DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

[CMS-9964-F]

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), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule provides detail and parameters related to: the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for Federally-facilitated Exchanges; advance payments of the premium tax credit; the Federally-facilitated Small Business Health Option Program; and the medical loss ratio program. Cost-sharing reductions and advance payments of the premium tax credit, combined with new insurance market reforms, are expected to significantly increase the number of individuals with health insurance coverage, particularly in the individual market. In addition, we expect the premium stabilization programs – risk adjustment, reinsurance, and risk corridors – to protect against the effects of adverse selection. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue) 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: This final rule is effective on [OFR-insert date 60 days after the date of filing for public inspection at OFR].

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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 payments of the premium tax credit
ASO	Administrative services only contractor
AV	Actuarial Value

CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
EHB	Essential health benefits
ERISA	Employee Retirement Income Security Act
FFE	Federally-facilitated Exchange
FF-SHOP	Federally-facilitated Small Business Health Options Program Exchange
FPL	Federal poverty level
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	United States 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

TPA Third party administrator

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, "Exchanges," or "Marketplaces." Individuals who enroll in qualified health plans through Exchanges may receive premium tax credits that make health insurance more affordable and financial assistance to cover some or all cost sharing for essential health benefits. We expect that 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 – are expected to protect against the effects of adverse selection. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue), 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 care.

Premium stabilization programs: The Affordable Care Act establishes a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors 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 and Exchanges facilitate increased enrollment. The reinsurance program will reduce the uncertainty of insurance risk in the

individual market by partially offsetting issuers' risk associated with high-cost enrollees. The risk corridors program will protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial 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[1] 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 final rule. In this final rule, we describe these standards, and include payment parameters for these programs.

Advance payments of the premium tax credit and cost-sharing reductions: This final rule establishes standards for advance payments of the premium tax credit and for cost-sharing reductions. These programs assist eligible 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.

[1] 77 FR 17220 (March 23, 2012).

112–10) (125 Stat. 38 (2011)). The section 36B credit is designed to make a qualified health plan (QHP) purchased on an Exchange affordable by reducing an eligible taxpayer's out-of-pocket premium cost.

Under sections 1401, 1411, and 1412 of the Affordable Care Act and 45 CFR part 155 subpart D, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in QHP coverage through the Exchange and seek financial assistance. Using information available at the time of enrollment, the Exchange determines whether the individual meets the income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. Advance payments are made periodically under section 1412 of the Affordable Care Act to the issuer of the 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 a QHP through an Exchange, and section 1412 of the Affordable Care Act provides for the advance payment of these reductions to issuers. This assistance will help eligible low- and moderate-income qualified individuals and families afford the out-of-pocket spending associated with health care services provided through Exchange-based QHP coverage. The statute 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 payments of the premium tax credit. 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 contract health services.

HHS published a bulletin[2] outlining an intended regulatory approach to calculating actuarial value and implementing cost-sharing reductions on February 24, 2012 (AV/CSR Bulletin). The AV/CSR Bulletin outlined an intended regulatory approach governing 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,[3] we set forth eligibility standards for these cost-sharing reductions. In this final rule, we make minor revisions to the eligibility standards for families and 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. When operating a Federally-facilitated Exchange under section 1321(c)(1) of the Affordable Care Act, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the statute to collect and spend such user fees. In addition, 31 U.S.C. 9701 permits a Federal 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

[2] Available at: http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.
[3] 77 FR 18310 (March 27, 2012).

this final rule, we establish a user fee for issuers participating in a Federally-facilitated Exchange.

Small Business Health Options Program (SHOP): Section 1311(b)(1)(B) of the Affordable Care Act directs each State that chooses to operate an Exchange to establish a SHOP that provides QHP options for small businesses. The Exchange Establishment Rule sets forth standards for the administration of SHOP Exchanges. In this final rule, we clarify and expand upon the standards established in the Exchange Establishment Rule.

Medical loss ratio (MLR) program: Section 2718 of the Public Health Service Act (PHS Act) generally requires health insurance issuers to submit an annual MLR report to HHS and provide rebates of premium 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) which established standards for the MLR program. Since then, we have made several revisions and technical corrections to those rules. This final rule amends the regulations to specify how issuers are to account for payments or receipts from the risk adjustment, reinsurance, and risk corridors programs, and to change the timing of the annual MLR report and distribution of rebates required of issuers to account for the premium stabilization programs. This final rule also amends the regulations to revise the treatment of community benefit expenditures in the MLR calculation for issuers exempt from Federal income tax to promote a level playing field.

B. Summary of the Major Provisions

This final rule fills in the framework established by the Premium Stabilization Rule with 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 establishes key provisions governing advance payments of the premium tax credit, cost-sharing reductions, and user fees for Federally-facilitated Exchanges. Finally, the final rule includes a number of amendments relating to the SHOP and the MLR program.

Risk Adjustment: The goal of the Affordable Care Act risk adjustment program is to mitigate the impact of possible adverse selection and stabilize the premiums in the individual and small group markets as and after insurance market reforms are implemented. We are finalizing 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 expect 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 final rule, we establish a number of standards and parameters for implementing the reinsurance program, including:

- Provisions excluding certain types of health insurance coverage and plans from reinsurance contributions;
- The national per capita contribution rate and the methodology for calculating the contributions to be paid by health insurance issuers and self-insured group health plans;

- Provisions establishing eligibility for reinsurance payments;
- The uniform reinsurance payment parameters and the approach that HHS will use to calculate and administer the reinsurance program on behalf of a State; and
- The distributed data collection approach we will 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 through 2016. We are finalizing a change to the risk corridors calculation in which reinsurance contributions will be treated as a regulatory fee instead of an adjustment to allowable costs, and are replacing the term "taxes" in our proposed definition of taxes with the term "taxes and regulatory fees." We are also finalizing provisions governing the treatment of profits and taxes and regulatory fees within the risk corridors calculation. This provision aligns the risk corridors calculation with the MLR calculation. We are also finalizing 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 a QHP through an Exchange. In this final rule, we are finalizing 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 silver level health plans offered in the individual market on Exchanges. It also provides for reductions in cost sharing for Indians enrolled in QHPs at any metal level. In this final rule, we establish 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 to implement cost-sharing reductions;
- The maximum annual limitations on cost sharing applicable to the plan variations;
- Provisions governing the assignment and reassignment of enrollees to plan variations based on eligibility for cost-sharing reductions;
- Provisions governing issuer submissions of estimates of cost-sharing reductions, which are paid in advance to QHP issuers by the Federal government; and
- Provisions governing reconciliation of these advance estimates against actual cost-sharing reductions provided.

User Fees: This final rule establishes a user fee, calculated as a percentage of the premium for a QHP, applicable to issuers participating in a Federally-facilitated Exchange. This final 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 final rule, we establish a number of 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 and whether an employee is a full-time employee;
- A method for employers to make a QHP available to employees in the Federally-facilitated SHOP (FF-SHOP);
- The default minimum participation rate in the FF-SHOP;
- QHP standards linking FFE 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 an issuer to rebate a portion of premiums if its medical loss ratio falls short of the applicable standard for the reporting year. This ratio is calculated as the sum of health care claims costs and amounts spent on quality improvement activities divided by premium revenue, excluding taxes and regulatory fees, and after accounting for the premium stabilization programs. In this final rule, we establish a number of standards governing the MLR program, including:

- Provisions accounting for risk adjustment, reinsurance, and risk corridors payments and charges 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 final 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.[4]

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,[5] while only around 10.8 million were enrolled in the individual market.[6] 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 final 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 help to stabilize premiums in the individual market. 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. 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 the expected cost of 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

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[4] 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.
[5] 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.
[6] 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.

adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets.

The risk adjustment program protects against the potential of 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 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.

Provisions addressing advance payments of the premium tax credit and cost-sharing reductions will help provide financial assistance for certain eligible individuals enrolled in QHPs 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 significant barrier to obtaining needed health care.[7] The availability of premium tax credits and cost-sharing reductions 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, leading to a healthier risk pool and to reductions in premium rates for current policyholders.[8]

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[7] 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.

[8] 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

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 small employers to preserve control over health plan choices while saving employers money by spreading issuers' 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.

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. In addition, States may incur administrative and operating costs if they choose to establish their own programs. 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 qualified health plans – private health insurance that has been certified as meeting certain standards – through competitive marketplaces, called Exchanges. The Department of Health and Human Services, the Department of Labor, and the Department of the Treasury have been working in close coordination to release guidance related to qualified health plans and Exchanges in several phases. The Patient Protection and Affordable

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Implementation of the Affordable Care Act in New York State, Urban Institute, March 2012.

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 final rule. HHS published detail and parameters related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for Federally-facilitated Exchanges; advance payments of the premium tax credit; the Federally-facilitated Small Business Health Option Program; and the medical loss ratio program, in a December 7, 2012 **Federal Register** proposed rule entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014" (77 FR 73118).

A. Premium Stabilization

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. The Premium Stabilization 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. A white paper on risk adjustment concepts was published on September 12, 2011 (Risk Adjustment White Paper). A bulletin was published 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 and 8, 2012, we hosted a public meeting in which we discussed that approach (Risk Adjustment Spring Meeting).

A bulletin was published 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). HHS 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

The AV/CSR Bulletin was published on February 24, 2012 outlining an intended regulatory approach to calculating actuarial value and implementing cost-sharing reductions. 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 the provisions relating to cost-sharing reductions in this final 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 (77 FR 30377, to be codified at 26 CFR parts 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 March 27, 2012 **Federal Register** (77 FR 18310).

A proposed rule which, among other things, reflects new statutory eligibility provisions, titled "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing" was published in the January 22, 2013 **Federal Register** (78 FR 4594) (Medicaid and Exchange Eligibility Appeals and Notices).

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). The final rule was made available for public inspection at the Office of the **Federal Register** on February 22, 2013 (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). The final rule was published in the **Federal Register** on February 25, 2013 (78 FR 12834) (EHB/AV Rule).

G. Medical Loss Ratio

HHS published a request for comment on section 2718 of the PHS Act in the April 14, 2010 **Federal Register** (75 FR 19297), and published an interim final rule with 60-day comment period relating to MLR program on December 1, 2010 (75 FR 74864). An interim final rule with 30-day comment period and a final rule with 30-day comment period were published in the **Federal Register** on December 7, 2011 (76 FR 76596 and

76574). A final rule was published in the **Federal Register** on May 16, 2012 (77 FR 28790).

H. Tribal Consultations

Following publication of the proposed rule, we issued a letter to Tribal leaders seeking input on the provisions of the proposed rule. We also discussed the provisions of the proposed rule in an all-Tribes webinar and conference call and in two meetings with the Tribal Technical Advisory Group. We considered the comments offered during these discussions in developing the provisions in this final rule.

III. Provisions of the Proposed Rule and Responses to Public Comments

We received approximately 420 comments from consumer advocacy groups, health care providers, employers, health insurers, health care associations, and individuals. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding proposed changes. In this section, we summarize the provisions of the proposed rule and discuss and provide responses to the comments (with the exception of comments on the paperwork burden or the economic impact analysis, which we discuss in those sections of this final rule). We have carefully considered these comments in finalizing this rule.

Comment: We received a number of comments requesting that the comment period be extended to 60 days.

Response: HHS provided a 30-day comment period, which is consistent with the Administrative Procedure Act. We note that HHS previously sought and received significant comment on the Risk Adjustment White Paper, the Risk Adjustment Bulletin, presentations made during the Risk Adjustment Spring Meeting, the Reinsurance Bulletin, the AV/CSR Bulletin, and the Premium Stabilization Rule, which outlined the

policy proposed in the proposed rule. HHS believes that interested stakeholders had adequate opportunity to provide comment on the policies established in this final rule.

Comment: One commenter requested that HHS issue a separate final rule containing provisions for each part of the Code of Federal Regulations.

Response: As noted in the Premium Stabilization Rule, the proposed rule, and this final rule, many of the programs covered by this rule are closely linked. To simplify the regulatory process, facilitate public comment, and provide the information needed to meet statutory deadlines, we elected to propose and finalize these regulatory provisions in one rule.

Comment: We received several comments pertaining to the proposed EHB/AV Rule and the proposed Market Reform Rule.

Response: Those comments are addressed in the final EHB/AV Rule and the final Market Reform Rule.

Comment: One commenter suggested that the standards set forth by HHS pertaining to the HHS-operated risk adjustment or reinsurance programs be the minimum requirements for State-operated risk adjustment or reinsurance programs.

Response: HHS aims to provide States with flexibility in implementing these programs while ensuring that the goals of the premium stabilizations programs are being met. Many of the provisions applicable to the risk adjustment and reinsurance programs when operated by a State are also applicable to these programs when operated by HHS on behalf of a State.

Comment: Several commenters asked that HHS monitor and oversee the implementation of the premium stabilization programs.

Response: HHS takes seriously its responsibility to monitor the implementation of these programs to protect consumers, prevent fraud and abuse, and ensure the

programs achieve their goals. We will provide further detail on the oversight of these programs in future rulemaking and guidance.

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

In §153.100(c), we proposed 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 for 2014, whichever is later. Because the effective date of this rule will be 60 days after its publication, we will not finalize the proposed change to §153.100(c). Nevertheless, consistent with our proposal, we are finalizing our policy that, for 2014 only, a State must publish a State notice of benefit and payment parameters by the 30th day following publication of this final rule by deeming the March 1 deadline specified in the existing regulation to be extended until the date that is 30 days after publication of this final rule.

Comment: A number of commenters supported the proposed deadline extension for benefit year 2014, while others opposed such an extension. Some suggested that HHS not allow States to operate risk adjustment or reinsurance.

Response: We believe that States should have the flexibility to operate risk adjustment and reinsurance. Because of the publication date of this final rule, it is clear that a State will not have the notice necessary to publish a State notice of benefit and payment parameters by the deadline specified in the regulation – that is, March 1, 2013 for the 2014 benefit year. Thus, as described above, although we are not finalizing our proposal to amend the regulation, we are setting the deadline for 2014 only as the 30th day after publication of this final rule.

B. Provisions and Parameters for the Permanent Risk Adjustment Program

The risk adjustment program is a permanent program created by Section 1343 of

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. Section 1343 of the Affordable Care Act requires each State to operate a risk adjustment program. In States that have elected not to operate their own risk adjustment program, HHS will operate a program on their behalf. Our authority to operate risk adjustment on the State's behalf arises from sections 1321(c)(1) and 1343 of the Affordable Care Act. Based on HHS's communications with States, as of February 25, 2013, Massachusetts is the only State electing to operate a risk adjustment program for the 2014 benefit year.

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 the proposed rule, we proposed 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). In section III.B.2. of the proposed rule, we proposed a small fee to support HHS operation of the risk adjustment program. In section III.B.3. of the proposed rule, we described the methodology that HHS would use when operating a risk adjustment program on behalf of a State. States operating a risk adjustment program can

use this methodology, or submit an alternate methodology, in a process we described in section III.B.4. of the proposed rule. Finally, in section III.B.5. of the proposed rule, we described the data validation process we proposed to use when operating a risk adjustment program on behalf of a State. (These provisions are discussed fully in the proposed rule at 77 FR at 73123-73149).

1. Approval of State-Operated Risk Adjustment

a. Risk Adjustment Approval Process

In the proposed rule, we proposed an approval process for States seeking to operate their own risk adjustment program. Specifically, we proposed a new paragraph (c) in §153.310, entitled "State responsibility for risk adjustment," which sets forth a State's responsibilities with regard to risk adjustment program operations. With this change, we also proposed to redesignate paragraphs (c) and (d) to paragraphs (e) and (f) of §153.310.

In paragraph §153.310(c)(1), we proposed 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 Federally certified risk adjustment methodology the State has chosen to use.

As proposed in §153.310(c)(1)(i), the entity must be operationally ready to implement 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 potential effects of adverse selection. To meet this standard, we proposed that a State demonstrate that the

risk adjustment entity: (1) have 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) have tested, or have 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. We proposed that States 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 proposed in paragraph §153.310(c)(1)(ii) that the entity have relevant experience to operate a risk adjustment program. To meet this standard, we proposed that a State demonstrate that the entity have on staff, or have 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 proposed 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, we proposed that the State ensure that the entity complies with the privacy and security standards set forth in §153.340.

We proposed 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 proposed to consider the State's plan to monitor the conduct of the entity.

Finally, we proposed 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).

Comment: Commenters generally agreed with our approach to approving State risk adjustment programs beginning in benefit year 2015.

Response: We are finalizing these provisions as proposed.

b. Risk Adjustment Approval Process for Benefit Year 2014

Because of the unique timing issues for approving a State-operated risk adjustment program, we proposed a transitional policy for benefit year 2014. We proposed not to require that a State-operated risk adjustment program receive approval for benefit year 2014. Instead, we proposed a transitional, consultative process that would commence shortly after the provisions of this final rule are effective. We are finalizing these provisions as proposed.

Comment: One commenter supported the transitional process but urged that the transitional process not be applied to future years. Another commenter requested that HHS require approval in 2014, but make the approval determination on the basis of the proposed consultative process. Other commenters suggested that HHS not allow States to conduct risk adjustment until the agency could formally approve States, beginning in 2015.

Response: We proposed the transitional policy based on the unique circumstances of 2014, and we do not anticipate extending it to future years. Although we are mindful of concerns that States may not be fully ready to operate a complex risk adjustment program for benefit year 2014, we note that each aspect of a State's operations (including data collection) must be performed in line with one of the Federally

certified risk adjustment methodologies published in this final rule. Finally, we note that any State that begins operation of risk adjustment under this transitional process must obtain formal certification for benefit year 2015. We believe this process is sufficiently robust to ensure any State operating risk adjustment in 2014 will be prepared to do so.

2. Risk Adjustment User Fees

In the proposed rule, we noted that, 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. Our authority to operate risk adjustment on the State's behalf arises from sections 1321(c)(1) and 1343 of the Affordable Care Act. In States where HHS is operating risk adjustment, we proposed that issuers of risk adjustment covered plans remit a user fee to fund HHS's operation of a Federally operated risk adjustment program. The authority to charge this user fee can be found under sections 1343, 1311(d)(5), and 1321(c)(1) of the statute, and under 31 U.S.C. 9701, which permits a Federal agency to establish a charge for a service provided by the agency. OMB Circular No. A-25R, which establishes Federal policy regarding user fees, specifies that a user charge will be assessed against each identifiable recipient of 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 OMB Circular No. A-25R to an issuer of a risk adjustment covered plan because it will mitigate the financial instability associated with adverse 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 further proposed to determine the total amount needed to fund HHS risk adjustment operations by examining the contract costs of operating the program,

including 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 (not including Federal personnel costs). We proposed to develop a per capita user fee rate by dividing the amount we intend to collect over the course of the benefit year by the expected annual enrollment in risk adjustment covered plans (other than plans not subject to market reforms and student health plans) for that benefit year. We also proposed a standardized schedule for assessment and collection of risk adjustment user fees. Although the user fees would be assessed on a per-enrollee-per-month basis to account for fluctuations in monthly enrollment, we proposed to collect them only once, in June of the year following the benefit year, in order to synchronize user fee collection with risk adjustment payments and charges.

Based on comments received, we are adding §153.610(f), finalizing our risk adjustment user fee assessment and collection approach as proposed. We clarify that enrollment data for each month will be captured by the servers used in the distributed data collection approach. We are also finalizing our intention to set a per capita user fee rate in the annual HHS notice of benefit and payment parameters using the proposed methodology. The user fee will be determined by dividing HHS's total contract costs for risk adjustment operations in the applicable benefit year by the expected annual enrollment in risk adjustment covered plans for that benefit year. Based on this methodology, for benefit year 2014, we are establishing a per capita annual user fee rate of $0.96, which we will apply as a per-enrollee-per-month risk adjusted user fee of $0.08.

Comment: One commenter expressed support for the proposal to collect user fees to fund HHS risk adjustment operations. Other commenters, though not commenting on risk adjustment user fees specifically, urged HHS to minimize or eliminate the fees it

collects from issuers in order to maintain affordable coverage in the post-2014 health insurance market.

Response: We believe that a reliable funding source is necessary to ensure a robust Federal risk adjustment program. We clarify that we are establishing the risk adjustment user fee for the sole purpose of funding HHS's costs for operating the Federal risk adjustment program, and we intend to keep the user fee amount as low as possible.

3. Overview of the risk adjustment methodology HHS will 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 in the proposed rule, 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 of the Premium Stabilization Rule, 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 to be transferred between plans. In the proposed rule, these two elements of the methodology were presented together as the payment transfer formula.

- The data collection approach describes the program's approach to obtaining data. HHS will do so using the distributed model described in section III.G. of this final rule.

- The schedule for the risk adjustment program describes the timeframe for risk adjustment operations.

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 are calculated from the payment transfer formula. 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 the proposed rule, the risk adjustment methodology developed by HHS:

- Was developed on commercial claims data for a population similar to the expected population to be risk adjusted;

- Uses the 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.

We are finalizing the methodology HHS will use when operating the risk adjustment program as proposed, with the following modifications: we have included individuals over 64 in the demographic factors; we have updated the cost-sharing reduction (CSR) adjustment factors for zero cost-sharing plan variations to align with the induced demand factors used in the CSR program; we have made technical corrections to the payment transfer formula; we have clarified that geographic cost factors will be calculated for each risk pool in each market in a State; and we have clarified how transfers will be calculated at the plan level.

Comment: We received many comments supporting HHS's general approach to the risk adjustment methodology we will use when operating risk adjustment on behalf of a State.

Response: We are finalizing the methodology as proposed with minor modifications.

Comment: We received one comment suggesting that current risk adjustment methodologies are inadequate because they do not fully account for the sickest patients with the most complex medical conditions. Another commenter suggested that HHS take an expanded view of risk mitigation by working to ensure a stable risk pool.

Response: The Affordable Care Act establishes a risk adjustment program, and permits the Secretary to base this program on the criteria and methods used in Medicare

Parts C and D. While we used criteria and methods from Medicare when appropriate, we also customized this methodology to best mitigate adverse selection based on our projections of the 2014 marketplace. Though we anticipate making future adjustments to the model, we seek to balance stakeholders' desire for a stable model in the initial years with introducing model improvements as additional data becomes available. We look forward to engaging with stakeholders throughout this process. We believe that this program, along with the other 2014 market reforms, will help ensure a stable risk pool.

Comment: We received one comment that HHS should provide issuers information to assess their risk scores and State average risk scores as part of the premium development process for 2014.

Response: As noted in the proposed rule, risk adjustment transfers depend not only on a plan's average risk score, but also on its cost factors compared to the average of these factors within a risk pool within a market within a State. HHS does not currently have the data necessary to calculate the State average risk score to provide to issuers in time for the development of 2014 premiums. HHS contemplates providing technical assistance to States and issuers who are interested in this information.

Comment: We received several comments that HHS should monitor the risk adjustment methodology's performance, with a particular focus on the newly insured population.

Response: We intend to monitor the methodology's performance to determine future adjustments to the model, as data become available.

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

In the Premium Stabilization Rule, we 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 proposed 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 other plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology." We noted 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 HHS notice of benefit and payment parameters, which is subject to notice and comment.

We described 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.

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 in the Market Reform Rule and the EHB/AV Rule. In addition, plans providing benefits through health insurance policies that begin in 2013, with renewal dates in 2014, would not be subject to these requirements until renewal in 2014. The statute 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 stated that 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 of part 156 (essential health benefits), and so are generally able to minimize actuarial risk by excluding certain conditions (for example, maternity coverage for women of child-bearing age) and denying coverage to those with certain high-risk conditions.

In the proposed rule, we proposed 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" for 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 of part 156 (essential health benefits package). We stated that because 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 proposed 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 noted that plans offering coverage through policies 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. In the proposed rule, we stated our belief that student health plans, because of their unique characteristics, will have relatively uniform actuarial risk. We proposed 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 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 proposed 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. We did not propose 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) of the Affordable Care Act 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 proposed to merge markets when operating risk adjustment on behalf of a State if the State elects to

do the same for single risk pool purposes. When the individual and small group markets are merged, we proposed that the State average premium described in section III.B.3.c would be the average premium of all applicable individual and small group market plans in the applicable risk pool, and normalization under the transfer equation 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 market within a State, 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. 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 proposed 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 are finalizing these provisions as proposed, with a clarification that risk adjustment covered plans in the small group market will be subject to risk adjustment in the State in which the employer's policy is filed and approved.

Comment: We received a number of comments that expressed support for our proposed approach to student health plans, plans not subject to market reform rules, and catastrophic plans. Several of these commenters urged HHS to align the single risk pool approach to student health plans with the proposed approach in risk adjustment. Some commenters expressed concern that separately risk adjusting catastrophic plans would prevent the enrollees in these plans from contributing to the general risk pool.

Response: Provisions related to the single risk pool provision were finalized in the Market Reform Rule, which was made available for public inspection at the Office of the **Federal Register** on February 22, 2013. Non-grandfathered student health insurance coverage is exempt from the single risk pool requirement.

As commenters noted, the risk adjustment program complements the single risk pool provision, which broadens the risk pool by including catastrophic claims experience in the development of the index rate. Because enrollment in catastrophic plans is limited to certain enrollees that are likely to have a different risk profile than enrollees in metal-level plans, we believe it is appropriate to risk adjust these plans in a separate risk pool. For this reason, we are finalizing the treatment of catastrophic plans, student health plans, and plans not subject to the market reform rules as proposed.

Comment: We received comments suggesting several different approaches to our proposal that risk adjustment covered plans be subject to risk adjustment in the State in which the enrollee's policy is filed and approved, including that we modify the requirement to mirror the MLR program's situs of contract requirement, and that we clarify that the employer, not the enrollee, is the policyholder in the small group market.

Response: We are modifying the proposed provision to clarify that risk adjustment covered plans in the small group will be subject to risk adjustment in the State in which the employer's policy is filed and approved.

b. Overview of the HHS Risk Adjustment Model

The proposed HHS risk adjustment models predict plan liability for an enrollee based on that person's age, sex, and diagnoses (risk factors), producing a risk score. We proposed separate models for adults, children, and infants to account for cost differences in each of these age groups. Each HHS risk adjustment model predicts individual-level risk scores, but is designed to predict average group costs to account for risk across plans.

This method accords with the Actuarial Standard Board's Actuarial Standard of Practice for risk classification.

We are finalizing the HHS risk adjustment models as proposed with the following modifications: we have fixed a typographical error to include individuals over 64 in the demographic factors, we have clarified the calculation of age for infants who were born in one benefit year and discharged in the following benefit year, and we have updated the CSR adjustment factors to align with the induced demand factors used in the CSR program.

Comment: We received a number of comments supporting HHS's general approach to establishing risk adjustment models.

Response: We are finalizing the models as proposed with minor modifications.

Comment: One commenter expressed concern that the number of HHS risk adjustment models proposed would create inaccuracies in the model.

Response: The statistical performance of each of the models is well within the published ranges for concurrent models. The HHS risk adjustment models better predict plan liability because they account for age-related clinical and cost differences and differing plan liabilities due to differences in actuarial value across metal levels.

(1) Data used to develop the HHS risk adjustment models

In the proposed rule, we described the data used to develop (that is, calibrate) the HHS risk adjustment models. We proposed that the HHS risk adjustment models would be concurrent and not include prescription drug use as a predictor. Finally, we proposed 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 received the following comments about these approaches:

Comment: We received several comments in support of HHS's decision not to include prescription drug data as a predictor in the HHS risk adjustment models. A number of other commenters suggested that HHS include prescription drug data as a predictor in the HHS risk adjustment models to improve each model's predictive accuracy, or consider inclusion of this data as a predictor in the future.

Response: HHS is finalizing its proposal to exclude prescription drugs for the initial HHS risk adjustment models, but will consider how prescription drugs could be included in future HHS risk adjustment models.

Comment: We received a number of comments in support of the concurrent modeling approach, though a number of these comments suggested that we transition to a prospective model.

Response: In 2014, 2013 diagnostic data for individuals enrolled in risk adjustment covered plans will not be available. We also anticipate that enrollees may move between plans, or between programs. A concurrent model is 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. We are therefore finalizing our approach to use a concurrent model. We plan to investigate the feasibility of transitioning to a prospective approach in the future.

Comment: One commenter asked for further information about the standardized benefit designs used to estimate plan liability in the HHS risk adjustment models.

Response: Plan liabilities were defined by applying standardized benefit design parameters for each given metal level to total expenditures. The standard benefit designs were created using the Actuarial Value Calculator to ensure that each benefit design aligns with the applicable metal level. While an individual plan's design may differ from the standardized benefit, we believe the design is a reasonable approximation for the

average plan design at each metal level. The catastrophic plan design was estimated using the estimated maximum annual limitation on cost sharing described in section III.E. of this final rule.

Comment: We received several comments on HHS's approach to account for infant claims if there is no separate infant birth claim from which to gather diagnoses. Some commenters encouraged HHS to require separate claims for mothers and infants. Some commenters recommended that HHS separate these claims in operations. One commenter noted that in the State of Washington there are legal impediments to separating claims for mothers and infants in the first 21 days of life.

Response: HHS calibrated the HHS risk adjustment models by excluding infant claims that were bundled with the mothers, as well as infants without birth codes due to data limitations. In operation, issuers will separate infant and mother claims when possible. If an infant claim cannot be separated, HHS will assign the infant to the lowest severity category and the "term" maturity category. We note that HHS does not intend to unbundle claims in operation.

Comment: We received one comment that data used to calibrate the HHS risk adjustment models will not reflect the risk adjustment population beginning in 2014. Several commenters suggested that the calibration data set did not reflect benefits that issuers will offer beginning in 2014.

Response: We believe that the commercial data set used for calibration is a reasonable approximation of the population that will be risk adjusted in 2014. The calibration data set was restricted to individuals with prescription drug coverage, mental health coverage, and medical coverage, which are part of the essential health benefits package that issuers will offer starting in 2014.

(2) Principles of Risk Adjustment and the HCC Classification System

We proposed to use a diagnostic 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 HCC classification system for the Medicare risk adjustment model also guided the creation of the HHS risk adjustment models that we proposed to use when HHS operates risk adjustment on behalf of a State. We selected 127 of the full classification of 264 HHS HCCs for inclusion in the HHS risk adjustment models.

Comment: We received several comments in support of the HHS HCC classification system.

Response: We are finalizing the HHS HCC classification system as proposed.

Comment: Several commenters requested that HHS provide the ICD-9 codes included in each HHS HCC.

Response: We have provided this information for the proposed HHS risk adjustment models on our website at: http://cciio.cms.gov/resources/files/ra_instructions_proposed_1_2013.pdf and http://cciio.cms.gov/resources/files/ra_tables_proposed_1_2013.xlsx. We intend to provide a final version of these documents to reflect the HHS risk adjustment models in the future.

Comment: Several commenters requested the classification of ICD-10 codes to HHS HCCs.

Response: We are completing the mapping of ICD-10 codes to HHS HCCs and will release this information in future guidance.

Comment: Several commenters suggested that additional HHS HCCs should be included in the HHS risk adjustment models.

Response: In selecting the factors to be included in the HHS risk adjustment models, 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;
- Whether the HCCs represent poor quality of care; and
- Whether the HCC is applicable to the model age group.

We also included a factor to measure increased utilization due to receipt of CSRs. Each model's R-squared and predictive ratios were within published ranges for concurrent models. Thus, we have not included additional HCCs at this time.

Comment: We received a comment in support of our approach to HHS HCC selection.

Response: We are finalizing the HHS HCCs included in the HHS risk adjustment models as proposed.

(3) Factors included in the HHS risk adjustment models

The proposed HHS risk adjustment models predict annualized plan liability expenditures using age and sex categories, HHS HCCs, and, where applicable, disease interactions. Dollar coefficients were estimated for these factors 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 coefficients divided by a weighted average plan liability for the full modeling sample. Due to the inherent clinical and cost differences in the adult (age 21+), child (age 2-20), and infant (age 0-1) populations, HHS proposed separate risk adjustment models for each age group.

Comment: We received a few comments suggesting the weights of specific factors in the HHS risk adjustment models were lower than expected.

Response: The HHS risk adjustment models predict annualized plan liability. The factors were estimated using weighted least squares regression. For each risk adjustment model, the factors were the statistical regression dollar values for each factor in the model divided by a weighted average plan liability for the full modeling sample. Some factors were grouped or constrained and thus do not exactly represent the statistical regression dollar value. Some factors were grouped or constrained to reduce model complexity, avoid inclusion of HHS HCCs with small sample size, limit upcoding by severity within an HCC hierarchy, reduce additivity within a disease group, and avoid coefficient values in which a lower-ranked HCC in a disease hierarchy had higher coefficient than a higher-ranked HCC.

Comment: A few commenters requested that age be calculated at the time of enrollment. Several commenters asked that age for newborns be defined as date of birth rather than the age as of the last day of enrollment in a risk adjustment covered plan. Another commenter requested that HHS clarify that age determinations be consistent between model calibration and program operation.

Response: The HHS risk adjustment models were calibrated using age as of the last month of enrollment due to data limitations. To align with model calibration, an enrollee's age for risk score calculation will be the age as of the enrollee's last day of enrollment in a risk adjustment covered plan in the applicable benefit year will be used

for enrollees in program operation. We are clarifying our approach to calculating the age of infants who are born in a benefit year but are not discharged until the following year. In such a case, the infant will be defined as age 0 for both benefit years. For example, if an infant is born in December of 2014 but has a discharge date of January 2015, the infant would be assigned age 0 for purposes of risk score calculation in benefit year 2014 and for the entire 2015 benefit year.

Comment: We received comments supporting the inclusion of a demographic factor to account for individuals aged 65 or older. We also received comments requesting that the HHS risk adjustment models include additional factors such as income, receipt of care from an essential community provider, and enrollee language.

Response: In response to comments, we made a typographical correction to re-label the highest adult age factor as 60+. Because data for individuals 65 or older is not captured in the calibration dataset, the estimation of a separate demographic factor for those 65 or older is impractical at this time. Other factors such as income are also not feasible to include due to data limitations. Therefore, we have not modified the HHS risk adjustment models to include such factors. Tables 2, 4, and 5 contain the final factors for the HHS risk adjustment models.

Comment: We received several comments that the HHS risk adjustment models do not appropriately account for short-term enrollment. One commenter suggested that risk scores for individuals that were enrolled for only part of a year would be inaccurate.

Response: Our models were calibrated to account for short-term enrollment in several ways. First, enrollee diagnoses were included from the time of enrollment. Also, in the statistical estimation strategy for the HHS HCCs, average monthly expenditures were defined as the enrollee's expenditures for the enrollment period divided by the number of enrollment months, annualized expenditures (plan liability) were defined as

average monthly expenditures multiplied by 12, and regressions were weighted by months of enrollment divided by 12. We believe that this statistical strategy, alongside the minimum enrollment requirement, ensures that monthly expenditures are correctly estimated for all individuals.

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

We proposed to include an adjustment for the receipt of CSRs in the HHS risk adjustment models, but not to adjust for receipt of reinsurance payments.

Comment: We received comments that were generally supportive of the CSR adjustment to risk scores. One commenter stated that the proposed factors do not adequately account for changes in utilization as enrollees in cost-sharing plan variations may also use more high cost services. Another commenter requested that HHS clarify whether plan liability for increased utilization due to CSR is accounted for by the CSR adjustment factor in the HHS risk adjustment models.

Response: We are finalizing the CSR adjustment factor as proposed, with the modification to the typographical error described in Table 1 below. The CSR adjustment factor for the HHS risk adjustment models is intended to account for the increased plan liability due to increased utilization of health care services by enrollees receiving CSRs.

Comment: We received several comments that noted a typographical error in the zero cost-sharing adjustments.

Response: We have revised the CSR adjustment to align with the CSR adjustment in section III.E. for enrollees in zero cost-sharing plan variations. Table 1 contains the final CSR adjustment factors.

Comment: Several commenters supported our proposal to not adjust the HHS risk adjustment models for reinsurance payments.

Response: We are finalizing our proposal to not adjust the HHS risk adjustment models for reinsurance payments since reinsurance is a temporary program and already offsets adverse selection.

TABLE 1: Cost-Sharing Reduction Adjustment

Household Income	Plan AV	Induced Utilization Factor
Silver Plan Variant Recipients		
100-150 percent of FPL	Plan Variation 94 percent	1.12
150-200 percent of FPL	Plan Variation 87 percent	1.12
200-250 percent of FPL	Plan Variation 73 percent	1.00
>250 percent of FPL	Standard Plan 70 percent	1.00
Zero Cost-Sharing Recipients		
<300 percent of FPL	Platinum (90 percent)	1.00
<300 percent of FPL	Gold (80 percent)	1.07
<300 percent of FPL	Silver (70 percent)	1.12
<300 percent of FPL	Bronze (60 percent)	1.15
>300 percent of FPL	Limited Cost-Sharing Recipients	1.00

(5) Model performance statistics

To evaluate model performance, we examined the R-squared and predictive ratios of the HHS risk adjustment models.

Comment: Several commenters asked for further details on the statistical performance of the HHS risk adjustment models.

Response: HHS analyzed the statistical performance of each model (adult, child, infant at each metal level). The R-squared (the percentage of individual variation explained by the model) for each model was within the range of published estimates for concurrent models.[9] These values can be found in Table 8. Additionally, the predictive ratios for the overall samples for each of the 15 models were also within the range of published estimates.

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

(6) Summary of models

For clarity, we describe here the HHS risk adjustment models that we are finalizing. An individual's risk score will be calculated for adults and children as the sum of the factors in the applicable model for the relevant age and sex categories, HHS HCCs, and, where applicable, disease interactions. These factors are listed below in Tables 2 and 4. In the adult models, an individual with at least one of the HCCs that comprises the severe illness indicator variable and at least one of the HCCs interacted with the severe 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. The HCCs that comprise the severe illness indicator variable can be found in Table 3. The CSR adjustment factors listed in Table 1 are multiplied by the sum of the applicable demographic, HHS HCCs, and disease interaction factors.

The infant model utilizes a mutually exclusive group 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. As discussed previously, infants who are born in a benefit year but are not discharged until the following year will be defined as age 0 for both benefit years. 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). The male-age factor would be added to the maturity-severity category to which the infant is assigned, and the sum of the factors would be multiplied by the CSR adjustment factor. The maturity-severity factors and the HCCs that comprise these factors can be found in Tables 5-7.

TABLE 2: 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+, 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+, 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	7.277	7.140	7.083	7.117	7.129

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Meningitis					
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/Complicatio ns	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

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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	7.878	7.622	7.508	7.545	7.559

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Fasciitis					
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	3.080	2.959	2.899	2.880	2.872

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Hematological Disorders					
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	3.379	3.094	2.967	2.927	2.919

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
and Other Anterior Horn Cell Disease					
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/Tracheostomy 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	33.372	33.025	32.877	32.978	33.014

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Device/Artificial Heart					
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/Inflammation, 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	1.098	0.978	0.904	0.810	0.780

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Pulmonary Disease, Including Bronchiectasis					
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	9.788	9.570	9.480	9.521	9.536

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Vertebral or Humerus Fractures					
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	12.094	12.327	12.427	12.527	12.555

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Neuropathy					
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

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
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 3: HHS HCCs in the Severe 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 4: 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

Factor	Platinum	Gold	Silver	Bronze	Catastrophic
Age 15-20, Female	0.379	0.304	0.198	0.101	0.077
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[10]	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

[10] 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 5: 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
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 6: 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 7: 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 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 Category	HCC
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 Level 3	Benign/Uncertain Brain Tumors, and Other Cancers and Tumors11
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

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

Severity Category	HCC
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
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 Category	HCC
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

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

In the proposed rule, we proposed to calculate risk adjustment transfers after the close of the applicable benefit year, following the completion of issuer risk adjustment data reporting.

Transfers are calculated at the geographic rating area level for each plan (HHS would calculate two separate transfer amounts for a plan that operates in two rating areas). In other words, the payment transfer formula would treat each rating area segment of enrollment as a separate plan for the purposes of calculating transfers. 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.

The payment transfer formula 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 are based on the State average premium. 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 (AV): a particular plan's premium may differ from the State average premium based on the plan's cost-sharing structure, or AV. 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.

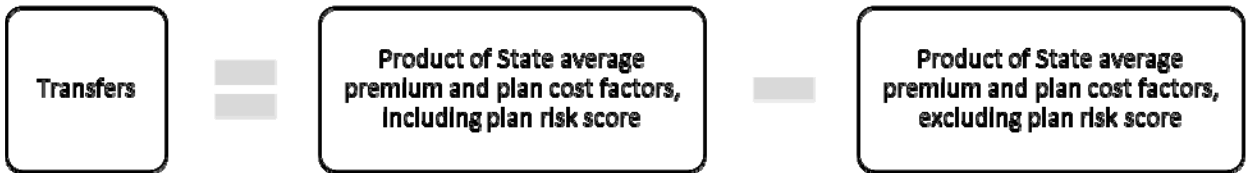
- Geographic cost differences: differences in unit costs and utilization may lead to differences in the average premium between intra-State rating areas, holding other cost factors (for example, benefit design) constant. The geographic cost adjustment accounts for cost differences across rating areas.

- 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:



We are finalizing the payment transfer formula as proposed, with several technical corrections. We clarify that IDF stands for induced demand factor in the equations, and modify the denominator of the plan average premium formula within the State average premium and geographic cost factor calculations to reflect the billable member calculation. Therefore, the 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= plan *i*'s 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.

Risk adjustment transfers will be 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, depending on how the State treats these pools under the single risk pool provisions.

The payment transfer formula provides a per member per month (PMPM) transfer amount for a plan within a rating area. The PMPM transfer amount derived from the

payment transfer formula (T_{FMPM}) will be multiplied by each plan's rating area billable member months ($\sum_b M_b$) to calculate the plan's total risk adjustment payment for a given rating area (T_i).

$$T_i = T_{FMPM} * \sum_b M_b$$

Comment: We received a number of comments in support of the general approach to calculating payment transfers, including HHS's approach to adjusting for plan cost factors in the transfer equation.

Response: We are finalizing the payment transfer formula as proposed with minor technical corrections, specified below.

Comment: We received one comment requesting that HHS clarify the calculation of payment transfers at the plan level.

Response: Because we have proposed and are finalizing a geographic cost factor, transfers must be calculated for each rating area in which a plan operates. However, we note that, because the denominator of each term of the payment transfer equation is the Statewide average of the product of the terms, transfers occur within the risk pool within the market within the State.

Comment: We received one comment requesting that HHS provide detailed examples of the payment transfer formula.

Response: We anticipate working closely with issuers and other stakeholders to provide examples of the payment transfer formula and its application in a market.

(1) State Average Premium

We proposed a payment transfer formula that is based on the State average premium for the applicable market. Plan average premiums will be calculated from the actual premiums charged to their enrollees, weighted by the number of months enrolled.

We make a technical correction to the formula to calculate PMPM plan average premiums, as described below. The equations for calculating State average premiums were proposed as:

$$\overline{P_s} = \sum_t s_t^s \overline{P_t}$$

and

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

The first equation calculates the State average premium $\overline{P_s}$ as the average of individual plan averages, $\overline{P_t}$ weighted by each plan's share of Statewide enrollment in the risk pool in the market, s_t^s (based on billable member months).

The second equation shows the proposed formula to calculate plan average premiums. The proposed formula, which we are modifying as described below, was the weighted mean over all subscribers *s* of subscriber premiums P_s, with M_s representing the number of billable member months of enrollment for each subscriber *s*. Due to a typographical error and to align with the calculation of plan average risk score, we have modified the denominator of the plan average premium equation from the proposed rule. The denominator in the revised formula is equal to the sum of the billable member months for all billable members *b* enrolled in the plan. The numerator of this formula remains unchanged from the proposed rule. The numerator is equal to the product of each subscriber's billable member months (the billable member months attributed to the individual that is the policy subscriber) and the average monthly premium for the subscriber, summed across all of the subscribers *s* in the plan. The calculation of each plan's total premium revenue – the numerator of this formula – uses subscriber-level premiums in order to align with the way that premium information will be captured in

data on issuers' distributed data environments. The final formula is:

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

Billable member months are defined as the number of months during the risk adjustment period billable members are enrolled in the plan (billable members exclude children who do not count towards family rates). In non-community rated States, issuers are required to individually rate each member covered under a family policy and, in the case of large families, issuers are only allowed to include the three oldest children in the development of family rates. Therefore, for large families, only the three oldest children are counted as billable members in the risk adjustment transfer formula. In community rated States that require family tiering, the number of billable members under a family policy may vary based on the State's tiering structure. For example, if a State's largest family tier is set at two or more children, only the first two children under the family policy would count as billable members. HHS will assess each State's rating requirements and will provide community rated States with additional details on how billable members will be counted in the transfer formula.

Comment: We received a number of comments in support of our proposal to use the State average premium as the basis for risk adjustment transfers. One commenter suggested that use of a plan's own premium may cause unintended distortions in the transfer formula. One commenter suggested that we use net claims, or approximate net claims by using 90 percent of the State average premium, as the basis for risk adjustment transfers.

Response: The goal of the payment transfer formula is, to the extent possible, to promote risk-neutral premiums. We agree with commenters that use of a plan's own premium may cause unintended distortions in transfers. We also believe that both claims

and administrative costs include elements of risk selection, and therefore, that transfers should be based on the entire premium. We are finalizing our proposal to base the payment transfer formula on the State average premium.

(2) Plan Average Risk Score

The proposed plan average risk score calculation included an adjustment to account for the family rating rules set forth in the Market Reform Rule, which limits the number of dependent children in non-community rated States that count toward the build-up of family rates to three. The formula below shows the final 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 is enrolled in the plan; and

M_b is the number of months during the risk adjustment period the billable member b is enrolled in the plan (billable members exclude children who do not count towards family rates).

We received the following comments regarding the calculation of the plan average risk score:

Comment: We received comments in support of this approach to calculating plan average risk score. We received one comment that calculating plan average risk score

with an adjustment for billable members would be administratively burdensome for issuers.

Response: We are finalizing this term as proposed. We note that, when HHS is operating risk adjustment on behalf of the State, HHS will calculate the plan average risk score and so there will be no additional administrative burden for issuers.

(3) Actuarial Value (AV)

The proposed AV adjustment in the payment transfer formula accounts for relative differences in plan liability due to differences in AV. Table 9 shows the AV adjustment that will be used for each category of metal level plans. We received no comments on this adjustment, and are finalizing this provision as proposed.

TABLE 9: Actuarial Value (AV) 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

(4) Allowable rating variation

We proposed an allowable rating factor adjustment in the payment transfer formula. The Allowable Rating Factor (ARF) adjustment accounts only for age rating. Tobacco use, wellness discounts, and family rating requirements will not be included in the payment transfer formula. Geographic cost variation is treated as a separate adjustment in the payment transfer formula. We recognize that there may be special rating circumstances in States (for example, community rating) and we intend to clarify how the payment transfer formula will address these circumstances through future

rulemaking or guidance. We received comments in support of the allowable rating variation adjustment, and are finalizing this provision as proposed.

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 percent	40.00 percent	10.00 percent	31.70 percent
(Age bands from 22-39 omitted)					
40	1.278	33.30 percent	40.00 percent	20.00 percent	33.30 percent
(Age bands from 41-63 omitted)					
64 and older	3.000	33.30 percent	20.00 percent	70.00 percent	35.00 percent
Total member-months		300,000	200,000	100,000	600,000
Allowable Rating Factor		1.758	1.511	2.456	1.793

(5) Induced demand

We proposed to use the same induced demand factors in the payment transfer formula, shown in Table 11. We received the following comments regarding the induced demand proposed provisions:

Comment: We received comments that, due to a typographical error, the definition of the induced demand factor expressed in the full payment transfer formula in the proposed rule was "plan i's allowable rating factor" rather than "plan i's induced demand factor."

Response: We have made this change in the equation above.

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
Platinum	1.15

(6) Geographic Area Cost Variation

The proposed geographic cost factor (GCF) is 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. GCFs will be calculated for each rating area established by the State under §147.102(b). These factors will be calculated based on the observed average silver plan premium for the metal-level risk pool (calculated separately for individual and small group if the State does not have a merged market) or catastrophic plan premium for the catastrophic risk pool, in a geographic area relative to the Statewide average silver or catastrophic plan premium. Calculation of the GCF involves three steps. First, the average premium is computed for each silver or catastrophic plan, as applicable, in each rating area (using the same formula that is used to compute plan premiums in the State average premium calculation discussed above). We note that the same modification described above regarding the calculation of the plan average premium also applies to this term. The proposed calculation was:

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

Where:

$\overline{P_i}$, 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;* and

P_s is the premium for subscriber *s.*

The final calculation is:

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

Where:

$\overline{P_i}$, 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 the subscriber *s;*

P_s is the premium for subscriber *s;* and

M_b is the number of billable members *b* enrolled in the plan.

The second step is 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 (calculated at the rating area level), the enrollment-weighted rating factor applied to all billable members (discussed above). This formula is:

$$\overline{P_i}^{AS} = \overline{P_i}/(ARF_i)$$

Where:

$\overline{P_i}^{AS}$ is plan *i*'s age standardized average premium;

$\overline{P_i}$, is the average premium for plan *i*; and

ARF_i is the allowable rating factor.

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

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

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

With the exception of the plan average risk score calculation discussed above, all of the other calculations used in the 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.

Comment: We received one comment requesting that HHS include a geographic cost adjustment even if the State elected to use one rating area. Another commenter suggested that HHS include an adjustment in the risk adjustment methodology that accounts for the increased cost of providing care in rural areas.

Response: The purpose of the geographic cost adjustment is to remove differences in premium due to allowable geographic rating variation. We believe that the cost of care in a particular area are reflected in premiums, and therefore captured in the geographic cost factor adjustment. Issuers of plans in a State with a single rating area would not vary rates within the State based on geography, and so it would not be necessary to remove differences in premiums due to allowed rating variation based on geography.

d. Overview of the data collection approach

In §153.20, we proposed a technical correction to the definition of risk adjustment data collection approach. We proposed 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." We received no comments on the proposed technical correction to the definition of data collection

approach, and are finalizing the provision as proposed. Comments regarding the data collection approach for the risk adjustment program are addressed in section III.G. of this final rule.

We also proposed 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)." "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).[12] 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. We received no comments on the proposed modification and are finalizing the provision as proposed.

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 final rule, for benefit year 2014 beginning January 1, 2014. Enrollee risk scores will be calculated based on enrollee enrollment periods and claims dates of discharge 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.

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

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 run-out 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). Comments in response to the proposed §153.730 are addressed in section III.G of this final rule.

Comment: We received a number of comments that HHS should provide issuers with interim reports of risk scores and other information.

Response: We are committed to implementing the risk adjustment program in a transparent way, and seek to provide issuers with the information necessary for program operations and rate development. We are assessing the feasibility of providing program information prior to the close of the benefit year.

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. We proposed to 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. We did not receive any comments on this proposed change, and will finalize it as proposed.

b. State Alternate Risk Adjustment Methodology Evaluation Criteria

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. We proposed to evaluate risk adjustment methodologies based on the information submitted under §153.330(a). We proposed additional evaluation criteria to certify alternate risk adjustment methodologies in a new paragraph §153.330(b).

In the new §153.330(b)(1), we proposed 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 stated that we would 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 population, 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.

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 issuers, 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 proposed 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 would do so as well.

Under the proposed HHS risk adjustment methodology, we will apply risk adjustment to catastrophic plans in their own risk pool – that is, we will 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 will not 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 proposed 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.

Comment: A commenter requested further clarity on §153.330(a)(2)(iii), which requires that a State's request to operate an alternate methodology must include an assessment of the extent to which the methodology encourages favorable behavior among providers and discourages unfavorable behavior.

Response: We provided examples of favorable and unfavorable behavior in the proposed rule, at 77 FR at 73146. There, we stated that we would consider whether the alternate methodology discriminates against vulnerable populations, as evidenced by unjustified differential treatment on the basis of features like age, disability, or expected length of life. We also stated that alternate methodologies should take into account the health care needs of diverse segments of the risk adjustment population, including but not limited to women, children, people with disabilities, and other vulnerable groups. We will provide further guidance on these criteria in connection with our evaluation of particular proposed State alternate methodologies.

Comment: A commenter requested that HHS delete the reference to "stakeholders" in the criterion that an alternate methodology be easy to understand and replace it with the term "carriers."

Response: Risk adjustment affects the overall stability of State insurance markets, with potential impacts on many individuals and entities, including State governments and enrollees. Therefore, we believe the methodology should be reasonably

comprehensible to all enrollees and entities, or "stakeholders." We will maintain our use of "stakeholders" rather than "carriers" because we believe that all affected individuals should be reasonably able to understand the methodology.

Comment: A commenter requested that HHS approve alternate methodologies independent of a State's factor weights.

Response: An alternate methodology's factor weights may influence the risk adjustment methodology's ability to meet the evaluation criteria. The factor weights, therefore, will be included in the evaluation process.

Comment: A commenter generally supported our alternate methodology certification process, but recommended that we additionally require that a State's proposed alternate methodology must perform similarly to or better than the HHS methodology in that State.

Response: We believe it would be difficult to assess whether a State's methodology performs "better" than the HHS methodology in light of the various policy goals that different States may have in mind. We believe that States understand their markets well, and that the proposed set of criteria is sufficiently detailed to achieve a high quality risk adjustment methodology. Therefore, we are finalizing these criteria as proposed.

Comment: A commenter recommended that State alternate methodology applications be made available to the public.

Response: HHS is committed to transparency in its process of evaluating and certifying State alternate methodologies. We will publish approved State alternate methodologies in the annual HHS notice of benefit and payment parameters. Because we require that States publish their alternate methodologies in the State notice of benefit and

payment parameters, we believe that this publication is sufficient for public access to the methodology itself and other supporting information.

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. In the proposed rule, we expanded on this approach by designating areas of State flexibility within the general approach to payment transfers. We received no comments on the national method for calculating payments and charges or the State flexibility within this method. We are finalizing this approach as proposed.

5. Risk Adjustment Data Validation

We proposed to add a new subsection, §153.630, which set forth risk adjustment data validation standards applicable to all issuers of risk adjustment covered plans when HHS is operating risk adjustment. We proposed that, beginning in 2014, HHS will 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 noted that States are not required to adopt this HHS data validation methodology. We are finalizing these provisions as proposed.

Comment: We received a comment asking that the cost of the audits associated with data validation be paid for by the Federal government.

Response: At this time, it is the policy of HHS that costs related to the second validation audit process be borne by the Federal government, while costs associated with initial validation audit process be borne by the applicable issuer. We note that a State may choose to allocate the costs of data validation differently when operating its own risk adjustment program.

Comment: We received a comment requesting that data validation requirements be expressed in §153.710(c), relating to data collection standards.

Response: We are finalizing the data validation requirements in §153.630. We believe that the data validation requirements should remain independent of the data collection standards because the data validation requirements are specific to the HHS-operated risk adjustment program and the data collection standards apply to both the risk adjustment and reinsurance programs when operated by HHS.

Comment: We received a comment expressing concern that the data validation process as described will extend beyond a year, potentially affecting payment transfers.

Response: We appreciate the concerns of the commenter. We intend to complete the data validation process within one year, in time for payment adjustments to be made the following benefit year.

Comment: We received a comment asking that States operating risk adjustment programs be required to follow uniform Federal data validation standards, particularly during the first few years of the program.

Response: The risk adjustment program is intended to be a State-based program. We believe that a State operating its own risk adjustment program should have the flexibility to implement a data validation program that best complements its program design, including the State's data collection approach and desired level of audit complexity. We note, however, that States and issuers still must abide by the standards for developing a data validation program as described in the Premium Stabilization Rule.

Comment: We received a comment requesting clarification on how issuers that leave a market during the year will affect the Statewide data validation process.

Response: We will provide further detail on this and other data validation issues in future rulemaking and guidance.

a. Data Validation Process When HHS Operates Risk Adjustment

(1) Sample Selection

In §153.630 of the proposed rule, we discussed some of the guidelines for selecting a statistically valid sample for data validation. We proposed that HHS would choose an adequate sample size of enrollees such that the estimated payment errors would be statistically sound and enrollee-level risk score distributions would reflect enrollee characteristics for each issuer. Additionally, the sample would cover applicable subpopulations for each issuer, such as enrollees with and without risk adjustment diagnoses.

Comment: We received a comment asking for additional information on the statistical validity of the expected sample size of 300, including the confidence interval and expected error rate tolerance. We also received numerous comments requesting the opportunity to comment on a proposed statistical selection methodology in future guidance.

Response: We anticipate providing more detailed information on the HHS sampling methodology in future rulemaking and guidance, including sample sizes and expected tolerances and confidence intervals.

Comment: We received a comment expressing support for the inclusion of enrollees both with and without risk adjustment diagnoses in the sample. The commenter also suggested that HHS conduct more comprehensive audits for members without any risk adjustment diagnoses, including full medical record review during the second validation audit.

Response: Individuals without risk adjustment diagnoses will be subject to audits of their demographic information as well as medical record reviews during both the initial and second validation audits to determine whether any risk adjustment HCCs

should have been assigned that were not. We anticipate revisiting this policy after the first year of the program to assess the utility of performing medical record reviews on enrollees with no HCCs. Over time, we anticipate that issuers will utilize the front-end HHS-operated data submission processes to ensure they are providing all relevant risk adjustment diagnosis for enrollees as opposed to relying on back-end audit processes to reveal this information.

(2) Initial Validation Audit

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

We also proposed that issuers conduct data validation in accordance with audit standards established by HHS. We described three methods for establishing these audit standards, and requested comment on these approaches.

Comment: We received multiple comments suggesting that auditors conduct interim checks of issuer data during the plan year before the formal validation audit. We received a few comments proposing that auditors report the findings of the interim checks

to HHS so that issuers found to have outlier results could be subject to greater audit scrutiny.

Response: We believe that requiring auditors to perform multiple interim checks of issuer data throughout the plan year will be burdensome for issuers. However, an issuer may voluntarily have such checks performed if it believes them to be necessary for appropriate implementation of risk adjustment and compliance.

Comment: We received a comment asking that HHS specify in future guidance the common coding and documentation standards that issuers will be subject to, and provide issuers an opportunity to comment on the standards.

Response: We will clarify in future rulemaking and guidance the uniform audit standards that issuers and auditors will be subject to.

Comment: We received many comments supporting a certification requirement for auditor firms before acting as a validation auditor. A number of commenters supported the development of audit standards. One commenter supported HHS adopting both approaches.

Response: We considered prospectively certifying entities prior to acting as validation auditors. This approach is utilized before performing audits on organizations collecting and reporting performance measures through Health Effectiveness Data and Information Set (HEDIS). While this approach may ensure that entities performing validation audits are capable of conducting the audits in accordance with HHS standards, we believe at this time that issuers will be diligent in selecting audit entities capable of complying with HHS audit standards, and that adequate enforcement remedies exist should an audit entity fail to comply with the standards. We will monitor the performance of validation auditors to determine whether such certification or additional safeguards are necessary in the future.

(3) Second Validation Audit

In §153.630(c), we proposed that HHS retain an independent second validation auditor to verify the accuracy of the findings of the initial validation audit using a sub-sample of the initial validation audit sample enrollees for review. 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. We are finalizing these provisions as proposed.

Comment: We received a comment suggesting that HHS provide, for both the initial and secondary validation audits, a comparison of a plan's diagnosis reporting accuracy to the calibration data set for the risk adjustment models' diagnosis accuracy as reported through MarketScan®.

Response: We do not have access to the underlying medical records necessary to perform such an audit for the calibration data set. We will consider performing similar analyses in future years, as more data becomes available.

Comment: We received a comment seeking clarity on whether the error process would be based exclusively on the second validation audit, and whether the results of the second validation audit would be applied only to the subsample under §153.630(c).

Response: We anticipate applying any error rate determined by the second validation audit to the error rate calculated by the initial validation audit. This reconciled error rate will be extrapolated to an issuer's entire risk adjusted population, not just the subsample under §153.630(c). We intend to consult with stakeholders on the details of the methodology for error rate calculation to inform future rulemaking.

Comment: We received a comment asking HHS to permit issuers to submit additional information to the second validation auditor if the initial information provided to the initial validation auditor does not meet the proposed audit standards.

Response: We do not believe that it is appropriate or efficient to permit issuers to submit additional information to the second validation auditor in the event that the initial information provided does not meet the proposed audit standards. We believe that limiting the review of the second validation audit to only that information made available during the initial validation will help to ensure the entire validation process is completed in a timely manner and will provide incentives for making all relevant information available to the initial validation auditor.

(4) Error Estimation

In the preamble to the proposed rule, we stated that we would estimate risk score error rates based on the findings from the data validation process. HHS plans to conduct further analysis to determine the most effective methodology for adjusting plan risk scores for calculating risk adjustment payment transfers. We are finalizing these provisions as proposed.

Comment: We received a few comments regarding the error estimation process generally. One comment proposed a three-tiered approach to extrapolating error rates to overall plan payment. The commenter suggested that sufficiently low error rates within a certain range of model accuracy would receive no extrapolation to plan payment, while high outlier error rates would subject an issuer to an additional round of audits. All other plans would receive an extrapolation of the plan's error rate to its payment rate. Another commenter asked that HHS perform an outlier analysis on risk scores within a State. Another commenter suggested that HHS audit all issuers to determine a mean or expected error rate, then perform appropriate statistical tests to compare issuer error rates to this expected error rate, and then determine the impact on plan payments. We also received a comment requesting that HHS use a dollar adjustment instead of a percent adjustment to the risk score.

Response: Following additional engagement with stakeholders, we expect to provide further detail on our approach to error estimation and payment transfer adjustments in future rulemaking and guidance.

Comment: We received a comment requesting clarification on whether error adjustments apply if an issuer under-reports its risk scores.

Response: Consistent with the approach in Medicare Advantage, we intend to apply error adjustments if an issuer under-reports its risk scores. We will provide further detail on these adjustments in future rulemaking and guidance.

(5) Appeals

Pursuant to §153.350(d), HHS or a State operating risk adjustment must provide an administrative process to appeal data validation findings. We proposed 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 charges. We anticipate that appeals would be limited to instances in which the audit was not conducted in accordance with the second validation audit standards established by HHS.

Comment: We received a few comments expressing support that the appeals process be limited to the application of audit standards, and not the standards themselves.

Response: We are finalizing this provision as proposed.

(6) Payment Adjustments

We proposed that HHS would use a prospective approach when making payment adjustments based on findings from the data validation process. Specifically, 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 transfer year. Additionally, because the credibility of the system is important for the success of the program, we proposed in paragraph §153.630(e) that HHS may also 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).

Comment: We received a comment requesting further clarity on what impact a prospective approach to payment adjustments will have on plan pricing assumptions, and how actuarial soundness will be maintained if an issuer's risk profile changes substantially from year to year.

Response: We anticipate addressing these issues following stakeholder consultations prior to further rulemaking on data validation.

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

We proposed that issuers of risk adjustment covered plans adhere to the data validation process beginning with data for the 2014 benefit year. However, due to the complexity of the risk adjustment program and the data validation process, and the uncertainty in the market that will exist in 2014, 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 proposed that issuers conduct an initial validation audit and that we conduct a second validation audit for benefit years 2014 and 2015, but that we would not adjust payments and charges based on validation findings during these first two years of the program. Although we proposed not to adjust payments and charges based on error estimates discovered, we noted 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 requested 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.

We also requested comments on the possibility of conducting the second validation audits at the auditor level as opposed to the issuer level in future years. As we anticipate that a small number of audit firms will perform the majority of the initial audits, this 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.

Comment: A number of commenters supported not altering payments and charges based on 2014 and 2015 data validation results. Numerous other commenters requested that HHS apply error rates to payment transfers from the outset of the program, while another commenter supported a one-year observation period before effecting data validation payment transfers.

Response: While we appreciate the concerns of the commenters, we continue to believe that in light of the complexity of the data validation process, two years of observation experience will help HHS refine its data validation process by enabling us to gather sufficient data on issuer and auditor error, and will provide issuers and auditors enough time to adjust to the audit program. Although we are not adjusting payments and charges based on error rates, 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 when HHS operates risk adjustment on behalf of a State.

Comment: We received multiple comments supporting the publishing of a report on error rates discovered during the first two years of the data validation program. One commenter asked for additional clarification of the overall goal of the report, whether the report will identify issuers and providers, and if the report will disclose error rates attributable to providers.

Response: The intent of the report is to provide issuers and auditors information on the level of error in the commercial market under the HHS-operated risk adjustment program. Additionally, we may study the extent to which errors at the auditor level contribute to risk score error rate findings during the initial validation audits. We do not anticipate that the report will identify providers, but it may identify issuers. We do anticipate that the report will identify the error rates attributable to auditors.

Comment: We received one comment requesting further clarification on the timeframe in which issuers will be directed to provide sample data for a benefit year. The commenter also asked for further clarification on program integrity efforts if payment transfers are not altered by data validation audit results.

Response: We will issue further guidance and rulemaking on these matters.

c. Data Security and Transmission

In §153.630(f), we proposed data security and transmission requirements for issuers related to the HHS data validation process. In §153.630(f)(1), we proposed 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 proposed 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. We did not receive any comments on these provisions, and are finalizing them as proposed.

6. State-Submitted Alternate Risk Adjustment Methodology

HHS received an alternate risk adjustment methodology from one State, the Commonwealth of Massachusetts. We are certifying this methodology as a Federally certified methodology for use in Massachusetts. A summary of that methodology, as

prepared by the Commonwealth, is provided below. More detailed information about this methodology can be obtained from the Commonwealth of Massachusetts upon request. In addition, the Commonwealth of Massachusetts must publish a State notice of benefit and payment parameters, which will contain additional detail, within 30 days of the publication date of this final rule. Issuers and other interested parties should consult both of these sources. Additional questions may be addressed to Jean Yang, Executive Director of the Massachusetts Health Connector, at (617) 933-3059.

a. Policy Goals of the Massachusetts 2014 State Alternate Risk Adjustment Methodology

The Commonwealth of Massachusetts shares the same view as the Federal government with respect to the importance of the risk adjustment program and strives to achieve similar policy goals through the State-operated risk adjustment program powered by an alternate methodology. These specific goals include the following:

- The risk adjustment models should accurately explain variation in health care costs;
- The clinical classification used in the Commonwealth's alternate risk adjustment models should link risk factors to daily clinical practice and should be clinically meaningful to providers;
- The design of the clinical classification and the risk weights in the Commonwealth's alternate risk adjustment models should encourage favorable behavior from providers and health plans and discourage unfavorable behavior;
- The design of the Commonwealth's alternate risk adjustment methodology should reflect the Commonwealth's market characteristics, experience with risk adjustment, and be supportive of other health care reform initiatives in the Commonwealth;

- The Commonwealth's alternate risk adjustment methodology should use data that is complete, high quality and available in a timely fashion;
- The Commonwealth's alternate risk adjustment methodology should be easy for stakeholders to understand and implement;
- The methodology should account for risk selection across metal levels;
- The risk adjustment models and additional adjustment factors should provide stable risk scores over time and across plans;
- The operations of the Commonwealth's risk adjustment program should minimize administrative costs; and
- There should be reasonable alignment among different elements of the alternate methodology.

Starting from the same conceptual foundation as the proposed HHS risk adjustment methodology, the proposed Massachusetts alternate methodology is designed to address a number of Massachusetts-specific market characteristics and leverage existing data infrastructures to reduce the administrative burden for health plan issuers as well as for the Health Connector, which will be administering the program.

b. Conceptual Framework for Risk Adjustment Funds Transfer

Massachusetts's conceptual framework for calculating risk adjustment funds transfer is consistent with the proposed Federal risk adjustment methodology in that funds transfer is based on State average premium and should provide plans with payments to help cover excess actuarial risk due to risk selection; that is, risk exposure beyond the premiums issuers can charge reflecting allowable rating and their applicable cost factors.

Massachusetts proposes a single, merged risk adjustment pool for metal level

plans in the small group and non-group market to be consistent with Massachusetts's merged market rules. Consistent with the proposed HHS methodology, Massachusetts proposes to keep catastrophic plans in their own risk adjustment pool, separate from the rest of the merged market. Massachusetts believes this will help ensure the accuracy of the risk adjustment calculations as well as the affordability of the catastrophic plans because funds transfer will take place amongst the catastrophic plans only, instead of between the catastrophic plans and the metal level plans if all plans were merged in one risk adjustment pool. It should be noted that under the current regulations in Massachusetts, pricing of the catastrophic plans is subject to the same merged market rules as the small group and non-group plans. Keeping catastrophic plans in a separate risk adjustment pool does not segment the market from a pricing perspective because catastrophic plans are still subject to single risk pool requirements, and risk adjustment is retrospective and applies to all non-grandfathered small group and non-group health plans, including catastrophic plans.

Due to the lack of empirical data, Massachusetts is unable to calibrate a separate risk adjustment model for catastrophic plans. It proposes to use the bronze risk adjustment model and an actuarial value adjustment factor of 0.57 in the funds transfer calculation for catastrophic plans in the initial years, and revisit this approach in future recalibrations when empirical data is available. Massachusetts proposes to treat student health plans and plans that are not subject to the Affordable Care Act Market Reform Rules in the same manner as the Federal methodology.

c. Data Used to Develop Risk Adjustment Methodology

Massachusetts used data from three different sources to develop the risk adjustment models and additional adjustment factors in the Commonwealth's alternate risk adjustment methodology:

- **For the non-group and small group market, data from the Massachusetts All Payer Claims Database (APCD).** Calendar Year 2010, and 7/1/2011 to 6/30/2012 membership and claims data from the Massachusetts APCD. The Commonwealth obtained data extracts on non-group policy holders and small group members for group size up to 100 with ages 0 to 64 and eligible for medical and pharmacy coverage during the two observation periods. Collectively, Massachusetts thinks they are representative of a significant portion of the population that is subject to the risk adjustment program under the Affordable Care Act. About 700,000 unique individuals were included in the model development sample.

- **For enrollees under 300 percent FPL who are not eligible for Medicaid, data from the Commonwealth Care program.** Fiscal Years 2010 and 2011 Commonwealth Care program's membership and claims. More than 100,000 unique members with ages 0 to 64 from Commonwealth Care met the selection criteria and were included in the model development sample.

Commonwealth Care is a subsidized insurance program created as part of the 2006 Massachusetts health care reform law. It is administered by the Health Connector, and serves individuals with income up to 300 percent FPL who are not eligible for Medicaid and generally do not have access to employer-sponsored health insurance. As of December 2012, there are close to 198,000 members enrolled in the program. Massachusetts anticipates that, effective January 1, 2014, a portion of the current Commonwealth Care members will enroll in the expanded Medicaid program, and the remainder will access QHPs with tax credits

through the Exchange.

Most health plan issuers that participate in the current Commonwealth Care program are local Medicaid managed care organizations ("MMCOs") whose provider reimbursement level is typically lower than that of the commercial payers in Massachusetts for the same types of services. To normalize plan paid amount between the APCD data and the Commonwealth Care data, Massachusetts re-priced Commonwealth Care claims using unit prices derived from the APCD data. This was done using the Milliman Health Cost Guidelines® ("HCG") Grouper. The HCG categorizes claims into more than 80 types of services, allowing us to directly compare unit prices by service type between the Commonwealth Care claims and the APCD claims. There were service types with very few members in either dataset. To obtain robust unit cost estimates, Massachusetts consolidated them with other service types that are similar in nature.

- **For additional sample size for calibration purposes, Calendar Year 2010 Truven Health Analytics Marketscan® Commercial Claims and Encounters database for New England States.** Massachusetts selected members with ages 0 to 64 who were eligible for medical and pharmacy coverage in PPO or Comprehensive plan type, and re-sampled them to match the age/gender distribution of the APCD data. The primary reason for using the Marketscan® data was to obtain a larger sample size which allowed for calibrating more robust risk adjustment models and to strengthen the data quality of the overall model development sample. Massachusetts notes that data from Marketscan® mostly

represent large group experience. However, Massachusetts thinks that it is still a useful additional data source. More than 700,000 unique members were included from the Marketscan® New England States.

The consolidated claims data was then processed again through the Milliman Health Cost Guidelines® grouper system. The results from the grouper were compared to regional cost and utilization benchmarks and checked for reasonability. In this process, Massachusetts excluded some commercial payers in the APCD data, as well as certain claim lines in the Marketscan® data.

d. Risk Adjustment Models

(1) HCC Clinical Classification

Using claims from clinically valid sources (for example, laboratory, radiology, durable medical equipment, and transportation are not considered clinically valid), Massachusetts grouped diagnosis codes using the HCC classification system. Massachusetts referenced the HCC classification system in Pope et al. (2000), a Federally funded research study that laid the foundation for the CMS HCC risk adjustment payment system for Medicare Advantage.[13] The classification system in Pope et al. (2000) contains approximately 780 DxGroups which are then aggregated to more than 180 condition categories ("CC"s). Clinical hierarchies are then applied on the CCs to create HCCs. Because the HCC classification system was originally designed for the senior population, the designs of the condition categories may not be fully reflective of the characteristics of the commercial population. Through an iterative process using the model development sample, Massachusetts identified 20 DxGroups that were not very

[13] Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04summerpg119.pdf

well predicted under the original HCC grouping and promoted them into their own HCCs.

When determining acceptable types of claims for grouping the HCCs, Massachusetts modified the approach outlined by Pope et al. (2000) to ensure that risk adjustment does not create unintended consequences with respect to how care is accessed in the current Massachusetts market environment. For example, Massachusetts accepted diagnosis codes from visits/encounters with nurse practitioners and physician assistants, recognizing that in patient-center medical home and ACO care settings, nurse practitioners and physician assistants play active and important roles in preventive care and chronic care management. Massachusetts also accepted diagnosis codes in claims from skilled nursing facilities and ambulatory surgical centers if the claims were coded by a clinician.

In the process of revising the original HCCs to better reflect the characteristics of the commercial population, Massachusetts followed the same 10 principles for designing a risk adjustment classification system as discussed in the proposed Federal risk adjustment methodology.

Compared with the 127 HHS-defined HCCs used by the Federal methodology, Massachusetts's methodology includes 162 Massachusetts-defined HCCs.[14] Below, Massachusetts discusses the key considerations with regard to the Commonwealth's decision to apply a more expansive set of condition categories.

Risk adjustment is a premium redistribution process that equalizes actuarial risks amongst a State's health plan issuers and helps stabilize premiums under modified community rating and individual mandate. Conceptually, risk adjustment models should

[14] Massachusetts's list of HCCs is available in Table 16 of this alternate methodology, while HHS's list of HCCs is published elsewhere in this rule. Note that the two lists are numbered differently, and different ICD-9 codes are associated with different HCCs and DxGs.

be as accurate as possible while minimizing the potential for "gaming" and coding creep. A more accurate model typically requires a higher number of predictive factors, and in the case of the HCCs, more HCCs. However, having more HCCs may also open up more opportunities for coding creep and gaming of the system. Therefore, a careful balance must be achieved. Although Massachusetts acknowledges that its higher number of HCCs may create some added potential for gaming or coding creep, it believes this risk is minimal because it will use only certain claims types and certain provider types, will impose clinical hierarchies, and will exclude certain vague diagnoses and codes subject to discretionary coding. Further, Massachusetts and its issuers have experience with the necessary best practices of risk adjustment and intend to implement an effective data validation process.

The Affordable Care Act risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers. Health insurance issuers expect fair and adequate transfer of funds; that is, member risk profiles should be accurately stratified and correctly ranked.

The complete list of the condition categories included in the Massachusetts models is provided in Table 16. Although Massachusetts includes more HCCs than under the proposed Federal methodology, the Commonwealth notes that most commercial risk adjustment models use almost twice as many condition categories as it includes here.

(2) HCC Models

Similar to the HHS approach, Massachusetts calibrated models for bronze, silver, gold and platinum benefit tiers separately based on actuarial value. Due to the lack of empirical data, Massachusetts is unable to apply a separately-calibrated risk adjustment model for catastrophic plans until a sufficient amount of data becomes available in the

future. At the present time, it plans to apply the risk adjustment model developed for bronze plans to catastrophic plans, and proposes to use the actuarial value adjustment factor of 0.57 (as provided by the Federal methodology) to account for benefit design related utilization differences between catastrophic plans and other metal level plans. For calculating funds transfer, Massachusetts plans to keep the catastrophic plans in their own risk adjustment pool in the initial years, which is consistent with the proposed Federal methodology. Please also refer to the conceptual framework for risk adjustment funds transfer above for more information on Massachusetts's treatment of catastrophic plans in risk adjustment.

The model dependent variable is total plan paid amount, or "plan liability." Factors or explanatory variables included in the risk adjustment models are – 1 constant term, 2 age/gender factors, 162 HCCs and 2 disease interaction terms. Unlike the proposed Federal methodology where there are 3 sets of risk weights by age cohort for each metal level, that is, 15 models in total, Massachusetts's models do not contain separate risk weights by age cohort. The Massachusetts methodology has 4 models, one for each metal level. The bronze model will be applicable to both the bronze plans and the catastrophic plans.

In risk adjustment modeling work, partial-year eligibility is typically addressed by annualizing the dependent variable and weighting the least squares regressions by the fraction of eligibility. Massachusetts began modeling using this approach and found that the predictive accuracy for members with short eligibility, especially newborns, was low. Upon further analyses, Massachusetts believes that this was related to annualizing the dependent variable and using eligibility duration as weight in regressions. As a result Massachusetts explored nonlinear modeling techniques and developed a set of factors to adjust for partial-year eligibility. In its risk adjustment models, the minimum eligibility

duration requirement is 1 month.

Massachusetts's thinking on this issue reflects the Commonwealth's experience with programs that have high turnover rates, such as the Commonwealth Care program. Massachusetts believes that prediction biases associated with partial-year eligibility could aggravate selection issues if not addressed adequately.

Massachusetts took an iterative approach to developing the risk adjustment models. In each iteration, factors with negative and/or statistically insignificant coefficients and factors without adequate sample size were either excluded or combined with other factors. The unique feature of the HCC risk adjustment models is clinical hierarchy – that is, the coefficient of a less severe condition category should not exceed the coefficient of a more severe condition in the same clinical hierarchy. This ensures clinical validity and preserves healthcare resource for treating more severe medical conditions. Massachusetts ensured that all coefficients follow the clinical hierarchies. Where they did not, it forced monotonicity in the regression coefficients using restricted regressions.

Because the models are by metal level, one HCC may receive 4 different risk weights in the 4 models. Under the assumption that an HCC treated in a lower metal level plan should not lead to higher plan liability than if it were treated in a higher metal level plan, Massachusetts also forced monotonicity by HCC across metal levels.

In the final models, all factors have nonnegative and statistically significant coefficients, and have met the monotonicity requirements of the HCCs and the monotonicity requirements Massachusetts imposed by metal level. Massachusetts also checked that the member-level total predictions are monotonic across benefit tiers by age/gender groups. Table 17 provides the full set of coefficients.

Below is an example of how to calculate an individual risk score from these HCC

models.

Example: Member 001, male, 25 years old, is enrolled in a Gold plan for 6 months, and has three HCCs - HCC005, HCC032, and HCC072.

Member Risk Score = Constant Term + Demographic Factor + Sum (Medical Risk Factors)/Duration Adjustment Factor

= 0.108698 + 0 + (4.203378 + 1.093277 + 4.025404)/0.742262

= 12.667685

The Constant Terms, Demographics Factor and Medical Risk Factors are provided in Table 17. The Duration Adjustment Factors are provided in Table 18.

(3) Predictive Accuracy

The final model R-Squared is provided below in Table 12.

TABLE 12: Final Model R-Squared

	Counts of Unique Members	**Model R-Squared for Predicting Paid $PMPY**
Platinum	344,472	48. 54 percent
Gold	171,207	52. 91 percent
Silver	415,245	46. 66 percent
Bronze	193,725	47. 58 percent

These are comparable to the R-Squared levels observed in many commercial risk adjustment models. Massachusetts also validated the models using a more recent data extract from the Commonwealth's APCD and obtained similar R-Squared values.

e. Adjusting for Induced Demand

(1) Adjusting for Metallic Tier and Cost-Sharing Reduction

In the proposed rule, a set of induced utilization adjustment factors were provided to account for the expected utilization level differences associated with different benefit levels of plans, as well as those that result from CSRs applied to Silver Variation plans.

Massachusetts proposes to use the HHS proposed induced demand factors to adjust for induced utilization tied to metallic tiers. In terms of adjusting for induced utilization associated with CSR through Silver Variation plans, however, its methodology must appropriately account for Massachusetts's unique circumstance as related to the anticipated cost-sharing wrap above and beyond the Federal CSR.

As a result, from the perspective of induced utilization adjustment, the factors supplied in the HHS methodology (specifically calibrated for target AVs of 73 percent, 87 percent and 94 percent) may not be adequate for Massachusetts. To overcome this limitation, Massachusetts constructed a continuous induced demand curve by fitting a polynomial trend line to the HHS proposed induced utilization factors by metal level, which Massachusetts extended to 100 percent AV and validated as described below.

Using the APCD and Commonwealth Care data sets Massachusetts calculated an average member-month-weighted risk score and an average PMPM claim amount for each metallic tier. It then backed out the average risk score to calculate a risk-neutral PMPM claim amount for each metallic tier. Massachusetts performed this analysis separately for non-group and small group after adjusting the non-group results for the impact of non-group selection. The difference in the risk neutral rate by tier is the impact of benefit design induced utilization. With data from both the APCD and Commonwealth Care, Massachusetts was able to populate the curve with a continuous range of AV values including those that are close to 100 percent.

The sample size for bronze and silver metal levels was too small to be credible but for the gold and platinum metal levels the results were consistent with the HHS factors. Massachusetts determined that this validated its decision to use the HHS-proposed induced demand factors to adjust for induced utilization tied to metallic tiers.

For plans subject to anticipated cost-sharing wrap subsidies Massachusetts intends

to use the same induced demand curve to determine the increased utilization as a result of subsidized cost sharing. In Table 13 below it has listed induced demand factors by actuarial value in 2 percent increments.

TABLE 13: Induced Demand Factors

Plan AV	Induced Demand Factor
0. 70	1. 000
0. 72	1. 008
0. 74	1. 017
0. 76	1. 027
0. 78	1. 037
0. 80	1. 049
0. 82	1. 061
0. 84	1. 073
0. 86	1. 087
0. 88	1. 101
0. 90	1. 117
0. 92	1. 132
0. 94	1. 149
0. 96	1. 167
0. 98	1. 185

(2) Adjusting for Non-Group Selection

The proposed Market Reform Rule and the proposed HHS notice of benefit and payment parameters for 2014 contemplate separate risk pools for individual and small group policies and modified community rating to be applied separately within each risk pool. The Commonwealth has had a merged small and non-group market since its landmark reform in 2006, where small groups and non-group plans are subject to the same index rate and pricing methodology.

In order to determine if there is an underlying selection dynamic related only to members' group versus non-group status, Massachusetts applied concurrent risk adjustment models developed for the Commonwealth to merged market membership and

claims data from the Commonwealth's APCD. The models account for cost variations due to demographics, medical comorbidities and plan benefit design. The risk-adjusted paid amount was calculated at the member level.

Members were grouped by non-group versus small group. Groups of 1 were treated as non-group policies in its analysis. The average actual annual paid amount and the average risk-predicted annual paid amount were compared in total and by metal level. The ratio of actual paid to the risk-predicted paid for those enrolled in non-group products was compared to the same ratio for those enrolled in small group products. Any meaningful difference between the ratios for these two groups would indicate that there is a cost difference between the types of members – *that is,* non-group versus small group – that is not explained by the characteristics accounted for in the risk adjustment models.

Massachusetts found a higher average ratio for the non-group market segment. However, it also found that this selection was limited to platinum plans. As such, Massachusetts's methodology includes an induced demand factor that will only be applied to those enrolled in platinum plans. Based on two years' worth of APCD data, Massachusetts found that on average the ratio for platinum plans was 5.7 percent higher for non-group over small group, while for gold plans it was broadly consistent between non-group and small group. The Commonwealth plans to re-calibrate this factor periodically based on up-to-date experience of the market. This factor will be applied to individuals who enrolled in platinum plans and do not receive premium subsidies or CSRs. The individual risk score will be multiplied by this factor.

This adjustment mechanism as part of the risk adjustment methodology is uniquely relevant to the merged market in Massachusetts. In other States where there are separate risk pools for individual plans and small group plans the selection differential is embedded in the underlying claims level of each risk pool.

f. Calculation of Funds Transfer

The funds transfer calculation Massachusetts proposes is structurally the same as the proposed Federal methodology, although some of the adjustment factors included in the Commonwealth's calculation are defined differently and were developed from the Commonwealth's own data.

Massachusetts will use the following formula to calculate risk adjustment funds transfers.

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \bar{P}_S \qquad (1), \text{ where}$$

T_i = plan *i*'s risk adjustment transfer amount

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

$\bar{P}_S$ = average premium for Massachusetts

AV_i = plan *i*'s metal level AV

ARF_i = allowable rating factor for plan *i*

IDF_i = plan *i*'s induced demand factors for benefit design and non-group selection

GCF_i = plan *i*'s geographic cost factor

s_i = plan *i*'s share of the Commonwealth's enrollment

The first fraction in formula (1) is premium with risk selection, and the second fraction is premium without risk selection. Each component will average to 1.0 across all plans in the Commonwealth's merged market. Massachusetts will keep catastrophic plans in their own risk adjustment pool. In this case, formula (1) will apply to the catastrophic risk adjustment pool and the metal level plans risk adjustment pool separately.

The calculation of $PLRS_i$, plan *i*'s plan liability risk score, is the enrolled member

month weighted risk scores of plan *i* using the risk adjustment models and adjusted by billable member months. It is calculated as shown by HHS. See the section above on HCC models and Tables 17 and 18 below for the risk weights and how to calculate member level risk scores. Massachusetts proposes to use this approach for calculating plan liability risk scores under the assumption that the proposed Federal rule for family rating will be replicated by the Commonwealth.

The calculation of the State average premium is as shown by HHS.

Massachusetts will use the Federal adjustment factors for plan AV in the Commonwealth's funds transfer calculations. The AV adjustment factors (AV_i for plan *i*) are listed in Table 14 below.

TABLE 14: AV Adjustment Factors

Metal Level	AV Adjustment Factor
Catastrophic	0. 57
Bronze	0. 60
Silver	0. 70
Gold	0. 80
Platinum	0. 90

Massachusetts's methodology includes two separate induced demand factors (IDF_i for plan *i*), one relates to benefit design and CSR and one for group selection. These two factors are multiplicative, except for individuals who will receive Federal subsidies and additional State subsidies, because their cost-sharing level is prescribed rather than selected.

Allowable rating factors (ARF_i for plan *i*) will include the State-defined uniform age rating curve. Pending final State decision on all rating factors applicable to 2014, Massachusetts will provide additional specifications as needed on additional adjustment steps to ensure the accuracy of risk adjustment.

Massachusetts proposes to calculate geographic cost factors consistent with the HHS methodology, except that it plans to use gold plans as the benchmark for the calculations because gold plans are expected to attract the most enrollment in the Massachusetts merged market after 2014, whereas silver plans will likely have relatively low enrollment based on the product market in Massachusetts today. Having a data sample with sufficient enrollment is necessary in order to credibly measure regional cost differences. Massachusetts has not yet made a final decision on the number of rating areas, permissible range of the rates by area, or the schedule for implementing the changes. However, regardless of the specific decisions that determine the actual factors, the calculations will follow the formula shown by HHS.

g. Data Collection Approach

Massachusetts proposes an approach to risk adjustment data collection that leverages the Commonwealth's existing APCD as a resource for data submission to support risk adjustment data collection. This approach facilitates Massachusetts's policy goals of administrative simplicity and minimizing the number and types of data submissions by health plan issuers. Consistent with Federal requirements, it also facilitates the use of data that is complete, high in quality, and available in a timely fashion. Moreover, as elaborated below, use of the APCD ensures that the Commonwealth does not as part of risk adjustment data collection store any personally identifiable information for use as a unique identifier (except as may be required for data validation).

The APCD is maintained by the Massachusetts Center for Health Information and Analysis (CHIA) and requires data submission from the following entities: public payers, commercial insurance issuers, health maintenance organizations, third-party administrators, and self-insured plans. Data submissions must be filed monthly.

The APCD collects payer data for all members living in Massachusetts. Health plan issuers and other payers submit five files each month: member eligibility, medical claims, pharmacy claims, dental claims and provider details. Product description files from all of the payers are submitted to the APCD on a quarterly basis. Detailed data submission requirements are in place and available for review on CHIA's website, http://www.mass.gov/chia/researcher/health-care-delivery/hcf-data-resources/apcd/. Members of a Massachusetts employer group who live out of State are currently excluded unless the payer also holds a contract with the Commonwealth's employee health administrator to provide data for State-covered non-resident individuals. The Commonwealth is working with CHIA and the affected data submitters actively to have this resolved before 2014 to ensure the accuracy of risk adjustment. It is also working with CHIA and issuers in the Commonwealth to evaluate additional data elements needed to support risk adjustment calculations.

The APCD already collects most of the data elements to support risk adjustment (see discussion of the data extract elements below), and nearly all other elements have to this date been scheduled to be added as part of APCD collection. As part of data intake, automated data quality checks are performed by CHIA. Once data are quality checked the subset required for risk adjustment are processed for purposes of creating an extract for risk adjustment calculations. Creation of the extract signifies the beginning of the risk adjustment data collection process. The extract provides only those data elements that are necessary for risk adjustment and contains no personally identifiable information for use as a unique identifier for an enrollee's data.

Using the data extract from the APCD, the Health Connector will be responsible for performing all risk adjustment calculations as well as facilitating payment and charge transactions. The data extracts will be maintained in a secure environment that meets

applicable Federal and State security standards.

Below Massachusetts describes the data elements currently submitted to the APCD that will be used to create the risk adjustment extract. The Commonwealth also reviews the Health Connector's authority to use the APCD to support risk adjustment data collection, and provide additional details on data quality monitoring and control, data privacy and security standards, and the data management plan for risk adjustment operations.

h. Available Data in APCD for Risk Adjustment

As noted, the APCD already collects most of the data elements needed for risk adjustment. Member files include member and subscriber identifiers, relationships, demographics, information about the payer, product and coverage, and duration of enrollment. Claims files include all paid claims (including encounter data on capitated services) for covered services, including but not limited to institutional and professional services, therapies, durable medical equipment (DME), transportation, laboratory services, imaging, and skilled nursing. Pharmacy files include all prescribed and dispensed medications. Dental claims files include all treatments and services. Provider files support the identification of providers by specialty and location. Product files provide limited information about the different insurance products that correspond to the Member file.

On the Commonwealth of Massachusetts website, http://www.mass.gov/chia/researcher/health-care-delivery/hcf-data-resources/apcd/submitting-data-to-the-apcd.html#regulations, it has made available a table of a subset of the data elements that are currently collected from payers. It will use the identified elements as inputs for calculating risk adjustment funds transfers and the assignment of a member to the correct plan.

There are data elements required to calculate risk adjustment funds transfer that the APCD currently does not collect, such as monthly premium, employer zip code, household income level, Indian status, and AV or inputs used to calculate AV using the Federal AV calculator. Massachusetts is currently working with CHIA, other State agencies, and the issuers in Massachusetts to add these data elements as part of APCD data collection and is working with plans to have them submitted by June 1, 2013. Some data elements – Indian status and household income – will be submitted to the APCD via the Exchange.

In addition, certain plans may not have sufficient claims experience reported in the APCD. This gap may occur because plans may be exempt from data submission or are new to the Massachusetts market. Current APCD regulations exempt small plans with less than 1,000 covered lives in Massachusetts-based plans from submitting regular data files. This exemption recognizes the administrative cost of programming and providing regular data extracts. Health plan issuers that are new to the Massachusetts market will need to take time to build up the capacity to submit data to the APCD on a regular basis. As such, Massachusetts plans to establish a method for small and new-to-market plans to submit minimally necessary data for risk adjustment through an alternate mechanism than the APCD. The specifications for this alternate submission, the secure data transfer methodology, and the communication of results to the issuers will be developed as part of risk adjustment operations and will not use any personally identifiable information as a unique identifier.

(1) Legal Authority for the Health Connector to Access APCD Data for Risk Adjustment

Massachusetts General Laws (M. G. L.) Chapter 118G§6 authorized the Division of Health Care Finance and Policy (DHCFP) to collect uniform information from public and private health care payers and to operate the Commonwealth's APCD. The

Commonwealth's authority to collect, analyze and report health care cost and utilization was further expanded with the passage and subsequent enactment of Chapter 224 of the Acts of 2012. Section 19 of this law established CHIA with broad responsibility for health care data collection, analysis and reporting, including the APCD. CHIA assumes all of the data collection, management and analysis tasks previously performed by DHCFP. In addition, the statute enables CHIA to provide government agencies and other parties access to data for the purpose of lowering total medical expenses, coordinating care, benchmarking, quality analysis and other research, for administrative or planning purposes. CHIA may also provide information to and work with other State agencies to "collect and disseminate data concerning the cost, price and functioning of the health care system in the Commonwealth and the health status of individuals."

Massachusetts is currently developing an agreement with CHIA to obtain data management and analytic support to administer the risk adjustment program, consistent with M. G. L. ch. 12C which gives CHIA the authority to enter into interagency service agreements with other Massachusetts agencies "for transfer and use of data."

(2) Data Security and Privacy Protection

As noted, under existing law and regulation, the Commonwealth already collects a range of data through its APCD and protects this information as described below.

Specifically in relation to data collection under risk adjustment and Federal requirements, the risk adjustment extract created through the APCD will not use or store any personally identifiable information for use as a unique identifier for an enrollee's data. Only those data fields that are reasonably necessary as part of the risk adjustment methodology will be included in the extract.

For background, the APCD data is hosted on servers located at the offices of the Commonwealth of Massachusetts Executive Office of Health and Human Services Center

for Health Information and Analysis at Two Boylston Street, Boston, Massachusetts 02116. CMS has approved CHIA's application to receive and hold Medicare data under the newly created APCD category. In fact, CHIA was the first APCD to apply and be approved. CHIA is fully compliant with the CMS Data Use Agreement (See CMS DUA #20937).

CHIA is an experienced custodian of protected health information. Since 1982, CHIA (as DHCFP) has served as the repository for the State's Hospital Discharge Data, Emergency Room Data and Outpatient Observation Data. CHIA has extensive claims processing experience as the operator of the State's Health Safety Net program. CHIA has passed two independent third party security audits – a HIPAA security audit and a SAS-70 Type 2 audit. In addition, PCI security audits are done quarterly on CHIA's web portal.

As indicated above, the data extract produced by the APCD on behalf of the Health Connector for calculating risk adjustment funds transfer will contain no personally identifiable information for use as a unique identifier for an enrollee's data. All personal identifiers will be replaced with a scrambled Unique Member Identification number that is created independent of any HIPAA Protected Health Information or other personally identifiable information. This number will be a string of letters, numbers and symbols that cannot be "de-encrypted" to yield decipherable data.

The risk adjustment data extract will be securely transmitted into a secure data environment that will be established by the Health Connector. Calculations of plan actuarial risks and funds transfer will take place in this secure environment, with no personally identifiable information being used as a unique identifier. Massachusetts states that it has a fully HIPAA-compliant facility and data infrastructure in active use for operating the risk adjustment program for the Commonwealth Care program, which can

be used for administering the Affordable Care Act risk adjustment program. Massachusetts also states that it is in active discussions with CHIA on the possibility of establishing a dedicated secure data environment for risk adjustment at CHIA's Data Center.

Finally, leveraging funding applied through the Health Connector's Level 2 Exchange Establishment Grant (currently under CCIIO review), CHIA plans to upgrade its disaster recovery program to meet the performance requirement necessary for supporting risk adjustment.

(3) Data Quality Control

The APCD data intake and warehousing operation incorporates data quality evaluation and monitoring processes to ensure the integrity and accuracy of downstream files.

CHIA has published a set of data completeness checks containing nearly 800 unique automated tests that are conducted at intake within the secure processing environment. These checks are used to assess the file's compliance with minimum standards. A full list of these checks is available on CHIA's website: http://www.mass.gov/chia/researcher/health-care-delivery/hcf-data-resources/apcd/submitting-data-to-the-apcd.html.

When this evaluation process is complete, a report is generated for the payer's review. The report shows the test results and whether the file "passes" and can move forward into the next phase of processing. If a file does not pass at any point in this process, the APCD does not conduct any further processing and notifies the payer that errors must be corrected and the files resubmitted. Full resubmission of a file is required in order to maintain file integrity.

CHIA will submit further supplemental information detailing its plans to collect

data from any non-compliant issuers, including additional information on alternate data submission procedures.

(4) Data Collection Timeline

Massachusetts plans to provide quarterly funds transfer calculation summaries to each issuer that is subject to risk adjustment and will be working with the issuers to determine the appropriate content and level of detail for the quarterly report summaries. The proposed timeline for processing and analyzing APCD data for Calendar Year 2014 for the purpose of risk adjustment is illustrated below. Massachusetts is in discussions with CHIA and the issuers regarding the timeline and also plan to conduct test runs to ensure the feasibility of the timeline and quality of the data collection process.

TABLE 15: Proposed Timeline for Risk Adjustment Data Collection

Time Period	Activity
Each quarter: Months 1,2,3	Issuers submit data. Data submitters submit on a monthly basis.
Month 3+1 month (Month 4)	Claims run-out period
Month 3+2 months (Month 5)	Quality checks at designated points in current APCD process Member identity resolution and de-identification via removal of personal identifiers CHIA creates extract with minimally necessary data elements and sends to Connector or Connector's designee to calculate risk adjustment Quality review by the Connector or its designee. The purpose here is to determine whether data meets quality standards for risk adjustment purposes. Identified issues and recommended action steps will be sent to CHIA and the issuers regarding resubmission
Month 3+3 months (Month 6)	Conducts all calculations relating to risk adjustment Sends a preliminary report to data submitters for review and discusses results and observations with issuers
January through March of the following year	Claims run-out period. The proposed data submission deadline is March 31 of the following year, *i. e.* , 3 months claims runout
April of the following year	Filing deadline for claims paid through March 31 of the following year
May of the following year	Quality assurance process and creation of the data extract

	Grouping and review with data submitters
June of the following year	Funds transfer settlements calculated and reports generated by June 30 of the following year

i. Schedule of Calibration and Recalibration

The risk adjustment models and the additional adjustment factors proposed will need to be calibrated and recalibrated periodically to be reflective of current market conditions, the evolving insured population, medical technology and other secular trends in Massachusetts. Massachusetts will evaluate the goodness of fit of the risk adjustment models and the appropriateness of the additional adjustment factors on an ongoing basis and recalibrate every three years if the evaluation justifies. On October 1, 2014, the entire country is expected to transition to ICD-10-CM coding. Massachusetts expects to update the current clinical classification system such that it can group ICD-10-CM diagnosis codes into the existing HCCs in 2014. However, it does not plan to recalibrate the risk factors in the models due to the lack of claims experience under the new coding system.

j. Data Validation

While not part of the risk adjustment methodology, Massachusetts is considering a range of potential data validation approaches. The Premium Stabilization Rule, §153.350 requires States operating a risk adjustment program to conduct data validation and provide an appeals process. The key goal from Massachusetts's perspective is to strike a balance between a data validation process that optimizes the identification of errors while implementing a workable system that is not administratively burdensome and that recognizes the zero sum nature of transfers between health plan issuers. Under the Premium Stabilization Rule, Massachusetts will be developing its approach to data validation and an appeals process, and will provide an overview of current considerations

in its State notice of benefit and payment parameters.

Table 16: List of HCCs in Massachusetts Risk Adjustment Methodology for 2014

HCC	Description
HCC001	HIV/AIDS
HCC201	Bacteremia
HCC002	Septicemia/Shock
HCC003	Central Nervous System Infection
HCC004	Tuberculosis
HCC005	Opportunistic Infections
HCC202	Secondary Cancer Except Lymph Node
HCC203	Secondary Cancer of Lymph Node
HCC204	Cancer of the Brain/Nervous System/Pituitary, Pineal Glands
HCC205	Acute Leukemia
HCC008	Lung, Upper Digestive Tract, and Other Severe Cancers
HCC009	Lymphatic, Head and Neck, Brain, and Other Major Cancers
HCC010	Breast, Prostate, Colorectal and Other Cancers and Tumors
HCC011	Other Respiratory and Heart Neoplasms
HCC012	Other Digestive and Urinary Neoplasms
HCC013	Other Neoplasms
HCC015	Diabetes with Renal Manifestation
HCC016	Diabetes with Neurologic or Peripheral Circulatory Manifestation
HCC017	Diabetes with Acute Complications
HCC018	Diabetes with Ophthalmologic Manifestation
HCC019	Diabetes with No or Unspecified Complications
HCC020	Type I Diabetes Mellitus
HCC021	Protein-Calorie Malnutrition
HCC022	Other Significant Endocrine and Metabolic Disorders
HCC023	Disorders of Fluid/Electrolyte/Acid-Base Balance
HCC025	End-Stage Liver Disease
HCC026	Cirrhosis of Liver
HCC027	Chronic Hepatitis
HCC028	Acute Liver Failure/Disease
HCC029	Other Hepatitis and Liver Disease
HCC030	Gallbladder and Biliary Tract Disorders
HCC031	Intestinal Obstruction/Perforation

HCC	Description
HCC032	Pancreatic Disease
HCC033	Inflammatory Bowel Disease
HCC034	Peptic Ulcer, Hemorrhage, Other Specified Gastrointestinal Disorders
HCC035	Appendicitis
HCC036	Other Gastrointestinal Disorders
HCC037	Bone/Joint/Muscle Infections/Necrosis
HCC038	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
HCC206	Spinal Stenosis
HCC039	Disorders of the Vertebrae and Spinal Discs (See HCC206)
HCC040	Osteoarthritis of Hip or Knee
HCC041	Osteoporosis and Other Bone/Cartilage Disorders
HCC042	Congenital/Developmental Skeletal and Connective Tissue Disorders
HCC207	Hemophilia
HCC044	Severe Hematological Disorders (See HCC207)
HCC045	Disorders of Immunity
HCC208	Hereditary Hemolytic Anemias and Coagulation Defects
HCC209	Toxic/Unspecified Encephalopathy
HCC048	Delirium and Encephalopathy (See HCC209)
HCC049	Dementia
HCC050	Senility, Nonpsychotic Organic Brain Syndromes/Conditions
HCC051	Drug/Alcohol Psychosis
HCC052	Drug/Alcohol Dependence
HCC054	Schizophrenia
HCC055	Major Depressive, Bipolar, and Paranoid Disorders
HCC056	Reactive and Unspecified Psychosis
HCC057	Personality Disorders
HCC058	Depression
HCC059	Anxiety Disorders
HCC061	Profound Mental Retardation/Developmental Disability
HCC062	Severe Mental Retardation/Developmental Disability
HCC063	Moderate Mental Retardation/Developmental Disability
HCC064	Mild/Unspecified Mental Retardation/Developmental Disability
HCC065	Other Developmental Disability
HCC066	Attention Deficit Disorder
HCC067	Quadriplegia, Other Extensive Paralysis

HCC	Description
HCC068	Paraplegia
HCC069	Spinal Cord Disorders/Injuries
HCC070	Muscular Dystrophy
HCC071	Polyneuropathy
HCC072	Multiple Sclerosis
HCC073	Parkinson's and Huntington's Diseases
HCC074	Seizure Disorders and Convulsions
HCC075	Coma, Brain Compression/Anoxic Damage
HCC076	Mononeuropathy, Other Neurological Conditions/Injuries
HCC077	Respirator Dependence/Tracheostomy Status
HCC078	Respiratory Arrest
HCC210	Post Trauma/Surgery Pulmonary Insufficiency, Incl Adult Respir Distress Syndr
HCC079	Cardio-Respiratory Failure and Shock (See HCC210)
HCC080	Congestive Heart Failure
HCC081	Acute Myocardial Infarction
HCC082	Unstable Angina and Other Acute Ischemic Heart Disease
HCC083	Angina Pectoris/Old Myocardial Infarction
HCC084	Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease
HCC085	Heart Infection/Inflammation, Except Rheumatic
HCC086	Valvular and Rheumatic Heart Disease
HCC087	Major Congenital Cardiac/Circulatory Defect
HCC088	Other Congenital Heart/Circulatory Disease
HCC092	Specified Heart Arrhythmias
HCC093	Other Heart Rhythm and Conduction Disorders
HCC095	Cerebral Hemorrhage
HCC096	Ischemic or Unspecified Stroke
HCC097	Precerebral Arterial Occlusion and Transient Cerebral Ischemia
HCC098	Cerebral Atherosclerosis and Aneurysm
HCC100	Hemiplegia/Hemiparesis
HCC102	Speech, Language, Cognitive, Perceptual Deficits
HCC104	Vascular Disease with Complications
HCC105	Vascular Disease
HCC106	Other Circulatory Disease
HCC107	Cystic Fibrosis

HCC	Description
HCC108	Chronic Obstructive Pulmonary Disease
HCC109	Fibrosis of Lung and Other Chronic Lung Disorders
HCC110	Asthma
HCC111	Aspiration and Specified Bacterial Pneumonias
HCC112	Pneumococcal Pneumonia, Empyema, Lung Abscess
HCC113	Viral and Unspecified Pneumonia, Pleurisy
HCC114	Pleural Effusion/Pneumothorax
HCC115	Other Lung Disorders
HCC116	Legally Blind
HCC117	Major Eye Infections/Inflammations
HCC118	Retinal Detachment
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
HCC120	Diabetic and Other Vascular Retinopathies
HCC122	Glaucoma
HCC125	Significant Ear, Nose, and Throat Disorders
HCC126	Hearing Loss
HCC128	Kidney Transplant Status
HCC130	Dialysis Status
HCC211	Acute Renal Failure
HCC131	Non-Acute Renal Failure (See HCC211)
HCC132	Nephritis
HCC133	Urinary Obstruction and Retention
HCC134	Incontinence
HCC135	Urinary Tract Infection
HCC136	Other Urinary Tract Disorders
HCC137	Female Infertility
HCC138	Pelvic Inflammatory Disease and Other Specified Female Genital Disorders
HCC141	Ectopic Pregnancy
HCC142	Miscarriage/Abortion
HCC143	Completed Pregnancy With Major Complications
HCC144	Completed Pregnancy With Complications
HCC145	Completed Pregnancy Without Complications (Normal Delivery)
HCC146	Uncompleted Pregnancy With Complications
HCC147	Uncompleted Pregnancy With No or Minor Complications

HCC	Description
HCC148	Decubitus Ulcer of Skin
HCC150	Extensive Third-Degree Burns
HCC151	Other Third-Degree and Extensive Burns
HCC152	Cellulitis, Local Skin Infection
HCC154	Severe Head Injury
HCC155	Major Head Injury
HCC156	Concussion or Unspecified Head Injury
HCC157	Vertebral Fractures
HCC158	Hip Fracture/Dislocation
HCC159	Major Fracture, Except of Skull, Vertebrae, or Hip
HCC160	Internal Injuries
HCC161	Traumatic Amputation
HCC164	Major Complications of Medical Care and Trauma
HCC168	Extremely Low Birthweight Neonates
HCC169	Very Low Birthweight Neonates
HCC212	Low Birthweight (1500-2499 grams) or Unspecified
HCC170	Serious Perinatal Problem Affecting Newborn (See HCC212)
HCC171	Other Perinatal Problems Affecting Newborn
HCC172	Normal, Single Birth
HCC213	Bone Marrow Transplant Status/Complications
HCC174	Major Organ Transplant Status (See HCC213)
HCC175	Other Organ Transplant/Replacement
HCC176	Artificial Openings for Feeding or Elimination
HCC177	Amputation Status, Lower Limb/Amputation Complications
HCC180	Radiation Therapy
HCC181	Chemotherapy
HCC182	Rehabilitation

TABLE 17: Proposed Risk Adjustment Models for Massachusetts Risk Adjustment Methodology for 2014

Factor	Platinum	Gold	Silver	Bronze / Catastrophic
Constant Term	0. 108698	0. 108698	0. 054613	0. 054613
Female, 0-	0. 120243	0. 120243	0. 120243	0. 076300

Factor	Platinum	Gold	Silver	Bronze / Catastrophic
1				
Male, 0-1	0. 430573	0. 252549	0. 252549	0. 130423
HCC001	4. 151453	4. 151453	3. 974417	3. 974417
HCC201	5. 439483	5. 439483	5. 439483	5. 439483
HCC002	4. 911655	4. 911655	4. 911655	4. 911655
HCC003	2. 070673	2. 070673	2. 070673	2. 070673
HCC004	1. 458104	0. 580915	0. 580915	0. 580915
HCC005	4. 203378	4. 203378	4. 203378	4. 203378
HCC202	6. 482786	6. 482786	6. 482786	6. 482786
HCC203	6. 482786	6. 482786	5. 475333	5. 475333
HCC204	6. 047288	4. 581452	4. 147687	2. 272855
HCC205	10. 703344	10. 703344	10. 703344	10. 703344
HCC008	2. 272855	2. 272855	2. 272855	2. 272855
HCC009	1. 075169	1. 075169	1. 075169	1. 075169
HCC010	1. 075169	1. 075169	1. 075169	1. 075169
HCC011	1. 075169	1. 075169	1. 075169	1. 075169
HCC012	0. 375903	0. 373614	0. 373614	0. 373614
HCC013	0. 375903	0. 373614	0. 373614	0. 373614
HCC015	0. 921977	0. 921977	0. 921977	0. 921977
HCC016	0. 395184	0. 395184	0. 395184	0. 395184
HCC017	0. 395184	0. 395184	0. 395184	0. 320869
HCC018	0. 320869	0. 320869	0. 320869	0. 320869
HCC019	0. 320869	0. 320869	0. 320869	0. 320869
HCC020	0. 844671	0. 844671	0. 769198	0. 769198
HCC021	8. 780537	8. 780537	8. 780537	8. 780537
HCC022	0. 976845	0. 976845	0. 976845	0. 976845
HCC023	1. 346099	1. 346099	1. 346099	1. 346099
HCC025	1. 601166	1. 601166	1. 346120	1. 346120
HCC026	0. 986228	0. 986228	0. 408007	0. 408007
HCC027	0. 460726	0. 460726	0. 408007	0. 408007
HCC028	1. 601166	1. 601166	1. 346120	1. 346120
HCC029	0. 408007	0. 408007	0. 408007	0. 408007
HCC030	1. 977590	1. 977590	1. 882379	1. 882379
HCC031	3. 749986	3. 749986	3. 749986	3. 749986
HCC032	1. 093277	1. 093277	1. 093277	1. 093277
HCC033	1. 790188	1. 790188	1. 595541	1. 595541
HCC034	0. 940108	0. 940108	0. 940108	0. 940108

Factor	Platinum	Gold	Silver	Bronze / Catastrophic
HCC035	2. 683705	2. 683705	2. 683705	2. 011126
HCC036	0. 405518	0. 405518	0. 377057	0. 377057
HCC037	2. 952592	2. 952592	2. 952592	2. 952592
HCC038	1. 094796	1. 094796	1. 094796	1. 094796
HCC206	2. 098343	2. 098343	2. 098343	2. 098343
HCC039	0. 569751	0. 569751	0. 569751	0. 569751
HCC040	1. 094796	1. 094796	1. 094796	1. 094796
HCC041	0. 311993	0. 311993	0. 311993	0. 311993
HCC042	1. 125274	1. 125274	1. 125274	1. 125274
HCC207	30. 636640	30. 636640	14. 101544	7. 514115
HCC044	5. 694090	5. 694090	5. 694090	5. 694090
HCC045	1. 011533	1. 011533	1. 011533	1. 011533
HCC208	1. 404092	1. 404092	1. 404092	1. 404092
HCC209	2. 918243	2. 918243	2. 918243	2. 918243
HCC048	1. 345886	1. 345886	1. 182955	1. 182955
HCC049	1. 216549	1. 216549	1. 086774	1. 086774
HCC050	1. 019842	1. 019842	1. 019842	1. 019842
HCC051	1. 343297	1. 343297	1. 343297	1. 343297
HCC052	0. 845301	0. 845301	0. 845301	0. 845301
HCC054	2. 625043	2. 625043	2. 161218	2. 161218
HCC055	0. 848033	0. 848033	0. 772826	0. 772826
HCC056	0. 848033	0. 848033	0. 772826	0. 772826
HCC057	0. 338729	0. 338729	0. 338729	0. 338729
HCC058	0. 338729	0. 338729	0. 338729	0. 338729
HCC059	0. 293976	0. 234661	0. 234661	0. 234661
HCC061	2. 234452	0. 911836	0. 911836	0. 416412
HCC062	0. 551357	0. 551357	0. 416412	0. 416412
HCC063	0. 551357	0. 416412	0. 416412	0. 416412
HCC064	0. 416412	0. 416412	0. 416412	0. 206061
HCC065	0. 315057	0. 315057	0. 315057	0. 206061
HCC066	0. 229744	0. 229744	0. 206061	0. 206061
HCC067	5. 447025	5. 447025	5. 447025	5. 447025
HCC068	2. 224234	2. 224234	2. 224234	2. 224234
HCC069	2. 098343	2. 098343	2. 098343	2. 098343
HCC070	1. 390521	1. 390521	1. 390521	1. 390521
HCC071	1. 209341	1. 209341	1. 209341	1. 209341
HCC072	4. 312296	4. 025404	4. 025404	4. 025404

Factor	Platinum	Gold	Silver	Bronze / Catastrophic
HCC073	1. 217710	1. 217710	1. 217710	1. 217710
HCC074	1. 302181	0. 980434	0. 980434	0. 980434
HCC075	6. 388482	6. 388482	6. 388482	5. 638247
HCC076	0. 382239	0. 382239	0. 382239	0. 382239
HCC077	30. 588977	30. 588977	17. 179162	17. 179162
HCC078	6. 741034	6. 741034	6. 741034	2. 760821
HCC210	14. 638331	14. 638331	14. 638331	14. 638331
HCC079	4. 963995	4. 963995	2. 922954	2. 760821
HCC080	1. 268543	1. 268543	1. 268543	1. 268543
HCC081	5. 873126	5. 873126	5. 873126	5. 873126
HCC082	3. 409746	3. 409746	3. 409746	3. 170501
HCC083	1. 185868	1. 185868	1. 185868	1. 185868
HCC084	0. 518025	0. 518025	0. 518025	0. 518025
HCC085	3. 358496	3. 358496	3. 358496	3. 358496
HCC086	0. 748725	0. 748725	0. 748725	0. 748725
HCC087	4. 962870	4. 456078	2. 859281	2. 119499
HCC088	0. 748725	0. 748725	0. 748725	0. 748725
HCC092	1. 226834	1. 226834	1. 226834	1. 226834
HCC093	1. 005026	1. 005026	1. 005026	1. 005026
HCC095	6. 224877	6. 224877	4. 744856	4. 744856
HCC096	0. 917154	0. 917154	0. 705810	0. 705810
HCC097	0. 065189	0. 065189	0. 065189	0. 065189
HCC098	0. 065189	0. 065189	0. 065189	0. 065189
HCC100	2. 224234	2. 224234	2. 224234	2. 224234
HCC102	2. 941517	2. 941517	2. 941517	2. 941517
HCC104	2. 598472	2. 598472	2. 598472	2. 598472
HCC105	0. 831150	0. 831150	0. 831150	0. 831150
HCC106	0. 685084	0. 685084	0. 685084	0. 685084
HCC107	8. 318393	7. 678688	4. 188453	3. 417106
HCC108	0. 445827	0. 445827	0. 445827	0. 445827
HCC109	0. 445827	0. 445827	0. 445827	0. 445827
HCC110	0. 327310	0. 327310	0. 298068	0. 298068
HCC111	4. 185448	4. 185448	4. 185448	4. 185448
HCC112	2. 487771	2. 487771	2. 487771	2. 487771
HCC113	0. 459994	0. 459994	0. 459994	0. 459994
HCC114	4. 665050	4. 665050	4. 461861	4. 461861
HCC115	0. 245923	0. 245923	0. 174247	0. 174247

Factor	Platinum	Gold	Silver	Bronze / Catastrophic
HCC116	1. 846476	1. 846476	1. 846476	1. 846476
HCC117	0. 871167	0. 871167	0. 871167	0. 293138
HCC118	0. 425465	0. 303314	0. 303314	0. 303314
HCC119	0. 975698	0. 975698	0. 975698	0. 975698
HCC120	0. 975698	0. 629335	0. 629335	0. 387584
HCC122	0. 156864	0. 156864	0. 156864	0. 156864
HCC125	0. 441244	0. 441244	0. 441244	0. 441244
HCC126	0. 343108	0. 245527	0. 245527	0. 245527
HCC128	3. 935445	3. 086230	3. 086230	3. 086230
HCC130	25. 095071	25. 095071	25. 095071	25. 095071
HCC211	5. 931077	5. 931077	3. 957413	3. 957413
HCC131	0. 609381	0. 609381	0. 609381	0. 548312
HCC132	0. 609381	0. 609381	0. 548312	0. 548312
HCC133	0. 828794	0. 828794	0. 828794	0. 828794
HCC134	0. 333109	0. 333109	0. 179712	0. 179712
HCC135	0. 186132	0. 186132	0. 186132	0. 186132
HCC136	0. 308014	0. 308014	0. 308014	0. 308014
HCC137	2. 229861	2. 019901	1. 191632	1. 191632
HCC138	0. 587042	0. 587042	0. 587042	0. 587042
HCC141	1. 003553	1. 003553	1. 003553	0. 718760
HCC142	0. 557164	0. 557164	0. 480684	0. 431174
HCC143	4. 184966	4. 184966	3. 619387	3. 002414
HCC144	3. 332900	2. 868669	2. 280000	1. 954919
HCC145	1. 171729	0. 774339	0. 774339	0. 216043
HCC146	0. 557164	0. 557164	0. 480684	0. 216043
HCC147	0. 280304	0. 280304	0. 216043	0. 216043
HCC148	12. 543259	12. 543259	6. 014584	6. 014584
HCC150	2. 424426	2. 424426	2. 424426	2. 424426
HCC151	2. 424426	2. 424426	2. 424426	2. 424426
HCC152	0. 333411	0. 322440	0. 322440	0. 322440
HCC154	15. 385354	15. 385354	10. 060566	10. 060566
HCC155	1. 019842	1. 019842	1. 019842	1. 019842
HCC156	0. 378295	0. 378295	0. 378295	0. 378295
HCC157	2. 098343	2. 098343	2. 098343	2. 098343
HCC158	3. 274125	3. 274125	3. 274125	3. 274125
HCC159	0. 995242	0. 995242	0. 995242	0. 995242
HCC160	1. 169886	1. 169886	1. 169886	1. 169886

Factor	Platinum	Gold	Silver	Bronze / Catastrophic
HCC161	4. 800076	4. 800076	3. 252883	3. 252883
HCC164	4. 416936	4. 416936	4. 416936	4. 416936
HCC168	50. 030035	31. 846702	8. 770478	1. 517088
HCC169	31. 846702	31. 846702	8. 770478	1. 517088
HCC212	5. 348103	4. 531656	2. 869468	1. 517088
HCC170	5. 118321	3. 980982	2. 713315	1. 517088
HCC171	0. 944286	0. 944286	0. 833781	0. 833781
HCC172	0. 766750	0. 282812	0. 282812	0. 282812
HCC213	26. 085463	26. 085463	22. 031148	22. 031148
HCC174	13. 907770	13. 907770	10. 852783	6. 023029
HCC175	0. 417558	0. 391105	0. 391105	0. 145153
HCC176	5. 768476	5. 768476	5. 768476	5. 768476
HCC177	0. 879358	0. 879358	0. 879358	0. 879358
HCC180	4. 989476	4. 989476	4. 989476	4. 989476
HCC181	13. 774728	13. 774728	13. 774728	13. 774728
HCC182	1. 791185	1. 791185	1. 791185	1. 791185
INT01	3. 869565	3. 869565	3. 869565	3. 869565
INT02	1. 608754	1. 608754	1. 608754	1. 608754

Definition of the interaction terms:

INT01=CANCER*IMMUNE, and INT02=CVD*VD, where

CANCER=MAX(MAX(of HCC008-HCC014),MAX(of HCC202-HCC205));
IMMUNE=HCC045;
CVD=MAX(of HCC095-HCC103);
VD=MAX(HCC104,HCC105);

TABLE 18: Duration Adjustment in Risk Adjustment Models in Massachusetts Risk Adjustment Methodology for 2014

Month of Eligibility	Platinum	Gold	Silver	Bronze
1	0. 225160	0. 343520	0. 474510	1. 000000
2	0. 341279	0. 462802	0. 584191	1. 000000
3	0. 435275	0. 550953	0. 659754	1. 000000
4	0. 517282	0. 623502	0. 719223	1. 000000
5	0. 591389	0. 686292	0. 769018	1. 000000
6	0. 659754	0. 742262	1. 000000	1. 000000
7	0. 723686	0. 793130	1. 000000	1. 000000
8	1. 000000	0. 840003	1. 000000	1. 000000
9	1. 000000	1. 000000	1. 000000	1. 000000
10	1. 000000	1. 000000	1. 000000	1. 000000
11	1. 000000	1. 000000	1. 000000	1. 000000
12	1. 000000	1. 000000	1. 000000	1. 000000

TABLE 19: Clinical Hierarchies in Massachusetts Risk Adjustment Methodology for 2014

DISEASE HIERARCHIES Hierarchical Condition Category (HCC)	If the Condition Category is Listed in this column…	…Then drop the HCC(s) listed in this column
	Hierarchical Condition Category (HCC) Label	
5	Opportunistic Infections	112,113,115
202	Secondary Cancer Except Lymph Node	203,204,8,9,10,11,12,13
203	Secondary Cancer of Lymph Node	204,8,9,10,11,12,13
204	Cancer of the Brain/Nervous System/Pituitary, Pineal Glands	8,9,10,11,12,13
205	Acute Leukemia	8,9,10,11,12,13
8	Lung, Upper Digestive Tract, and Other Severe Cancers	9,10,11,12,13
9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	10,11,12,13
10	Breast, Prostate, Colorectal and Other Cancers and Tumors	11,12,13
11	Other Respiratory and Heart Neoplasms	12,13
12	Other Digestive and Urinary Neoplasms	13
15	Diabetes with Renal Manifestation	16,17,18,19

DISEASE HIERARCHIES Hierarchical Condition Category (HCC)	If the Condition Category is Listed in this column…	…Then drop the HCC(s) listed in this column
16	Diabetes with Neurologic or Peripheral Circulatory Manifestation	17,18,19
17	Diabetes with Acute Complications	18,19
18	Diabetes with Ophthalmologic Manifestation	19
25	End-Stage Liver Disease	26,27,28,29,34,36
26	Cirrhosis of Liver	27,29
27	Chronic Hepatitis	29
28	Acute Liver Failure/Disease	29
31	Intestinal Obstruction/Perforation	34,36
32	Pancreatic Disease	36
33	Inflammatory Bowel Disease	34,36
34	Peptic Ulcer, Hemorrhage, Other Specified Gastrointestinal Disorders	36
38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	39,40
206	Spinal Stenosis	39
207	Hemophilia	44,208
44	Severe Hematological Disorders	208
209	Toxic/Unspecified Encephalopathy	48,50
48	Delirium and Encephalopathy	50
49	Dementia	50
51	Drug/Alcohol Psychosis	52
54	Schizophrenia	55,56,57,58,59
55	Major Depressive, Bipolar, and Paranoid Disorders	56,57,58,59
56	Reactive and Unspecified Psychosis	57,58,59
57	Personality Disorders	58,59
58	Depression	59
61	Profound Mental Retardation/Developmental Disability	62,63,64,65,66
62	Severe Mental Retardation/Developmental Disability	63,64,65,66
63	Moderate Mental Retardation/Developmental Disability	64,65,66
64	Mild/Unspecified Mental Retardation/Developmental Disability	65,66
65	Other Developmental Disability	66
67	Quadriplegia, Other Extensive Paralysis	68,69,76,100,157
68	Paraplegia	69,76,100,157
69	Spinal Cord Disorders/Injuries	39,76,157
70	Muscular Dystrophy	76
71	Polyneuropathy	76
72	Multiple Sclerosis	76

DISEASE HIERARCHIES Hierarchical Condition Category (HCC)	If the Condition Category is Listed in this column…	…Then drop the HCC(s) listed in this column
73	Parkinson's and Huntington's Diseases	76
74	Seizure Disorders and Convulsions	76
75	Coma, Brain Compression/Anoxic Damage	209,48,50,76
77	Respirator Dependence/Tracheostomy Status	78,210,79
210	Post Trauma/Surgery Pulmonary Insufficiency, Incl Adult Respir Distress Syndrom	79
78	Respiratory Arrest	79
81	Acute Myocardial Infarction	82,83,84
82	Unstable Angina and Other Acute Ischemic Heart Disease	83,84
83	Angina Pectoris/Old Myocardial Infarction	84
85	Heart Infection/Inflammation, Except Rheumatic	86,88
86	Valvular and Rheumatic Heart Disease	88
87	Major Congenital Cardiac/Circulatory Defect	88
92	Specified Heart Arrhythmias	93
95	Cerebral Hemorrhage	96,97,98
96	Ischemic or Unspecified Stroke	97,98
97	Precerebral Arterial Occlusion and Transient Cerebral Ischemia	98
104	Vascular Disease with Complications	105,106
105	Vascular Disease	106
107	Cystic Fibrosis	108,109,110,115
108	Chronic Obstructive Pulmonary Disease	109,110,115
109	Fibrosis of Lung and Other Chronic Lung Disorders	110,115
110	Asthma	115
111	Aspiration and Specified Bacterial Pneumonias	112,113,115
112	Pneumococcal Pneumonia, Empyema, Lung Abscess	113,115
113	Viral and Unspecified Pneumonia, Pleurisy	115
114	Pleural Effusion/Pneumothorax	115
119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	120
128	Kidney Transplant Status	130,131,132,136,175
130	Dialysis Status	211,131,132,136
131	Non-Acute Renal Failure	132,136
132	Nephritis	136
137	Female Infertility	138
141	Ectopic Pregnancy	142,146,147
142	Miscarriage/Abortion	146,147
143	Completed Pregnancy With Major	144,145,146,147

DISEASE HIERARCHIES Hierarchical Condition Category (HCC)	If the Condition Category is Listed in this column…	…Then drop the HCC(s) listed in this column
	Complications	
144	Completed Pregnancy With Complications	145,146,147
145	Completed Pregnancy Without Complications (Normal Delivery)	146,147
146	Uncompleted Pregnancy With Complications	147
150	Extensive Third-Degree Burns	151
154	Severe Head Injury	209,48,50,75,76,155,156
155	Major Head Injury	50,156
157	Vertebral Fractures	206,39
161	Traumatic Amputation	177
168	Extremely Low Birthweight Neonates	169,212,170,171,172
169	Very Low Birthweight Neonates	212,170,171,172
212	Low Birthweight (1500-2499 grams) or Unspecified	171,172
170	Serious Perinatal Problem Affecting Newborn	171,172
171	Other Perinatal Problems Affecting Newborn	172
213	Bone Marrow Transplant Status/Complications	175
174	Major Organ Transplant Status	175

k. **Caveats and Limitations**

In preparing its application Massachusetts relied on data from Massachusetts APCD, Commonwealth Care and Marketscan® New England in developing the risk adjustment models and additional adjustment factors, and as such the results may not apply to other States' risk adjustment programs. Additionally, there are limitations in the datasets which may affect the accuracy and robustness of the models and factors presented here.

C. Provisions and Parameters for the Transitional Reinsurance Program

The Affordable Care Act directs the establishment of a transitional reinsurance program 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 equitably stabilizing premiums in the individual market 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.

In the proposed rule, we aimed to administer the reinsurance program to provide reinsurance payments in an efficient, fair, and accurate manner, where reinsurance assistance is needed most, to effectively stabilize premiums nationally. In addition, we stated our intent to implement the reinsurance program in a manner that minimizes the administrative burden of collecting contributions and making reinsurance payments. For example, we proposed to collect contributions from health insurance issuers and self-insured group health plans in all States, including States that elect to operate reinsurance. We also stated our intent to simplify collections by using a uniform per capita contribution rate. In addition, in the HHS-operated reinsurance program, we proposed to calculate reinsurance payments using the same distributed approach for data collection that we will use when operating the risk adjustment program on behalf of States.[15] This would 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 the proposed rule, we proposed uniform reinsurance payment parameters to be used across all States, regardless of whether the State, or HHS on behalf of a State,

[15] See our discussion of this distributed data collection approach in section III.G. of this final rule.

operates reinsurance. In addition, we proposed an annual calendar under which reinsurance contributions would be collected from all contributing entities, and reinsurance payments would be disbursed to issuers of reinsurance-eligible plans. Furthermore, we proposed to distribute reinsurance payments based on the need for reinsurance payments in each State. We believe that allocating contributions in this manner better meets States' individual reinsurance needs and fulfills HHS's obligation to provide equitable allocation of these funds under section 1341(b)(2)(B) of the Affordable Care Act, than does a policy that limits the disbursement of reinsurance payments only to the State in which the contributions are collected.

Comment: One commenter requested that HHS consider extending the reinsurance program past 2016.

Response: Section 1341 of the Affordable Care Act mandates that the transitional reinsurance program operate in the three year period beginning January 1, 2014, which we interpret to mean that the program will operate in benefit years 2014, 2015 and 2016. As a result, we have no statutory authority to extend the program. We note that, under this final rule, reinsurance payments for benefit year 2016 will be made in 2017, and section 1341(a)(4)(B) provides that amounts remaining unexpended as of December 2016 may be used to make payments under any reinsurance program of a State in the individual market in effect in the two-year period beginning on January 1, 2017.

1. State Standards Related to the Reinsurance Program

a. State-operated reinsurance programs, generally

In the proposed rule, we set forth a reinsurance contribution and payment process, and the uniform contribution rate and reinsurance payment parameters that would apply to all States in the 2014 benefit year. We proposed to amend §153.100(a)(1) to delete the reference to State modification of data collection frequency as set forth in the Premium

Stabilization Rule. That deletion would remove the ability of a State electing to operate reinsurance to modify, via a State notice of benefit and payment parameters, the data collection frequency for issuers to receive reinsurance payments. Under §153.100(a)(1), a State establishing a reinsurance program may still 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 that specifies those modifications.

In §153.100(a)(2), we proposed that a State electing to collect additional reinsurance contributions for purposes of making supplemental reinsurance payments or using additional funds for supplemental reinsurance payments under §153.220(d) publish supplemental State reinsurance payment parameters in its State notice of benefit and payment parameters. To create the most effective reinsurance program, we proposed 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 proposed 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 would no longer be able to attribute additional funds for administrative expenses back to a State. We therefore proposed to amend §153.100(a)(3) of the Premium Stabilization Rule to clarify that any additional contributions collected for administrative expenses must be collected by the State operating reinsurance.

Section 1341 of the Affordable Care Act provides that States may elect to operate reinsurance. Based on HHS's communications with States, as of February 25, 2013, Maryland and Connecticut are the only States electing to operate reinsurance for 2014. Pursuant to §153.100, a State that wishes to collect additional reinsurance funds pursuant to §153.220(d) must publish the supplemental contribution rate and supplemental State

reinsurance payment parameters in a State notice of benefit and payment parameters, which for 2014 must be published by the 30th day following the publication of this final rule.

We are finalizing these provisions as proposed, with a technical amendment to §153.210(a)(2) in which we clarify that a State's obligation to ensure that each applicable reinsurance entity operates in a distinct geographic area applies regardless of whether the State contracts with or establishes the applicable reinsurance entities. As we also clarify below, governmental entities may serve as applicable reinsurance entities. We are also amending §153.100(a)(2) by replacing the cross-reference to §153.220(d) with §153.220(d)(1). We are making corresponding revisions in §153.100(d)(2); and §153.110(b); 153.400(a).

Comment: One commenter requested that HHS prohibit States operating reinsurance from modifying the data requirements for health insurance issuers to receive reinsurance payments.

Response: Although we recognize the efficiencies to multi-State issuers of having a uniform set of data requirements, we believe that a State should have the flexibility to collect the data it deems necessary, in the manner it deems most appropriate, to calculate reinsurance payments for issuers of non-grandfathered individual market plans in the State. Accordingly, we will permit State flexibility regarding data requirements. As set forth in §153.100(a)(1), a State modifying the data requirements must describe those requirements in its State notice of benefit and payment parameters.

Comment: One commenter asked that HHS permit a governmental entity to be eligible to serve as an applicable reinsurance entity.

Response: We interpret the definition of an applicable reinsurance entity in section 1341(c)(1) of the Affordable Care Act as a "not-for-profit organization," the

purpose of which is to stabilize premiums in the first three years of Exchange operation and the duties of which are to carry out the reinsurance program, to be broad enough to include a governmental entity. Accordingly, we believe that an applicable reinsurance entity is a not-for-profit organization that is exempt from taxation under Chapter 1 of the Internal Revenue Code of 1986, including a governmental entity and a quasi-governmental entity that was not created for and does not operate to make a profit, and carries out reinsurance functions under this part on behalf of the State.

Comment: One commenter requested that HHS permit a State to obtain a waiver from the reinsurance program set forth in section 1341 of the Affordable Care Act.

Response: HHS has no authority to grant such a waiver. As set forth in the Premium Stabilization Rule, if a State does not elect to operate reinsurance, HHS will operate reinsurance on behalf of the State.

Comment: One commenter asked whether HHS will implement an approval process for States choosing to operate reinsurance, similar to the process used to approve States choosing to operate the risk adjustment program.

Response: Unlike the risk adjustment program, there will be no formal approval process for State-operated reinsurance programs. However, HHS will establish a consultative pre-implementation process to ensure that each State operating reinsurance is ready to operate beginning in 2014. HHS intends to work closely with States throughout the duration of the reinsurance program to ensure States' operational readiness.

Comment: One commenter sought clarification on the functions that a State operating reinsurance must perform.

Response: This final rule sets forth a number of functions that a State operating reinsurance must perform, consistent with the functions of the HHS-operated reinsurance program. For example, under §153.240, a State operating reinsurance must ensure that

the State's applicable reinsurance entity collects data required to calculate reinsurance payments, makes reinsurance payments, and provides a process for reinsurance-eligible plans that do not generate individual enrollee claims in the normal course of business to submit claims. In addition, a State operating reinsurance must notify issuers of requests for reinsurance payments made and actual reinsurance payments to be provided. In addition to performing payment functions, a State operating reinsurance may elect to collect additional funds or use State funds under §153.220(d)(1)(ii) or §153.220(d)(2) (proposed as (d)(3) in the proposed rule) to fund administrative expenses or set up and fund supplemental reinsurance payment parameters that "wrap around" the uniform reinsurance payment parameters.

b. Reporting to HHS

In §153.210(e) of the proposed rule, we stated that a State establishing the reinsurance program would be required to provide information to HHS regarding all requests for reinsurance payments received from all reinsurance-eligible plans for each quarter during the benefit year in the State. In §153.240(b)(2), we proposed that a State, or HHS on behalf of the State, would use the information collected by HHS or submitted under §153.210(e) to provide issuers of reinsurance-eligible plans with quarterly updates of requests for reinsurance payments for the plan under both the uniform payment parameters and any State supplemental payments parameters set forth under §153.232, as determined by HHS or the State's applicable reinsurance entity, as applicable. This information could be used by an individual market issuer in developing rates in subsequent benefit years. We are finalizing these provisions as proposed, with modifications in §153.240(b)(2) to clarify that a State must provide to an issuer of a reinsurance-eligible plan the calculation of the total reinsurance payments requested under the national reinsurance payment parameters and State supplemental reinsurance

payment parameters, on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS.

Comment: Several commenters supported the proposal that HHS or States operating reinsurance provide to issuers quarterly updates of requests for reinsurance payments made under the uniform payment parameters and State supplemental payment parameters, as applicable. Several commenters urged HHS not to require a State operating reinsurance to provide these quarterly estimates.

Response: Because the purpose of the reinsurance program is to help stabilize premiums, and because interim information on reinsurance claims will be useful for issuers in setting rates in subsequent benefit years, we are finalizing §153.240(b) as proposed.

Comment: One commenter requested clarification on whether updates of reinsurance payment requests made would be provided on a rolling basis throughout the benefit year, or only after all reinsurance payment requests have been submitted. Commenters suggested that total payment requests across all issuers be specified so that issuers can estimate whether total payments will exceed total contributions.

Response: A State operating reinsurance or HHS, on behalf of the State, will issue reports on a quarterly basis on the total amount of reinsurance requests submitted. We appreciate the suggestions for the quarterly reporting format, and will take them under consideration. We anticipate issuing guidance for States and issuers regarding quarterly reporting.

c. Additional State Collections

In §153.220(d), we proposed that a State operating reinsurance 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 for additional reinsurance payments. In addition, under §153.220(d)(2), we proposed that 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 are finalizing these provisions as proposed with the following modification: we are deleting §153.220(d)(2), which required a State to 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.

Comment: We received several comments asking HHS to eliminate the requirement set forth in §153.220(d)(2), which provided that 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. However, one commenter encouraged HHS to keep this requirement.

Response: Because HHS will no longer collect additional contributions on behalf of a State, and will not immediately need this information, we are removing §153.220(d)(2) from this final rule. Any State operating reinsurance and electing to collect additional contributions under §153.220(d) must set forth any additional contribution rate that it elects to collect in its State notice of benefit and payment parameters.

Comment: One commenter asked HHS to clarify that States may collect additional administrative expenses only when a State is operating reinsurance.

Response: Only a State operating reinsurance is permitted to collect additional administrative expenses under §153.220(d). The State must set forth any additional contribution rate in its State notice of benefit and payment parameters.

Comment: One commenter asked HHS to prohibit States from collecting

additional funds for administrative expenses.

Response: To allow State flexibility in operating reinsurance, a State operating reinsurance will be permitted to collect additional funds for administrative expenses as the State deems necessary.

Comment: Several commenters opposed the collection of additional funds by States from self-insured plans, and urged HHS to specify in regulatory text that States cannot collect from self-insured plans covered by ERISA.

Response: We reiterate that nothing in section 1341 of the Affordable Care Act or 45 CFR part 153 of this final rule gives a State the authority to collect any funds – whether under the national contribution rate or under an additional State contribution rate – from self-insured group health plans covered by ERISA.

Comment: One commenter requested that HHS specify that the Federal Employees Health Benefit Act prohibits States from imposing additional State reinsurance fund collections on Federal Employees Health Benefits Program (FEHB) plans.

Response: Although §153.220(d) provides that a State may elect to collect additional reinsurance contributions for administrative expenses or reinsurance payments, we do not interpret section 1341 of the Affordable Care Act or 45 CFR part 153 of this final rule as giving States any additional authority to collect from contributing entities. Any such authority must come from other State or Federal law.

d. State Collections

In §153.220(a), we proposed that if a State establishes a reinsurance program, HHS will collect all reinsurance contributions from all contributing entities for that State under a national contribution rate. In §153.220(d)(3) of the proposed rule (which we now renumber as §153.220(d)(2)), we proposed that States may use additional funds, which

were not collected as additional reinsurance contributions, to make supplemental reinsurance payments under the State supplemental reinsurance payment parameters. This would allow States to use other revenue sources, such as funds collected for State high-risk pools. This would also ensure that additional State collections for reinsurance payments and other State funds may be used to reduce premiums. We are finalizing these provisions as proposed.

Comment: Several commenters asked that HHS permit States to collect contributions from health insurance issuers. Other commenters supported the proposed centralized collection of reinsurance contribution under the national contribution rate.

Response: HHS will collect contributions from health insurance issuers and self-insured group health plans in all States, including States that elect to operate reinsurance. This will allow for a centralized and streamlined process for the collection of contributions, and will avoid inefficiencies resulting from the use of different collection processes in different States. Federal collections will also leverage economies of scale, reducing the overall administrative costs of the transitional reinsurance program.

e. High-Risk Pools

Section 1341(d) of the Affordable Care Act and §153.250 of the Premium Stabilization Rule provide that 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), we proposed that State high-risk pools would be excluded from making reinsurance contributions and would not receive reinsurance payments.

The Affordable Care Act permits a State to coordinate its high-risk pool with the reinsurance program "to the extent not inconsistent"[16] with the statute. We clarify that nothing in the Premium Stabilization Rule or this final rule prevents a State that establishes the reinsurance program from using State money designated for the State's high-risk pool towards the reinsurance program. However, a State may not use funds collected for the Affordable Care Act reinsurance program for its high-risk pool. Finally, a State could designate its high-risk pool as its applicable reinsurance entity, provided that the high-risk pool meets all the criteria for being an applicable reinsurance entity.

Comment: Several commenters requested that we permit State high-risk pools to be eligible for reinsurance payments for their high-risk enrollees. Commenters stated that the sudden termination of high-risk pools in 2014 would result in high-risk pool enrollees flooding the individual market, potentially resulting in premium increases for all individual market enrollees and a loss of access to providers currently administering care for high-risk pool enrollees.

Response: Under the definition of a reinsurance-eligible plan in §153.20 of the Premium Stabilization Rule, State high-risk pools are not eligible to receive reinsurance payments for their high-risk enrollees because high-risk pool coverage is not individual market coverage. We note that if a high-risk pool were to be structured as individual market coverage subject to the market reform rules, it would be eligible for reinsurance payments and would also, therefore, be a contributing entity.

Comment: Several commenters asked that HHS clarify that States can continue to operate high-risk pools to complement the reinsurance program and to provide continuity of coverage to risk pool enrollees.

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

Response: States have the flexibility to decide whether to maintain, phase-out, or eliminate their high-risk pools. Because State high-risk pools and the reinsurance program both target high-cost enrollees, high-risk pools can operate alongside reinsurance serving a distinct subset of the target population.

Comment: Several commenters asked that the Federal government continue to provide funding for the State High Risk Pool Grant program.

Response: Funding for the State High Risk Pool Grant Program is not addressed in this final rule.

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. In the proposed rule, we stated that, with respect to insured coverage, issuers are responsible for making reinsurance contributions. With respect to a self-insured group health plan, the plan is responsible, although a third party administrator (TPA) or administrative services only (ASO) contractor may be utilized to transfer reinsurance contributions on behalf of a plan. A self-insured, self-administered group health plan without a TPA or ASO contractor would make its reinsurance contributions directly. For the reasons described above and in the preamble of the proposed rule, we are modifying the definition of "contributing entity" in §153.20 to clarify that a "contributing entity" is a health insurance issuer or a self-insured group health plan.

Comment: Several commenters asked that HHS amend the definition of contributing entity, clarifying the liability of TPAs.

Response: We have amended the definition of "contributing entity" in §153.20 to include the clarification we provided in the proposed rule at 77 FR 73152. This amended

definition states that a contributing entity is a health insurance issuer or a self-insured group health plan. Thus, we clarify that a self-insured group health plan is ultimately responsible for the reinsurance contributions, even though it may elect to use a TPA or ASO contractor to transfer the reinsurance contributions.

Comment: Several commenters sought clarification regarding whether self-insured group health plans may remit reinsurance contributions directly to HHS even if the plan otherwise contracts with a TPA or ASO contractor for administration of benefits.

Response: A self-insured group health plan may elect to make its reinsurance contributions directly to HHS or through a TPA or an ASO contractor.

Comment: One commenter suggested that requiring issuers to submit a separate payment for each insured group would add significant administrative burden.

Response: HHS will provide details on the process for submission of reinsurance contributions in future guidance.

Comment: One commenter stated that the proposed rule does not address whether a TPA may charge administrative fees for the additional work it will undertake to collect reinsurance fees and forward them to HHS.

Response: Any fee for such services would be negotiated between the plan and the TPA or ASO contractor. We note that the program is designed to minimize administrative costs, which we expect to be relatively low.

Comment: Several commenters asked that HHS clarify that a plan with several TPAs should determine if and which TPA will calculate the enrollment count and submit reinsurance payments.

Response: The self-insured group health plan is liable for reporting enrollment counts and making reinsurance contributions. It may utilize any TPA or ASO contractor it wishes (or none) to perform these functions.

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 reinsurance contributions are not required for coverage that is not "major medical coverage" or for health insurance coverage that is non-commercial. We also interpret this statutory language to exclude expatriate health coverage, as defined by the Secretary. HHS plans to define expatriate health coverage in the near future.

(1) Major Medical Coverage: In §153.400(a)(1)(i), we proposed that a contributing entity make reinsurance contributions for its health coverage except to the extent that such coverage is not "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. The preamble to the proposed rule at 77 FR 73152 discussed the definition that should apply for reinsurance purposes. We are finalizing the provisions as proposed.

Comment: One commenter requested that we codify in regulation text the description of major medical coverage that was set forth in preamble.

Response: We reiterate that for purposes of the reinsurance program only, our view is that 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. Coverage that is limited in scope (for example, dread disease coverage, hospital indemnity coverage, or stand-alone vision coverage or stand-alone dental coverage), or extent (for

example, coverage that is not subject to section 2711 of the PHS Act and its implementing regulations) would not be major medical coverage.[17]

In the proposed rule, we stated that when an individual has both Medicare coverage and employer-provided group health coverage, the Medicare Secondary Payer (MSP) rules under section 1862(b) of the Act would apply, 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 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 stated that individuals entitled to Medicare because of disability or end-stage renal disease that have other primary coverage under the MSP rules would be treated consistently with the working aged, as outlined above.

We are finalizing the proposed provisions with the following revisions, described below: (a) we are modifying the exception in §153.400(a)(1)(iii) to exclude from reinsurance contributions expatriate health coverage, as defined by the Secretary; (b) we

[17]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.

are adding §153.400(a)(1)(iv) to codify the Medicare coordination rule; and (c) we are adding §153.400(a)(2)(xiii) to exclude a self-insured group health plan or health insurance coverage that is limited to prescription drug benefits from reinsurance contributions.

Comment: Several commenters supported the proposed treatment of group health coverage that is considered secondary to Medicare under the MSP rules; some requested that the Medicare coordination rule contained in the preamble of the proposed rule appear in regulation text.

Response: We have added paragraph (iv) to §153.400(a)(1) to codify the rule in regulation text. We have included this rule at §153.400(a)(1) to clarify that, to the extent a plan or coverage applies to individuals with respect to which benefits under Title XVIII of the Social Security Act (Medicare) are primary under the MSP rules, reinsurance contributions are not required on behalf of those enrollees under that plan or coverage. In order for a contributing entity to determine its enrollment count as required by §153.405 while taking into account enrollees for which the employer group health coverage is considered secondary to Medicare under the MSP rules, we clarify that the contributing entity may use any reasonable method of estimating the number or percentage of its enrollees. For example, a contributing entity may calculate the percentage of enrollees for which the employer group health coverage is secondary under the MSP rules on the dates it uses when applying the snapshot counting method or actual count method, or on other periodic dates, and reduce the enrollment count calculated using one of the methods in §153.405 by that percentage. A contributing entity may also calculate the total enrollment of individuals for which the employer group health coverage is secondary under the MSP rules on the last day of the third quarter and reduce the enrollment count that was calculated using one of the methods in §153.405.

Comment: Several commenters requested that employer-provided retiree coverage be excluded from reinsurance contributions.

Response: We have no statutory authority to make the requested change under section 1341 of the Affordable Care Act. We clarify that employer-provided retiree coverage is subject to reinsurance contributions unless one of the general exceptions applies (for example, the coverage is not major medical coverage).

Comment: One commenter requested that we expand the Medicare coordination rule to exclude from reinsurance contributions *any* employer-provided coverage that is secondary to any other coverage.

Response: We decline to make this exclusion because we believe that it would be difficult for an individual sponsor or issuer to determine and verify (and it would be difficult for HHS to confirm) without extensive coordination with other issuers and sponsors which enrollees have another source of coverage, whether that other source of coverage is major medical coverage, and which coverage is primary. We also believe that few individuals will have two sources of primary major medical coverage.

Comment: Two commenters requested additional clarification as to how the MSP rules interact with the reinsurance program when an individual has employer-provided group health coverage and is eligible for Medicare due to end-stage renal disease or disability.

Response: If an individual is eligible for Medicare due to end-stage renal disease or disability, then whether reinsurance contributions would be required on behalf of the individual would depend upon whether the Medicare coverage is primary, as with the working-aged.

Comment: A few commenters requested that the preamble language in the proposed rule clarifying that a separate plan that provides coverage for prescription drugs

is excluded from reinsurance contributions be codified in regulation text. One commenter requested clarification that retiree drug plans including employer group waiver plans and other employer-sponsored Part D plans are excluded from reinsurance contributions.

Response: We are amending §153.400(a)(2) to include a new paragraph (xiii) providing that a self-insured group health plan or health insurance coverage that is limited to prescription drug benefits is excluded from reinsurance contributions. Since they only provide coverage for prescription drug benefits, these plans are not major medical coverage. We also note that §153.400(a)(2)(ii)(A) contains an exception for coverage provided by an issuer under contract to provide benefits under Medicare because these private Medicare plans are not part of an issuer's commercial book of business (as discussed in the next section of this preamble). .

(2) Commercial Book of Business: The second general exception at §153.400(a)(1)(ii) from the reinsurance contribution requirement applies to health insurance coverage that is not part of an issuer's commercial book of business. Section 1341(b)(3)(B)(i) of the Affordable Care Act refers to a "commercial book of business," which we proposed to interpret to refer to large and small group health insurance policies and individual market health insurance 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 are finalizing the provisions as proposed.

Comment: One commenter agreed that coverage offered to Federal, State, or Tribal employees should be subject to reinsurance contributions, and that this coverage would be part of an issuer's commercial book of business. Another commenter stated that since Federal and State employee plans make up a significant share of the market's large group enrollment, these plans should be included in a carrier's book of business for purposes of the reinsurance contribution.

Response: For reinsurance purposes, we agree that insured coverage offered to Federal, State or Tribal employees is part of an issuer's commercial book of business. As discussed in the preamble to the proposed rule, we interpret "commercial book of business" to refer to insured large and small group policies and individual market policies.

(3) Policy filed and approved by a State: The third proposed general exception from reinsurance contributions at §153.400(a)(1)(iii) was for insured coverage not filed or approved by a State. As noted in the preamble to the proposed rule at 77 FR at 73153, this exception was intended primarily to address group expatriate coverage for individuals whose work requires them to spend a substantial period of time overseas. We are amending §153.400(a)(1)(iii) so that expatriate health coverage, as defined by the Secretary, is excluded from reinsurance contributions.

Comment: Some commenters requested that all expatriate coverage be excluded from reinsurance contributions, including coverage filed with and approved by a State, as well as self-insured expatriate coverage.

Response: As described above, we are amending this provision so that all expatriate health coverage, as defined by the Secretary, is excluded from reinsurance contributions. We plan to define expatriate health coverage, as well as explain the applicability of the Affordable Care Act to such coverage, in the near future.

Comment: A few commenters noted considerable variation in filing methods for issuers of health insurance coverage in the large group market. The commenters expressed concern that issuers that should make reinsurance contributions may be excluded because of the different filing and approval requirements. For example, some States may not require explicit approval of certain new policy forms, but instead those forms may be deemed approved via issuer certification. One commenter requested clarification as to whether an issuer that is regulated by a State agency other than a department of insurance would be subject to reinsurance contributions under the "filed and approved by a State" language.

Response: We recognize that States can and do use different filing methods to obtain the information from issuers necessary to carry out their regulatory responsibilities. However, we are amending §153.400(a)(1)(iii) so that the exception from reinsurance contributions applies to all expatriate health coverage, as defined by the Secretary.

We proposed in §153.400(a)(2) to explicitly exclude the following types of plans and coverage from reinsurance contributions. We are finalizing these provisions as proposed.

(a) Excepted benefits. We proposed no 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)(i) of the Premium Stabilization Rule.

Comment: A few commenters noted that stand-alone dental or vision coverage is excluded from reinsurance contributions, and requested that other dental or vision coverage should be excluded as well. One commenter suggested that reinsurance contributions should not apply to "carve-out" arrangements that must be offered alongside an employer's major medical coverage that are similar to prescription drug carve-outs, for example, behavioral health and transplant coverage.

Response: An employer decides whether to offer group health coverage, the scope of the coverage, and its structure. An employer that provides dental or vision coverage may do so on a stand-alone basis, in which case the benefits may qualify as excepted benefits, or may include the coverage with the major medical benefits as part of a group health plan. Excepted benefits are not subject to reinsurance contributions.

(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 clarified in the proposed rule 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. Section 153.400(a)(2)(v) of the proposed rule excluded HRAs that are integrated

with a group health plan offered in conjunction with a major medical plan (integrated HRAs) from reinsurance contributions. The preamble to the proposed rule noted that reinsurance contributions generally would be required for that group health plan.

Comment: Several commenters requested that stand-alone HRAs be excluded from reinsurance contributions. Alternatively, some commenters requested that the "one covered life" rule that the Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust final rule (the PCORTF Rule)[18] applies to stand-alone HRAs also apply for purposes of reinsurance contributions. Some commenters requested clarification on when an HRA is "integrated" with a traditional group health plan or health insurance coverage, on how to classify arrangements similar to HRAs that do not meet the technical definition of an HRA, and regarding the treatment of specific types of HRAs (for example, an HRA that only may be used to pay premiums under a fully insured plan).

Response: As described above, integrated HRAs are excluded from reinsurance contributions. We note that the Department of Labor, the U.S. Treasury and HHS recently issued guidance on certain HRA-related issues in "Affordable Care Act Implementation FAQs-Set 11," which can be found at http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs11.html.

(d) Health saving accounts (HSAs): Section 153.400(a)(2)(vi) of the proposed rule excluded HSAs from reinsurance contributions. An HSA is an individual arrangement that is offered along with a high 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

[18]See the Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust final rule (the PCORTF Rule) published on December 6, 2012 (77 FR 72721)

purposes, and thus would be excluded from reinsurance contributions. We note that reinsurance contributions generally would be required for the high deductible health plan because it is major medical coverage.

Comment: Some commenters requested clarification on HSAs "integrated with a group health plan" for reinsurance contributions purposes.

Response: HSAs are excluded from reinsurance contributions because they consist of a fixed amount of funds that are available for both medical and non-medical purposes and therefore do not provide 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 (indexed for inflation), we believe that a health FSA is not major medical coverage under this final rule, and therefore is 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 that are additional benefits to employees, participants, and beneficiaries. If the program (whether self-insured or insured) does not provide major medical coverage, we proposed to exclude it from reinsurance contributions and we are finalizing that provision in the final rule. We also note that employers that provide one or more of these ancillary benefits often sponsor major medical plans which would be subject to reinsurance contributions, absent other excluding circumstances.

(g) Stop-loss and indemnity reinsurance policies: For purposes of reinsurance, we proposed 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 all or most 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.

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. Because we do not consider these programs to be part of a commercial book of business, such military health programs are excluded from reinsurance contributions.

(i) Tribal coverage: Section 153.400(a)(2)(xi) of the proposed rule excluded 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 their capacity as Tribal members (and not in their capacity as current or former employees of the Tribe or their dependents). Similarly, we proposed that coverage provided to Tribal members 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 be required to make reinsurance contributions.

Comment: Some commenters asked that self-insured Tribal plans that cover Tribal employees be excluded from reinsurance contributions, in a manner similar to Tribal plans that cover Tribal members based on their status as Tribal members.

Response: Similar to Federal and State-based employment coverage, these Tribal plans are based on employment relationships. We do not have the authority to make this exclusion.

We received additional comments which requested exceptions for other types of entities.

Comment: Several commenters requested that plans or coverage provided by a voluntary employee beneficiary association (VEBA) established and maintained under the terms of a class action or bankruptcy settlement ordered by a court (court-ordered VEBA) be excluded from reinsurance contributions. A court-ordered VEBA provides retiree medical benefits to former employees of certain companies. The court order specifies the funding and the eligible individuals, and the former employers have no ongoing financial or administrative responsibility. A significant percentage of existing court-ordered VEBAs are not well funded.

Response: We are unable to categorically exclude court-ordered VEBAs. We note, however, that many VEBAs may be excluded from reinsurance contributions because they do not provide major medical coverage.

Comment: Some commenters requested that certain jointly administered Taft-Hartley plans that provide health coverage to collectively bargained employees be excluded from reinsurance contributions. Generally, many of these plans are self-insured and self-administered, and include multiemployer plans within the meaning of section 3(37) of ERISA.

Response: While we recognize the unique nature of these plans, and their important role in providing coverage to collectively bargained employees and covered dependents, we do not have authority under the statute to exclude them from reinsurance contributions. As clarified in the Premium Stabilization Rule and in this final rule, we do not interpret the application of section 1341 of the Affordable Care Act to be limited to issuers and TPAs on behalf of group health plans. We view the plans' coverage as

employment-based, and as a result subject to reinsurance contributions (unless another exclusion applies).

Comment: Several commenters asked for clarification as to whether individuals with group health coverage that elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage or similar continuation coverage under State law are covered lives for reinsurance purposes.

Response: Our view is that COBRA or other continuation coverage is a form of employment-based group health coverage paid for by the former employee. Therefore, to the extent the COBRA coverage qualifies as major medical coverage (and no other exception applies), it is subject to reinsurance contributions.

Comment: A few commenters stated that employer-provided coverage for part-time employees should be excluded from reinsurance contributions.

Response: Unless the coverage for part-time employees is self-insured and is not major medical coverage, or is not part of an issuer's commercial book of business, it is subject to reinsurance contributions (so long as no other exception applies).

3. National Contribution Rate

a. 2014 Rate

As specified in §153.220(c) of the Premium Stabilization Rule, HHS plans to publish in the annual HHS notice of benefit and payment parameters the national per capita reinsurance contribution rate for the upcoming benefit year. Section 1341(b)(3)(B)(iii) of the Affordable Care Act specifies the total contribution amounts to be collected from contributing entities (reinsurance pool) as $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016, and sections 1341(b)(3)(B)(iv) and 1341(b)(4) of the Affordable Care Act direct the collection of funds for contribution to the U.S. Treasury in the amounts of $2 billion for 2014, $2 billion for 2015, and $1 billion for

2016. We sought comments on whether deferring the collection of the $2 billion in funds payable to the U.S. Treasury for 2014 until 2016 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. 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 is $20.3 million (or 0.2 percent of the $10 billion dispersed), as 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 an annual per capita contribution rate of $63.00 in benefit year 2014 or $5.25 per month.

Section 153.220(c) of the proposed rule (previously designated as §153.220(e) in the Premium Stabilization Rule) stated that HHS plans to set in the annual HHS notice of benefit and payment parameters for the applicable benefit year 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 20, we specify these proportions (or amounts, as applicable):

TABLE 20: Proportion of Contributions Collected under the National Contribution Rate for Reinsurance Payments, Payments to the 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 million/$12.02 billion)	$20.3 million

In light of the comments received, we are finalizing these provisions as proposed.

Comment: Many commenters stated that a national contribution rate would penalize States with lower medical costs, and require those States to subsidize other States with higher medical costs. Some commenters asked that HHS vary the contribution rate using an index of health care costs by State. Conversely, many commenters supported a national per capita contribution rate. One commenter asked that the national contribution rate be calculated based on a percentage of premium and not on a per capita basis.

Response: As stated in the Premium Stabilization Rule (77 FR 17227), we are using a national, per capita contribution rate because it is a simpler approach that minimizes the administrative burden of collections. In addition, varying the contribution rate using an index of health care costs would not capture a State's reinsurance needs, which will also vary based upon the relative sizes of the State's individual, group, self-insured markets, and the uninsured.

Comment: Several commenters expressed concern about the annual per capita national contribution rate of $63.00 for benefit year 2014, and suggested lowering the rate. Many commenters were concerned with the expense of the reinsurance contribution for employees.

Response: Section 1341 of the Affordable Care Act states that the total contribution amounts to be collected from contributing entities for 2014 is $12 billion plus administrative expenses. We estimate that the $63 annual ($5.25 monthly) per capita contribution rate for benefit year 2014 will lead to collections in the statutory amount (plus administrative expenses) which we have concluded we have no regulatory authority to change.

Comment: One commenter expressed concern that self-insured group health plans are excluded from receiving reinsurance payments and do not benefit proportionally or directly from their reinsurance contribution. As such, this commenter suggested that HHS prorate the contribution rate for self-insured group health plans, by collecting less than the $63 annual per capita national contribution rate from those plans.

Response: Section 1341 of the Affordable Care Act directs health insurance issuers and self-insured group health plans to make reinsurance contributions. HHS has set forth a national per capita contribution rate for the 2014 benefit year which applies to all contributing entities, including self-insured group health plans.

Comment: Several commenters asked HHS to defer the collection of the $2 billion payable to the U.S. Treasury in 2014 until 2016.

Response: We considered the commenters' statutory interpretations for how such a deferral may be permissible under section 1341 of the Affordable Care Act and would support such a deferral, but concluded that we have no statutory authority to defer the collection.

Comment: Several commenters asked HHS to eliminate the $20.3 million collection for administrative expenses. One commenter stated that HHS has no authority to collect administrative expenses to pay for HHS operating reinsurance on behalf of a State.

Response: We interpret section 1341(b)(3)(B)(ii) of the Affordable Care Act to authorize the collection of additional amounts for administrative expenses, including for HHS when HHS operates reinsurance on behalf of a State. We agree with the commenters on the need to keep these administrative expenses at a minimum, and intend to operate the program efficiently. We note that our estimate of administrative expenses – $20.3 million – represents approximately 0.2 percent of the reinsurance amounts to be collected for 2014, and the costs of Federal employees are not included in the national contribution rate.

Comment: Several commenters asked for clarification regarding whether an employer may pass the cost of the reinsurance contribution to its enrollees in self-insured group health plans.

Response: This final rule does not address how an employer would meet the reinsurance contribution requirements.

Comment: One commenter asked how the national contribution rate will affect premiums or the affordability of coverage once implemented.

Response: As set forth in the regulatory impact analysis to this final rule, HHS estimates that reinsurance payments to issuers will reduce premiums in the individual market by between 10 to 15 percent. This is an HHS estimate for the 2014 benefit year, based in part on a 2009 analysis of health insurance premiums by the Congressional Budget Office.

Comment: Several commenters asked HHS to explain the methodology used to develop the national contribution rate and the assumptions behind the enrollment estimates that were used to calculate the national contribution rate for 2014.

Response: As described in the proposed rule, HHS developed the Affordable Care Act Health Insurance Model (ACAHIM), which estimates market enrollment in a manner that incorporates the effects of State and Federal policy choices and accounts for the behavior of individuals and employers. We used the ACAHIM, which was developed with reference to existing models such as those of the Congressional Budget Office and the Office of the Actuary, to characterize medical expenditures and enrollment choices across the 2014 marketplace. The ACAHIM is made up of integrated modules which predict the number and characteristics of market entrants and medical spending. The outputs of the ACAHIM, especially the estimated enrollment and expenditure distributions, were used to analyze estimated enrollment in the 2014 marketplace.

The market enrollment module of the ACAHIM predicts coverage status of individuals in 2014, incorporating the effects of State and Federal policy choices and accounting for the behavior of individuals and employers. Using recent Current Population Survey data with appropriate population adjustments, the ACAHIM assigns individuals to a single health insurance market as their baseline (pre-Affordable Care Act) insurance status. The module estimates transitions from coverage status in the baseline to individuals' projected status in 2014, taking into account factors such as Medicaid eligibility, eligibility for advance payments of the premium tax credit and cost-sharing reductions under the Exchange, and current take-up rates of insurance.

Comment: Several commenters sought clarification on whether the reinsurance contributions may be charged back to an ERISA plan as a reasonable plan expense. Several commenters asked whether IRS had indicated that the reinsurance contribution is

tax-deductible as an ordinary and necessary business expenses. Several commenters also asked HHS to clarify that the contribution amount will be considered a "plan cost" for all purposes.

Response: The Department of Labor advised HHS upon its review of this final rule that paying reinsurance contributions would constitute a permissible expense of the plan for purposes of Title I of the ERISA because the payment is required by the plan under the Affordable Care Act (*see*, 77 FR 73198, fn 56). Questions seeking clarification regarding particular situations should be directed to the Department of Labor. *See generally* Advisory Opinion 2001–01A to Mr. Carl Stoney, Jr., available at www.dol.gov/ebsa (discussing settlor versus plan expenses). For a discussion regarding the tax status of reinsurance contributions pursuant to the Affordable Care Act, see the FAQ issued by the IRS (http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs).

b. Federal Administrative Fees

In the proposed rule, we estimated the Federal administrative expenses of operating reinsurance for the 2014 benefit year to be approximately $20.3 million, or 0.2 percent of the $10 billion in reinsurance funds to be distributed for the 2014 benefit year. This figure reflects the Federal government's significant economies of scale in operating the program, and results in a national per capita contribution rate of $0.11 annually for HHS administrative expenses.

In the proposed rule, we set forth the process for apportioning the annual per capita amount of $0.11 of administrative expenses as follows: $0.055 of the total amount collected per capita would be allocated to administrative expenses incurred in the collection of contributions from health insurance issuers and self-insured group health plans; and $0.055 of the total amount collected per capita would be allocated to

administrative expenses incurred for activities supporting the administration of payments to issuers of reinsurance-eligible plans. We proposed that if a State operates reinsurance, HHS would retain $0.055 to offset the costs of contributions collection, and would allocate $0.055 towards administrative expenses for reinsurance payments. The total amounts allocated towards administrative expenses for reinsurance payments would be distributed to States operating reinsurance (or retained by HHS where HHS is operating reinsurance) in proportion to the State-by-State total requests for reinsurance payments made under the uniform payment parameters. We are finalizing these provisions as proposed.

Comment: Several commenters sought clarification on how administrative expenses will be distributed to States operating reinsurance.

Response: The 2014 allocation for Federal administrative expenses for operating reinsurance totals $20.3 million. HHS will keep 50 percent to cover the administrative expense of collecting reinsurance contributions from health insurance issuers and self-insured group health plans. The 50 percent allocated for reinsurance payment activities will be distributed in proportion to the State-by-State total requests for reinsurance payments (by total dollars) made under the uniform payment parameters. States operating reinsurance will receive that allocation; HHS will retain the allocation for States not operating reinsurance.

Comment: Several commenters sought clarification on the methodology used to develop the Federal administrative expenses of implementing the reinsurance program in 2014.

Response: We determined HHS's total costs for administering reinsurance on behalf of States by examining HHS's contract costs of operating reinsurance. These contracts cover collections, payments, account management, data collection, program

integrity, operational and fraud analytics, stakeholder training, and operational support. We did not include the cost of Federal personnel. We divided HHS's projected total costs for administering reinsurance on behalf of States by the expected enrollment in health insurance plans and self-insured group health plans. We anticipate that the total cost for HHS to operate reinsurance on behalf of States for the 2014 benefit year will be $20.3 million, or $0.11 per capita per year.

Comment: One commenter expressed concern that HHS under-estimated the cost to a State of administering reinsurance.

Response: The cost estimates in the proposed rule are estimates of HHS's costs of administering the program. HHS may benefit from economies of scale not available to the States. We understand that States operating reinsurance may need to collect additional funds for administrative expenses.

4. Calculation and Collection of Reinsurance Contributions

a. Calculation of Reinsurance Contribution Amount and Timeframe for Collections

HHS intends 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 proposed 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 reinsurance program and the burden on contributing entities.

In the Premium Stabilization Rule, we stated that we would collect reinsurance contributions through a per capita assessment on contributing entities. To clarify how this assessment is made, we proposed in §153.405 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.

In §153.405(b), we proposed that a contributing entity must submit to HHS an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees no later than November 15 of benefit year 2014, 2015, and 2016, as applicable. The count must be determined as specified in proposed §153.405(d), (e), (f), or (g), as applicable. We proposed to amend §153.400(a) so that each contributing entity would make annual reinsurance contributions at the national contribution rate, and under any additional applicable State supplemental contribution rate, if a State elects to collect additional contributions for administrative expenses or supplemental reinsurance payments under §153.220(d). We believe that this annual collection schedule will ensure a more accurate count of a contributing entity's average covered lives, and will avoid the need for any initial estimates and subsequent reconciliation to account for fluctuations in enrollment during the course of the benefit year.

In §153.405(c)(1), we proposed that within 15 days of submission of the annual enrollment count or by December 15, whichever is later, HHS would notify each contributing entity of the reinsurance contribution amounts to be paid based on the submitted annual enrollment count. We specified 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 would be based upon the notification received under §153.405(c)(1).

We are finalizing these provisions as proposed, with technical corrections to §153.400, where we clarify that each contributing entity must make reinsurance contributions annually at the national contribution rate; to §153.405(c), where we clarify that HHS will notify a contributing entity of reinsurance contributions amounts to be paid

for a benefit year by the later of December 15 or 30 days after the submission of the annual enrollment count; and §153.405(a)(1), §153.405(b) and §153.405(d), where we delete "average" to clarify that reinsurance contributions are calculated by multiplying the number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all contributing entities by the national contribution rate, pursuant to §153.405(a).

Comment: Several commenters asked HHS to collect contributions after all reinsurance payment requests are submitted and aggregated, emphasizing that the reinsurance contributions should equal the 2014 requests for reinsurance payments.

Response: Under the Affordable Care Act, the total contribution amounts to be collected from contributing entities for reinsurance payments and payments to the U.S. Treasury for 2014 are $12 billion. We estimate that the $63.00 ($5.25 monthly) annual per capita contribution rate for benefit year 2014 will lead to collections in that amount, including the $20.3 million in administrative expenses. We recognize the possibility that reinsurance payment requests for 2014 may be less than contributions collected for 2014, but section 1341(b)(3)(B)(4)(A) of the Affordable Care Act provides that unused funds after making the 2014 reinsurance payments may be used to stabilize premiums for the three years of the reinsurance program. As set forth in §153.235(b), any unused funds will be used for reinsurance payments under the uniform reinsurance payment parameters for subsequent benefit years.

Comment: One comment received sought clarification on whether contributing entities are required to make reinsurance contributions once per year.

Response: As set forth in §153.400(a), a contributing entity makes reinsurance contributions at the national contribution rate annually.

Comment: Several commenters requested that HHS revise the date by which a

contributing entity must submit the annual enrollment count date to the end of the benefit year, so that issuers may submit enrollment counts on 12 months of data.

Response: Due to operational time constraints surrounding the collection of reinsurance contributions, HHS must receive annual enrollment counts by November 15 of the applicable benefit year in order to invoice and collect contributions in time to aggregate payment requests and make payments. We do not believe the earlier submission will significantly impair the accuracy of the enrollment count.

Counting Methods for Health Insurance Issuers: In §153.405(d), we proposed 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 (77 FR 72721), modified for applicability to the transitional reinsurance program so that a health insurance issuer may determine an annual enrollment count during the fourth quarter of the benefit year. 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 proposed 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 of the benefit year.

(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" 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 will be subject to large increases in enrollment between 2014 and 2016. Therefore, we proposed a modified counting method based upon the ratio of covered lives per policy in the NAIC or State form. Specifically, we proposed 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.[19]

Counting Methods for Self-Insured Group Health Plans: In §153.405(e), we proposed 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 for sponsors of self-insured group health plans under the PCORTF Rule, modified slightly for timing with the reinsurance program, so that enrollment counts may be obtained on a more current basis.

(1) Actual Count Method or Snapshot Count Method: We proposed 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 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 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.[20] For this purpose, the same months must be used for each quarter (for

[19]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.

[20]The preamble to the proposed PCORTF Rule published on April 17, 2012 (77 FR 22691) 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

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 the corresponding dates for the second and third quarters of the benefit 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 proposed 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 final rule, suggests that enrollment in self-insured group health plans is less likely to fluctuate than enrollment in the individual market. Thus, we proposed that a self-insured group health 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

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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."

proposed 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, a plan sponsor 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 proposed in §153.405(g)(1) that if a plan sponsor maintains two or more group health plans or health insurance plans that collectively provide major medical coverage for the same covered lives, which we refer to as "multiple plans" for purposes 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 reinsurance contributions. We proposed to define "plan sponsor" in proposed §153.405(g)(2) based on the definition of the term in the PCORTF Rule 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 multiemployer 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 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 under (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 proposed two exceptions to this aggregation rule, in §153.405(g)(3). A plan sponsor is not required to include as part of a single group health plan as determined under paragraph §153.405(g)(1): (a) any group health plan that consists solely of excepted benefits within the meaning of section 2791(c) of the PHS Act

(such as stand-alone dental or vision benefits); or (b) benefits related to prescription drug coverage. These exceptions were designed to reduce the burden on plan sponsors who have chosen to structure their coverage in that manner.

Multiple Plans: In §153.405(g)(4), we proposed the counting requirements for multiple plans in which at least one of the plans is an insured plan (§153.405(g)(4)(i)), and multiple plans not including an insured plan (§153.405(g)(4)(ii)). First, we anticipate that a plan sponsor would 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 proposed 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 proposed 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 will operate on a benefit year basis, which is defined in §153.20 of the proposed rule (by reference to §155.20) as the calendar year. Therefore, the applicable counting methods, whether or not a particular plan operates on a calendar year basis, would not vary.

Multiple Group Health Plans Including an Insured Plan: When one or more of the multiple group health plans is an insured plan, we proposed 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 proposed 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 proposed 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 described 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 §153.405(g)(4)(ii). There are four counting methods available for self-insured plans which are set forth in §153.405(e)(1) through §153.405(e)(4). Section 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. Paragraph (e)(2) permits an additional method (the snapshot factor method) for self-insured plans. We proposed 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 proposed three possible methods for multiple self-insured plans under paragraph §153.405(g)(4)(ii). We further proposed that the plan sponsor must report to HHS, in a timeframe and manner established by 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 proposed not to require consistency in counting methods between the count calculated under the PCORTF Rule and the count calculated for reinsurance purposes. In other words, we would allow a contributing entity to use, either the counting method corresponding to the method selected for the PCORTF Rule or a different counting method for reinsurance purposes. 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) for purposes of reinsurance, the same counting method would be used across all of the multiple plans, because they would be treated as a single plan for counting purposes.

We are finalizing these provisions as proposed, with the following modifications: we updated the footnotes that referenced the proposed PCORTF Rule with the citation for the final POCRTF Rule; we made a number of technical adjustments to the aggregation rules set forth in §153.405 – we provided plan sponsors with the option to count any coverage options within a single group health plan separately if the coverage options are treated as offering major medical coverage, we provided plan sponsors with the option not to aggregate group health plans for purposes of counting covered lives if each group health plan is treated as offering major medical coverage, and we included HRAs, HSAs, and FSAs in the categories of group health plans that are excluded from the counting rules.

Comment: One commenter asked that HHS confirm that the count of covered lives for purposes of determining reinsurance contributions would be members enrolled

in the first nine months of each year throughout the reinsurance program (and will not be calculated on a twelve-month basis for the second and third years of the reinsurance program).

Response: We intend that the number of covered lives will be determined based on the first nine months of each of the 2014, 2015, and 2016 benefit years.

Comment: Some commenters asked HHS to clarify how the counting methods apply to plans that have a non-calendar plan year.

Response: The reinsurance program will operate on a calendar year basis. As set forth in §153.405, a contributing entity will determine its enrollment count by counting the average number of covered lives of reinsurance contribution enrollees during the first nine months of the benefit year (that is, calendar year) for all of the contributing entity's plans and coverage that must pay reinsurance contributions.

Comment: Several commenters stated that when a TPA or ASO contractor is submitting reinsurance contributions on behalf of a self-insured group health plan, the TPA or ASO contractor should be permitted to count members consistent with the methodology they use for fully insured lives.

Response: Many of the counting methods available to fully insured plans are also available to self-insured plans. If a self-insured plan's TPA or ASO contractor is an issuer that can easily perform such a count, such a choice may be the most efficient. However, this final rule does not require one specific counting method, and provides a self-insured plan, which is responsible for reporting the enrollment count and ensuring the payment of the reinsurance contribution, with the flexibility to use the counting method that it chooses.

Comment: Several commenters generally appreciated the use of PCORTF counting methods. Some commenters suggested that HHS direct plan sponsors or issuers

to count enrollment on the last day of each month and calculate membership based on an average across all months.

Response: In order to relieve the administrative burden of submitting the annual enrollment count, HHS has incorporated, with slight modifications for timing, the counting methods set forth in the PCORTF Rule. Allowing contributing entities to choose from a variety of counting methods gives contributing entities the flexibility to choose a counting method that works best for that plan or coverage.

Comment: Numerous commenters stated that it is unreasonable to believe that employers are unable to identify the States in which their employees reside or work. Several commenters supported HHS's proposal to eliminate the need for employers to allocate employees by State of residence.

Response: State-based allocation of enrollees in a contributing entity's plans or coverage is not necessary because reinsurance contributions will be collected by HHS and placed into a national pool from which reinsurance payments will be made in an efficient, fair, and accurate manner where they are needed most. We believe that this will be most effective in helping stabilize premiums nationally.

Comment: One commenter asked HHS to revise the snapshot counting methods so that issuers would be permitted to use the same date in the first month in each quarter for counting members, in addition to being able to use any date within the same week of the quarter.

Response: Under the "snapshot count method," a health insurance issuer or self-insured group health plan would add the totals of covered lives 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 fall 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). Under the "snapshot factor method," 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 benefit year must fall within the same week of the quarter as the date selected for the first quarter. We believe that those counting methods provide sufficient flexibility, and intend to keep these methods consistent with the PCORTF Rule.

Comment: One commenter asked that HHS permit contributing entities to submit enrollment counts and contributions electronically. One commenter encouraged HHS to permit contributing entities to submit reinsurance contributions electronically in a manner similar to that used for submissions of collections under the PCORTF Rule.

Response: HHS will provide details on the submission of enrollment counts and contributions in future guidance.

Comment: One commenter asked that HHS give contributing entities flexibility in correcting errors when making reinsurance contributions.

Response: Given the complexities related to the first year of the reinsurance program, HHS is aware that operational difficulties may arise. We intend to work closely with contributing entities in establishing the operational processes for the submission of enrollment counts and contributions.

Comment: One commenter suggested that HHS clarify that the enrollee counting methods exclude plan participants who do not have major medical coverage.

Response: As set forth in §153.400(a)(1)(i), reinsurance contributions are not required for a plan or health insurance coverage that is not major medical coverage. Consequently, enrollees in those plans are not required to be included in a count of

covered lives for purposes of reinsurance contributions unless required under §153.405(f) or (g).

Comment: One commenter stated that in order to apply the enrollee counting rules accurately, an employer must be able to determine in what circumstances different health coverage options constitute a single group health plan. The commenter suggested that for the purposes of reinsurance, group health plans be identified by reference to the COBRA rules because they are widely used. Under the COBRA rules, group health arrangements maintained by the same employer generally are treated as a single group health plan unless the instruments governing the arrangements designate them as separate plans and the employer operates them as separate plans.

Response: Section 1301(b)(3) of the Affordable Care Act defines "group health plan" by reference to section 2791(a) of the Public Health Service Act, which states that a group health plan is an employee welfare benefit plan (as defined in section 3(1) of ERISA) to the extent that the plan provides medical care (as defined in section 2791(a)(2)) to employees or their dependents (as defined under the terms of the plan), directly or through insurance, reimbursement, or otherwise.

However, we note that the IRS has promulgated COBRA regulations for determining the number of group health plans an employer maintains. 26 CFR 54.4980B-2, QA 6 (2001)[21] states, in relevant part, that except as otherwise provided in the regulation, all health care benefits provided by a corporation, partnership or other entity or trade or business shall constitute one group health plan unless it is clear from the instruments governing the arrangement(s) that the benefits are being provided under separate plans, and the arrangement(s) are operated under such instruments as separate

[21] See http://www.gpo.gov/fdsys/pkg/CFR-2011-title26-vol17/pdf/CFR-2011-title26-vol17-sec54-4980B-2.pdf.

plans. The COBRA regulations include an anti-abuse rule which states that if a principal purpose of establishing separate plans is to evade any requirement of law, the separate plans will be considered a single plan to the extent necessary to prevent the evasion. We clarify that for purposes of counting covered lives for reinsurance contributions, an employer may count its group health plans in accordance with these regulations, subject to the anti-abuse rule.

Comment: One commenter suggested that HHS revise proposed §153.405(f) to permit employers to disaggregate a group health plan that offers both self-insured and insured coverage options to different groups, and to permit an issuer with respect to one group health plan that contains multiple insured options written by more than one issuer to treat the insured options as separate group health plans for purposes of the counting rules. The commenter stated that §153.405(f) as currently drafted is not consistent with current plan sponsor and issuer practices.

Response: We are amending §153.405(f) to permit such disaggregation, so long as each coverage option is treated as major medical coverage, except if a coverage option consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, only provides benefits related to prescription drugs, or is an HRA, HSA, or FSA. This amendment is designed to allow contributing entities flexibility in performing enrollment counts, while collecting reinsurance contributions for all enrollees with major medical coverage, without "double-counting."

Comment: One commenter suggested that the plan aggregation rules be permissive rather than mandatory, and that it should apply only to overlapping simultaneous coverage.

Response: We agree that the plan aggregation rules should only apply to overlapping, simultaneous coverage. For the reasons set forth in the prior response, we

are amending §153.405(f) and (g) to permit disaggregation, so long as each coverage option or separate group health plan is treated as major medical coverage, except if a coverage option or separate group health plan consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, only provides benefits related to prescription drugs, or is a HRA, HSA, or FSA.

Comment: One commenter suggested that the plan aggregation rules set forth in §153.405(g) should not apply to any plan or health insurance coverage that is excluded from making reinsurance contributions.

Response: We have clarified that the plan aggregation rules do not apply to a plan or health insurance coverage that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, only provides benefits related to prescription drugs, or is an HRA, HSA, or FSA. However, we decline to exempt other plans or coverage excluded from making reinsurance contributions from the aggregation rules because the aggregation rules are designed in part to ensure reinsurance contribution collections from arrangements involving multiple plans that collectively provide major medical coverage, even when each component plan does not. Thus, a plan providing only hospital benefits might have to be aggregated with a plan that provides medical coverage other than hospital benefits, even though the hospital benefit plan on its own would be excluded from making reinsurance contributions because it is not major medical coverage.

b. State Use of Contributions Attributed to Administrative Expenses

In the proposed rule, HHS provided guidance on three restrictions that we intend to propose on the use of reinsurance contributions for administrative expenses, to permit States operating the reinsurance program to accurately estimate the cost of administrative expenses. First, we intend to apply the prohibitions described in section 1311(d)(5)(B) of the Affordable Care Act to the reinsurance program which prohibit an Exchange from

using funds intended for administrative and operational expenses of the Exchange for such purposes as staff retreats, promotional giveaways, and excessive executive compensation. Second, we intend to propose that reinsurance funds intended for administrative expenses may not be used for any expense not necessary to the operation or 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. We received no comments on this guidance. We intend to issue future rulemaking including these provisions.

5. Eligibility for Reinsurance Payments under the Health Insurance Market Reform Rules

We proposed to add §153.234 to clarify that, under either the uniform reinsurance payment parameters or the State supplemental reinsurance payment parameters, 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 of part 156 (essential health benefits package) – would not count toward either the uniform or State supplemental attachment points, reinsurance caps, or coinsurance rates. In other words, those claims would not be eligible for reinsurance payments. We noted in the preamble of the proposed rule that, unlike plans subject to the 2014 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 individuals. (We also noted 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 meet those modified requirements to be eligible for reinsurance payments.) The market reform rules will be effective for the individual market for policy years beginning on or after January 1, 2014. 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 individuals. We also proposed that State-operated reinsurance programs similarly limit eligibility for reinsurance payments, although we recognize that this policy contrasts with the approach proposed for State-operated risk adjustment programs, under which States are permitted 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 their renewal dates, permitting State flexibility on the 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. Last, we proposed to operate the reinsurance program on a calendar year basis, which we believe to be most feasible from policy and administrative standpoints. For the reasons described in the proposed rule and considering the comments received, we are finalizing the provisions proposed in §153.234.

Comment: Commenters generally supported the operation of the reinsurance

program on a calendar year basis. Commenters also requested that HHS use a calendar year approach versus a plan year approach for administrative simplicity. A commenter also requested that HHS use the term "calendar year" instead of "benefit year" to avoid confusion among issuers.

Response: We use the term "benefit year" throughout this final rule instead of "calendar year" because, under §155.20 of the Exchange Establishment Rule, "benefit year" is defined as a calendar year for which a health plan provides coverage for health benefits. For consistency, HHS will continue to use the term "benefit year."

6. Reinsurance Payment Parameters

As described in the Premium Stabilization Rule, reinsurance payments to eligible issuers would be made for a portion of an enrollee's claims costs paid by the issuer that exceeds an attachment point, subject to a coinsurance rate and a reinsurance cap. The coinsurance rate, attachment point, and reinsurance cap are the reinsurance "payment parameters." We proposed uniform reinsurance payment parameters that would be applicable to the reinsurance program for each State, whether or not operated by a State. We believe that using uniform payment parameters will result in equitable access to the reinsurance funds across States and will further the goal of premium stabilization across all States by disbursing reinsurance contributions where they are most needed.

We noted in the proposed rule that 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. 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. 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. To that end, the reinsurance program is designed to alleviate the concern of new high-cost claims from newly insured individuals.

We proposed that the 2014 uniform reinsurance payment parameters be established at: (a) an attachment point of $60,000, when reinsurance payments would begin, (b) a national reinsurance cap of $250,000, when the reinsurance program stops paying claims for a high-cost individual, and (c) a uniform coinsurance rate of 80 percent, which is the reimbursement percentage applied to the issuer's aggregated paid claims amounts on behalf of an enrollee while giving issuers an incentive to contain costs between the attachment point and reinsurance cap. These three proposed payment parameters would help offset high-cost enrollees. The parameters would not interfere with traditional commercial reinsurance, which typically has attachment points in the $250,000 range. We estimate that these uniform payment parameters will result in total requests for reinsurance payments of approximately $10 billion in the 2014 benefit year. We intend to continue to monitor individual market enrollment and claims patterns to appropriately disburse reinsurance payments throughout each of the benefit years during which the reinsurance program is in effect.

We are finalizing the proposed payment parameters, and the associated payment provisions proposed in §153.230(a) through §153.230(c), with a technical revision in §153.230(a) changing "non-grandfathered individual market plan" to "reinsurance-eligible plan" and clarifying in §153.230(c) that national reinsurance payments are 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 in the applicable benefit year.

Comment: Several commenters supported the use of uniform payment parameters. Many commenters, however, suggested that States should be able to set their own payment parameters using State contributions to better target their local markets. Several commenters sought State flexibility and autonomy, with some commenters stating that they had spent substantial time and money preparing a State-operated program specific to the State. One commenter stated that uniform payment parameters and the national allocation of reinsurance payments will not ensure issuers of the aggregate funding available to pay claims in their respective markets until well after premium setting decisions for the next benefit year must be made.

Response: We believe that these uniform payment parameters best meet the reinsurance program's goals to promote premium stabilization and market stability in all States while providing plans incentives to continue effective management of enrollee costs. We aim to administer the transitional reinsurance program in an efficient, fair, and accurate manner so that reinsurance funds are allocated equitably and can maximize downward pressure on premiums. To maximize the program's impact on premiums, uniform reinsurance payment parameters would allow the allocation of reinsurance contributions where they are most needed, to reimburse issuers with high costs in the individual market in 2014, 2015 and 2016. This policy is consistent with the statutory goals of the reinsurance program – to stabilize premiums in the initial years of Exchange implementation and market reform. Additionally, as set forth in §153.240(b)(2), a State, or HHS on behalf of the State, will provide each reinsurance-eligible plan the expected requests for reinsurance payments made under the national payment parameters and State supplemental parameters, if applicable. These reports can provide the information

necessary for issuers to set rates in subsequent benefit years.

Comment: Several commenters requested more detail on the methodology used to calculate the uniform reinsurance payment parameters. One commenter requested that HHS detail the methodology used to determine the $60,000 attachment point. Another commenter requested that HHS raise the reinsurance cap to $500,000 to account for attachment points in commercial reinsurance higher than $250,000. Alternately, one commenter suggested that HHS use a first-dollar approach with no attachment point and a lower coinsurance rate to better incentivize issuers to control costs from the beginning of an individual's care. Several commenters suggested that the proposed contribution rate is insufficient to fully fund the proposed uniform reinsurance payment parameters, and asked HHS to set the uniform payment parameters such that expected payments would be fully funded.

Response: As described in the proposed rule and earlier in this preamble, we used the ACAHIM, which estimates market enrollment incorporating the effects of State and Federal policy choices and accounting for the behavior of individuals and employers. These assumptions and projections led to our estimate of the 2014 individual and employer-sponsored insurance markets and expenditures, and permitted us to estimate uniform payment parameters that will lead to requests for reinsurance payments of approximately $10 billion.

Comment: One commenter asked HHS for guidance on how to account for quality improvement costs and attribute those to an individual, though they are not claims costs. Another commenter suggested that HHS use an alternate method for reinsurance payments, such as a fixed fee schedule or a percentage of Medicare reimbursement rates, instead of claims costs.

Response: HHS believes that using claims costs most appropriately reimburses issuers for costs related to higher risk individuals and will most effectively stabilize premiums.

Comment: One commenter suggested that HHS synchronize reinsurance payments with rules governing claims responsibility, such that if a patient changes coverage over the course of a single claim, the issuer paying the claim should be eligible for reinsurance payments.

Response: We believe that using the date of discharge for claims payments effectively synchronizes reinsurance payments with claims responsibility.

7. Uniform Adjustment to Reinsurance Payments

We proposed in §153.230(d) that HHS would adjust reinsurance payments by a uniform, pro rata adjustment rate if HHS determines that the total requests for reinsurance payments under the reinsurance payment parameters will exceed the reinsurance contributions collected under the national contribution rate during a given benefit year. In the preamble to the proposed rule, we stated that 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. We are finalizing §153.230(d) as proposed.

Comment: Several commenters supported the uniform adjustment to reinsurance payments in the event that total payment requests exceed reinsurance contributions. One commenter objected to the lower coinsurance rate that will effectively result from a uniform adjustment to payments, stating that this could lead to additional uncertainty for issuers.

Response: We developed the national contribution rate and uniform reinsurance payment parameters using enrollment and expenditure estimates for 2014, based on the

ACAHIM. We recognize that requests for reinsurance payments may be greater than predicted, or that collections may be lower than predicted. However, we believe that a uniform adjustment to payments is the most equitable approach in these situations.

Comment: We received a comment seeking clarification on when, if necessary, the uniform adjustment to national reinsurance payments set forth in §153.230(d) would occur, and how HHS will disburse reinsurance funds to States operating reinsurance, in order for the States to make reinsurance payments.

Response: As described in §153.235, HHS plans to allocate and disburse to each State operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of a State), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The disbursed funds would be based on the total requests for reinsurance payments made under the national reinsurance payment parameters by all States and submitted under §153.410, net of any adjustment under §153.230(d). Thus, prior to the disbursement, HHS would uniformly adjust reinsurance payments, if applicable, following the collection of contributions and after the receipt of all claims for reinsurance payments, which must be submitted by April 30 of the year following the applicable benefit year. Following that adjustment, HHS will make reinsurance payments in States where HHS is operating reinsurance on behalf of the State, and will distribute funds to States operating reinsurance.

8. Supplemental State Reinsurance Payment Parameters

In §153.232(a), we proposed that a State establishing the reinsurance program may modify the uniform reinsurance payment parameters only by establishing State supplemental payment parameters that cover an issuer's claims costs beyond the uniform reinsurance payment parameters. We further proposed that reinsurance payments under

these State supplemental payments parameters be made only with the additional funds that the State collects for reinsurance payments under §153.220(d)(1)(ii) or State funds applied to the reinsurance program under §153.220(d)(2) (proposed as (d)(3) in the proposed rule). We stated our belief 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 issuers in all States access to the reinsurance payments from the contributions collected under the national reinsurance contribution rate.

We proposed in §153.232(a) that a State choosing to establish State supplemental reinsurance payment parameters must set those parameters by adjusting the uniform 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. We also proposed that a State may not alter the uniform reinsurance payment parameters in a manner that could result in reduced reinsurance payments.

To provide issuers with greater certainty for premium rate setting purposes, we proposed that a State must ensure that any additional funds for reinsurance payments it collects under §153.220(d)(1)(ii) or State funds under §153.220(d)(2) (proposed as (d)(3) in the proposed rule), as applicable, are reasonably calculated to cover additional reinsurance payments projected to be made under the State's supplemental reinsurance payment parameters for a given benefit year. In §153.232(b), we proposed that contributions collected under §153.220(d)(1)(ii) or additional funds collected under §153.220(d)(2) (proposed as (d)(3) in the proposed rule), 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 proposed in §153.232(c) that a reinsurance-eligible 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 exceed: (1) the supplemental State attachment point; (2) the national reinsurance cap; or (3) 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 uniform reinsurance payment parameters so that the State could apply any additional contributions it collects under proposed §153.220(d) towards reinsurance payments beyond the uniform reinsurance payment parameters. We explained in the proposed rule that this approach permits HHS to distribute funds under the uniform payment formula to where they are needed most, while allowing States that elect to operate reinsurance the flexibility to supplement nationally calculated reinsurance payments. As set forth in §153.240(b), States would be required to separate in their reporting to issuers the reinsurance payments paid under the uniform reinsurance payment parameters and State supplemental reinsurance payment parameters.

To ensure that reinsurance payments under State supplemental payment parameters do not overlap with the uniform reinsurance payment parameters, we proposed the method for calculating State supplemental reinsurance payments. Specifically, we proposed 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.

Similar to payment calculations under the uniform reinsurance payment parameters, we proposed in §153.232(e) that if all reinsurance payments requests 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)(2) (proposed as (d)(3) in the proposed rule) as applicable, the State must determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments in the State. We proposed that each applicable reinsurance entity in the State must reduce all 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 proposed 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 claims, 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 are finalizing these provisions as proposed, with a technical correction changing "non-grandfathered individual market plan" to "reinsurance-eligible plan" and clarifying that the incurred claims costs for an individual enrollee's covered benefits are those incurred in the applicable benefit year in §153.232(c). We are clarifying in

§153.232(d) that reinsurance payments will be calculated with respect to an issuer's incurred claims costs for an individual enrollee's covered benefits incurred in the applicable benefit year.

Comment: Several commenters urged HHS to allow additional State flexibility for the State supplemental reinsurance payment parameters under the reinsurance program. In addition, several commenters requested flexibility for a State to design a program that would cover any shortfall in payments under the reinsurance program's uniform parameters.

Response: One of HHS's goals is to provide the greatest amount of flexibility to States while ensuring consistency with the policy goals of the reinsurance program. Therefore, under these final rules, we have provided States with the flexibility to increase the coinsurance rate on reinsurance-eligible claims, which would have the effect of increasing payouts under the uniform parameters. Additionally, nothing in these final rules prevents a State from establishing a separate program that would operate alongside the reinsurance program established under section 1341 of the Affordable Care Act. A State establishing such a program is free to implement the collections methodology and payment formula of its own choosing.

9. Allocation and Distribution of Reinsurance Contributions

Section 153.220(d) of the Premium Stabilization Rule provided that HHS would distribute reinsurance contributions collected for reinsurance payments from a State to the applicable reinsurance entity for that State. In the proposed rule, we proposed to replace this section with §153.235(a), which provided that HHS would allocate and distribute the reinsurance contributions collected under the national contribution rate based on the need for reinsurance payments, regardless of where the contributions are collected. HHS would 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 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 proposed to amend §153.220(a) to clarify that even if a State establishes the reinsurance program, HHS would directly collect the reinsurance contributions for enrollees who reside in that State from both health insurance issuers and self-insured group health plans.

We are finalizing the provisions as proposed in §153.220(a). We are revising §153.235(a) to provide that HHS will allocate and disburse to each State operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of a State), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The disbursed funds would be based on the 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). We are amending §153.410(a) to clarify that an issuer of a reinsurance-eligible plan may make requests for reinsurance payments when an issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payments in 45 CFR subpart B and this final rule and where applicable the State notice of benefit and payment parameters.

Comment: Several commenters stated that the proposed allocation of reinsurance payments would penalize States that effectively and efficiently manage health care costs and have fewer uninsured individuals. Commenters stated that individual markets are largely State-based and that reinsurance works in conjunction with risk adjustment, which

is also a State-based program. Commenters also stated that disbursing reinsurance payments under uniform reinsurance payment parameters in all States is contrary to the intent of the statute for a State-based program. We also received comments stating that the implementation of the reinsurance program as proposed would increase the burden for States that wish to supplement the reinsurance program. One commenter suggested that reinsurance payment allocations in accordance with need could discourage issuers from maintaining grandfathered status in order to compete for funds, thereby making it difficult for enrollees to keep their current plan.

Response: To maximize the reinsurance program's impact on premium rates, an allocation of reinsurance payments under uniform payment parameters allows for HHS to disburse reinsurance contributions where they are most needed, to reimburse issuers with high cost claims in the individual market in 2014, 2015 and 2016. This policy is consistent with the statutory goals of the reinsurance program – to stabilize premiums in the initial years of Exchange implementation and market reform. Considering the comments received, we are finalizing these provisions as proposed.

Comment: Several commenters asked that HHS refund any unused contributions collected or use those funds to lower the contribution rate for subsequent benefit years.

Response: The purpose of the reinsurance program is to stabilize premiums in the individual market beginning in 2014. If any funds remain after all requests for reinsurance payments are made for any benefit year, as required by the statute, HHS plans to use those funds for reinsurance payments in subsequent benefit years, furthering the goal of section 1341 of the Affordable Care Act.

Comment: Several commenters supported HHS's proposed annual payments schedule coupled with quarterly reporting estimates. One commenter requested clarification on whether reinsurance payments would be issued on a rolling basis

throughout the year, or once annually. Several commenters requested that HHS administer reinsurance payments throughout the year instead of annually to better accommodate issuers' cash flow.

Response: Because we are seeking to stabilize premiums nationally, an annual disbursement of payments preserves fairness in making reinsurance payments and allows for HHS to appropriately adjust payments, if needed. To better address administrative and operational issues, we proposed to make an annual reinsurance payment for each benefit year. 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.

Comment: Several commenters sought clarification on the process by which HHS plans to ensure that reinsurance funds will be used to reduce and stabilize premiums in the individual market.

Response: We expect that an issuer that receives reinsurance payments will reduce premiums in the individual market accordingly. We note that a State, or HHS operating reinsurance on behalf of the State, will provide issuers the estimated amount of the reinsurance payments throughout a benefit year so that those issuers can account for reinsurance payments in developing their premiums for subsequent benefit years. We note that under the single risk pool requirement of the final Market Reform Rule (§156.80), issuers of non-grandfathered individual market plans must adjust their index rate based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the State, and based on Exchange user fees.

Comment: Several commenters asked HHS how excess reinsurance funds would be distributed after 2016.

Response: HHS will provide details regarding this issue in future rulemaking and guidance.

10. Reinsurance Data Collection Standards

a. Data Collection Standards for Reinsurance Payments

Section 153.240(a) of the Premium Stabilization Rule directs a State's applicable reinsurance entity to collect data needed to determine reinsurance payments as described in §153.230. We proposed to amend §153.240(a) by adding subparagraph (1) which would direct a State to ensure that its applicable reinsurance entity either collects or is provided access to the data necessary to determine reinsurance payments from an issuer of a reinsurance-eligible plan. When HHS operates reinsurance on behalf of a State, HHS would utilize the same distributed data collection approach proposed for risk adjustment. This proposed amendment was meant to 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 issuers' secure servers.

We also proposed 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 proposed 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 reinsurance 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. As set forth in §153.710(c), a capitated plan would be required to use its principal internal methodology for pricing encounters for reinsurance purposes, such as the methodology in use for other State or Federal programs (for example, a methodology used for the Medicare Advantage market). If a capitated 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 reinsurance program, would 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 have responded to the comments received regarding capitated plans in section III.G. of this final rule, where capitated plans are discussed in §153.710(c). We are finalizing these provisions as proposed.

b. Notification of Reinsurance Payments

We proposed to add §153.240(b)(1), which would direct 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 applicable 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 would 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 proposed in §153.240(b)(2) that a State provide quarterly notifications of estimates to each reinsurance-eligible plan of the expected requests for reinsurance payments. HHS intends to collaborate with issuers and States to develop these early notifications. We are finalizing these provisions as proposed.

Comment: Several commenters requested that HHS specify a date by which HHS will make reinsurance payments.

Response: Under §153.240(b), HHS would notify issuers of reinsurance payments to be made under the uniform payment parameters by June 30 of the year following the applicable benefit year. We will make every effort to issue payments as quickly as possible. We anticipate issuing further guidance regarding reinsurance payments.

Comment: One commenter requested that, if a State is operates reinsurance in the 2014 benefit year, the deadline for issuers to file rates be moved to April 30 because State supplemental reinsurance payment parameters will affect premium rate setting. The

commenter also requested that for the 2015 and 2016 benefit years, HHS require States to publish the State notice of benefit and payments parameters no later than January 31 of the prior year to provide issuers with ample time to calculate and submit rates for filing approval by March 28.

Response: We understand the challenges posed by various State and Federal deadlines, and anticipate that all stakeholders will work together with both States and HHS to meet those deadlines. However, State deadlines for submitting rates are within the authority of the State.

c. Privacy and Security Standards

We proposed in §153.240(d)(1) that a State establishing the reinsurance program ensure that the applicable reinsurance entity's collection of personally identifiable information[22] 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). In §153.240(d)(2), we proposed 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 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. We are finalizing these provisions as proposed.

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

Comment: We received comments supporting the privacy and security standards set forth in §153.240(d) and suggesting audits and other safeguards to protect personal health information from inappropriate disclosure.

Response: HHS takes seriously its responsibility to monitor the implementation of these programs, including the protection of the privacy of consumers. We will provide more information on our approach to these and other oversight matters in future rulemaking.

d. Data Collection

We proposed in §153.420(a) that an issuer of a reinsurance-eligible plan seeking reinsurance payments submit or make accessible data, in accordance with the reinsurance data collection approach established by the State, or HHS on behalf of the State. In §153.420(b), we proposed 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. Further details surrounding the data collection process when HHS is operating reinsurance on behalf of a State is set forth in subpart H of part 153 and section III.G. of this final rule. We are finalizing these provisions as proposed.

Comment: Several commenters requested clarification on the claims run-out period.

Response: 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 would submit data for a benefit year by April 30 of the year following the applicable benefit year. For example, claims incurred in the 2014 benefit year must be submitted to HHS by April 30, 2015. The submission deadline (the latest date by which data can be

provided for the applicable benefit year) will allow issuers the time necessary to process claims and submit data to their distributed data systems for HHS evaluation. The submission deadline of April 30 of the year following the applicable benefit year also permits HHS an appropriate timeline for payment calculations. However, as described in section III.G. of this final rule, claims submitted for the reinsurance program and encounter data submitted for the risk adjustment program must be for claims and encounters with discharge dates within the applicable benefit year. Use of the discharge date best ensures that services provided across benefit years will be considered in their entirety rather than being partially or fully excluded from consideration as a result of the data submission timing requirements.

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. Therefore, in the proposed rule, we proposed 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 regulatory fees and taxes and assessments deductible from premiums in the MLR calculation. We used this definition to define "after-tax premiums earned," which we proposed to mean, with respect to a QHP, premiums earned minus "taxes." We also proposed 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 noted that under this broader definition, administrative costs may

also include regulatory fees and assessments other than those included in "taxes," as defined above.

Using the definitions above, we proposed 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 proposed to define profits for a QHP through the use of the risk corridors equation; however, we provided for a 3 percent profit margin so that the risk corridors program would protect a reasonable profit margin (subject to the 20 percent cap on allowable administrative costs as described below).

Finally, using the definition of profits discussed above, we proposed to revise the definition of "allowable administrative costs" in §153.500 to mean, 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, assessments and regulatory fees other than those taxes, assessments and regulatory fees defined as deductible from premium revenue under the MLR rules, a result that is consistent with the way they are accounted for by the MLR rules.

The preamble to our proposed rule contained an example that illustrated the proposed operation of the risk corridors calculation. We have included a minor correction to the calculation of profits in this example:

- 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.

- 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 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 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 * $185 = $5.55; 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 $5.55

- Allowable administrative costs are 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 sought comments on the estimates, data sources, and appropriate profit margin to use in the risk corridors calculation in the proposed rule. We are finalizing these proposed provisions with the following modifications. As discussed below, in order to conform with changes finalized in this rule for the MLR program, and in response to comments, we are deleting §153.530(b)(1)(ii) to eliminate the adjustment to allowable costs for reinsurance contributions made by an issuer, and are clarifying the treatment of community benefit expenditures within the risk corridors calculation. We are also modifying our proposed definition of "taxes" in §153.500, by replacing the term "taxes" with "taxes and regulatory fees."

Comment: A few commenters noted that, while the proposed rule stated that the risk corridors profits calculation was based on after-tax premiums, the example in the preamble to the proposed rule calculated 3 percent of profits based on a pre-tax premium amount (that is, earned premiums).

Response: We are finalizing the definition of "profits" based on after-tax premiums, as proposed. We have corrected the profits calculation example in the preamble.

Comment: Two commenters stated that the risk corridors formula is potentially circular, and asked us to reexamine the treatment of profits and taxes in the risk corridors calculation. Because taxes are a parameter in the risk corridors calculation, if risk

corridors payments are taken into account when estimating taxes, the commenters believed that it would result in an iterative effect that could affect the width of the risk corridors. They stated that a similar effect would occur with respect to profits.

Response: In response to these comments, we are clarifying that, similar to the manner in which the MLR is calculated, an issuer should not consider risk corridors payments and charges when estimating taxes under the risk corridors formula. As described in the preamble to the Premium Stabilization Rule, we seek alignment between the MLR and risk corridors programs when practicable so that similar concepts in the two programs are handled in a similar manner, and similar policy goals are reflected. Consequently, our treatment of taxes for risk corridors purposes follows the approach of the MLR program, as outlined in section 3C of the model MLR regulation published by the National Association of Insurance Commissioners (NAIC).[23] We note that, because of the way profits is defined for the risk corridors calculation, no such circularity will occur with profits.

Comment: One commenter asked whether reinsurance contributions could be considered as "taxes and regulatory fees" when determining "allowable administrative costs" in the denominator of the risk corridors calculation.

Response: We note that other provisions of this final rule amend the MLR calculation so that reinsurance contributions are included in Federal and State licensing and regulatory fees paid with respect to the QHP as described in §158.161(a), and are deducted from premiums for MLR purposes. Our proposed definition of "taxes" for purposes of the risk corridors program cross-referenced §158.161(a) and similarly

[23] Section 3C of the NAIC model regulation, available at http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf states, "[a]ll terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates provided for in sections 8, 9, and 10 [rebate calculation sections]."

included reinsurance contributions. Thus, in response to these comments, and to maintain consistency with the MLR calculation and our proposed definition, which we are finalizing as proposed, we are making a conforming amendment to §153.530(b)(1). In this final rule, we are deleting §153.530(b)(1)(ii) and clarifying that reinsurance contributions are included in Federal and State licensing and regulatory fees paid with respect to the QHP as described in §158.161(a), and thus are included in allowable administrative costs for risk corridors purposes. We are also making a conforming change to §153.520(d) to remove the requirement that a QHP issuer must attribute reinsurance contributions to allowable costs for the benefit year. In addition, we are making a conforming modification to the proposed definition of "taxes" in §153.500, by replacing the term "taxes" with "taxes and regulatory fees."

Comment: Nearly all those that commented on the risk corridors profit margin agreed with the 3 percent profit margin set in the proposed rule. One commenter suggested that a 2 percent profit margin would be more appropriate.

Response: Based on the comments received and the policy arguments outlined in our proposed rule, we are finalizing the definition of "profits" in §153.500 as proposed.

Comment: One commenter expressed concern that an allowance for up to 3 percent profit could disrupt the budget neutrality of the risk corridors program, and asked for clarification on HHS's plans for funding risk corridors if payments exceed receipts.

Response: The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.

Comment: One commenter stated that the risk corridors calculation does not account for the credibility adjustment that is part of the MLR formula, and recommended setting maximum allowable administrative costs at 20 percent plus the allowed credibility

adjustment for the carrier's block of business. The commenter believed that this change would be consistent with the MLR formula and make it more viable for carriers to maintain their smaller blocks of business, given the higher claims volatility that often characterizes these smaller blocks of business.

Response: Although we seek consistency with MLR where the risk corridors and MLR formulas contain similar parameters, we believe that the credibility adjustment is a unique parameter in the MLR formula. The MLR statute provides for a credibility adjustment through "methodologies . . . designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans" at section 2718(c) of the Affordable Care Act. No similar reference appears in section 1342 of the Affordable Care Act.

Comment: One commenter requested clarification on whether community benefit expenses would be included in the taxes of non-profit entities for the purposes of calculating the risk corridors target amount.

Response: We believe that accounting for these expenses as taxes when calculating the target amount would appropriately align the risk corridors formula with the MLR calculation. Our proposed definition of "taxes" in §153.500 includes Federal and State taxes defined in §158.162(b), which describes payments made by a tax-exempt issuer for community benefit expenditures. Consequently, we are clarifying that non-profit entities may account for community benefit expenditures as "taxes and regulatory fees" in a manner consistent with the MLR reporting requirements set forth in §158.162 for the purposes of calculating the risk corridors target amount.

2. Risk Corridors Establishment and Payment Methodology

We proposed 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. By June 30 of the year following an applicable benefit year, under §153.310(e), QHP issuers will have been notified of risk adjustment payments and charges for the applicable benefit year. By that same date, under §153.240(b)(1), QHP issuers also will have been notified of all reinsurance payments to be made for the applicable benefit year. As such, we proposed 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 also proposed that the MLR reporting deadline be revised to align with this schedule. We are finalizing this provision as proposed.

Comment: We received several supportive comments on our proposal to require issuers to submit risk corridors information by July 31 of the year following the applicable benefit year.

Response: We are finalizing §153.530(d) as proposed, so that the due date for QHP issuers to submit all risk corridors information is July 31 of the year following the applicable benefit year. In section III.I.1. of this final rule, we also finalize our proposal to align the MLR reporting deadline with this schedule.

Comment: One commenter asked how payments made under the State supplemental reinsurance payment parameters are taken into account in the risk corridors calculation. Another commenter requested that HHS clarify the treatment of State "wrap-around" reinsurance payments under the risk corridors calculation, and asked for information on the way in which HHS analyzed the impact of the administrative burden associated with removing these costs.

Response: Under section 1342(c)(1)(B) of the Affordable Care Act, allowable costs are to be reduced by any risk adjustment and reinsurance payments received under sections 1341 and 1343. Supplemental reinsurance payments made under State

supplemental reinsurance payment parameters are reinsurance payments received under sections 1341 of the Affordable Care Act; thus, allowable costs in the risk corridors formula are to be reduced by the reinsurance payments received both under the uniform payment parameters and any State supplemental reinsurance payment parameters.

We do not believe that adjusting the risk corridors formula to account for this parameter will result in any additional administrative burden on issuers, because issuers will be performing the calculations to account for these adjustments at the same time they adjust for reinsurance payments under the uniform payment parameters.

Comment: One commenter suggested that we align the risk corridors calculation with their suggestions on the MLR calculation, which would entail accounting for risk adjustment transfers and reinsurance contributions as adjustments to premiums, rather than claims. Another commenter similarly recommended that reinsurance payments be treated as an adjustment to premiums in the risk corridors calculation, noting that such an approach would reflect current market practices.

Response: We do not believe we have the statutory authority to accommodate this request, because section 1342(c)(1)(B) of the Affordable Care Act requires reducing allowable costs for reinsurance and risk adjustment payments received.

Comment: A number of commenters indicated that risk corridors should be calculated at the issuer level as opposed to the QHP level. One commenter indicated that the current policy of calculating risk corridors at the plan level is inconsistent with the single risk pool requirement in the proposed Market Reform Rule (77 FR 70584), and other issuers pointed out other policy concerns, such as non-alignment with MLR and lack of statistical credibility.

Response: We agree that a plan-level risk corridors calculation creates an incongruity with the single risk pool requirement set forth at §156.80. Under the

regulation as written, risk corridors would compare allowable costs (adjusted claims), which are currently plan-specific, and target amount (adjusted premiums), which under the single risk pool requirement must be based on market-wide expected claims. After considering comments received on the proposed rule, we are publishing an interim final rule elsewhere in this issue of the **Federal Register** to address alignment of the risk corridors calculations with the single risk pool requirement. Under the approach implemented in the interim final rule, an issuer could reasonably allocate, in accordance with §153.520, allowable administrative costs across its business pro rata by premiums earned, leading to an issuer-level risk corridors calculation for its QHP business.

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 issuer 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 that 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, received reinsurance payments of $35, and received cost-sharing reduction payments of $15, the QHP issuer's allowable costs would be $125 ($200 allowable costs - $25 risk adjustment payments received - $35 reinsurance payments received – $15 cost-sharing reduction payments).

We additionally proposed 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. We proposed 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, we clarified that 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.

We also proposed 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. We received no responses to our request for comment on this proposal. Therefore, we are finalizing this provision as proposed.

4. Manner of Risk Corridor Data Collection

We also proposed 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. We received no responses to our request for comment on this proposal. Therefore, we are finalizing this provision as proposed.

E. Provisions for the Advance Payment 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 proposed to amend §155.305(g)(3), currently entitled "special rule for multiple tax households." Our proposed amendment renamed this paragraph "special

rule for family policies," added a category for qualified individuals who are not eligible for any cost-sharing reductions, and revised the introductory text to address situations in which Indians (as defined in §155.300(a)) and non-Indians enroll in a family policy. The proposed amendment also extended 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 noted 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 discuss this policy further with regard to Indians eligible for cost-sharing reductions under section 1402(d) of the Affordable Care Act in section III.E.4.i. of this final rule. We are finalizing these provisions as proposed.

Comment: Several commenters supported the proposed policy, noting that it would be operationally infeasible for QHP issuers to have two family members with different cost-sharing levels enrolled in the same policy. Other commenters stated that families should not need to purchase multiple individual plans so that each family member can receive the full value of the cost-sharing reductions for which they are eligible. Commenters expressed concern that for large families, premiums for multiple individual plans could offset the value of the cost-sharing reduction, as well as potentially subjecting family members to separate out-of-pocket maximums and separate deductibles. One commenter suggested the option of a family-based plan that offers a weighted actuarial value reflecting the cost-sharing reductions available to individual members. Another commenter was concerned about the ability of Exchanges to explain to consumers the advantages and disadvantages of buying multiple policies versus one family policy.

Response: As deductibles and out-of-pocket limits are calculated at the policy level, we believe it will be operationally difficult to establish separate cost-sharing requirements for different enrollees covered by the same policy at this time. HHS will encourage Exchanges to provide appropriate guidance to consumers on the relative costs and benefits of enrolling in one family policy versus multiple individual policies so that families can best take advantage of cost-sharing reductions.

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

We proposed to add paragraph (g) to §155.330 to clarify how an Exchange would redetermine the eligibility of an enrollee during a benefit year if an Exchange receives and verifies new information reported by an enrollee or identifies updated information through data matching that affects eligibility for advance payments of the premium tax credit and cost-sharing reductions. We proposed that when an Exchange recalculates the amount of advance payments of the premium tax credit available after considering such a change, an Exchange must account for any advance payments already made on behalf of the tax filer in that benefit year to minimize, to the extent possible, any projected discrepancies between the advance payments and the tax filer's projected premium tax credit for the benefit year. We specified that this recalculation will only include months for which the tax filer has been determined eligible for advance payments of the premium tax credit. We also proposed 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. Further detail and examples of this policy were provided in the proposed rule.

We further noted in the preamble that we considered taking a different approach if an eligibility redetermination during the benefit year resulted 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. We solicited comments regarding whether we should adopt this approach, and if so, how QHP issuers should be required to provide the retroactive payments to enrollees. Several commenters raised concerns regarding the operational and administrative challenges associated with such retroactive payments.

We are finalizing the policy substantially as proposed, with modifications to the language in paragraph (g) to increase clarity. We are not implementing the retroactive payment approach.

Comment: A number of commenters expressed their support for the proposed approach, though some sought further clarification regarding the impact of eligibility redeterminations on advance payments of the premium tax credit and cost-sharing reductions. Several commenters also requested that HHS modify the proposed approach, by placing a limit on the number of redeterminations per benefit year to reduce administrative burden, or by providing that when accounting for advance payments of the premium tax credit already received by an enrollee whose income has since increased, an Exchange should never reduce the enrollee's future payments by more than the limits on repayment following the benefit year as specified in 26 CFR 1.36B-4(a). Another commenter urged that HHS require QHP issuers to conduct extensive outreach to enrollees to effectively implement this provision.

Further, although several commenters expressed support for how the alternative proposal could assist enrollees with issues such as past due premium amounts, we also

received several comments raising concerns and seeking additional specificity. Commenters mentioned the operational and administrative challenges that the alternative proposal would pose for both QHP issuers as well as HHS, and stated that the potential advantages for enrollees would be minimal.

Response: We provide additional detail on redeterminations during the benefit year and their implications for cost-sharing reductions in §156.425. We note that redetermining eligibility when changes occur is important to the accuracy of eligibility determinations during the year. We also note that we expect that QHP issuers will provide guidance to enrollees regarding the importance of reporting changes, and the avenues through which changes can be reported. In finalizing the policy as proposed, we do not specify that the Exchange will consider the statutory limits on repayment, as these limits are separate from the premium tax credit calculation itself, and are intended to be applied at the time of tax filing.

After considering the comments regarding the operational and administrative challenges involved with the alternative proposal, we decided to maintain the approach proposed. We believe that the comments received that questioned the benefits associated with the alternative on which we requested comment, combined with the operational concerns regarding how HHS would provide such retroactive payments to QHP issuers and the process through which QHP issuers would reimburse enrollees, outweigh the potential benefit for enrollees.

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

Under our authority to administer the payment of cost-sharing reductions and advance payments of the premium tax credits conferred in section 1412 and the rulemaking authority conferred in section 1321(a) of the Affordable Care Act, we

proposed to add two paragraphs to §155.340. First, we proposed 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 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 would allocate the advance payment of the premium tax credit(s) in accordance with the methodology proposed in §155.340(e)(1) and (2). Under that methodology, 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. 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. We provided additional detail on the allocation methodology in the proposed rule and welcomed comments on this proposal.

As discussed in greater detail below, we received a number of comments on the allocation of advance payments of premium tax credits among QHPs and stand-alone dental plans. We also received one comment expressing concern that the proposed allocation methodology was too complicated and may prevent consumers from selecting a plan or the plans that are in the household's best interest. In particular, the proposed pro rata distribution by premium delays the calculation of the allocation of the advance payments until after QHPs have been selected. This delay would prevent an Exchange

from displaying the amount of premium that a household would pay out-of-pocket for each plan until all plans have been selected.

We do not want to restrict the way that an Exchange develops the consumer shopping experience, and therefore, considering the comment received on this approach, we are modifying the proposed rule and finalizing a policy to allow Exchanges greater flexibility in allocating the advance payment of the premium tax credit if the individuals in the tax filers' tax household(s) are enrolled in more than one QHP or stand-alone dental plan. Specifically, as finalized in §155.340(e), if one or more advance payments of the premium tax credit are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan, then the advance payment 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 a reasonable and consistent manner specified by the Exchange; and (2) any remaining advance payment of the premium tax credit must be allocated among the stand-alone dental policies (if any) in a reasonable and consistent manner specified by the Exchange. We do not choose to set specific parameters for the allocation approach; however, the Exchange must apply the same approach to all advance payments of the premium tax credit provided during a benefit year. We are also making some clarifying modifications to the language of this provision.

For Federally-facilitated Exchanges, we establish a methodology at §155.340(f) in which the advance payment of the premium tax credit is allocated based on the number of enrollees covered under the QHP or stand-alone dental policy, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS

under §147.102(e) of the final Market Reform Rule.[24] If this methodology results in an advance payment of the premium tax credit allocation that exceeds a QHP's adjusted monthly premium properly allocated to EHB, the surplus advance payment of the premium tax credit will be allocated evenly to any of the other QHP policies, up to the applicable adjusted monthly premium properly allocated to EHB. And, in accordance with the general policy, any advance payment of the premium tax credit above the aggregate adjusted monthly premiums for the QHP policies properly allocated to EHB must be allocated among the stand-alone dental policies in a similar manner. We provide the following example:

- A family that is eligible for a premium tax credit and is made up of a child age 18 and two parents age 53 purchases two QHP policies and a stand-alone dental policy on an FFE. One parent and the child are enrolled in QHP A, with an adjusted monthly premium allocable to EHB of $470. The other parent is enrolled in QHP B, with an adjusted monthly premium allocable to EHB of $350. The child is enrolled in the stand-alone dental policy, with an adjusted monthly premium of $20, with all $20 allocable to EHB. The family receives a monthly advance payment of the premium tax credit equal to $830. On an FFE, $820 would be allocated between the two QHPs (that is, the portion of the advance payment of the premium tax credit that is less than or equal to the aggregate premiums for the QHP policies allocable to EHB), and the remainder ($10) would be allocated to the stand-alone dental plan. Assuming the default uniform age curve requires rates for an individual aged 53 to be adjusted by 2.04, and rates for an individual aged 18 to be adjusted by 0.635, $465 ((820/(2.04+2.04+0.635))* (2.04+0.635)) would be allocated to QHP A and $355 (820/(2.04+2.04+0.635))*2.04)

[24] We note that to simplify operations, even if a State establishes a uniform age rating curve as allowed under §147.102(e), we will continue to use the default uniform age rating curve with a 3:1 ratio established by the Secretary of HHS for purposes of allocating advance payments of the premium tax credit.

would be allocated to QHP B. However, because $355 exceeds the portion of QHP A's premium allocable to EHB, the surplus allocation ($5) is shifted from QHP A to QHP B. Therefore, $350 will be applied to the premium for QHP A, $470 for QHP B, and $10 for the stand-alone dental plan.

This approach will allow an FFE to determine the allocation of the advance payment of the premium tax credit prior to plan selection so that we may display the amount of premium that a household would pay out-of-pocket for each plan during the shopping experience. At the same time, this approach approximates an allocation based on premiums (prioritizing the QHP policies over the stand-alone dental plan coverage as we proposed). State-based Exchanges may choose to adopt the Federal methodology or another reasonable methodology under §155.340(e) of this final rule.

Comment: We received a comment stating that the methodology proposed in §155.340(e)(1) and (2) will be too complicated for the average consumer to understand, particularly for complex households. The proposed methodology would prevent an Exchange from displaying the amount of premium that a household would pay out-of-pocket for each plan until all plans have been selected. If out-of-pocket costs cannot be shown at a plan level prior to selection, consumers could be dissuaded from purchasing coverage or might select a single plan for all household members, even if doing so is not in the household's best interest. The commenter proposed that Exchanges allocate the advance payment of the premium tax credit(s) equally to each household member to allow consumers to view the amounts of advance payment of the premium tax credit(s) allocated to each QHP or stand-alone dental plan during the shopping experience, and to permit consumers to compare more effectively different plan options and family member groupings.

Response: We recognize the importance of providing a transparent and consumer-friendly shopping experience, and are modifying our proposal to allow Exchanges the flexibility to choose a reasonable allocation methodology. This policy would allow an Exchange to allocate the portion of the advance payment of the premium tax credit that is less than or equal to the aggregated adjusted monthly premiums for the QHP policies properly allocated to EHB among the QHPs using a per member approach. However, the Exchange must still allocate the remainder to the stand-alone dental plan(s), though this portion may also be allocated using a per member approach.

The approach that will be used by FFEs to allocate the advance payment of the premium tax credit will allow the FFE to display the amount of premium that a household would pay out-of-pocket for each plan during the shopping experience. In addition, the FFE approach approximates an allocation based on premiums (prioritizing the QHP policies).

Comment: We received several comments regarding the methodology proposed in §155.340(e)(2). Commenters noted that because we proposed that advance payments of the premium tax credit(s) be allocated first to QHP policies, and any remainder be allocated to stand-alone dental policies, it is unlikely that advance payments of the premium tax credit(s) will be available to offset the cost of the stand-alone dental policies. One commenter stated that advance payments of the premium tax credit(s) should be allocated pro rata among QHP policies and stand-alone dental policies according to premium to assist families with purchasing pediatric dental coverage, which is one of the essential health benefits. Another commenter suggested that advance payments of the premium tax credit(s) should be allocated first to any stand-alone dental policy, and the remainder allocated to the QHP(s). A third commenter stated that the cost to issuers of stand-alone dental policies to develop a process to accept advance payments

of the premium tax credit(s) on behalf of enrollees outweighs the potential benefit, and consequently, advance payments of the premium tax credit(s) should only be allocated to QHP policies.

Response: We believe that advance payments of the premium tax credit(s) should first be allocated to QHP policies, and any remainder should be allocated to stand-alone dental policies. This approach will ensure that the majority of the tax credit is allocated to the most costly portion of an individual's coverage. While we understand the burden on stand-alone dental plans of implementing a process to accept the advance payments of the premium tax credit, we believe that consumers should not be required to wait until tax filing in order to receive the full amount of their premium tax credit benefit.

We are finalizing paragraph (e) with the changes from the proposed rule noted above. The second provision we proposed to add to §155.340 was paragraph (f), now relabeled as paragraph (g) in this final rule. The standards proposed in this paragraph are discussed below in section III.E.4.g.

2. Exchange Functions: Certification of Qualified Health Plans

We proposed to add §155.1030 to 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 proposed 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 Act, including the establishment of programs for the provision of advance payments of the premium tax credit and cost-sharing reductions.

In §155.1030(a)(1), we proposed 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 and certify that the submitted plan variations meet the requirements of §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 proposed in §155.1030(a)(2) that the Exchange provide the actuarial values of the QHPs and silver plan variations to HHS. As described in proposed §156.430, HHS would use this information to determine the advance payments to QHP issuers for the value of the cost-sharing reductions.

In §155.1030(b)(1), we proposed the Exchange collect and review 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; in addition, the proposal would direct an Exchange to ensure that the allocations provided by the issuer are consistent with the standards identified in §156.470(c)-(d). Specifically, in §156.470(a), we proposed 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),[25] and (2) any other services or benefits offered by the health plan not described in clause (1). In the preamble to the proposed rule, we explained that 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 §156.430.

In §156.470(e), we further proposed 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 standards 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 and finalized in §155.170(c) of the final 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 were a premium under the fair health insurance premium standards described at §147.102, the single risk pool standards

[25] 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.

described at §156.80, and the same premium rate standards described at §156.255. We proposed this standard because we believe the allocation of rates should be performed consistent with the standards applicable to the setting of rates.

In §156.470(b), we proposed somewhat similar standards for the allocation of premiums for stand-alone dental plans. Specifically, we proposed 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 the 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 noted that unlike issuers of metal level health plans, issuers of stand-alone dental plans would be required to submit a dollar allocation of the expected premium for the plan. We specified this because, unlike QHPs, issuers of stand-alone dental plans are not required to finalize premiums prior to the start of the benefit year. However, §156.470(b) as proposed and finalized here directs stand-alone dental plan issuers to finalize the dollar amount of the premium allocable to the pediatric dental essential health benefit prior to the start of the benefit year to allow for the calculation of advance payments of the premium tax credit.

In §156.470(e), we also proposed 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 were 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. Specifically, in §156.470(d)(1) and (2) we proposed 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 proposed that the allocation be calculated as if it were a premium subject to the fair health insurance premium standards at §147.102 and the single risk pool standards at §156.80, as well as the same premium standard described at §156.255. However, in §156.470(d)(4) we provided a specific standard for age-adjustments to account for the fact that the dental essential health benefit only applies to the pediatric population. We also noted 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 proposed 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, to ensure that such allocations meet the standards set forth in §156.470(c) and (d). To ensure that the allocations are completed appropriately, we explained in the preamble to the proposed rule that 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 as finalized in the Exchange Establishment Rule. In addition, 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 because the revised reporting requirements for issuers seeking to increase rates set forth in the Market Reform Rule at §154.215(d)(3)-(4), and

detailed in the accompanying PRA package, include the rate allocation and expected allowed claims cost allocation information. These reporting requirements will reduce the need for duplicate submissions by issuers and reviews by Exchanges. However, we noted 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 seeking to increase rates. Therefore, the preamble identified our expectation that Exchanges will collect the allocation information through either securing access to the data submission by QHP issuers for rate increases under §154.215, or the QHP certification and annual submission process under parts 155 and 156, as appropriate.

In §155.1030(b)(2), we proposed that the Exchange submit to HHS the approved allocation(s) and actuarial memorandum for each QHP and stand-alone dental plan. In paragraph (b)(4), we proposed 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 credit programs.

In §155.1030(b)(3), we proposed 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 would then submit the estimates and supporting documentation to HHS for review. We clarified further that the Exchange would not review these estimates, and HHS's review would simply ensure that the estimates were developed in a manner consistent with the methodology established by HHS in the preamble to §156.430(a) of this final rule, in keeping with HHS's obligation to safeguard Federal funds.

We are finalizing the provisions in §155.1030 as proposed, with technical corrections to §155.1030(a) and (b)(2). We replace the phrase, "The Exchange" in the beginning of proposed §155.1030(a) with "An Exchange," to align with other provisions in part 155. We also replace the phrase "[an issuer] offers or seeks to offer" from the proposed rule with the phrase "[an issuer] offers, or intends to offer" in the final rule, to align with the language in §156.430(a) requiring issuers to submit information for the advance payment of cost-sharing reductions; the scope of these regulatory requirements is intended to be the same. Similarly, we are making technical corrections to §156.470(a), (b) and (e) to standardize the phrase describing the issuers who must comply with the rule as those issuers with plans "offered, or intended to be offered" on an Exchange.

We are also adding paragraph (c) to §155.1030 and paragraph (f) to §156.470 to clarify the application of these provisions to multi-State plans. Section 1334 of the Affordable Care Act directs OPM to enter into contracts with issuers to offer multi-State plans. Accordingly, OPM is responsible for ensuring that multi-State plans and their issuers comply with various Exchange standards, including standards relating to cost-sharing reductions and advance payments of the premium tax credit.

We are also finalizing the provisions proposed in §156.470(a), (b), (c), (d)(1), and (e). To allow greater flexibility for stand-alone dental plan issuers in developing the allocation of dental premiums to EHB, we are not finalizing the allocation standards described in paragraphs (d)(2), (3), and (4) of the proposed rule. We believe the allocation standard previously described in subparagraph (d)(1), which requires that the allocation be performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, is a sufficient standard for ensuring that stand-alone dental plan issuers allocate the premium

accordingly. We intend to provide further details on the reporting process for stand-alone dental plan premium allocations for the FFE.

Comment: We received one comment in support of the provisions at §155.1030 that all QHP issuers provide the plan variations as part of the certification process. We also received a comment requesting that HHS provide to issuers a good-faith compliance safe harbor on the new cost-sharing reductions standards and suggesting that this safe harbor could be revisited prior to the 2016 plan year.

Response: We will take the comment into consideration in future rulemaking on oversight functions.

Comment: In regard to §156.470, we received a comment asking for one set of guidance on all actuarial data submissions required for QHP certification, rate review, and market stabilization. The commenter suggested that HHS develop a standard template for the annual actuarial memorandum with specific instructions on what data should be included in the actuarial memorandum. In addition, we received a specific comment asking for guidance on how issuers should allocate the cost of prescription drug essential health benefits.

Response: As discussed in the preamble of the proposed rule, we have attempted to streamline actuarial reporting requirements. In the Market Reform Rule, at §154.215(d)(3)-(4), and detailed in the accompanying PRA package, we revised the reporting requirements for issuers seeking to increase rates to include the rate allocation and expected allowed claims cost allocation information that issuers of metal level health plans would submit to an Exchange under§156.470(a) finalized here. We created a unified data template for the submission, as well as detailed instructions for completing the actuarial memorandum. We suggest that Exchanges require issuers not seeking rate increases, and stand-alone dental plan issuers who are not subject to the rate review

program, to use similar reporting processes in order to submit the rate and claims cost allocation information to the Exchange under §156.470 as finalized in this final rule.

In response to the specific comment asking for guidance on allocating the cost of prescription drug essential health benefits, we refer readers to §156.122 of the final EHB/AV Rule, which specifies that for a plan to meet the EHB requirements, it must cover at least the greater of: (1) one drug in every category and class within the United States Pharmacopeia's (USP) classification system; or (2) the same number of drugs in each category and class as the EHB-benchmark plan. We do not specify a maximum number of drugs that a plan may cover. Therefore, when determining the claims costs for EHB, QHP issuers should include all prescription drug claims costs within the USP classification system, except for claims costs associated with drugs for services described in §156.280(d)(1).

Comment: We received several comments relating to the provisions at §156.470(b) and (d) on the allocation of premiums for stand-alone dental plans for purposes of calculating advance payments of the premium tax credit. One commenter stated that because stand-alone dental plans are exempt from the rating standards set forth in the final Market Reform Rule, issuers of stand-alone dental plans should not be required to follow such standards when determining the premium allocation. Another commenter supported the proposed policy because it provides equal treatment for the pediatric dental essential health benefit with other essential health benefits. However, the same commenter asked for clarification that this policy permits an issuer of a stand-alone dental plan to offer adult and family dental benefits through an Exchange so long as they are offered and priced separately. The commenter also asked for clarification of the definition of pediatric coverage and the standard proposed at §156.470(d)(4), given that

the final EHB/AV Rule specified that states may set alternative age limits for pediatric coverage.

Response: We agree that stand-alone dental plans, as defined at §155.1065, are "excepted benefits" under section 2791(c) of the PHS Act, and clarify that issuers of stand-alone dental plans are not required to follow the rating standards set forth in the final Market Reform Rule for purposes of pricing stand-alone dental coverage. In addition, to allow greater flexibility in the implementation of the provisions in §156.470 related to stand-alone dental plans, we are not finalizing the allocation standards proposed in paragraphs (d)(2), (3), and (4) of §156.470. We believe the allocation standard proposed at §156.470(d)(1), which requires that the allocation be performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, is a sufficient standard for ensuring that issuers allocate the premium accordingly, so we are finalizing that provision in this final rule. We intend to provide further details on the reporting process for stand-alone dental plan premium allocations for the FFE.

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

Under HHS's rulemaking authority under sections 1311(c)(1), 1321(a)(1), 1402 and 1412 of the Affordable Care Act, we proposed 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 proposed 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). We received no comments on this provision. For the reasons described in the proposed rule, we are finalizing these provisions as proposed.

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 proposed 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 some definitions set forth in the final EHB/AV Rule; the terms "advance payments of the premium tax credit" and "Affordable Care Act" were proposed as defined by reference to §155.20, and the term "maximum annual limitation on cost sharing" was proposed as defined by reference to §156.130 of the final EHB/AV Rule. The terms "Federal poverty level or FPL" and "Indian" were proposed to be defined by reference to §155.300(a). The term "de minimis variation" was proposed to be defined by reference to §156.140(c)(1) of the final EHB/AV Rule. We also proposed to define "stand-alone dental plan" as a plan offered through an Exchange under §155.1065.

We proposed to rely on the definitions of "cost sharing" and "cost-sharing reductions" from §156.20. Finally, we noted in the preamble to the proposed rule that cost-sharing reductions are subject to §156.280(e)(1)(ii) and do not apply to benefits that are not EHB.

Other definitions were proposed to effectuate the regulations proposed in subpart E. These definitions were described in detail in the proposed rule and listed below for reference:

- We proposed 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 proposed 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 proposed to define "zero cost sharing plan 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 proposed 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 proposed to define "plan variation" as a zero cost sharing plan variation, limited cost sharing plan variation, or silver plan variation. We emphasized 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 proposed these definitions to administer and implement the cost-sharing reductions established under section 1402 of the Affordable Care Act. Although an issuer will only offer one actual QHP (for example, a standard silver plan) with one standard cost-sharing structure, we proposed 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 proposed that each plan variation would reflect the enrollee's portion of the cost sharing requirements for the QHP. We referred to "assigning" enrollees to the applicable plan variation to describe how the enrollees will receive the benefits described in section 1402 of the Affordable Care Act. We reiterated 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.

In addition, we also proposed to define "de minimis variation for a silver plan variation" as a single percentage point. That is, we proposed that a 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 noted that this proposal differed from the 2 percentage point de minimis variation standard for health plans finalized in §156.140(c) of the final EHB/AV Rule.

We proposed 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).

We proposed 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 noted that this definition refers to the plan-specific cost-sharing parameters, while the defined term "maximum annual limitation on cost sharing" was proposed to refer to the uniform maximum that would apply to all QHPs (other than QHPs with cost-sharing reductions) for a particular year under standards at §156.130. Finally, we proposed 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 was 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. *See* §156.20 (defining cost sharing) and §156.130(c).

We are finalizing these provisions, with the following modification: we are amending the reference for the definition of the term "de minimis variation" to §156.140(c) instead of §156.140(c)(1), in alignment with the final EHB/AV rule. The reduced maximum limitation on cost sharing for each silver plan variation is finalized in section III.E.4.c. below.

<u>Comment</u>: Several commenters recommended that the de minimis variation for silver plan variations be increased to +/-2 percent as proposed in the AV/CSR Bulletin

and proposed for standard plans under the final EHB/AV rule. Other commenters supported the +/-1 percent de minimis variation for silver plan variations.

Response: We believe that a narrower de minimis variation for plan variations prevents differences in cost sharing between plan variations and ensures that low- and moderate-income enrollees receive the cost-sharing reductions for which they are eligible. 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 their 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.

Comment: One commenter suggested we define "de minimis" variation to mean the allowable variation in the AV of a health plan such that the proportion of EHB paid by the health plan is within the range established in §156.140(c).

Response: The definition of de minimis variation is incorporated by reference to §156.140(c) of the final EHB/AV rule. We do not believe that a separate definition of the term "de minimis" itself for the purpose of plan variations is warranted.

Comment: We received a number of comments requesting that cost-sharing reductions be limited to in-network services. One commenter opposed excluding out-of-network services from counting towards the annual limitation on cost sharing.

Response: As provided in §156.130(c) of the final EHB/AV rule, in the case of a plan using a network of providers, cost sharing for services provided out of network do not count toward the annual limitation on cost sharing. We reference this definition and we note that cost-sharing requirements for out-of-networks services will similarly not count towards a reduced annual limitation on cost sharing. We note, however, that section 1402(c)(2) of the Affordable Care Act does not specify how any additional reductions

should be achieved for individuals eligible for cost-sharing reductions. We therefore clarify that in developing silver plan variations, issuers have the flexibility to reduce cost sharing only for in-network services as long as the required AV levels are achieved and the plan design does not violate the standards set forth in §§156.420(c)-(f).

b. Cost-sharing reductions for enrollees

In §156.410(a), we proposed 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. We also proposed in this paragraph that the enrollee receive this reduction in cost sharing when the cost sharing is collected, which might occur when the enrollee visits the emergency room for care. This proposal would apply to all forms of cost sharing, including copayments, coinsurance, and deductibles. Under our proposal, the QHP issuer would ensure that the enrollee is not charged any type of cost sharing after the applicable annual limitation on cost sharing has been met. Furthermore, we explained in the preamble that for services subject to cost sharing, 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 the reasons described in the proposed rule and considering the comments received, we are finalizing these provisions as proposed.

Comment: Several commenters supported this policy. One commenter was concerned that the reduced deductible must be applied before an enrollee becomes eligible for the cost-sharing reductions. Another commenter was concerned there could be confusion among providers about the amount of cost sharing to collect and suggested that HHS require QHP issuers to issue membership cards to enrollees that clearly explain the enrollee's cost-sharing obligations.

Response: We believe it is appropriate for enrollees eligible for cost-sharing reductions to continue to be required to pay any applicable deductibles before taking advantage of other cost-sharing reductions. We recognize that QHP issuers will be required to supply providers with the necessary cost-sharing information to meet the obligation under §156.410(a) of this final rule to ensure that the cost-sharing reductions are provided when the cost sharing is collected.

In §156.410(b), we proposed that after a qualified individual makes a plan selection, a QHP issuer would assign the individual to the applicable plan variation based on the eligibility determination sent to the QHP issuer by the Exchange. We noted in preamble 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 proposed 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. Comments on §156.410(b)(2) and (3) are discussed below in the section of this final rule related to the special cost-sharing reduction rules for Indians. In §156.410(b)(4), we proposed 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. We are finalizing these provisions without modification.

Comment: Commenters generally supported requiring QHP issuers to assign enrollees to the plan variation for which they are eligible. One commenter specifically suggested that Exchanges only display the plan variation of each QHP for which the consumer is eligible to avoid confusion.

Response: The standards set forth in §156.420 ensure that consumers will be best served by being assigned to the most generous plan variation for which they are eligible.

Therefore, we encourage Exchanges to only display the variation of each QHP plan for which the consumer is eligible. As noted in the proposed rule, if an individual does not wish to receive cost-sharing reductions, the individual may elect to decline to apply for cost-sharing reductions.

c. Plan Variations

In §156.420, we proposed 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 clarified 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 insureds 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. 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.

For individuals with household incomes of 250 to 400 percent of the FPL, we noted 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, we

proposed not to reduce the maximum annual limitation on cost sharing for individuals with household incomes between 250 and 400 percent of the FPL. We are finalizing this policy as proposed, with the following modifications. We are adding a new paragraph (g) to clarify that OPM, rather than the Exchange, will determine the time and manner for multi-State plans to submit silver plan variations and zero and limited cost sharing plan variations for the purpose of certification. Additionally, we note a technical correction with regard to the submission of plan variations under §156.420(a); we replace the phrase "[an issuer] seeks to offer or to continue to offer" with the phrase "[an issuer] offers, or intends to offer," to align with the language in §156.430(a).

Comment: Two commenters recommended that HHS require plans to provide individuals with incomes between 250 percent and 400 percent of FPL the option of enrolling in a plan variation with a lower annual limitation on cost sharing and higher deductibles, copayments, and coinsurance in order to reach the statutorily required AV. Another commenter recommended that HHS rebate excess cost sharing for individuals between 250 percent and 400 percent of the FPL or work with IRS to issue a tax credit.

Response: As noted in the proposed rule, a reduction in the maximum annual limitation on cost sharing could require corresponding increases in other forms of cost sharing to maintain the statutorily required AV levels for individuals between 250-400 percent of FPL. Since we anticipate that most individuals would not be expected to reach the annual limitation on cost sharing, most individuals would be required to pay more up-front costs under such a cost-sharing structure. Furthermore, given the additional administrative burden required in designing and operating additional silver plan variations, we do not modify the proposed policy in this final rule. In addition, we do not believe we have the authority to provide individuals in this income range with an

additional tax credit (beyond that provided for in sections 1401 and 1411 of the Affordable Care Act and section 36B of the Code).

For individuals with a household income of 100 to 250 percent of the FPL, we proposed 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 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.

Maximum Annual Limitation on Cost Sharing for Benefit Year 2014: As discussed in §156.130(a) of the final EHB/AV Rule, the maximum annual limitation on cost sharing for 2014 is the dollar limit on cost sharing for high deductible health plans set by the IRS under section 223(c)(2)(A)(ii) of the Code 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 proposed to estimate the dollar limit for 2014. Based on the proposed methodology, we estimated 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).[26] This estimate was developed and proposed 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, as

[26] The methodology is discussed in detail at 77 FR 73171-73172 of the proposed rule.

defined in §156.20, in 2014 cannot exceed the limit set by the IRS under section 223(c)(2)(A)(ii)(I) and (II) of the Code for the 2014 plan year. 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.

Step 2. In the second step, we 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 may adjust the reduction in the maximum annual limitation on cost sharing, if necessary, to ensure that the actuarial values of the applicable silver plan variations do not exceed the actuarial values specified in section 1402(c)(1)(B)(i). We proposed to describe these analyses and the reduced annual limitations on cost sharing for the three income categories in the annual HHS notice of benefit and payment parameters.

Reduced Maximum Annual Limitation on Cost Sharing for Benefit Year 2014.

As described in the proposed rule, for the 2014 benefit year, we analyzed the impact on the actuarial values of three model silver level QHPs 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). 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. 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.

As described in the preamble to the proposed rule, we determined that a reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with household incomes between 100 and 150 percent of the FPL (2/3 reduction), and 150 and 200 percent of the FPL (2/3 reduction), would not cause the AVs of any of the model QHPs to exceed the statutorily specified AV levels (94 and 87, respectively). In contrast, the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with household incomes 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 proposed that QHP issuers only be required to reduce their annual limitation on cost sharing for enrollees in the 2014 benefit year with household incomes between 200 and 250 percent of FPL by approximately 1/5, rather than 1/2. We further proposed to moderate the reductions in the maximum annual limitation on cost sharing for all three income categories, as shown in Table 21, 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. Based on this analysis, in Table 21, we proposed the following reduced maximum annual limitations on cost sharing for benefit year 2014:

TABLE 21: 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 percent of FPL)	$2,250	$4,500

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)(ii) (that is, 150-200 percent of FPL)	$2,250	$4,500
Individuals eligible for cost-sharing reductions under §155.305(g)(2)(iii) (that is, 200-250 percent of FPL)	$5,200	$10,400

We proposed 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.

Step 3. In the proposed third step of the process for structuring cost sharing in the silver plan variations, a QHP issuer offering coverage in the individual market on an Exchange would be required to 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 §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.

We proposed specifications in §156.420(a)(1) through (3) for the three silver plan variations, and proposed that they may deviate from the required AV levels by the de minimis variation for silver plan variations that is, 1 percentage point. We further proposed that issuers submit these silver plan variations annually to the Exchange for certification, prior to the benefit year. Under our proposal, silver plan variations would 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. For the reasons described in the proposed rule and considering the comments received and discussed below, we are finalizing these provisions, including the reductions in the maximum limitation on cost sharing for silver plan variations offered in the 2014, as proposed with certain clarifications.

Comment: One commenter noted that the IRS does not release the dollar limit on cost sharing until late spring and this would be too late for issuers to adjust their product designs to be compliant with the IRS limit and also meet State and Federal filing deadlines. The commenter suggested that HHS develop an estimate of the maximum annual limit on cost sharing that can be used as a safe harbor.

Response: We are finalizing the proposal to permit QHP issuers to 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 plan to provide separate guidance on the maximum annual limitation on cost sharing for standard plans to QHP issuers seeking to participate in a Federally-facilitated Exchange consistent with the approach finalized in this Payment Notice.

Comment: One commenter recommended that the maximum annual limitation on cost sharing should be published no later than July 1 of the year prior to open enrollment, with a 45-day comment period.

Response: We understand the need for issuers and stakeholders to have adequate time to consider how the maximum annual limitation on cost-sharing should be applied in the development of plan variations. We note that in later benefit years, the maximum annual limitation on cost sharing will be established under a premium adjustment percentage established by HHS in the annual notice of benefit and payment parameters for the applicable plan year.

Comment: One commenter suggested that HHS should not adjust the reductions in the maximum annual limitation on cost sharing, as these adjustments could affect other cost-sharing requirements that a State-based Exchange might put in place under its authority to develop certification standards, as described at §155.1000(c)(2).

Response: We believe it is important to make these adjustments to ensure that issuers have flexibility when developing their plan designs. Without these adjustments, it could be difficult for issuers to achieve the required actuarial value levels for certain plan variations, while complying with other applicable rules on cost-sharing structures, such as the provision at §156.420(e). Additionally, we anticipate working with States and Exchanges individually to address the interaction between the standards in the Payment Notice and any additional Exchange-specific certification standards.

Comment: One commenter suggested that when silver plan variations cannot be accommodated by the AV calculator, HHS should require that the AV determinations be certified by a member of the American Academy of Actuaries.

Response: We clarify that the definition of and standards for determining actuarial value in §156.20 and §156.135 of the final EHB/AV Rule apply to both standard plans and plan variations. Accordingly, if a health plan's design for plan variation is not compatible with the AV calculator, the issuer would be required to follow the processes specified in §156.135(b) of the final EHB/AV Rule.

Comment: One commenter requested that HHS clarify which "desired metal tier" should be inputted into the AV calculator to determine the AV for the silver plan variations.

Response: We have designed the AV Calculator such that users may select the option to determine whether the plan design satisfies the plan variations standards finalized here. To use the AV Calculator to verify the AV of a plan variation, users should select the indicator that the plan meets the cost-sharing reduction standard, and select the desired metal tier. In the below table, we provide guidance on which metal tier should be chosen to align with the expected utilization for each plan variation. Additional information on the AV Calculator can be found at http://cciio.cms.gov/resources/regulations/index.html#pm.

TABLE 22: Desired Metal Tier for Silver Plan Variation AV

Household Income	Silver Plan Variation AV	Desired Metal Tier
100-150 percent of FPL	Plan Variation 94 percent	Platinum
150-200 percent of FPL	Plan Variation 87 percent	Gold
200-250 percent of FPL	Plan Variation 73 percent	Silver

Comment: One commenter asked HHS to clarify how silver plan variations could be designed to be compatible with HSAs.

Response: We are considering this issue and will provide future guidance.

Comment: One commenter asked if HHS could make public its modeling regarding the expected rate of change in cost-sharing reduction eligibility within a plan year.

Response: HHS does not have such an analysis to share at this time.

Comment: Another commenter was concerned about the ability of States to supplement cost-sharing reductions under the proposed policy, and requested HHS give

States that wish to supplement cost sharing the flexibility to determine whether issuers must offer all plan variations.

Response: We intend to work with States to assess how the requirements regarding plan variations would interact with any supplemental cost-sharing reductions a State intends to provide.

Comment: Several commenters recommended that HHS establish parameters for deductibles in silver plan variations. One commenter suggested that cost-sharing reductions to reach the required AV levels identified in §156.420(a) should first be used to lower the deductible and then reduce coinsurance or copayments, and that enrollees should receive negotiated pharmacy prices during the deductible phase. The same commenter suggested waiving or reducing the deductible for outpatient pharmacy for individuals eligible for cost-sharing reductions and making cost-sharing reductions in the forms of lower coinsurance and copayments available to enrollees assigned to plan variations immediately. One commenter asked for allowances to be made to permit issuers to develop innovative plan designs.

Response: We believe that the standards we are finalizing strike 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 protects low-income populations who are assigned to plan variations. We also clarify that, for purposes of the plan variations, any cost sharing that an enrollee would have been required to pay under the standard plan, but was not required to pay under the plan variation, should not be applied to the annual limitation on cost sharing.

Comment: Several commenters sought clarification on whether issuers must submit a silver plan variation for every plan offered on the individual market.

Response: We clarify that for each silver health plan that an issuer offers, or intends to offer in the individual market on an Exchange, the issuer must submit the three silver plan variations. This policy will ensure that low-income individuals can receive cost-sharing reductions while enrolled in any silver level QHP offered through the Exchange, consistent with section 1402 of the Affordable Care Act.

Sections 156.420(b) and (d) are discussed below in section III.E.4.i. related to the special cost-sharing reduction rules for Indians.

In §156.420(c) and (e), we proposed additional coverage standards for silver plan variations as part of implementing section 1402. In §156.420(c), we proposed that silver plan variations cover the same benefits and include the same providers as the standard silver plan. We further proposed that silver plan variations must require the same out-of-pocket spending for benefits other than EHB. Lastly, we proposed 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 final 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 proposed these requirements explicitly as regulatory standards to ensure that QHP issuers develop appropriate plan variations.

In §156.420(e), we proposed 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. 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 in higher AV silver plan variations. For the reasons described in the proposed rule and considering the comments received, we are finalizing these provisions in paragraphs (c) and (e) as proposed.

Comment: A number of commenters supported the requirement that silver plan variations cover the same benefits and include the same providers as the standard silver plan. Several commenters also generally supported the proposal that 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. One commenter supported allowing QHP issuers to have greater flexibility to vary cost-sharing structures across plan variations, and asked for clarification on whether QHP issuers can continue to use medical management policies for silver plan variations. Another commenter asked whether issuers may switch between copayments and coinsurance for silver plan variations as long as the cost sharing in aggregate does not exceed that of plans with lower actuarial values.

Response: We are finalizing the policy as proposed at §156.420(e). We intend to interpret and enforce this provision such that a QHP issuer may not switch between copayments and coinsurance for silver plan variations for the same benefit. We believe that allowing this type of substitution could result in an enrollee being subject to greater cost sharing under a plan variation with a higher AV, which §156.420(e) is intended to prohibit. However, this provision does not limit an issuer's ability to appropriately use reasonable medical management techniques in managing costs consistently in its silver plan variations. We also direct the commenter's attention to §156.125(c) of the final

EHB/AV Rule, which codifies this protection in connection with anti-discrimination requirements, and section 1563(d) of the Affordable Care Act.

In §156.420(f), we proposed 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. We are finalizing the provision as proposed.

Comment: Several commenters supported this requirement. Another commenter was concerned about the ability of issuers to create a viable 73 percent plan variation given the number of plan design constraints.

Response: We believe that a 2 percentage point differential will ensure that a difference in cost-sharing reductions provided to each income category is maintained, while providing issuers the flexibility to adjust cost-sharing requirements within these standards.

d. Changes in Eligibility for Cost-Sharing Reductions

In §156.425(a), we proposed 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 proposed that the QHP issuer effectuate the change in eligibility in accordance with the effective date of eligibility provided by the Exchange. We explained in preamble that an Exchange would establish such dates under §155.330(f). We noted 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 §156.410(b). We are finalizing these provisions as proposed.

Comment: Commenters generally supported the policy, but several stated that a change in an enrollee's eligibility for cost-sharing reductions should only be applied prospectively. One commenter requested that HHS clarify that cost-sharing reductions would not be available until the first day of the following month, to eliminate the need to re-adjudicate claims. Another commenter suggested that if retroactive changes in eligibility for cost-sharing reductions are permitted, only claims the issuer receives after the effective date of the new assignment should be processed under the new cost-sharing requirements.

Response: We are finalizing the policy as proposed. This policy aligns with the eligibility standards and effective dates proposed for the amendment at §155.330(f) of the proposed Medicaid and Exchange Eligibility Appeals and Notices Rule, which aim to reduce the need for retroactive eligibility changes for cost-sharing reductions, except in certain limited scenarios, discussed in that rule.

Comment: One commenter recommended that HHS ensure that individuals who are not assigned to the applicable plan variation in a timely manner should be refunded any cost sharing they should not have been responsible for after the effective date of the eligibility change.

Response: We believe that it is important that eligible individuals receive the appropriate cost-sharing reductions as of the effective date required by the Exchange. As noted in the proposed rule, an individual would not be penalized based on changes in

eligibility for cost-sharing reductions during the benefit year, although he or she 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.

Comment: We received a comment seeking clarification that the QHP issuer be held harmless for any cost-sharing reductions provided beyond the enrollee's actual eligibility level so long as the QHP issuer makes assignments and reassignments in accordance with Exchange instructions.

Response: We reiterate that our final rule requires a QHP issuer to follow the eligibility instructions from an Exchange in ensuring the provision of cost-sharing reductions and plan variation assignments under §156.410(a) and §156.425. Therefore, a QHP issuer may rely upon the eligibility determination sent by the Exchange. If a QHP issuer does not receive notification of an eligibility redetermination, the QHP issuer would not be permitted to re-assign the enrollee to a different plan variation or standard plan.

In §156.425(b), we proposed 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 newly assigned plan variation (or standard plan without cost sharing) for the remainder of the benefit year. As discussed above, we noted in the preamble that a change from or to an individual or family policy of a QHP due to the addition or removal of a family member does not

constitute a change in plan for the family members originally on the individual or family policy. We are finalizing these provisions as proposed.

Comment: One commenter suggested that enrollees not be permitted to switch QHPs as a result of a mid-year change in eligibility for cost-sharing reductions, because an enrollee could mistakenly forfeit credit for previously paid cost sharing. Another commenter suggested that Exchanges be required to explain to consumers the policy relating to continuity of deductibles and annual limitations on cost sharing and the implications of switching QHPs mid-year.

Response: Prohibiting enrollees from switching QHPs would conflict with §155.420(d)(6) of the Exchange Establishment Rule, which allows an individual who has a change in eligibility for cost-sharing reductions to enroll in or change from one QHP to another during a special enrollment period. We note that enrollees may choose a plan variation of the same QHP in order to ensure that any cost sharing previously paid by the individual is taken into account. We encourage Exchanges to provide information to consumers on this topic.

Comment: One commenter asked HHS to consider instituting safe harbors if the enrollee already met the annual limit on cost sharing, but due to lags in data the QHP is not informed.

Response: We appreciate the difficulties caused by lags in data, and anticipate consulting with stakeholders to provide guidance on these sorts of operational issues.

Comment: One commenter requested an example to illustrate whether an individual will be required to satisfy the additional deductible amount when moving to a plan with a higher deductible. Another commenter recommended that deductible amounts carried forward to a policy with a lower deductible be counted towards the annual limitation on cost sharing.

Response: In accordance with the rule finalized here at §156.425(b), as long as the change of assignment is to a different plan variation of the same QHP, any cost sharing paid by the applicable individual under the previous plan variation must be taken into account. This requirement would also apply to Indians who change plan variations within the same QHP as a result of a change in income, such as an Indian who moves from a limited cost sharing plan variation to a zero cost sharing plan variation, and then returns to the limited cost sharing plan variation of the same QHP.

Furthermore, as noted in the proposed rule, an individual eligible for cost-sharing reductions would not be eligible for a reduced copayment or coinsurance until the applicable deductible has been met. For example, if the individual satisfies a $500 deductible and pays $100 in co-payments in one plan variation, then moves to a different plan variation of the same QHP with a $750 deductible as a result of a change in eligibility, the plan would apply $600 towards the new deductible and the individual would need to satisfy the remaining $150 of the new deductible to be eligible for the reduced co-payment or coinsurance. Conversely, if an enrollee satisfies a $900 deductible in a standard plan and then moves to a plan variation of the same QHP with a $750 deductible as a result of a change in eligibility, the additional $150 the individual already paid must be applied towards the reduced annual limitation on cost sharing of the new plan variation. However, as we explained in connection with this proposal, the enrollee would not receive a rebate for the amount already paid above the deductible for the new plan variation.

Comment: One commenter sought clarification on how the requirements for continuity of deductibles and the annual limitation on cost sharing would apply if a QHP enrollee becomes eligible for Medicaid, and then later, re-enrolls in the QHP. The same

commenter asked how the policy would apply if the individual switches to a different QHP.

Response: As noted in the proposed rule, the requirement regarding the continuity of deductibles and out-of-pocket maximums would apply as long as the change in assignment is to a different plan variation of the same QHP. We interpret this to include re-enrollment into the QHP following enrollment in a different QHP or another type of coverage such as Medicaid within the coverage year. As we also noted in the proposed rule, the QHP issuer is not prohibited from or required to extend the continuity of deductibles and annual limitations on cost sharing policy to situations in which the individual changes QHPs, but is *permitted* to extend this policy, provided that this extension of the policy is applied across all enrollees in a uniform manner.

Comment: One commenter sought clarification on how the proposed policy will affect the reconciliation of advance payments of cost-sharing reductions with actual payments.

Response: Under the reconciliation policy finalized in this rule, cost-sharing reductions properly provided in accordance with this rule will be reimbursed. Thus, if an enrollee changes plan variations mid-year and is properly credited with amounts previously accumulated towards a deductible, then cost-sharing reductions on copayments and coinsurance that are provided because the deductible under the new plan variation is reached more quickly are reimbursable as part of reconciliation.

e. Payment for Cost-Sharing Reductions

We proposed 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.[27] 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. We expect that this approach would not require issuers to fund the value of any cost-sharing reductions prior to reimbursement. This approach is similar to the one employed for the low-income subsidy under Medicare Part D.

We are finalizing our payment approach as proposed with five specific modifications. The first two modifications relate to reimbursement for cost-sharing reductions for Indians, which are discussed in section III.E.4.i. of this final rule. The third modification is the addition of paragraph §156.430(a)(4), clarifying that issuers of multi-State plans must provide the estimates described in paragraphs (1) and (2) of §156.430(a) to OPM, rather than the Exchange, in the time and manner established by OPM. The fourth modification authorizes HHS to adjust the advance payments for cost-sharing reductions during the benefit year. As we acknowledged in the proposed rule, QHP issuers will have access to limited data on its expected enrollees prior to 2014, which could reduce the accuracy of the estimates used to develop the advance payment amounts. Because we wish to use the advance payment process to protect QHP issuers from being required to bear the entire financial burden of providing cost-sharing reductions over the benefit year, we are finalizing a change from the proposed rule to authorize HHS to adjust the advance payments if the QHP issuer provides evidence, certified by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, that the advance payments for a particular QHP are likely to be substantially different than the cost-sharing reduction

[27] We noted 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).

amounts provided by the issuer that will be reimbursed by HHS after the end of the year during the reconciliation process. We discuss this policy further below in relation to §156.430(b).

The fifth modification is to §156.430(c). As discussed below, we are preserving the intent of the provisions proposed at §156.430(c)(1) and (2) in finalized paragraphs (c)(1), (2) and (5). This restructuring allows for the addition of paragraphs (c)(3), and (4), which are established in an interim final rule with comment published elsewhere in this issue of the **Federal Register**. In that interim final rule with comment, we describe an approach that would permit a QHP issuer to calculate the value of the cost-sharing reductions provided under the methodology described in this final rule at §156.430(c)(2), or to use an alternative, simplified methodology, under which the QHP issuer would calculate the value of the cost-sharing reductions provided using certain summary cost-sharing parameters. As discussed below and in that interim final rule with comment, we believe this flexibility to use an alternative methodology will reduce the administrative burden on QHP issuers.

Comment: We received several comments on our proposed payment approach. One commenter supported our proposal to provide advance payments and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts. Another commenter suggested that the advance payment and reconciliation process would be too cumbersome and instead, HHS should simply reimburse issuers at the end of the year for the actual value of cost-sharing reductions provided. A third commenter agreed that an annual reconciliation process would be burdensome, and suggested that in the initial years the submission of data on the amount of cost-sharing reductions provided and the reconciliation of payments should be optional. These

commenters urged that in future years, HHS should reimburse based on monthly estimates of the amount of cost-sharing reductions provided.

Response: We discuss below, in relation to §156.430(c) and (d), our approach for addressing commenters' concerns regarding the submission of the amount of cost-sharing reductions provided and the reconciliation process.

To implement our proposed payment approach, in §156.430(a)(1)(i) through (iv), we proposed 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 HHS for review as required by §156.1030(b)(3) finalized under this rule. Sections 156.430(a)(1)(ii) and 156.430(a)(2) are further described in section III.E.4.i. of this final rule.

We further proposed 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 proposed that HHS approve estimates that follow this methodology. For the 2014 benefit year, we proposed 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 under this proposal 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.

Methodology for Developing Estimate of Value of Cost-Sharing Reductions for Silver Plan Variations for 2014 Benefit Year.

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

Per Enrollee Per Month Advance Payment

= Monthly Expected Allowed Claims Costs for Silver Plan Variation

x (Silver Plan Variation AV – Standard Plan AV)

In this formula, the monthly expected allowed claims cost for a silver plan variation would equal one-twelfth of the annual expected allowed claims costs allocated to EHB, other than services described in §156.280(d)(1),[28] 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 proposed in §156.470, the QHP issuer would submit the expected allowed claims cost information to the Exchange annually. The Exchange would then review this estimate, and submit the approved information to HHS, as described in §155.1030(b)(2) above, for use in the advance payment calculation. HHS would 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 proposed the

[28]Based on the definition of "cost sharing" in 45 CFR 156.20 and limits on cost-sharing reductions in section 1402(c)(4) of the Affordable Care Act, 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.

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.[29]

TABLE 23: Induced Utilization Factors for Purposes of Cost-Sharing Reduction Advance Payments

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

In the second half of the formula, we proposed 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. We proposed to use the actuarial values of the QHPs and silver plan variations that the Exchange will submit to HHS under §155.1030(a)(2).

We are finalizing the methodology for determining advance payments for the 2014 benefit year as proposed. As noted above, we are also adding paragraph (4) to §156.430(a), clarifying that issuers of multi-State plans must provide the estimates described in paragraphs (1) and (2) of §156.430(a) to OPM, in the time and manner established by OPM.

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

[29] http://cciio.cms.gov/resources/regulations/index.html#pm.

(b) relating to the advance payments as proposed, with the following modification. In response to comments discussed below, we are adding subparagraph (b)(2) in the final rule to authorize HHS to adjust the advance payment amount for a particular QHP during the benefit year if the QHP issuer provides evidence, certified by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, that the advance payments for a particular QHP are likely to be substantially different than the cost-sharing reduction amounts that the QHP provides that will be reimbursed by HHS. Although QHP issuers will be made whole for the value of all cost-sharing reductions provided through the reconciliation process after the close of the benefit year, we recognize that in certain situations, QHP issuers may require adjustments to the advance payments during the benefit year. We do not include in this final rule a formal process for the submission of information for the adjustment of advance payments because we believe the need for an adjustment will be rare, and the circumstances necessitating the adjustment will likely be unique to each QHP issuer. HHS is also considering other mechanisms for mid-year adjustments to advance payments to ensure that QHP issuers are provided sufficient advance payments and to safeguard Federal funds. We anticipate providing further details on such mechanisms in future rulemaking. We also anticipate working closely with QHP issuers in order to monitor whether the advance payments are likely to be significantly greater than or less than the reconciled cost-sharing reduction amounts.

Comment: We received several comments on the methodology for developing estimates of the value of cost-sharing reductions for advance payments. One commenter stated that the formula appeared to be appropriate and will likely result in accurate estimates. However, the commenter was concerned that the formula could produce results that vary based on member rating factors.

Response: As discussed in the proposed Payment Notice in regard to the submission of the expected allowed claims costs under §156.470(a) and (c), which is the basis of the proposed methodology for estimating the value of cost-sharing reductions, we expect issuers to calculate the expected allowed claims cost for a plan based on the cost of the EHB for all enrollees in all plans in the relevant risk pool under §156.80 of the final Market Reform Rule, and not across a standardized population or a plan-specific population. This approach should average the effects of the allowable rating factors on plan liability. Therefore, we believe the results of the formula will be appropriately adjusted for the allowable rating factors.

Comment: Although commenters generally supported adjusting the expected allowed claims costs by an induced utilization factor, one commenter stated that the proposed factors do not adequately account for changes in utilization as enrollees in plan variations may also use more high-cost services.

Response: We recognize that additional adjustments are necessary to account for the expected increased utilization of enrollees in plan variations, and as a result created a cost-sharing reduction adjustment for the HHS risk adjustment model. As described in section III.B.3.b. of this final rule, this factor will help compensate QHP issuers with a high number of enrollees that qualify for cost-sharing reductions.

Comment: We received comments asking for additional detail on the process that HHS will use to approve the advance payment amounts. One commenter asked that issuers be permitted to make adjustments to the advance payment amounts to account for enrollment fluctuations or changing demographics of their enrolled population. Another commenter suggested that a process be developed to handle discrepancies in the advance payments on a prospective basis.

Response: Section 156.430(a)(3) as finalized here states that HHS's approval of the advance payment amounts will be based on whether the estimate is made consistent with the methodology specified in the HHS notice of benefit and payment parameters.

In addition, as discussed above, in response to the comments received, we are finalizing an additional provision to allow HHS to adjust the advance payment amount for a particular QHP during the benefit year if the QHP issuer provides evidence that meets certain standards. The addition of subparagraph (b)(2) aligns with our goal to reduce the financial burden resulting from cost-sharing reductions on QHP issuers during the benefit year, our proposal to perform periodic reconciliations, and the comments received.

In §156.430(c), we proposed that a QHP issuer report to HHS the actual amount of cost-sharing reductions provided for use by HHS under §156.430(d) in performing periodic reconciliations of the advance payments to the cost-sharing reductions actually provided. We noted that additional specifications regarding the submission of actual cost-sharing reduction amounts will be provided in future guidance; however, the preamble indicated our expectation 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 proposed specific standards for the reporting of cost-sharing reduction amounts. In §156.430(c)(1), we proposed 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 proposed 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 referred to compensation made on a capitated basis in this context, we meant 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 noted that a non-fee-for-service provider is not required to be reimbursed by the issuer. However, we indicated that we expected that issuers and providers in non-fee-for-service arrangements would make available to providers compensation for cost-sharing reductions through their negotiated capitation payments. We sought comments on this assumption and other payment approaches for QHPs that use a capitated system to pay providers.

In §156.430(d), we proposed 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 are finalizing paragraph (d) as proposed. However, as noted before, we are modifying §156.430(c). We are preserving the intent of the provisions proposed at §156.430(c)(1) and (2), but restructuring the provisions into finalized paragraphs (c)(1),

(2) and (5). This restructuring allows for the addition of paragraphs (c)(3) and (4), which are established in an interim final rule with comment published elsewhere in this issue of the **Federal Register**, and discussed below.

In this final rule, we simplify the language proposed at §156.430(c)(1) so that it applies to all benefits, including those for which the QHP issuer compensates the applicable provider in a manner other than fee-for-service. Specifically, we establish that a QHP issuer, for each plan variation that it offers on the Exchange, submit to HHS, in the manner and timeframe established by HHS, for each policy, the total allowed costs for EHB charged for the policy for the benefit year, broken down by: (i) the amount the issuer paid; (ii) the amount the enrollee(s) paid; and (iii) the amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions. In paragraph (c)(2), we codify in regulation text the methodology discussed in the preamble of the proposed rule for calculating the amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions. We specify that QHP issuers must apply the actual cost-sharing requirements for the standard plan to the allowed costs for EHB under the enrollee's policy for the benefit year.

Lastly, we establish in paragraph (c)(5) that in the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid under the standard plan without cost-sharing reductions only to the extent the amount was either payable by the enrollee(s) as cost sharing under the plan variation or was reimbursed to the provider by the QHP issuer. This provision has the same effect as the language in §156.430(c)(1) of the proposed rule. Although we do not specify a similar provision for issuers and providers in non-fee-for-

service arrangements, we expect that those issuers will compensate providers for cost-sharing reductions through other payment processes.

Comment: We received a number of comments stating that the reporting requirements under §156.430(c) are too burdensome. Commenters noted that although the reporting and reconciliation process is appropriate for the Medicare Part D Low-Income Subsidy Program, medical benefits are more complex than pharmaceutical benefits and often have a longer lag between submission and adjudication. Commenters stated that to meet the reporting requirements under §156.430(c), QHP issuers would need to re-adjudicate each claim for enrollees receiving cost-sharing reductions in order to determine the difference in cost sharing between the applicable plan variation and the standard plan. This process could require the development of new information systems in a short period of time. One commenter stated that QHP issuers could provide HHS with access to member-level claims data for enrollees receiving cost-sharing reductions through a distributed data model, similar to the approach used for the risk adjustment program. The commenter stated that this would simplify administrative processes and provide issuers with more time to modify their IT systems. We also received several comments suggesting that HHS should allow QHP issuers to calculate an estimate of the value of cost-sharing reductions at the end of the year using a formula similar to that used for the advance payments, but based on the actual claims experience of the enrollees. These calculated amounts could be used for a reconciliation process, and would place less of a reporting burden on issuers. Commenters also offered another alternative approach under which issuers would file with the appropriate State department of insurance an adjusted net claims rate for each of their plan variations. HHS would then reimburse QHP issuers for cost-sharing reductions by multiplying the number of enrollees in each plan variation by the difference in net claims for the plan variation and the standard plan.

Commenters also requested additional guidance on the reporting and reconciliation process.

Response: In the initial years of the Exchanges, before adequate data is available on the costs that will be associated with QHPs and their plan variations, we believe it is necessary to balance the need to safeguard Federal funds and the need to minimize burden on issuers. Therefore, as noted above, we are restructuring §156.430(c) to allow for the addition of paragraphs (c)(3) and (4), which are established in an interim final rule with comment published elsewhere in this issue of the **Federal Register**. Paragraph (c)(3) permits QHP issuers to choose to calculate the amounts that would have been paid under the standard plan without cost-sharing reductions using a simplified methodology. Under this simplified methodology, as described in paragraph (c)(4), a QHP issuer may calculate the value of the cost-sharing reductions provided by using a formula based on certain summary cost-sharing parameters of the standard plan, applied to the total allowed costs for each policy. We believe this amendment will allow QHP issuers to choose the methodology that best aligns with their operational practices, which should reduce the administrative burden on issuers in the initial years of the Exchanges.

Comment: We received several comments stating that both the advance payments and the reconciliation process should account for the full cost of any induced utilization resulting from the cost-sharing reductions.

Response: Section 1402(c)(3) provides for the Secretary of HHS to make payments to QHP issuers equal to the value of the cost-sharing reductions. We interpret this provision to require the Secretary to reimburse QHP issuers for the reduction in cost sharing associated with any induced utilization; however, we do not believe this provision provides for the reimbursement of the remaining plan liability resulting from any induced utilization. Therefore, we finalize the payment methodology as proposed.

Comment: In response to the provisions proposed in §156.430(c) under which QHP issuers would submit to HHS the portion of the total allowed costs for EHB paid by the enrollee, one commenter noted that issuers cannot report this amount with certainty since the provider ultimately collects this amount from the enrollee.

Response: We clarify that QHP issuers should report the amount that a provider could charge to an enrollee, accounting for the cost-sharing reduction. We also clarify that the amount reported as paid by the enrollee should include any cost sharing paid by a third party, including a State, on behalf of the enrollee.

Comment: We received several comments that the reporting requirements under §156.430(c) will be difficult for issuers to meet that do not use fee-for-service reimbursement methods. Commenters suggested that such issuers should receive capitated payments and be exempt from the reconciliation process.

Response: We support the use of such payment methods by issuers to pay providers; therefore, the restriction finalized at §156.430(c)(5) does not apply to issuers that do not use fee-for-service reimbursement methods. However, we believe that these plans must still reconcile the advance cost-sharing reductions payments they receive from the Federal government.

Comment: Another commenter proposed that QHP issuers make available to providers the amounts reported under §156.430(c). The commenter stated that this information would allow providers to verify that enrollees received the correct cost-sharing reductions and to identify any inappropriate payments from QHP issuers.

Response: At this time, we are not addressing this issue, but encourage QHP issuers and providers to develop processes to support the provision of cost-sharing reductions.

We proposed in §156.430(e) that if the actual amounts of cost-sharing reductions exceed the advance payment amounts provided to the issuer, HHS would reimburse the issuer for the shortfall, assuming that the issuer has submitted its actual cost-sharing reduction amounts to HHS in accordance with §156.430(c). If the actual amounts of cost-sharing reductions are less than the advance payment amounts provided to the issuer, we proposed that the QHP issuer must repay the difference to HHS.

In §156.430(f), we proposed 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. In §156.430(f)(1), we proposed 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. This proposed policy aligns with the approach for advance payments of the premium tax credit described in §156.270(e).

We proposed 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.

In §156.430(f)(4), we proposed 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).

We are finalizing these provisions as proposed.

Comment: In general, commenters expressed their support for the policies set forth at §156.430(f), but asked for clarification on the application of the grace period in relation to cost-sharing reductions. Commenters noted that in many states, issuers are not permitted to pend claims, and that pharmaceutical claims in particular are typically processed at the time and place of service. Other commenters stated that QHP issuers should not be permitted to pend claims because it shifts the collection burden to health care providers. Commenters also requested clarification on whether QHP issuers may pend cost-sharing reductions during the second and third months of a grace period.

Response: The Exchange Establishment Final Rule, at §156.270(d), authorizes QHP issuers to pend or pay claims during the second and third month of a grace period in accordance with company policy and State laws. However, as provided in §156.270(d)(3), QHP issuers must notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. We continue to believe this policy appropriately balances these financial risks, while protecting enrollees.

We clarify that we expect QHP issuers to ensure throughout the grace period that cost-sharing reductions are applied at the point of collection for eligible enrollees, as required by §156.410(a) as finalized here. If an enrollee's coverage is terminated, QHP issuers may deny any claims that were pending, including the reimbursement to the provider for the value of the cost-sharing reductions. Providers could then seek payment directly from the enrollee for any services provided after the termination of coverage, including a refund for the cost-sharing reduction. For a discussion of the standards finalized at §156.430(b), (d) and (g) in relation to cost-sharing reductions for Indians, please refer to section III.E.4.i below.

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

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

However, we proposed in §156.440(a) that the provisions not apply to catastrophic plans because 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 proposed that enrollment in a catastrophic plan precludes eligibility for cost-sharing reductions.

We proposed in §156.440(b) that the provisions of subpart E, to the extent related 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. The Exchange Establishment Rule, at §155.1065, implements these provisions. 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. Thus, 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.

In §156.440(b), we also proposed that the provisions of subpart E, to the extent relating to advance payments of the premium tax credit, apply to stand-alone dental plans because section 36B(b)(3)(E) of the Code provides for the portion of the premium for such plans that is allocable to EHB coverage be taken into account in calculating the premium tax credit.

We proposed 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) provide 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 subpart E. We are finalizing these provisions as proposed with minor technical corrections in paragraphs (a) and (c) to clarify the cross-references.

Comment: One commenter was concerned with the exclusion of stand-alone dental plans from the cost-sharing reduction program. The commenter stated that,

because pediatric dental coverage is a required essential health benefit and the statute guarantees cost-sharing reductions for eligible individuals for essential health benefits, cost-sharing reductions should apply to stand-alone dental plans.

Response: We read section 1402(c)(5) of the Affordable Care Act to provide that cost-sharing reductions are not payable with respect to pediatric dental benefits offered by a stand-alone dental plan. Additionally, requiring payment of cost-sharing reductions on pediatric dental benefits offered by a stand-alone dental plan would create significant operational complexities. However, cost-sharing reductions will be provided for pediatric dental benefits if they are offered by a QHP (that is not a stand-alone dental plan).

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

In §156.460(a), we proposed to codify QHP issuer requirements set forth in section 1412(c)(2)(B) (i) – (iii) of the Affordable Care Act. The law authorizes the payment of advance tax credits to QHP issuers on behalf of certain eligible enrollees. The advance payment must be used to reduce the portion of the premium charged to enrollees. In §156.460(a)(1), we proposed 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 proposed 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 would 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 proposed 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.

Further, in §156.460(b), we proposed to prohibit QHP issuers from terminating or refusing to commence coverage on account of any delay in payment of an advance premium tax credit on behalf of an enrollee if the issuer has been notified by the Exchange under §155.340(a) that it will receive such advance payment. We stated that we expect that monthly advance payments of the premium tax credit will be paid in the middle of the month, and proposed to prohibit QHP issuers from declining or terminating coverage when the enrollee's payments have been timely but the advance payments of the premium tax credit are not made before the due date for the premium.

We also proposed to add paragraph (f) to §155.340 (which we designated as §155.340(g) in this final rule), 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 §156.460(a), proposed §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). Proposed §155.340(f)(2) directs an Exchange to display the amount of the advance payment of the premium tax credit for the applicable month(s) on an enrollee's billing statement. Collectively,

proposed §155.340(f) and §156.460 as proposed 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. The goals of these provisions are to promote transparency between Exchanges or QHP issuers and consumers, accurate application of advance payments of the premium tax credit, and continuity of coverage for individuals. For the reasons described in the proposed rule and considering the comments received, we are finalizing §156.460 as proposed, and are finalizing proposed §155.340(f) as §155.340(g).

Comment: A number of commenters stated their support for these provisions directing QHP issuers and Exchanges facilitating the collection and payment of premiums to reduce premiums collected from enrollees by the amount of the advance payments of the premium tax credit. The commenters also supported having QHP issuers and Exchanges display the advance payment of the premium tax credit on enrollees' billing statements. One commenter urged HHS to test the format of the billing statement to ensure it is clear to consumers. Several commenters also supported the proposed prohibition on a QHP issuer terminating coverage following a delay in the issuer's receipt of advance payments of the premium tax credit if the issuer has been notified by the Exchange that it will receive the payment. One commenter stated that HHS should implement a process to ensure that individuals prematurely terminated in violation of such a provision have coverage reinstated quickly.

Response: Although at this time we do not intend to propose additional requirements related to the format of billing statements, we encourage Exchanges and QHP issuers to test billing statement formats with consumers to ensure that the purpose of the document is clear. We appreciate the comment that we implement a process to

quickly correct instances of premature termination. We will take this into consideration in future rulemaking.

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 final rule, we proposed 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. Under the proposal, issuers would 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 would use this memorandum to verify that these allocations meet the standards set forth in paragraphs (c) and (d) of §156.470.

The comments on the provisions at §156.470, and our response, are discussed in section III.E.2. of this final rule. We are finalizing the provisions proposed in §156.470, with a modification to paragraph (d), and technical modifications to §156.470(a),(b), and (e). We are also adding paragraph (f) to §156.470 to clarify the application of these provisions to multi-State plans.

i. Special Cost-Sharing Reduction Rules for Indians

In this section, we address certain provisions throughout proposed subpart E governing cost-sharing reductions for Indians.

Interpretation of section 1402(d)(2) of the Affordable Care Act: In the proposed rule, we discussed in detail our interpretation of sections 1402(d)(1), 1402(d)(2), and 1402(f)(2) of the Affordable Care Act. The implication of these interpretations is that cost-sharing reductions under sections 1402(a) and 1402(d)(1) of the Affordable Care Act

are only available to individuals who are eligible for premium tax credits. However, we stated that under our interpretation, 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.

We also noted 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 proposed 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) and because we believe that Congress did not intend for reductions in cost sharing to be available outside the individual market Exchanges. We are finalizing this interpretation of the statute, which underlies the provisions implementing cost-sharing reductions for Indians.

Comment: Several commenters recommended that HHS issue uniform operational guidance on the identification of Indians for use by Exchanges and by the IRS that is consistent with the existing HHS regulations under 42 CFR 447.50. Commenters expressed concern that the lack of uniform operational guidance will impede Exchange, Medicaid, and IRS staff in efficiently making accurate and consistent determinations of eligibility and will result in delayed or denied access for some Indians to specific benefits afforded them under the Affordable Care Act.

Response: The definition proposed for Indian in §156.400 has the meaning given the term in §155.330(a). We also note that §155.350 of the Exchange Establishment Rule currently provides guidance on the verification of Indian status. Further guidance on this issue is outside the scope of this Payment Notice.

Proposed provisions of part 156 relating to Indians: Similar to cost-sharing reductions for non-Indians, we proposed to use the concept of plan variations to describe how Indians would pay only limited, or as appropriate, none of the total cost sharing required under that QHP, with the Federal government bearing the remaining cost-sharing obligation. Our proposed regulations cross-referenced the eligibility regulations at §155.305(g), as finalized here, and §155.350(b), finalized in the Exchange Establishment Rule. In §156.410(b)(2), we proposed 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 proposed 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. In the preamble, we also discussed 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 waive the cost-sharing requirements, as appropriate. We proposed the approach first described above, but sought comments on which approach HHS should adopt beginning January 1, 2016. For the reasons described in the proposed rule, and considering the comments we received, we are finalizing the policy as proposed, though we continue to welcome comments on what approach HHS should adopt for benefit year beginning on or after January 1, 2016.

Comment: Several commenters expressed their support for the proposed policy at §155.305(g)(3), noting that the alternative approach would be difficult to administer and would require QHP issuers to make significant changes to their claims systems because issuers today are not able to administer member-based cost-sharing rules. One commenter was concerned that it would be difficult for issuers to waive cost sharing for Indians at or below 300 percent of FPL at the point of service under the alternate approach.

Other commenters, however, expressed concern that the proposed approach would require families with Indian members and non-Indian members to purchase multiple plans in order for each family member to receive the full value of the cost-sharing reductions to which they are entitled. Commenters stated that under this policy, the cost savings available to Indians could be negated by shifting the liability to other non-eligible family members.

A number of commenters recommended a different approach to address the potential increase in costs to be paid by Indian and non-Indian members who elect to enroll in different plans in order to take full advantage of the cost-sharing reductions available to them. These commenters recommended that if family members are enrolled in separate plan variations, the combination of the premiums be required to be no greater than the premium the family would pay if all members were enrolled in the same plan variation. They also recommended that the maximum out-of-pocket liability for the plan

variation in which the non-Indians enrolled be set at a proportion of the maximum liability of a single family plan. These commenters also suggested that HHS should implement the alternative approach sooner than 2016.

Response: We will consider adopting the approach recommended by commenters for future benefit years; however, given the current timeframe and operational concerns, we believe that for the 2014 benefit year it is infeasible to require issuers to submit plan variations that take into account cost-sharing obligations for Indian and non-Indian family members covered under a single QHP policy. Therefore, in accordance with the policy in the proposed rule that we are finalizing here, the assignment of Indians to plan variations would be subject to §155.305(g)(3). If we propose to change the policy for years beginning in 2016, we will provide issuers with sufficient notice and opportunity to comment to effectuate the required operational change.

In §156.420(b), we proposed that QHP issuers submit to the Exchange the zero cost sharing plan variation and limited cost sharing plan variation 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 noted that unlike silver plan variations, zero cost sharing plan variations and

limited cost sharing plan variations must only be submitted for certification when the standard plan is submitted for QHP certification.

In §156.420(d), we proposed language similar to that proposed in §156.420(c) for silver plan variations – that the zero cost sharing plan variations 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 proposed 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 proposed that zero cost sharing plan variations 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 are finalizing these provisions as proposed with two modifications. With regard to the submission of plan variations under §156.420(b), we are revising the language to align with the language in §156.420(a), and §156.470(a) and (b) as finalized. We are also adding paragraph (g) to §156.420 to clarify the applicability of these provisions to multi-State plans.

Comment: We received a comment stating that QHP issuers should not be required to count the cost sharing that an enrollee in a zero cost sharing plan variation would have paid towards the annual limitation on cost sharing, stating that this would require a manual process which would be resource-intensive and result in errors.

Response: We clarify that for purposes of administering the plan variations and providing cost-sharing reductions, QHP issuers are not required to apply any cost sharing

that an enrollee would have been required to pay under the standard plan but was not required to pay under the plan variation to the annual limitation on cost sharing. However, any cost sharing that an enrollee is required to pay (for example, for those in the limited cost sharing plan variation, cost sharing for services provided by non-IHS or related providers), would count towards the annual limitation on cost sharing. This would also apply to silver health plans when there is no cost sharing for a benefit or service.

Comment: We received a comment in relation to the policy proposed at §156.410(a), requiring QHP issuers to ensure than an individual eligible for cost-sharing reductions pay only the cost sharing required of an eligible individual when the cost sharing is collected. The commenter suggested that this language might be confusing since in many cases, individuals assigned to a zero cost sharing plan variation or a limited cost sharing plan variation will have no cost sharing. The commenter also suggested that QHP issuers should provide information electronically to providers concerning an individual's cost-sharing protections.

Response: We are finalizing the regulation as proposed without modification, though we clarify that a QHP issuer would be required to ensure that an individual assigned to a zero cost sharing plan variation must not be required to pay any cost sharing at the time when cost sharing would normally be collected. Similarly, a QHP issuer must ensure that an individual assigned to a limited cost sharing plan variation must not be required to pay any cost sharing at the time when cost sharing would normally be collected if the individual receives services or items from IHS or a related provider.

Comment: Several commenters stated that cost-sharing reductions for Indians should not be limited to EHB. Commenters stated that the cost-sharing exemptions for Indians in section 1402(d) of the Affordable Care Act were enacted as distinct, special

provisions for Indians and are not subject to the general cost sharing limitation to EHB in section 1402(c)(4) of the Affordable Care Act.

Response: We interpreted and implemented section 1301(c) of the Affordable Care Act to limit the definition of cost sharing to EHB when finalizing §155.20 of the Exchange Establishment Rule. The regulation defines "cost sharing" as any expenditure required by or on behalf of an enrollee with respect to EHB. Further, section 1402(c)(4) of the Affordable Care Act provides that all cost-sharing reductions under that section are applicable only to cost-sharing for EHB and not for additional benefits.

Comment: Several commenters raised concerns that providers would be confused regarding the payment they can expect from QHP issuers when an Indian is referred through the contract health services program to an out-of-network provider, or when an Indian is not enrolled in a QHP. Some commenters requested further clarification on the definition of "contract health services."

Response: We are working to ensure that referrals through the contract health services program are processed in accordance with the standards in this final rule in a manner that is clear to providers and QHP issuers. In addition, we note that "contract health services" is defined under 25 U.S.C. section 1603, and we do not propose to codify this definition in the final rule.

In addition, we note that the proposed Medicaid and Exchange Eligibility Appeals and Notices Rule proposes to codify a prohibition in section 1916(j) of the Social Security Act on imposing premiums or cost sharing on an Indian who is eligible to receive or has received and item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services. We note the similarity in the statutory language, but note the different income levels and benefits provided under the respective statutes.

We intend to continue to review this issue and anticipate issuing guidance to address the operational concerns raised by the commenters.

Comment: Several commenters suggested that issuers should be permitted to submit zero cost sharing plan variations at only one metal level, unless there are significant differences in plan design such as prescription drug formularies, provider networks or covered benefits between metal levels. These commenters noted that it is unlikely that an individual will choose a higher cost plan in that situation because the lower metal level plan will provide the same benefits and networks, at a lower premium and with no cost sharing. One commenter suggested that QHP issuers could administer cost-sharing reductions for Indians regardless of income on a case-by-case basis.

Response: We recognize that there is no practical need to ensure that eligible Indians have access to higher metal level plans if a lower metal level plan offers identical benefits and networks, at a lower premium and with no cost sharing. We also recognize the burden on QHP issuers of developing plan variations that provide no additional benefit to enrollees. Finally, we do not wish to unnecessarily task Exchanges with certifying such plan variations. Therefore, we clarify that HHS will deem an Exchange to be adequately enforcing the requirements of §156.420(b)(1) if, within a set of standard plans offered by an issuer that differ only by the cost sharing or premium (that is, the benefits, networks, and all other aspects of the standard plans are exactly the same), the Exchange allows the issuer to submit one zero cost sharing plan variation for only the standard plan within the set with the lowest premium. If an issuer offers standard plans with different benefits or networks, each set of standard plans must have a zero cost sharing plan variation. We do not propose to extend this interpretation to the submission of limited cost sharing plan variations because these variations may still have cost sharing, which could vary among standard plans. We note that for 2014, for operational

reasons, the FFE will still require QHP issuers to submit a zero cost sharing plan variation for any level of coverage that the QHP issuer seeks certification. While this operational limitation for 2014 does present additional data inputs, we do not expect it to require additional analysis by issuers because the content of the submissions would be identical except for cost sharing, which would be eliminated for the zero cost sharing plan variation. We will consider changing this approach in later benefit years through future rulemaking.

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 proposed to use the same payment approach to reimburse cost-sharing reductions for Indians under section 1402(d) of the Affordable Care Act as we proposed 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 proposed 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 in order 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. We are finalizing the payment approach as proposed, with one amendment at §156.430(g) relating to compensation for items and services provided directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.

In §156.430(a)(1)(ii), we proposed 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 proposed 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 under the proposal 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:

Per Enrollee Per Month Advance Payment

= Monthly Expected Allowed Claims Costs for Zero Cost Sharing Plan Variation

x (Zero Cost Sharing Plan Variation AV – 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 proposed at §156.470, the QHP issuer would 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 proposed 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 24: Induced Utilization Factors for Advance Payments of 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 proposed 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 are finalizing these provisions as proposed.

Comment: One commenter requested clarification on the induced utilization factors for cost-sharing reductions for Indians, and whether these factors would ensure that QHP issuers are "made whole" for the value of the cost-sharing reductions.

Response: As in the case of the silver plan variations, we incorporated an induced utilization factor into the advance payment formula to ensure that QHP issuers are compensated for the elimination of cost sharing for any increase in utilization resulting from the modification of the cost-sharing requirements. In addition, we developed an induced utilization adjustment for the risk adjustment model, to further offset the higher costs that enrollees eligible for cost-sharing reductions might incur, as described in section III.B.3.b. of this final rule. We believe this approach ensures that issuers are appropriately compensated for the value of the cost-sharing reductions.

In §156.430(a)(2), we proposed 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 proposed 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 would 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. Under our proposal, the estimate would 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 proposed 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 did 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.

We are finalizing both our proposal for annual rulemaking in the notice of benefits and payment provisions to establish a methodology for advance payments for cost-sharing reductions under the limited cost sharing plan variation, and our proposal of a specific methodology for the 2014 benefit year. 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, and future notices of benefits and payment parameters may include different methodologies. We welcome comments to consider as part of this process. We are also clarifying the language at §156.430(a)(2) by replacing the phrase "[an issuer] offers or seeks to offer" from the proposed rule with the phrase "[an issuer] offers, or intends to offer" in the final rule, to align with the language in §156.430(a)(1).

As described above, the Exchange will collect the estimate and supporting documentation, and submit the estimate and supporting documentation to HHS for review, as finalized under §155.1030. If HHS finds the estimate to be reasonable, HHS will make advance payments to a QHP issuer following the same procedure as for the other plan variations, under §156.430(b), as finalized in this rule.

In §156.430(c) through (e), we proposed that QHP issuers submit to HHS the amount of cost-sharing reductions provided under each plan variation. These amounts would then be reconciled against any advance payments. As explained in more detail in

section III.E.4.e, we are modifying the reporting provisions described in §156.430(c), and finalizing as proposed the reconciliation process described in §156.430(d) and (e). We are also publishing an interim final rule with comment elsewhere in this issue of the **Federal Register** providing an alternative methodology for reporting the value of the cost-sharing reductions provided. We expect that QHP issuers would be able to use this alternative methodology, if they so choose, for reporting the value of cost-sharing reductions provided under the zero cost sharing plan variation and the limited cost sharing plan variation.

Comment: In general, commenters supported HHS's proposal to use the same payment approach to reimburse cost-sharing reductions for Indians under section 1402(d) as we proposed 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. One commenter, however, stated that due to demographics, very few individuals will be assigned to the limited cost sharing plan variation, and as a result, QHP issuers should simply receive a capitated payment for the value of these cost-sharing reductions, and not be required to submit information for the reconciliation of payments.

Response: At this time, we believe it would be difficult for issuers and HHS to accurately estimate the "increase in AV of the plan" resulting from the cost-sharing reductions provided under section 1402(d)(2) of the Affordable Care Act. 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. Therefore, we finalize the approach set forth in the proposed rule for QHP issuers to submit data on the dollar value of cost-

sharing reductions provided to eligible Indians under zero cost sharing and limited cost sharing plan variations, which will be reconciled against any advance payments.

Comment: Another commenter was concerned about the prohibition on cost sharing under the limited cost sharing plan variation for services or items provided through referral under the contract health services program. The commenter suggested that until an accurate, online verification system for contract health services referrals can be established, QHP issuers should be able to rely on the information they receive from providers, and be held harmless for these cost-sharing reductions in the reconciliation process.

Response: We recognize issuers' concerns about this provision, and plan to issue guidance on this topic in the future.

In the proposed rule, we noted that section 1402(d)(2)(B) of the Affordable Care Act states that QHP issuers cannot 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 proposed not to codify this provision in regulation because we believed 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 noted 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.

Comment: Commenters asserted that regulation text is needed to ensure there are no reductions in 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.

Response: We have codified this provision by adding §156.430(g) to the final rule. Regardless of the contracting relationship between a QHP issuer and the Indian health provider, the issuer may not reduce payments to the provider by the amount of any cost sharing that would be due from the Indian under this final rule.

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 does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the statute directs HHS to operate an Exchange within the State. In addition, 31 U.S.C. 9701 permits a Federal 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 of special benefits derived from Federal activities beyond those received by the general public. We proposed to revise §156.50(b) and to add paragraph (c) to provide for a user fee from participating issuers (as defined in §156.50(a)) to support the operation of FFEs under these authorities.

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 FFE). However, Circular No. A-25R also allows for exceptions to this policy, if approved by OMB. Because we wish to encourage issuers to offer plans on

FFEs and 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 are seeking an exception to the policy for 2014.

We proposed to revise §156.50(b) so that it would apply only to user fees to support State-based Exchanges. In §156.50(c), we proposed that a participating issuer offering a plan through a FFE 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 the 2014 benefit year, we proposed 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 note that this user fee would apply to plans offered through FF-SHOPs, as well as individual market FFEs. We noted that additional guidance on user fee collection processes would be provided in the future. We anticipate collecting user fees by deducting the user fee from Federally-administered Exchange-related program payments. If a QHP issuer does not receive any Exchange-related program payments, the issuer would be invoiced for the user fee on a monthly basis.

In addition, we welcomed comments on a policy that we were considering that would provide for the pooling of Exchange user fees, distribution costs, or all administrative costs across a particular market (in the case of the FFE, however, the user fee would be collected only from issuers participating in the FFE). We note that our proposed rule, "Coverage of Certain Preventive Services under the Affordable Care Act" (78 FR 8457), contemplates a proposal to reduce the amount of the FFE user fee for QHP issuers that provide coverage for contraceptive services for participants of a self-insured plan that is established or maintained by an eligible organization (or have an affiliated

issuer that does so).[30] Comments are separately welcome on that proposed regulation on or before April 8, 2013.

Based on the comments we received, we are finalizing the proposal and the regulation text with the following modification: we are clarifying the calculation of the user fee so that the user fee rate is applied directly to the premium set by the issuer for a policy and is charged on each policy with enrollment through the FFE.

Comment: A number commenters expressed concern that our proposed FFE user fee would increase coverage costs for consumers; however, other commenters expressed support for the proposed FFE user fee.

Response: We do not believe that the FFE user fee rate, set at 3.5 percent of premiums, would increase the cost of coverage or discourage consumers from purchasing health insurance through an FFE. We anticipate that the user fee will account for the cost of many of the Exchange-related administrative functions that issuers would otherwise have to perform, such as consumer assistance and enrollment support, and that the cost of the user fee will be outweighed by the many benefits that result from participation in an Exchange. The Exchanges are expected to enhance competition among issuers in the non-group market, which should lower premiums due to the elimination of medical underwriting and the associated issuer administrative costs. Exchanges will also create larger purchasing pools, which should create economies of scale, lowering administrative costs for QHP issuers, and further reducing premiums.

Comment: Several commenters requested that we provide more details regarding our user fee calculations and a breakdown of costs by jurisdiction. Several commenters suggested that we calculate the FFE user fee amount on a per capita basis rather than as a

[30] See 78 FR 8474.

percent of premiums, and a few other commenters supported the percent of premium approach.

Response: We are finalizing our policy to calculate the FFE user fee as a percentage of premium; however, we are modifying the proposed rule to clarify that the FFE user fee amount is set as a percent of premium, without regard to the number of billable members on a policy. This clarification does not change the value of the user fee. We appreciate commenters' concerns that FFE operating costs be minimized and transparent, and will take those comments into consideration in our approach to FFE operating costs.

Comment: One commenter noted that basing the user fee amount on a percent of premium for a particular policy was confusing.

Response: We are clarifying that an issuer's monthly user fee amount is equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year - which for 2014 is 3.5 percent - and the monthly premium charged by the issuer for *each policy* offered through a Federally-facilitated Exchange.

Comment: One commenter expressed concern about HHS's proposal to align the FFE user fee rate with the user fee rate assessed by State-based Exchanges. Other commenters urged HHS to ensure that the overall amount of the FFE user fee reflected only HHS's actual costs related to FFE operations.

Response: We are clarifying that we are establishing the FFE user fee rate for 2014 only, with the intent of keeping the user fee as low as possible. Independent of final SBE user fee rates, we clarify that we are not considering raising the FFE user fee beyond our operating costs in the future.

Comment: We received several comments on our proposal to pool user fees

across all plans in a market within a State. Some commenters suggested that this policy would unfairly increase costs for members that are not enrolled on an Exchange. However, other commenters supported the pooling Exchange user fees. A few commenters requested clarification on how issuers would be permitted to account for user fees on their members' bills, specifically whether issuers would be able to account for user fees in their premium amounts or whether user fees would be billed separately.

Response: We believe that including Exchange user fees in the single risk pool requirement will help prevent adverse selection against QHPs on Exchanges. In the final Market Reform Rule at §156.80, we require issuers to pool all user fee costs across their applicable market in a State. We refer readers to the discussion associated with §156.80 of the Market Reform Rule for additional details on this policy.

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

1. Background

In the proposed rule, we proposed to amend 45 CFR part 153 by adding subpart H, entitled "Distributed Data Collection for HHS-Operated Programs," which set forth the data collection process that HHS would use when operating a risk adjustment or reinsurance program on behalf of a State. We proposed to use a distributed approach to data collection for the risk adjustment and reinsurance programs when HHS operates those programs on behalf of a State. In the proposed rule, we described a distributed approach as one in which each issuer formats its own data in a manner consistent with the applicable database, and then passes the relevant information to the entity responsible for making payments and charges for the program. We believe that this approach minimizes issuer burden while protecting enrollees' privacy. We received a number of comments supporting the proposed distributed data approach, and are finalizing the provisions as

proposed.

2. Issuer Data Collection and Submission Requirements

Under the HHS-operated risk adjustment and reinsurance programs, we proposed to 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 requires close technological coordination between issuers and HHS.

a. Distributed data environments

In §153.700(a), we proposed 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 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 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. Except for purposes of data validation and audit, HHS will not store any personally identifiable enrollee information or individual claim-level information.

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.

Comment: Several commenters expressed concern that the distributed approach would have limited use because it would not track the same enrollee across multiple years.

Response: The distributed data approach would not constrain the risk adjustment methodology when HHS operates risk adjustment because the concurrent model does not require tracking of enrollees over multiple years

Comment: We received a few comments requesting clarification as to what information from the distributed data environments would be shared with States. A few commenters asked for States to have access to data on the distributed data environments.

Response: We are considering ways to provide States with information about HHS-operated programs, and welcome feedback about the types of summary information would be most useful to States. In doing so, we must balance program transparency with protection of potentially sensitive information, including consumer health information. We will provide further information in subsequent guidance, as appropriate.

Comment: A number of commenters requested technical details about the distributed data environment. Several commenters requested the specific requirements for the necessary enrollment, claims and encounter data, applicable software and testing schedule for risk adjustment data submissions. One commenter asked that issuers be permitted to provide two separate data sets on the distributed data environment – one for risk adjustment in the individual and small group markets, and a second for the reinsurance that will only include data for the individual market. One commenter asked for further details on the types of accepted information and recommended that chart reviews be considered acceptable data.

Response: HHS has provided a list of required data for the HHS-operated distributed data approach in the PRA package approved under OMB Control Number

0938-1155. HHS will make available the data formats, definitions, and technical standards applicable to the HHS-operated distributed data approach in future guidance, including standards relating to data from chart reviews.

Comment: We received comments requesting further clarification about the uses of data collected through the distributed data approach.

Response: We intend to provide further guidance on this issue. We do note that data use will be consistent with HHS's commitment to protecting the privacy and security of enrollees. As a result, we would not store any personally identifiable enrollee information or individual claim-level information in connection with this data collection, except for the purposes of data validation and audit. We believe that this approach minimizes issuer burden while protecting enrollees' privacy.

Comment: One commenter requested that the recalibrations of the risk adjustment models not be based on data from the distributed data environment, but asked that HHS conduct a separate data collection designed specifically for the recalibration of the risk adjustment models.

Response: We are exploring using data from the distributed data environment for future recalibration of the HHS risk adjustment models. We will provide further details on model recalibration in future rulemaking and guidance.

b. Timeline

We proposed 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.

Comment: A few commenters sought clarification on when HHS would conduct testing of the distributed data environment in order to develop the distributed data

environment for full operation.

Response: To ensure accuracy in the application of the distributed data approach, HHS will work with issuers to establish robust systems. Issuers will have the opportunity to submit data files to a test environment. HHS will provide support for issuers who conduct such testing as well as provide ongoing support for the duration of the programs. As testing and implementation will be ongoing, we note that 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 full operation, that is, three months prior to the first date the plan could accrue claims for risk adjustment and reinsurance purposes. Even after an issuer's dedicated data environment is fully operational, further testing and modifications may be necessary. Further details and specifications for such testing will be provided in future guidance.

c. Enrollment, claims and encounter data

In §153.710(a), we proposed 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, 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.

Comment: Several commenters sought clarification on whether claims will be dated by the date of admission or the date of discharge. One commentator requested clarification on how claims that straddle the benefit year would be handled. Several commenters requested that claims be dated by date of admission rather than date of discharge, to address the issue of claims that straddle multiple years. Another commenter recommended that risk adjustment scores be based on claims with dates of service from

January 1 through December 31.

Response: The proposed rule stated that data should be submitted for the applicable benefit year by April 30 of the year following the end of the applicable benefit year. The discharge date would be used to date claims, because we believe that the discharge date best ensures that services provided across benefit years will be considered in their entirety rather than being partially or fully excluded from consideration as a result of the data submission timing requirements. For example, if an individual is admitted to a hospital in December 2014 and is discharged in January 2015, the incurred costs that occurred in both December 2014 and January 2015 would be considered in the 2015 benefit year for both reinsurance payments and calculation of enrollee risk scores for risk adjustment when HHS operates either of those programs.

Comment: We received several comments requesting clarification on HHS' data storage requirements.

Response: Under §153.620(b), an issuer that offers risk adjustment covered plans would be required to retain any information requested to support risk adjustment data validation for a period of at least ten years after the date of the report. We will provide further guidance on the data storage requirements for reinsurance-eligible plans and risk adjustment covered plans in forthcoming rulemaking and guidance.

d. Data Requirements

In the proposed rule, we described the types of data that would be acceptable for the reinsurance and risk adjustment programs when HHS operates these programs on behalf of a State.

When HHS is operating reinsurance on behalf of a State, we proposed that medical and pharmacy claims with discharge dates or through dates of service (when no discharge date is applicable, as is often the case for professional services) that fall in the

applicable benefit year would be eligible for reinsurance payments for that benefit year.

When HHS is operating risk adjustment on behalf of a State, we proposed that institutional and medical claims and encounter data with discharge dates or through dates of service that fall in the applicable benefit year would be eligible for risk adjustment payments and charges for that benefit year. The data to calculate enrollee risk scores for purposes of risk adjustment would include diagnoses reported on institutional and medical claims that result in final payment action or encounters that result in final accepted status. Only the diagnoses reported on certain hospital inpatient facility, hospital outpatient, and physician provider claims will be acceptable when HHS operates risk adjustment. The risk adjustment model discussed earlier in this preamble provides a description of HHS's criteria for identifying and excluding claims from providers.

Comment: We received a comment requesting clarification on the acceptable provider types.

Response: Diagnoses will only be acceptable for risk adjustment enrollee risk score calculations if they meet criteria that are acceptable for HHS risk adjustment data collection. Generally, for both inpatient and outpatient services, diagnoses are acceptable if from a qualified provider, but only if the procedure code was not for diagnostic laboratory or diagnostic radiology services. HHS will release the full list of acceptable provider types and criteria in forthcoming guidance.

Comment: One commenter recommended that unpaid claims be included in the calculation of enrollee risk scores.

Response: While there may be some advantages to inclusion of unpaid claims, we do not plan to accept claims where services were denied or not covered because HHS risk adjustment models were calibrated on paid claims. However, if services were approved and an issuer incurred no expenses because the claim was fully paid through

cost sharing, then those claims would be acceptable for consideration (for example, if the allowable cost of a service provided was $15 and the enrollee's co-pay was $15).

e. Claims Data

We proposed 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 (payment of cost sharing by the enrollee). 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.

Comment: Several commenters asked HHS to notify issuers when HHS identifies errors with data submitted to distributed data environments. One commenter requested that HHS flag claims with derived costs that have not been accepted for payment.

Response: We intend to provide each issuer with a periodic report on data functions performed in each issuer's distributed data environment, and to identify reinsurance-eligible claims. The reports would indicate whether HHS accepted or rejected submitted files and data, and would identify 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 reinsurance processing. Timeframes for the processing and reporting of these reports, including for receipt of corrected files and discrepancy resolution, will be provided in future guidance.

Comment: Several commenters requested that HHS provide interim estimates for

reinsurance payments and risk adjustment scores. These comments noted that interim estimates will assist issuers in completing financial statements and developing rates for the next calendar year.

Response: We recognize that both the risk adjustment and reinsurance programs are important programs in stabilizing premiums in the individual and small group markets. We will provide further detail on our approach to interim reporting in forthcoming guidance.

f. Claims data from capitated plans

In §153.710(c), we proposed that an issuer that does not generate claims in the normal course of business must derive costs on all applicable provider encounters using their principal internal methodology for pricing those encounters. If a plan has no such methodology, or has an incomplete methodology, we proposed that the plan 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.

Comment: Commenters generally supported HHS's inclusion of capitated plans' data in the reinsurance and risk adjustment programs. We received many comments asking HHS to provide additional guidance on deriving claims costs or methodological examples of how different types of capitation arrangements would derive their costs, including deriving costs for value-based strategies. Commenters also requested that the State and HHS approve fee schedules to ensure compliance with the reinsurance program.

Response: The proposed approach allows capitated plans the flexibility to use current pricing methodologies, if applicable. Many capitated plans have methods in place for deriving the costs of encounters for participation in other State and Federal programs. If a plan has no such methodology, or has an incomplete methodology, the plan 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. We believe that permitting flexibility, rather than setting forth specific methodologies or fee schedules, better enables issuers to determine methodologies which are reasonable for the issuer's market.

Comment: One commenter stated that some health plans that sub-capitate payments to providers may face difficulty in collecting comprehensive and accurate data on a timely basis.

Response: HHS initially considered a claims submission deadline of March 31 but extended the deadline to April 30 to allow issuers more time to submit the necessary enrollment and claim data. The claims submission deadline of April 30 of the year following the applicable benefit year is the latest possible date for HHS to meet our payment processing and reporting obligations codified in the Premium Stabilization Rule. Reinsurance and risk adjustment payment reporting obligations must be completed before the calculations for the risk corridors and MLR programs, and consequently require claims to be submitted by April 30.

Comment: Commenters requested that HHS set forth in regulatory text that capitated plans' derived cost claims will be subject to audit.

Response: Capitated plans, like all plans that submit reinsurance payment requests, or data to be considered for reinsurance payments or risk adjustment, would be subject to validation and audit. We have included data validation language in §153.240(a)(3) for State-operated reinsurance programs, and in §153.350 and §153.630 for State- and HHS-operated risk adjustment programs, respectively. We will issue further rulemaking with regard to HHS-operated reinsurance program oversight for all claims, including those from capitated plans.

g. Establishment and usage of masked enrollee identification numbers:

We proposed in §153.720(a) that an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS operates risk adjustment or reinsurance, as applicable, must establish a 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 enrollments or plans within the issuer, within the State, during a benefit year. In §153.720(b), we proposed 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. As discussed in OMB Memorandum M-07-16, 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).[31]

Comment: We received several comments in support of using a masked enrollee number. However one commenter expressed concern that the provisions may not be sufficiently protective.

Response: HHS has taken several steps to ensure robust privacy and security standards. A distributed data approach protects consumer health data in a number of ways. First, a distributed data approach eliminates the need to transmit sensitive data. Data can be particularly vulnerable during transmission, so this approach eliminates this risk. HHS expects that information provided to HHS will be limited to information

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

reasonably necessary for use in the risk adjustment and reinsurance programs. Also, with this approach, we are better able to limit the amount of data needed for program operations. We will be releasing, in forthcoming rulemaking, compliance standards for privacy and security standards, as applicable.

h. Deadline for submission of data

We proposed in §153.730 that an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a State in which HHS operates risk adjustment or reinsurance, 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. In order for HHS to provide periodic reports on data functions performed in each issuer's distributed data environment, HHS recommends issuers submit data at least quarterly throughout the benefit year to support the calculation of reinsurance payments and risk adjustment payments and charges.

Comment: We received a comment requesting clarification on the penalty for non-compliant data submission.

Response: Compliance requirements will be forthcoming. We note, however, that one consequence of an issuer failing to timely submit claims and enrollment data would be that the information needed to calculate risk scores and reinsurance allowable amounts would not be available, potentially resulting in a loss of risk adjustment or reinsurance payments for the issuer.

Comment: Several commenters requested clarification on the claims run out period.

Response: An issuer of a risk adjustment covered plan or reinsurance eligible plan in a State in which HHS operates risk adjustment or reinsurance should submit data by April 30 of the year following the applicable benefit year. For example, claims

incurred in the 2014 benefit year must be submitted to HHS by April 30, 2015. The submission deadline will allow issuers time to process claims and submit data to their distributed data systems for HHS evaluation, and will provide HHS adequate time to calculate payments and charges.

H. Small Business Health Options Program

1. Employee Choice in the Federally-Facilitated SHOP (FF-SHOP)

In our proposed rule, we proposed that qualified employers in FF-SHOPs will choose a level of coverage (bronze, silver, gold, or platinum) and a contribution, and employees can then choose any QHP at that level.

In stakeholder consultations following the publication of the Exchange Establishment Rule, 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. We sought comments on whether FF-SHOPs should offer an additional employer option 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 also sought comments on a transitional policy in which a Federally-facilitated SHOP (FF-SHOP) would allow or direct employers to choose a single QHP from those offered through the FF-SHOP. We received the following comments regarding the proposed provisions of choice in the Federally-facilitated SHOP:

Comment: A few commenters opposed offering employers the single QHP option, suggesting that each SHOP should focus on providing employee choice. Most commenters on this issue supported offering a single QHP option for employers, either as

an additional option or as the only option in the initial years of each SHOP. The commenters who supported allowing a qualified employer only the option of offering a single QHP in the initial years of SHOP operation cited several concerns, including whether issuers could complete enrollment and accounting system changes required to interact with the SHOP enrollment and premium aggregation systems required by employee choice; and whether there would be adequate time to educate employers, employees, brokers about the employer and employee choices available in the SHOP. They further suggested that tying Exchange participation to SHOP participation could lead some issuers to participate in neither the Exchange nor the SHOP.

Response: Each SHOP has the option to allow employers to offer employees a single QHP. We have concluded for the reasons identified by the commenters that, as a transition to broader employer adoption of employee choice models, each FF-SHOP should exercise this option, providing employers the option of offering a single QHP to employees, as the small group market customarily does today. This employer option will allow employers who prefer to offer employees a single QHP to participate in an FF-SHOP and retain potential eligibility for the small business tax credit, which is only available through a SHOP Exchange beginning in 2014.

We have also concluded that effective implementation of employee choice in the federally-facilitated SHOP will not be possible in 2014 because of operational challenges noted by the commenters. Therefore, we are proposing in the Small Business Health Options Program proposed rule issued simultaneously with this final rule and published elsewhere in this issue of the **Federal Register** that: (1) the effective date of the employee choice requirements (§155.705(b)(2)) and the premium aggregation requirements (§155.705(b)(4)) will be January 1, 2015; (2) SHOP Exchanges may offer employee choice and perform premium aggregation for plan years beginning on or after

January 1, 2014; and (3) an FF-SHOP will not offer employee choice and premium aggregation until plan years beginning on or after January 1, 2015.

Comment: A few commenters supported a single QHP option but only if linked to the required use of composite premiums.

Response: We believe the decision about the use of calculated composite premiums should remain an employer decision, unless State law requires that premiums be presented to employers as composite premiums, and have not adopted the linkage suggested by the commenters.

Comment: The employer option of broader, two-level plan choice was supported by a number of commenters, either as proposed or as two-level plan choice among all plans at those levels, without the QHP issuer's choice whether to offer as a buy-up. Several commenters characterized employee choice as a key distinguishing feature of the SHOP, and one suggested considering full employee choice. Many commenters, however, cited the adverse selection that may occur with choices across levels of coverage and recommended restricting employee choice to a single level of coverage chosen by the employer. One commenter noted the operational complexity of a buy-up option.

Response: We are not finalizing the rule with provisions for the FF-SHOPs to accommodate the two-level plan choice because of concerns about adverse selection in the first year of SHOP operation. We note that broader employee choice is a desirable feature of a FF-SHOP that will be explored in subsequent years. Further, the final rule at §155.705(b)(3)(i) permits each SHOP the flexibility to offer qualified employers choices beyond making one metal level available to employees. Although we are not exercising this flexibility for the FF-SHOPs, we anticipate that some State-based SHOPs may do so.

Comment: One commenter asked that the final notice reflect that employer

offerings may also be subject to collective bargaining agreements.

Response: We concur with that comment and note here that employer offers of benefits may be subject to the provisions of collective bargaining agreements.

We are finalizing the rule for the FF-SHOPs with some modifications from the proposal. Under §155.705(b)(3) as finalized, each FF-SHOP will allow qualified employers the choice of offering employees either all QHPs at a single level of coverage selected by the employer or a single QHP selected by the employer. However, we are proposing elsewhere in this issue of the **Federal Register** that, as a matter of transition, each SHOP have the option to choose whether to implement employee choice and premium aggregation beginning January 1, 2014 or January 1, 2015, with each FF-SHOP exercising the January 1, 2015 implementation option.

2. Methods for Employer Contributions in an FF-SHOP

Employers may elect a variety of ways to contribute toward health coverage that are consistent with Federal law. Because employees in the SHOP may be choosing their own coverage and will need to know the net cost to them after the employer's contribution, each employer will need to choose a contribution method before its employees select their qualified health plans. To facilitate this, we proposed in §155.705 (b)(11)(i) that each SHOP could define a standard method by which employers would contribute toward the employee coverage. We also proposed in §155.705 (b)(11)(ii) a specific, standardized method for the FF-SHOPs – a method that reflects a meaningful employer choice and that conforms to existing Federal law.[32]

Comment**:** A broad range of commenters supported our proposal. One commenter expressed concern about the effect on older employees, but recognized the

[32]See 77 FR 73184-85.

need to match the outside market options. Two commenters suggested requiring a calculated composite premium as the only allowable method.

Response: The choice of contribution method offered in each FF-SHOP reflects a meaningful choice available to employers in 2014, absent a provision in State law to the contrary. We note that the premium differential effect on older employees is limited by the maximum 3:1 ratio for adults. As noted in the proposal, we believe the decision about whether to use a calculated composite premium is best made by the employer so long as that choice is consistent with applicable State law.

Comment**:** One commenter suggested addressing the contribution method by allowing employers to offer only a single QHP as a transition, which would also give issuers time to adopt SHOP per member rating rules.

Response: Whether an employer offers a single QHP or all QHPs at a given level of coverage, an FF-SHOP will still need to adopt an approach to employer contributions. The approach proposed in the draft Notice and finalized in this rule will allow employers options regarding how they and their employees contribute toward coverage that applies to both single QHP and single level of coverage offers.

Comment: One commenter stated that an issuer should not be involved in employer decisions about allocation of premium between employer and employee.

Response: We do not believe that either the proposed rule or the final rule involves the QHP issuer in employer decisions about the employer contribution toward the premium. The FF-SHOP standard contribution method, as proposed and finalized, does establish a method by which the employer can contribute in a standardized, non-discriminatory way. The QHP issuer is not involved in the FF-SHOP policy nor is the issuer involved in employer decisions about the allocation of premium between employer and employee.

Comment: One commenter asked for clarification about how mid-year turnover would be handled with a calculated composite premium method.

Response: In future guidance, we will discuss mid-year changes in group composition and how a SHOP might address the resulting changes in the average premium for the group.

We proposed at §155.705(b)(11)(ii)(D) to permit a qualified employer participating in an FF-SHOP to establish, to the extent allowed by Federal and State law, different contribution percentages for different employee categories. We have concluded that this provision is inconsistent with the uniformity provisions established in Internal Revenue Service Notice 2010-82, which require employers to contribute a uniform percentage to all employees in order to claim a small business tax credit for health insurance premiums paid. Although the provisions in Notice 2010-82 apply only to employers claiming the tax credit in tax years through December 31, 2013, the use of a uniform percentage for all employees helps assure that the employer contributions do not violate other anti-discrimination provisions. We therefore are not finalizing the proposal at §155.705(b)(11)(ii)(D) and the final rule redesignates the proposed paragraphs (b)(11)(ii)(E) and (F) as paragraphs (b)(11)(ii)(D) and (E). We are otherwise finalizing the rule as proposed.

3. Linking Issuer Participation in an FFE to Participation in an FF-SHOP

We proposed standards that we believe will help ensure that qualified employers and qualified employees enrolling through an 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 proposed in §156.200(g) to leverage issuers' participation in an FFE to ensure participation in the corresponding FF-SHOP, provided that no issuer would be required to begin offering small group market products as a result of this provision. We sought comments on this issue and whether or not the policy meets three intended goals: enhancing employer and employee choice, assuring similar effects on single issuers and issuer groups, and not requiring any issuer to begin offering coverage in the small group market in order to meet this provision.

Comment: A substantial number of commenters supported the tying provision and the issuer group definition, concluding that the provision would enhance consumer choice in FF-SHOPs.

Many commenters opposed the tying provision, arguing that plans should have full choice about participation and that requiring participation may make it harder to meet the timeline for QHP submission in the individual market FFE. Several commenters specifically suggested that the tying provision might result in decreased issuer participation in the individual market FFE in some states. Several commenters noted the extensive efforts that would be required to offer plans in the SHOP, even if the issuer were already participating in the State's small group market.

Response: We have considered the concerns about the tying provision and conclude that adopting the provision will help assure that small group market QHPs are available to employers and employees. We have also considered comments that tying would lead to issuers declining participation in both the FFE and the FF-SHOP, and concluded that it is more likely to result in that outcome among issuers with relatively low market shares for whom the administrative costs to modify systems to enable SHOP participation may outweigh the value of increased enrollment. Finally, we considered how these issuer concerns about tying might relate to issuer concerns about the effects of

employee choice, and whether those concerns might be reduced by our concurrent proposal to allow SHOPs to delay the implementation of employee choice by a year.

Adoption of a tying standard that applies only to issuers with more than a threshold market share will serve the goal of assuring that QHPs are available in each FF-SHOP in 2014 without unduly burdening issuers. We examined small group market share data based on earned premiums reported to HHS in conjunction with evaluations of issuer minimum loss ratios and have concluded that using a 20 percent market share to determine whether a small group market issuer is subject to the tying provision will result in sufficient competition and the ability to offer a robust set of QHPs in the FF-SHOPs, while minimizing the burden on small issuers. We are finalizing the rule accordingly.

Comment*:* One commenter objected because OPM does not require multi-State plans to offer SHOP products until 2017, and CO-OPs are not subject to a similar provision.

Response: In a final rule published elsewhere in this issue of the **Federal Register**, OPM establishes a similar tying provision for multi-State plans based on market share. CO-OPs operate under a different tying provision. We direct the commenter's attention to §156.515(c)(2), which requires CO-OPs to comply with a strict tying provision with no market share exception. If a CO-OP participates in a State's small group market, it must offer silver and gold plans on the SHOP.

Comment*:* One commenter suggested implementing the tying provision but reevaluating the policy in two years. A second commenter suggested the possibility of delaying introduction of the tying provision.

Response: We will be evaluating on an ongoing basis the effectiveness of the tying provision in enhancing employer and employee choice in FF-SHOPs without adversely affecting participation in the FFEs.

We are finalizing these provisions as proposed, with a modification to limit the tying rule to at the applicant issuer itself or an issuer member of the same issuer group that has a 20 percent share of the small group market in the State, based on the most recent earned premium data reported under §158.110 to fulfill minimum loss ratio reporting requirements.

4. Broker Compensation for Coverage Sold Through an FFE or FF-SHOP

In a new paragraph §156.200(f), we proposed that QHP certification by an FFE and an FF-SHOP be conditioned on the QHP issuer paying similar broker compensation for QHPs offered through an FFE or FF-SHOP that it would pay for similar health plans offered outside an FFE and an FF-SHOP. We requested comments on whether "similar health plans" is a sufficient standard and if not, which factors should be considered in identifying "similar health plans." We also requested comments 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.

Comment: Multiple commenters representing both consumer groups and issuers supported the compensation proposal, with several recommending that "similar" be more clearly defined. One commenter proposed that "similar" be defined by the issuer. One commenter opposed the proposal, recommending that the issuer be allowed to set different compensation on and off the Exchange.

Response: For the reasons outlined in the preamble to the proposed rule, we are finalizing these provisions as proposed. We do not at this time propose a specific definition of "similar." We expect to issue further guidance at a later date.

5. Minimum Participation Rate in FF-SHOPs

As discussed the preamble to the proposed rule, we aim to minimize the potential for risk selection in the small group market and in SHOPs. In the final Market Reform

Rule, we discussed this issue in connection with section 2702 of the PHS Act, which requires issuers in the individual and group markets to accept every employer and individual that applies for such coverage but permits issuers to limit enrollment in coverage to only open and special enrollment periods. That final rule implements this provision by permitting an issuer offering health insurance coverage in the small group market to limit its offering of coverage to the limited open enrollment periods described in §147.104(b)(1) in the case of an employer that fails to meet contribution or minimum participation requirements. In connection with the SHOP, the Exchange Establishment final rule permits a SHOP to authorize minimum participation requirements for qualified employers participating in the SHOP so long as the participation is measured at the SHOP level and not based on enrollment in a single QHP.

We proposed a minimum participation rate for an FF-SHOP of 70 percent, calculated at the level of the participation of the employees of the qualified employer in the FF-SHOP and not enrollment in a single QHP. We based the proposed rate on consultations with issuer organizations and regulators about customary minimum participation rates and proposed that it 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 proposed an option for an 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, we proposed to exclude employees with certain types of alternative coverage 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.

The preamble, and the proposed regulation text, also acknowledged that imposition of any minimum participation rate would have to be subject to the exception to the guaranteed issue requirements of section 2702 of the PHS Act and the then-pending proposed rule implementing guaranteed issue.

We sought comments 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.

Comment: Many commenters were supportive of both setting a default and allowing flexibility to adapt to different states.

Response: We are retaining both the default and the flexibility, as proposed.

Comment: One commenter questioned the necessity of a minimum participation rate given market reforms and suggested using minimum contribution instead.

Response: While the degree of risk segmentation is substantially reduced by market reform, we conclude that a minimum participation rate should be applied, at least in the early years of an FF-SHOP. We have no authority under the Exchange Establishment Rule to set a minimum contribution rate for an FF-SHOP. We note, however, that a minimum participation rate encourages employers to set their contributions toward coverage high enough that the minimum participation rate is achieved.

We are finalizing the provisions as proposed, with minor revisions to the text consistent with the discussion in the preamble. The introductory text at §155.705(b)(10), as well as the text at subparagraph (b)(10)(i), is amended to include the phrase "Subject to §147.104 of this title" to clarify when and how a minimum participation rate may be imposed under applicable law. Under this final rule, when an FF-SHOP makes the

employee choice model available to qualified employers, it will use a consistent minimum participation rate across issuers.

6. Determining Employer Size for Purposes of SHOP Participation

We proposed to amend the definitions of "small employer" and "large employer" in §155.20 to specify the method for determining employer size for Exchange purposes 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 proposed 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 sought comments on the proposed definition.

Comment: Some commenters suggested that each SHOP, including FF-SHOPs, should use State counting methods permanently. Other commenters supported an immediate move to a federal standard counting method that takes all employees into account. One commenter noted that the more comprehensive reference for the counting method used in the IRC would be Section 4980H(c)(2), which includes a provision to exclude certain seasonal employees when determining whether an employer is subject to the shared responsibility provisions.

Response: We believe that the Affordable Care Act requires the use of a counting method that takes part time employees into account, and that the full-time equivalent method used in section 4980H(c)(2)(e) of the IRC is a reasonable method to apply with regard to Exchanges. We have changed the IRC reference from section 4980H(c)(2)(e) to 4980H(c)(2) in response to the comment. We believe that the broader cross-reference is appropriate because it brings here the limit in § 49080H(c)(2)(B) on how certain seasonal employees are counted. We believe that excluding certain seasonal employees when determining whether an employer has more than 50 employees would be closer to

counting provisions used in many states and that employers should be able to use the same method to determine SHOP eligibility that they will use to determine whether they will be subject to section 4980H. This method of determining SHOP eligibility will be reevaluated before 2016, when the small group market in all states will consist of employers with from 1 to 100 employees rather than 1 to 50 employees.

Comment: Several commenters recommended that any counting method used to define employer size and thus the corresponding group market should apply for all ACA purposes, not just for purposes relating to Exchanges.

Response: Based on the scope of the proposed regulations, we are unable to adopt definitions in this Notice that apply beyond the Exchange regulations.

We are finalizing the provisions as proposed, changing the reference to section 4980H(c)(2) of the IRC.

7. Definition of a Full-Time Employee for Purposes of Exchanges and SHOPs

We proposed 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.

Comment: Only one commenter addressed the definition of full time employee, suggested that full-time employee be defined as an employee working more than 1300 hours in the past year.

Response: We find no rationale for adopting that definition of a full time employee, and retain instead the definition based on 30 hours a week used elsewhere in the Affordable Care Act.

We are finalizing the definition as proposed.

8. Transitional Policies

With our proposed definitions of large and small employer and full-time employee, for purposes of Exchange and SHOP administration, we proposed policies to provide for a transition from different, existing State law. With respect to State-operated SHOPs for 2014 and 2015 only, we proposed that 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. Our proposal did not address application of State-specific definitions or counting rules that would exclude a small group health plan from protections provided under federal law. 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.

Under our proposal, however, each FF-SHOP would use a counting method that takes part-time employees into account. We proposed that these definitions will be effective October 1, 2013 for each FF-SHOP. We requested comments on the proposed definitions and on the proposed transition policies.

Comment: Most commenters supported using State methods, either long term or as a transitional method in 2014-2015. Two commenters supported an immediate move to a federal standard counting method that takes all employees into account.

Response: We conclude that, for purposes relating to the Exchange regulations, the definition of "full-time employee" and the definitions of "small employer" and "large employer" and their associated counting methods using a full-time equivalent (FTE) methodology should be effective for plan years beginning on or after January 1, 2016. During 2014 and 2015, when states have the discretion to choose whether the upper limit of small employer size is 50 or 100, we will exercise enforcement discretion, relying on State methods of determining group size and status as a full-time employee. However, in operating the FF-SHOPs, we do not have the same discretion; for plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013, we will use definitions of full-time employee, small employer, and large employer based on the FTE method of determining group size. Thus, prior to 2016, an FF-SHOP will use the State's choice of 50 or 100 employees, but will count those employees using the full-time equivalent method referenced in the definitions.

We are finalizing the effective dates of the definitions of "full-time employee," "small employer," and "large employer" as proposed, with a minor modification to clarify that the definitions will apply to plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013. As the SHOP, including FF-SHOPs, will not provide access to coverage until January 1, 2014, we believe the proposed text may have been subject to unintended ambiguity and are finalizing revised text to eliminate that concern.

9. Web Site Disclosures Relating to Agents and Brokers

We proposed modifications to the website disclosure standards relating to brokers in §155.220(b). Specifically, we proposed 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 believed 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 welcomed comments on these proposals.

Comment: Several commenters expressed strong support for the authority to list only registered brokers. One suggested the broader authority to list only those actually selling exchange QHPs. None opposed the proposal.

Response: We are finalizing the regulation as proposed. At this time, we do not propose further limiting the listing based on actual sales.

10. QHP issuer standards specific to SHOP.

We proposed modifications to the QHP issuer standards specific to SHOP for enrollment in §156.285. Specifically, we proposed a technical correction in paragraph (c)(7) such that 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.

Comment: One commenter supported the proposed regulation. No other comments were received.

Response: We are finalizing the regulation as proposed.

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

In the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule (77 FR 73187), we proposed to 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. Specifically, we proposed to account for all premium stabilization amounts in a way that would not have a net impact on the adjusted earned premium used in calculating the MLR denominator and rebates. Additionally, we proposed to amend §158.140(b) to include all premium stabilization amounts (positive or negative) as adjustments to incurred claims in calculating the MLR numerator as provided in §158.221. We invited comment on this approach. We also indicated in the proposed rule that we considered adopting a methodology under which premium stabilization amounts would have a net impact on the MLR denominator, and invited public comment on that approach as well.

In addition, as discussed in the proposed rule, we proposed to amend §158.110(b), §158.240(d), and §158.241(a)(2) to 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. Comments on the proposed timeline were welcomed.

Comment: Most commenters supported our proposal to include risk corridors amounts and reinsurance payments as adjustments to the MLR numerator, but many commenters suggested a change in our proposed approach with respect to reinsurance

contributions and all risk adjustment amounts, which these commenters recommended be applied as adjustments to the MLR denominator. With respect to the reinsurance contributions, most commenters expressed the view that these are assessments on issuers that are more properly regarded as assessments or regulatory fees, and consequently should be deducted from premium in MLR and rebate calculations. With respect to risk adjustment, several commenters asserted that because State average premium is used to calculate risk adjustment amounts, MLR and rebate calculations should treat these transfer amounts as adjustments to premium. Two commenters expressed concern that including any premium stabilization amounts in the MLR numerator would reduce rebates. One commenter also suggested that we clarify the rebate calculation example in §158.240(c)(2) to make it clear that the rebate calculations account for premium stabilization amounts at the aggregation level, rather than at an individual enrollee level.

Response: We recognize commenters' concerns regarding inclusion of risk adjustment amounts in the MLR numerator. However, as noted in the proposed rule, while PHS Act section 2718 provides that premium revenue should "account for" collections or receipts for the premium stabilization programs, section 1342(c) of the Affordable Care Act requires that risk corridors calculations treat reinsurance and risk adjustment payments as adjustments to allowable cost. Because the MLR and the risk corridors programs are closely related and rely on the same definitions, there should be consistency between these two programs. Proper functioning of the MLR and premium stabilization programs will be especially important in 2014-2016, the initial years the health insurance market will undergo significant changes. Thus, with respect to premium stabilization amounts other than reinsurance contributions (that is, risk adjustment amounts, risk corridors amounts, and reinsurance payments), we are adopting our proposed approach that these adjustments have a net impact on the MLR numerator.

However, we agree with those commenters that stated that reinsurance contributions could reasonably be characterized as fees or assessments deductible from premium in MLR and rebate calculations, and this final rule amends §158.161(a) accordingly. Additionally, we are making clarifying changes to the rebate calculation example in §158.240(c)(2) in response to comments.

In sum, this final rule amends the formula for calculating the MLR as follows:

$$MLR = [(i + q - s + n - r) / \{(p + s - n + r) - t - f - (s - n + r)\}] + c$$

Where,

i	=	incurred claims
q	=	expenditures on quality improving activities
p	=	earned premiums
t	=	Federal and State taxes and assessments
f	=	licensing and regulatory fees, including transitional reinsurance contributions
s	=	issuer's transitional reinsurance receipts
n	=	issuer's risk corridors and risk adjustment related payments
r	=	issuer's 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 MLR falls below the minimum MLR standard in a given State market will be calculated using the following amended formula:

$$Rebates = (m - a) * [(p + s - n + r) - t - f - (s - n + r)]$$

Where,

m	=	the applicable minimum MLR standard for a particular State and

market

a = issuer's MLR for a particular State and market.

The amendments made by this final rule will be effective for MLR reporting years beginning in 2014.

Comment: Three commenters recommended that HHS include the Federally-facilitated Exchange user fees and user fees assessed on issuers participating in the HHS-operated risk adjustment programs as regulatory fees deductible from premium in MLR and rebate calculations. Two commenters recommended that issuer costs associated with operating risk adjustment data validation systems also be deducted for MLR purposes, either as an addition or offset to the payments or receipts related to the premium stabilization programs, or as regulatory fees or assessments deducted from premium. Three commenters further suggested that fees and/or operational costs related to the premium stabilization programs and Exchanges, that are priced into premium for policy years spanning 2013-2014, and consequently will be partially reflected in 2013 premium, be either deducted or excluded from 2013 premium.

Response: We have previously addressed the deductibility of State and Federal Exchange user fees in sub-regulatory guidance issued on April 20, 2012.[33] We agree with the commenters' suggestion regarding the deductibility of the risk adjustment user fees, and we interpret §158.161(a) as allowing these user fees to be deducted from premium in MLR and rebate calculations. However, we do not agree with commenters that issuer expenditures on risk adjustment data validation systems, or any other operational costs related to the premium stabilization programs, constitute a regulatory fee or assessment or a transfer under the premium stabilization programs. We do not

[33] CCIIO Technical Guidance (CCIIO 2012—002): Questions and Answers Regarding the Medical Loss Ratio Regulation, Q&A #34 (Apr. 20, 2012), *available at* http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf.

think that these types of expenditures can be distinguished from issuers' other administrative costs involved in compliance with laws and regulations. We also do not agree with comments suggesting that it would be appropriate to reduce rebates to 2013 enrollees by applying estimated 2014 regulatory fees priced into 2013 premium to 2013 MLR and rebate calculations. PHS Act section 2718 does not provide for estimated regulatory fees for future years to be deducted from premium used in MLR and rebate calculations for the reporting year.

Comment: We received several comments supporting our proposal to extend the MLR and rebate deadlines. Two commenters opposed extending the rebate deadline.

Response: We appreciate the comments regarding the proposed deadlines. As noted in the proposed rule, we recognize both 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, as well as issuers' interests in having the necessary data to submit their annual MLR reports and having sufficient time to disburse any rebates. We believe that the proposed deadlines strike a balance between these competing interests. Therefore, this final rule extends the MLR and rebate deadlines in §158.110(b), §158.240(d), and §158.241(a)(2) as proposed in the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule (77 FR 73187).

2. Deduction of Community Benefit Expenditures

In the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule (77 FR 73187), we proposed to amend §158.162(b)(1)(vii) to allow an issuer exempt from Federal income tax to deduct both State premium taxes and community benefit expenditures from earned premium in MLR and rebate calculations. The proposal limited the community benefit expenditure deduction available to a tax exempt issuer to the higher of (1) the highest premium tax rate in the State; or (2) 3

percent of premium, ensuring a level playing field. The proposed amendment 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.

Comment: Several commenters suggested that the proposed treatment is unnecessary and would give Federal income tax exempt entities a competitive advantage. These commenters suggested that tax-exempt entities have sufficient advantages stemming from their favored tax treatment. These commenters further asserted that the deduction of community benefit expenditures should not depend on an issuer's tax status because such funds are not available to be used on subscribers' claims. The commenters proposed either allowing any issuer to deduct all taxes and community benefit expenditures, or eliminating the community benefit expenditure deduction.

In contrast, most other commenters agreed that a Federal income tax exempt issuer is required to make community benefit expenditures to maintain its Federal income tax exempt status and supported the deduction of both State premium taxes and community benefit expenditures from earned premium for such issuers. These commenters agreed that the proposed treatment levels the MLR playing field and 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.

Response: We agree that, because an issuer that is exempt from Federal income taxes must make community benefit expenditures, such an issuer should be allowed to deduct community benefit expenditures and State premium taxes. This final rule allows a Federal income tax exempt issuer to deduct its community benefit expenditures in the same manner that another issuer is allowed to deduct its Federal income taxes. This rule does not alter the community benefit expenditure deduction currently available to an issuer that is not exempt from Federal income taxes. Such issuers are allowed to deduct

the higher of (1) their State premium taxes or (2) their community benefit expenditures limited to the highest premium tax rate charged to an issuer in the State. This final rule accordingly amends §158.162(b)(1)(vii) as proposed in the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule (77 FR 73187). We note that the amount of community benefit expenditures deducted is not allowed to exceed the amount of actual community benefit expenditures in the reporting year.

Comment: One commenter suggested that the proposed community benefit expenditure deduction could lead to abuse, while another suggested that the deduction limit was speculative. However, most commenters agreed with the proposed community benefit expenditure limit.

Response: In its MLR model rule, the National Association of Insurance Commissioners (NAIC) adopted and limited the community benefit deduction to the State premium tax rate. We adopted the NAIC methodology in the December 1, 2010 interim final rule (75 FR 74864, as amended), and comments in response to it noted that some States do not subject every type of issuer to State premium taxes and the community benefit deduction might not be available to those tax exempt issuers. In balancing the availability of the deduction and the potential for abuse, this final rule implements the community benefit expenditure deduction cap of the highest of (1) 3 percent of premium, or (2) the highest premium tax rate charged in the State, as proposed in the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule (77 FR 73187).

3. Summary of Errors in the MLR Regulation

In the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule (77 FR 73187), we proposed to correct three errors in the December 1, 2010 interim final rule (75 FR 74864, as amended): the date by which issuers must

define the formula they use for the blended rate adjustment, described in §158.140(b)(5)(i); the date after which partially-credible issuers that consistently fail to meet the MLR standard will not be allowed to use a credibility adjustment, described in §158.232(d); and the calculation of the per-person deductible described in §158.232(c)(1)(i).

Comment: We received one comment regarding our proposed correction to §158.232(d). The commenter recommended that an issuer that fails to meet the MLR standard for four or more consecutive years be penalized only once every three years. The commenter stated that after an issuer fails to meet the MLR standard for three consecutive years (the statistical probability of which is generally 50 percent x 50 percent x 50 percent, or 12.5 percent), the probability of it failing to meet the MLR standard for the fourth consecutive year is 50 percent.

Response: We disagree with the commenter's calculation. The commenter is correct that the statistical probability of an issuer failing to meet the MLR standard in any given year may be 50 percent. However, the probability of an issuer failing to meet the MLR standard for a number of consecutive years is 50 percent ^ n, where n is the number of years. Consequently, the probability of an issuer failing to meet the MLR standard for four consecutive years is 6.25 percent, and for five consecutive years it is 3.125 percent. With each additional year, the probability of an issuer failing to meet the MLR standard due to statistical fluctuations continues to shrink, increasingly indicating an intentional pricing below the MLR standard.

This final rule therefore implements the technical corrections to §158.140(b)(5)(i), §158.232(d), and §158.232(c)(1)(i) as proposed in the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule (77 FR 73187).

Comment: We received several comments suggesting that HHS clarify the MLR

treatment of State high-risk pool assessments, events occurring after MLR reporting deadlines, and cost-sharing reductions. We also received one comment suggesting a larger adjustment for fraud prevention activities, an extension of allowable ICD-10 costs to the 2013 reporting year, and inclusion of all-payer claims databases in quality improving activities.

Response: The matters discussed in these comments are not within the scope of this final rule. However, we will continue to consider the need to issue clarifying guidance regarding the various accounting and actuarial elements affecting MLR and rebate calculations.

IV. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rule. Those provisions of this final rule that differ from the proposed rule are as follows:

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

- We are not amending §153.100(c) to provide that, if a State is required to publish an annual State notice of benefit and payment parameters for benefit year 2014, it must do so by the 30th day following the publication of the final HHS notice of benefit and payment parameters.

B. Provisions and Parameters for the Permanent Risk Adjustment Program

- We are modifying the requirement at §153.360 to clarify that small group market plans will be risk adjusted in the State in which the employer's policy was filed and approved.
- We are adding §153.610(f) to describe the risk adjustment user fees.

C. Provisions and Parameters for the Transitional Reinsurance Program

- We are amending the definition of "contributing entity" in §153.20 to include clarifying language that a contributing entity is a health insurance issuer or a self-insured group health plan.
- We are amending §153.100(a)(2) by replacing the cross-reference to §153.220(d) with §153.220(d)(1). We are making corresponding revisions in §153.100(d)(2); and §153.110(b); 153.400(a).
- We are deleting §153.220(d)(2), which required a State to 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 are revising §153.230(a) by replacing non-grandfathered individual market plan with reinsurance-eligible plan.
- We are revising §153.230(c) to clarify that national reinsurance payments are 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 in the applicable benefit year.
- We are revising §153.232(c) by replacing non-grandfathered individual market plan with reinsurance-eligible plan and clarifying that the incurred claims costs for an individual enrollee's covered benefits are those incurred in the applicable benefit year.
- We are revising §153.232(d) by clarifying that reinsurance payments will be calculated with respect to an issuer's incurred claims costs for an individual enrollee's covered benefits incurred in the applicable benefit year.
- We are revising §153.235(a) to provide that HHS will allocate and disburse to each State operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of a State), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The

disbursed funds would be based on the 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).

- We are amending §153.240(b)(2) to clarify that a State must provide to an issuer of a reinsurance-eligible plan the calculation of the total reinsurance payments requested, on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS, made under the national reinsurance payment parameters and State supplemental reinsurance payment parameters.
- We are amending §153.400 to clarify that each contributing entity must make reinsurance contributions annually at the national contribution rate for all reinsurance contribution enrollees, in a manner specified by HHS.
- We are amending §153.400(a)(1)(iii) to exclude from reinsurance contributions expatriate health coverage, as defined by the Secretary.
- We are amending §153.400(a)(1) by adding paragraph (iv) to exempt employer-provided health coverage, when such coverage applies to individuals with respect to which benefits under Title XVIII of the Social Security Act (Medicare) are primary under the Medicare Secondary Payor rules under section 1862(b) of the Social Security Act.
- We are amending §153.400(a)(2) by adding paragraph (xiii) to exempt a self-insured group health plan or health insurance coverage that is limited to prescription drug benefits from reinsurance contributions.
- We are revising §153.405(a)(1), §153.405(b) and §153.405(d) by deleting "average" to clarify that reinsurance contributions are calculated by multiplying the number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all contributing entities by the national contribution rate, pursuant to §153.405(a).

- We are amending §153.405(c) to provide that HHS will notify contributing entities of the reinsurance contribution amount to be paid for the applicable benefit year within 30 days of submission of the annual enrollment count.
- We are amending §153.405(f) to revise the procedures for counting covered lives for group health plans with a self-insured coverage option and an insured coverage option.
- We are amending §153.405(g) to revise the aggregation of multiple group health plans maintained by the same plan sponsor.
- We are amending §153.405(g)(3) to clarify that a plan sponsor is not required to include as part of a single group health plan any group health plan that consists solely of excepted benefits, that only provide prescription drugs benefits, or that is an HRA, HSA, or FSA.
- We are amending §153.410(a) to clarify that an issuer of a reinsurance-eligible plan may make requests for reinsurance payments when an issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payments in 45 CFR subpart B and this final rule and where applicable the State notice of benefit and payment parameters.

D. Provisions for the Temporary Risk Corridors Program

- We are modifying our proposed definition of "taxes" in §153.500, by replacing the term "taxes" with the term "taxes and regulatory fees." We are clarifying that reinsurance contributions are included within the definition of "taxes and regulatory fees" in §153.500.
- We are amending §153.520 to remove references to reinsurance contributions in paragraph (d).

- We are also deleting §153.530(b)(1)(ii) and amending §153.530(b)(1) to eliminate the adjustment to allowable costs for reinsurance contributions made by an issuer, and are clarifying the treatment of community benefit expenditures within the risk corridors calculation.

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

- We are finalizing the provisions in §155.330(g) substantially as proposed, with modifications to the language to increase clarity.
- We are adding additional language at §155.340(e) to allow Exchanges greater flexibility in allocating the advance payment of the premium tax credit if one or more individuals in a tax household enroll in more than one policy through the Exchange. We also clarify our language in regard to tax filers covered by the same plan(s). In addition, we are adding paragraph (f) in which we specify the methodology that will be used for allocating advance payments of the premium tax credit provided through Federally-facilitated Exchanges.
- We are relabeling §155.340(f) as §155.340(g).
- We are making a minor technical correction at §155.1030(a).
- We are making clarifying revisions to the provisions at §155.1030(a) and (b)(2), §156.420(a) and (b), §156.430(a)(2), and 156.470(a), (b), and (e) to standardize language across the final rule.
- We are adding paragraph (c) to §155.1030, paragraph (g) to §156.420, paragraph (a)(4) to §156.430, and paragraph (f) to §156.470 to clarify the application of these provisions to issuers of multi-State plans.
- We are substituting §156.140(c) for §156.140(c)(1) as the cross-reference for the term “de minimis variation” in §156.400.

- We are making a clarifying revision to the provision at §156.410(a).
- We are modifying the provisions at §156.430(b) to permit HHS to adjust the cost-sharing reduction advance payments if the QHP issuer demonstrates that the cost-sharing reductions provided are likely to differ significantly from the advance payment amounts.
- We are modifying paragraph (c)(1) and (2) of §156.430, reserving paragraphs (c)(3) and (4), and adding paragraph (c)(5). The modified structure of §156.430(c) will allow for the amendments established in the interim final rule with comment published elsewhere in this issue of the **Federal Register**.
- We are adding paragraph (g) to §156.430 to provide that if an Indian is enrolled in a QHP in the individual market through an Exchange and is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, the QHP issuer may not reduce the payment to any such entity for such item or service by the amount of any cost sharing that would be due from the Indian but for the prohibitions on cost sharing set forth in §156.410(b)(2) and (3).
- We are making minor technical corrections to paragraphs (a) and (c) of §156.440 to clarify the cross-references.
- We are deleting paragraphs (d)(2) through (4) of §156.470, relating to certain allocation standards for stand-alone dental plans.

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

- We are removing the reference to billable enrollees, so that the user fee rate is applied directly to the premium set by the issuer.

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

- We are finalizing the proposed provisions.

H. Small Business Health Options Program

- In §155.20, the definitions of "full-time employee," "small employer," and "large employer," we are clarifying the effective date for use of these definitions. In addition, in the definition of "large employer," we are correcting the word "larger" to "large."
- In §155.705(b)(3)(ii), we are adding a provision requiring each FF-SHOP to allow qualified employers the choice of offering employees either all QHPs at a single level of coverage selected by the employer or, as a transition policy, a single QHP selected by the employer.
- We are revising §155.705(b)(10) to include language limiting authority to impose a minimum participation rate subject to 45 CFR 147.104.
- In §155.705(b)(11)(ii), we are deleting a provision at subparagraph (D) requiring each FF-SHOP to allow employers to define different contribution percentages for different employee categories and relabeling the remaining subparagraphs accordingly.
- We are finalizing §156.200(g) with modifications in new subparagraph (g)(3) so that the QHP certification standard relating to participation in the FFE and FF-SHOP does not apply if neither the issuer nor any other issuer in the issuer group has a market share of the State's small group market greater than 20 percent, as determined using information submitted pursuant to 45 CFR 158.110.

I. Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act

- We are amending the MLR formula to subtract reinsurance contributions from earned premium as regulatory fees, instead of treating them as an addition to incurred claims.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-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 estimates of paperwork burden; however, not all of these estimates are subject to the information collection requirements (ICRs) under the PRA for the reasons noted.

A. Collections Related to State Operation of Reinsurance & Risk Adjustment Programs (§153.210 through §153.240, §153.310)

In sections §153.210 through §153.240 and §153.310 of the proposed rule, we estimated the cost of collecting data for State-operated reinsurance and risk adjustment. Fewer than 10 States have told HHS that they will operate reinsurance or risk adjustment for the 2014 benefit year. Since collections from fewer than 10 persons are exempt from the PRA under 44 U.S.C. 3502(3)(A)(i), we are not seeking PRA approval for these information collection requirements. However, if more than nine States elect to operate

risk adjustment in the future, we will seek PRA approval for these information collections.

Comment: One commenter stated that our administrative cost estimates for these provisions were too low to be credible. Another commenter stated that we underestimated the cost to States of administering supplemental reinsurance payment parameters and monitoring fund balances. In particular, the commenter stated that establishing a governing board, engaging with stakeholders, and hiring independent actuaries would be expensive. One commenter believed that the cost to submit a report should include the State's costs for executive-level review to determine whether to operate reinsurance, and that HHS was confusing regulatory cost with the PRA's information collection burden.

Response: We limited our estimates in the proposed rule to the incremental information collection associated with the requirements of these provisions. In the "Supporting Statement for Paperwork Reduction Act submissions: Standards related to Reinsurance, Risk Corridors, and Risk Adjustment" (Premium Stabilization Rule Supporting Statement), we estimated a baseline cost for the development of the State notice of benefit and payment. Therefore, we believe that there will only be a small incremental cost to States as a result of the reporting requirements at §153.210 through §153.240, §153.310. However, for reasons described earlier in this Collection of Information section, we are not seeking PRA approval for these collections. We have moved our discussion of the administrative costs associated with these provisions to the Regulatory Impact Analysis section of this final rule.

B. ICRs Regarding Calculation of Reinsurance Contributions (§153.405)

In §153.405, we finalize the rules related to an annual enrollment count of covered lives by contributing entities using counting methods derived from the PCORTF

Rule. We are requiring contributing entities to provide annual counts of their enrollment and remit reinsurance contributions to HHS based on that enrollment count. The work associated with this requirement is the time and effort required by an issuer or self-insured group health plan to derive an annual enrollment count. Because issuers or self-insured group health plans will already be obligated to determine a count of covered lives using a PCORTF counting method, the cost associated with this requirement is conducting these counts using the slightly modified counting methods specified in this final rule. In this final rule, we are modifying our estimate of the number of contributing entities from the proposed rule. We estimate that 22,900 contributing entities will be subject to this requirement, based on the Department of Labor's estimated count of self-insured plans and the number of fully insured issuers that we estimate will make reinsurance contributions.[34] On average, we estimate it will take each issuer or self-insured group health plan 1 hour (at a wage rate of $55 for an operations analyst) to calculate and submit final enrollment counts to HHS. Therefore, we estimate an aggregate cost of $1,259,500 for 22,900 reinsurance contributing entities as a result of this requirement. We will revise the Premium Stabilization Rule Supporting Statement to include the required data elements that issuers or self-insured group health plans will need to submit their annual enrollment counts in accordance with the counting methodology established in this final rule.

C. Requests for Reinsurance Payment (§153.410)

As described in §153.410, issuers of reinsurance-eligible plans seeking reinsurance payments must make requests in accordance with the requirements of this

34 We use an estimate of self-insured entities published by the Department of Labor in the April 2012 "Report to Congress: Annual Report of Self-insured Group Health Plans," which reflects only those self-insured health plans (including 14,800 self-insured plans and 6,300 plans that mixed self-insurance and insurance) that are required to file a Form 5500 with the Department of Labor.

final 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 to HHS or the State, as applicable, all necessary data to be considered for reinsurance payments for the applicable benefit year.

To minimize burden on issuers, HHS intends to collect data in an identical manner for HHS-operated reinsurance programs and HHS-operated risk adjustment. Although we clarified 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 the Premium Stabilization Rule Supporting Statement with an October 31, 2015 expiration date, and we will update it to reflect these clarified data elements.

D. Upload of Risk Adjustment and Reinsurance Data (§153.420, §153.700, §153.710, §153.720)

Under the HHS-operated risk adjustment and reinsurance programs, HHS will use a distributed data collection approach for enrollee-level enrollment, claims and encounter data that reside on an issuer's dedicated data environment. Under §153.710(a), 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 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 §153.720(a), we require 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 cost associated with this requirement is the time and effort to ensure that information in the dedicated data environment complies with HHS requirements. We estimate this will affect 1,800 issuers and will cost each issuer approximately $178 per year, reflecting three hours of work by a technical employee at $59.39 per hour. Therefore, we estimate an aggregate cost of $320,706 for all issuers as a result of these provisions.

In addition, we discussed in the proposed rule an updating amendment to the Premium Stabilization Rule Supporting Statement that was approved with an October 31, 2015 expiration date reflecting updated cost estimates for implementing the distributed data approach. We are making a slight modification to the labor estimate we assumed in our proposed rule by assuming Federal holidays and two weeks of vacation time for full time employees. In this final rule, we estimate that this data submission requirement will affect 1,800 issuers, and will cost each issuer approximately $342,086 in total labor costs. This cost reflects an estimate of three full-time equivalent employees (5,760 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 (at an average cost of $15,000), and these servers will process approximately 9 billion claims and enrollment files. Therefore, we estimate an aggregate cost that includes labor and capital of $621,754,800 for all issuers as a result of these provisions. Although we had previously accounted for this estimate as a new administrative cost to issuers in the proposed rule, we are not doing so in this final rule because it is not an incremental cost that issuers will incur as a result of the provisions in this final rule. We had previously estimated the costs associated with these risk adjustment and reinsurance enrollment data submission requirements in the Premium Stabilization Rule Supporting Statement that was approved with an October 31, 2015 expiration date. We will revise that supporting statement to reflect our updated estimate. We are also amending the tables in the Collection of Information section and Regulatory Impact Analysis section of this final rule so that the tables reflect only those incremental costs that result from provisions of this final rule.

Comment: One commenter stated that there was no basis for the proposed estimate and that the values seemed low considering the importance and complexity of the tasks involved. The commenter also believed that the estimate did not account for costs associated with overhead, administrative tasks, and employee benefits.

Response: We believe that our proposed estimate is reasonable for first year operations. The estimate reflects average labor and capital costs associated with standing up a dedicated data environment, as well as average claims volume. Some issuers will have appropriate staff and infrastructure in place to support the data collection and other issuers will need to acquire resources. While we anticipate an initial concentrated effort for set-up of the dedicated data environment, we believe that three full-time equivalents would cover the number of hours needed (on average) for set-up and maintenance in the

first year of operations. The average hourly rate of $59.39 is based on the Bureau of Labor Statistics, U.S. Department of Labor, *National Compensation Survey*: *Occupational Earnings in the United States, 2011*. We note that it approximates the lower range of hourly wages, $60, estimated by respondents to a recent industry survey[35], and that industry respondents' cost estimates ranged widely to reflect different pricing and conditions. Our aggregate cost estimate also includes costs associated with capital purchases, overhead, and fringe benefits.

E. ICR Regarding User Fee when HHS operates Risk Adjustment (§153.610)

Under §153.610(f), we establish a user fee to support Federal operation of risk adjustment. This per capita monthly fee will be charged to issuers of risk adjustment covered plans based on enrollment estimates provided to HHS in the distributed data environment. HHS will calculate user fees owed, and issuers will remit the fee owed only once, in June of the year following the benefit year, in connection with processing of payments and charges for risk adjustment.

We estimate that 1,800 issuers will be required to pay risk adjustment user fees, and the additional cost associated with this requirement is the time and effort for an issuer to provide monthly enrollment data and remit fees. Because HHS will utilize existing data collection and payments and charges processing, we do not anticipate that this provision will alter the collection cost that is already approved in the Premium Stabilization Rule Supporting Statement under OMB control number 0938-1155 with an October 31, 2015 expiration date.

35 "Health Plans' Estimated Costs of Compliance with Expanded Federal Rate Review and with Data Collection for Risk Adjustment and Reinsurance," Center for Policy Research, America's Health Insurance Plans, December 2012.

F. ICRs Regarding Data Validation Requirements When HHS Operates Risk Adjustment (§153.630)

Under §153.630(b), 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 cost 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 approximately two-thirds of the sample consisting of enrollees with HCCs. We anticipate that this audit will affect approximately 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 will cost approximately $180 ($90 per hour for two hours) for an auditor to review the medical record documentation for one enrollee with two HCCs. In the proposed rule, we did not estimate the cost of reviewing medical records for enrollees without HCCs. HHS intends to require the review of medical records for all sample enrollees in the initial validation audit. Therefore, we are revising our estimate to align with the policy finalized in this rule. We expect that it may cost approximately $60 per enrollee ($90 per hour for 40 minutes) to validate demographic information and review

medical records for all enrollees in the audit sample, totaling approximately $210 per enrollee with HCCs ($90 per hour for two hours and 20 minutes) and $60 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. Based on the information above, we estimate that the total cost per issuer to retain initial validation auditors to perform the initial validation would cost approximately $48,000. Therefore, for 1,800 issuers, the total cost of conducting initial validation audits will be $86.4 million. We will revise the information collection 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 information collection requirements established under §153.630(d) at a future date.

G. 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) of this final rule, we establish that the Exchange must ensure that each issuer that offers or intends to offer a QHP in the individual market on the Exchange submit the required plan variations, as set forth in §156.420, for each of its health plans proposed to be offered as a QHP in the individual market on the Exchange. Further, the Exchange must certify that the plan variations meet the requirements detailed in §156.420. We expect that an Exchange will 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 as part of QHP 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 will collect or calculate the actuarial values of each QHP and silver plan variation, calculated under §156.135 of the final EHB/AV Rule. We proposed in §155.1030(a)(2) that the Exchange provide the actuarial values of the QHPs and silver plan variations to HHS. As set forth 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 §156.430 finalized here. Because HHS will already have this information for Federally-facilitated Exchanges, the burden associated with this requirement is the time and effort for a State participating in each State Partnership and for a State-based Exchange to submit this information to HHS. We estimate that the submission from each of these entities will take approximately 3.5 hours to collect, validate, and submit 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 submitting entity 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 established 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 or the rate information that the QHP issuers submits through the Effective Rate Review program. Therefore, we believe that the cost for Partnership Exchanges or State-based Exchanges to submit to HHS this information collected from QHPs is generally part of the cost that is accounted for in the PRA approved under OMB Control Number 0938-1141 or the cost that is accounted for in the supporting statement published under CMS form number 10433, which is pending OMB approval. We estimate that Partnership and State-based Exchanges will incur additional cost 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 cost 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 establish 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

provision will impose minimal burden, and that it will take an insurance analyst five 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 cost of $3.21 for each Partnership or State-based Exchange as a result of this requirement.

H. ICRs Regarding Plan Variations (§156.420)

In §156.420, we set forth standards for issuers to 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 the required levels of cost-sharing reductions. We provide an overview of the submission process associated with this requirement in this final rule. In paragraph (a), we establish that, for each silver health plan that an issuer offers or intends 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 establish 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. However, in this final rule, we clarify that an Exchange is adequately enforcing this requirement if, within a set of standard plans offered by an issuer that differ only by the cost sharing or premium, it allows an issuer to submit one zero cost sharing plan variation for only the standard plan with the lowest premium within the set. Although this approach will likely reduce the burden on issuers and Exchanges, it is unclear how many Exchanges will adopt this approach, and as a result, we have not adjusted our burden estimates below.

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 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). Based on the figures above, we estimate it will cost each issuer approximately $866 to submit 11 plan variations annually, for an aggregate cost of $1,039,698 for all issuers participating in the Exchanges. 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 establish 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, as described in the preamble to this final rule, we are finalizing 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 for QHP issuers.

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 with a household income above 300 percent of the FPL, described in §156.420(b)(2). If a QHP issuer seeks advance payments for 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 one hour 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 cost to submit responses for four 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)(1), (c)(2), and (c)(5), we finalize a standard that directs a QHP

issuer to 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 the actual cost-sharing reduction amounts. Based upon preliminary discussions with the issuer and vendor community regarding the costs associated with implementing the standard methodology, we assume that the information technology necessary to implement the standard methodology will be developed by three vendors at a cost of approximately $6 million per vendor, for total costs of approximately $18 million. We also expect that each issuer will need to spend approximately $100,000 to customize the vendor solution technology and/or modify their claims system. Therefore, we estimate total administrative costs of approximately $138 million. 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. We note that we have not included our initial cost estimate of this approach in Table 25 or Table 26.

As discussed in section III.E.4.e, we are issuing an interim final rule with comment elsewhere in this issue of the **Federal Register** to provide QHP issuers with the option to submit data about the actual amount of cost-sharing reductions using an alternate methodology for purposes of payment reconciliation. We address the burden associated with this alternate approach in the Collection of Information section of the interim final rule with comment.

J. ICRs Regarding Reduction of an Enrollee's Share of Premium to Account for Advance Payment of the Premium Tax Credit (§156.460)

Under §156.460(a)(2), 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 acknowledgment process that already exists under the final Exchange Establishment Rule (77 FR 18310), at §156.265(g), we believe that this requirement will impose minimal burden on QHP issuers, and that it will take an insurance analyst five minutes (at an hourly wage of $38.49), to collect and submit this information to each Exchange Therefore, we estimate a cost of approximately $3.21 for each QHP issuer, and an aggregate cost of approximately $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 establish that an issuer provide to the Exchange annually for approval, for each metal level health plan offered or intended 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 establish that an issuer of a stand-alone dental plan provide to the Exchange for approval a dollar allocation required by the expected premium for the plan to the pediatric dental essential health benefit. In §156.470(c), we are finalizing standards for QHP issuers for calculating the allocation required by paragraph (a). As discussed above, we are modifying §156.470(d) and finalizing one standard for issuers of stand-alone dental plans for calculating the allocation in paragraph (b). Lastly, in §156.470(e), we are finalizing the requirement that an issuer of a metal level health plan

or stand-alone dental plan offered, or intended 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 (as finalized in the Market Reform Rule at §154.215(d)(3)-(4), and detailed in the accompanying PRA package with OMB Control Number 0938-1141) or directly to the Exchange if the issuer is not required to submit rates to the Effective Rate Review program. The Rate Increase Disclosure and Review Rule establishes 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 also revising the supporting statement of the information collection 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 five hours to prepare and submit this information to the Exchange. We assumed that this requirement will require three hours of labor by an insurance analyst (at an hourly wage rate of $38.49) and two 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 cost 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 QHP Participation Standards in SHOP (§156.200)

In §156.200(g)(1), we establish a QHP certification standard for the FFE. 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 has a share of the State's small group market greater than 20 percent, 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). The market share determination is based on earned premiums already submitted by all issuers in the State's small group market under §158.110, and thus poses no additional reporting burden.

M. ICRs Regarding Medical Loss Ratio Reporting (§158.130, §158.140, §158.162, §158.221, §158.240)

This final rule directs 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 25: 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 [36] ($)	Total Labor Cost ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
§153.405	0938-1155	22,900	22,900	1.00	22,900	55.00	1,259,500	0	1,259,500
§153.630(b)	0938-1155	1,800	540,000	1.78	960,000	90.00	86,400,000	0	86,400,000
§153.720(a)	0938-1155	1,800	1,800	3.00	5,400	59.39	320,706	0	320,706
§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	4.25	38.49	164	0	164
§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
§156.460(a)(2)	0938-NEW/CMS 10433	1,200	1,200	0.08	100	38.49	3,849	0	3,849

[36] 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 [36] ($)	Total Labor Cost ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
§156.470	0938-NEW/CMS-10433	20	20	5	100	45.85	4,585	0	4,585
Total		24,171					89,267,039	0	89,267,039

VI. Regulatory Impact Statement (or Analysis)

A. Statement of Need

This final rule implements standards related to premium stabilization programs (reinsurance, risk adjustment, and risk corridors), consistent with the Affordable Care Act. This final 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. The purpose of the three premium stabilization programs is to prevent adverse selection and to protect consumers from increases in premiums due to issuer uncertainty. The Premium Stabilization Rule explained that further details on the implementation of these programs, including the specific parameters applicable to these programs, would be included in this rule.

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 at least one year. Accordingly, we have prepared a regulatory impact analysis that presents the costs and benefits of this final rule.

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 final 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. The cost-sharing reductions program and advance 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 consumers, 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[37] analyzed the effects of increased insurance coverage. The analysis studied the health effects of expanded Medicaid eligibility in three States (New York, Maine, and

[37] Sommers, Ben et al "Mortality and Access to Care among Adults after State Medicaid Expansions" New England Journal of Medicine .No: 367 20121025-1034

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) during the period of study;
- 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[38] of the importance of health coverage in improving health and delaying mortality.

There are administrative costs to States to administer these programs, although Federal grants are available through 2014 for States seeking to establish State-based Exchanges, and to support certain State activities related to the establishment of FFEs or State Partnership Exchanges.

Issuers making reinsurance contributions but not receiving reinsurance payments may receive indirect benefits in the form of lower uncompensated care costs. . There are also reporting costs for issuers to submit data and financial information. This regulatory impact analysis discusses the benefits and costs of the provisions in this final rule.

In this analysis, we discuss programs and standards newly implemented by the final 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 were introduced in the Premium Stabilization Rule (77 FR 17220). In addition to building on the

[38] Finkelstein, A et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." NBER Working Paper No. 17190, July 2011.

regulatory impact analysis for that earlier rule, we are able, for the analysis of much of the final rule, to use the Congressional Budget Office's estimates of the Affordable Care Act's impact on Federal spending, revenue collection, and insurance enrollment.

Comment: Two commenters urged further analysis of the costs and benefits of the rule. Specifically, one commenter asked HHS to provide analysis showing how this rule would affect consumer premiums, employer costs, and taxpayer subsidies. The commenter asked HHS to project how increased use of health care would impact employers and wages for lower-income workers.

Response: While we cannot precisely predict the price of insurance, the premium stabilization programs are designed to mitigate premium increases for all consumers. In the individual and small group markets, the advance payment of the premium tax credit and cost-sharing reduction programs are intended to make health insurance affordable for low-income individuals. 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. Table 26 shows accounting projections on the costs and transfers of this rule. We are unable to project either the potential economic and social benefit from a more productive workforce that could result from access to health care or the potential economic and social cost when more people use health care. HHS relied on the Bureau of Labor Statistics, U.S. Department of Labor, *National Compensation Survey Occupational Earnings in the United States, 2011,* for estimates of most job descriptions and wages. We believe that our analysis reflects our best estimate of the costs associated with the proposed rule. Therefore, we are not modifying the proposed estimates of regulatory impact in this final rule.

C. Impact Estimates of the Payment Notice Provisions and Accounting Table

In accordance with OMB Circular A-4, Table 26 below depicts an accounting statement summarizing HHS's assessment of the benefits, costs, and transfers associated with this rule.

This final 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 the benefits of the final rule, such as improved health, longevity, and national productivity due to increased insurance enrollment, and some of its costs, such as the cost of providing additional medical services to newly-enrolled individuals. Direct costs in the Table 26 below reflect administrative costs to States (including those costs associated with operating risk adjustment and reinsurance), health insurance issuers, and Exchanges, but do not include administrative costs incurred by the Federal government. As discussed earlier, we estimate costs associated with establishing a dedicated data environment in the Premium Stabilization Rule Supporting Statement, and do not include those costs in Table 26. The effects in Table 26 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 five-year period from fiscal years (FYs) 2013 through 2017. Estimated transfers do not reflect any user fees paid by insurance issuers for the Federally-facilitated Exchange. Estimated transfers from health insurance issuers resulting from risk adjustment user fees are included in the table below.

TABLE 26: 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)	$68.95	2013	7%	2013-2017
	$70.37	2013	3%	2013-2017
Transfers				
Federal Annualized Monetized ($millions/year)	$6,529.29	2013	7%	2013-2017
	$6,803.02	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 final 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 by CBO 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 regulatory impact analysis, we are shifting the estimates for the reinsurance and risk adjustment programs to reflect the four-year period from FYs 2014 through 2017. Table 27 includes the CBO estimates for outlays and receipts for the reinsurance and risk adjustment programs from FYs 2014 through 2017. These estimates for reinsurance and risk adjustment reflect CBO's scoring of these provisions. 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 in section III.B. of this final rule; therefore, the estimates are assigned one year later in Table 27 than they were in the original CBO report.

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 27 summarizes the effects of the risk adjustment and reinsurance programs on the Federal budget, with the additional, societal effects of this rule discussed in this regulatory impact analysis. We note that transfers associated with risk adjustment and reinsurance were previously estimated in the Premium Stabilization Rule; therefore, to avoid double-counting, we do not include them in the accounting statement for this rule (Table 26).

TABLE 27: Estimated Federal Government Outlays and Receipts for the Reinsurance and Risk Adjustment Programs from FYs 2014-2017, in billions of dollars

Year	**2014**	**2015**	**2016**	**2017**	**2014-2017**
Reinsurance and Risk Adjustment Program Payments*	--	11	18	18	47
Reinsurance and Risk Adjustment Program Receipts*	--	12	16	18	46

*Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time. The CBO estimates do not reflect the $5 billion in reinsurance contributions that are submitted to the U.S. Treasury.
Source: Congressional Budget Office. 2011. *Letter to Hon. Nancy Pelosi.* March 20, 2010.

Risk Adjustment

Risk adjustment is a permanent program that may be administrated by States that operate an HHS-approved Exchange. States have 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. 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 transfers do not occur between States 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 final rule, we establish a risk adjustment State approval process. 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 administrative costs of approximately $9,612 for each entity, as a result of these approval requirements.[39]

The details of the HHS-developed risk adjustment methodology are specified in this final 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 final 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 annually in the HHS notice of benefit and payment parameters.

[39] For purposes of Table 26, we assume that one State will operate risk adjustment.

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 final 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 final 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. Under Section 1312(c)(3) of the Affordable Care Act, States have the flexibility to merge the individual and small group markets into a single risk pool, or keep them separate. In this final rule, we clarify that HHS will merge markets when operating risk adjustment on behalf of a State if the State elects to do the same for single risk pool purposes.

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 cost 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.

In this final 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 final 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 final rule, we establish data validation standards for when HHS operates risk adjustment on behalf of a State. HHS will 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 will engage independent initial auditors to conduct an initial audit of an HHS-selected sample of risk adjustment data. HHS will retain a second validation auditor to verify the findings of the initial validation audit and provide error estimates. However, in this final rule we note that there will 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 final rule. We also describe 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. In addition, HHS will collect approximately $20 million in user fees to support the Federally operated risk adjustment program.

Risk adjustment transfers dollars from health plans with lower-risk enrollees to health plans with higher-risk enrollees. We are updating the cost estimates for this RIA to include 2017,

using CBO estimates.[40] From 2014 through 2017, we estimated that there will be $45 billion transferred among 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 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 non-grandfathered individual and small group plans inside and outside of the Exchange. This mitigates the potential for excessive premium growth within the Exchange due to anticipated adverse selection.

Comment: One commenter disagreed with the $600 million in aggregate administrative costs estimated in the Collection of Information section of the proposed rule, and reflected in this regulatory impact analysis. The commenter stated that the cost associated with this rule would be much higher than the $600 million estimated in the proposed rule.

Response: The cost to States of developing their own risk adjustment and reinsurance programs was addressed in the Premium Stabilization Rule, Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, published March 23, 2012. We recognize States may require significant analysis to assess whether to operate risk adjustment or reinsurance programs. Many states received grants available under the Affordable Care Act to underwrite such analyses

[40] Congressional Budget Office. 2011. *Letter to Hon. Nancy Pelosi*. March 20, 2010. We note that these estimates include only risk adjustment transfers whereas Table 27 shows transfer estimates for risk adjustment and reinsurance.

(although we note that these grants would affect who bears the cost of the rule, not the amount incurred by society as a whole). States choosing in the future to operate risk adjustment may benefit from methodologies developed by other States and approved by HHS. The cost of reporting data to HHS should decline once systems are in place.

We have limited our estimate to the incremental information collection associated with the requirements of the proposed rule. HHS relied on the Bureau of Labor Statistics, U.S. Department of Labor, *National Compensation Survey Occupational Earnings in the United States, 2011,* for estimates of most job descriptions and wages. We believe that our analysis reflects our best estimate of the costs associated with the proposed rule. We also note we have modified some estimates from our proposed rule to better reflect the most current agency estimates.

Reinsurance

The Affordable Care Act creates a transitional reinsurance program for benefit years 2014, 2015, and 2016. Each State is eligible to operate reinsurance. If a State operates reinsurance, the State must enter into a contract with an applicable reinsurance entity to carry out the program. If a State does not elect to operate reinsurance, HHS will carry out reinsurance 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 payable 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 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. In this final rule, HHS establishes 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 reinsurance in 2014. We estimate that we will collect these authorized amounts from 2014 through 2016.

HHS will collect the required contributions under the national contribution rate from health insurance issuers and self-insured group health plans.[41] States operating reinsurance may collect additional contributions for administrative costs, reinsurance payments, or both. Section 1341(a)(3)(B) of the Affordable Care Act requires that the reinsurance contribution amount for each issuer reflect each issuer's fully insured commercial book of business for all major medical products. In this final 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 the 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 final rule, we establish that HHS will 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 applicable reinsurance entity complies with program requirements. HHS will share some of its collections for administrative costs with

[41] The Department of Labor has reviewed this 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 rule. (See generally, Advisory Opinion 2001-01A to Mr. Carl Stoney, Jr., available at www.dol.gov/ebsa discussing settlor versus plan expenses.)

States that run the program. If a State operates reinsurance, HHS would retain $0.055 per capita per year to offset the costs of contributions collection, and would allocate $0.055 per capita per year towards administrative expenses for reinsurance payments. The total amounts allocated towards administrative expenses for reinsurance payments would be distributed to States operating reinsurance (or retained by HHS where HHS is operating the reinsurance program) in proportion to the State-by-State total requests for reinsurance payments made under the uniform payment parameters. A State may have more than one applicable reinsurance entity, and two or more States may jointly enter into an agreement with the same applicable reinsurance entity to carry out reinsurance functions in their State. Administrative costs will likely increase if multiple applicable reinsurance entities are established within a State, whereas administrative efficiencies may be found if multiple States contract with one applicable reinsurance entity.

We also finalize an annual collections and payment cycle in this final rule. We 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. Additionally, 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, issuers would receive only limited benefits from a quarterly payment cycle.

Under §153.100(a), a State operating reinsurance must 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 the reinsurance program will also maintain any records associated

with the reinsurance program, as set forth in §153.240(c) of the Premium Stabilization Rule. The Premium Stabilization Rule established that reinsurance contributions will be based on a per capita amount. The per capita approach will 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 will be permitted to collect additional contributions towards supplemental reinsurance payments. 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 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 believe that it will cost each State choosing to collect additional contributions approximately $594 to comply with this requirement. Additionally, under §153.232(e), if all requested reinsurance payments under the State supplemental reinsurance parameters 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 supplemental reinsurance payments. The State or the applicable reinsurance entity must reduce all such requests for supplemental 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.[42]

[42] For purposes of Table 26, we assume that two States will operate reinsurance.

In this final rule, we establish the methodology to be used for counting covered lives for purposes of calculating reinsurance contributions. This methodology offers contributing entities a choice similar to 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 final 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 will provide enrollment data to HHS to substantiate contribution amounts.

Reinsurance payments will be made to issuers of individual market insurance coverage for high claims costs for enrollees. In this final rule, we establish 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 cost sharing above the attachment point and below the cap, is designed to 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.

A State operating reinsurance may supplement the reinsurance payment 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. We estimate that it will take an operations analyst 2 hours (at $55 an hour) to gather the relevant information, for a total burden of $110 per State electing to run reinsurance. Note that a State may develop a separate reinsurance program using entirely its own design.

In this final rule, we require States to provide a process through which a reinsurance-eligible plan that does not generate individual enrollee claims in its normal course of business may derive costs to request reinsurance payments. In addition, we clarify that when HHS operates the reinsurance program on behalf of a State that these plans may price encounters in accordance with their existing principal, internal encounter pricing methodology. Additionally, in §153.240(b) of this final rule, States operating the reinsurance program must notify issuers annually of reinsurance payments to be made, as well as provide reinsurance-eligible plans quarterly estimates of requests for reinsurance payments. Moreover, we establish that for both State- and HHS-operated reinsurance programs, only plans subject to the 2014 market reform rules are eligible for reinsurance payment.

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 also believe that these provisions 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 these requirements.

In this final 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 finalized in this rule are reflected in these cost estimates.

A wide range of health insurance issuers and self-insured group health plans contribute to the reinsurance pool because successful implementation of this rule, in combination with the range of Affordable Care Act reforms starting in 2014, benefit all of their enrollees; for example, those reforms should lead to fewer unreimbursed health costs, lowering the costs for issuers and group health plans. Providing reinsurance payments to health insurance issuers with plans in the individual market serves to stabilize premiums in the individual market. Reinsurance will put downward pressure on individual market rates as new enrollees with unknown risk join the market. 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 1 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[43] 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.

Comment: One commenter asked how HHS derived the estimate that reinsurance contributions would increase total market premiums paid by 1 percent, and that reinsurance payments to issuers would reduce premiums in the individual market by between 10 percent and 15 percent.

Response: This is an HHS estimate for the effects of reinsurance in 2014 that relied in part on a 2009 analysis of health insurance premiums by the Congressional Budget Office.

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

[43] Swartz, K. "Health New York: Making Insurance More Affordable for Low-Income Workers." *The Commonwealth Fund*. November 2001.

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 markets 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 subject to adjustments for health care quality, health IT, risk adjustment payments and charges and reinsurance payments) and the target amount – the difference between a plan's earned premiums and allowable administrative costs. In this final 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, a QHP with allowable costs that exceed its target amount by at least 3 percent will receive payments. 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 final rule, HHS also specifies 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 final 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 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.[44]

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

[44] Brook, et. al.

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 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.[45] Participation rates are expected to be lower in the first few years of Exchange availability as employers and individuals adjust to the features of the Exchanges.[46]

In this final rule, we provide additional details for Exchanges and QHP 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

[45] "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," Congressional Budget Office, March 2012.
[46] 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.

eligible individuals who purchase a family policy. We also establish standards applicable to Exchanges when 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 final 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 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 set forth standards relating to advance payments of cost-sharing reductions and reconciliation of those advance payments against actual cost-sharing reduction provided. In addition, we establish standards for QHP issuers to 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 final rule.

The cost-sharing reductions and advance payments 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 and advance payments of the premium tax credit. 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 those individuals who qualify for those programs.

User Fees

To support certain Federal operations of Federally-facilitated Exchanges, we establish in this final 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 must remit a user fee to HHS each month equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan offered through a Federally-facilitated Exchange. For the 2014 benefit year, we establish a monthly user fee rate equal to 3.5 percent.

SHOP

The 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 regulatory impact analysis published in conjunction with the Exchange Establishment Rule.[47] This impact analysis addresses the additional costs and benefits of the proposed modifications in this rule to the SHOP sections of the Exchange Establishment Rule.

In this final rule, we implement policies for FF-SHOPs designed to prevent significant adverse selection while promoting QHP choice for 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.

Section 1312 of the Affordable Care Act permits a qualified employer participating in a

47 Available at: http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf

SHOP to select a metal level of coverage and make all plans in that level of coverage available to its employees. Permitting employers to choose a single level of coverage reduces potential adverse selection within the group and therefore any additional cost due to expanded choice. In the Exchanges Establishment final rule, we provided each SHOP the flexibility to choose additional means by which a qualified employer could make QHPs available to qualified employees. In this final rule, we add an FF-SHOP option to allow qualified employers to offer qualified employees only a single QHP. This employer option is designed to further reduce adverse selection, although it may reduce the benefit to the employee resulting from broader 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, and we do not quantify the reduction in risk premium or consumer benefit resulting from this change.

The Exchange Final Rule permits a SHOP to set a minimum participation rate; such authority is limited to the extent a 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 final rule establishes, 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 final rule establishes that health insurance issuers with shares of a State's small

group market greater than 20 percent will participate in the FF-SHOP if they also seek to participate in the FFE in the State. This policy promotes robust issuer participation in the FF-SHOP which will help qualified 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 value to consumers ("consumer surplus") of 20 percent of the premium cost of coverage.[48] Some of this benefit is due to expanded choice in plan type and health insurance issuer. There are two additional impacts 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 transfer associated with user fees for additional enrollees in QHPs in the FF-SHOP.

Medical Loss Ratio

This final rule amends the MLR and rebate calculation methodologies to include payments and receipts related to the premium stabilization programs. The definition of premium revenue is 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 will be considered a part of gross earned premium reported to the Secretary, similar to other elements involved in the derivation of earned premium. Gross earned premium will not be reduced by the amount of contributions under the transitional reinsurance program. The MLR annual reporting form will then account for premium stabilization payment and receipt amounts other than the reinsurance contributions by removing them from adjusted earned

48 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.

premium, so that these amounts do not have a net impact on the adjusted earned premium used in calculating the MLR denominator and rebates. Contributions under the transitional reinsurance program will be included with the Federal assessments that are deducted from earned premium in MLR and rebate calculations. Additionally, this final rule amends the MLR calculation methodology to add or subtract premium stabilization payment and receipt amounts, other than reinsurance contributions, in the MLR 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[49] 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

[49] 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.

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 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.

This final rule also changes 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, this final rule changes 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 previous MLR calculation methodology allowed 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 final rule amends the MLR methodology to 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 will continue to use the previous methodology. This will 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 will 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 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 in 2012 issuers will maintain the level of community

benefit expenditures as reported in their MLR annual reports for the 2011 MLR reporting year. Therefore, 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, which is the same as the experience in the 2011 MLR reporting year. The adopted 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 will need to send fewer rebate notices, and therefore, will have lower administrative costs related to rebates and rebate notices.

D. Alternatives Considered

Risk Adjustment

We considered State flexibility for risk adjustment. This option would have allowed States to develop State-specific characteristics but it would have resulted in few Federal standards by which to compensate for risk. This final rule describes a HHS risk adjustment methodology but allows States to seek HHS approval for alternate methodologies based on criteria established in this final rule. This compromise gives States some flexibility but also reduces the burden on multi-State issuers and the Federal government.

Reinsurance

We proposed State flexibility to establish the reinsurance program in the Premium Stabilization Rule. This option would have allowed for State innovation, but it would have greatly increased the administrative burden on self-insured group health plans, multi-State issuers and the Federal government. A national approach is more efficient and less expensive.

Moreover, we believe that uniform reinsurance payment parameters deliver payments where they are most needed—to issuers with high cost claims in the individual market. Centralized collection of contributions, an annual contribution and payment schedule, as well as a national contribution rate provide a more effective approach to stabilize premiums, while decreasing administrative burden.

Risk Corridors

Elsewhere in this issue of the **Federal Register,** we are implementing an alternative to our current policy, under which the risk corridor calculation methodology compares plan-specific allowable costs (adjusted claims) to a target amount (adjusted premiums). In order to align the risk corridor calculation methodology with the single risk pool requirements finalized at §156.80, we are modifying the definition of "allowable costs" for the risk corridors calculation at §153.500 such that "allowable costs" are calculated in a manner consistent with the single risk pool requirement for premiums. We believe that this approach will better align risk sharing under the program with how issuers will be required to set rates. We address the burden associated with this approach in the Collection of Information Section of the interim final rule with comment "Amendments to the HHS Notice of Benefit and Payment Parameters for 2014", published elsewhere in this issue of the **Federal Register.**

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

As discussed in section III.E.4.i, we considered requiring QHP issuers to provide cost-sharing reductions to Indians by waiving the cost sharing as appropriate, rather than assigning the eligible Indian to a particular plan variation. However, we believe this alternative approach would be too burdensome for issuers to implement in the short term. As discussed in section III.E.4.e, we are issuing an interim final rule with comment to provide QHP issuers with the

option to submit data about the actual amount of cost-sharing reductions using an alternate methodology for purposes of payment reconciliation. This alternative will provide greater flexibility to issuers and may reduce the reporting burden for some issuers. We describe the burden associated with this alternative in the Collection of Information Section of the interim final rule with comment "Amendments to the HHS Notice of Benefit and Payment Parameters for 2014", published elsewhere in this issue of the **Federal Register.**

User Fees

We considered calculating user fees on a per capita basis, but that approach fails to adjust for premium variation and geographic wage differences, and commenters suggest that most issuers and stakeholders prefer that such costs be calculated as a percentage of premium.

SHOP

We considered making no change to the employer options in the FF-SHOP, but concluded that allowing employers the option of offering a single QHP to employees would simplify the transition from current market practices to the SHOP. We will be proposing further rulemaking to ease the transition from the current market to the SHOP.

We considered a range of threshold values for determining which issuers would be subject to the QHP certification requirement linking FFE and FF-SHOP participation and chose a threshold (20 percent market share) that minimized the number of issuers affected by the certification requirement while still ensuring that at least one large issuer in each State would offer QHPs in the FF-SHOP.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq*.) (RFA) requires agencies to prepare a final 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 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 final rule contains rules for premium stabilization programs required of health plan issuers and self-insured group health plans. These programs include the risk adjustment program, the transitional reinsurance program and the 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 a final 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 final rule: (1) health insurance issuers; (2) health insurance plan sponsors; (3) applicable reinsurance entities; (4) risk adjustment entities; (5) self-insured group health plans and (6) 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); applicable 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. 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.

We believe that a number of sponsors of self-insured group health plans could qualify as "small entities." This final rule specifies that third-party administrators may incur the operational costs associated with submitting reinsurance contributions to HHS. We do not believe that the reinsurance contribution amount or the operational cost associated with submitting the contribution are likely to result in a change in revenues of more than 3 to 5 percent for a substantial number of self-insured group health plans or third-party administrators that meet the definition of a small entity. We requested comment on whether the small entities affected by the proposed rule have been fully identified. We also requested comment and information on potential costs for these entities and on any alternatives that we should consider.

Comment: We received no comments on whether the small entities described in this rule have been fully identified or on potential costs to them. However, one State expressed concern that the number of small self-insured entities is expected to grow and could cause an uneven playing field if not included in reinsurance contribution assessments. The State said maintaining a level playing field is desirable so as not to provide additional incentive to self-insure and

thereby deny employees the consumer protection applicable to insured products on the Exchange.

Response*:* We are aware that a growing number of small entities may consider self-insuring since self-insured groups are exempt from community ratings and minimum health care benefits. HHS will collect reinsurance contributions on a per enrollee basis from all self-insured group health plans regardless of their size. This will help ensure that entities are not incentivized to self-insure in order to avoid making reinsurance contributions. Because these contributions will be calculated on a per capita basis, we believe that is it unlikely that the amount of these contributions (or the operational costs associated with making these contributions) will result in a significant change in revenue for a substantial number of small entities.

In this final rule, we establish 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 employer-sponsored coverage. For example, the FF-SHOP will generally match existing minimum participation rates in the outside market. Additionally, as discussed in the regulatory impact analysis, we believe the employee choice option will ultimately provide greater choice for the employee among QHPs and issuers, benefitting both employer and employee and simplifying the process for the employer of administering multiple health benefit plans while allowing a SHOP to let an employer choose one plan eases the transition from the current marketplace. 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.

F. 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 2013, that threshold is approximately $141 million. Although we have not been able to quantify the user fees that will be associated with this rule, the combined administrative cost and user fee impact on State, local, or Tribal governments and the private sector may be above the threshold. Earlier portions of this RIA constitute our UMRA analysis.

G. 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 risk adjustment, reinsurance, and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish a risk adjustment or reinsurance program, or an Exchange.

In HHS's view, while this final 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 a risk adjustment or reinsurance program or an Exchange must adopt the Federal standards contained in the Affordable Care Act and in this final rule, 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 these programs. Additionally, the Affordable Care Act does not require States to establish these programs; if a State elects not to establish these programs (or the State's risk adjustment program or Exchange is not approved), HHS must establish and operate these programs 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 final 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.

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 amends 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. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

2. Section 153.20 is amended by revising the definitions of "Contributing entity", "Risk adjustment covered plan" and "Risk adjustment data collection approach" to read as follows:

§153.20 Definitions.

* * * * *

Contributing entity means a health insurance issuer or self-insured group health plan. A self-insured group health plan is responsible for the reinsurance contributions, though it may elect to use a third party administrator or administrative services only contractor for transfer of the reinsurance contributions.

* * * * *

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 (d)(1).

G. Removing paragraph (d)(2).

H. Redesignating paragraphs (d)(3) and (4) as paragraphs (d)(2) and (3).

I. Revising newly designated paragraph (d)(2).

J. Removing paragraph (d)(5).

K. 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)(1) or use additional funds for reinsurance payments under §153.220(d)(2); or

* * * * *

(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)(1) and the use of additional funds for reinsurance payments under §153.220(d)(2);

* * * * *

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. Redesignating paragraph (c)(3) as paragraph (c)(2).

G. Removing newly designated paragraph (c)(4).

H. Removing newly designated paragraph (c)(5).

I. Redesignating paragraph (c)(6) as paragraph (c)(3).

J. Removing paragraph (e).

K. 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)(1) or use additional funds for reinsurance payments under §153.220(d)(2), 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)(2)), 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 or establishes 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) 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 reinsurance-eligible 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 benefit year commencing in 2014 and ending in 2016 set forth in the annual HHS notice of benefit and payment parameters for each 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 in the applicable benefit year 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)(2), 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)(2), as applicable, for any applicable

benefit year are reasonably calculated to cover additional reinsurance payments that are projected to be made only under the State 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)(2), 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 State supplemental reinsurance payment parameters under §153.232(a)(1), a reinsurance-eligible plan becomes eligible for reinsurance payments from contributions under §153.220(d)(1)(ii) or funds under §153.220(d)(2), as applicable, if its incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(1) Exceed the State supplemental 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 State supplemental 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)(2), as applicable, will be calculated with respect to an issuer's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year as the sum of the following:

(1) If the State has established a State supplemental attachment point, to the extent the issuer's incurred claims costs for such benefits in the applicable benefit year exceed the State supplemental attachment point but do not exceed the national attachment point, the product of such claims costs between the State supplemental attachment point and the national attachment point multiplied by the national coinsurance rate (or, if the State has established a State supplemental coinsurance rate, the State supplemental coinsurance rate);

(2) If the State has established a State supplemental reinsurance cap, to the extent the issuer's incurred claims costs for such benefits in the applicable benefit year exceed the national reinsurance cap but do not exceed the State supplemental reinsurance cap, the product of such claims costs between the national reinsurance cap and the State supplemental reinsurance cap multiplied by the national coinsurance rate (or, if the State has established a State supplemental coinsurance rate, the State supplemental coinsurance rate); and

(3) If the State has established a State supplemental coinsurance rate, the product of the issuer's incurred claims costs for such benefits in the applicable benefit year 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.

(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)(2) 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 payment parameters or the State supplemental reinsurance payment 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 disburse to each State operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of a State), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The disbursed funds would be based on the 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 issuer of a reinsurance-eligible plan the calculation of total reinsurance payment requests, on a quarterly basis during the applicable benefit year in a timeframe and manner specified by HHS, made under:

(i) The national reinsurance payment parameters, and

(ii) State supplemental reinsurance payments parameters if applicable.

* * * * *

(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) <u>State responsibility for risk adjustment</u>. (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) Evaluation criteria for alternate risk adjustment methodology. 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 employer'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 rate 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)(1), 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) Such plan or coverage is expatriate health coverage, as defined by the Secretary; or

(iv) In the case of employer-provided health coverage, such coverage applies to individuals with respect to which benefits under Title XVIII of the Act (Medicare) are primary under the Medicare Secondary Payor rules under section 1862(b) of the Act and the regulations issued thereunder.

(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 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);

(xii) Health programs operated under the authority of the Indian Health Service; or

(xiii) A self-insured group health plan or health insurance coverage that consists solely of benefits for prescription drugs.

(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 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 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 30 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 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); or

(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.

(f) Procedures for counting covered lives for group health plans with a self-insured coverage option and an insured coverage option.

(1) 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.

(2) Notwithstanding paragraph (f)(1), a plan with multiple coverage options may use any of the counting methods specified for self-insured coverage or insured coverage, as applicable to each option, if it determines the number of covered lives under each option separately as if each coverage option provided major medical coverage (not including any coverage option that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, that only provides benefits related to prescription drugs, or that is a health reimbursement arrangement, health savings account, or health flexible spending arrangement).

(g) Multiple group health plans maintained by the same plan sponsor.

(1) General rule. If a plan sponsor maintains two or more 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 simultaneously, then those multiple plans must be treated as a single group health plan for purposes of calculating any reinsurance contribution amount due under this section. However, a plan sponsor may treat the multiple plans as separate group health plans for purposes of calculating any reinsurance contribution due

under this section if it determines the number of covered lives under each separate group health plan as if the separate group health plan provided major medical coverage.

(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 group health plan as determined under paragraph (g)(1) of this section any group health plan that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, that only provides benefits related to prescription drugs, or that is a health reimbursement arrangement, health savings account, or health flexible spending arrangement.

(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 that issuer's claims costs for 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 and regulatory fees" 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 and regulatory fees.

After-tax premiums earned mean, with respect to a QHP, premiums earned with respect to the QHP minus taxes and regulatory fees.

Allowable administrative costs mean, with respect to a QHP, the sum of administrative costs of the QHP, other than taxes and regulatory fees, 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 and regulatory fees.

* * * * *

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 and regulatory fees 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 153.520 is amended by revising paragraph (d) to read as follows:

§153.520 Attribution and allocation of revenue and expense items.

* * * * *

(d) Attribution of reinsurance and risk adjustment to benefit year. A QHP issuer must attribute reinsurance payments and risk adjustment payments and charges to allowable costs for

the benefit year with respect to which the reinsurance payments or risk adjustment calculations apply.

* * * * *

24. Section 153.530 is amended by –

A. Revising paragraphs (a), (b) introductory text, (b)(1), (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–

(1) Increased by any risk adjustment charges paid by the issuer for the QHP under the risk adjustment program established under subpart D of this part.

(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.

25. Section 153.610 is amended by adding paragraph (f) to read as follows:

§153.610 Risk adjustment issuer requirements.

* * * * *

(f) Assessment and collection of user fees for HHS risk adjustment operations. Where HHS is operating risk adjustment on behalf of a State, an issuer of a risk adjustment covered plan (other than a student health plan or a plan not subject to 45 CFR 147.102, 147.104, 147.106, 156.80, and subpart B of part 156) must, for each benefit year—

(1) Submit or make accessible to HHS its monthly enrollment for the risk adjustment covered plan for the benefit year through the risk adjustment data collection approach established at §153.610(a), in a manner and timeframe specified by HHS; and

(2) Remit to HHS an amount equal to the product of its monthly enrollment in the risk adjustment covered plan multiplied by the per-enrollee-per-month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

26. 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 paragraphs (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.

27. 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 (or payment of cost sharing by the enrollee).

(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

28. 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.

29. 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 January 1, 2014 and in connection with open enrollment activities beginning 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 large 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) 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 January 1, 2014 and in connection with open enrollment activities beginning 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) 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 January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013.

* * * * *

30. 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.

* * * * *

31. 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).

* * * * *

32. 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 an eligibility redetermination in accordance with this section results in a change in the amount of advance payments of the premium tax credit for the benefit year, the

Exchange must recalculate the amount of advance payments of the premium tax credit in such a manner as to —

(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 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).

(2) When an eligibility redetermination in accordance with this section results in a change in cost-sharing reductions, 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)).

33. Section 155.340 is amended by adding paragraphs (e), (f), and (g) 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 among policies. If one or more advance payments of the premium tax credit are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan, then the advance payment 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 a reasonable and consistent manner specified by the Exchange; and

(2) Any remaining advance payment of the premium tax credit must be allocated among the stand-alone dental policies in a reasonable and consistent manner specified by the Exchange.

(f) Allocation of advance payments of the premium tax credit among policies offered through a Federally-facilitated Exchange. If one or more advance payments of the premium tax credit are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan offered through a Federally-facilitated Exchange, then 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), properly allocated to EHB for the QHP policies, will be allocated among the QHP policies, as described in §155.340(f)(1); and any remaining advance payment of the premium tax credit will be allocated among the stand-alone dental policies based on the methodology described in §155.340(f)(2).

(1) That portion of the advance payment(s) of the premium tax credit to be allocated among QHP policies will be allocated based on the number of enrollees covered under the QHP, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR 147.102(e), with the portion allocated to any single QHP policy not to exceed the portion of the QHP's adjusted monthly premium properly allocated to EHB. If the portion of the advance payment(s) of the premium tax credit allocated to a QHP under this subparagraph exceeds the portion of the same QHP's adjusted monthly premium

properly allocated to EHB, the remainder will be allocated evenly among all other QHPs in which individuals in the tax filers' tax households are enrolled.

(2) That portion of the advance payment(s) of the premium tax credit to be allocated among stand-alone dental policies will be allocated based on the number of enrollees covered under the stand-alone dental policy, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR 147.102(e), with the portion allocated to any single stand-alone dental policy not to exceed the portion of the stand-alone dental policy premium properly allocated to EHB. If the portion of the advance payment(s) of the premium tax credit allocated to a stand-alone dental policy under this subparagraph exceeds the portion of the same policy's premium properly allocated to EHB, the remainder will be allocated evenly among all other stand-alone dental policies in which individuals in the tax filers' tax households are enrolled.

(g) 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.

34. Section 155.705 is amended by revising paragraph (b)(3), (b)(10), and (b)(11) 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 either:

(A) All QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section, or

(B) A single QHP.

* * * * *

(10) Participation rules. Subject to §147.104 of this subchapter, the SHOP may authorize uniform group participation rules for the offering of health insurance coverage in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.

(i) Subject to §147.104 of this subchapter, 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) Premium calculator. In the SHOP, the premium calculator described in § 155.205(b)(6) must facilitate the comparison of available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost sharing reductions.

(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 serve 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) 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.

(E) The resulting contribution amounts for each employee's coverage may then be applied toward the QHP selected by the employee.

35. 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) An Exchange must ensure that each issuer that offers, or intends 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 intended 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.

(c) Multi-State plans. The U.S. Office of Personnel Management will ensure compliance with the standards referenced in this section for multi-State plans, as defined in §155.1000(a).

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

36. 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).

37. 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.

* * * * *

38. 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 monthly user fee rate specified in the annual

HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.

39. 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 has a share of the small group market, as determined by HHS, greater than 20 percent, based on the earned premiums submitted by all issuers in the State's small group market, under §158.110 of this

subchapter, on the reporting date immediately preceding the due date of the application for QHP certification.

40. 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]

41. 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 SHOP –

(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.

* * * * *

42. 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).

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, pays 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 offers, or intends 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 offers, or intends to offer in 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.

(g) Multi-state plans. The U.S. Office of Personnel Management will determine the time and manner for multi-State plans, as defined in §155.1000(a) of this subchapter, to submit silver plan variations, zero cost sharing plan variations, and limited cost sharing plan variations.

§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 intends 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.

(4) Issuers of multi-State plans, as defined in §155.1000(a) of this subchapter, must provide the estimates described in paragraphs (a)(1) and (2) of this section to the U.S. Office of Personnel Management, in the time and manner established by the U.S. Office of Personnel Management.

(b) Advance payments for cost-sharing reductions. (1) 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.

(2) HHS may adjust the advance payment amount for a particular QHP during the benefit year if the QHP issuer provides evidence, certified by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, that the advance payments for a particular QHP are likely to be substantially different than the cost-

sharing reduction amounts that the QHP provides that will be reimbursed by HHS.

(c) Submission of actual amounts. (1) General. For each plan variation that a QHP issuer offers on the Exchange, it must submit to HHS, in the manner and timeframe established by HHS, for each policy, the total allowed costs for essential health benefits charged for the policy for the benefit year, broken down by all of the following:

(i) The amount the issuer paid.

(ii) The amount the enrollee(s) paid.

(iii) The amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions.

(2) Standard methodology. A QHP issuer must calculate the value of the amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions by applying the actual cost-sharing requirements for the standard plan to the allowed costs for essential health benefits under the enrollee's policy for the benefit year.

(3) [Reserved]

(4) [Reserved]

(5) Reimbursement of providers. In the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid under the standard plan without cost-sharing reductions only to the extent the amount was either payable by the enrollee(s) as cost sharing under the plan variation or was reimbursed to the provider by the QHP issuer.

(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 cost-sharing reduction 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 cost-sharing reduction 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 cost-sharing reduction 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 cost-sharing reduction 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.

(g) Prohibition on reduction in payments to Indian health providers. If an Indian is enrolled in a QHP in the individual market through an Exchange and is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, the QHP issuer may not reduce the payment to any such entity for such item or service by the amount of any cost sharing that would be due from the Indian but for the prohibitions on cost sharing set forth in §156.410(b)(2) and (3).

§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 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, 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 intended 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 intended 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 is performed by a member of the

American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies.

(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 intended 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.

(f) Multi-State plans. Issuers of multi-State plans, as defined in §155.1000(a) of this subchapter, must submit the allocations and actuarial memorandum described in this section to the U.S. Office of Personnel Management, in the time and manner established by the U.S. Office of Personnel Management.

PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

43. 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.

44. 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

45. 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.

46. 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.

* * * * *

47. 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.

48. 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) Receipts related to the transitional reinsurance program and net payments or receipts related to risk adjustment and risk corridors 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.

* * * * *

49. Section 158.161 is amended by revising paragraph (a) to read as follows:

§158.161 Reporting of Federal and State licensing and regulatory fees.

(a) Licensing and regulatory fees included. The report required in §158.110 must include statutory assessments to defray operating expenses of any State or Federal department, transitional reinsurance contributions assessed under section 1341 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, and examination fees in lieu of premium taxes as specified by State law.

* * * * *

50. 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.

* * * * *

51. 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 related to risk adjustment, risk corridors, and reinsurance, described in §158.130(b)(5).

52. 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:

* * * * *

53. 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, 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 a pro rata portion of taxes and fees and accounting for payments or receipts related to reinsurance, risk adjustment and risk corridors. If the issuer's total earned premium for the MLR reporting year in the individual market in the State is $200,000, the issuer received transitional reinsurance payments of $2,500, and made net payments related to risk adjustment and risk corridors of $20,000, the issuer's gross earned premium in the individual market in the State would be $200,000 plus $2,500 minus $20,000, for a total of $182,500. If the issuer's Federal and State taxes and licensing and regulatory fees, including reinsurance contributions, that may be excluded from premium revenue as described in §§158.161(a), 158.162(a)(1) and 158.162(b)(1), allocated to the

individual market in the State are $15,000, and the net payments related to risk adjustment and risk corridors, reduced by reinsurance receipts, that must be accounted for in premium revenue as described in §§158.130(b)(5), 158.221 and 158.240, are $17,500 ($20,000 reduced by $2,500), then the issuer would subtract $15,000 and add $17,500 to gross premium revenue of $182,500, for a base of $185,000 in premium. The issuer would owe rebates of 5 percent of $185,000, or $9,250 in the individual market in the State. In this example, if an enrollee of the issuer in the individual market in the State paid $2,000 in premiums for the MLR reporting year, or 1/100 of the issuer's total premium in that State market, then the enrollee would be entitled to 1/100 of the total rebates owed by the issuer, 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.

* * * * *

54. 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: February 25, 2013.

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Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: February 27, 2013.

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Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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