). We note that an Exchange, under §155.340(a), must submit to HHS the dollar amount of the advance payment that will be made to each QHP on behalf of the enrollee.

We propose the following allocation methodology: as described in §155.340(e)(1), the Exchange must first allocate the portion of the advance payment of the premium tax credit(s) that is less than or equal to the aggregate adjusted monthly premiums for the QHP policies, as defined under 26 CFR 1.36B-3(e), properly allocated to EHB, among the QHP policies in proportion to the respective portions of the premiums for the policies properly allocated to EHB. As described in proposed §155.340(e)(2), any remaining advance payment of the premium tax credit(s) must be allocated among the

stand-alone dental policies in proportion to the respective portions of the adjusted monthly premiums for the stand-alone dental policies properly allocated to the pediatric dental EHB. The portion of the adjusted monthly premium for a QHP policy or a stand-alone dental policy that is allocated to EHB would be determined based on the information that the QHP issuer submits, under the proposed §156.470, and described in section III.E.2. of this proposed rule. For example, if a family collectively eligible for advance payments of the premium tax credit purchases two QHPs and a stand-alone dental plan, with a $500 adjusted monthly premium allocated to EHB, a $400 adjusted monthly premium allocated to EHB, and a $100 adjusted monthly premium allocated to the pediatric dental essential health benefit, respectively, the Exchange must allocate five-ninths of the advance payment of the premium tax credit (up to $500) to the first QHP, and four-ninths (up to $400) to the second QHP. If there is any remaining advance payment of the premium tax credit, this will be allocated to the stand-alone dental plan. This rule ensures a pro rata allocation (by premium) of the advance payment of the premium tax credit to the QHPs, while ensuring that the advance payment of premium tax credits are only for (and based on) the portion of premiums for EHB. We welcome comments on this proposal.

Second, we propose to add paragraph (f) to §155.340, which sets forth standards for an Exchange when it is facilitating the collection and payment of premiums to QHP issuers and stand-alone dental plans on behalf of enrollees, as permitted under §155.240(c). Consistent with our proposed provision in §156.460(a), §155.340(f)(1) would direct the Exchange to reduce the portion of the premium for the policy collected from the enrollee by the amount of the advance payment of the premium tax credit for the applicable month(s) when the Exchange elects to collect premiums on behalf of QHPs. Because the Exchange is responsible for premium collections in these circumstances, the

Exchange must also take responsibility for lowering the premium costs charged to enrollees by the amount of the credit. Proposed §155.340(f)(2) would direct Exchanges to display the amount of the advance payment of the premium tax credit for the applicable month(s) on an enrollee's billing statement. This is the Exchange equivalent of the requirement for QHP issuers proposed in §156.460(b). Both rules are drafted for the same purpose: to ensure that an enrollee is aware of the total cost of the premium so that he or she may verify that the correct advance payment of the premium tax credit has been applied. We welcome comments on this proposal.

2. Exchange Functions: Certification of Qualified Health Plans

We propose to add §155.1030. This section would set forth standards for Exchanges to ensure that QHPs in the individual market on the Exchange meet the requirements related to advance payments of the premium tax credit and cost-sharing reductions, as proposed in §156.215 and described below. We propose these standards under section 1311(c) of the Affordable Care Act, which provides for the Secretary to establish criteria for the certification of health plans as QHPs, as well as section 1321(a)(1), which provides general rulemaking authority for title I of the Affordable Care, including the establishment of programs for the provision of advance payments of the premium tax credit and cost-sharing reductions. We believe that it is appropriate to incorporate these standards into the QHP certification criteria because Exchanges are the primary entities that interact with and oversee QHPs.

In §155.1030(a)(1), we propose that the Exchange ensure that each issuer that offers or seeks to offer a QHP in the individual market on the Exchange submit the required plan variations, as proposed in §156.420, for each of its health plans proposed to be offered in the individual market on the Exchange. Further we propose that the Exchange must certify that the plan variations meet the requirements detailed in

§156.420. We expect that an Exchange would collect prior to each benefit year the information necessary to validate that the issuer meets the requirements for silver plan variations, as detailed in §156.420(a), and collect for certification the information necessary to validate that the issuer meets the requirements for zero and limited cost sharing plan variations, as detailed in §156.420(b) . We expect that this data collection would include the cost-sharing requirements for the plan variations, such as the annual limitation on cost sharing, and any reductions in deductibles, copayments or coinsurance. In addition, the Exchange would collect or calculate the actuarial values of each QHP and silver plan variation, calculated under §156.135 of the proposed EHB/AV Rule. We propose in §155.1030(a)(2) that the Exchange provide the actuarial values of the QHPs and silver plan variations to HHS. As described in §156.430, HHS would use this information to determine the payments to QHP issuers for the value of the cost-sharing reductions.

In §155.1030(b)(1), we propose to require the Exchange to collect certain information that an issuer must submit under §156.470 that would allow for the calculation of the advance payments of cost-sharing reductions and the premium tax credit. Specifically, in §156.470(a), we propose that an issuer provide to the Exchange annually for approval, for each metal level health plan (that is, a health plan at any of the four levels of coverage, as defined in §156.20) offered, or proposed to be offered, in the individual market on the Exchange, an allocation of the rate and the expected allowed claims costs for the plan, in each case, to: (1) EHB, other than services described in §156.280(d)(1),[36] and (2) any other services or benefits offered by the health plan not described in clause (1). We propose this annual submission of the rate allocation

[36] 45 CFR 156.280(e)(1)(i) provides that if a QHP provides coverage of services described in paragraph (d)(1) of that section, the QHP issuer must not use Federal funds, including advance payments of the premium tax credit or cost-sharing reductions, to pay for the services.

information, under section 36B(b)(3)(D) of the Code, as added by section 1401 of the Affordable Care Act, to allow for the removal of the cost of "additional benefits" from the advance payments of the premium tax credit. The rate allocation information would allow the Exchange to calculate the percentage of the rate attributable to EHB; this percentage could then be multiplied by the adjusted monthly premium, as defined by 26 CFR 1.36B-3(e), and the monthly premium of the QHP in which the taxpayer enrolls, to calculate the premium assistance amount. The allocation of the expected allowed claims costs would be used to validate the rate allocation, and to calculate the advance payments for cost-sharing reductions as described in proposed §156.430 of this proposed rule.

In §156.470(e), we further propose that an issuer of a metal level health plan offered, or proposed to be offered, in the individual market on the Exchange also submit to the Exchange annually for approval, an actuarial memorandum with a detailed description of the methods and specific bases used to perform the allocations. The Exchange and HHS would use this memorandum to verify that the allocations meet the standard, proposed in §156.470(c). First, the issuer must ensure that the allocation is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies. Second, the rate allocation should reasonably reflect the allocation of the expected allowed claims costs attributable to EHB (excluding those services described in §156.280(d)(1)). Third, the allocation should be consistent with the allocation of State-required benefits to be submitted by the issuer as proposed in §155.170(c) of the proposed EHB/AV Rule, and the allocation requirements described in §156.280(e)(4) for certain services. Fourth, the issuer should calculate the allocation as if it was a premium under the fair health insurance premium standards described at §147.102, the single risk pool standards described at §156.80, and the same premium rate standards described at §156.255. We propose this requirement

because we believe the allocation of rates should be performed consistent with the standards applicable to the setting of rates. Thus, for example, an issuer should calculate the allocation of premiums using costs for essential health benefits across all enrollees in all plans in the relevant risk pool, under §156.80, and not across a standardized population or a plan-specific population. Although the last approach might yield a more accurate allocation, it would increase the analytical burden on issuers, and it would not align with other reporting requirements, such as for the Effective Rate Review program (established under section 2794 of the PHS Act), which requires projections based on the single risk pool standards. We welcome comment on this proposed standard and alternative approaches.

In §156.470(b), we propose somewhat similar standards for the allocation of premiums for stand-alone dental plans. Specifically, we propose that an issuer provide to the Exchange annually for approval, for each stand-alone dental plan offered, or proposed to be offered, in the individual market on the Exchange, a dollar allocation of the expected premium for the plan, to: (1) the pediatric dental essential health benefit, and (2) any benefits offered by the stand-alone dental plan that are not the pediatric essential health benefit. As described in 26 CFR 1.36B-3(k), this allocation will be used to determine premium tax credit, and thus the advance payment of the premium tax credit, available if an individual enrolls in both a QHP and a stand-alone dental plan. We note that unlike issuers of metal level health plans offered or proposed to be offered as QHPs, issuers of stand-alone dental plans would be required to submit a dollar allocation of the expected premium for the plan (rather than a percentage of the rate, which would be multiplied by the premium to determine the allocation of the premium).

We propose this approach because issuers of stand-alone dental plans are exempt from certain standards in the proposed Market Reform Rule, including §147.102 and

156.80 (related to fair health insurance premiums and the single risk pool), and as a result, are not required to develop rates under the same limitations that apply to issuers of QHPs in the individual and small group markets. Implicit in the allocation methodology required for issuers of QHPs proposed in §156.470(a) is a requirement that the premium rating methodology be set prior to the allocation. We anticipate that issuers of stand-alone dental plans may take into account additional rating factors, up to and including medical underwriting, which would make the completion and submission of final premium rating methodologies to the Exchange problematic. Our proposal at §156.470(b) does not require issuers of stand-alone dental plans to finalize the total premium prior to the benefit year, but does require issuers to finalize the dollar amount of the premium allocable to the pediatric dental essential health benefit to allow for the calculation of advance payments of the premium tax credit. This approach will ensure that Exchanges have sufficient information to calculate advance payments of the premium tax credit at the time an applicant selects coverage.

In proposed §156.470(e), we also propose that issuers of stand-alone dental plans submit to the Exchange annually for approval an actuarial memorandum with a detailed description of the methods and specific bases used to perform the allocations, demonstrating that the allocations meet the standards proposed in §156.470(d). These standards are similar to those proposed for issuers of metal level health plans offered or proposed to be offered as QHPs, with some adaptations specific to stand-alone dental plans. In §156.470(d)(1) and (2) we propose that the allocation be performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, and be consistent with the allocation applicable to State-required benefits to be submitted by the issuer under §155.170(c). In addition, in §156.470(d)(3), we propose that the allocation be calculated under the fair health

insurance premium standards described at 45 CFR 147.102, except for the provision related to age set forth at §147.102(a)(1)(ii); the single risk pool standards described at 45 CFR 156.80; and the same premium rate standards described at 45 CFR 156.255 (in each case subject to the standard proposed in subparagraph (4) described below). We propose these standards because we believe that Congress intended that premium tax credits be available based on the market reforms embodied in the Affordable Care Act. However, in the place of the fair health insurance premium standards related to age, we propose in subparagraph (4) that the allocation be calculated so that the amount of the premium allocated to the pediatric dental essential health benefit for an individual under the age of 19 years does not vary, and the amount of the premium allocated to the pediatric dental essential health benefit for an individual aged 19 years or more is equal to zero. Thus, for example, an issuer of a stand-alone dental plan should calculate the dollar allocation for individuals under 19 years of age across all such enrollees in all plans in the relevant risk pool, under §156.80. This will ensure that advance payments of the premium tax credit are applied to policies that include individuals who may benefit from the pediatric dental essential health benefit as interpreted in the proposed EHB/AV Rule. We seek comment on this approach and the proposed allocation standards. We also note that issuers of stand-alone dental plans are not required to submit an allocation of their expected allowed claims costs because these plans are not eligible for cost-sharing reductions, as described in §156.440(b).

In §155.1030(b)(1), we propose that the Exchange collect and review annually the rate or premium allocation, the expected allowed claims cost allocation, and the actuarial memorandum that an issuer submits; and ensure that such allocations meet the standards set forth in §156.470(c). To ensure that the allocations are completed appropriately, we expect that the Exchange will review the allocation information in conjunction with the

rate and benefit information that the issuer submits under §156.210. To facilitate this review, we proposed revisions to the reporting requirements for the Effective Rate Review program in the proposed Market Reform rule to include the rate allocation and expected allowed claims cost allocation information that issuers of metal level health plans would submit. Therefore, an Exchange that coordinates its review of QHP rates and benefits with the State's Effective Rate Review program would be able to also coordinate the allocation review, avoiding duplication. This approach should streamline the submission process for issuers. We note, however, that it is ultimately the responsibility of the Exchange to ensure that the issuer performs the allocations appropriately for each health plan or stand-alone dental plan that the issuer offers, or seeks to offer, on the individual market in the Exchange, including those that are not reported as part of the Effective Rate Review program. Therefore, we expect that Exchanges will collect the allocation information through the Effective Rate Review program or the QHP certification and annual submission process, as appropriate.

As discussed above, the rate and premium allocation information would then be used by the Exchange to calculate the dollar amounts of the advance payments of the premium tax credit, and the expected allowed claims cost allocation would be used by HHS to calculate the advance payments of the cost-sharing reductions, as described in §156.430. To allow for these calculations, and to ensure that Federal funds are spent appropriately, we propose under §155.1030(b)(2) that the Exchange be required to submit to HHS the approved allocation(s) and actuarial memorandum for each QHP and stand-alone dental plan. We propose to provide further detail on the manner and timeframe of this submission to HHS in the future; however, we expect that the Exchange would be required to submit the information prior to the start of the benefit year. In paragraph (b)(4), we propose authority for the use of this data by HHS for the approval of the

estimates that issuers submit for advance payments of cost-sharing reductions described in §156.430, and for the oversight of the advance payments of cost-sharing reductions and premium tax credits programs.

In §155.1030(b)(3), we propose that the Exchange collect annually any estimates and supporting documentation that a QHP issuer submits to receive advance payments for the value of the cost-sharing reductions under §156.430(a). The Exchange must then submit the estimates and supporting documentation to HHS for review and approval. This collection from issuers should occur as part of the initial QHP certification process and any annual submission process. We propose to provide further detail on the manner and timeframe of the submission to HHS in the future; however, we expect that the Exchange would be required to submit the information prior to the start of the benefit year.

3. QHP Minimum Certification Standards Relating to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

Under HHS rulemaking authority under sections 1311(c)(1), 1321(a)(1), 1402 and 1412 of the Affordable Care Act, we propose to add §156.215. This section would amend the QHP minimum certification standards and specify that an issuer seeking to offer a health plan on the individual market in the Exchange meet the requirements described in subpart E of part 156 related to the administration of advance payments of the premium tax credit and cost-sharing reductions. We propose to add this section to clarify that compliance with part 156 subpart E, including the standards and submission requirements proposed at §156.420 and §156.470, is a requirement of QHP certification, and therefore, is included in the standard described at §155.1000(b), under which an Exchange must offer only health plans that meet the minimum certification requirements. Under our proposal, continuing compliance with subpart E requirements by QHPs and

QHP issuers is a condition of certification; failure to comply with the requirements could result in decertification of the QHP as well as other enforcement actions. This corresponds to the proposed addition of §155.1030, which sets forth the Exchange responsibilities on certification with respect to advance payments of the premium tax credit and cost-sharing reductions (described previously).

4. Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

a. Definitions

Under §156.400, we propose definitions for terms that are used throughout subpart E of part 156. These terms apply only to subpart E. Some of these definitions cross-reference definitions elsewhere in parts 155 or 156, including definitions proposed in the proposed EHB/AV Rule: the terms "advance payments of the premium tax credit" and "Affordable Care Act" are defined by reference to §155.20, and the term "maximum annual limitation on cost sharing" is defined as the highest annual dollar amount that health plans (other than QHPs with cost-sharing reductions) may require in cost sharing for a particular year, as established for that year under §156.130 of the proposed EHB/AV Rule. The terms "Federal poverty level or FPL" and "Indian" are defined by reference to §155.300(a). The term "de minimis variation" is defined as the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan as established in §156.140(c)(1) of the proposed EHB/AV Rule. We also propose to define "stand-alone dental plan" as a plan offered through an Exchange under §155.1065. We seek comment on these definitions.

We propose to rely on the definitions of "cost sharing" and "cost-sharing reductions" from §156.20. We note that the definitions of cost sharing and cost-sharing reductions apply only with respect to EHB, though without regard to whether the EHB is

provided inside or outside of a QHP's network. We propose to define "annual limitation on cost sharing" to mean the annual dollar limitation on cost sharing required to be paid by an enrollee that is established by a particular health plan. However, as proposed in §156.130(c) of the proposed EHB/AV Rule, we note again that the annual limitation on cost sharing would not include cost sharing for benefits provided outside of a QHP's network. If a State requires a QHP to cover benefits in addition to EHB, the provisions of this subpart E (except for §156.420(c) and (d)) relating to cost-sharing reductions do not apply to those additional State-required benefits. For clarity, we note these provisions apply to State-required benefits included in EHB under §156.110(f) of the proposed EHB/AV Rule. Finally, we note that cost-sharing reductions are subject to §156.280(e)(1)(ii).

Other definitions are proposed here to effectuate the regulations proposed in subpart E. This Payment Notice includes five related definitions: standard plan, silver plan variation, zero cost sharing plan variation, limited cost sharing plan variation, and plan variation, as follows:

- We propose to define "standard plan" as a QHP offered at one of the four levels of coverage, defined at §156.140, with an annual limitation on cost sharing that conforms to the requirements of §156.130(a). A standard plan at the bronze, silver, gold, or platinum level of coverage is referred to as a standard bronze plan, a standard silver plan, a standard gold plan, and a standard platinum plan, respectively.

- We propose to define "silver plan variation" as, with respect to a standard silver plan, any of the variations of that standard silver plan described in §156.420(a).

- We propose to define "zero cost sharing variation" as, with respect to a QHP at any level of coverage, the variation of such QHP described in §156.420(b)(1), which provides for the elimination of cost sharing for Indians based on household income level..

- We propose to define "limited cost sharing variation" as, with respect to a QHP at any level of coverage, the variation of such QHP described in §156.420(b)(2), which provides for the prohibition on cost sharing applicable to the receipt of benefits from IHS or certain other providers, irrespective of income level.

- We propose to define "plan variation" as a zero cost sharing plan variation, limited cost sharing plan variation, or silver plan variation. We emphasize that the plan variations of a QHP are not separate plans, but variations in how the cost sharing required under the QHP is to be shared between the enrollee(s) and the Federal government.

We propose these definitions to administer and implement the cost-sharing reductions established under section 1402 of the Affordable Care Act. As described in more detail below, although there will only be one actual QHP (for example, a standard silver plan) with one standard cost-sharing structure, we use the concept of plan variations to describe how certain eligible individuals will pay only a portion of the total cost sharing required under that QHP, with the Federal government bearing the remaining cost-sharing obligations under section 1402 of the Affordable Care Act.

To reflect how the Affordable Care Act creates different eligibility categories with different associated cost-sharing reductions, we propose that each plan variation will reflect the enrollee's portion of the cost sharing requirements for the QHP. We refer to "assigning" enrollees to the applicable plan variation to describe how the enrollee will receive the benefits described in section 1402 of the Affordable Care Act. We reiterate that these variations are not different QHPs and that a change in eligibility for cost-sharing reductions simply changes the enrollee's responsibility for part of the total cost sharing under the same QHP. We seek comment on these definitions.

We propose to define "de minimis variation for a silver plan variation" as a single percentage point. That is, we propose that 1 percentage point variation in the AV of a

silver plan variation would not result in a material difference in the true dollar value of the silver plan variation. We note that this proposal differs from the 2 percentage point de minimis variation standard for health plans, proposed in §156.140(c)(1) of the proposed EHB/AV Rule. We believe that because cost-sharing reductions are reimbursed by the Federal government, the degree of flexibility afforded to issuers of silver plan variations in the cost-sharing design should be somewhat less. With this standard we seek to balance the need to ensure that individuals receive the full value of the cost-sharing reductions for which they are eligible, and issuers' ability to set reasonable cost-sharing requirements.

We propose to define "most generous" or "more generous" as, between a QHP (including a standard silver plan) or plan variation and one or more other plan variations of the same QHP, the QHP or plan variation designed for the category of individuals last listed in §155.305(g)(3). That list, as proposed to be amended under this rule, first lists the QHP with no cost-sharing reductions, followed by the limited cost sharing plan variation, the 73 percent, 87 percent, and 94 percent silver plans, and finally, the zero cost sharing plan variation. We seek comment on this definition.

We propose to define the "annual limitation on cost sharing" as the annual dollar limit on cost sharing required to be paid by an enrollee that is established by a particular QHP. We note that this definition refers to the plan-specific cost-sharing parameter, while the defined term "maximum annual limitation on cost sharing" refers to the uniform maximum that would apply to all QHPs (other than QHPs with cost-sharing reductions) for a particular year.

Finally, we propose to define the "reduced maximum annual limitation on cost sharing" as the dollar value of the maximum annual limitation on cost sharing for a silver plan variation that remains after applying the reduction in the maximum annual limitation

on cost sharing required by section 1402 of the Affordable Care Act, as announced in the annual HHS notice of benefit and payment parameters. The reduced maximum annual limitation on cost sharing for each silver plan variation for 2014 is proposed in the preamble for §156.420 of this Payment Notice. The reduced maximum annual limitation applies, as does the maximum annual limitation, only with respect to cost sharing on EHB, and does not apply to cost sharing on services provided by out-of-network providers.

b. Cost-sharing reductions for enrollees

In §156.410(a), we propose that a QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pay only the cost sharing required of an eligible individual for the applicable covered service under a plan variation. For example, if an individual is assigned to an 87 percent AV silver plan variation, and the copayment for a hospital emergency room visit is reduced from $100 to $50 under that silver plan variation, the individual must be charged only the reduced copayment of $50. We also specify in this paragraph that the enrollee receive this reduction in cost sharing when the cost sharing is collected, which in this instance might occur when the enrollee visits the emergency room for care. This means that a QHP issuer may not create a system in which an eligible enrollee is required to pay the full cost sharing requirement and apply for a reimbursement or refund. This proposal applies to all forms of cost sharing, including copayments, coinsurance, and deductibles. Similarly, the QHP issuer must ensure that the enrollee is not charged any type of cost sharing after the applicable annual limitation on cost sharing has been met. We note, however, that an individual eligible for cost-sharing reductions would not be eligible for a reduced copayment or coinsurance rate until any applicable (potentially reduced) deductible has been paid. For example, assume that a QHP issuer requires a

$750 deductible for individuals eligible for a 73 percent AV silver plan variation, with reduced cost sharing occurring after the deductible is met. Further assume that an individual eligible for cost-sharing reductions has not previously incurred cost sharing during the benefit year under the QHP and has a two day hospital stay that costs $500 per day. Under this plan variation, the individual must pay $500 for the first day and $250 for the second day to meet the plan's deductible requirements before receiving the reduced coinsurance or copayment under the 73 percent AV plan variation. We seek comment on these provisions.

In §156.410(b), we propose that after a qualified individual makes a plan selection, a QHP issuer would assign the individual to the applicable plan variation under the eligibility determination sent to the QHP issuer by the Exchange. For example, an individual determined by the Exchange to be eligible for a 94 percent AV silver plan variation would be provided the option to enroll in any silver health plan with the appropriate cost-sharing reductions applied (the statute specifies that cost-sharing reductions are available to non-Indians only in silver health plans). We note that the QHP issuer is entitled to rely upon the eligibility determination sent to the QHP issuer by the Exchange.

In §156.410(b)(1), we propose that a QHP issuer assign a qualified individual who chooses to enroll in a silver plan in the individual market in the Exchange to the silver plan variation for which the qualified individual is eligible. This proposal is consistent with section 1312(a)(1) of the Affordable Care Act, which permits the individual to enroll in the silver health plan. However, section 1312(a)(1) does not address whether the individual could opt out of the most generous silver plan variation (that is, to refuse the most generous cost-sharing reductions for which the individual is eligible). We believe that allowing opting out of the most generous silver plan variation

could cause significant consumer confusion, with no attendant policy benefit. Furthermore, we note that if a qualified individual does not want to take advantage of the cost-sharing reductions for which he or she is eligible, the individual may elect to decline to apply for cost-sharing reductions when seeking enrollment through the Exchange. In addition, we note that section 1402(a) states the requirement on QHP issuers to provide cost-sharing reductions to eligible individuals once the QHP issuer has been notified of the individual's eligibility. We invite comment on this approach.

Section §156.410(b)(2) and (3) are discussed below in the section of this proposed rule related to special cost-sharing reduction rules for Indians.

In §156.410(b)(4), we propose that a QHP issuer must assign an individual determined ineligible by the Exchange for cost-sharing reductions to the selected QHP with no cost-sharing reductions.

c. Plan Variations

In §156.420, we propose that issuers submit to the Exchange for certification and approval the variations of the health plans that they seek to offer, or continue to offer, in the individual market on the Exchange as QHPs that include required levels of cost-sharing reductions. We further clarify that under our proposal, multi-State plans, as defined in §155.1000(a), and CO–OP QHPs, as defined in §156.505, would be subject to the provisions of this subpart. OPM will certify the plan variations of the multi-State plans and determine the time and manner for submission.

Sections 1402(a) through (c) of the Affordable Care Act direct issuers to reduce cost sharing for EHB for eligible insured enrolled in a silver health plan with household incomes between 100 and 400 percent of the FPL, such that the plan's share (before any reimbursement from HHS for cost-sharing reductions) of the total allowed costs of the benefits are a certain percentage (that is, the health plan meets a certain AV level). To

achieve these AV levels, the law directs issuers to first reduce the maximum annual limitation on cost sharing. The amount of the reduction in the maximum annual limitation on cost sharing is specified in the statute; however, under section 1402(c)(1)(B)(ii) of the Affordable Care Act, the Secretary may adjust the reduction to ensure that the resulting limits do not cause the AVs of the health plans to exceed the specified levels. After the issuer reduces the annual limitation on cost sharing to comply with the applicable reduced maximum annual limitation, section 1402(c)(2) of the Affordable Care Act directs the Secretary to establish procedures under which an issuer is to further reduce cost sharing if necessary to achieve the specified AV levels.

Table 14 sets forth the reductions in the maximum annual limitation on cost sharing (subject to revision by the Secretary) and AV levels applicable to silver plans for these individuals, under section 1402(c) of the Affordable Care Act:

TABLE 14: Statutory Reductions in Maximum Annual Limitation on Cost Sharing

Household Income	Reduction in Maximum Annual Limitation on Cost Sharing (subject to revision by the Secretary)	AV Level (calculated before any reimbursement from HHS)
100-150% of FPL	2/3	94%
150-200% of FPL	2/3	87%
200-250% of FPL	½	73%
250-300% of FPL	½	70%
300-400% of FPL	1/3	70%

For individuals with household incomes of 250 to 400 percent of the FPL, we note that without any change in other forms of cost sharing, any reduction in the maximum annual limitation on cost sharing will cause an increase in AV. Therefore, a reduction in the maximum annual limitation on cost sharing for the standard silver plan could require corresponding increases in other forms of cost sharing to maintain the required 70 percent AV. For example, if a plan were directed to lower its annual limitation on cost sharing for individuals with household income between 250 and 400

percent of the FPL from $6,000 to $5,000, the issuer might be required to significantly increase plan deductibles, coinsurance, and co-payments to maintain the required 70 percent AV. We anticipate that most individuals would not expect to reach the annual limitation on cost sharing, and therefore, would be required to pay more in up-front costs under such a cost-sharing structure. Given the effect of the reductions in the maximum annual limitation on cost sharing outlined above and the additional administrative burden required in designing and operating additional silver plan variations, we propose not to reduce the maximum annual limitation on cost sharing for individuals with household incomes between 250 and 400 percent of the FPL. We believe that this approach is within the Secretary's authority under section 1402(c)(1)(B)(ii) of the Affordable Care Act, and would benefit those individuals who do not expect to reach the annual limitation on cost sharing, who are likely to represent the majority of eligible individuals. The majority of those who commented on this approach in response to the AV/CSR Bulletin were supportive of this proposed implementation of section 1402(c)(1) of the Affordable Care Act.

For individuals with a household income of 100 to 250 percent of the FPL, we propose, as outlined in the AV/CSR Bulletin, an annual three-step process for the design of cost-sharing structures in the silver plan variations, as follows:

Step 1. In the first step, we would identify in the annual HHS notice of benefit and payment parameters the maximum annual limitation on cost sharing applicable to all plans that will offer the EHB package. This limit would be used to set the reduced maximum annual limitation on cost sharing applicable to silver plan variations.

Section 156.130(a) of the proposed EHB/AV Rule relates to the maximum annual limitation on cost sharing for EHB packages. For benefit year 2014, cost sharing (except for cost sharing on services provided by out-of-network providers) under self-only

coverage and non-self-only coverage may not exceed the annual dollar limit on cost sharing for high deductible health plans as described in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Code, respectively. For a benefit year beginning after 2014, the maximum annual limitation on cost sharing will equal the dollar limit for 2014 benefit year adjusted by a premium adjustment percentage determined by HHS, under section 1302(c)(4) of the Affordable Care Act. We plan to propose the premium adjustment percentage applicable to the 2015 benefit year in the next HHS notice of benefit and payment parameters.

Maximum Annual Limitation on Cost Sharing for Benefit Year 2014: As discussed above, the maximum annual limitation on cost sharing for 2014 will be the dollar limit on cost sharing for high deductible health plans set by the IRS for 2014. The IRS will publish this dollar limit in the spring of 2013. However, to allow time for HHS to analyze the impact of the reductions in the maximum annual limitation on cost sharing on health plan AV levels, and to allow issuers adequate time to develop the cost-sharing structures of their silver plan variations for submission during the QHP certification process, we propose to estimate the dollar limit for 2014, using the methodology detailed in sections 223(c)(2)(A)(ii) and 223(g) of the Code. This methodology calls for a base dollar limit to be updated annually by a cost-of-living adjustment, which for 2014 is based on the average Consumer Price Index for all urban consumers, published by the Department of Labor, for a 12-month period ending March 31, 2013. Because that the Consumer Price Index for March 2013 is not yet available, we propose to use a projection of this number developed by the Office of Management Budget for the President's Budget for Fiscal Year 2013. Using this projection, and the methodology described in the Code, we estimate that the maximum annual limitation on cost sharing for self-only coverage for 2014 will be approximately $6,400 (the maximum annual limitation on cost

sharing for other than self-only coverage for 2014 would be twice that amount, or $12,800). This is slightly more than a 2 percent increase from the limit set by IRS for 2013 ($6,250). We emphasize that this estimate was developed only for purposes of setting the reduced maximum annual limitation on cost sharing for silver plan variations. Under section 1302(c)(1)(A) of the Affordable Care Act, cost sharing incurred under plans offering EHB packages in 2014 cannot exceed the limit set by IRS under section 223(c)(2)(A)(ii)(I) and (II) of the Code for 2014 plan years. We welcome comment on this approach.

Step 2. In the second step under our proposal, we would analyze the effect on AV of the reductions in the maximum annual limitation on cost sharing described in section 1402(c)(1)(A) of the Affordable Care Act. Under section 1402(c)(1)(B)(ii), we would adjust the reduction in the maximum annual limitation on cost sharing, if necessary, to ensure that the actuarial value of the applicable silver plan variations would not exceed the actuarial value specified in section 1402(c)(1)(B)(i). A description of our analyses and the reduced annual limitations on cost sharing for the three income categories will be published in this annual HHS notice of benefit and payment parameters.

Reduced Maximum Annual Limitation on Cost Sharing for Benefit Year 2014. For the 2014 benefit year, we analyzed the impact on actuarial value of the reductions described in the Affordable Care Act to the estimated maximum annual limitation on cost sharing for self-only coverage for 2014 ($6,400). We began by developing three model silver level QHPs. These model plans were meant to represent the broad sets of plan designs that we expect issuers to offer at the silver level of coverage through an Exchange. To that end, the model plans include a PPO plan with a typical cost-sharing structure ($1,675 deductible and 20 percent in-network coinsurance rate), a PPO plan with a lower deductible and above-average coinsurance ($575 deductible and 40 percent

in-network coinsurance rate), and an HMO-like plan ($2,100 deductible, 20 percent coinsurance rate, and the following services with copays that are not subject to the deductible or coinsurance: $500 inpatient stay, $350 emergency department visit, $25 primary care office visit, and $50 specialist office visit).[37] All three model plans meet the actuarial value requirements for silver health plans, and start with an annual limitation on cost sharing equal to the estimated maximum annual limitation on cost sharing ($6,400). The plan design features of the model QHPs were entered into the AV calculator developed by HHS and proposed at §156.135(a) in the proposed EHB/AV Rule, implementing section 1302(d) of the Affordable Care Act. We then observed how the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act (that is, 2/3 or 1/2 of the annual limitation on cost sharing, as applicable) affected the AV of the plans.

We found that the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income level between 100 and 150 percent of the FPL (2/3 reduction), and 150 and 200 percent of the FPL (2/3 reduction), did not cause the AV of any of the model QHPs to exceed the statutorily specified AV level (94 and 87, respectively). This suggests that it is unnecessary to adjust the reduction under section 1402(c)(1)(B)(ii) of the Affordable Care Act for benefit year 2014. In contrast, the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income level

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[37] We note that these plan structures are broadly consistent with structures suggested by research from "Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits." *America's Health Insurance Plans Center for Policy and Research*. July 2011; "Employer Health Benefits: 2011 Summary of Findings." *The Kaiser Family Foundation and Health Research & Educational Trust.* Accessed on June 7, 2012 from http://ehbs.kff.org/pdf/8226.pdf; and "What the Actuarial Values in the Affordable Care Act Mean." *The Kaiser Family Foundation: Focus on Health Reform*. April 2011. Accessed on June 7, 2012 from http://www.kff.org/healthreform/upload/8177.pdf.

between 200 and 250 percent of FPL (1/2 reduction), did cause the AVs of the model QHPs to exceed the specified AV level of 73 percent. As a result, we propose that QHP issuers only be required to reduce their annual limitation on cost sharing for enrollees in the 2014 benefit year with a household income between 200 and 250 percent of FPL by approximately 1/5, rather than 1/2. We further propose to moderate the reductions in the maximum annual limitation on cost sharing for all three income categories, as shown in Table 15, to account for any potential inaccuracies in our estimate of the maximum annual limitation on cost sharing for 2014, and unique plan designs that may not be captured by our three model QHPs. We note that selecting a lesser reduction for the maximum annual limitation on cost sharing will not reduce the benefit afforded to enrollees in aggregate as QHP issuers are required to further reduce their limit on cost sharing, or reduce other types of cost sharing, if the required reduction does not cause the actuarial value of the QHP to meet the specified level, as detailed in step 3 of this proposal. Based on this analysis, in Table 15, we propose the following reduced maximum annual limitations on cost sharing for benefit year 2014:

TABLE 15: Reductions in Maximum Annual Limitation on Cost Sharing for 2014

Eligibility Category	Reduced Maximum Annual Limitation on Cost Sharing for Self-Only Coverage for 2014	Reduced Maximum Annual Limitation on Cost Sharing for Other Than Self-Only Coverage for 2014
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(i) (that is, 100-150% of FPL)	$2,250	$4,500
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(ii) (that is, 150-200% of FPL)	$2,250	$4,500
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(iii) (that is, 200-250% of FPL)	$5,200	$10,400

We do not believe there will be a need to revise our analyses once the IRS dollar limit for 2014 is published, and propose that QHP issuers may rely on the reduced maximum annual limitations on cost sharing published in the final HHS notice of benefit and payment parameters to develop their silver plan variations for the 2014 benefit year. We welcome comment on this approach.

Step 3. In the third step under our proposal, a QHP issuer offering coverage in the individual market on the Exchange would develop three variations of its standard silver plan – one each for individuals with household incomes between 100 and 150 percent of the FPL, 150 and 200 percent of the FPL, and 200 and 250 percent of the FPL – with each variation having an annual limitation on cost sharing that does not exceed the applicable reduced maximum annual limitation on cost sharing published in the annual HHS notice of benefit and payment parameters. If the application of the reduced annual limitation on cost sharing results in an AV for a particular silver plan variation that differs from the required 73, 87, or 94 percent AV level by more than the permitted amount (that is, the 1 percent de minimis amount for silver plan variations, subject to proposed §156.420(f), as described below), the QHP issuer would adjust the cost-sharing structure in that silver plan variation to achieve the applicable AV level.

For example, we propose to set the reduced maximum annual limitation on cost sharing for self-only coverage for 2014 at $2,250 for individuals with household incomes between 150 and 200 percent of the FPL. However, an issuer might find that even when the limitation on cost sharing for the proposed plan is reduced to $2,250, the actuarial value of the plan may only increase to 82 percent. The issuer would then amend its cost-sharing structure by decreasing copayments, deductibles or coinsurance (or further reducing the annual limitation on cost sharing) so that the silver plan variation achieves the required AV of 87 percent (plus or minus the de minimis variation for silver plan

variations). The AV of the silver plan variation would be calculated using the AV calculator or other permitted methods, as described in §156.135 of the proposed EHB/AV Rule.

We set forth in §156.420(a)(1) through (3) proposed specifications for the three silver plan variations, and propose that they may deviate from the required AV levels by the de minimis variation for silver plan variations, established as 1 percentage point. We further propose that issuers submit these silver plan variations annually to the Exchange for certification, prior to the benefit year. Silver plan variations must be approved annually even if the standard silver plan does not change, since the reduced maximum annual limitation on cost sharing may change annually due to the premium adjustment percentage. We welcome comment on this proposed provision.

Sections 156.420(b) and (d) are discussed below in the section related to special cost-sharing reduction rules for Indians.

In §156.420(c), we propose that silver plan variations cover the same benefits and include the same providers as the standard silver plan. We further propose that silver plan variations must require the same out-of-pocket spending for benefits other than EHB. Lastly, we propose that silver plan variations be subject to all requirements applicable to the standard silver plan (except for the requirement that the plan have an AV as set forth in §156.140(b)(2) of the proposed EHB/AV Rule). This means, for example, that silver plan variations must meet standards relating to marketing and benefit design of QHPs, network adequacy standards, and essential community providers. Although these requirements are implicit because a plan variation is not a separate plan, we seek to make these requirements explicit to ensure that QHP issuers develop appropriate plan variations.

In §156.420(e), we propose a standard to govern the design of cost sharing structures for silver plan variations. Under this approach, the cost sharing for enrollees under any silver plan variation for an EHB from a provider may not exceed the corresponding cost sharing in the standard silver plan or any other silver plan variation of the standard silver plan with a lower AV. For example, if the co-payment on an emergency room visit at a particular university hospital is $30 in the silver plan variation with a 73 percent AV, the co-payment in the silver plan variation with an 87 percent AV for that issuer would be $30 or less. This proposed standard would apply to all types of cost-sharing reductions, including reductions to deductibles, coinsurance, and co-payments. An issuer would have the flexibility to vary cost sharing on particular benefits or providers so long as that cost sharing did not increase for a particular benefit or provider for higher AV silver plan variations. This standard, along with the proposed requirements in §156.420(c), would help ensure that silver plan variations with higher AVs would always provide the most cost savings to enrollees while providing the same benefits and provider network. Furthermore, consumers would be best served by enrolling in the highest AV variation of the standard silver plan selected for which they are eligible. We also believe that this proposed standard is appropriate as the plan variations are meant to be the same as the QHP, except as to the payer of the cost sharing and the reduction in out-of-pocket costs charged to the eligible individual.

We provided an overview of this proposed approach in the AV/CSR Bulletin. One commenter expressed concern about the differential effect of deductibles on low-income populations, and suggested that we also set limits on deductibles in silver plan variations. A number of other commenters also urged HHS to adopt more restrictive requirements on issuers' designs of cost-sharing structures in silver plan variations. One

commenter urged HHS to systematically monitor a number of aspects of how QHP issuers implement cost-sharing reductions.

We believe that, at this point, this proposal strikes the appropriate balance between protecting consumers and preserving QHP issuer flexibility. The standard in §156.420(e) that cost sharing for a silver plan variation not exceed the corresponding cost sharing for a standard silver plan or silver plan variation with a lower AV, along with non-discrimination standards described in §156.130(g) of the proposed EHB/AV Rule, protects low-income populations who are assigned to these QHP plan variations through the Exchange. We seek comment on this approach.

In §156.420(f), we propose that, notwithstanding the permitted de minimis variation in AV for a health plan or the permitted de minimis variation for a silver plan variation, the AV of the standard silver plan (which must be 70 percent plus or minus 2 percentage points) and the AV of the silver plan variation applicable to individuals with household incomes between 200 and 250 percent of the FPL (which must be 73 percent plus or minus 1 percentage point) must differ by at least 2 percentage points. For example, under the de minimis standard proposed in §156.140(c)(1) of the proposed EHB/AV rule, an issuer would be permitted to offer a standard silver plan with an AV of 72 percent. Under the proposed rule in §156.420(f), that issuer would be permitted to offer a silver plan variation with an AV of 74 percent to individuals with household incomes between 200 and 250 percent of the FPL, but not a silver plan variation with an AV of 73 percent. This proposal helps ensure that eligible enrollees with household incomes between 200 and 250 percent of the FPL can purchase a plan with a cost-sharing structure that is more generous than that associated with the standard silver plan, consistent with Congressional intent for cost-sharing reductions under section 1402(c). We chose to propose a 2 percentage point differential to ensure that a difference in cost-

sharing reductions provided to each income category is maintained, while still allowing issuers the flexibility to set the AV within the de minimis variation standards and to develop plan designs with easy-to-understand cost sharing arrangements. We welcome comments on this approach.

d. Changes in Eligibility for Cost-Sharing Reductions

In §156.425(a), we propose that if the Exchange notifies a QHP issuer of a change in an enrollee's eligibility for cost-sharing reductions (including a change following which the enrollee will not be eligible for cost-sharing reductions), then the QHP issuer must change the individual's assignment so that the individual is assigned to the applicable standard plan or plan variation. We also propose that the QHP issuer effectuate the change in eligibility in accordance with the effective date of eligibility provided by the Exchange, as described in §155.330(f). We clarify that if an enrollee changes QHPs after the effective date of the eligibility change as the result of a special enrollment period, once the Exchange notifies the issuer of the new QHP of the enrollment, that QHP issuer must assign the enrollee to the applicable standard plan or plan variation of the QHP selected by the enrollee, consistent with the proposed §156.410(b).

In paragraph (b) of §156.425, we propose that in the case of a change in assignment to a different plan variation (or standard plan without cost-sharing reductions) of the same QHP in the course of a benefit year (including in the case of a re-enrollment into the QHP following enrollment in a different plan), the QHP issuer must ensure that any cost sharing paid by the applicable individuals under the previous plan variations (or standard plan without cost-sharing reductions) is accounted for in the calculation of deductibles and annual limitations on cost sharing in the individual's new plan variation for the remainder of the benefit year. We note that a change from or to an individual or

family policy of a QHP due to the addition or removal of family members does not constitute a change in plan for the family members who remain on the individual or family policy. Individuals would therefore not be penalized by changes in eligibility for cost-sharing reductions during the benefit year or the addition or removal of family members, although they would be ineligible for any refund on cost sharing to the extent the newly applicable deductible or annual limitation on cost sharing is exceeded by prior cost sharing. The QHP issuer would not be prohibited from or required to extend this policy to situations in which the individual changes QHPs, including by enrolling in a QHP at a different metal level, but would be permitted to so extend this policy, provided that this extension of the policy is applied across all enrollees in a uniform manner. We seek comment on this provision.

e. Payment for Cost-Sharing Reductions

Section 1402(c)(3) of the Affordable Care Act directs a QHP issuer to notify the Secretary of HHS of cost-sharing reductions made under the statute for individuals with household incomes under 400 percent of the FPL, and directs the Secretary to make periodic and timely payments to the QHP issuer equal to the value of those reductions. Section 1402(c)(3)(B) also permits the Secretary to establish a capitated payment system to carry out these payments. Further, section 1412(c)(3) of the Affordable Care Act permits advance payments of cost-sharing reduction amounts to QHP issuers based upon amounts specified by the Secretary. Under these authorities, we propose to implement a payment approach under which we would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance

payments at the end of the benefit year to the actual cost-sharing reduction amounts.[38] This approach fulfills the Secretary's obligation to make "periodic and timely payments equal to the value of the reductions" under section 1402(c)(3) of the Affordable Care Act. This proposal would not require issuers to fund the value of any cost-sharing reductions prior to reimbursement (to the extent the issuers provide the required actuarial information), and ensures that payments are made only for actual cost-sharing reduction amounts realized by Exchange enrollees. This approach is similar to the one employed for the low-income subsidy under Medicare Part D. We welcome comments on this and alternative approaches, and whether this approach should change over time.

To implement our proposed payment approach, in §156.430(a)(1)(i) through (iv), we propose that for each health plan that an issuer offers, or intends to offer, in the individual market on the Exchange as a QHP, the issuer must provide to the Exchange annually prior to the benefit year, for approval by HHS, an estimate of the dollar value of the cost-sharing reductions to be provided over the benefit year. If the QHP is a silver health plan, the submission must identify separately the per member per month dollar value of the cost-sharing reductions to be provided under each silver plan variation identified in §156.420(a)(1), (2), and (3). And for each QHP, regardless of metal level, the submission must identify the per member per month dollar value of the cost-sharing reductions to be provided under the zero cost sharing plan variation. In addition, the estimate should be accompanied by supporting documentation validating the estimate. We expect that Exchanges will collect this information from issuers through the QHP certification process or an annual submission process, and then send the information to

[38] We note that these payments (both advance and reconciled), and the estimated or actual cost-sharing reductions underlying them, are subject to 45 CFR 156.280(e)(1)(ii).

HHS for review and approval. Sections 156.430(a)(1)(ii) and 156.430(a)(2) are further described in section III.E.4.i. of this proposed rule.

We further propose that issuers develop the estimates using the methodology specified by HHS in the applicable annual HHS notice of benefit and payment parameters. In §156.430(a)(3), we propose that HHS will approve estimates that follow this methodology. For the 2014 benefit year, we propose that issuers use a methodology that utilizes the data that issuers submit under §156.420 and §156.470. As a result, issuers would not be required to submit any additional data or supporting documentation to receive advance payments in benefit year 2014 for the value of the cost-sharing reductions that would be provided under silver plan variations. Below, we describe in detail how the data that issuers will submit under §156.420 and §156.470 will be used to develop the estimate of the value of the cost-sharing reductions for the 2014 benefit year.

Methodology for Developing Estimate of Value of Cost-Sharing Reductions for Silver Plan Variations for 2014 Benefit Year. We propose that for the 2014 benefit year, issuers use a simplified methodology for estimating the value of the cost-sharing reductions under silver plan variations and calculating the advance payments. We believe that the lack of data regarding the costs that will be associated with the QHPs and their plan variations will make it difficult to accurately predict the value of the cost-sharing reductions, even if a complex methodology is used. We intend to review the methodology for estimating the advance payments in future years, once more data is available. We also note that the payment reconciliation process described §156.430(c) through paragraph (e) would ensure that the QHP issuer is made whole for the value of any cost-sharing reductions provided during the year, which may not be equal to the value of the advance payments.

For the 2014 benefit year, we propose that advance payments be estimated on a per enrollee per month basis using the following formula:

$$\text{Per Enrollee Per Month Advance Payment} = \text{Monthly Expected Allowed Claims Costs for Silver Plan Variation} \times (\text{Silver Plan Variation AV} - \text{Standard Plan AV})$$

In this formula, the monthly expected allowed claims cost for a silver plan variation would equal one-twelfth of the expected allowed claims costs allocated to EHB, other than services described in §156.280(d)(1),[39] for the standard silver plan, multiplied by a factor to account for the increased utilization that may occur under the specific plan variation due to the reduced cost-sharing requirements. As described in §156.470, the QHP issuer will submit the expected allowed claims cost information to the Exchange annually. The Exchange will then review this estimate, and submit the approved information to HHS, as described in proposed §155.1030(b)(2) above, for use in the advance payment calculation. HHS will then multiply the monthly expected allowed claims cost by one of the following induced utilization factors, to arrive at the monthly expected allowed claims cost for the particular plan variation. We propose the following induced utilization factors based on our analysis of the expected difference in expenditures for enrollees in QHPs of different actuarial values. For this analysis, we used the Actuarial Value Calculator, developed by HHS using the Health Intelligence Company, LLC (HIC) database from calendar year 2010. This database includes detailed enrollment and claims information for individuals who are members of regional insurers and covers over 54 million individuals. The database includes current members of small

[39] Under §156.20, cost-sharing reductions are only provided on EHB. In addition, §156.280(e)(1)(i) states that if a QHP provides coverage of services described in paragraph (d)(1) of that section, the QHP issuer must not use federal funds, including cost-sharing reductions, to pay for the service.

group health plans, and a population relatively similar to the population of enrollees likely to participate in the health exchanges.[40]

TABLE 16: Induced Utilization Factors for Purposes of Cost-Sharing Reduction Advance Payments

Household Income	Silver Plan AV	Induced Utilization Factor
100-150% of FPL	Plan Variation 94%	1.12
150-200% of FPL	Plan Variation 87%	1.12
200-250% of FPL	Plan Variation 73%	1.00

In the second half of the formula, we propose the multiplication of the monthly expected allowed claims cost for the particular plan variation by the difference in AV between the standard silver plan and the plan variation. This will allow us to estimate the difference in cost sharing between the standard plan and the plan variation. We propose to use the actuarial values of the QHPs and silver plan variations that the Exchange will submit to HHS under §155.1030(a)(2).

This methodology should limit the burden of estimating cost-sharing reduction amounts on QHP issuers, and provide a standardized per enrollee per month estimate of the value of cost-sharing reductions. This estimate can then be multiplied by the number of enrollees assigned to a particular plan variation in a given month to arrive at the total advance payment that will be provided to the issuer for each plan variation of each QHP, for a given month. We welcome comment on this methodology and the proposed induced utilization factors, as well as the value of increasing the complexity of the methodology versus the value of operational efficiency.

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[40] We note that these induced utilization factors appear to be broadly consistent with results from the RAND Health Insurance Experiment, described in Robert H. Brook, John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy Donald Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patti Camp, and Joseph P. Newhouse. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment*. Santa Monica, Calif.: RAND Corporation, R-3055-HHS, December 1984.

In §156.430(b), we propose making periodic advance payments to issuers based on the approved advance estimates provided under §156.430(a) and the confirmed enrollment information. We propose to use the methodology described above to determine the amount of these advance payments.

In §156.430(c), we propose that a QHP issuer report to HHS the actual amount of cost-sharing reductions provided. In general, for a particular benefit provided by the QHP, this amount would equal the difference between the cost sharing required of an enrollee in the corresponding standard silver plan with no cost-sharing reductions and the cost sharing that was actually required of the enrollee under the plan variation at the point where the service was provided. For example, if an individual enrolled in a silver plan variation receives a benefit that would be subject to a $20 copayment under the standard silver plan but is subject to only a $5 copayment under the silver plan variation in which the individual is enrolled, the cost-sharing reduction amount would be $15. Additional specifications regarding submission of actual cost-sharing reduction amounts will be provided in future guidance; however, we expect that QHP issuers will submit the actual amount of cost-sharing reductions provided after the close of the benefit year.

In §156.430(c)(1) and (c)(2), we propose specific standards for the reporting of cost-sharing reduction amounts. In §156.430(c)(1), we propose that in the case of a benefit for which the QHP issuer compensates the applicable provider in whole or in part on a fee-for-service basis, the QHP issuer submit the total allowed costs for essential health benefits charged for an enrollees' policy for the benefit year, broken down by what the issuer paid, what the enrollee paid, and the amount reimbursed to the provider for the amount that the enrollee would have paid under the standard QHP without cost-sharing reductions. In §156.430(c)(2), we propose that in the case of a benefit for which the QHP issuer compensates the applicable provider in any other manner (such as on a capitated

basis), the QHP issuer submit the total allowed costs for essential health benefits charged for an enrollees' policy for the benefit year, broken down by what the issuer paid, what the enrollee paid, and the amount that the enrollee would have paid under the standard QHP without cost-sharing reductions. When we refer to compensation made on a capitated basis in this context, we mean a compensation model under which issuers make payments to providers based on a contracted rate for each enrollee, commonly referred to as a "per-member-per-month" rate, regardless of the number or type of services provided. We note that a non-fee-for-service provider is not required to be reimbursed by the issuer. However, we expect that issuers and providers in non-fee-for-service arrangements will make available to providers compensation for cost-sharing reductions through their negotiated capitation payments. We seek comments on this assumption and other payment approaches for QHPs that use a capitated system to pay providers.

In §156.430(d), we propose to periodically reconcile advance payments to issuers against the actual cost-sharing reduction amounts reported under §156.430(c). Thus, where a QHP issuer compensates a provider in whole or in part on a fee-for-service basis, we would reconcile the advance payments provided to the issuer against the actual amount of cost-sharing reductions reimbursed to providers and provided to enrollees. Where the QHP issuer compensates a provider under another arrangement, such as a capitated arrangement, we would reconcile the advance payments made to issuers against the actual cost-sharing reduction amounts provided to enrollees. We propose this differentiated reimbursement approach because if issuers are paying providers on a basis other than a fee-for-service basis, the parties may not be exchanging data or making payments on a per-service basis. We do not wish to interfere with contractual payment arrangements between issuers and providers by imposing per-service accounting or payment streams if an issuer and provider have elected not to structure their relationship

in that manner. However, in all cases we would condition reimbursement upon provision to the enrollee at the point-of-service of the cost-sharing reduction under the applicable plan variation. We welcome comment on this proposal.

We propose in §156.430(e) that if the actual amounts of cost-sharing reductions exceed the advance payment amounts provided to the issuer (including if the QHP issuer elected not to submit an advance estimate of the cost-sharing reduction amounts provided under the limited cost sharing plan variation, and therefore received no advance payments), HHS would reimburse the issuer for the shortfall, assuming that the issuer has submitted its actual cost-sharing reduction amount report to HHS in a timely fashion. If the actual amounts of cost-sharing reductions are less than the advance payment amounts provided to the issuer, we propose that the QHP issuer must repay the difference to HHS. Detailed procedural requirements and interpretive guidance on cost-sharing reduction reconciliation will be provided in the future.

In §156.430(f), we propose rules on advance payment and reimbursement of cost-sharing reductions during special transitional periods of coverage where eligibility and enrollment are uncertain, including requirements relating to cost-sharing reductions provided during grace periods following non-payment of premium. Under §156.270, a QHP issuer must establish a standard policy for termination of coverage for non-payment of premiums by enrollees. Under that policy, a three-month grace period applies if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. In the first month of the grace period, the QHP issuer must pay all appropriate claims for services rendered and HHS would reimburse the QHP issuer for cost-sharing reductions for such claims (and the QHP issuer may retain any advance payments of cost-sharing reductions), but the issuer may pend claims for services rendered to the enrollee in the second and third months of

the grace period. If an enrollee exhausts the grace period without making full payment of the premiums owed, the QHP issuer may terminate coverage and deny payment for the pending claims.

In §156.430(f)(1), we propose standards related to the non-payment of premiums and exhausted grace periods. We propose that a QHP issuer will be eligible for reimbursement of cost-sharing reductions provided prior to a termination of coverage effective date. Furthermore, any advance payments of cost-sharing reductions would be paid to a QHP issuer for coverage prior to a determination of termination, including during any grace period as described in §155.430(b)(2)(ii)(A) and (B). The determination of termination occurs on the date that the Exchange sends termination information to the QHP issuer and HHS under §155.430(c)(2).

The QHP issuer would be required to repay any advance payments of cost-sharing reductions made with respect to any month after any termination of coverage effective date during a grace period. A QHP issuer generally would not be eligible for reimbursement of cost-sharing reductions provided after the termination of coverage effective date with respect to a grace period. For example, if an individual receiving advance payments of the premium tax credit is eligible for cost-sharing reductions, and stops paying his or her premium, HHS would continue to provide advance payments of the cost-sharing reductions during the grace period. HHS would reimburse the QHP issuer for any reduction in cost sharing provided during the first month of the three-month grace period, but not after the termination of coverage effective date (that is, there will be no reimbursement for cost-sharing reductions provided during the second and third month of the grace period if retroactive termination occurs). The issuer may pend claims and payments for cost-sharing reductions for services rendered to the individual in the second and third month of the grace period, as described in §156.270(d). The QHP

issuer must return to HHS any advance payments of the cost-sharing reduction applicable to the second and third months. This proposed policy aligns with the approach for advance payments of the premium tax credit described in §156.270(e).

We propose in §156.430(f)(2) and (3) that in the case of any other retroactive termination, if the termination (or late determination thereof) is the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer would not be eligible for advance payments and reimbursement for cost-sharing reductions provided during the period following the termination of coverage effective date and prior to the determination of the termination; and if the termination (or the late determination thereof) is not the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer would be eligible for advance payments and reimbursement for cost-sharing reductions provided during such period. For example, if a QHP issuer fails to timely notify the Exchange that an enrollee requested a termination of coverage, the Exchange could reasonably determine that the QHP issuer is at fault and would not be eligible for advance payments and reimbursement for cost-sharing reductions provided during the period following the termination of coverage effective date and prior to the determination of the termination. Alternatively, if an individual was incorrectly enrolled in a QHP due to an error by the Exchange, the QHP issuer would not be at fault and would be eligible for advance payments and reimbursement for cost-sharing reductions provided during the period following the termination of coverage effective date and prior to the determination of the termination. We welcome comment on this proposal and other approaches, and seek comment on the relative equities of, incentives created by, and consequences of this proposal and other approaches, including the potential costs to HHS.

In §156.430(f)(4), we propose that a QHP issuer would be eligible for advance payments and reimbursement of cost-sharing reductions provided during any period for

resolution of inconsistencies in information required to determine eligibility for enrollment under §155.315(f). Under §155.315(f), if an Exchange cannot verify eligibility information for an individual, it must provide the individual at least 90 days to present satisfactory evidence of eligibility to resolve the inconsistency. In the interim, the Exchange must make an eligibility determination based upon the individual's attestation and other verified information in the application, including with respect to the cost-sharing reductions for which the individual is eligible. At the end of the inconsistency period, if the Exchange cannot confirm the attestation, the Exchange must make the eligibility determination based upon the data available, subject to certain exceptions. In the event the Exchange cannot confirm the attestation and determines the individual to be ineligible for cost-sharing reductions provided during the inconsistency period, we propose to reimburse those cost-sharing reductions because there is no clear mechanism under the Affordable Care Act for seeking reimbursement of those amounts from the individual. We welcome comment on this proposal and other approaches, and seek comment on the relative equities of, incentives created by, and consequences of this proposal and other approaches, including the potential costs to HHS.

f. Plans Eligible for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

In §156.440, we clarify the applicability of advance payments of the premium tax credit and cost-sharing reductions to certain QHPs. We propose that the provisions of part 156 subpart E generally apply to qualified health plans offered in the individual market on the Exchange.

However, we propose in §156.440(a) that the provisions not apply to catastrophic plans as described in §156.155 of the proposed Market Reform Rule to be consistent with 26 CFR 1.36B-1(c). Section 36B(c)(3)(A) of the Code defines a QHP to exclude

catastrophic plans – a definition that also applies to section 1402 of the Affordable Care Act, by means of section 1402(f)(1) of the Affordable Care Act. Further, eligibility for cost-sharing reductions is tied to a "coverage month with respect to which a premium tax credit is paid," which would exclude months during which the individual is enrolled in a catastrophic health plan. Therefore, we propose that enrollment in a catastrophic plan precludes eligibility for cost-sharing reductions. Effectively, this proposal restricts the provision of cost-sharing reductions with respect to Indians only, because non-Indians can only receive cost-sharing reductions when enrolled in a silver plan variation.

We propose in §156.440(b) that the provisions of this subpart E, including §156.410, §156.420, §156.425, §156.430, and §156.470, to the extent each relate to cost-sharing reductions, not apply to stand-alone dental plans. Section 1311(d)(2)(B)(ii) of the Affordable Care Act provides that an Exchange must allow a stand-alone dental plan that provides pediatric dental benefits that are EHB to be offered separately from or in conjunction with a QHP. However, section 1402(c)(5) of the Affordable Care Act states if an individual enrolls in both a QHP and a stand-alone dental plan, the provisions on cost-sharing reductions under sections 1402(a) and (c) of the Affordable Care Act do not apply to that portion of the cost-sharing reductions properly allocable to pediatric dental EHB, meaning that if an individual enrolls in both a QHP and a stand-alone dental plan offered on an Exchange, cost-sharing reductions are not payable with respect to pediatric dental benefits offered by the stand-alone dental plan. However, cost-sharing reductions would be payable with respect to pediatric dental benefits provided by a QHP. Requiring payment of cost-sharing reductions on pediatric dental benefits within a stand-alone dental plan offered on an Exchange would create significant operational complexities. For example, stand-alone dental plans would be required to submit plan variations, and since the calculation of AV for stand-alone dental plans will not be standardized, the

review and approval of the plan variations and advance estimates would be difficult to oversee.

We propose to clarify in §156.440(c) that the provisions of this subpart E apply to child-only plans. Section 1302(f) of the Affordable Care Act and §156.200(c)(2) of this subchapter provides that an issuer that offers a QHP at any level of coverage in an Exchange also must offer the plan at the same level of coverage in the Exchange only to individuals that have not attained age 21. Under section 1302(f) of the Affordable Care Act, the child-only plan is to be treated as a QHP, and is therefore subject to the provisions of this subpart E.

g. Reduction of Enrollee's Share of Premium to Account for Advance Payments of the Premium Tax Credit

In §156.460(a), we propose to codify QHP issuer requirements set forth in section 1412(c)(2)(B) of the Affordable Care Act. The law authorizes the payment of advance tax credits to QHP issuers on behalf of certain qualified enrollees. The advance payment must be used to reduce the portion of the premium charged to enrollees. In §156.460(a)(1), we propose to codify clause (i) of that subparagraph, which requires that a QHP issuer reduce the portion of the premium charged to the enrollee by the amount of the advance payment of the premium tax credit for the applicable month(s).

In §156.460(a)(2), we propose to codify section 1412(c)(2)(B)(ii) of the statute, which requires that the QHP issuer notify the Exchange of any reduction in the portion of the premium charged to the individual. This notification will be sent to the Exchange through the standard enrollment acknowledgment in accordance with §156.265(g). That information will then be submitted to the Secretary via enrollment information sent from the Exchange to HHS under §155.340(a)(1).

In §156.460(a)(3), we propose to codify section 1412(c)(2)(B)(iii), which requires that a QHP issuer display the amount of the advance payment of the premium tax credit for the applicable month(s) on an enrollee's billing statement. This requirement would ensure that the enrollee is aware of the total cost of the premium and would allow the enrollee to verify that the correct amount for the advance payment of the premium tax credit has been applied to his or her account.

In §156.460(b), we propose that a QHP issuer may not refuse to commence coverage under a policy or terminate a policy on account of any delay in payment from the Federal government of an advance payment of the premium tax credit on behalf of an enrollee if the QHP issuer has been notified by the Exchange that it would receive an advance payment. We expect that monthly advance payments of the premium tax credit would be paid in the middle of the month, and propose to require that issuers not decline to cover individuals nor terminate policies for which the enrollee's payments have been timely made on account of the timing of the advance payments of the premium tax credit.

We welcome comment on these proposals.

h. Allocation of Rates and Claims Costs for Advance Payments of Cost-Sharing Reductions and the Premium Tax Credit

As described in section III.E.2. of this proposed rule, we propose in §156.470 to direct issuers to allocate the rate or expected premium for each metal level health plan and stand-alone dental plan offered, or proposed to be offered, in the individual market on the Exchange, and the expected allowed claims costs for the metal level health plans, among EHB and additional benefits. Issuers must submit these allocations annually to the Exchange, along with an actuarial memorandum with a detailed description of the methods and specific bases used to perform the allocations. The Exchange and HHS will

use this memorandum to verify that these allocations meet the standards set forth in paragraphs (c) and (d) of §156.470.

We propose that issuers submit the allocation information to the Exchange as part of the QHP certification process and an annual submission process for QHPs that are already certified, though an Exchange may specify alternative submission channels. For example, for issuers interested in participating in a Federally-facilitated Exchange, we propose to collect the metal level health plan allocation information through the Effective Rate Review program. We proposed revisions to the rate review reporting requirements in the proposed Market Reform Rule to include the allocation submission. This approach should streamline the submission process for issuers. We note that multi-State plans, as defined in §155.1000(a), are subject to these provisions. OPM would determine the time and manner for multi-State plans to submit the allocation information. We welcome comment on this proposal.

i. Special Cost-Sharing Reduction Rules for Indians

We discuss in greater detail below a number of provisions throughout this proposed subpart E implementing section 1402(d) of the Affordable Care Act, which governs cost-sharing reductions for Indians.

Interpretation of section 1402(d)(2) of the Affordable Care Act: Section 1402(d)(1) of the Affordable Care Act directs a QHP issuer to treat an Indian with household income not more than 300 percent of the FPL as an "eligible insured" – a defined term in the statute triggering cost-sharing reductions for non-Indians – and to eliminate all cost sharing for those Indians. Conversely, section 1402(d)(2) of the Affordable Care Act, which prohibits cost sharing under a plan for items or services to an Indian enrolled in a QHP provided directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract

health services, does not direct the issuer to treat the Indian as an "eligible insured." Section 1402(f)(2) of the Affordable Care Act permits cost-sharing reductions only for months in which the "insured" – which we interpret to be synonymous with the term "eligible insured" – is allowed a premium tax credit. The implications of this interpretation are that cost-sharing reductions under sections 1402(a) and 1402(d)(1) of the Affordable Care Act are only available to individuals eligible for premium tax credits. However, cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act would be available to Indians regardless of their eligibility for premium tax credits. This approach aligns with the typical practice today, under which cost sharing is not required with respect to services provided to an Indian by the IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization. Furthermore, as described in §155.350(b), an Exchange may determine an Indian eligible for cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act without requiring the applicant to request an eligibility determination for insurance affordability programs. We welcome comment on our interpretation of sections 1402(d)(2) and 1402(f)(2) of the Affordable Care Act.

We note also that section 1402(d) of the Affordable Care Act specifies that reductions in cost sharing must be provided to Indians who purchase coverage on the Exchange. Although section 1402(d)(1) of the Affordable Care Act applies only to the individual market, section 1402(d)(2) of the Affordable Care Act does not contain this explicit restriction. We propose to interpret section 1402(d)(2) of the Affordable Care Act to apply only to the individual market because we believe section 1402(d)(2) flows from and builds upon the identification of "any qualified health plans" made in section 1402(d)(1). Further, we believe that Congress did not intend for reductions in cost sharing to be available outside the individual market Exchanges. We welcome comment on this interpretation and any other interpretation of this language.

Finally, we note that section 1402(d)(2)(B) of the Affordable Care Act states that QHP issuers are not to reduce payments to the relevant facility or provider for an item or service by the amount of any cost sharing that would be due from an Indian but for the prohibition on cost sharing set forth in section 1402(d)(2) of the Affordable Care Act. We propose not to codify this provision in regulation because we believe it is clear and self-enforcing, and because we believe that it would also be impermissible for an issuer to reduce payments to a provider for any cost-sharing reductions required under sections 1402(a) or 1402(d)(1) of the Affordable Care Act – particularly because these cost-sharing reductions are to be reimbursed by HHS. We also note that nothing in this section exempts an issuer from section 206 of the Indian Health Care Improvement Act, which provides that the United States, an Indian Tribe, Tribal organization, or urban Indian organization has the right to recover from third party payers, including QHPs, up to the reasonable charges billed for providing health services, or, if higher, the highest amount an insurer would pay to other providers.

Proposed provisions of part 156 relating to Indians: Similar to cost-sharing reductions for non-Indians, we propose to use the concept of plan variations to describe how Indians would pay only a portion, or as appropriate, none of the total cost sharing required under that plan, with the Federal government bearing the remaining cost-sharing obligation. In §156.410(b)(2), we propose that a QHP issuer assign an Indian determined by the Exchange to have an expected household income that does not exceed 300 percent of the FPL to a zero cost sharing plan variation of the selected QHP (no matter the level of coverage) with no cost sharing, based on the enrollment and eligibility information submitted to the QHP issuer by the Exchange. In §156.410(b)(3), we propose that a QHP issuer assign an Indian determined eligible by the Exchange for cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act to a limited cost sharing plan

variation of the selected QHP (no matter the level of coverage) with no cost sharing required on benefits received from the IHS and certain other providers. The assignments to the plan variations would be subject to §155.305(g)(3), which governs plan variation placement decisions when a single policy covers two or more individuals who are eligible for different levels of cost-sharing reductions. We also considered an alternative approach to the provision of cost-sharing reductions for Indians. Rather than requiring QHP issuers to assign Indians to zero and limited cost sharing plan variations, QHP issuers would simply assign Indians to the standard plan (or as appropriate, silver plan variation), and would waive the cost-sharing requirements, as appropriate. We note that this latter approach would permit an Indian and non-Indian to enroll in the same plan, and for each to receive the cost-sharing reductions to which they would be individually entitled. We are proposing the approach described above in part because we believe that the use of plan variations will permit issuers to efficiently and effectively provide to all enrollees eligible for cost-sharing reductions, especially Indians, their appropriate level of cost-sharing reductions. Because of technical constraints, we understand that complying with the alternative approach would be nearly impossible for many issuers for the 2014 benefit year. Due to these considerations, adopting the alternative approach could lead many issuers to implement cost-sharing waivers manually, which could lead to fewer cost-sharing reductions being available to Indians. In addition, we note that under the proposed Market Reform Rule at §147.102(c)(1), the total premium for family coverage in a State that has not adopted community rating principles is to be determined by summing the premiums for each individual family member (but that premiums for no more than the three oldest family members who are under age 21 must be taken into account). Thus, in many instances, a family made up of Indians and non-Indians would lose no premium savings from enrolling in different policies to obtain the maximum cost-

sharing reductions for which each family member is eligible. However, we seek comment on which approach HHS should adopt beginning January 1, 2016. We propose the approach first described above pending the adoption of any change in approach. We also seek comment on the burdens that may be imposed on individuals, providers and insurers under the proposed and alternative approaches. Finally, we will monitor whether providers are receiving less payment for Indians who choose to enroll in a family policy without the benefit of cost-sharing.

In §156.420(b), we propose that QHP issuers submit to the Exchange the zero cost sharing plan variation and limited cost sharing plan variations for each of the QHPs (at any level of coverage) that it intends to offer on the Exchange. The zero cost sharing plan variation – addressing cost-sharing reductions under section 1402(d)(1) of the Affordable Care Act and available to Indians with expected household incomes that do not exceed 300 percent of the FPL, as determined under §155.350(a) – must have all cost sharing eliminated. The limited cost sharing plan variation – addressing cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act and available to all Indians as determined in §155.350(b) – must have no cost sharing on any item or service furnished directly by the IHS, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services, as defined in 25 U.S.C. 1603. We note that unlike silver plan variations, zero cost sharing plan variation and limited cost sharing plan variations must only be submitted for certification when the standard plan is submitted for QHP certification. We welcome comment on this proposal.

In §156.420(d), we propose language similar to that proposed in §156.420(c) for silver plan variations – that the zero cost sharing plan variation and limited cost sharing plan variations cover the same benefits and include the same providers as the standard

QHP, and require the same out-of-pocket spending for benefits other than EHB. We also propose that a limited cost sharing plan variation, which would have no cost sharing on any item or service furnished directly by the IHS, Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, must have the same cost sharing on items or services not described in §156.420(b)(2) as the QHP with no cost-sharing reductions. Lastly, we propose that zero cost sharing plan variation and limited cost sharing plan variations be subject to all standards applicable to the standard QHP (except for the requirement that the plan have an AV as set forth in 156.140(b)). We believe that these standards are appropriate, as a plan variation and a standard plan are meant to be the same QHP, except for the reductions in cost sharing. We welcome comment on this proposal.

Section 1402(d)(3) of the Affordable Care Act directs the Secretary to pay a QHP issuer the amount necessary to reflect the increase in AV of a QHP required by reason of the changes in cost sharing for Indians under section 1402(d) of the Affordable Care Act. We propose to use the same payment approach to reimburse cost-sharing reductions for Indians under sections 1402(d) as we propose to use for cost-sharing reductions provided to eligible individuals with household incomes between 100 and 250 percent of the FPL under section 1402(a) of the Affordable Care Act. That is, we propose that QHP issuers submit estimates for the dollar value of the cost-sharing reductions to be provided under the zero cost sharing plan variation and limited cost sharing plan variations, to receive advance payments, and then reconcile the advance payments to the actual cost-sharing reduction amounts. This unified approach satisfies both the requirement for "periodic and timely payments equal to the value of the reductions" under section 1402(c)(3) of the Affordable Care Act, and payment of "the amount necessary to reflect the increase in AV of the plan" under section 1402(d)(3) of the Affordable Care Act. Because AV is a

mechanism for identifying how much the plan pays for benefits compared to the costs paid by an enrollee, we believe reimbursement of the dollar value of the reductions satisfies the requirement to pay QHP issuers an amount necessary to reflect the increase in actuarial value of the qualified health plan as a result of the reductions. Furthermore, at this time, it would be difficult for issuers and HHS to accurately estimate the "increase in AV of the plan" resulting from the cost-sharing reduction rules for Indians. Relevant data on Indian populations' cost sharing is not easily available, and issuers would not be able to use the AV calculator to estimate Indian-only cost-sharing features of a plan because the calculator is based on a standard population. Our proposed combined approach to reimbursing both cost-sharing reductions for eligible individuals with household incomes between 100 and 250 percent of the FPL and cost-sharing reductions for Indians should reduce the operational and financial burden on issuers and HHS, who would otherwise be required to operate under and implement two separate reimbursement programs.

In §156.430(a)(1)(ii) we propose that for each metal level QHP that an issuer offers or intends to offer in the individual market on the Exchange, the issuer must provide to the Exchange annually prior to the benefit year, for approval by HHS, estimates, and supporting documentation validating the estimates, of the per member per month dollar value of cost-sharing reductions to be provided under the zero cost sharing plan variation. These estimates must be developed using the methodology specified by HHS in the applicable annual HHS notice of benefit and payment parameters. We propose that issuers use the same methodology described above for estimating advance payments for the cost-sharing reductions provided under silver plan variations for estimating advance payments for the cost-sharing reductions provided under the zero cost sharing plan variation. This methodology would utilize data that QHP issuers submit for

other requirements, such as §156.420 and §156.470. As a result, QHP issuers would not be required to submit separate estimates or supporting documentation to receive advance payments in benefit year 2014 for the value of the cost-sharing reductions that would be provided under the zero cost sharing plan variation.

As in the case of silver plan variations, the following formula would be used:

$$\text{Per Enrollee Per Month Advance Payment} = \text{Monthly Expected Allowed Claims Cost for Zero Cost Sharing Plan Variation} \times (\text{Zero Cost Sharing Plan Variation AV} - \text{Standard Plan AV})$$

In this formula, the monthly expected allowed claims cost for the zero cost sharing plan variation would equal one-twelfth of the expected allowed claims costs allocated to EHB, other than services described in §156.280(d)(1), for the standard plan, multiplied by a factor to account for the increased utilization that may occur under the zero cost sharing plan variation due to the elimination of the cost-sharing requirements. As described in §156.470, the QHP issuer should submit the expected allowed claims cost information to the Exchange annually. The Exchange would then review this allocation, and submit the approved allocation to HHS, as described in §155.1030(b)(2), for use in the advance payment calculation. HHS would then multiply the monthly expected allowed claims cost by the induced utilization factor, to arrive at the monthly expected allowed claims cost for the zero cost sharing plan variation. We propose the following induced utilization factors for the zero cost sharing plan variation, based on our analysis of the HIC database from calendar year 2010.

TABLE 17: Induced Utilization Factors for Advance Payments for Cost-Sharing Reductions for Indians

Zero Cost Sharing Plan Variation	Induced Utilization Factor
Zero Cost Sharing Plan Variation of Bronze QHP	1.15
Zero Cost Sharing Plan Variation of Silver QHP	1.12
Zero Cost Sharing Plan Variation of Gold QHP	1.07

Zero Cost Sharing Plan Variation of Platinum QHP	1.00

In the second half of the formula, we propose to multiply the monthly expected allowed claims cost for the zero cost sharing plan variation by the difference in AV between the standard plan and the plan variation. The AV of the zero cost sharing plan variation would be 100, because all cost sharing is eliminated for this plan variation. Lastly, the per enrollee per month estimate will be multiplied by the number of individuals assigned to the zero cost sharing plan variation (based on the most recent confirmed enrollment data) in a given month to arrive at the total advance payment that will be provided to the issuer for each QHP. We welcome comment on this methodology and the proposed induced utilization factor, as well as the value of increasing the complexity of the methodology versus the value of operational efficiency.

In §156.430(a)(2), we discuss the process for estimating the value of cost-sharing reductions to be provided under the limited cost sharing plan variation open to Indians regardless of household income. We propose that QHP issuers have the option to forgo submitting an estimate of the value of these cost-sharing reductions if they believe the operational cost of developing the estimate is not worth the value of the advance payment. If a QHP issuer chooses to not submit an estimate, the issuer would provide the cost-sharing reductions as required, and would be reimbursed by HHS after the close of the benefit year, as proposed in §156.430(c). If a QHP issuer does seek advance payments for the these cost-sharing reductions, the issuer must provide to the Exchange annually prior to the benefit year, for approval by HHS, an estimate, and supporting documentation validating the estimate, of the per member per month dollar value of the cost-sharing reductions to be provided under the limited cost sharing plan variation of the QHP. The estimate must be developed using the methodology specified by HHS in the

applicable annual HHS notice of benefit and payment parameters. For the 2014 benefit year, we simply propose that issuers submit a reasonable estimate of the value of the reductions, developed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, and that the estimate should be no higher than the corresponding estimate for the zero cost sharing plan variation. We do not propose a standardized methodology because, unlike other plan variations, these cost-sharing reductions are to be provided for only a specific subset of providers, and the Affordable Care Act does not prescribe an AV for these reductions. As noted above, because the actuarial value calculator is based on a standard population, it will not have the functionality to generate an accurate AV for these plan variations. However, as in the case of the other plan variations, we plan to review the methodology for calculating the advance payments once more data is available. We also note that the payment reconciliation process described in §156.430(c) through (e) would ensure that the QHP issuer is made whole for the value of any cost-sharing reductions provided during the benefit year that may not be adequately covered by the advance payments.

The Exchange will collect the estimate and supporting documentation, as described in §155.1030(b)(3), and submit the estimate and supporting documentation to HHS for review. Assuming the estimate is reasonable, HHS would make advance payments to the QHP issuer following the same procedure as for the other plan variations, and as discussed in §156.430(b).

We welcome comment on this approach.

F. Provisions on User Fees for a Federally-facilitated Exchange (FFE)

Section 1311(d)(5)(A) of the Affordable Care Act contemplates an Exchange charging assessments or user fees to participating health insurance issuers to generate funding to support its operations. If a State is not an electing State or does not have an

approved Exchange, section 1321(c)(1) directs HHS to operate an Exchange within the State. In addition, 31 U.S.C. 9701 permits an agency to establish a charge for a service provided by the agency. Circular No. A-25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. Based on section 1311(d)(5)(A) of the Affordable Care Act and Circular No. A-25, we are proposing that HHS collect a user fee from participating issuers (as defined in §156.50(a)) to support the operation of Federally-facilitated Exchanges. Participating issuers will receive two special benefits not available to the general public when they offer plans through a Federally-facilitated Exchange: (1) the certification of their plans as QHPs, and (2) the ability to sell health insurance coverage through a Federally-facilitated Exchange to individuals determined eligible for enrollment in a QHP. These special benefits are provided to participating issuers based on the following Federal operations in connection with the operation of Federally-facilitated Exchanges:

- Provision of consumer assistance tools;
- Consumer outreach and education;
- Management of a Navigator program;
- Regulation of agents and brokers;
- Eligibility determinations;
- Administration of advance payments of the premium tax credit and cost-sharing reductions;
- Enrollment processes;
- Certification processes for QHPs (including ongoing compliance verification, recertification and decertification); and
- Administration of a SHOP Exchange.

Activities performed by the Federal government that do not provide issuers participating in a Federally-facilitated Exchange with a special benefit will not be covered by this user fee.

Circular No. A-25R states that user charges should generally be set at a level so that they are sufficient to recover the full cost to the Federal government of providing the service when the government is acting in its capacity as sovereign (as is the case when HHS operates a Federally-facilitated Exchange). However, Circular No. A-25R also allows for exceptions to this policy, if approved by OMB. To maintain a competitive balance between plans inside and outside the Exchanges, to align with the administrative cost structure of State-based Exchanges, and because we believe that growing enrollment is likely to increase user fee receipts in future years, we have requested an exception to the policy for 2014. As a result, in §156.50(c), we propose that a participating issuer offering a plan through a Federally-facilitated Exchange remit a user fee to HHS each month, in the time and manner established by HHS, equal to the product of the billable members enrolled through the Exchange in the plan offered by the issuer, and the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year. For purposes of this paragraph, billable members are defined under the proposed §147.102(c)(1) as the number of members on a policy, with a limitation of three family members under age 21. This approach will ensure that the user fee generally aligns with the number of enrollees for each issuer.

For the 2014 benefit year, we propose a monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan. We seek to align this rate with rates charged by State-based Exchanges, and may adjust this rate to take into account comparable State-based Exchange rates in the final Payment Notice. We note that this policy does not affect the ability of a State to use grants

described in section 1311 of the Affordable Care Act to develop functions that a State elects to operate under a Partnership Exchange, and to support State activities to build interfaces with a Federally-facilitated Exchange, as described in the "State Exchange Implementation Questions and Answers," published November 29, 2011.

Circular No. A-25R provides for a user fee to be collected simultaneously with the rendering of services, and thus we further propose to assess user fees throughout the benefit year in which coverage is offered. Additional guidance on user fee collection processes will be provided in the future; however, we anticipate that user fees will be calculated based on the number of billable members enrolled in a plan each month. We anticipate collecting user fees by deducting the user fee from Exchange-related program payments. If an issuer does not receive any Exchange-related program payments, the issuer would be invoiced for the user fee on a monthly basis. We welcome comment on these proposals and the operational processes related to user fee assessment and collections.

In addition, we welcome comments on a policy that we are considering that would provide for the pooling of Exchange user fees or all administrative costs across a particular market (however, the user fee would be collected only from issuers participating in the Federally-facilitated Exchange). The Market Reform proposed rule proposes an implementation of section 1312(c) of the Affordable Care Act under which the claims experience of all enrollees in health plans offered by an issuer in a State in the individual, small group, or combined market, as applicable, are to be pooled. We are considering further developing this policy, which we would codify in regulation at §156.80,[41] by requiring that Exchange user fees also be subject to risk pooling.

[41] We issued a proposed regulation on risk pooling at §156.80 of the proposed Market Reform Rule.

Specifically, we are considering proposing that issuers be allowed an adjustment to the index rate for the pooled, expected Exchange user fees for the set of health plans offered in a particular market. We are considering this additional specification to provide further protection against adverse selection for QHP coverage, and to ensure that the costs of Exchange user fees are spread evenly across the market. We seek comment on this policy, including whether it should apply to a broader set of administrative costs. For example, under this alternative, it could apply to both Exchange user fees and distribution costs, or all administrative costs. In addition, we seek comment on an alternative approach, under which the proposed risk pooling would apply across all health plans within a product (defined as a specific set of benefits), rather than across a market.

G. Distributed Data Collection for the HHS-operated Risk Adjustment and Reinsurance Programs

1. Background

The Premium Stabilization Rule specifies at §153.20 that a risk adjustment methodology must include a risk adjustment data collection approach. Therefore, the Federally certified risk adjustment methodology described in this proposed rule must include such a data collection approach. As already discussed, we propose to add new §153.420(a) to establish that an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State, or by HHS on behalf of the State. In addition, we propose to amend Part 153 by adding Subpart H, entitled "Distributed Data Collection for HHS-Operated Programs." We intend to clarify in Subpart H the data collection process that HHS would use when operating a risk adjustment or reinsurance program on behalf of a State.

In the preamble to the proposed Premium Stabilization Rule, we described a distributed approach as one in which each issuer formats its own data in a manner consistent with the risk assessment database, and then passes risk scores to the entity responsible for assessing risk adjustment charges and payments. In the preamble to the Premium Stabilization Rule, we indicated that we intend to use a distributed approach to collect data for the HHS-operated risk adjustment program. In the Reinsurance Bulletin, we stated that we will also use such an approach when we operate the reinsurance program. We believe that this approach minimizes issuer burden while protecting enrollees' privacy.

2. Issuer Data Collection and Submission Requirements

Under the HHS-operated risk adjustment and reinsurance programs, HHS will use a distributed data collection approach to run software on enrollee-level and claims-level data that reside on an issuer's dedicated data environment. This approach will require close technological coordination between issuers and HHS.

Distributed data environment: In §153.700(a), we propose that an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State where HHS is operating the risk adjustment or reinsurance program on behalf of the State, must establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for risk adjustment and reinsurance operations. To accomplish the distributed data collection approach for both the reinsurance and risk adjustment programs, issuers would be required to establish secure, dedicated, electronic server environments to house medical and pharmacy claims, encounter data, and enrollment information. Issuers would be directed to make this data accessible to HHS in HHS-specified electronic formats, and to provide HHS with access to the data environment to install, update, and operate common software and specific reference tables for the

purpose of executing risk adjustment and reinsurance program operations. Issuers would also be directed to correct submitted files to resolve problems detected by HHS during file processing. We will provide further technical details on these standards in the future.

We note that HHS will store, in a private and secure HHS computing environment, aggregate plan summary data and reports based on activities performed on each issuer's dedicated server environment. Except for purposes of data validation and audit, HHS will not store any personally identifiable enrollee information or individual claim-level information.

We propose in §153.700(b) that issuers must establish the dedicated data environment (and confirm proper establishment through successfully testing the environment to conform with HHS standards for such testing) three months prior to the first date of full operation. For example, for benefit year 2014, implementation, including testing, will begin in March 2013, and continue through October 2013, in preparation for the commencement of risk adjustment and reinsurance program operations on January 1, 2014. HHS also plans to schedule technical assistance trainings for issuers in 2013.

Data Requirements: In §153.710(a), we propose that an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to the enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data specified by HHS.

We propose in §153.710(b) that all claims data submitted by an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer. The enrollee-level data must include information from claims and

encounter data (including data related to cost-sharing reductions, to permit HHS to calculate enrollee paid claims net of cost-sharing reductions) as sourced from all medical and pharmacy providers, suppliers, physicians, or other practitioners who furnished items or services to the issuer's health plan members for all permitted paid medical and pharmacy services during the benefit period. All data must be provided at the level of aggregation specified by HHS.

A listing of required data, proposed data formats, and data definitions for the HHS-operated distributed data approaches for the risk adjustment and reinsurance programs will be provided in the in the PRA approved under OMB Control Number (OCN) 0938-1155 with an October 31, 2015 expiration date.

In §153.710(c), we propose that an issuer that does not generate claims in the normal course of business[42] must derive costs on all applicable provider encounters using their principal internal methodology for pricing those encounters (for example, a pricing methodology used for the Medicare Advantage encounter data collection). If a plan has no such methodology, or has an incomplete methodology, it would be permitted to implement a methodology or supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific market that the plan is serving.

Establishment and usage of masked enrollee identification numbers: We propose in §153.720(a) that an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must establish an unique masked enrollee identification number for each enrollee, in accordance with HHS-defined requirements as described in this section, and maintain the same masked enrollee identification number for an enrollee across

[42] Examples of such plans include staff-model health maintenance organizations and plans that pay providers on a capitated basis.

enrollments or plans within the issuer, within the State, during a benefit year. In §153.720(b), we propose that an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, may not include an enrollee's personally identifiable information in the masked enrollee identification number or use the same masked enrollee identification number for different enrollees enrolled with the issuer. The requirements here align the specific requirements for data collection with the requirements in §153.340(b) of the Premium Stabilization Rule and the proposed §153.240(d). As discussed above, the term "personally identifiable information" is a broadly used term across Federal agencies, and has been defined in the Office of Management and Budget Memorandum M-07-16 (May 22, 2007).[43] To reduce duplicative guidance or potentially conflicting regulatory language, we are not defining personally identifiable information in this proposed rule, and incorporate the aforementioned definition in to this proposed rule.

Deadline for submission of data: We propose in §153.730 that an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, submit data to be considered for risk adjustment payments and charges and reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year. This timeline will permit sufficient time for HHS to calculate and notify issuers of those payments and charges in time to meet the June 30 deadline set forth in §153.310(e), as proposed to be renumbered, and proposed in §153.240(b)(1).

[43] Available at: http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2007/m07-16.pdf.

Proposed §153.240(b)(2) provides that States administering their own reinsurance program must notify issuers of reinsurance-eligible plans of their expected requests for reinsurance payments on a quarterly basis. We believe that these interim reports will provide issuers in the individual market with information to assist in the development of premiums and rates in subsequent benefit years. Acceptable enrollment and claims/encounter data not submitted in a timely manner will be considered in the next quarter or during the annual processing period. The annual reinsurance payments will not be determined until after April 30 of the year following the applicable benefit year, once all requests for reinsurance payments have been submitted, and any adjustments have been made under proposed §153.230(d). Therefore, for claims to be eligible for reinsurance payments, acceptable enrollment and paid claims or encounter data must be available on the issuer's environment prior to the April 30 deadline, as specified in future guidance.

3. Risk Adjustment Data Requirements

HHS's data collection approach is aligned with the HHS risk adjustment model and its calculation of payments and charges. This section describes the types of data that will be acceptable for risk adjustment.

a. Data collection period: The data collection period will encompass enrollment and services for the applicable benefit year.

(1) Claim-level service dates. Institutional and medical claims and encounter data where the discharge date or through date of service occurs in the applicable benefit year will be allowed for risk adjustment, provided that all other criteria defined under this section are met.

(2) Enrollment periods. Issuers must provide data for all individuals enrolled in risk adjustment covered plans in the applicable benefit year with enrollment effective dates beginning on or after January 1 of that benefit year.

b. Acceptable Risk Adjustment Data. Acceptable risk adjustment data for enrollee risk score calculation will be determined using the criteria listed below.

(1) Acceptable claim types. Data to calculate enrollee risk scores will include diagnoses reported on institutional and medical claims that result in final payment action or encounters that result in final accepted status. The specific criteria for capturing a complete inpatient stay (across multiple bills) for single hospital admission will be provided in future guidance.

(2) Acceptable provider types. Diagnoses reported on certain hospital inpatient facility, hospital outpatient and physician provider claims will be acceptable for risk adjustment. The risk adjustment model discussion provides HHS' description for identifying and excluding claims from providers based on these criteria.

(3) Acceptable diagnoses. Diagnoses will be acceptable for enrollee risk score calculation if they are present on medical claims and encounters that meet criteria that are acceptable for HHS-operated risk adjustment data collection.

c. Risk Adjustment Processing and Reporting. Issuers are responsible for correcting errors and problems identified by HHS in the distributed data environment.

4. Reinsurance Data Requirements

This section describes the types of data that would be necessary for the evaluation of claims eligible for reinsurance payments to reinsurance-eligible plans as defined under §153.20. HHS would use the same distributed data collection approach used for risk adjustment; however, only data elements necessary for reinsurance claim selection will

be considered for the purpose of determining a reinsurance payment. Data considered acceptable for reinsurance payment calculations are described below.

a. Data collection period. Medical and pharmacy claims, where a claim was incurred in the benefit year beginning on or after January 1 of the applicable benefit year and paid before the applicable data submission deadline (provided all other criteria are met) would be accepted for consideration.

b. Acceptable Reinsurance Data. Acceptable reinsurance data leading to eligible claim selection for the reinsurance program will be determined using the criteria listed below.

(1) Claim types. Data to identify eligible reinsurance paid claims would include medical and pharmacy claims. Claims that resulted in payment by the issuer as the final action and encounters priced in accordance with issuer pricing methodologies would be considered for payment. Replacement claims for the purposes of adjusting data elements submitted on prior claim submissions, including, but not limited to changes in payment amounts, services rendered, diagnosis, would be accepted, but interim bills and late charges would not be accepted. The specific criteria for submitting complete data for inpatient stays will be provided in future guidance.

(2) Capitated plans: Encounter data submitted by issuers that do not generate claims in the normal course of business would be accepted for consideration when services were performed in the benefit year beginning on or after January 1, 2014 and submitted prior to the applicable data-submission deadline. Specific information related to the assessment and application of encounter claims for reinsurance calculations will be provided in future guidance.

c. Reinsurance Processing and Reporting. HHS plans to provide each issuer with a periodic report on data functions performed in each issuer's distributed data

environment, including the identification of reinsurance eligible claims by State. The reports would indicate whether HHS accepted or rejected submitted files and data, and errors detected by HHS. Issuers would need to provide corrected files and data to address errors identified in HHS-provided reports for those files and data to be eligible for identification during reinsurance processing. Timeframes for the processing and reporting of these reports, including receipt of corrected files or discrepancy resolution, will be provided in future guidance.

H. Small Business Health Options Program

1. Employee Choice in the Federally-Facilitated SHOP (FF-SHOP)

Employee choice is a central SHOP concept, and facilitating employee choice at a single level of coverage selected by the employer – bronze, silver, gold, or platinum – is a required SHOP function.[44] In addition, the SHOP may also allow a qualified employer to make QHPs available to employees by other methods.[45] For the FF-SHOP, we continue to consider whether to allow a qualified employer to offer its employees only a single QHP. We note that, once an employer has selected a single QHP and decided on a contribution toward that QHP, the employer can then offer employees a choice of all the other plans at the same metal level at no additional cost to the employer. Since adding employee choice would have no adverse financial impact on the employer, we propose that Federally-facilitated SHOPs will not offer a single QHP option to employers but will focus instead on the innovative features of a SHOP: a simpler employer experience and enhanced employee choice. In FF-SHOPs, we propose that employers will choose a level of coverage (bronze, silver, gold, or platinum) and a contribution, and employees can then choose any QHP at that level.

[44] §155.705(b)(2).
[45] §155.705(b)(3).

In addition to this choice within single level of coverage, many employers expressed support for employer and employee choice across metal levels both in comments to the Exchange Establishment NPRM and in stakeholder discussions. Issuers, however, have expressed concern about the potential risk segmentation that may result. In comments submitted to HHS in connection with the Exchange Final Rule,[46] issuers urged that employee choice be limited to a single level of coverage selected by the employer based on the potential for risk segmentation with a greater degree of employee choice. There was general agreement among these commenters that the degree of risk segmentation is small if employee choice is limited to a single metal level of coverage, particularly given the presence of risk adjustment, and increases as employee choice is extended across metal levels of coverage. Many commenters suggested that the risk segmentation associated with broad choice across all metal levels may adversely affect premiums.

Some issuers expressed openness to allowing the employee to "buy up" to certain plans at the next higher level of coverage, thereby offering employees a broader range of health plans. Therefore, we seek comment on adding an additional employer option in the FF-SHOP that would allow a qualified employer to make available to employees all QHPs at the level of coverage selected by the employer plus any QHPs at the next higher level of coverage that a QHP issuer agrees to make available under this option. QHP issuers could decide whether or not to make available QHPs at the next higher level of coverage above the level of coverage selected by the employer.

We note that concerns about risk selection will be mitigated both by the risk adjustment program which addresses risk selection directly and by consumer tools

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[46] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (CMS-9989), 77 FR 18310 (Mar. 27, 2012).

showing expected "total costs" of coverage (premium, deductibles, copayments and coinsurance) that help consumers compare the cost of a high premium/low cost sharing plan with a low premium/high cost sharing plan. Nonetheless, particularly in the early years of implementation, the FF-SHOP in each State will need to balance the fundamental goal of enhancing employer and employee choice against concerns about potential risk selection to achieve the broadest issuer participation, the best range of plan design choices, and the most effective competition in the small group market. Therefore, we seek comment on a transitional policy in which a Federally-facilitated SHOP would allow or direct employers to choose a single QHP from those offered through the SHOP.

2. Methods for Employer Contributions in the FF-SHOP

Employers may elect a variety of ways to contribute toward health coverage that are consistent with Federal law. Because employees in the FF-SHOP will be choosing their own coverage and will need to know the net cost to them after the employer's contribution, the employer will need to choose a contribution method before employees select their qualified health plans. To facilitate this, each SHOP would offer "safe harbor" methods of contributing toward the employee coverage – methods that reflect a meaningful employer choice and that conform to existing Federal law. The safe harbor methods described below are not the only allowable methods of contribution, but are those that will be available initially to qualified employers participating in FF-SHOPs.

Under this proposed rule at § 155.705(b)(11), FF-SHOPs would base the employer contribution methods on the cost of a reference plan chosen by the qualified employer. This reference plan approach is one of the methods described in section III.G. of IRS Notice 2010-82 regarding allowable ways an employer may contribute to the employees' premiums and qualify for the small business premium tax credit prior to

2014.[47] We note that the IRS plans to issue additional guidance applicable to plan years beginning after 2013.

The IRS Notice describes two types of reference plan premiums – one in which the premium for the reference plan is a composite premium that is the same for each member and a second in which the premium for the reference plan varies with the age of the covered individual (or other permissible rating factor). In both cases, the small business can define its contribution toward a member's coverage as a percentage of the premium for the reference plan.

Except in States that prohibit employee contributions that vary by age or require issuers to quote only composite premiums, the qualified employer would be asked the following question: "Do you want each employee to contribute the same amount toward the reference plan premium, or do you want the employee's contribution to vary with age within the allowed limits?"[48],[49] This option to charge younger employees lower premiums for a given coverage may help attract younger individuals into the risk pool and may help employer groups meet any minimum participation rates. On the other hand, this option also results in higher premium contributions by older employees who are also more likely to incur higher out-of-pocket costs.[50]

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[47] IRS Notice 2010-82, section III.G. describes employer contribution methods using a reference plan with a variety of different rating methods: per member rating (referred to in the Notice as "list billing"), composite rating (referred to as "composite billing"), and the hybrid method (referred to as an "employer-computed composite rate"). Although prepared as guidance regarding employer contributions eligible for the small business premium tax credit and applicable only through 2013, it provides a clear description of "safe harbor" methods that will be used in the FF-SHOP.

[48] Thus, the ratio of the employee contribution made by the oldest adult and the youngest adult toward the reference plan cannot exceed 3:1 before any tobacco use factor is applied.

[49] Because tobacco use information from employees will not be available when estimating total premiums for the group and average premiums per employee, tobacco use will always be a surcharge applied to an employee's or dependent's premium. See the proposed Health Insurance Market Rules (77 Fed. Reg. at 70595-70597) and the Incentives for Nondiscriminatory Wellness Programs in Group Health Plans Proposed Rule (77 Fed. Reg. 70620) for further discussion of the tobacco use surcharge and wellness programs.

[50] See 29 CFR 1625.10 for a description of the ways in which employee contributions toward premiums may vary according to employee age without constituting impermissible age discrimination.

If the qualified employer decides that the employee's contribution should vary by age, then the employer contribution would be based on the reference plan, and the remaining employee contribution for the employee's plan would not be affected by other employees' decisions about participation. Once the employees have chosen their plans, the qualified employer would approve the final application and the FF-SHOP would enroll the employees in their chosen health plans.

If the qualified employer decides that each employee pays the same amount for the reference plan coverage, regardless of age, the composite premium for the reference plan, and the employer contribution based on that plan, may change based on which employees choose to participate, just as composite premiums may need to be re-quoted by the issuer today. Operationally, once the employee choices have been made, the composite premium for the reference plan would be recalculated, and the employer and employees notified of any changes.

We welcome comments on this approach.

3. Linking Issuer Participation in an FFE to Participation in an FF-SHOP

Consistent with the goal of ensuring choice of affordable insurance plans, in this proposed rule, we propose standards that we believe will help ensure that qualified employers and qualified employees enrolling through a FF-SHOP are offered a robust set of QHP choices in a competitive small group marketplace. We believe that a competitive marketplace offering qualified individuals, qualified employers, and qualified employees a choice of issuers and QHPs is a central goal of the Affordable Care Act, and that the SHOP can provide an effective way for small employers to offer their employees a choice of issuers and QHPs. We propose in §156.200(g) to leverage issuers' participation in an FFE to ensure participation in the FF-SHOP, provided that no issuer would be required to begin offering small group market products as a result of this provision.

While a State-operated SHOP has a variety of options available to ensure a robust choice of QHPs and issuers, an FFE is limited to the QHP certification process. We propose in §156.200(g) that an FFE may certify a QHP in the individual market of an FFE only if the QHP issuer meets one of the following conditions: (1) the issuer offers through the FF-SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; (2) the QHP issuer does not offer small group market plans in that State, but another issuer in the same issuer group (as defined below) offers through the FF-SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or (3) neither the issuer nor any issuer in the same issuer group offers a small group market product in the State. Thus, no issuer would be required to begin offering small group market plans to meet this requirement.

We note that §156.515(c)(2) has already implemented similar provisions for the Consumer Operated and Oriented Plans (CO-OPs). A CO-OP is not required to offer plans in the small group market, but if the CO-OP does offer a small group market plan, it must offer a silver and a gold QHP in each SHOP that serves the geographic regions in which the CO-OP offers coverage in the small group market.

We propose to add to §156.20 a definition of "issuer group" that will be specific to this section of the regulations. The proposed definition includes both issuers affiliated by common ownership and control and issuers affiliated by the common use of a nationally licensed service mark. We believe that either of these elements–common control or common use of a licensed mark–would appropriately identify an issuer group. We define "issuer group" to help assure that the certification standard linking Exchange participation with SHOP participation has similar effects on small issuers and large issuer groups. We seek comment on this issue and whether or not the policy meets its three

intended goals: enhancing employer and employee choice, assuring similar effects on single issuers and issuer groups, and not requiring any issuer not already offering coverage, to begin offering coverage in the small group market.

4. Broker Compensation for Coverage Sold Through an FFE or FF-SHOP

While a State also has a variety of policies it might adopt with regard to broker compensation that would help create a level playing field for enrollment inside and outside the SHOP due to the State's broad authority to regulate insurance markets, FFE and FF-SHOP options for creating a level playing field are again limited to QHP certification standards. In a new paragraph §156.200(f), we propose that QHP certification by an FFE and an FF-SHOP be conditioned on the QHP issuer paying similar broker compensation for QHPs offered through a FFE or FF-SHOP that it would pay for similar health plans offered outside an FFE and an FF-SHOP. We request comment on whether "similar health plans" is a sufficient standard and if not, which factors should be considered in identifying "similar health plans." We also request comment on how this standard might apply when small group market product commissions are calculated on a basis other than an amount per employee or covered life or a percentage of premium.

5. Minimum Participation Rate in the FF-SHOP

Section 155.705(b)(10) specifies that a SHOP may establish a uniform minimum participation rate for its QHPs. Further rulemaking is needed to establish a minimum participation rate in the FF-SHOP. We recognized in the proposed Exchange Establishment Rule, 76 FR at 41886, that minimum participation rates calculated at the level of the issuer are currently in wide use by issuers as one method to reduce the potential for adverse selection. We note here that the ability of a SHOP, including an FF-SHOP, to adopt a minimum participation rate as an exception to the guaranteed issue

requirements of the Affordable Care Act is dependent on the final adoption of §147.104 (b)(1) of the proposed Health Insurance Market Rule, (77 FR 70612), which conditions employer eligibility for the year-around open enrollment period in the SHOP (or FF-SHOP) on meeting any minimum participation rate that the SHOP (or FF-SHOP) might establish.

Because we believe risk selection based on employee decisions to participate is likely without a minimum participation rate, we propose a minimum participation rate for the FF-SHOP of 70 percent, calculated at the level of the FF-SHOP. This rate is based on consultations with issuer organizations and regulators about customary minimum participation rates and would apply to all qualified employers in the FF-SHOP serving a given State. Because State law, regulation, and market practices vary from State to State, we also propose an option for the FF-SHOP to adopt a different uniform minimum participation rate in a State with a FF-SHOP if there is evidence that:

(1) A State law sets the rate; or

(2) A higher or lower rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

In addition, in accordance with State laws, we propose that certain types of alternative coverage will exclude an employee entirely from the calculation of the minimum participation rate:

(1) A group health plan offered by another employer; or

(2) A governmental program such as Medicare, Medicaid, or TRICARE.

We seek comment on the default minimum participation rate and the exceptions that will help ensure alignment with current State practice and standards inside and outside the SHOP.

6. Determining Employer Size for Purposes of SHOP Participation

While the Exchange Establishment Rule did not finalize a method for determining employer size, we note that part-time employees must be taken into account in some reasonable way to be consistent with the Affordable Care Act standards for determining employer size. We propose to amend the definitions of "small employer" and "large employer" in §155.20 to specify the method for determining employer size and to add the definition of large employer to §157.20. In determining whether an employer is a small employer for purposes related to the SHOP, we propose that the full-time equivalent method used in section 4980H(c)(2)(e) of the Code, as added by section 1513 of the Affordable Care Act, be used. We seek comment on the proposed definition. We believe that having a single method will provide greater clarity and simplicity both for employers and for States seeking to reconcile State methods of determining group size with Federal methods in the operation of Exchanges and for determining employer eligibility to participate in the SHOP. We discuss the timing of this action in the "Transitional Policies" section below.

7. Definition of a Full-Time Employee for Purposes of Exchanges and SHOPs

Section 1312(f)(2)(A) of the Affordable Care Act defines a qualified employer as one "that elects to make all full-time employees of such employer eligible for one or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans." The Affordable Care Act does not define a full-time employee for purposes of this provision. We propose to add to §155.20 a definition of full-time employee that cross-references section 4980H(c)(4) of the Code, which provides that a full-time employee with respect to any month is generally an employee who is employed an average at least 30 hours of service per week, subject to the transitional policies discussed in the next paragraph. Under our proposal, this definition

would control for purposes of the section 1312(f)(2)(A) requirement that qualified employers offer coverage to all full-time employees.

8. Transitional Policies

Most States currently use definitions of a full-time employee and methods of counting employees to determine employer size that differ from Federal definitions and methods. We believe that certain provisions of the Affordable Care Act that distinguish between the small group market and large group market and between large employers and small employers require that a Federal definition be used. We also note that section 1304(b)(3) of the Affordable Care Act provides States with some discretion in how they define their small group market in 2014 and 2015. Because States will generally take legislative action before January 1, 2016, to redefine the upper limit of the small group market as 100 employees, we believe that States can also act at that time to adopt a counting method that is consistent with Federal law.

Therefore, we propose that the definitions of small employer and full-time employee proposed above be effective January 1, 2016, for purposes of Exchange and SHOP administration. With respect to State-operated SHOPs for 2014 and 2015 only, HHS will not take any enforcement actions against a State-operated SHOP for including a group in the small group market based on a State definition that does not include part-time employees when the group should have been classified as part of the large group market based on the Federal definition. Similarly, during 2014 and 2015, an employer and a State-operated SHOP may adopt a reasonable basis for their determination of whether they have met the SHOP requirement to offer coverage to all full-time employees, such as the definition of full-time employee from the State's small group market definition or the Federal definition from section 4980H of Chapter 43 of the Code.

The FF-SHOP, however, must use a counting method that takes part-time employees into account. We propose that these definitions will be effective October 1, 2013 for the FF-SHOP. To make an employer eligibility determination, the FF-SHOP will ask employers about the number of employees based on the full-time equivalent method used in section 4980H of Chapter 43 of the Code, as added by section 1513 of the Affordable Care Act. Thus, in FF-SHOP States, there may be a few employers who can purchase a small group market plan outside of the FF-SHOP (because they have fewer than 50 full time employees) but will not be eligible to purchase through the FF-SHOP (because they have more than 50 full time equivalent employees).

We request comment on the proposed definitions and on the proposed transition policies.

9. Web Site Disclosures Relating to Agents and Brokers

We propose modifications to the website disclosure standards relating to brokers in §155.220(b). Specifically, we propose a new paragraph (b)(1) that would allow an Exchange or SHOP to limit the display of agent and broker information to include only those licensed agents and brokers who are registered with the Exchange or SHOP and a new paragraph (b)(2) that would specifically adopt this provision for an FFE and an FF-SHOP. We believe that listing only brokers who have registered with the Exchange is in the best interest of the consumer, both because the registration and training helps assure that the agent or broker is familiar with the Exchange policies and application process and because the proposed listing will not contain large numbers of licensed brokers who are not active in the market. We welcome comments on these proposals.

10. QHP issuer standards specific to SHOP.

We propose modifications to the QHP issuer standards specific to SHOP for enrollment in §156.285. Specifically, we propose a technical correction in paragraph

(c)(7) such QHP issuers participating in the SHOP must enroll qualified employees if they are eligible for coverage. This correction aligns SHOP enrollment standards to Exchange enrollment standards.

I. Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act

1. Treatment of Premium Stabilization Payments, and Timing of Annual MLR Reports and Distribution of Rebates

Our previous rulemakings concerning PHS Act section 2718 did not address how issuers are to account for the premium stabilization programs in their MLR reports and in calculating their MLR and any rebates owing, given that the premium stabilization programs are effective beginning in 2014. This proposed rule would modify the definition of premium revenue in §158.130, the formula in §158.221(c) for calculating an issuer's MLR, and the formula in §158.240(c) for calculating an issuer's rebate if the MLR standard is not met, in the current MLR regulation to account for payments and receipts related to the premium stabilization programs. When the MLR annual reporting form is updated for the reporting year 2014 and later, premium stabilization amounts would be considered a part of total premium revenue reported to the Secretary, similar to other elements involved in the derivation of earned premium. The MLR annual reporting form would then account for premium stabilization amounts by removing them from adjusted earned premium, so that these amounts do not have a net impact on the adjusted earned premium used in calculating the MLR denominator and rebates. Additionally, this proposed rule would amend §158.140(b) to include premium stabilization amounts as an adjustment to incurred claims in calculating the MLR numerator as provided in §158.221. This approach would address stakeholder concerns that netting premium stabilization amounts directly against adjusted earned premium in MLR and rebate calculations would

result in an issuer paying either a higher total amount or a lower total amount for rebates and the premium stabilization programs combined, depending on whether the issuer's net premium stabilization obligations resulted in payment or receipt of funds by the issuer. The approach in this proposed rule would also preserve consistency between the MLR and risk corridors programs by treating premium stabilization amounts in MLR and rebate calculations the same way section 1342(c) of the Affordable Care Act treats reinsurance and risk adjustment amounts in risk corridors calculations, by applying them as adjustments to cost, not revenue. Although PHS Act section 2718 provides that premium revenue should "account for" collections or receipts for the premium stabilization programs, we believe the statutory language provides flexibility as to whether to account for the effects of such collections or receipts in determining revenue (the denominator) or costs (the numerator) of the MLR formula. We considered netting premium stabilization payments or receipts against revenue, but for the reasons discussed above, have not proposed that approach. We invite comment on this decision.

In sum, the formula for calculating the MLR would be amended as follows to take into account payments for and receipts related to the premium stabilization programs:

Adjusted MLR = $[(i + q + n - r) / \{(p + n - r) - t - f - n + r\}] + c$

Where,

i = incurred claims

q = expenditures on quality improving activities

p = earned premiums

t = Federal and State taxes

f = licensing and regulatory fees

n = reinsurance, risk corridors, and risk adjustment payments made by issuer

r = issuer's reinsurance, risk corridors, and risk adjustment related receipts

c = credibility adjustment, if any.

Issuers must provide rebates to enrollees if their MLRs fall short of the applicable MLR standard for the reporting year. Rebates for a company whose adjusted MLR value in a State falls below the minimum MLR standard in a given market would be calculated using the following amended formula:

Rebates = (m – a) * [(p + n – r) – t – f – n + r]

Where,

m = the applicable minimum MLR standard for a particular State and market

a = issuer's adjusted MLR for a particular State and market.

The amendments made by this proposed rule would be effective for MLR reporting years beginning in 2014.

In addition, this proposed rule would change the MLR reporting and rebate deadlines, beginning with the 2014 MLR reporting year, to coordinate them with the reporting cycles of the premium stabilization programs. Currently, an issuer must file its annual MLR report by June 1 and pay any rebates it owes to consumers by August 1 of the year that follows the MLR reporting year. However, looking ahead, the amounts associated with the premium stabilization programs that issuers must take into account in their MLR calculations will not be known until after June 1 each year. For example, a state, or HHS on behalf of a state, has until June 30 of the year following a benefit year to notify issuers of the risk adjustment and reinsurance payments due or charges owed for that benefit year (§153.310(e); §153.240(b)(1) as proposed in this proposed rule). As further specified above in section III.C. of this proposed rule issuers must submit risk

corridors data and calculations by July 31 of the year following a benefit year (§153.530(d) as proposed in this proposed rule). Accordingly, we propose to amend §158.110(b) to change the date of MLR reporting to the Secretary from June 1 to July 31 beginning with the 2014 MLR reporting year, and we propose to amend §158.240(d) to change the rebate due date from August 1 to September 30 to accommodate the schedule for the premium stabilization programs beginning with the 2014 MLR reporting year. Similarly, we propose to amend §158.241(a)(2) to change the due date for rebates provided by premium credit from August 1 to September 30, to apply to the first month's premium that is due on or after September 30 following the MLR reporting year, beginning with the 2014 MLR reporting year. In choosing these dates, we tried to balance consumers' and policyholders' interests in maintaining the dates for MLR reporting and rebates as close to the June 1 and August 1 dates as possible with issuers' interests in having the necessary data to submit their annual MLR report and sufficient time to disburse any rebates. Although we must provide issuers any reconciliation of their risk corridors calculations by August 31, as described above in Section C of this proposed rule, we believe that there will be few changes to the risk corridors calculations submitted by issuers to the Secretary by July 31. This would give issuers one additional month from any reconciliation to disburse any rebates owed, which we believe is sufficient time. Comments on the proposed timeline are welcome.

2. Deduction of Community Benefit Expenditures

While we did not specifically solicit comments on the deduction from premium for community benefit expenditures in the MLR December 7, 2011 final rule with comment period, we received a few comments that recommend that a tax exempt not-for-profit issuer should be able to deduct both community benefit expenditures and State premium tax. These commenters suggest that prior to publication of the final rule, the

MLR interim final rule published on December 1, 2010 gave a tax exempt not-for-profit issuer this flexibility. Two commenters assert that a Federal income tax exempt issuer is required to make community benefit expenditures to maintain its Federal income tax exempt status, and that allowing a deduction for community benefit expenditures takes the place of a Federal income tax deduction in the MLR calculation. Commenters have made clear that deducting both State premium taxes and community benefit expenditures would help level the playing field because it would allow a Federal income tax exempt issuer to deduct its community benefit expenditures in the same manner that a for-profit issuer is allowed to deduct its Federal income taxes. We agree, and this proposed rule would amend §158.162(b)(1)(vii) to allow a Federal income tax exempt issuer to deduct both State premium taxes and community benefit expenditures from earned premium in the MLR calculation. This proposed rule would not change the treatment of State premium taxes and community benefit expenditures for those issuers that are not exempt from paying Federal income tax. Comments are welcome on the merits of allowing a tax exempt issuer to deduct both State premium taxes and community benefit expenditures from earned premium.

In its model MLR recommendation[51], the NAIC determined that the deduction from premium for community benefit expenditures should be limited to a reasonable amount to discourage fraud and abuse and that this limit should be the State premium tax rate. We applied this principle in allowing issuers exempt from State premium tax to deduct community benefit expenditure, up to the State premium tax rate, in their MLR calculation. However, the MLR final rule published on December 7, 2011 allowed issuers exempt from Federal income tax to deduct community benefit expenditures in lieu

[51] Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 per Section 2718(b) of the Public Health Service Act, available at http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

of State premium taxes, not Federal income taxes.

Commenters have suggested that a 3 percent limit on the deduction from premium for community benefit expenditures would be sufficient to allow a tax exempt issuer to maintain its current community benefit expenditure. The 2011 MLR data indicate that, of the not-for-profit issuers that reported non-zero community benefit expenditures, the average spent on community benefit expenditures (deductible and non-deductible) was about 1.6 percent of premium. This suggests that a 3 percent community benefit expenditure deduction limit would not discourage a tax exempt issuer from making community benefit expenditures. In light of the NAIC model rule and the comments received, we propose to limit the deduction from premium for community benefit expenditures for issuers that are exempt from Federal income tax to the higher of either 3 percent of premium or the highest premium tax rate charged in a State. Comments are solicited on the proposed community benefit expenditures deduction limit.

3. Summary of Errors in the MLR Regulation

a. Errors in the December 1, 2010 interim final rule

We are making two changes to the December 1, 2010 interim final rule (75 FR 74864) to make the language of the rule consistent with the NAIC's recommendations, which in the preamble we stated that we were adopting.

On page 74924, in §158.140 (b)(5)(i), we mistakenly specified the date by which issuers must define the formula they use for the blended rate adjustment as ''January 1, 2011'' instead of ''January 1 of the MLR reporting year.'' We are updating this date to ensure that all issuers are able to choose to make the blended rate adjustment going forward. We mistakenly omitted the words "by the issuer" following the words ''will be defined'' and mistakenly used the word "will" instead of "must" in describing the objective formula to be used in reporting group coverage at a blended rate.

On page 74928, in §158.232(d), we inadvertently used the word ‘‘For’’ instead of ‘‘Beginning with’’ when describing the date after which partially-credible issuers that consistently fail to meet the MLR standard will not be allowed to use a credibility adjustment.

b. Error in the May 16, 2012 Correcting Amendment

Section 158.232(c)(1)(i) of the MLR regulation was amended by the May 16, 2012 correcting amendment (77 FR 28788), which currently reads: ‘‘[t]he per person deductible for a policy that covers a subscriber and the subscriber’s dependents shall be the lesser of: The sum of the deductible applicable to each of the individual family members; or the overall family deductible for the subscriber and subscriber’s family, divided by two (regardless of the total number of individuals covered through the subscriber).’’ In this correcting amendment, we further amend §158.232(c)(1)(i) by deleting the words ‘‘The sum of’’ after the words ‘‘the lesser of:’’ and the comma after the words ‘‘subscriber’s family,’’ which we inadvertently did not delete in the May 16, 2012 correcting amendment.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.

- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The following sections of this document contain paperwork burden but not all of them are subject to the information collection requirements (ICRs) under the PRA for reasons noted.

A. Collections Related to State Operation of Reinsurance & Risk Adjustment Programs (§153.210 through §153.240, §153.310)

Although the number of States that will elect to operate their own reinsurance or risk adjustment programs is unknown, we anticipate that fewer than nine States will choose to do so. Collections from fewer than 10 persons are exempt from the PRA under 44 U.S.C. 3502(3)(A)(i). Therefore, we do not plan to seek OMB approval for the following collections. However, in the event that, by the time of the final Payment Notice, we believe that the number of States will be greater than 9, we will seek PRA approval based on the burden estimates outlined below.

1. Reporting to HHS (§153.210)

We are proposing under §153.210(e) that a State operating its own reinsurance program must ensure that its applicable reinsurance entity provide information regarding the requests for reinsurance payments under the national contribution rate made under §153.410 of this part for all reinsurance-eligible plans for each quarter during the applicable benefit year. We estimate that it will take an operations analyst 2 hours (at $55 an hour) to gather information from applicable reinsurance entities and to submit this information to HHS, for a total burden of $110 per State selecting to run reinsurance.

2. Collection of Reinsurance Contribution Funds (§153.220)

Under proposed §153.220(d), a State that operates its own reinsurance program and elects to collect additional reinsurance contributions for additional administrative expenses or supplemental reinsurance payments or use additional State funds for supplemental reinsurance payments must notify HHS of its intent to do so within 30 days after publication of the draft annual HHS notice of benefit and payment parameters for the applicable benefit year. We believe that the burden associated with this requirement is the time and effort necessary for the State to provide this notification, and estimate it will take each State approximately 1 hour by an operations analyst (at $55 an hour) to submit this notification requirement. Consequently, we estimate a total burden of $55 for each State as a result of this requirement.

3. Collections Related to Reinsurance Payments Made under a State Additional Contribution Rate (§153.232)

Under §153.232(a), we propose to require a State running its own reinsurance program that chooses to collect additional contributions under §153.220(d) to set supplemental State reinsurance payment parameters and to ensure that reinsurance contributions collected and funds used are reasonably calculated to cover additional reinsurance payments that are projected to be made only under the supplemental reinsurance payment parameters. We estimate that it will take an operations analyst 8 hours (at $55 an hour) and a senior manager 2 hours (at $77 an hour) to determine appropriate supplemental payment parameters. Therefore, we estimate that it will cost each State choosing to collect additional contributions approximately $594 to comply with this requirement.

Under §153.232(d), we propose that States that run their own reinsurance program and that choose to collect additional contributions under §153.220(d) calculate the supplemental reinsurance payments from their additional funds collected under the

State additional contribution rate using supplemental payment parameters in conjunction with the national payment parameters to reimburse a particular portion of claims. Additionally, under §153.232(e), we propose that, if all requested reinsurance payments under the State supplemental reinsurance parameters calculated will exceed all reinsurance contributions collected under the additional State contribution rate for the benefit year, the State must determine a uniform pro rata adjustment to be applied to all requests for reinsurance payments. The State or the applicable reinsurance entity must reduce all such requests for reinsurance payments for the applicable benefit year by that adjustment. We estimate it will take an operations analyst 40 hours (at $55 an hour) and a senior manager 12 hours (at $77 an hour) to determine appropriate payment calculations and, if necessary, a pro rata adjustment. Therefore, we estimate that it will cost each State choosing to collect additional contributions approximately $3,124 to comply with this requirement.

4. Collections Related to Disbursement of Reinsurance Payments (§153.240)

We propose to amend §153.240(a) to direct a State operating its own reinsurance program to ensure that the applicable reinsurance entity either collects data or is provided access to the data required to determine reinsurance payments as described in §§153.230 and 153.232. In §153.240(b) we propose that a State or HHS on behalf of the State notify issuers of the total amount of reinsurance payments that will be made no later than June 30 of the year following the benefit year, as well as an estimate to each reinsurance-eligible plan of expected requests for reinsurance payments from the plan on a quarterly basis during the applicable benefit year. We estimate it will take an operations analyst 40 hours (at $55 an hour), 10 hours per quarter, and a senior manager 12 hours (at $77 an hour), 3 hours per quarter, to determine appropriate quarterly estimates of expected reinsurance payments and to notify plans. Additionally, we expect it will take an

operations analyst 40 hours (at $55 an hour) and a senior manager 12 hours (at $77 an hour) to determine the total amount of reinsurance payments for each reinsurance-eligible plan. Therefore, we estimate that it will cost each State choosing to run reinsurance approximately $6,248 to comply with this requirement. We will also revise the supporting statement of 0938-1155 to reflect the additional burden for States choosing to run reinsurance of providing quarterly estimates of expected reinsurance payments and notice of total reinsurance payments to reinsurance-eligible plans. At the final Payment Notice stage, we will revise the supporting statement of 0938-1155 to clarify that a State has the option to ensure that the applicable reinsurance entity provides access to data required to determine reinsurance payments, and that the State is not required to verify that the reinsurance entity is collecting this data directly.

In §153.240(a)(3), we propose that a State must provide a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims in the normal course of business, such as a capitated plan, may use estimated claims costs to make a request for payment (or to submit data to be considered for reinsurance payments) for such plan in accordance with the requirements of §153.410. In addition, the State must ensure that such requests for reinsurance payment are subject to validation. We estimate that our proposal will result in a small administrative cost to States associated with determining a format for submission of reinsurance payment data and notifying capitated plans of the acceptable method and format of data collection. We anticipate that a State will only need to establish this process once. On average, we estimate that it will take each State approximately 50 hours to comply with this requirement. We estimate it will take an operations analyst 40 hours (at $55 an hour) and a senior manager 10 hours (at $77 an hour) to determine an appropriate format for submission of reinsurance payment data for capitated plans and to notify plans of the

acceptable method and format for data collection. Therefore, we estimate that it will cost each State choosing to run reinsurance approximately $2,970 to comply with this proposal.

In §153.240(d)(1), we propose that, if a State establishes a reinsurance program, the State must ensure that the applicable reinsurance entity's collection of personally identifiable information is limited to information reasonably necessary for use in the calculation of reinsurance contributions or payments. Furthermore, in §153.240(d)(2), we propose that, if a State establishes a reinsurance program, it must ensure that the applicable reinsurance entity implements security standards that provide administrative, physical, and technical safeguards for the individually identifiable information consistent with the security standards. To comply with this requirement, we believe that most States will require the applicable reinsurance entity to comply with privacy and security standards that are similar to the Federal standards already established under the HIPAA and The Health Information Technology for Economic and Clinical Health Act (HITECH) (Pub.L. 104-191, 110 Stat. 1936, enacted August 21, 1996) or with privacy and security standards that are already established under State law, rather than developing entirely new standards to apply to reinsurance entities. We further anticipate that most States will incorporate this requirement into their contracting process with reinsurance entities. We estimate it will take a contract administrator 2 hours (at $40 an hour) and a lawyer 2 hours (at $77 an hour) to establish privacy and security standards for reinsurance entities and to notify reinsurance entities of these standards. Therefore, we estimate a total burden of 4 hours and $234 for each State choosing to operate reinsurance to comply with this proposal.

5. HHS Approval of Risk Adjustment States (§153.310)

Under §153.310(a)(4), we are proposing that a State that operates risk adjustment must be approved by HHS to do so. The burden associated with this process is the time and effort required by a State to submit evidence that it meets the approval standards set forth in §153.310(c). Note that these processes will start in benefit year 2015 – prior to that, HHS will engage in informal consultations with States. In any given benefit year after 2015, different States may apply for approval.

We estimate it will take each State approximately 180 hours to complete the initial risk adjustment entity approval process. We estimate it will take an operations analyst 72 hours (at $55 an hour), a contract administrator 72 hours (at $40 per hour), a senior manager 24 hours (at $77 an hour), and an attorney 12 hours (at $77 an hour) to meet the initial approval requirements. Therefore, we estimate a total burden of $9,612 for each entity, as a result of these approval requirements.

B. ICRs Regarding Calculation of Reinsurance Contributions (§153.405)

In §153.405, we propose an annual enrollment count of covered lives by contributing entities using counting methods derived from the PCORTF Rule. We propose requiring contributing entities to provide annual counts of their enrollment and reinsurance contributions to HHS based on their last reported PCORTF number as modified for reinsurance purposes. The burden associated with this requirement is the time and effort required by an issuer to derive an annual, enrollment count. Because issuers will already be under an obligation to determine a count of covered lives using a PCORTF method, the burden associated with this requirement is the additional burden of conducting these counts using the slightly modified counting methods specified in this proposed rule. On average, we estimate it will take each issuer 1 hour to reconcile and submit final enrollment counts to HHS. Assuming an hourly wage rate of $55 for an operations analyst, we estimate an aggregate burden of $110,000 for 2,000 reinsurance

contributing entities subject to this requirement. We are revising supporting statement of OMB Control Number 0938-1155 to include the required data elements that issuers will need to submit their enrollment counts and to specify that issuers must follow the methodology when they derive enrollee counts for reinsurance contributions.

C. Requests for Reinsurance Payment (§153.410)

As described in §153.410, we propose that issuers of reinsurance-eligible plans seeking reinsurance payment must request payment in accordance with the requirements of this proposed rule or the State notice of benefit and payment parameters, as applicable. To be eligible for reinsurance payments, issuers of reinsurance-eligible plans must submit or make accessible all necessary data to be considered for reinsurance payments for the applicable benefit year.

Issuers operating reinsurance-eligible plans in the individual market that are subject to the reinsurance data collection requirements are eligible to make reinsurance payment requests. To minimize burden on issuers, HHS intends to collect data in an identical manner for the HHS-operated reinsurance program and HHS-operated risk adjustment programs. In addition, when HHS operates reinsurance on behalf of a State, the maximum out-of-pocket differential between a cost-sharing reduction plan variation and the national maximum out-of-pocket limit established by the Federal government would be factored into an issuer's reinsurance payment. Although we are clarifying the data elements issuers would be required to submit as part of the reinsurance payment request process, the burden associated with this requirement is already accounted for under OMB Control Number 0938-1155 with an October 31, 2015 expiration date. We are updating the supporting statement approved under 0938-1155 with an October 31, 2015 expiration date to reflect these clarified data elements.

D. Upload of Risk Adjustment and Reinsurance Data (§153.420)

Under the HHS-operated risk adjustment and reinsurance programs, HHS proposes to use a distributed data collection approach to run software on enrollee-level plan enrollment, claims and encounter data that reside on an issuer's dedicated data environment. We propose in §153.700(a) to require that an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State where HHS is operating the risk adjustment or reinsurance program on behalf of the State, as applicable, must provide HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. Under §153.710(b), all claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating risk adjustment or reinsurance, as applicable, must have resulted in payment by the issuer. Under §153.710(c), an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating risk adjustment or reinsurance, as applicable, that does not generate individual enrollee claims in the normal course of business must derive costs on all applicable provider encounters using its principal internal methodology for pricing those encounters. Issuers will be directed to make risk adjustment and reinsurance data accessible to HHS in a way that conforms to HHS-established guidelines and applicable standards for electronic data collection and submission, storage, privacy and security, and processing. In addition, in §153.720(a), we propose requiring these issuers to establish a unique masked enrollee identification number for each enrollee, in accordance with HHS-defined requirements and maintain the same masked enrollee identification number for enrollees that enroll in different plans within the issuer, within the State, during a benefit year. Issuers must provide all data to HHS in the specified formats, and must correct submitted files to resolve problems detected by HHS during file processing. The burden

associated with this requirement is the time and effort to ensure that information in the dedicated data environment complies with HHS requirements.

We estimate that this data submission requirement will affect 1,800 issuers, and will cost each issuer approximately $327,600 in total labor and capital costs (including the average cost of $15,000 for a data processing server) during the start-up year. This cost will be lower in future years when fixed costs decrease. This cost reflects an estimate of 3 full-time equivalent employees (5,460 hours per year) at an average hourly rate of $59.39 per hour. We anticipate that approximately 400 data processing servers will be established across the market in 2014, and these servers will process approximately 9 billion claims and enrollment files. Therefore, we estimate an aggregate burden, including labor and capital costs, of $589,680,000 for all issuers as a result of these requirements. We are revising the supporting statements associated with the submission of risk adjustment data and reinsurance enrollment data approved under OMB Control Number 0938-1155 with an October 31, 2015 expiration date to account for this burden.

E. ICRs Regarding Data Validation Requirements When HHS Operates Risk Adjustment (§153.630)

Under §153.630, an issuer that offers at least one risk adjustment covered plan in a State where HHS is operating risk adjustment on behalf of the State for the applicable benefit year must have an initial validation audit performed on its risk adjustment data. The burden associated with this requirement is the issuer's time and effort to provide HHS with source claims, records, and enrollment information to validate enrollee demographic information for initial and second validation audits, and the issuer's cost to employ an independent auditor to perform the initial validation audit on a statistically valid sample of enrollees.

The statistically valid sample of enrollees provided to each issuer will consist of enrollees both with and without HCCs. We estimate that each issuer sample will consist of approximately 300 enrollees, with a disproportionate share of approximately two-thirds of the sample consisting of enrollees with HCCs. We also anticipate that this audit burden will affect about 1,800 issuers.

Based on Truven Health Analytics 2010 MarketScan® data, we have determined that for enrollees with HCCs, the average number of HCCs to be reviewed by an auditor per enrollee is approximately two. Additionally, based on HHS audit experience, we estimate that it may cost approximately $180 ($90 per hour for 2 hours) for an auditor to review the medical record documentation for one enrollee with roughly two HCCs. We expect that it may cost approximately $30 per enrollee ($90 per hour for 20 minutes) to validate demographic information for all enrollees in the audit sample, totaling approximately $210 per enrollee with HCCs and $30 per enrollee with no HCCs. We assume that an initial validation audit will be performed on 180,000 enrollees without HCCs, and 360,000 enrollees with HCCs. We have developed this estimate assuming that medical records will not be reviewed for enrollees without HCCs, and that validation for these enrollees will be conducted using demographic data only. Based on the information above, we estimate that the total burden per issuer to retain initial validation auditors to perform the initial validation would cost approximately $45,000. Therefore, for 1,800 issuers, we anticipate that the total burden of conducting initial validation audits will be $81 million. We are revising the PRA currently approved OMB Control Number 0938-1155 with an October 31, 2015 expiration date to account for this additional burden.

Under §153.630(d), issuers will have the opportunity to appeal errors identified through the second validation audit process. Because we intend to provide further detail

on this process in later guidance and rulemaking, we currently cannot estimate the number of issuers that will appeal HCC findings, or the cost per issuer for doing so. Therefore, we will seek OMB approval and solicit public comment on the appeal information collection requirements established under §153.630(d) at a future date.

F. ICRs Regarding QHP Certification Standards Related to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§155.1030)

In §155.1030(a)(1), we propose that the Exchange ensure that each issuer that offers or seeks to offer a QHP in the individual market on the Exchange submit the required plan variations, as proposed in §156.420, for each of its health plans proposed to be offered as a QHP in the individual market on the Exchange. Further we propose that the Exchange must certify that the plan variations meet the requirements detailed in §156.420. We expect that an Exchange would collect prior to each benefit year the information necessary to validate that the issuer meets the requirements for silver plan variations, as detailed in §156.420(a), and collect for certification the information necessary to validate that the issuer meets the requirements for zero and limited cost sharing plan variations, as detailed in §156.420(b) . We expect that this data collection would include the cost-sharing requirements for the plan variations, such as the annual limitation on cost sharing, and any reductions in deductibles, copayments or coinsurance. In addition, the Exchange would collect or calculate the actuarial values of each QHP and silver plan variation, calculated under §156.135 of the proposed EHB/AV Rule. We propose in §155.1030(a)(2) that the Exchange provide the actuarial values of the QHPs and silver plan variations to HHS. As proposed in § 155.1030(b)(4), HHS may use this information in connection with approving estimates for advance payment of cost-sharing reductions submitted by issuers under proposed §156.430. Because HHS will already have this information for Federally-facilitated Exchanges, the burden associated with this

requirement is the time and effort for each Partnership or State-based Exchange to submit this information. We estimate that it will take each Partnership or State-based Exchange approximately 3.5 hours to collect, validate, and submit the data to HHS (3 hours by a database administrator at $47.70 per hour, and 0.5 hours by a manager at $75.15 per hour). We estimate that this will cost each Exchange approximately $181 per year. We plan to revise the supporting statement published under CMS form number 10433, which is pending OMB approval, to account for this additional burden.

In paragraph (b)(1) and (2), we propose that the Exchange collect, review, and submit the rate or expected premium allocation, the expected allowed claims cost allocation, and the actuarial memorandum that a metal level health plan or stand-alone dental plan issuer submits under §156.470. This collection will allow for the calculation of the advance payments of cost-sharing reductions and the premium tax credit. The Exchange must ensure that such allocations meet the standards set forth in §156.470(c) and (d). This allocation information must be collected and approved before a health plan or stand-alone dental plan can be certified for participation in the Exchange. We expect that the Exchange will collect the allocation information in conjunction with the rate and benefit information that the issuer submits under §156.210 and/or the rate information that the QHP issuers submits through the Effective Rate Review program. Therefore, we believe that the burden for Partnership Exchanges or State-based Exchanges to submit to HHS this information collected from QHPs is generally part of the burden that is accounted for in the PRA approved under OMB Control Number 0938-1141. We estimate that Partnership and State-based Exchanges will incur additional burden to submit allocation information to HHS for stand-alone dental plans. We estimate that it will take each Exchange 30 minutes to submit this information for each stand-alone dental plan, and assume that this submission will be performed at the hourly wage rate of

$38.49 for an insurance analyst. Assuming 20 stand-alone dental plans across the market, we estimate an aggregate burden of approximately $385 for all Partnership or State-based Exchanges to submit this information to HHS. We plan to revise the supporting statement published under CMS form number 10433, which is pending OMB approval, to account for this additional burden.

In subparagraph (b)(3), we propose that the Exchange must collect any estimates and supporting documentation that a QHP issuer submits to receive advance payments of certain cost-sharing reductions, as described in §156.430(a), and submit, in the manner and timeframe established by HHS, the estimates and supporting documentation to HHS for review. Because HHS will already have this information for Federally-facilitated Exchanges, the burden associated with this requirement is the time and effort for each Partnership or State-based Exchange to submit this information. We believe that this requirement will impose minimal burden, and that it will take an insurance analyst 5 minutes (at an hourly wage rate of $38.49), to collect and submit this information to HHS for each Partnership or State-based Exchange. Therefore, we estimate a burden of $3.08 for each Partnership or State-based Exchange as a result of this requirement.

G. ICRs Regarding QHP Participation Standards in SHOP (§156.200)

In §156.200(g)(1), we propose that if the issuer of a QHP in an FFE also participates in the State's small group market, the QHP certification standard would be met if the issuer offers at least one small group market QHP at the silver level of coverage and one QHP at the gold level of coverage in a FF-SHOP serving that State. We also propose that, if neither the issuer nor any issuer in the same issuer group participates in the small group market of the State, the standard would be met. Therefore, no issuer would be required to begin offering small group market plans to meet this requirement. The burden associated with this requirement is the time and effort for an

issuer to prepare a QHP certification application for a SHOP for at least one silver level and one gold level plan design. This burden would be incurred by issuers who, absent this requirement, would otherwise not have participated in a SHOP. We describe the burden associated with this requirement in the 30-day **Federal Register** Notice for the Initial Plan Data Collection published on November 21, 2012 (77 FR 69846).

H. ICRs Regarding Plan Variations (§156.420)

In §156.420, we propose that issuers submit to the Exchange for certification the variations of the health plans that they offer or propose to offer in the individual market on the Exchange that include required levels of cost-sharing reductions. We provide an overview of the submission process associated with this requirement in this proposed rule. In paragraph (a), we propose that, for each silver health plan that an issuer offers or proposes to offer in the individual market on the Exchange, the QHP issuer must submit to the Exchange for certification the standard silver plan and three variations of the standard silver plan. In paragraph (b), we further propose that a QHP issuer must, for each of its health plans at any metal level of coverage, submit a zero cost sharing plan variation and a limited cost sharing plan variation of each health plan offered or proposed to be offered in the individual market on the Exchange.

We estimate that 1,200 issuers will participate in an Exchange nationally, and that each issuer will offer one QHP per metal level with four zero cost sharing plan variations and four limited cost sharing plan variations (one per metal level QHP) and three plan variations for low-income populations, for a total of four standard plans and eleven plan variations. Our burden estimate assumes that each issuer will submit these plan variations as part of their electronic QHP application, which is described in further detail in the "Supporting Statement for Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations," which was provided for public

comment on November 21, 2012 (77 FR 69846). We estimate that it will take approximately 1.5 hours to submit the requisite information for a plan variation (0.75 hours by an actuary at a wage rate of $56.89, 0.5 hours by an insurance analyst at a wage rate of $38.49, and 0.25 hours by an insurance manager at a wage rate of $67.44). We estimate that each submission for a plan variation will cost an issuer $78.77, for a total estimated annual cost of $866.47 per issuer for the 11 plan variations. We estimate an aggregate burden of $1,039,764 for all issuers participating in the Exchange. We plan to revise the supporting statement published under CMS form number 10433, which is pending final OMB approval, to account for this additional burden.

I. ICRs Regarding Payment of Cost-Sharing Reductions (§156.430)

In §156.430(a)(1), we propose that for each silver plan variation and zero cost sharing plan variation that an issuer offers or proposes to offer in the individual market on the Exchange, the QHP issuer must provide to the Exchange, for approval by HHS, estimates, and supporting documentation validating the estimates, of the dollar value of cost-sharing reductions to be provided. However, we propose a simplified methodology for calculating the advance payments for the initial years of the cost-sharing reduction program. This methodology will utilize data that QHP issuers submit for other requirements, such as §156.420 and §156.470. As a result, there will be no additional burden associated with this requirement.

In §156.430(a)(2), we discuss the process for estimating the value of cost-sharing reductions to be provided under the plan variation open to Indians with a household income above 300 percent of the FPL, described in §156.420(b)(2). If a QHP issuer seeks advance payments for the these cost-sharing reductions, the issuer must provide to the Exchange, for approval by HHS, an estimate, and supporting documentation validating the estimate, of the dollar value of the cost-sharing reductions to be provided

under the limited cost sharing plan variation of the QHP. We estimate that 1,200 issuers will participate in Exchanges nationally, and that each issuer will offer one QHP per metal level, with one limited cost sharing plan variation for each metal level. For each plan variation, the issuer may submit an estimate and supporting documentation of the dollar value of the cost-sharing reductions. We expect estimates and supporting documentation will be submitted as part of the electronic QHP application, which is described in further detail in the "Supporting Statement for Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations," which was provided for public comment on November 21, 2012 (77 FR 69846). We estimate that it will take approximately 1.0 hours to submit each response for a plan variation (0.5 hours by an actuary at a wage rate of $56.89 and 0.5 hours by an insurance analyst at a wage rate of $38.49. We estimate that each response for a plan variation will cost an issuer $47.69, for an estimated total issuer burden to submit responses for 4 plan variations of $228,912 for the year. We plan to revise the supporting statement published under CMS form number 10433, which is pending final OMB approval, to account for this additional burden.

In §156.430(c), we propose that a QHP issuer submit to HHS, in the manner and timeframes established by HHS the actual amount of cost-sharing reductions provided to each enrollee. This information is necessary so that HHS can reconcile advance payments made throughout the year to actual cost-sharing amounts. While these information collection requirements are subject to the Paperwork Reduction Act, the information collection process and instruments associated with this requirement are currently under development. We will seek OMB approval and solicit public comments upon their completion.

J. ICRs Regarding Reduction of an Enrollee's Share of Premium to Account for Advance Payment of the Premium Tax Credit (§156.460)

In §156.460(a)(2), we propose that if a QHP issuer receives an advance payment of the premium tax credit on behalf of an individual, the QHP issuer must notify the Exchange of any reduction in premium through the standard enrollment acknowledgment in accordance with §156.265(g). Because this notification will occur through the enrollment acknowledgement process that already exists under the final Exchange Establishment rule (77 FR 18310), we believe that this requirement will impose minimal burden on QHP issuers, and that it will take an insurance analyst 5 minutes (at an hourly wage of $38.49), to collect and submit this information to each Exchange Therefore, we estimate a burden of $3.20 for each QHP issuer, and an aggregate burden of $3,849 for all 1,200 QHP issuers, as a result of this requirement.

K. ICRs Regarding Allocation of Rates and Claims Costs for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§156.470)

In §156.470(a), we propose that an issuer provide to the Exchange annually for approval, for each metal level health plan offered or proposed to be offered in the individual market on the Exchange, an allocation of the rate and the expected allowed claims costs for the plan, for EHB, other than services described in §156.280(d)(1), and any other services or benefits offered by a health plan that do not meet the definition of EHB. In §156.470(b) we propose that an issuer of a stand-alone dental plan provide to the Exchange for approval a dollar allocation of the expected premium for the plan to the pediatric dental essential health benefit. In §156.470(c) and (d), we propose that issuers ensure that the allocation described in paragraphs (a) and (b), respectively, are calculated following specific standards. Lastly, in §156.470(e), we propose that an issuer of a metal level health plan or stand-alone dental plan offered, or proposed to be offered, in the

individual market on the Exchange, submit an actuarial memorandum with a detailed description of the methods and specific bases used to perform the allocations that would be required under paragraphs (a) and (b) of that section, demonstrating that the allocations meet the standards set forth in paragraphs (c) and (d).

QHP issuers will submit these allocations and justifications through the Effective Rate Review program (Rate Increase Disclosure and Review Rule, 76 FR 29964). The Rate Increase Disclosure and Review Rule develops a process to ensure the public disclosure of all information and justifications relating to unreasonable rate increases. To that end, the regulation establishes various reporting requirements for health insurance issuers, including a Preliminary Justification for a proposed rate increase, a Final Justification for any rate increase determined by a State or HHS to be unreasonable, and a notification requirement for unreasonable rate increases that will not be implemented. The Preliminary Justification includes data supporting the potential rate increase as well as a written explanation of the rate increase. For those rates HHS will be reviewing, issuers' submissions also will include data and information that HHS will need to make a valid actuarial determination regarding whether a rate increase is unreasonable. Therefore, there will be no additional burden on QHP issuers that submit their rates through the Effective Rate Review program. The burden for the Effective Rate Review submission is already accounted for in OMB Control Number 0938-1141. We are additionally revising the supporting statement of the PRA approved under OMB Control Number 0938-1141 to clarify that we will be collecting this allocation information from metal plans to be offered on an Exchange, whether they are new or existing.

This requirement will result in additional burden for stand-alone dental plans. We estimate that it will take each stand-alone dental plan 5 hours to prepare and submit this information to the Exchange. We assume that this requirement will require 3 hours of

labor by an insurance analyst (at an hourly wage rate of $38.49) and 2 hours of labor by an actuary (at an hourly wage rate of $56.89). Assuming 20 stand-alone dental plans across the market, we estimate an aggregate burden of approximately $4,585 for all stand-alone dental plans to submit these allocations and justifications to the Exchange. We plan to revise the supporting statement published under HHS form number 10433, which is pending final OMB approval, to account for this additional burden.

L. ICRs Regarding Medical Loss Ratio Reporting (§158.130, §158.140, §158.162, §158.221, §158.240)

This proposed rule would direct issuers to include all payments and receipt amounts related to the reinsurance, risk corridors and risk adjustment programs in the annual MLR report.

The existing information collection requirement is approved under OMB Control Number 0938-1164. This includes the annual reporting form that is currently used by issuers to submit MLR information to HHS. Prior to the deadline for the submission of the annual MLR report for the 2014 MLR reporting year, and in accordance with the PRA, HHS plans to solicit public comment and seek OMB approval for an updated annual form that will include reporting of the premium stabilization payments and will reflect the changes in deduction for community benefit expenditures for federal income tax exempt not-for-profit issuers.

TABLE 18: Estimated Fiscal Year Reporting Recordkeeping and Cost Burdens

Regulation Sections	OMB Control No./CMS Form No.	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting[52] ($)	Total Labor Cost ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
§153.405	0938-NEW	2,000	2,000	1.00	2,000	55.00	110,000	0	110,000
§153.420	0938-1155	1,800	9,000,000,000	0.001	9,828,000	59.39	583,680,000	6,000,000	589,680,000
§153.630(b)	0938-1155	1,800	540,000	1.67	900,000	90.00	81,000,000	0	81,000,000
§155.1030(a)	0938-NEW/CMS-10433	51	51	3.50	179	51.62	9,240	0	9,240
§155.1030(b)(2)	0938-NEW/CMS-10433	20	20	0.50	10	38.49	385	0	385
§155.1030(b)(3)	0938-NEW/CMS-10433	51	51	0.08	4.1	38.49	158	0	158
§156.420	0938-NEW/CMS-10433	1,200	13,200	1.50	19,800	52.51	1,039,698	0	1,039,698
§156.430(a)(2)	0938-NEW/CMS-10433	1,200	4,800	1.00	4,800	47.69	228,912	0	228,912

[52] Bureau of Labor Statistics, U.S. Department of Labor, *National Compensation Survey: Occupational Earnings in the United States, 2011*. United States Government Printing Office. May 2011. Retrieved from http://www.bls.gov/ncs/ncswage2010.htm

Regulation Sections	OMB Control No./CMS Form No.	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting[52] ($)	Total Labor Cost ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
§156.460(a)(2)	0938-NEW	1,200	1,200	0.08	96	38.49	3,695	0	3,695
§156.470	0938-NEW/CMS-10433	20	20	5	100	45.85	4,585	0	4,585
Total		3,271					666,076,673	6,000,000	672,076,673

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule implements standards related to premium stabilization programs (reinsurance, risk adjustment, and risk corridors), consistent with the Affordable Care Act. The purpose of these three programs is to protect issuers from the negative effects of adverse selection and to protect consumers from increases in premiums due to issuer uncertainty. The Premium Stabilization Rule provided that further details on the implementation of these programs, including the specific parameters applicable to these programs, would be forthcoming in this proposed rule. This proposed rule also includes provisions governing the cost-sharing reductions program, the advance payment of the premium tax credit program, the medical loss ratio program, the SHOP Exchange, and user fees for Federally-facilitated Exchanges.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104-4), Executive

Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year).

OMB has determined that this Payment Notice is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any one year. Accordingly, we have prepared an RIA that presents the costs and benefits of this proposed rule.

It is difficult to discuss the wide-ranging effects of these provisions in isolation, though the overarching goal of the premium stabilization and Exchange-related provisions and policies in the Affordable Care Act is to make affordable health insurance available to individuals who do not have access to affordable employer-sponsored coverage. The provisions within this proposed rule are integral to the goal of expanding coverage. For example, the premium stabilization programs (risk adjustment, reinsurance, and risk corridors) decrease the risk of financial loss that health insurance issuers might otherwise expect in 2014 and the cost-sharing reductions program and advanced payments of the premium tax credit assist low- and moderate-income consumers in purchasing health insurance. The combined impacts of these provisions

affect the private sector, issuers, and customers, through increased access to health care services including preventive services, decreased uncompensated care, lower premiums, and increased plan (and thereby cost) transparency. Through the reduction of financial uncertainty for issuers and increased affordability for consumers, the provisions are expected to increase access to health coverage.

Recent research[53] analyzed the effects of increased insurance coverage. The analysis studied the health effects of expanded Medicaid eligibility in three States (New York, Maine, and Arizona) with comparable States that did not expand Medicaid over a multiyear time period. The study found that increased coverage resulted in:

- Significant reduction in mortality (19.6 deaths per 100,000);
- Increased rate of self-reported health status (by three percent); and
- Reduction in cost-related delays in care (by 21 percent).

While these results may not be entirely generalizable given the population and coverage type, they do replicate other research findings[54] of the importance of health coverage in improving health and reducing mortality.

There are administrative costs to States to set up and administer these programs. For issuers not receiving payments, any contribution is an additional cost, which an issuer could pass on to beneficiaries through premium increases. There are also reporting costs for issuers to submit data and financial information. This RIA discusses in detail the benefits and costs of the provisions in this proposed rule.

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[53] Sommers, Ben et al "Mortality and Access to Care among Adults after State Medicaid Expansions" New England Journal of Medicine .No: 367 20121025-1034

[54] Finkelstein, A et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." NBER Working Paper No. 17190, July 2011

In this RIA, we discuss programs and requirements newly implemented by the proposed rule, such as certain provisions related to the cost-sharing reductions program, the advance payment of the premium tax credit program, the medical loss ratio program, the SHOP Exchange, and user fees for a Federally-facilitated Exchange, as well as new regulatory provisions for the three premium stabilization programs (reinsurance, risk adjustment, and risk corridors) which had been introduced as part of the Premium Stabilization Rule (77 FR 17220). In addition to building on the RIA for that earlier rule, we are able, for the analysis of much of the proposed rule, to use the Congressional Budget Office's estimates of the Affordable Care Act's impact on federal spending, revenue collection, and insurance enrollment.

C. Impact Estimates of the Payment Notice Provisions and Accounting Table

In accordance with OMB Circular A-4, Table 19 below depicts an accounting statement summarizing HHS' assessment of the benefits, costs, and transfers associated with this regulatory action.

This proposed rule implements standards for programs that will have numerous effects, including providing consumers with affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in an Exchange. We are unable to quantify benefits of the proposed rule—such as improved health and longevity due to increased insurance enrollment—and some costs—such as the cost to society of providing additional medical services to newly-enrolled individuals. Direct costs in the table below reflect administrative costs to States, health insurance issuers, and Exchanges. The effects in Table 19 reflect estimated cost-sharing reduction payments, which are transfers from the General Fund of the U.S. Treasury to consumers who qualify for cost-sharing

reductions. These transfer estimates are based on the Congressional Budget Office's March 2012 baseline estimates, and have been annualized over the 5 year period from FYs 2013-2017. Estimated transfers do not yet reflect any user fees paid by insurance issuers for the Federally-facilitated Exchange because we cannot estimate those fee totals until the number of States operating an Exchange is determined.

TABLE 19: Accounting Table

Category	Estimates	Units		
		Year Dollar	Discount Rate	Period Covered
Benefits				
Annualized Monetized ($millions/year)	Not Estimated			
	Not Estimated			
Costs				
Annualized Monetized ($millions/year)	$518.85	2013	7%	2013-2017
	$529.56	2013	3%	2013-2017
Transfers				
Federal Annualized Monetized ($millions/year)	$6,513.85	2013	7%	2013-2017
	$6,787.26	2013	3%	2013-2017

This impact analysis for the premium stabilization programs references estimates from CBO and CMS. CBO's estimates remain the most comprehensive accounting of all the interacting provisions pertaining to the Affordable Care Act, and contain Federal budget impact estimates of some provisions that have not been independently estimated by CMS. Based on our review, we expect that the provisions of this proposed rule will not significantly alter CBO's estimates of the budget impact of the reinsurance, risk corridors, and risk adjustment programs. The requirements of these programs are well within the parameters used in the modeling of the Affordable Care Act. Our review and

analysis of the requirements indicate that the impacts are likely within the model's margin of error.

For this RIA, we are updating the estimates for the reinsurance and risk adjustment programs to reflect the five-year period from fiscal years (FYs) 2013 through 2017. Table 20 includes the CBO estimates for outlays and receipts for the reinsurance and risk adjustment programs from FYs 2013 through 2017. These estimates for reinsurance and risk adjustment reflect CBO's scoring of these provisions. Unlike the current policy, CBO assumed risk adjustment payments and charges would begin to be made in 2014, when in fact these payments and charges will begin in 2015 as discussed above. Additionally, the CBO estimates do not reflect the $5 billion in reinsurance contributions that are submitted to the U.S. Treasury. There are no outlays and receipts for reinsurance and risk adjustment in 2013 because the provisions do not take effect until 2014.

CBO did not separately estimate the program costs of risk corridors, but assumed aggregate collections from some issuers would offset payments made to other issuers. Table 20 summarizes the effects of the risk adjustment and reinsurance programs on the Federal budget, with the additional, societal effects of this proposed rule discussed in this Regulatory Impact Analysis.

TABLE 20: Estimated Federal Government Outlays and Receipts for the Reinsurance and Risk Adjustment Programs from FYs 2013-2017, in billions of dollars

Year	**2013**	**2014**	**2015**	**2016**	**2017**	**2013-2017**
Reinsurance and Risk Adjustment Program Payments*	--	11	18	18	18	65
Reinsurance and	--	12	16	18	18	64

Year	**2013**	**2014**	**2015**	**2016**	**2017**	**2013-2017**
Risk Adjustment Program Receipts*						

*Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time.
Source: Congressional Budget Office. 2011. *Letter to Hon. Nancy Pelosi.* March 20, 2010.

Risk Adjustment

Risk adjustment is a permanent program administrable by States that operate an HHS-approved Exchange, with risk adjustment criteria and methods established by HHS, with States having the option of proposing alternative methodologies. Risk adjustment is generally applied to non-grandfathered health plans offered in the individual and small group markets, both inside and outside of the Exchange. A State that does not operate an Exchange cannot operate risk adjustment, although a State operating an Exchange can elect not to run risk adjustment. For States that do not operate an Exchange, do not elect to operate risk adjustment, or do not obtain HHS approval to operate risk adjustment, HHS will administer the risk adjustment functions on the State's behalf.

The Exchange may operate risk adjustment, although a State may also elect to have an entity other than the Exchange perform the risk adjustment functions, provided that the State is approved by HHS to operate risk adjustment. Similar to the approach for reinsurance, multiple States may contract with a single entity to administer risk adjustment, provided that risk is pooled at the State level and that each State is approved to operate their risk adjustment program. Having a single entity administer risk adjustment in multiple States may provide administrative efficiencies. In this proposed rule, we propose to establish a risk adjustment State approval process. We describe these

administrative costs in the Collection of Information Requirements section of this proposed rule.

The details of the HHS-developed risk adjustment methodology are specified in this proposed rule. The HHS-developed risk adjustment methodology is based on a model that is concurrent and uses demographic and diagnosis information in a benefit year to predict total plan liability in the benefit year. The national payment transfer methodology is based on the State average premium to ensure that payments and charges net to zero.

States may use this methodology or develop and propose alternate risk adjustment methodologies that meet Federal standards. Once HHS approves an alternate risk adjustment methodology, it will be considered a Federally certified risk adjustment methodology that any State may elect to use. In this proposed rule, we lay out the criteria that HHS will use to evaluate alternate risk adjustment methodologies. Approved Federally certified risk adjustment methodologies will be published in the final HHS notice of benefit and payment parameters.

States that elect to develop their own risk adjustment methodologies are likely to have increased administrative costs. Developing a risk adjustment methodology requires complex data analysis, including population simulation, predictive modeling, and model calibration. States that elect to use the HHS developed methodology would likely reduce administrative costs. We describe these administrative costs in the Collection of Information Requirements section of this proposed rule.

In the Premium Stabilization Rule, we defined a risk adjustment covered plan as any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in

§146.145(c) of this subchapter, individual health insurance coverage described in §148.220 of this subchapter, and any other plan determined not to be a risk adjustment covered plan in the annual HHS notice of benefit and payment parameters. In this proposed rule, we clarify that plans not subject to certain market reforms and student health plans will not be subject to the issuer requirements in subparts G and H of 45 CFR Part 153.

States have the flexibility to merge the individual and small group markets into one risk pool, or keep them separate for the purposes of risk adjustment. Risk adjustment must be conducted separately in unmerged markets. Developing the technology infrastructure required for data submission will likely require an administrative investment. The risk adjustment process will require significant amounts of demographic and diagnostic data to run through a risk assessment model to determine individual risk scores that form the basis for plan and State averages. The Premium Stabilization Rule requires States to collect or calculate individual risk scores at a minimum. States may vary the amount and type of data collected, provided that States meet specified data collection standards.

Administrative costs will vary across States and health insurance issuers depending on the type of data collection approach used in the State. In States opting to operate risk adjustment using a distributed model of data collection, the costs associated with mapping and storing the required data and, in some cases, the costs associated with running the risk adjustment software will likely be borne by the issuer.

States and issuers that already have systems in place for data collection and reporting will have reduced administrative costs. For example, issuers that already report data for Medicare Advantage (MA) or Medicaid Managed Care may see minimal

additional administrative burden for risk adjustment. Additionally, some States risk-adjust their Medicaid Managed Care programs. States with all-payer or multi-payer claims databases may need to modify their systems to meet the requirements of risk adjustment. However, these costs of modification will be less than the costs of establishing these systems. States and issuers that do not have existing technical capabilities will have larger administrative costs related to developing necessary infrastructure.

Issuer characteristics, such as size and payment methodology, will also affect administrative costs. In general, national issuers will likely be better prepared for the requirements of risk adjustment than small issuers. Additionally, administrative costs may be greater for issuers whose providers are paid by capitation and who do not receive claims or encounter data, as they will have to modify their systems to account for the information required for risk adjustment methodology.

In this proposed rule, we provide more details on the data collection approach when we operate risk adjustment on behalf of a State. The Premium Stabilization Rule established that when HHS operates risk adjustment on behalf of a State, it will use a distributed approach. We believe that this approach minimizes issuer burden while protecting enrollee privacy. Under a distributed approach, issuers will need to format risk adjustment data, and maintain that data in compliance with HHS-established guidelines and applicable standards. We describe these administrative costs in the Collection of Information Requirements section of this proposed rule.

The Premium Stabilization Rule directs States to audit a sample of data from each issuer and to ensure proper implementation of risk adjustment software by all issuers that participate in risk adjustment. States may extrapolate results from the sample to adjust

the average actuarial risk for the plan. This approach is consistent with the approach now used in Medicare Advantage, where audit sample error rates will be extrapolated to contract-level payments to recoup overpayment amounts.

In this proposed rule, we propose data validation standards for when HHS operates risk adjustment on behalf of a State. We are proposing that HHS conduct a data validation program consisting of six stages: (1) sample selection; (2) initial validation audit; (3) second validation audit; (4) error estimation; (5) appeals; and (6) payment adjustments. Issuers would engage independent initial auditors to conduct an initial audit of an HHS-selected sample of risk adjustment data. HHS would retain a second validation auditor to verify the findings of the initial validation audit and provide error estimates. However, in this proposed rule we propose that there be no adjustments to payments and charges based on the error estimates for benefit years 2014 and 2015. We describe these administrative costs in the Collection of Information Requirements section of this proposed rule. We are also proposing a process to appeal data validation findings. Issuers will have an opportunity to appeal findings from both the initial validation audit and second validation audit.

Risk adjustment transfers dollars from health plans with lower-risk enrollees to health plans with higher-risk enrollees. From 2014 through 2016, it is estimated that $27 billion will be transferred between issuers. We are updating the cost estimates for this RIA to include 2017, using CBO estimates.[55] From 2014 through 2017, we estimate that there will be $45 billion transferred between issuers.

Risk adjustment protects against adverse selection by allowing insurers to set premiums according to the average actuarial risk in the individual and small group

[55] Congressional Budget Office. 2011. *Letter to Hon. Nancy Pelosi*. March 20, 2010.

market without respect to the type of risk selection the insurer would otherwise expect to experience with a specific product offering in the market. This should lower the risk premium and allow issuers to price their products closer to the average actuarial risk in the market. In addition, it mitigates the incentive for health plans to avoid unhealthy members.

The risk adjustment program also serves to level the playing field inside and outside of the Exchange, as payments and charges are applied to all non-grandfathered individual and small group plans. This mitigates the potential for excessive premium growth within the Exchange due to anticipated adverse selection.

Reinsurance

The Affordable Care Act creates a transitional reinsurance program for the years 2014, 2015, and 2016. Each State is eligible to establish a reinsurance program. If a State establishes a reinsurance program, the State must enter into a contract with an applicable reinsurance entity to carry out the program. If a State does not elect to establish its own reinsurance program, HHS will carry out the reinsurance program for that State.

The Affordable Care Act requires a reinsurance pool of $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. It also requires annual contributions to the U.S. Treasury of $2 billion, $2 billion, and $1 billion for those years, respectively. These contributions are funded by health insurance issuers and third party administrators on behalf of self-insured group health plans. Section 1341(b)(3) of the Affordable Care Act directs the Secretary of HHS to establish the method for determining contribution levels for the program. HHS proposes to establish a national per capita contribution rate designed to collect the $12.02 billion in 2014 to cover the required $10 billion in reinsurance payments, the $2 billion contribution to the U.S. Treasury, and the additional

$20.3 million to cover the Federal administrative expenses of operating the reinsurance program in 2014. We continue to estimate that we will collect these amounts authorized from 2014 through 2016 for the reinsurance pool, including the annual contributions to the U.S. Treasury.

HHS proposes to collect the required contributions under the national contribution rate from health insurance issuers and self-insured group health plans.[56] States establishing their own reinsurance program may collect additional contributions for administrative costs and/or reinsurance payments. Section 1341(a)(3)(B) of the Affordable Care Act requires that the reinsurance contribution amount for each issuer reflect each issuers' fully insured commercial book of business for all major medical products. In this proposed rule, we clarify which types of health insurance coverage and self-insured group health plans are to make reinsurance contributions, and which are not. This clarification does not affect the amounts authorized to be collected for reinsurance.

A State that establishes a reinsurance program may elect to collect additional contributions to provide funding for administrative expenses or supplemental reinsurance payments. Additional contributions for administrative expenses may be collected by the State's applicable reinsurance entity, at the State's election. Any additional contributions for reinsurance payments must be collected by the State's applicable reinsurance entity. In this proposed rule, we propose to collect administrative expenses for HHS-operated reinsurance programs. A State that operates the reinsurance program bears the administrative costs of the applicable reinsurance entity, and must ensure that the

[56] The Department of Labor has reviewed this proposed rule and advised that paying required reinsurance contributions would constitute a permissible expense of the plan for purposes of Title I of the Employee Retirement Income Security Act (ERISA) because the payment is required by the plan under the Affordable Care Act as interpreted in this proposed rule. (See generally, Advisory Opinion 2001-01A to Mr. Carl Stoney, Jr., available at www.dol.gov/ebsa discussing settlor versus plan expenses.)

reinsurance entity complies with program requirements. HHS will share some of its collections for administrative costs with States that run the program. If a State operates its own reinsurance program, HHS would transfer $0.055 of the per capita administrative fee to the State for purposes of administrative expenses incurred in making reinsurance payments, and retain the remaining $0.055 to offset the costs of contribution collection. A State may have more than one reinsurance entity, and two or more States may jointly enter into an agreement with the same applicable reinsurance entity to carry out reinsurance in their State. Administrative costs will likely increase if multiple reinsurance entities are established within a State, whereas administrative efficiencies may be found if multiple States contract with one applicable reinsurance entity.

We propose in this proposed rule an annual collections and payment cycle. We also considered a quarterly collections and payment cycle, as envisioned by the Premium Stabilization Rule. However, a quarterly cycle would impose significant costs on contributing entities. Because HHS and States operating reinsurance would likely need to hold back a significant portion of reinsurance funds until the end of the year to ensure equitable payment of requests for reinsurance payments. We believe that issuers would receive only limited benefits from a quarterly payment cycle.

In §153.100(a), a State is required to issue an annual notice of benefit and payment parameters specific to that State if it elects to: (i) modify the data requirements from the HHS-operated reinsurance program; (ii) collect additional reinsurance contributions, under §153.220(d); or (iii) use more than one applicable reinsurance entity.

States that establish a reinsurance program will also maintain any records associated with the reinsurance program, as set forth in §153.240(c). In addition, a State will notify HHS if it intends to collect additional administrative expenses and provide

justification for the additional collection. The Premium Stabilization Rule established that reinsurance contributions will be based on a per capita amount. The per capita approach would be less complex to administer in comparison to the percent of premium approach that HHS considered but ultimately decided not to pursue. Further, the per capita approach will better enable HHS to maintain the goals of the reinsurance program by providing issuers with a more straightforward approach to reinsurance contributions. States would be permitted to collect additional contributions towards supplemental reinsurance payments. We describe the administrative costs in the Collection of Information Requirements section of this proposed rule.

In this proposed rule, we establish the methodology to be used for counting covered lives for purposes of calculating reinsurance contributions. This methodology is based upon counting methods permitted under the PCORTF Rule. We believe that relying on a previously established process set forth in the PCORTF Rule for counting enrollees will minimize issuer burden for conducting these counts. In the Collection of Information Requirements section of this proposed rule, we describe the administrative costs for issuers associated with the data requirements in §153.400(b) for all contributing entities both inside and outside the Exchange. The contributing entities would be required to provide enrollment data to HHS to substantiate contribution amounts.

Reinsurance payments will be made to issuers of individual insurance coverage for high claims costs for enrollees. In this proposed rule, we propose a national attachment point, national reinsurance cap, and national coinsurance rate. In the Premium Stabilization Rule, we established that payments will be made on a portion of claims costs for enrollees in reinsurance eligible plans incurred above an attachment point, subject to a reinsurance cap.

Use of a reinsurance cap, as well as the requirement for health insurance issuer costsharing above the attachment point and below the cap, may incentivize health insurance issuers to control costs. This approach based on claims costs is simpler to implement and more familiar to health insurance issuers, and therefore will likely result in savings in administrative costs as compared to a condition-based reinsurance approach. The program costs of reinsurance are expected to be reflected in changes to health insurance premiums.

A State operating its own reinsurance program may opt to supplement the reinsurance parameters proposed by HHS only if the State elects to collect additional contributions for supplemental reinsurance payments or use additional State funds for supplemental reinsurance payments, and must specify these supplemental payment parameters in its State notice of benefit and payment parameters.

In this proposed rule, we propose that States provide a process through which a reinsurance-eligible plan that does not generate individual enrollee claims may derive costs to request reinsurance payments. In addition, we clarify that when HHS operates a reinsurance program on behalf of a State that these plans may price encounters in accordance with its existing principal, internal encounter pricing methodology. Additionally, we propose in §153.240(b) of this proposed rule that States operating their own reinsurance program must notify issuers of reinsurance payments to be made, as well as provide reinsurance-eligible plans an estimate of expected requests for reinsurance payments. Moreover, we propose for both State- and HHS-operated reinsurance programs, that only plans subject to the 2014 market reform rules would be eligible for reinsurance payment.

In this proposed rule, we also provide more details on the data collection approach for HHS-operated reinsurance programs. HHS plans to use the same distributed data collection approach used for risk adjustment; however, only data elements necessary for reinsurance claim selection will be considered for the purpose of determining reinsurance payments. In the Collection of Information Requirements section, we describe the administrative costs required in §153.410 for issuers of reinsurance-eligible plans in States where HHS is operating reinsurance to receive reinsurance payments. We believe details on the reinsurance data collection approach proposed in the HHS notice of benefit and payment parameters are reflected in these cost estimates.

All health insurance issuers contribute to the reinsurance pool, because successful implementation of the range of reforms in 2014 benefit all of their enrollees (for example, those reforms should lead to fewer unreimbursed health costs, lowering the costs for all issuers and group health plans) while only health insurance issuers with plans in the individual market are eligible to receive payments. This serves to stabilize premiums in the individual market while having a minimal impact on large group issuers and plans. Reinsurance will attenuate individual market rate increases that might otherwise occur because of the immediate enrollment of higher risk individuals, potentially including those currently in State high-risk pools. It will also help prevent insurers from building in risk premiums to their rates given the unknown health of their new enrollees. It is expected that the cost of reinsurance contributions will be roughly equal to one percent of premiums in the total market in 2014, less in 2015 and 2016, and will end in 2017. In contrast, it is anticipated that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent.

Evidence from the Healthy New York (Healthy NY) program[57] supports the magnitude of these estimates. In 2001, the State of New York began operating Healthy NY and required all HMOs in the State to offer policies for which small businesses and low-income individuals would be eligible. The program contained a "stop-loss" reinsurance provision designed to lower premiums for enrollees. Under the program, if any enrollee incurred $30,000 in annual claims, his or her insurer was reimbursed for 90 percent of the next $70,000 in claims. Premiums for Healthy NY policies were about 15 percent to 30 percent less than those for comparable HMO policies in the small group market.

Medical Loss Ratio

This proposed rule proposes to amend the MLR and rebate calculation methodologies to include payments and receipts related to the premium stabilization programs. The definition of premium revenue would be modified to account for these payments and receipts. When the MLR annual reporting form is updated for the reporting year 2014 and later, premium stabilization payment and receipt amounts would be considered a part of gross earned premium reported to the Secretary, similar to other elements involved in the derivation of earned premium. The MLR annual reporting form would then account for premium stabilization payment and receipt amounts by removing them from adjusted earned premium, so that these amounts do not have a net impact on the adjusted earned premium used in calculating the MLR denominator and rebates. Additionally, this proposed rule proposes to amend the MLR calculation methodology to add or subtract premium stabilization payment(s) and receipt amounts in the MLR

[57] Swartz, K. "Health New York: Making Insurance More Affordable for Low-Income Workers." *The Commonwealth Fund*. November 2001.

numerator, consistent with the way the statute prescribes the calculation methodology for risk corridors. These adjustments will reduce or increase issuers' MLRs, and may increase or reduce issuers' rebates, respectively. The amended methodology will result in a more accurate calculation of MLR and rebate amounts, since it will reflect issuers' actual claims-related expenditures. This approach will also support the effectiveness of both the MLR and the premium stabilization programs by correctly offsetting the premium stabilization payment and receipt amounts against rebates, consistently with the risk corridors calculation methodology adopted in §153.530.

Based on HHS's experience with the 2011 MLR reporting year, there are 466 health insurance issuers[58] offering coverage in the individual and group markets to almost 80 million enrollees that will be affected by the proposed amendment to account for premium stabilization payments in MLR and rebate calculations. In 2012, an estimated 54 issuers paid $396 million in rebates for the 2011 MLR reporting year to approximately 4 million enrollees in the individual markets, while 59 issuers in the small group market provided approximately $289 million in rebates to policyholders and subscribers on behalf of over 3 million enrollees, and 47 issuers in the large group market provided approximately $403 million in rebates to policyholders and subscribers on behalf of almost 6 million enrollees. Lack of data makes it difficult to predict how high-risk enrollees will be distributed among issuers and, therefore, how MLRs and total rebates would be affected. Issuers with relatively low-risk enrollees are likely to have positive net premium stabilization payments (that is, payments would be greater than receipts) and, if so, their MLRs will increase as a result of the amended MLR calculation

[58] Issuers represent companies (for example, NAIC company code). These estimates do not include issuers of plans with total annual limits of $250,000 or less (sometimes referred to as "mini-med" plans) or expatriate plans.

methodology. If any of these issuers fail to meet the MLR standard, taking the premium stabilization payments and receipts into account in the MLR calculations will result in lower rebate payments. Issuers with relatively high-risk enrollees are likely to have positive net receipts (that is, receipts would be greater than payments) and, if so, their MLRs would decrease as a result. If any such issuer fails to meet the MLR standard, its rebate amount will increase. Since such issuers are likely to have high claims expenditures and therefore, high MLRs, they would be less likely to owe rebates. So we do not anticipate that rebates will go up for such issuers.

The Payment Notice proposes to also change the deadlines for MLR report submission and rebate payments so that the deadlines occur after all the premium stabilization payment and receipt amounts are determined. The change in the deadlines will allow issuers to calculate the MLR and rebate amounts based on actual calculated payments and receipts rather than estimated amounts and will improve the accuracy of the rebate payments and reports. This will also reinforce the effectiveness of the premium stabilization programs, since issuers are less likely to pay higher or lower rebates based on inaccurate payment and receipt estimations. Accordingly, we propose to change the date of MLR reporting to the Secretary from June 1 to July 31, and the rebate due date from August 1 to September 30.

Issuers will also have to report their payments and receipts related to the premium stabilization programs in the annual MLR report beginning in the 2014 MLR reporting year. Once issuers calculate these amounts, which they will be required to do regardless of the MLR reporting requirements, the administrative cost of including these amounts in the report will be minimal.

The current MLR calculation methodology allows an issuer to deduct from premiums in the calculation of an issuer's MLR and rebates either the amount it paid in State premium taxes, or the amount of its community benefit expenditures up to a maximum of the highest premium tax rate in the State, whichever is greater, as provided in the final rule with comment period (76 FR 76574) published on December 7, 2011. This proposed rule proposes to amend the MLR methodology and allow a federal income tax exempt not-for-profit issuer to deduct from premium both community benefit expenditures and State premium taxes, limited to the higher of the State's highest premium tax rate or 3 percent of premium. Other issuers would continue to use the current methodology. This would create a level playing field for Federal income tax exempt not-for-profit issuers, who are required to make community benefit expenditures to maintain their federal income tax exempt status and would not discourage community benefit expenditures. This is likely to increase the MLRs for tax exempt not-for-profit issuers. If any of these issuers fail to meet the MLR standard, then this will result in lower rebate payments.

Based on MLR annual reports submitted by issuers for the 2011 MLR reporting year, we estimate that there are 132 not-for-profit issuers that will be affected by this proposed amendment. In the absence of data on tax exempt not-for-profit issuers, we use the estimates for not-for-profit issuers in our analysis. Therefore, the actual impact is likely to be lower. For the 20 not-for-profit issuers that submitted data on community benefit expenditures, such expenditures as a percentage of earned premiums ranged from 0.04 percent to 4.11 percent with an average of 1.57 percent, which is likely to be less than the current limit for most of the issuers and is less than the proposed limit as well. We assume that issuers will maintain the level of community benefit expenditures as

reported in their MLR annual reports for the 2011 MLR reporting year. We estimate that under the current policy, in the 2012 MLR reporting year, 17 not-for-profit issuers will owe approximately $182 million in rebates to approximately 1.5 million enrollees. The proposed change in treatment of community benefit expenditures for such issuers will have minimal effect on their MLRs and rebates under this assumption, since their current expenditures are below the current deduction limits.

Issuers with lower rebate payments as a result of these adjustments would need to send fewer rebate notices, and therefore, would have lower administrative costs related to rebates and rebate notices.

Risk Corridors

The Affordable Care Act creates a temporary risk corridors program for the years 2014, 2015, and 2016 that applies to QHPs. The risk corridors program creates a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers. The Affordable Care Act establishes the risk corridors program as a Federal program; consequently, HHS will operate the risk corridors program under Federal rules with no State variation. The risk corridors program will help protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains.

QHP issuers must submit to HHS data on premiums earned, allowable claims and quality costs, and allowable administrative costs, reflecting data categories required under the Medical Loss Ratio Interim Final Rule (75 FR 74918). In designing the program, HHS has sought to leverage existing data reporting for Medical Loss Ratio purposes as much as possible.

As noted above, the risk corridors program is intended to protect QHP issuers in the individual and small group market against inaccurate rate setting. Due to uncertainty about the population during the first years of Exchange operation, issuers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted. To determine whether an issuer pays into, or receives payments from, the risk corridors program, HHS will compare allowable costs (essentially, claims costs) and the target amount – the difference between a plan's earned premiums and allowable administrative costs. In this proposed rule, we have provided for adjustments to the risk corridors calculation to account for taxes and profits within its allowable administrative costs. The threshold for risk corridor payments and charges is reached when a QHP issuer's allowable costs exceed, or fall short of, the target amount by at least three percent. A QHP with allowable costs that are at least three percent less than its target amount will pay into the risk corridors program. Conversely, HHS will pay a QHP with allowable costs that exceed its target amount by at least 3 percent. Risk corridor payments and charges are a percentage of the difference between allowable costs and target amount and therefore are not on a "first dollar" basis.

In this proposed rule, HHS also specified the annual schedule for the risk corridors program, including dates for claims run-out, data submission, and notification of risk corridors payments and charges.

We believe the proposals on the risk corridors program in this proposed rule have a negligible effect on the impact of the program established by and described in the Premium Stabilization Rule.

Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

The impact analysis for Payment Notice provisions relating to advance payments of the premium tax credit and cost-sharing reductions references estimates from the CBO's March 2012 baseline projections. Based on our review, we expect that those proposed provisions will not alter CBO's March 2012 baseline estimates of the budget impact of those two programs. The requirements are well within the parameters used in the modeling of the Affordable Care Act. Our review and analysis of the requirements indicate that the impacts are likely within the model's margin of error. The Affordable Care Act provides for premium tax credits and the reduction or elimination of cost sharing for certain individuals enrolled in QHPs offered through the Exchanges. This assistance will help many low- and moderate-income individuals and families obtain health insurance – for many people, cost sharing is a barrier to obtaining needed health care.[59]

Section 1402(a)-(c) of the Affordable Care Act directs issuers to reduce cost sharing for essential health benefits for individuals with household incomes between 100 and 400 percent of the FPL who are enrolled in a QHP offered at the silver level of coverage in the individual market on the Exchange and are eligible for a premium tax credit or advance payment of premium tax credits. The Affordable Care Act, at section 1402(d), also directs issuers to eliminate cost sharing for Indians (as defined in §155.300) with a household income at or below 300 percent of the FPL who are enrolled in a QHP of any metal level in the individual market on the Exchange, and prohibits issuers from requiring cost sharing for Indians, regardless of household income, for items or services furnished directly by the IHS, an Indian Tribe, a Tribal Organization, or an Urban Indian Organization or through referral under contracted health services. Finally, the Affordable

[59] Brook, et. al., at footnote 5 above.

Care Act, at section 1412, provides for the advance payments of the premium tax credit and cost-sharing reductions.

A subset of the persons who enroll in QHPs in the individual market through the Exchanges beginning in 2014 will be affected by the provisions relating to advance payments of premium tax credit and cost-sharing reductions (those with household incomes below 400 percent of the FPL and Indians enrolled in QHPs). In March 2012, CBO estimated that there will be approximately 20 million enrollees in Exchange coverage by 2016, including approximately 16 million Exchange enrollees who will be receiving subsidies.[60] Participation rates among potential enrollees are expected to be lower in the first few years of Exchange availability as employers and individuals adjust to the features of the Exchanges.[3]

In this proposed rule, we provide additional details for Exchanges and issuers on the administration of advance payments of premium tax credit and cost-sharing reductions for individuals and families. We clarify the approach to providing for cost-sharing reductions to individuals who purchase a family policy. We also propose standards applicable to Exchanges when setting effective dates for changes in eligibility, collecting premiums from enrollees, and administering advance payments of cost-sharing reductions and the premium tax credit. We describe these administrative costs in the Collection of Information Requirements section of this proposed rule.

Finally, we direct QHP issuers to enroll individuals in the plan variation with the correct cost-sharing structure, and to provide those individuals with the cost-sharing

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[60] "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," Congressional Budget Office, March 2012.
[3]Congressional Budget Office, "Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act," Washington, DC, 2009.

reductions for which they are eligible. QHP issuers are responsible for submitting plan variations containing the cost-sharing structures proposed by HHS as required by the Affordable Care Act. We also clarify which plans are eligible for cost-sharing reductions, and we propose standards relating to advance payments of cost-sharing reductions and reconciliation of those advance payments against actual cost-sharing reduction provided. In addition, we propose that QHP issuers reduce an enrollee's share of premium to account for advance payments of the premium tax credit, and submit allocations of rates and claims costs to allow for the calculation of advance payments of cost-sharing reductions and the premium tax credit. We describe these administrative costs in the Collection of Information Requirements section of this proposed rule.

The cost-sharing reduction and advance payment of the premium tax credit policies will apply to all issuers that choose to seek certification to offer QHPs through the Exchanges for the individual market. QHP issuers will experience costs related to preparing and submitting to HHS data to support the administration of cost-sharing reductions. We anticipate that the provisions for advance payments of the premium tax credit and cost-sharing reductions will result in transfers from the General Fund of the Treasury to people receiving cost-sharing reductions and advance payments of the premium tax credit.

User Fees

To support certain Federal operations of Federally-facilitated Exchanges, we propose in this proposed rule, under section 1311(d)(5)(A) of the Affordable Care and 31 U.S.C. 9701, that a participating issuer offering a plan through a Federally-facilitated Exchange remit a user fee to HHS each month equal to the product of the billable members (that is, members that count towards the premium) enrolled in the QHP offered

by the issuer in the Exchange, and the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year. In this proposed rule we set forth our intention to have the Federally-facilitated Exchange user fee generally reflect the user fee in place by State-based Exchanges in 2014. For the 2014 benefit year, we propose a monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the QHP. Because we seek to align this rate with rates charged by State-based Exchanges, we may adjust this rate to conform with State-based Exchange rates in the final Payment Notice. We do not have an aggregate estimate of the collections from the user fee at this time because we do not yet have a count of the number of States in which HHS will run a Federally-facilitated Exchange. We anticipate that this user fee collection will be sufficient to cover the majority of costs related to the operation of Federally-facilitated Exchanges and maintain balance within the market.

SHOP

The Small Business Health Options Program (SHOP) facilitates the enrollment of small businesses into small group health insurance plans. A qualitative analysis of the costs and benefits of establishing a SHOP was included in the RIA published in conjunction with the Exchange Establishment Rule.[61] This Impact Analysis addresses the additional costs and benefits of the proposed modifications in this proposed rule to the SHOP sections of the Exchange Final Rule.

In this proposed rule, we propose to implement policies for FF-SHOPs designed to prevent significant adverse selection while promoting robust plan choice for

[61] Available at: http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf

employees. These policies include methods a qualified employer may use to make QHPs available to its employees, rules to ensure parity with a market's group participation requirements, rules to permit the display of agent and broker information on FF-SHOP websites, alignment of market definitions with other applicable rules, and incentives for issuers to participate in FF-SHOPs. Many of these proposed policies are expected to create no significant new costs.

The Affordable Care Act permits a qualified employer participating in a SHOP to select a metal level of coverage and make all plans in that level of coverage available to its employees. This represents an increase in plan choice over what many employees of small employers have today. Limiting this choice to a single level of coverage reduces potential adverse selection within the group and therefore any additional cost due to expanded choice. In the Exchange Establishment Rule, we did not quantify either the small risk premium or the modest additional consumer benefit resulting from employee choice at a single level of coverage. We seek comment on both limiting employee choice to prevent adverse selection and allowing for choice across two rather than one metal level.

The Exchange Final Rule permits a SHOP to set a minimum participation rate; such authority is limited to the extent the minimum participation rate is permissible under the PHS Act and applicable State law. Minimum participation rates require participation in the health plan by a substantial portion of the employer's group, thereby assuring a more representative risk pool and reducing adverse selection. Setting a minimum participation rate that is too low would make it ineffective, while setting it too high would reduce the number of employers offering coverage. This proposed rule proposes, subject to permissibility under the PHS Act, that FF-SHOPs use a default participation rate of 70

percent that may be modified if there is evidence that a higher or lower rate is either customary in the State or required by State statute. Because this policy results in no change in market dynamics, it places no additional costs on employers or issuers.

This proposed rule proposes new incentives for some health insurance issuers to participate in the FF-SHOP. Health insurance issuers that offer coverage in both the individual and small group markets and wish to sell QHPs in an FFE must also offer QHPs in an FF-SHOP. This policy promotes robust issuer participation in the FF-SHOP which will help small employers offer their employees a broad choice of health plan.

The benefits of broad plan choice are quite significant. One study suggests expanding plan choice while holding premiums constant for employees results in a median increase in consumer surplus by 20 percent of the premium cost of coverage.[62] Some of this benefit is due to expanded choice in plan type and health insurance issuer. There are two costs associated with this policy. The first is the cost for the QHP issuer of submitting plans for certification in the FF-SHOP, which is described in the 30-day **Federal Register** Notice for the Initial Plan Data Collection published on November 21, 2012 (77 FR 69846). The second is the cost of additional user fees QHP issuers must pay for participating in the FF-SHOP.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq*.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the final rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA

[62] Dafny, L., Ho, K., & Varela, M. (2010). *Let them have choice: Gains from shifting away from employer-sponsored health insurance and toward an individual exchange* (No. w15687). National Bureau of Economic Research.

generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." HHS uses a change in revenues of more than three to five percent as its measure of significant economic impact on a substantial number of small entities.

This proposed rule contains proposed rules for premium stabilization programs required of health plan issuers including the risk adjustment program as well as the transitional reinsurance program and temporary risk corridors programs. Because we believe that few insurance firms offering comprehensive health insurance policies fall below the size thresholds for "small entities" established by the SBA, we do not believe that an initial regulatory flexibility analysis is required with respect to such firms.

For purposes of the RFA, we expect the following types of entities to be affected by this proposed rule: (1) health insurance issuers; (2) health insurance plan sponsors; (3) reinsurance entities; (4) risk adjustment entities; and (5) third-party administrators. We believe that health insurance issuers and plan sponsors would be classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers); reinsurance entities, risk adjustment entities and third party administrators would be classified under NAICS codes 524130 (Reinsurance Carriers), 524298 (Actuarial Services) and 524292 (Third Party Administration of Insurance). According to SBA size standards, entities with average annual receipts of $7 million or less would be considered small entities for these NAICS codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $10 million or less.

Based on data from Medical Loss Ratio annual report submissions for the 2011 MLR reporting year, there are 22 small entities (companies), each with less than $7 million in earned premiums, that offer individual or group health insurance coverage and would therefore be subject to the provisions related to MLR. These small entities account for less than 5 percent of the estimated 466 issuers that would be affected by the provisions of this rule. Thirty six percent of these small issuers belong to holding groups, and many if not all of these small issuers are likely to have other lines of business that would result in their revenues exceeding $7 million.

In this proposed rule, we propose requirements on employers that choose to participate in a SHOP Exchange. As discussed above, the SHOP is limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many employers would meet the SBA standard for small entities. We do not believe that the regulation imposes requirements on employers offering health insurance through SHOP that are more restrictive than the current requirements on small employers offering ESI. For example, we propose to generally match existing minimum participation rates in the outside market. Additionally, as discussed in the Regulatory Impact Analysis, we believe the proposed policy will provide greater choice for the employee among plans and issuers, benefitting both employer and employee and simplify the process for the employer of administering multiple health benefit plans. We believe the processes that we have established constitute the minimum amount of requirements necessary to implement statutory mandates and accomplish our policy goals, and that no appropriate regulatory alternatives could be developed to further lessen the compliance burden.

We believe that a substantial number of sponsors of self-insured group health plans could qualify as "small entities." This proposed rule specifies the reinsurance contributions that would be required from third-party administrators on behalf of such entities. However, we do not believe that these contributions are likely to result in a change in revenues of more than 3 to 5 percent. We request comment on whether the small entities affected by this proposed rule have been fully identified. We also request comment and information on potential costs for these entities and on any alternatives that we should consider.

E. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any one year by a State, local, or Tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately $139 million. Since the impact on State, local, or Tribal governments and the private sector is below the threshold, no analysis under UMRA is required.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct costs on State and local governments, pre-empts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange. For States electing to operate an

Exchange, risk adjustment and reinsurance, much of the initial cost of creating Exchanges and Exchange-related programs will be funded by Exchange Planning and Establishment Grants. After establishment, Exchanges will be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In HHS's view, while this proposed rule does not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. Each State electing to establish an Exchange must adopt the Federal standards contained in the Affordable Care Act and in this Payment Notice, or have in effect a State law or regulation that implements these Federal standards. However, HHS anticipates that the Federalism implications (if any) are substantially mitigated because under the statute, States have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require States to establish an Exchange; if a State elects not to establish an Exchange or the State's Exchange is not approved, HHS, either directly, or through agreement with a non-profit entity, must establish and operate an Exchange in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and

attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

Throughout the process of developing this proposed rule, HHS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

G. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects

45 CFR Part 153

Administrative practice and procedure, Adverse selection, Health care, Health insurance, Health records, Organization and functions (Government agencies), Premium stabilization, Reporting and recordkeeping requirements, Reinsurance, Risk adjustment, Risk corridors, Risk mitigation, State and local governments.

45 CFR Part 155

Administrative practice and procedure, Health care access, Health insurance, Reporting and recordkeeping requirements, State and local governments, Cost-sharing reductions, Advance payments of premium tax credit, Administration and calculation of advance payments of the premium tax credit, Plan variations, Actuarial value.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory Committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, American Indian/Alaska Natives, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

45 CFR Part 157

Employee benefit plans, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting

and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

45 CFR Part 158

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, penalties, Reporting and recordkeeping requirements, Premium revenues, Medical loss ratio, Rebating.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 153, 155, 156, 157, and 158 as set forth below:

PART 153 – STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

1. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

2. Section 153.20 is amended by revising the definitions of "Risk adjustment covered plan" and "Risk adjustment data collection approach" as follows:

§153.20 Definitions.

* * * * *

Risk adjustment covered plan means, for the purpose of the risk adjustment program, any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in §146.145(c) of this subchapter, individual health insurance coverage described in §148.220 of this subchapter, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.

* * * * *

Risk adjustment data collection approach means the specific procedures by which risk adjustment data is to be stored, collected, accessed, transmitted, and validated and the applicable timeframes, data formats, and privacy and security standards.

* * * * *

3. Section 153.100 is amended by –

A. Revising paragraph (a)(1).

B. Removing paragraph (a)(2).

C. Redesignating paragraphs (a)(3) and (4) as paragraphs (a)(2) and (3).

D. Revising newly designated paragraph (a)(2).

E. Removing paragraph (a)(5).

F. Revising paragraph (c).

G. Revising paragraph (d)(1).

H. Removing paragraph (d)(2).

I. Redesignating paragraphs (d)(3) and (4) as paragraphs (d)(2) and (3).

J. Revising newly designated paragraph (d)(2).

K. Removing paragraph (d)(5).

L. Redesignating paragraph (d)(6) as paragraph (d)(4).

The revisions read as follows:

§153.100 State notice of benefit and payment parameters.

(a) * * *

(1) Modify the data requirements for health insurance issuers to receive reinsurance payments from those specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year;

(2) Collect additional reinsurance contributions under §153.220(d) or use additional funds for reinsurance payments under §153.220(d)(3); or

* * * * *

(c) State notice deadlines. If a State is required to publish an annual State notice of benefit and payment parameters for a particular benefit year, then with respect to benefit year 2014, it must do so by March 1, 2013, or by the 30th day following the

publication of the final HHS notice of benefit and payment parameters, whichever is later. With respect to subsequent benefit years, a State must do so by March 1 of the calendar year prior to the benefit year for which the notice applies.

(d) * * *

(1) Adhere to the data requirements for health insurance issuers to receive reinsurance payments that are specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year;

(2) Forgo the collection of additional reinsurance contributions under §153.220(d) and the use of additional funds for reinsurance payments under §153.220(d)(3);

* * * * *

4. Section 153.110 is amended by:

A. Revising paragraph (a).

B. Removing paragraph (b).

C. Redesignating paragraph (c) as paragraph (b) and revising newly designated paragraph (b).

D. Redesignating paragraph (d) as paragraph (c).

E. Removing newly designated paragraph (c)(2).

F. Removing newly designated paragraph (c)(4).

G. Removing newly designated paragraph (c)(5).

H. Redesignating paragraph (c)(6) as paragraph (c)(3).

I. Removing paragraph (e).

J. Redesignating paragraph (f) as paragraph (d).

The revisions read as follows:

§153.110 Standards for the State notice of benefit and payment parameters.

(a) Data requirements. If a State that establishes a reinsurance program elects to modify the data requirements for health insurance issuers to receive reinsurance payments from those specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year, the State notice of benefit and payment parameters must specify those modifications.

(b) Additional collections. If a State that establishes a reinsurance program elects to collect additional funds under §153.220(d) or use additional funds for reinsurance payments under §153.220(d)(3), the State must publish in the State notice of benefit and payment parameters the following:

(1) A description of the purpose of the additional collection, including whether it will be used to cover reinsurance payments made under §153.232, administrative costs, or both;

(2) The additional contribution rate at which the funds will be collected; and

(3) If the purpose of the additional collection includes reinsurance payments (or if the State is using additional funds for reinsurance payments under §153.220(d)(3)), the State supplemental reinsurance payment parameters required under §153.232.

* * * * *

5. Section 153.210 is amended by revising paragraph (a)(2) and adding paragraph (e) to read as follows:

§153.210 State establishment of a reinsurance program.

(a) * * *

(2) If a State contracts with more than one applicable reinsurance entity, the State must ensure that each applicable reinsurance entity operates in a distinct geographic area with no overlap of jurisdiction with any other applicable reinsurance entity.

* * * * *

(e) Reporting to HHS. Each State that establishes a reinsurance program must ensure that each applicable reinsurance entity provides information regarding requests for reinsurance payments under the national contribution rate made under §153.410 for all reinsurance-eligible plans for each quarter during the applicable benefit year in a manner and timeframe established by HHS.

6. Section 153.220 is amended by –

A. Revising paragraph (a).

B. Removing paragraph (b).

C. Redesignating paragraph (c) as paragraph (b).

D. Removing paragraph (d).

E. Redesignating paragraph (e) as paragraph (c).

F. Revising newly designated paragraph (c)(2).

G. Removing paragraph (f).

H. Redesignating paragraph (g) as paragraph (d).

I. Revising newly designated paragraph (d).

J. Removing paragraph (h).

The revisions read as follows:

§ 153.220 Collection of reinsurance contribution funds.

(a) Collections. If a State establishes a reinsurance program, HHS will collect all reinsurance contributions from all contributing entities for that State under the national contribution rate.

* * * * *

(c) * * *

(2) Payments to the U.S. Treasury as described in paragraph (b)(2) if this section; and

* * * * *

(d) Additional State collections. If a State establishes a reinsurance program:

(1) The State may elect to collect more than the amounts that would be collected based on the national contribution rate set forth in the annual HHS notice of benefit and payment parameters for the applicable benefit year to provide:

(i) Funding for administrative expenses of the applicable reinsurance entity; or

(ii) Additional funds for reinsurance payments.

(2) The State must notify HHS within 30 days after publication of the draft annual HHS notice of benefit and payment parameters for the applicable benefit year of the additional contribution rate that it elects to collect for any additional contributions under paragraph (d)(1) of this section.

(3) A State may use additional funds which were not collected as additional reinsurance contributions under this part for reinsurance payments under the State supplemental payment parameters under §153.232.

* * * * *

7. Section 153.230 is revised to read as follows:

§ 153.230 Calculation of reinsurance payments made under the national contribution rate.

(a) Eligibility for reinsurance payments under the national reinsurance parameters. A health insurance issuer of a non-grandfathered individual market plan becomes eligible for reinsurance payments from contributions under the national contribution rate when its claims costs for an individual enrollee's covered benefits in a benefit year exceed the national attachment point.

(b) National reinsurance payment parameters. The national reinsurance payment parameters for each year commencing in 2014 and ending in 2016 set forth in the annual HHS notice of benefit and payment parameters for an applicable benefit year will apply with respect to reinsurance payments made from contributions received under the national contribution rate.

(c) National reinsurance payments. Each reinsurance payment made from contributions received under the national contribution rate will be calculated as the product of the national coinsurance rate multiplied by the health insurance issuer's claims costs for an individual enrollee's covered benefits that the health insurance issuer incurs between the national attachment point and the national reinsurance cap.

(d) Uniform adjustment to national reinsurance payments. If HHS determines that all reinsurance payments requested under the national payment parameters from all reinsurance-eligible plans in all States for a benefit year will exceed all reinsurance contributions collected under the national contribution rate in all States for an applicable benefit year, HHS will determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments for all States. Each applicable reinsurance entity, or

HHS on behalf of a State, must reduce all requests for reinsurance payments for the applicable benefit year by any adjustment required under this paragraph (d).

8. Section 153.232 is added to read as follows:

§153.232 Calculation of reinsurance payments made under a State additional contribution rate.

(a) State supplemental reinsurance payment parameters. (1) If a State establishes a reinsurance program and elects to collect additional contributions under §153.220(d)(1)(ii) or use additional funds for reinsurance payments under §153.220(d)(3), the State must set supplemental reinsurance payment parameters using one or more of the following methods:

(i) Decreasing the national attachment point;

(ii) Increasing the national reinsurance cap; or

(iii) Increasing the national coinsurance rate.

(2) The State must ensure that additional reinsurance contributions and funds projected to be received under §153.220(d)(1)(ii) and §153.220(d)(3), as applicable, for any applicable benefit year are reasonably calculated to cover additional reinsurance payments that are projected to be made only under the supplemental reinsurance payment parameters (that will not be paid under the national payment parameters) for the given benefit year.

(3) All applicable reinsurance entities in a State collecting additional reinsurance contributions must apply the State supplemental reinsurance payment parameters established under paragraph (a)(1) of this section when calculating reinsurance payments.

(b) General requirement for payments under State supplemental reinsurance parameters. Contributions collected under §153.220(d)(1)(ii) or funds under

§153.220(d)(3), as applicable, must be applied towards requests for reinsurance payments made under the State supplemental reinsurance payments parameters for each benefit year commencing in 2014 and ending in 2016.

(c) Eligibility for reinsurance payments under State supplemental reinsurance parameters. If a State establishes supplemental State reinsurance payment parameters under §153.232(a)(1), a health insurance issuer of a non-grandfathered individual market plan becomes eligible for reinsurance payments from contributions under §153.220(d)(1)(ii) or funds under §153.220(d)(3), as applicable, if its incurred claims costs for an individual enrollee's covered benefits in a benefit year:

(1) Exceed the supplemental State attachment point set forth in the State notice of benefit and payment parameters for the applicable benefit year if a State has established such a supplemental attachment point under §153.232(a)(1)(i);

(2) Exceed the national reinsurance cap set forth in the annual HHS notice of benefit and payment parameters for the applicable benefit year if a State has established a supplemental State reinsurance cap under §153.232(a)(1)(ii); or

(3) Exceed the national attachment point set forth in the annual HHS notice of benefit and payment parameters for the applicable benefit year if a State has established a supplemental coinsurance rate under §153.232(a)(1)(iii).

(d) Payments under State supplemental reinsurance parameters. Each reinsurance payment made from contributions received under §153.220(d)(1)(ii) or funds under §153.220(d)(3), as applicable, will be calculated with respect to a health insurance issuer's claims costs for an individual enrollee's covered benefits as the sum of the following:

(1) If the State has established a supplemental State attachment point, to the extent the issuer's incurred claims costs for such benefits exceed the supplemental State attachment point but do not exceed the national attachment point, the product of such claims costs between the supplemental State attachment point and the national attachment point multiplied by the national coinsurance rate (or, if the State has established a supplemental State coinsurance rate, the supplemental State coinsurance rate);

(2) If the State has established a supplemental State reinsurance cap, to the extent the issuer's incurred claims costs for such benefits exceed the national reinsurance cap but do not exceed the supplemental State reinsurance cap, the product of such claims costs between the national reinsurance cap and the supplemental State reinsurance cap multiplied by the national coinsurance rate (or, if the State has established a supplemental State coinsurance rate, the supplemental State coinsurance rate); and

(3) If the State has established a supplemental coinsurance rate, the product of the issuer's incurred claims costs for such benefits between the national attachment point and the national reinsurance cap multiplied by the difference between the supplemental coinsurance rate and the national coinsurance rate.

(e) Uniform adjustment to payments under State supplemental reinsurance payment parameters. If all requested reinsurance payments under the State supplemental reinsurance parameters calculated in accordance with paragraph (a)(1) of this section from all reinsurance-eligible plans in a State for a benefit year will exceed all reinsurance contributions collected under §153.220(d)(1)(ii) or funds under §153.220(d)(3) for the applicable benefit year, the State must determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments. Each applicable reinsurance entity

in the State must reduce all such requests for reinsurance payments for the applicable benefit year by that adjustment.

(f) Limitations on payments under State supplemental reinsurance parameters. A State must ensure that:

(1) The payments made to issuers must not exceed the issuer's total paid amount for the reinsurance-eligible claim(s); and

(2) Any remaining additional funds for reinsurance payments collected under §153.220(d)(1)(ii) must be used for reinsurance payments under the State supplemental reinsurance payment parameters in subsequent benefit years.

9. Section 153.234 is added to read as follows:

§153.234 Eligibility under health insurance market rules.

A reinsurance-eligible plan's covered claims costs for an enrollee incurred prior to the application of the following provisions do not count towards either the national reinsurance parameters or the State supplemental reinsurance parameters: 45 CFR 147.102, 147.104 (subject to 147.145), 147.106 (subject to 147.145), 156.80, and subpart B of part 156.

10. Section 153.235 is added to read as follows:

§153.235 Allocation and distribution of reinsurance contributions

(a) Allocation of reinsurance contributions. HHS will allocate and distribute reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments to each State based on total requests for reinsurance payments made under the national reinsurance payment parameters in all States and submitted under §153.410, net of any adjustment under §153.230(d).

(b) Excess reinsurance contributions. Any reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments for any benefit year but unused for the applicable benefit year will be used for reinsurance payments under the national reinsurance payment parameters for subsequent benefit years.

11. Section 153.240 is amended by revising paragraphs (a) and (b) and by adding a new paragraph (d) to read as follows:

§153.240 Disbursement of reinsurance payments.

(a) Data collection. If a State establishes a reinsurance program, the State must ensure that the applicable reinsurance entity:

(1) Collects data required to determine reinsurance payments as described in §153.230 and §153.232, as applicable, from an issuer of reinsurance-eligible plans or is provided access to such data, according to the data requirements specified by the State in the State notice of benefit and payment parameters described in subpart B of this part.

(2) Makes reinsurance payments to the issuer of a reinsurance-eligible plan after receiving a valid claim for payment from that health insurance issuer in accordance with the requirements of §153.410.

(3) Provides a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims in the normal course of business may use estimated claims costs to make a request for payment (or to submit data to be considered for reinsurance payments) in accordance with the requirements of §153.410. The State must ensure that such requests for reinsurance payment (or a subset of such requests) are subject to validation.

(b) Notification of reinsurance payments. For each applicable benefit year,

(1) A State, or HHS on behalf of the State, must notify issuers annually of:

(i) Reinsurance payments under the national payment parameters, and

(ii) Reinsurance payments under the State supplemental payment parameters if applicable, to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(2) A State must provide to each reinsurance-eligible plan the expected requests for reinsurance payments made under:

(i) The national payment parameters, and

(ii) State supplemental payments parameters if applicable, from such plan on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS.

* * * * *

(d) Privacy and security. (1) If a State establishes a reinsurance program, the State must ensure that the applicable reinsurance entity's collection of personally identifiable information is limited to information reasonably necessary for use in the calculation of reinsurance payments, and that use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected (including for purposes of data validation).

(2) If a State establishes a reinsurance program, the State must ensure that the applicable reinsurance entity implements security standards that provide administrative, physical, and technical safeguards for the personally identifiable information consistent with the security standards described at 45 CFR 164.308, 164.310, and 164.312.

12. Section 153.310 is amended by:

A. Redesignating paragraphs (c) and (d) as paragraphs (e) and (f), respectively.

B. Adding new paragraphs (a)(4), (c) and (d).

The additions read as follows:

§153.310 Risk adjustment administration.

(a) * * *

(4) Beginning in 2015, any State that is approved to operate an Exchange and elects to operate risk adjustment but has not been approved by HHS to operate risk adjustment prior to publication of its State notice of benefit and payment parameters for the applicable benefit year, will forgo implementation of all State functions in this subpart, and HHS will carry out all of the provisions of this subpart on behalf of the State.

* * * * *

(c) State responsibility for risk adjustment. (1) A State operating a risk adjustment program for a benefit year must administer the applicable Federally certified risk adjustment methodology through an entity that –

(i) Is operationally ready to implement the applicable Federally certified risk adjustment methodology and process the resulting payments and charges; and

(ii) Has experience relevant to operating the risk adjustment program.

(2) The State must ensure that the risk adjustment entity complies with all applicable provisions of subpart D of this part in the administration of the applicable Federally certified risk adjustment methodology.

(3) The State must conduct oversight and monitoring of its risk adjustment program.

(d) Certification for a State to operate risk adjustment. (1) To be approved by HHS to operate risk adjustment under a particular Federally certified risk adjustment methodology for a benefit year, a State must establish that it and its risk adjustment entity meet the standards set forth in paragraph (c) of this section.

(2) To obtain such approval, the State must submit to HHS, in a form and manner specified by HHS, evidence that its risk adjustment entity meets these standards.

13. Section 153.320 is amended by revising paragraphs (a)(1) and (a)(2) to read as follows:

§153.320 Federally certified risk adjustment methodology.

* * * * *

(a) * * *

(1) The risk adjustment methodology is developed by HHS and published in the applicable annual HHS notice of benefit and payment parameters; or

(2) An alternate risk adjustment methodology is submitted by a State in accordance with §153.330, reviewed and certified by HHS, and published in the applicable annual HHS notice of benefit and payment parameters.

* * * * *

14. Section 153.330 is amended by—

A. Redesignating paragraph (b) as paragraph (c).

B. Adding new paragraph (b).

The additions read as follows:

§153.330 State alternate risk adjustment methodology.

* * * * *

(b) <u>Evaluation criteria for alternate risk adjustment methodology.</u> An alternate risk adjustment methodology will be certified by HHS as a Federally certified risk adjustment methodology based on the following criteria:

(1) The criteria listed in paragraph (a)(2) of this section;

(2) Whether the methodology complies with the requirements of this subpart D;

(3) Whether the methodology accounts for risk selection across metal levels; and

(4) Whether each of the elements of the methodology are aligned.

* * * * *

15. Section 153.340 is amended by revising paragraph (b)(3) to read as follows:

§153.340 Data collection under risk adjustment.

* * * * *

(b) * * *

(3) If a State is operating a risk adjustment program, the State must ensure that any collection of personally identifiable information is limited to information reasonably necessary for use in the applicable risk adjustment model, calculation of plan average actuarial risk, or calculation of payments and charges. Except for purposes of data validation, the State may not collect or store any personally identifiable information for use as a unique identifier for an enrollee's data, unless such information is masked or encrypted by the issuer, with the key to that masking or encryption withheld from the State. Use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected (including for purposes of data validation).

* * * * *

16. Section 153.360 is added to subpart D to read as follows:

§153.360 Application of risk adjustment to the small group market.

Enrollees in a risk adjustment covered plan must be assigned to the applicable risk pool in the State in which the enrollee's policy was filed and approved.

17. Section 153.400 is revised to read as follows:

§153.400 Reinsurance contribution funds.

(a) General requirement. Each contributing entity must make reinsurance contributions annually: at the national contribution for all reinsurance contribution enrollees, in a manner specified by HHS; and at the additional State supplemental contribution rate if the State has elected to collect additional contributions under §153.220(d), in a manner specified by the State.

(1) A contributing entity must make reinsurance contributions for its self-insured group health plans and health insurance coverage except to the extent that:

(i) Such plan or coverage is not major medical coverage;

(ii) In the case of health insurance coverage, such coverage is not considered to be part of an issuer's commercial book of business;

(iii) In the case of health insurance coverage, such coverage is not issued on a form filed and approved by a State.

(2) Accordingly, as specified in paragraph (a)(1) of this section, a contributing entity is not required to make contributions on behalf of the following:

(i) A self-insured group health plan or health insurance coverage that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act;

(ii) Coverage offered by an issuer under contract to provide benefits under any of the following titles of the Social Security Act:

(A) Title XVIII (Medicare);

(B) Title XIX (Medicaid); or

(C)Title XXI (Children's Health insurance Program);

(iii) A Federal or State high-risk pool, including the Pre-Existing Condition Insurance Plan Program;

(iv) Basic health plan coverage offered by issuers under contract with a State as described in section 1331 of the Affordable Care Act;

(v) A health reimbursement arrangement within the meaning of IRS Notice 2002-45 (2002-2 CB 93) or any subsequent applicable guidance, that is integrated with a self-insured group health plan or health insurance coverage;

(vi) A health savings account within the meaning of section 223(d) of the Code;

(vii) A health flexible spending arrangement within the meaning of section 125 of the Code;

(viii) An employee assistance plan, disease management program, or wellness program that does not provide major medical coverage;

(ix) A stop-loss policy or an indemnity reinsurance policy;

(x) TRICARE and other military health benefits for active and retired uniformed services personnel and their dependents;

(xi) A plan or coverage provided by an Indian Tribe to Tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the Tribe), in the capacity of the Tribal members as Tribal members (and not in their capacity as current or former employees of the Tribe or their dependents); or

(xii) Health programs operated under the authority of the Indian Health Service.

(b) Data requirements. Each contributing entity must submit to HHS data required to substantiate the contribution amounts for the contributing entity, in the manner and timeframe specified by HHS.

18. Section 153.405 is added to read as follows:

§153.405 Calculation of reinsurance contributions.

(a) In general. The reinsurance contribution required from a contributing entity for its reinsurance contribution enrollees during a benefit year is calculated by multiplying:

(1) The average number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all plans and coverage described in §153.400(a)(1) of the contributing entity; by

(2) The contribution rate for the applicable benefit year.

(b) Annual enrollment count. No later than November 15 of benefit year 2014, 2015, or 2016, as applicable, a contributing entity must submit an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees for the applicable benefit year to HHS. The count must be determined as specified in paragraphs (d) or (e) of this section, as applicable.

(c) Notification and payment. (1) Within 15 days of the submission of the annual enrollment count described in paragraph (b) of this section or by December 15 of the applicable benefit year, whichever is later HHS will notify the contributing entity of the reinsurance contribution amount to be paid for the applicable benefit year.

(2) A contributing entity must remit reinsurance contributions to HHS within 30 days after the date of the notification.

(d) Procedures for counting covered lives for health insurance issuers. To determine the average number of covered lives of reinsurance contribution enrollees under a health insurance plan for a benefit year, a health insurance issuer must use one of the following methods:

(1) Adding the total number of lives covered for each day of the first nine months of the benefit year and dividing that total by the number of days in the first nine months;

(2) Adding the total number of lives covered on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year, and dividing that total by the number of dates on which a count was made. For this purpose, the same months must be used for each quarter (for example January, April and July) and the date used for the second and third quarter must fall within the same week of the quarter as the corresponding date used for the first quarter; or

(3) Multiplying the average number of policies in effect for the first nine months of the benefit year by the ratio of covered lives per policy in effect, calculated using the prior National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (or a form filed with the issuer's State of domicile for the most recent time period).

(e) Procedures for counting covered lives for self-insured group health plans. To determine the number of covered lives of reinsurance contribution enrollees under a self-insured group health plan for a benefit year, a plan must use one of the following methods:

(1) One of the methods specified in either paragraph (d)(1) or paragraph (d)(2) of this section;

(2) Adding the total number of lives covered on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year (provided that the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter), and dividing that total by the number of dates on which a count was made, except that the number of lives covered on a date is

calculated by adding the number of participants with self-only coverage on the date to the product of the number of participants with coverage other than self-only coverage on the date and a factor of 2.35. For this purpose, the same months must be used for each quarter (for example, January, April, and July);

(3) Using the number of lives covered for the benefit year calculated based upon the "Annual Return/Report of Employee Benefit Plan" filed with the Department of Labor (Form 5500) for the last applicable time period. For purposes of this paragraph (e)(3), the number of lives covered for the benefit year for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500, divided by 2, and the number of lives covered for the benefit year for a plan offering self-only coverage and coverage other than self-only coverage equals the sum of the total participants covered at the beginning and the end of the benefit year, as reported on the Form 5500; and

(f) Procedures for counting covered lives for group health plans with a self-insured coverage option and an insured coverage option. To determine the number of covered lives of reinsurance contribution enrollees under a group health plan with a self-insured coverage option and an insured coverage option for a benefit year, a plan must use one of the methods specified in either paragraph (d)(1) or paragraph (d)(2) of this section.

(g) Multiple group health plans maintained by the same plan sponsor -- (1) General rule. If a plan sponsor maintains two or more self-insured group health plans (including one or more group health plans that provide health insurance coverage) that collectively provide major medical coverage for the same covered lives, then those

multiple plans shall be treated as a single self-insured group health plan for purposes of calculating any reinsurance contribution amount due under paragraph (d) of this section.

(2) Plan Sponsor. For purposes of this paragraph (g), the term "plan sponsor" means:

(i) The employer, in the case of a plan established or maintained by a single employer;

(ii) The employee organization, in the case of a plan established or maintained by an employee organization;

(iii) The joint board of trustees, in the case of a multiemployer plan (as defined in section 414(f) of the Code);

(iv) The committee, in the case of a multiple employer welfare arrangement;

(v) The cooperative or association that establishes or maintains a plan established or maintained by a rural electric cooperative or rural cooperative association (as such terms are defined in section 3(40)(B) of ERISA);

(vi) The trustee, in the case of a plan established or maintained by a voluntary employees' beneficiary association (meaning that the association is not merely serving as a funding vehicle for a plan that is established or maintained by an employer or other person);

(vii) In the case of a plan, the sponsor of which is not described in paragraph (g)(2)(i) through (g)(2)(vi) of this section, the person identified by the terms of the document under which the plan is operated as the plan sponsor, or the person designated by the terms of the document under which the plan is operated as the plan sponsor, provided that designation is made, and that person has consented to the designation, by no later than the date by which the count of covered lives for that benefit year is required

to be provided, after which date that designation for that benefit year may not be changed or revoked, and provided further that a person may be designated as the plan sponsor only if the person is one of the persons maintaining the plan (for example, one of the employers that is maintaining the plan with one or more other employers or employee organizations); or

(viii) In the case of a plan, the sponsor of which is not described in paragraph (g)(2)(i) through (g)(2)(vi) of this section, and for which no identification or designation of a plan sponsor has been made under paragraph (g)(2)(i)(vii) of this section, each employer that maintains the plan (with respect to employees of that employer), each employee organization that maintains the plan (with respect to members of that employee organization), and each board of trustees, cooperative or association that maintains the plan.

(3) Exception. A plan sponsor is not required to include as part of a single self-insured group health plan as determined under paragraph (g)(1) of this section any self-insured group health plan (including a group health plan that provides health insurance coverage) that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, or that only provides benefits related to prescription drugs.

(4) Procedures for counting covered lives for multiple group health plans treated as a single group health plan. The rules in this paragraph (g)(4) govern the determination of the average number of covered lives in a benefit year for any set of multiple self-insured group health plans or health insurance plans (or a combination of one or more self-insured group health plans and one or more health insurance plans) that are treated as a single group health plan under paragraph (g)(1) of this section.

(i) Multiple group health plans including an insured plan. If at least one of the multiple plans is an insured plan, the average number of covered lives of reinsurance contribution enrollees must be calculated using one of the methods specified in either paragraph (d)(1) or paragraph (d)(2) of this section, applied across the multiple plans as a whole. The following information must be determined by the plan sponsor and reported to HHS, in a manner and timeframe specified by HHS:

(A) The average number of covered lives calculated;

(B) The counting method used; and

(C) The names of the multiple plans being treated as a single group health plan as determined by the plan sponsor and reported to HHS.

(ii) Multiple group health plans not including an insured plan. If each of the multiple plans is a self-insured group health plan, the average number of covered lives of reinsurance contribution enrollees must be calculated using one of the methods specified either in paragraph (e)(1) or paragraph (e)(2) of this section, applied across the multiple plans as a whole. The following information must be determined by the plan sponsor and reported to HHS, in a manner and timeframe specified by HHS:

(A) The average number of covered lives calculated;

(B) The counting method used; and

(C) The names of the multiple plans being treated as a single group health plan as determined by the plan sponsor.

19. Section 153.410 is amended by revising paragraph (a) as follows:

§153.410 Requests for reinsurance payments.

(a) General requirement. An issuer of a reinsurance-eligible plan may make a request for payment when an enrollee of that reinsurance-eligible plan has met the criteria

for reinsurance payment set forth in subpart B of this part and the HHS notice of benefit and payment parameters and State notice of benefit and payment parameters for the applicable benefit year, if applicable.

* * * * *

20. Section 153.420 is added to subpart E to read as follows:

§153.420 Data collection.

(a) Data requirement. To be eligible for reinsurance payments, an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State, or by HHS on behalf of the State.

(b) Deadline for submission of data. An issuer of a reinsurance-eligible plan must submit or make accessible data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year.

21. Section 153.500 is amended by--

A. Revising the definitions of "Administrative costs" and "Allowable administrative costs."

B. Adding the definitions of "After-tax premiums earned," "Profits," and "Taxes" in alphabetical order.

The revisions and additions read as follows:

§153.500 Definitions.

* * * * *

Administrative costs mean, with respect to a QHP, total non-claims costs incurred by the QHP issuer for the QHP, including taxes.

After-tax premiums earned mean, with respect to a QHP, premiums earned with respect to the QHP minus taxes.

Allowable administrative costs mean, with respect to a QHP, the sum of administrative costs of the QHP, other than taxes plus profits earned by the QHP, which sum is limited to 20 percent of after-tax premiums earned with respect to the QHP (including any premium tax credit under any governmental program), plus taxes.

* * * * *

Profits mean, with respect to a QHP, the greater of:

(1) Three percent of after tax premiums earned, and

(2) Premiums earned of the QHP minus the sum of allowable costs and administrative costs of the QHP.

* * * * *

Taxes mean, with respect to a QHP, Federal and State licensing and regulatory fees paid with respect to the QHP as described in §158.161(a) of this subchapter, and Federal and State taxes and assessments paid with respect to the QHP as described in §158.162(a)(1) and (b)(1) of this subchapter.

* * * * *

22. Section 153.510 is amended by adding new paragraph (d) to read as follows:.

§153.510 Risk corridors establishment and payment methodology.

* * * * *

(d) Charge submission deadline. A QHP issuer must remit charges to HHS within 30 days after notification of such charges.

23. Section 153.530 is amended by –

A. Revising paragraphs (a), (b) introductory text, (b)(2)(iii), and (c).

B. Adding new paragraph (d).

The revisions and additions read as follows:

§153.530 Risk corridors data requirements.

(a) Premium data. A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in a manner specified by HHS.

(b) Allowable costs. A QHP issuer must submit to HHS data on the allowable costs incurred with respect to each QHP that the QHP issuer offers in a manner specified by HHS. For purposes of this subpart, allowable costs must be–

* * * * *

(2) * * *

(iii) Any cost-sharing reduction payments received by the issuer for the QHP to the extent not reimbursed to the provider furnishing the item or service.

(c) Allowable administrative costs. A QHP issuer must submit to HHS data on the allowable administrative costs incurred with respect to each QHP that the QHP issuer offers in a manner specified by HHS.

(d) Timeframes. For each benefit year, a QHP issuer must submit all information required under this section by July 31 of the year following the benefit year.

24. Section 153.630 is added to subpart G to read as follows:

§153.630 Data validation requirements when HHS operates risk adjustment.

(a) General requirement. An issuer of a risk adjustment covered plan in a State where HHS is operating risk adjustment on behalf of the State for the applicable benefit year must have an initial and second validation audit performed on its risk adjustment data as described in this section.

(b) Initial validation audit.

(1) An issuer of a risk adjustment covered plan must engage one or more independent auditors to perform an initial validation audit of a sample of its risk adjustment data selected by HHS.

(2) The issuer must ensure that the initial validation auditors are reasonably capable of performing an initial data validation audit according to the standards established by HHS for such audit, and must ensure that the audit is so performed.

(3) The issuer must ensure that each initial validation auditor is reasonably free of conflicts of interest, such that it is able to conduct the initial validation audit in an impartial manner and its impartiality is not reasonably open to question.

(4) The issuer must ensure validation of the accuracy of risk adjustment data for a sample of enrollees selected by HHS. The issuer must ensure that the initial validation audit findings are submitted to HHS in a manner and timeframe specified by HHS.

(c) Second validation audit. HHS will select a subsample of the risk adjustment data validated by the initial validation audit for a second validation audit. The issuer must comply with, and must ensure the initial validation auditor complies with, standards for such audit established by HHS, and must cooperate with, and must ensure that the initial validation auditor cooperates with, HHS and the second validation auditor in connection with such audit.

(d) Data validation appeals. An issuer may appeal the findings of a second validation audit or the application of a risk score error rate to its risk adjustment payments and charges.

(e) Adjustment of payments and charges. HHS may adjust payments and charges for issuers that do not comply with audit requirements and standards, as specified in part (b) and (c) of this section.

(f) Data security and transmission.

(1) An issuer must submit the risk adjustment data and source documentation for the initial and second validation audits specified by HHS to HHS or its designee in the manner and timeframe specified by HHS.

(2) An issuer must ensure that it and its initial validation auditor comply with the security standards described at 45 CFR 164.308, 164.310, and 164.312 in connection with the initial validation audit, the second validation audit, and any appeal.

25. Subpart H is added to read as follows:

Subpart H—Distributed Data Collection for HHS-Operated Programs

Sec.

153.700 Distributed data environment.

153.710 Data requirements.

153.720 Establishment and usage of masked enrollee identification numbers.

153.730 Deadline for submission of data.

Subpart H—Distributed Data Collection for HHS-Operated Programs

§153.700 Distributed data environment.

(a) Dedicated distributed data environments. For each benefit year in which HHS operates the risk adjustment or reinsurance program on behalf of a State, an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in the State, as applicable, must establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment and reinsurance program.

(b) Timeline. An issuer must establish the dedicated data environment (and confirm proper establishment through successfully testing the environment to conform

with applicable HHS standards for such testing) three months prior to the first date of full operation.

§153.710 Data requirements.

(a) Enrollment, claims, and encounter data. An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS.

(b) Claims data. All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer.

(c) Claims data from capitated plans. An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving.

§153.720 Establishment and usage of masked enrollee identification numbers.

(a) Enrollee identification numbers. An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must –

(1) Establish a unique masked enrollee identification number for each enrollee; and

(2) Maintain the same masked enrollee identification number for an enrollee across enrollments or plans within the issuer, within the State, during a benefit year.

(b) Prohibition on personally identifiable information. An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program on behalf of the State, as applicable, may not –

(1) Include enrollee's personally identifiable information in the masked enrollee identification number; or

(2) Use the same masked enrollee identification number for different enrollees enrolled with the issuer.

§153.730 Deadline for submission of data.

A risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must submit data to be considered for risk adjustment payments and charges and reinsurance payments for the applicable benefit year by April 30 of the year following the applicable benefit year.

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

26. The authority citation for part 155 continues to read as follows:

Authority: Secs. 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1401, 1402, 1411, 1412, 1413.

27. Section 155.20 is amended by—

A. Revising the definitions of "Large employer" and "Small employer".

B. Adding definitions of "Federally-facilitated Exchange," "Federally-facilitated SHOP," and "Full-time employee" in alphabetical order.

The revisions and additions read as follows:

§155.20 Definitions.

* * * * *

Federally-facilitated Exchange means an Exchange established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

Federally-facilitated SHOP means a Small Business Health Options Program established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

Full-time employee has the meaning given in section 4980H (c)(4) of the Code effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which it is effective for plan years beginning on or after October 1, 2013.

* * * * *

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define larger employer by substituting "51 employees" for "101 employees." The number of employees shall be determined using the method set forth in section 4980H (c)(2)(E) of the Code, effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated

SHOP for which the method shall be used for plan years beginning on or after October 1, 2013.

* * * * *

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define small employer by substituting "50 employees" for "100 employees." The number of employees shall be determined using the method set forth in section 4980H (c)(2)(E) of the Code, effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which the method shall be used for plan years beginning on or after October 1, 2013.

* * * * *

28. Section 155.220 is amended by revising paragraph (b) to read as follows—

§155.220 Ability to States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(b)(1) Web site disclosure. The Exchange or SHOP may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange and may elect to limit the information to information regarding licensed agents and brokers who have completed any required Exchange or SHOP registration and training process.

(2) A Federally-facilitated Exchange or SHOP will limit the information provided on its Web site regarding licensed agents and brokers to information regarding licensed agents and brokers who have completed registration and training.

* * * * *

29. Section 155.305 is amended by revising paragraph (g)(3) to read as follows:

§155.305 Eligibility standards.

* * * * *

(g) * * *

(3) Special rule for family policies. To the extent that an enrollment in a QHP in the individual market offered through an Exchange under a single policy covers two or more individuals who, if they were to enroll in separate individual policies would be eligible for different cost sharing, the Exchange must deem the individuals under such policy to be collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible:

(i) Individuals not eligible for changes to cost sharing;

(ii) Individuals described in §155.350(b) (the special cost-sharing rule for Indians regardless of income);

(iii) Individuals described in paragraph (g)(2)(iii) of this section;

(iv) Individuals described in paragraph (g)(2)(ii) of this section;

(v) Individuals described in paragraph (g)(2)(i) of this section; and

(vi) Individuals described in §155.350(a) (the cost-sharing rule for Indians with household incomes under 300 percent of the FPL).

* * * * *

30. Section 155.330 is amended by adding paragraph (g) to read as follows:

§155.330 Eligibility redetermination during a benefit year.

* * * * *

(g) Recalculation of advance payments of the premium tax credit and cost-sharing reductions. (1) When recalculating the amount of advance payments of the premium tax credit for which a tax filer is determined eligible as a result of an eligibility redetermination in accordance with this section, the Exchange must —

(i) Account for any advance payments already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with 26 CFR 1.36B-3; and

(ii) Ensure that that the advance payment provided on the tax filer's behalf is greater than or equal to zero and is calculated in accordance with 26 CFR 1.36B-3(d)(1).

(2) When redetermining eligibility for cost-sharing reductions in accordance with this section, the Exchange must determine an individual eligible for the category of cost-sharing reductions that corresponds to his or her expected annual household income for the benefit year (subject to the special rule for family policies set forth in §155.305(g)(3).

31. Section 155.340 is amended by adding paragraphs (e) and (f) to read as follows:

§155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.

* * * * *

(e) Allocation of advance payments of the premium tax credit between policies. If advance payments of the premium tax credit are to be made on behalf of a tax filer (or

two tax filers who are a married couple), and individuals in the tax filer's tax household are enrolled in more than one QHP or stand-alone dental plan, then the advance payments must be allocated as follows:

(1) That portion of the advance payment of the premium tax credit that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR §1.36B-3(e), for the QHP policies properly allocated to EHB must be allocated among the QHP policies in proportion to the respective portions of the premiums for the policies properly allocated to EHB; and

(2) Any remaining advance payment of the premium tax credit must be allocated among the stand-alone dental policies (if any) in proportion to the respective portions of the adjusted monthly premiums for the stand-alone dental policies properly allocated to the pediatric dental essential health benefit.

(f) Reduction of enrollee's portion of premium to account for advance payments of the premium tax credit. If an Exchange is facilitating the collection and payment of premiums to QHP issuers and stand-alone dental plans on behalf of enrollees under §155.240, and if a QHP issuer or stand-alone dental plan has been notified that it will receive an advance payment of the premium tax credit on behalf of an enrollee for whom the Exchange is facilitating such functions, the Exchange must –

(1) Reduce the portion of the premium for the policy collected from the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit; and

(2) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s) and the remaining premium owed for the policy.

32. Section 155.705 is amended by revising paragraph (b)(3) and by adding new paragraphs (b)(10)(i), (b)(10)(ii), (b)(11)(i) and (b)(11)(ii) to read as follows:

§155.705 Functions of a SHOP.

* * * * *

(b) * * *

(3) (i) SHOP options with respect to employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(ii) A Federally-facilitated SHOP will only permit a qualified employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section.

* * * * *

(10) * * *

(i) Subject to sections 2702 and 2703 of the Public Health Service Act, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of qualified employees accepting coverage under the employer's group health plan, divided by the number of qualified employees offered coverage, excluding from the calculation any employee who, at the time the employer submits the SHOP application, is enrolled in coverage through another employer's group health plan or through a governmental plan such as Medicare, Medicaid, or TRICARE.

(ii) Notwithstanding paragraph (b)(10)(i) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum

participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) * * *

(i) To determine the employer and employee contributions, a SHOP may establish one or more standard methods that employers may use to define their contributions toward employee and dependent coverage.

(ii) A Federally-facilitated SHOP must use the following method for employer contributions:

(A) The employer will select a level of coverage as described in paragraph (b)(2) and (b)(3) of this section.

(B) The employer will select a QHP within that level of coverage to serves as a reference plan on which contributions will be based.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage under the reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage under the reference plan.

(D) An employer may establish, to the extent allowed by Federal and State law, different percentages for different employee categories.

(E) Either State law or the employer may require that a Federally-facilitated SHOP base contributions on a calculated composite premium for the reference plan for employees, for adult dependents, and for dependents below age 21.

(F) The resulting contribution amounts for each employee's coverage may then be applied toward the QHP selected by the employee.

33. Section 155.1030 is added to read as follows:

§155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.

(a) Review of plan variations for cost-sharing reductions. (1) The Exchange must ensure that each issuer that offers or seeks to offer a health plan at any level of coverage in the individual market on the Exchange submits the required plan variations for the health plan as described in §156.420 of this subchapter. The Exchange must certify that the plan variations meet the requirements of §156.420.

(2) The Exchange must provide to HHS the actuarial values of each QHP and silver plan variation, calculated under §156.135 of this subchapter, in the manner and timeframe established by HHS.

(b) Information for administering advance payments of the premium tax credit and advance payments of cost-sharing reductions. (1) The Exchange must collect and review annually the rate allocation, the expected allowed claims cost allocation, and the actuarial memorandum that an issuer submits to the Exchange under §156.470 of this subchapter, to ensure that such allocations meet the standards set forth in §156.470(c) and (d).

(2) The Exchange must submit, in the manner and timeframe established by HHS, to HHS the approved allocations and actuarial memorandum underlying the approved allocations for each health plan at any level of coverage or stand-alone dental plan offered, or proposed to be offered in the individual market on the Exchange.

(3) The Exchange must collect annually any estimates and supporting documentation that a QHP issuer submits to receive advance payments of certain cost-sharing reductions, under §156.430(a) of this subchapter, and submit, in the manner and

timeframe established by HHS, the estimates and supporting documentation to HHS for review.

(4) HHS may use the information provided to HHS by the Exchange under this section for the approval of the estimates that an issuer submits for advance payments of cost-sharing reductions, as described in §156.430 of this subchapter, and the oversight of the advance payments of cost-sharing reductions and premium tax credits programs.

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

34. The authority citation for part 156 is revised to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, and 1412, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

35. Section 156.20 is amended by adding definitions for "Federally-facilitated SHOP" and "Issuer group" in alphabetical order to read as follows:

§156.20 Definitions.

* * * * *

Federally-facilitated SHOP has the meaning given to the term in § 155.20 of this subchapter.

* * * * *

Issuer group means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of

corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.

* * * * *

36. Section 156.50 is amended by revising paragraph (b) and by adding paragraph (c) to read as follows:

§156.50 Financial support.

* * * * *

(b) Requirement for State-based Exchange user fees. A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under §155.160 of this subchapter.

(c) Requirement for Federally-facilitated Exchange user fee. To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the billable members enrolled through the Exchange in the plan offered by the issuer, and the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year. For purposes of this paragraph, billable members are defined under 45 CFR 147.102(c)(1) as each family member in a policy, with a limitation of three family members under age 21.

37. Section 156.200 is amended by adding paragraphs (f) and (g) to read as follows:

§156.200 QHP issuer participation standards.

* * * * *

(f) Broker compensation in a Federally-facilitated Exchange. A QHP issuer must pay the same broker compensation for QHPs offered through a Federally-facilitated Exchange that the QHP issuer pays for similar health plans offered in the State outside a Federally-facilitated Exchange.

(g) Certification standard specific to a Federally-facilitated Exchange. A Federally-facilitated Exchange may certify a QHP in the individual market of a Federally-facilitated Exchange only if the QHP issuer meets one of the conditions below:

(1) The QHP issuer also offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage as described in section 1302(d) of the Affordable Care Act;

(2) The QHP issuer does not offer small group market products in that State, but another issuer in the same issuer group offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or

(3) Neither the issuer nor any other issuer in the same issuer group offers a small group market product in that State.

38. Section 156.215 is added to read as follows:

§156.215 Advance payments of the premium tax credit and cost-sharing reduction standards.

(a) Standards relative to advance payments of the premium tax credit and cost-sharing reductions. In order for a health plan to be certified as a QHP initially and to maintain certification to be offered in the individual market on the Exchange, the issuer

must meet the requirements related to the administration of cost-sharing reductions and advance payments of the premium tax credit set forth in subpart E of this part.

(b) [Reserved]

39. Section 156.285 is amended by adding paragraph (c)(7) to read as follows:

§156.285 Additional standards specific to SHOP.

* * * * *

(c) * * *

(7) A QHP issuer must enroll a qualified employee only if the Exchange –

(i) Notifies the QHP issuer that the employee is a qualified employee; and

(ii) Transmits information to the QHP issuer as provided in § 155.400(a) of this subchapter.

* * * * *

40. Subpart E is added to read as follows:

Subpart E – Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

Sec.

156.400 Definitions.

156.410 Cost-sharing reductions for enrollees.

156.420 Plan variations.

156.425 Changes in eligibility for cost-sharing reductions.

156.430 Payment for cost-sharing reductions.

156.440 Plans eligible for advance payments of the premium tax credit and cost-sharing reductions.

156.460 Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.

156.470 Allocation of rates and claims costs for advance payments of cost-sharing reductions and the premium tax credit.

Subpart E – Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

§156.400 Definitions.

The following definitions apply to this subpart:

Advance payments of the premium tax credit has the meaning given to the term in §155.20 of this subchapter.

Affordable Care Act has the meaning given to the term in §155.20 of this subchapter.

Annual limitation on cost sharing means the annual dollar limit on cost sharing required to be paid by an enrollee that is established by a particular qualified health plan.

De minimis variation means the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan as established in §156.140(c)(1).

De minimis variation for a silver plan variation means a single percentage point.

Federal poverty level or FPL has the meaning given to the term in §155.300(a) of this subchapter.

Indian has the meaning given to the term in §155.300(a) of this subchapter.

Limited cost sharing plan variation means, with respect to a QHP at any level of coverage, the variation of such QHP described in §156.420(b)(2).

Maximum annual limitation on cost sharing means the highest annual dollar amount that qualified health plans (other than QHPs with cost-sharing reductions) may require in cost sharing for a particular year, as established for that year under §156.130.

Most generous or more generous means, between a QHP (including a standard silver plan) or plan variation, and one or more other plan variations of the same QHP, the QHP or plan variation designed for the category of individuals last listed in §155.305(g)(3) of this subchapter.

Plan variation means a zero cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation.

Reduced maximum annual limitation on cost sharing means the dollar value of the maximum annual limitation on cost sharing for a silver plan variation that remains after applying the reduction, if any, in the maximum annual limitation on cost sharing required by section 1402 of the Affordable Care Act as announced in the annual HHS notice of benefit and payment parameters.

Silver plan variation means, with respect to a standard silver plan, any of the variations of that standard silver plan described in §156.420(a).

Stand-alone dental plan means a plan offered through an Exchange under §155.1065 of this subchapter.

Standard plan means a QHP offered at one of the four levels of coverage, defined at §156.140, with an annual limitation on cost sharing that conforms to the requirements of §156.130(a). A standard plan at the bronze, silver, gold, or platinum level of coverage is referred to as a standard bronze plan, a standard silver plan, a standard gold plan, and a standard platinum plan, respectively.

Zero cost sharing plan variation means, with respect to a QHP at any level of coverage, the variation of such QHP described in §156.420(b)(1).

§156.410 Cost-sharing reductions for enrollees.

(a) General requirement. A QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pay only the cost sharing required of an eligible individual for the applicable covered service under the plan variation. The cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected.

(b) Assignment to applicable plan variation. If an individual is determined to be eligible to enroll in a QHP in the individual market offered through an Exchange and elects to do so, the QHP issuer must assign the individual under enrollment and eligibility information submitted by the Exchange as follows –

(1) If the individual is determined eligible by the Exchange for cost-sharing reductions under §155.305(g)(2)(i), (ii), or (iii) of this subchapter (subject to the special rule for family policies set forth in §155.305(g)(3) of this subchapter) and chooses to enroll in a silver health plan, the QHP issuer must assign the individual to the silver plan variation of the selected silver health plan described in §156.420(a)(1), (2), or (3), respectively.

(2) If the individual is determined eligible by the Exchange for cost-sharing reductions for Indians with lower household income under §155.350(a) of this subchapter (subject to the special rule for family policies set forth in §155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the zero cost sharing plan variation of the selected QHP with all cost sharing eliminated described in §156.420(b)(1).

(3) If the individual is determined by the Exchange to be eligible for cost-sharing reductions for Indians regardless of household income under §155.350(b) of this subchapter (subject to the special rule for family policies set forth in §155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the limited cost sharing plan variation of the selected QHP with the prohibition on cost sharing for benefits received from the Indian Health Service and certain other providers described in §156.420(b)(2).

(4) If the individual is determined by the Exchange not to be eligible for cost-sharing reductions (including eligibility under the special rule for family policies set forth in §155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the selected QHP with no cost-sharing reductions.

§156.420 Plan variations.

(a) Submission of silver plan variations. For each of its silver health plans that an issuer seeks to offer or to continue to offer in the individual market on an Exchange, the issuer must submit annually to the Exchange for certification prior to each benefit year the standard silver plan and three variations of the standard silver plan, as follows –

(1) For individuals eligible for cost-sharing reductions under §155.305(g)(2)(i) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 94 percent plus or minus the de minimis variation for a silver plan variation;

(2) For individuals eligible for cost-sharing reductions under §155.305(g)(2)(ii) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 87 percent plus or minus the de minimis variation for a silver plan variation; and

(3) For individuals eligible for cost-sharing reductions under §155.305(g)(2)(iii) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 73 percent plus or minus the de minimis variation for a silver plan variation (subject to §156.420(h)).

(b) Submission of zero and limited cost sharing plan variations. For each of its health plans at any level of coverage that an issuer seeks QHP certification for the individual market on an Exchange, the issuer must submit to the Exchange for certification the health plan and two variations of the health plan, as follows –

(1) For individuals eligible for cost-sharing reductions under §155.350(a) of this subchapter, a variation of the health plan with all cost sharing eliminated; and

(2) For individuals eligible for cost-sharing reductions under §155.350(b) of this subchapter, a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal

Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through referral under contract health services.

(c) Benefit and network equivalence in silver plan variations. A standard silver plan and each silver plan variation thereof must cover the same benefits and providers, and require the same out-of-pocket spending for benefits other than essential health benefits. Each silver plan variation is subject to all requirements applicable to the standard silver plan (except for the requirement that the plan have an AV as set forth in §156.140(b)(2)).

(d) Benefit and network equivalence in zero and limited cost sharing plan variations. A QHP and each zero cost sharing plan variation or limited cost sharing plan variation thereof must cover the same benefits and providers, and require the same out-of-pocket spending for benefits other than essential health benefits. A limited cost sharing plan variation must have the same cost sharing on items or services not described in paragraph (b)(2) of this section as the QHP with no cost-sharing reductions. Each zero cost sharing plan variation or limited cost sharing plan variation is subject to all requirements applicable to the QHP (except for the requirement that the plan have an AV as set forth in §156.140(b)).

(e) Decreasing cost sharing in higher AV silver plan variations. The cost sharing required of enrollees under any silver plan variation of a standard silver plan for an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding cost sharing required in the standard silver plan or any other silver plan variation thereof with a lower AV.

(f) Minimum AV differential between 70 percent and 73 percent silver plan variations. Notwithstanding any permitted de minimis variation in AV for a health plan

or permitted de minimis variation for a silver plan variation, the AVs of a standard silver plan and the silver plan variation thereof described in paragraph (a)(3) of this section must differ by at least 2 percentage points.

§156.425 Changes in eligibility for cost-sharing reductions.

(a) Effective date of change in assignment. If the Exchange notifies a QHP issuer of a change in an enrollee's eligibility for cost-sharing reductions (including a change in the individual's eligibility under the special rule for family policies set forth in §155.305(g)(3) of this subchapter due to a change in eligibility of another individual on the same policy), then the QHP issuer must change the individual's assignment such that the individual is assigned to the applicable standard plan or plan variation of the QHP as required under §156.410(b) as of the effective date of eligibility required by the Exchange.

(b) Continuity of deductible and out-of-pocket amounts. In the case of a change in assignment to a different plan variation (or standard plan without cost-sharing reductions) of the same QHP in the course of a benefit year under this section, the QHP issuer must ensure that any cost sharing paid by the applicable individual under previous plan variations (or standard plan without cost-sharing reductions) for that benefit year is taken into account in the new plan variation (or standard plan without cost-sharing reductions) for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

§156.430 Payment for cost-sharing reductions.

(a) Estimates of value of cost-sharing reductions for purposes of advance payments. (1) For each health plan that an issuer offers, or intends to offer, in the individual market on an Exchange as a QHP, the issuer must provide to the Exchange

annually prior to the benefit year, for approval by HHS, an estimate of the dollar value of the cost-sharing reductions to be provided over the benefit year. The estimate must:

(i) If the QHP is a silver health plan, identify separately the per member per month dollar value of the cost-sharing reductions to be provided under each silver plan variation identified in §156.420(a)(1), (2), and (3);

(ii) Regardless of the level of coverage of the QHP, identify the per member per month dollar value of the cost-sharing reductions to be provided under the zero cost sharing plan variation;

(iii) Be accompanied by supporting documentation validating the estimate; and

(iv) Be developed using the methodology specified by HHS in the applicable annual HHS notice of benefit and payment parameters.

(2) If an issuer seeks advance payments for the cost-sharing reductions to be provided under the limited cost sharing plan variation of a health plan it offers, or seeks to offer, in the individual market on the Exchange as a QHP at any level of coverage, the issuer must provide to the Exchange annually prior to the benefit year, for approval by HHS, an estimate of the per member per month dollar value of the cost-sharing reductions to be provided over the benefit year under such limited cost sharing plan variation. The estimate must:

(i) Be accompanied by supporting documentation validating the estimate; and

(ii) Be developed using the methodology specified by HHS in the annual HHS notice of benefit and payment parameters.

(3) HHS's approval of the estimate will be based on whether the estimate is made consistent with the methodology specified by HHS in the annual HHS notice of benefit and payment parameters.

(b) Advance payments. A QHP issuer will receive periodic advance payments based on the approved advance estimates provided under paragraph (a) of this section and the actual enrollment in the applicable plan variation.

(c) Submission of actual amounts. A QHP issuer must submit to HHS, in the manner and timeframe established by HHS, the following –

(1) In the case of a benefit for which the QHP issuer compensates the applicable provider in whole or in part on a fee-for-service basis, the total allowed costs for essential health benefits charged for an enrollees' policy for the benefit year, broken down by what the issuer paid, what the enrollee paid, and the amount reimbursed to the provider by the QHP issuer for the amount that the enrollee would have paid under the standard QHP without cost-sharing reductions; and

(2) In the case of a benefit for which the QHP issuer compensates the applicable provider in any other manner, the total allowed costs for essential health benefits charged for an enrollees' policy for the benefit year, broken down by what the issuer paid, what the enrollee paid, and what the enrollee would have paid under the standard QHP without cost-sharing reductions.

(d) Reconciliation of amounts. HHS will perform periodic reconciliations of any advance payments of cost-sharing reductions provided to a QHP issuer under paragraph (b) of this section against –

(1) The actual amount of cost-sharing reductions provided to enrollees and reimbursed to providers by the QHP issuer for benefits for which the QHP issuer compensates the applicable providers in whole or in part on a fee-for-service basis; and

(2) The actual amount of cost-sharing reductions provided to enrollees for benefits for which the QHP issuer compensates the applicable providers in any other manner.

(e) Payment of discrepancies. If the actual amounts of cost-sharing reductions described in paragraphs (d)(1) and (2) of this section are –

(1) More than the amount of advance payments provided and the QHP issuer has timely provided the actual amounts of cost-sharing reductions as required under paragraph (c) of this section, HHS will reimburse the QHP issuer for the difference; and

(2) Less than the amount of advance payments provided, the QHP issuer must repay the difference to HHS in the manner and timeframe specified by HHS.

(f) Cost-sharing reductions during special periods. (1) Notwithstanding the reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will not be eligible for reimbursement of any cost-sharing reductions provided following a termination of coverage effective date with respect to a grace period as described in §155.430(b)(2)(ii)(A) or (B) of this subchapter. However, the QHP issuer will be eligible for reimbursement of cost-sharing reductions provided prior to the termination of coverage effective date. Advance payments of cost-sharing reductions will be paid to a QHP issuer prior to a determination of termination (including during any grace period, but the QHP issuer will be required to repay any advance payments made with respect to any month after any termination of coverage effective date during a grace period).

(2) Notwithstanding the reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1)

of this section, and if the termination (or the late determination thereof) is the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will not be eligible for advance payments and reimbursement for cost-sharing reductions provided during the period following the termination of coverage effective date and prior to the determination of the termination.

(3) Subject to the requirements of the reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the reason for the termination (or late determination thereof) is not the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during such period.

(4) Subject to the requirements of the reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during any period of coverage pending resolution of inconsistencies in information required to determine eligibility for enrollment under §155.315(f) of this subchapter.

§156.440 Plans eligible for advance payments of the premium tax credit and cost-sharing reductions.

Except as noted in paragraph (a) through (c) of this section, the provisions of this subpart apply to qualified health plans offered in the individual market on the Exchange.

(a) Catastrophic plans. The provisions of this subpart do not apply to catastrophic plans as described in §156.155.

(b) Stand-alone dental plans. The provisions of this subpart, to the extent relating to cost-sharing reductions, do not apply to stand-alone dental plans. The provisions of this subpart, to the extent relating to advance payments of the premium tax credit, apply to stand-alone dental plans.

(c) Child-only plans. The provisions of this subpart apply to child-only QHPs, as described in §156.200(c)(2).

§156.460 Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.

(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit. A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must –

(1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit;

(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with §156.265(g); and

(3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.

(b) Delays in payment. A QHP issuer may not refuse to commence coverage under a policy or terminate coverage on account of any delay in payment of an advance payment of the premium tax credit on behalf of an enrollee if the QHP issuer has been notified by the Exchange under §155.340(a) of this subchapter that the QHP issuer will receive such advance payment.

§156.470 Allocation of rates and claims costs for advance payments of cost-sharing reductions and the premium tax credit.

(a) Allocation to additional health benefits for QHPs. An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each health plan at any level of coverage offered, or proposed to be offered in the individual market on an Exchange, an allocation of the rate and the expected allowed claims costs for the plan, in each case, to:

(1) EHB, other than services described in §156.280(d)(1), and

(2) Any other services or benefits offered by the health plan not described paragraph (a)(1) of this section.

(b) Allocation to additional health benefits for stand-alone dental plans. An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each stand-alone dental plan offered, or proposed to be offered, in the individual market on the Exchange, a dollar allocation of the expected premium for the plan, to:

(1) The pediatric dental essential health benefit, and

(2) Any benefits offered by the stand-alone dental plan that are not the pediatric dental essential health benefit.

(c) Allocation standards for QHPs. The issuer must ensure that the allocation described in paragraph (a) of this section—

(1) Is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies;

(2) Reasonably reflects the allocation of the expected allowed claims costs attributable to EHB (excluding those services described in §156.280(d)(1));

(3) Is consistent with the allocation applicable to State-required benefits to be submitted by the issuer under §155.170(c) of this subchapter, and the allocation requirements described in §156.280(e)(4) for certain services; and

(4) Is calculated under the fair health insurance premium standards described at 45 CFR 147.102, the single risk pool standards described at 45 CFR 156.80, and the same premium rate standards described at 45 CFR 156.255.

(d) Allocation standards for stand-alone dental plans. The issuer must ensure that the dollar allocation described in paragraph (b) of this section—

(1) Is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies;

(2) Is consistent with the allocation applicable to State-required benefits to be submitted by the issuer under §155.170(c) of this subchapter;

(3) Is calculated under the fair health insurance premium standards described at 45 CFR 147.102, except for the provision related to age set forth at §147.102(a)(1)(ii); the single risk pool standards described at 45 CFR 156.80; and the same premium rate standards described at 45 CFR 156.255 (in each case subject to paragraph (d)(4) of this section); and

(4) Is calculated so that the dollar amount of the premium allocable to the pediatric dental essential health benefit for an individual under the age of 19 years does not vary, and the dollar amount of the premium allocable to the pediatric dental essential health benefit for an individual aged 19 years or more is equal to zero.

(e) Disclosure of attribution and allocation methods. An issuer of a health plan at any level of coverage or a stand-alone dental plan offered, or proposed to be offered in the individual market on the Exchange must submit to the Exchange annually for

approval, an actuarial memorandum, in the manner and timeframe specified by HHS, with a detailed description of the methods and specific bases used to perform the allocations set forth in paragraphs (a) and (b), and demonstrating that the allocations meet the standards set forth in paragraphs (c) and (d) of this section, respectively.

PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

41. The authority citation for part 157 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1311, 1312, 1321, 1411, 1412, Pub. L. 111-148, 124 Stat. 199.

42. Section 157.20 is amended by adding the definitions for "Federally-facilitated SHOP," "Full-time employee," and "Large employer" in alphabetical order to read as follows:

§157.20 Definitions.

* * * * *

Federally-facilitated SHOP has the meaning given to the term in §155.20 of this subchapter.

Full-time employee has the meaning given to the term in §155.20 of this subchapter.

Large employer has the meaning given to the term in §155.20 of this subchapter.

* * * * *

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

43. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 U.S.C. 300gg-18),

as amended.

44. Section 158.110 is amended by revising paragraph (b) to read as follows:

§158.110 Reporting requirements related to premiums and expenditures.

* * * * *

(b) Timing and form of report. The report for each of the 2011, 2012, and 2013 MLR reporting years must be submitted to the Secretary by June 1 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary. Beginning with the 2014 MLR reporting year, the report for each MLR reporting year must be submitted to the Secretary by July 31 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary.

* * * * *

45. Section 158.130 is amended by adding paragraph (b)(5) to read as follows:

§158.130 Premium revenue.

* * * * *

(b) * * *

(5) Account for the net payments or receipts related to risk adjustment, risk corridors, and reinsurance programs under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, 18062, 18063.

46. Section 158.140 is amended by adding paragraph (b)(4)(ii) and revising paragraph (b)(5)(i) to read as follows:

§158.140 Requirements for clinical services provided to enrollees.

* * * * *

(b) * * *

(4) * * *

(ii) Net payments or receipts related to risk adjustment, risk corridors, and reinsurance programs under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, 18062, 18063.

(5) * * *

(i) Affiliated issuers that offer group coverage at a blended rate may choose whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula that must be defined by the issuer prior to January 1 of the MLR reporting year, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate.

* * * * *

47. Section 158.162 is amended by revising paragraph (b)(1)(vii) and adding paragraph (b)(1)(viii) to read as follows:

§158.162 Reporting of Federal and State taxes.

* * * * *

(b) * * *

(1) * * *

(vii) Payments made by a Federal income tax exempt issuer for community benefit expenditures as defined in paragraph (c) of this section, limited to the highest of either:

(A) Three percent of earned premium; or

(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market.

(viii) In lieu of reporting amounts described in paragraph (b)(1)(vi) of this section, an issuer that is not exempt from Federal income tax may choose to report payment for community benefit expenditures as described in paragraph (c) of this section, limited to the highest premium tax rate in the State for which the report is being submitted multiplied by the issuer's earned premium in the applicable State market.

* * * * *

48. Section 158.221 is amended by revising paragraph (c) to read as follows:

§158.221 Formula for calculating an issuer's medical loss ratio.

* * * * *

(c) Denominator. The denominator of an issuer's MLR must equal the issuer's premium revenue, as defined in § 158.130, excluding the issuer's Federal and State taxes and licensing and regulatory fees, described in §§ 158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, described in § 158.130(b)(5).

49. Section 158.232 is amended by revising paragraph (c)(1)(i) and paragraph (d) introductory text to read as follows:

§158.232 Calculating the credibility adjustment.

* * * * *

(c) * * *

(1) * * *

(i) The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be the lesser of: the deductible applicable to each of the

individual family members; or the overall family deductible for the subscriber and subscriber's family divided by two (regardless of the total number of individuals covered through the subscriber).

* * * * *

(d) No credibility adjustment. Beginning with the 2013 MLR reporting year, the credibility adjustment for and MLR based on partially credible experience is zero if both of the following conditions are met:

* * * * *

50. Section 158.240 is amended by revising paragraphs (c) and (d) to read as follows:

§158.240 Rebating premium if the applicable medical loss ratio standard is not met.

* * * * *

(c) Amount of rebate to each enrollee. (1) For each MLR reporting year, an issuer must rebate to the enrollee the total amount of premium revenue, as defined in §158.130 of this part, received by the issuer from the enrollee, after subtracting Federal and State taxes and licensing and regulatory fees as provided in §§158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance as provided in § 158.130(b)(5), multiplied by the difference between the MLR required by §158.210 or §158.211, and the issuer's MLR as calculated under §158.221.

(2) For example, an issuer must rebate a pro rata portion of premium revenue if it does not meet an 80 percent MLR for the individual market in a State that has not set a higher MLR. If an issuer has a 75 percent MLR for the coverage it offers in the individual market in a State that has not set a higher MLR, the issuer must rebate 5

percent of the premium paid by or on behalf of the enrollee for the MLR reporting year after subtracting taxes and fees and accounting for payments or receipts related to reinsurance, risk adjustment and risk corridors. In this example, an enrollee may have paid $2,000 in premiums for the MLR reporting year. If the issuer received net payments related to reinsurance, risk adjustment and risk corridors of $200, the gross earned premium would be $2,200. If the Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in §§158.161(a), 158.161(a)(1), and 158.162(b)(1) are $150 and the net payments related to reinsurance, risk adjustment and risk corridors that must be accounted for in premium revenue as described in §§ 158.130(b)(5), 158.221 and 158.240 are $200, then the issuer would subtract $150 and $200 from gross premium revenue of $2,200, for a base of $1,850 in premium. The enrollee would be entitled to a rebate of 5 percent of $1,850, or $92.50.

(d) Timing of rebate. For each of the 2011, 2012, and 2013 MLR reporting years, an issuer must provide any rebate owing to an enrollee no later than August 1 following the end of the MLR reporting year. Beginning with the 2014 MLR reporting year, an issuer must provide any rebate owing to an enrollee no later than September 30 following the end of the MLR reporting year.

* * * * *

51. Section 158.241 is amended by revising paragraph (a)(2) to read as follows:

§158.241 Form of rebate.

(a) * * *

(2) For each of the 2011, 2012, and 2013 MLR reporting years, any rebate provided in the form of a premium credit must be provided by applying the full amount due to the first month's premium that is due on or after August 1 following the MLR

reporting year. If the amount of the rebate exceeds the premium due for August, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited. Beginning with the 2014 MLR reporting year, any rebate provided in the form of a premium credit must be provided by applying the full amount due to the first month's premium that is due on or after September 30 following the MLR reporting year. If the amount of the rebate exceeds the premium due for October, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited.

* * * * *

Dated: November 28, 2012.

Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: November 28, 2012.

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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