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

December 10, 2012

On December 7, 2012, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) published in the *Federal Register* (77 FR 73118-73218)[1] a proposed a rule to give further detail and parameters related to provisions of the Affordable Care Act (ACA). These are: the risk adjustment, reinsurance, and risk corridors programs (also known as the Premium Stabilization Programs); cost-sharing reductions; user fees for a federally-facilitated Exchange; advance payments of the premium tax credit; a federally-facilitated Small Business Health Option Program (SHOP); and the medical loss ratio (MLR) program. Written comments, identified by file code CMS-9964-P, may be submitted to CMS. **The 30-day comment period closes on December 31, 2012.**

A detailed summary of the provisions of this proposed rule is provided below. Although CMS is the implementing agency, much of the proposed rule references the role of HHS in implementing and enforcing the various requirements and procedures.

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[1] www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf

I. Executive Summary

Earlier this year, CMS published the Patient Protection and Affordable Care Act: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule (Premium Stabilization Rule) (77 FR 17220) and the Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers Final Rule (77 FR 18310). These rules implement standards for Affordable Insurance Exchanges (Exchanges), states, and health insurance issuers related to the reinsurance, risk adjustment, and risk corridors programs established by the ACA and the establishment of Exchanges and qualified health plans (QHPs). CMS explains that these programs are designed to provide consumers with affordable health insurance coverage, to reduce incentives for health insurance issuers to avoid enrolling sicker people, and to stabilize premiums in the individual and small group health insurance markets inside and outside Exchanges.

The HHS Notice of Benefit and Payment Parameters is a proposed rule to expand upon the standards set forth in the rules published earlier in 2012. Key proposals include:

Specifications for the federal (HHS) risk adjustment methodology to use when operating risk adjustment on behalf of a state: Risk adjustment is intended to reduce the incentives for health insurance issuers to avoid enrolling people with pre-existing conditions. The permanent risk adjustment program called for by the ACA will assist health plans that cover individuals with higher health care costs and will help ensure that those who are sick have access to the coverage that they need. CMS also outlines the agency's proposed approach to validating risk adjustment data to instill confidence in the program. States that are running an Exchange and their own risk adjustment program can propose a different methodology.

Stabilizing premiums in the individual market for health insurance: The ACA calls for a transitional (three-year) reinsurance program to reduce medical risk for issuers and thereby reduce premiums for enrollees in the individual market to ensure market stability with the implementation of new market reforms and other consumer protections in 2014. The statute sets a fixed, national amount for the reinsurance program. CMS proposes uniform reinsurance payment parameters for this program. A state may supplement the uniform reinsurance payment parameters, but must pay for those supplementary parameters with additional state reinsurance collections or state funds (instead of funds collected by HHS under the national contribution rate). CMS also proposes: a per capita rate under which contributions would be collected annually by HHS from all applicable health insurance issuers and group health plans; exclusion of certain types of plans from the reinsurance contribution requirement; and standards governing the calculation of contributions.

Protecting health insurance issuers against uncertainty in setting premium rates: The ACA's temporary risk corridors program is intended to protect QHPs from uncertainty in rate setting from 2014 to 2016. Under this program, the federal government will share risk in losses and gains with QHPs. CMS proposes to account for profits and taxes in the calculations and to align this program with the MLR program.

Assisting low and moderate-income Americans in affording health insurance on Exchanges: CMS proposes further clarification regarding the administration of advance payments of the ACA's premium tax credit and cost-sharing reductions that are intended to help make health insurance covered offered through the Exchanges affordable for low- and middle-income individuals. Under this proposed rule, CMS makes advance payments of the premium tax credit to issuers on behalf of eligible individuals. The cost sharing reductions are provided by issuers to eligible individuals at the point of service and CMS directly reimburses issuers for these payments.

Exchange User Fees: Under the ACA, Exchanges are required to be self-sustaining entities. CMS proposes a user fee for health insurance issuers participating in a federally-facilitated Exchange (FFE) that would be commensurate with fees charged by state-based Exchanges. CMS proposes for the 2014 benefit year a monthly user fee rate for the FFE equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan.

Specification of standards for the Small Business Health Options Program (SHOP) Exchanges. Beginning in 2014, SHOP Exchanges will allow small employers to offer employees a variety of QHPs. CMS proposes several standards and processes for implementing SHOP Exchanges, including: standards governing the definitions and counting methods used to determine whether an employer is a small or large employer; a safe harbor method of employer contribution in a federally-facilitated SHOP (FF–SHOP); a default minimum participation rate; QHP standards linking Exchange and FF–SHOP participation and ensuring broker commissions in FF–SHOP that are the same as those in the outside market; and allowing Exchanges and SHOPs to selectively list only brokers registered with the Exchange or SHOP (and adopting that policy for FFEs and FF–SHOPs).

Additional standards for the Medical Loss Ratio (MLR) Program: Under the ACA, the MLR program requires issuers to rebate a portion of premiums if their MLRs fall short of the applicable MLR standard for the reporting year. MLR is calculated as a ratio of claims plus quality improvement activities to premium revenue, with adjustments for taxes, regulatory fees, and the premium stabilization programs. CMS proposes additional and revised standards governing the MLR program, including: provisions accounting for risk adjustment, reinsurance, and risk corridors in the MLR calculation; a revised timeline for MLR reporting and rebates; and provisions that modify the treatment of community benefit expenditures.

CMS also provides a high level summary of the costs and benefits of the proposed rule, based on its Regulatory Impact Analysis (see 77 FR 73121-2). **CMS solicits comments on strategies that could be used in addition to those discussed in this proposed rule (premium stabilization programs, tax credits and cost sharing subsidies, SHOP exchanges and MLR standards) consistent that are consistent with the ACA and that HHS or states might deploy to help make rates affordable in the current market and encourage timely enrollment for coverage in 2014.**

II. Background

CMS provides in this section a summary of the statutory and regulatory history related to the ACA provisions in this proposed rule and others that are inherently linked to these provisions (e.g., insurance market reforms). CMS notes that the HHS, Labor, and Treasury are working in close coordination to release guidance related to Exchanges in several phases. The following table identifies relevant prior regulations and guidance.

ACA Provisions	Prior Regulations or Guidance Date of Publication in the *Federal Register*
Premium Stabilization – Risk adjustment; reinsurance and risk corridors	Proposed rule: July 15, 2011 (76 FR 41930) Final rule: March 23, 2012 77 FR 17220
Risk Adjustment	White paper: September 12, 2011 Bulletin on intended HHS approach to implementing risk adjustment on behalf of a state : May 31, 2012 Public Meeting: May 7-8, 2012
Reinsurance	Bulletin on intended HHS approach to implementing reinsurance program on behalf of a state: May 31, 2012
Cost Sharing Reductions	Bulletin on intended HHS approach to calculating actuarial value and implementing cost-sharing reductions: February 24, 2012
Advance Payments of the Premium Tax Credit	Proposed Rule: August 17, 2011 (76 FR 50931) Final Rule: May 23, 2012 (26 CFR 1 and 602)
Exchanges	Request for Comment: August 3, 2010 (75 FR 45584). An Initial Guidance to States on Exchanges: November 18, 2010 Proposed rule: July 15, 2011 (76 FR 41866) Proposed rule re: specific functions in the individual market, eligibility determinations, and Exchange standards for employer: August 17, 2011(76 FR 51202) Final Rule on establishment of exchanges: March 27, 2012 (77FR 18310)
Market reform rules	Proposed rule: November 26, 2012 (77 FR 70584)
Essential Health Benefits and Actuarial Value	Proposed rule: November 26, 2012 (77 FR 70644)
Medical Loss Ratio	Request for comment: April 14, 2010 (75 FR 19297) Interim final rule with comment period: December 1, 2010 (75 FR 74864). Final rule with comment periods: December 7, 2011 (76 FR 76574).
Tribal consultation	Commence with comment period for this proposed rule

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

This section describes proposed changes to 45 CFR Part 153, which includes risk adjustment, reinsurance and risk corridors (also referred to as the ACA's premium stabilization measures). Certain of the proposed changes would amend the final rule published in the *Federal Register* on

March 2, 2012. HHS references its Risk Adjustment White Paper[2] (September 12, 2011) and its May 1, 2012 bulletin outlining its intended approach to implementing risk adjustment and reinsurance when it is operating these programs on behalf of a state.

A. Provisions of the State Notice of Benefit and Payment Parameters (§153.100)

Under §153.100(c), in the case of a state that seeks to modify the parameters for its reinsurance or risk adjustment methodology, the deadline to publish its state notice of benefit and payment parameters is March 1 of the calendar year prior to the applicable benefit year. Given potential difficulties of states meeting this deadline for the initial benefit year of 2014, CMS proposes to modify §153.100(c), to require that, for benefit year 2014 only the notice be published by March 1, 2013, or by the 30th day following publication of the final HHS notice of benefit and payment parameters, whichever is later. If a state that chooses to operate reinsurance or risk adjustment fails to publish the required notice within that timeframe, it would have to: (1) adhere to the data requirements for health insurance issuers to receive reinsurance payments that are specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year; (2) forgo the collection of additional reinsurance contributions under §153.220(d) and the use of additional funds for reinsurance payments under §153.220(d)(3); (3) forgo the use of more than one applicable reinsurance entity; and (4) adhere to the risk adjustment methodology and data validation standards published in the annual HHS notice of benefit and payment parameters.

B. Provisions and Parameters for the Permanent Risk Adjustment Program

CMS outlines the organization of its new risk adjustment program provisions. It notes that the risk adjustment program is a permanent program that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, in and outside of the Exchanges.

> In III.B.1 of this proposed rule, CMS proposes standards for HHS approval of a state-operated risk adjustment program (whether or not a state elects to use the HHS-developed methodology or an alternative, federally certified risk adjustment methodology). The approval process would be distinct from that for state-based Exchanges.
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> In III.B.2, CMS proposes a per-capita fee to support HHS operation of the risk adjustment program. The fee would be applied to issuers of risk adjustment covered plans in states where HHS is operating the risk-adjustment program.
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> In III.B.3, CMS describes the methodology that HHS would use operating a risk adjustment program on behalf of a state as well as the HHS-operated data collection approach, and the schedule for operating the HHS-operated risk adjustment program. Also described is the proposed data collection approach.

[2] Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Risk Adjustment Implementation Issues,* September 12, 2011, cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf

Under section III.B.4, a state operating its own risk adjustment program could use the HHS methodology or submit an alternate one, which is described.

In Section 111.B.5, CMS proposes a data validation process when operating a risk adjustment program on behalf of a state; a proposed process for appeals is also described.

1. Approval of State-Operated Risk Adjustment

a. Risk Adjustment Approval Process (§153.310)

CMS proposes to add §153.310(a)(4) based on its authority in §1321(a) of the ACA relating to standards for operation of risk adjustment programs and §1343(b) on criteria and methods to be used in carrying out risk adjustment activities. Beginning in 2015, HHS would carry out the risk adjustment functions on behalf of a state if the state is not approved by HHS (i.e., it is found not to meet the standards proposed in §153.310(c)) to operate a risk adjustment program prior to its publication of its notice of benefit and payment parameters. HHS believes "that an approval process for state-operated risk adjustment programs will promote confidence in these programs so that they can effectively protect against the effects of adverse selection."

New proposed paragraph (c) sets forth a state's responsibilities with regard to risk adjustment program operations. A state that is operating a risk adjustment program would have to administer it through an entity meeting certain standards to ensure that such entity has the capacity to operate the program throughout the benefit year. Specifically:

1. The entity must be operationally ready to implement the applicable federally certified risk adjustment methodology and process the resulting payments and charges; and has experience relevant to operating the risk adjustment program.
2. The entity complies with all applicable federal provisions in the administration of the applicable federally certified risk adjustment methodology.
3. The state must conduct oversight and monitoring of its risk adjustment program. (In the preamble, CMS proposes to examine the state's monitoring plan, including the state's requirements for data integrity and maintenance of records, and the state's standards for use of risk adjustment payments.)[3]

Under proposed §153.310(d), a state would be required to submit to HHS information, in a form and manner specified by HHS, that it and its risk adjustment entity meet the above requirements.

Under CMS's proposed framework, if a state wishes to operate risk adjustment for benefit year 2015, it will have to have obtained approval prior to the March 2, 2014 deadline for publication of its state notice of benefit and payment parameters. HHS will issue future guidance on application dates, procedures, and standards and **welcomes comments on these proposed provisions.**

[3] HHS plans to provide more detail about oversight in future rulemaking.

b. Risk Adjustment Approval Process for Benefit Year 2014

Given the unique timing issues for approving a state-operated risk adjustment program for benefit year 2014, HHS proposes a transitional policy. A state would not be required to obtain approval for 2014. Instead, HHS would request that a state planning to operate its own program consult with HHS to determine its capacity to do so. The state would identify the entity selected to operate risk adjustment, and describe its plans for risk adjustment operations. For 2015 and thereafter, states would have to obtain formal approval under the proposed process but ongoing consultations between HHS and states and their selected risk adjustment entities are envisioned. Through these consultations, states and entities would get feedback from HHS on whether they are adequately demonstrating the capacity of the entity to operate all risk adjustment functions. In the case of a state that failed to produce the requested evidence or make the requested changes in the specified timeframe, HHS may determine that the relevant criteria were not met, and may decline to approve that state's risk adjustment program. **Comments are welcomed on this proposal.**

2. Risk Adjustment User Fees

If a state is not approved by HHS to operate or chooses to forgo operating its own risk adjustment program, HHS would operate risk adjustment on the state's behalf. HHS intends to collect a user fee to support the administration of HHS-operated risk adjustment. The fee would apply to issuers of risk adjustment covered plans in states in which HHS is operating the risk adjustment program. HHS references federal policy under Circular No. A-25R with respect to collection of these user fees.

The user fees would be determined based on the costs to HHS of administering risk adjustment programs on behalf of states. These include the costs of contracts to develop the model and methodology, as well as for collections, payments, account management, data collection, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. Federal personnel costs would not be included.

HHS would set the user fee rate as a national per capita rate so as to spread the cost of the program across issuers of risk adjustment covered plans based on enrollment. Specifically, the projected total costs for HHS to administer the risk adjustment programs on behalf of states would be divided by the expected number of enrollees in risk adjustment covered plans in HHS-operated risk adjustment programs.

An applicable issuer would, therefore, pay a user fee equal to the product of its annual plan enrollment multiplied by the annual per capita risk adjustment user fee rate specified in the annual notice of benefit and payment parameters for the applicable benefit year. Total user fees charged to each issuer would be calculated based on the issuer's monthly enrollment, as provided to HHS using the data collection approach for the risk adjustment program (see III.G below). HHS would collect user fees in June of the year after the applicable benefit year and explains the rationale for this timeframe. CMS expects that the use of existing data collection and submission methods would minimize burden on issuers, while promoting accuracy.

CMS anticipates that the total cost for HHS to operate the risk adjustment program on behalf of states for 2014 would be less than $20 million; the per capita risk adjustment user fee would be no more than $1.00 per enrollee per year.

HHS seeks comment on the proposed user fee assessment to support HHS-operated risk adjustment programs.

3. Overview of the Risk Adjustment Methodology HHS would Implement when Operating Risk Adjustment on behalf of a State

CMS advises that its proposed risk adjustment methodology 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.

CMS reprises from its final risk adjustment rule (see §153.20), that a risk adjustment methodology is made up of the following elements:

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

States approved to operate risk adjustment may utilize this risk adjustment methodology, or they may submit an alternate methodology (see III.B.4).

CMS notes that 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. 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.

The HHS risk adjustment methodology:

- Is developed on commercial claims data for a population similar to the expected population to be risk adjusted;
- Uses the hierarchical condition categories ("HCC") grouping logic used in the Medicare population, with HCCs refined and selected to reflect the expected risk adjustment population;

- Calculates risk scores using a concurrent model (current year diagnoses predict current year costs);
- Establishes 15 risk adjustment models, one for each combination of metal level (platinum, gold, silver, bronze, catastrophic) and age group (adults, children, infants);
- Results in "balanced" payment transfers within a risk pool within a market within a state;
- Adjusts payment transfers for plan metal level, geographic rating area, induced demand, and age rating, so that transfers reflect health risk and not other cost differences; and
- Transfers funds between plans within a market within a state.

a. Risk Adjustment Applied to Plans in the Individual and Small Group Markets (§153.20); §153.360

CMS proposes definitional changes in §153.20 for the following:

"Risk adjustment covered plan" is defined in the current regulation text 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." CMS would replace the text in quotes with "and any plan determined not to be a risk adjusted covered plan in the applicable federally certified risk adjustment methodology." Under this revised definition, HHS would describe any plans not determined to be risk adjustment covered plans under the HHS risk adjustment methodology in the annual notice of benefit and payment parameters, which is subject to notice and comment.

Plans Not Subject to Market Reforms. CMS proposes how to treat plans that are not subject to the market reforms (see the November 26, 2012 "Market Reform and Essential Health Benefits and Actuarial Value" proposed rules) for purposes of risk adjustment and describes related policy decisions. States may propose different approaches to these plans and to risk pooling in state alternate methodologies, subject to the requirements established at §153.330(b) in this proposed rule. CMS also explains its proposed approach to risk adjustment when states elect to merge the risk pools of their individual and small group markets. Finally, CMS explains its proposed risk adjustment approach in the case of an issuer that is licensed in one state but with enrollment in another state.

CMS observes that plans not subject to the ACA market reform rules are able to effectively minimize actuarial risk (because, for example, they do not have to accept all applicants on a guaranteed issue basis) and, therefore, should not be subject to risk adjustment charges nor receive risk adjustment payments. In addition, they would not be subject to the issuer requirements in subparts G and H. Those plans issued in 2013 that are subject to the market reform requirements upon renewal, however, would be subject to risk adjustment (and the related requirements) upon renewal.

> **Student health plans:** CMS proposes that these not be subject to risk adjustment and related requirements.

Catastrophic plans: Because of the unique characteristics of this population (e.g., under 30 or individuals for whom insurance is deemed unaffordable), CMS proposes to establish "criteria and methods" to risk adjust catastrophic plans in a separate risk pool from the general (metal level) risk pool. The specific mechanisms for assessing risk, and for calculating payments and charges, are described below. These plans would also be required to comply with related risk adjustment program requirements under subparts G and H.

Merger of Markets: If a state elects to merge its individual and small group markets and if CMS is operating risk adjustment for that state, CMS would apply risk adjustment to a single merged pool. In such a case, rather than transferring funds between individual market plans only and between small group market plans only, CMS would transfer funds between all individual and small group market plans, considered as one market. In this case, 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 described in section III.B.3.c. 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 and requirements may differ from state to 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, CMS proposes 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.

CMS welcomes comments on these proposals.

b. Overview of the Risk Adjustment Model

HHS developed its risk adjustment model in consultation with states, providers, issuers, and consumers by soliciting comment via a proposed Premium Stabilization Rule and in the Risk Adjustment White Paper. Stakeholders were also consulted at the Risk Adjustment Spring Meeting and in user group calls with States.

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

The enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan within a geographic rating area are then input into the payment transfer formula, as

described in section III.B.3.c. of this proposed rule, to determine an issuer's payment or charge for a particular plan.

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

(1) Data Used to Develop the Risk Adjustment Model

Each HHS risk adjustment model was calibrated using de-identified data[4] for individuals living in all states, aged 0-64 enrolled in commercial insurance plans. The preamble provides information on the specific data base and its contents as well as decision rules elated to classification of enrollees in different types of plans. Diagnoses for model calibration were extracted from facility and professional claims (with certain exceptions). The concurrent model sample (approximately 20 million individuals) was generated using the following criteria: (1) the enrollee had to be enrolled in a fee-for-service (FFS) plan; (2) the enrollee must not have incurred any claims paid on a capitated basis; and (3) the enrollee must have been enrolled in a plan with drug benefits and mental health and substance abuse coverage.[5] CMS says that the final database reflects its best approximation of the ACA's essential health benefits package, which also includes prescription drug and mental health and substance abuse coverage. Inpatient, outpatient, and prescription drug expenditures for each enrollee were calculated by summing gross covered charges in, respectively, the inpatient, outpatient, and prescription drug services files.[6] Plan liability expenditures for a given plan type (platinum, gold, silver, bronze, catastrophic) were defined by applying the applicable standardized benefit design, as discussed in section III.B.3.b.10., to total expenditures. To more accurately reflect expected expenditures for 2014, the 2010 total expenditures were increased for projected cost growth. Average monthly expenditures were defined as the enrollee's expenditures for the enrollment period divided by the number of enrollment months. Annualized expenditures (total or plan liability) were defined as average monthly expenditures multiplied by 12. Data for each individual was weighted by months of enrollment divided by 12.

(2) Concurrent Model

CMS explains that the HHS risk adjustment model is a concurrent model, taking diagnoses from a given period to predict cost in the same period. It is using a concurrent model (as opposed to the more typically used prospective model) because 2013 diagnostic data will not be available for use in the model in 2014. Another reason for a concurrent model is that it will be better able to handle expected changes by individuals from one plan to another or between programs because individuals newly enrolling in health plans may not have prior data available that can be used for risk adjustment.

[4] Truven Health Analytics 2010 MarketScan® Commercial Claims and Encounters database (MarketScan)
[5] CMS explains that it limited the modeling sampling to enrollees in FFS plans because costs on non-FFS claims may not represent the full cost of care associated with a disease.
[6] "Gross covered charges" equals submitted charges minus non-covered charges minus pricing reductions.

(3) Prescription drugs

CMS is not including prescription drug use as a predictor in each HHS risk adjustment model because inclusion of such information (which may be useful for predicting expenditures) could create "adverse incentives to modify discretionary prescribing." **CMS seeks comments on possible approaches for future versions of the model to include prescription drug information while avoiding adverse incentives.**

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

CMS explains in the preamble that 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 had been used to develop the hierarchical condition category (HCC) classification system for the Medicare risk adjustment model guided the creation of the proposed HHS risk adjustment model. The principles are:[7]

1. Diagnostic categories should be clinically meaningful. Each diagnostic category is a set of International Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9-CM") codes.[8]
2. Diagnostic categories should predict medical (including drug) expenditures. Diagnoses in the same HCC should be reasonably homogeneous with respect to their effect on both current (this year's) costs (concurrent risk adjustment) or future (next year's) costs (prospective risk adjustment).
3. Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures.
4. In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate.
5. The diagnostic classification should encourage specific coding. Vague diagnostic codes should be grouped with less severe and lower-paying diagnostic categories to provide incentives for more specific diagnostic coding.
6. The diagnostic classification should not reward coding proliferation.
7. Providers should not be penalized for recording additional diagnoses (monotonicity). This has two consequences for modeling: (1) no HCC should carry a negative payment weight; and (2) a condition that is higher-ranked in a disease hierarchy (causing lower-rank diagnoses to be ignored) should have at least as large a payment weight as lower-ranked conditions in the same hierarchy. (There may be exceptions, as when a coded condition represents a radical change of treatment of a disease process.)
8. The classification system should be internally consistent. If diagnostic category A is higher-ranked than category B in a disease hierarchy, and category B is higher-ranked than category C, then category A should be higher-ranked than category C.

[7] The description of these principles is abbreviated (see 77 FR 73128).
[8] Note that CMS plan in future years to update the calibration of the HHS risk adjustment model to account for the transition from ICD-9-CM to ICD-10-CM codes.

9. The diagnostic classification should assign all ICD-9-CM codes (exhaustive classification).
10. Discretionary diagnostic categories should be excluded from payment models. Excluding these diagnoses reduces the sensitivity of the model to coding variation, coding proliferation, gaming, and up-coding.

(5) CMS HCC Diagnostic Classifications System

The risk adjustment model for the individual and small group markets is referred to as HHS HCCs. The CMS HCC diagnostic classification (which is used for Medicare Part C plans) provides the diagnostic framework for the classification and selection of HCCs for the HHS risk adjustment model. The CMS HCC classification system was reviewed and adapted to account for the different population to create the HHS HCC classification. Three major characteristics of that classification system required modification for use with the HHS risk adjustment model: (1) population; (2) type of spending; and (3) prediction year. The CMS HCCs were developed using data from the aged and/or disabled Medicare population. Although every ICD-9-CM diagnosis code is mapped and categorized into a diagnostic grouping, for some conditions (such as pregnancy) the sample size in the Medicare population is quite low. With larger sample sizes in the commercial population, HCCs were re-examined for infant, child, and adult subpopulations. Additionally, the CMS HCCs are configured to predict medical spending, while HHS HCCs predict both medical and drug spending. Finally, the CMS HCC classification is primarily designed for use with a prospective risk adjustment model. Each HHS risk adjustment model is concurrent, using current year diagnoses and demographics to predict the current year's spending. Medical conditions may predict current year costs that differ from future costs; HCC and DXG groupings should reflect those differences.

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

(6) Principles for HCC Selection

CMS selected 127 of the full classification of 264 HHS HCCs for inclusion in the HHS risk adjustment model, choosing those HCCs that were more appropriate for a concurrent model or for the expected risk adjustment population (e.g., low birth weight babies were included). The following criteria were used to determine which HCCs should be included:

- Whether the HCC represents clinically significant medical conditions with significant costs for the target population;
- Whether a sufficient sample size exists to ensure stable results for the HCC;
- Whether excluding the HCC would exclude (or limit the impact of) diagnoses particularly subject to discretionary coding;

- Whether the HCC identifies chronic or systematic conditions that represent insurance risk selection or risk segmentation, rather than random acute events;
- Do not represent poor quality of care; and
- Whether the HCC is applicable to the model age group.

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

(7) Grouping of HCCs

To balance the competing goals of improving predictive power and limiting coding variability to create a relatively simple risk adjustment model, a number of HHS HCCs were grouped into sets equivalent to a single HCC. CMS explains the rationale for such groupings (e.g., to reduce model complexity or limit up-coding by severity within an HCC hierarchy). After grouping, the number of HHS HCCs included in the proposed HHS risk adjustment model was effectively reduced from 127 to 100.

(8) Demographics

CMS explains that, in addition to the HHS HCCs included in the HHS risk adjustment model, enrollee risk scores are calculated from demographic factors. There are 18 age/sex categories for adults, and 8 age/sex categories for children. (Age/sex categories for infants are not used.) Adults are defined as ages 21+, children are ages 2-20, and infants are ages 0-1. The age categories for adult male and female are ages 21-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, and 60+. The age categories for children male and female are ages 2-4, 5-9, 10-14, and 15-20. Age will be defined as age as of the enrollee's last day of enrollment in risk adjustment covered plans within an issuer in the applicable benefit year.

For individuals who do not have any of the HHS HCCs included in the proposed HHS risk adjustment model, predicted expenditures are based solely on their demographic risk factors. In the calibration data set, 19% of adults, 9% percent of children, and 45% of infants have HCCs included in the risk adjustment models.

(9) Separate Adult, Child and Infant Models

Because of the "inherent clinical and cost differences in the adult (age 21+), child (age 2-20), and infant (age 0-1) populations," HHS developed separate risk adjustment models for each age group. The models for adults and children generally have similar specifications, including demographic age/sex categories and HHS HCCs, but differ slightly due to clinical and cost differences. However, infants have certain costs related to hospitalization at birth and can have severe and expensive conditions that do not apply to adults or children, while having relatively low frequencies for most HHS HCCs included in the model compared to adults and children. Therefore, CMS proposes to use a separate infant model and describes its specifications, which

involve assigning infants a maturity category (by gestation and birth weight) and a severity category.[9]

CMS observes that there may be cases in which there is no separate infant birth claim from which to gather diagnoses (because, for example, the mother and infant claims may be bundled such that infant diagnoses appear on the mother's record). Where newborn diagnoses appear on the mother's claims, HHS is exploring the feasibility of associating those codes with the appropriate infant. "This assumes that the mother and infant enrollment records exist and can be matched, which may also pose operational problems in some cases. Alternatively, we are considering requiring issuers to provide separate mother and infant claims when they have received a combined claim." **Comment is requested on the operational feasibility of both of these approaches.**

(10) Selection of Plan Liability Model

CMS proposes separate risk adjustment models for each benefit metal level of plan because plans at different metal levels would have different liability for enrollees with the same expenditure patterns. Plan liabilities for plan types (platinum, gold, silver, bronze, and catastrophic) were defined by applying standardized benefit design parameters for each given metal level to total expenditures. Average plan liability was estimated for each of the plan types, and an adult, child, and infant model was created for each plan type.

A total expenditure model was rejected in favor of this approach in order to more accurately account for the differences in plan liability resulting from different levels of required enrollee cost sharing. (In a total expenditure model, two individuals of the same age with the same set of HCCs would have the same risk score regardless of the metal level plan type in which the individuals were enrolled.)

(11) Disease Interactions

CMS further proposes that the HHS risk adjustment models for adults include interaction factors to improve model performance for low- and high-cost individuals and better reflect plan liability across metal levels. Disease interactions were created using the silver model (which is expected to attract the highest number of enrollees due to the availability of tax credits and cost-sharing reductions in those plans). Details are further explained at 77 FR 73130.

(12) List of Factors to be Employed in the Model

The proposed risk adjustment models predict annualized plan liability expenditures using age and sex categories and the HHS HCCs included in the HHS risk adjustment model(s). Dollar

[9] More details are available at 77 FR 73129 and also in tables 4-6 (see 77 FR 73135-8). CMS also notes that because evidence suggests that male infants have higher costs than female infants due to increased morbidity and neonatal mortality, there are 2 male-age indicator variables: Age 0 male and Age 1 Male. The male-age variable would be added to the interaction term to which the infant is assigned.

coefficients were estimated for these categories and HCCs using weighted least squares regression, where the weight was the fraction of the year enrolled.

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

See also:

> Table 1: factors for each adult risk adjustment model, including the interactions (see 77 FR 73130).
> Table 2: HHS HCCs in the severity illness indicator variable (77 FR 73133).
> Table 3: factors for each child risk adjustment model (see 77 FR 73133).
> Table 4: Infant risk adjustment models factors (77 FR 73135)
> Table 5: HHS HCCS included in infant model maturity categories (77 FR 73136)
> Table 6: HHS HCCS included in infant model severity categories (77 FR 73136)

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

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

CMS explains that under the ACA, enrollees in individual market plans in Exchanges are eligible for cost sharing reductions based on their income and/or Indian status. Such individuals may utilize health care services at a higher rate than would be the case in the absence of cost-sharing reductions. This higher utilization (to the extent not covered by required cost sharing by the enrollees or cost-sharing reductions reimbursed by the federal government) would neither be paid by cost sharing reductions nor built into premiums. The cost sharing reduction adjustment to the HHS risk adjustment models would be based on the adjustment for induced demand for advanced payment of cost-sharing reductions described in section III.E.

The proposed adjustment factors for induced utilization are shown in Table 7, reproduced below.

Cost Sharing Reduction Adjustment		
Household Income	**Plan AV**	**Induced Utilization Factor**
Non-Indian Cost Sharing Reduction Recipients		
100-150% of FPL	Plan variation 94%	1.12
150-200% of FPL	Plan variation 87%	1.12
200-250% of FPL	Plan variation 73%	1.00
>250% of FPL	Plan variation 70%	1.00
Indian Cost-Sharing Reduction Recipients		
<300% of FPL	Platinum (90%)	1.15
<300% of FPL	Gold (80%)	1.12
<300% of FPL	Silver (70%)	1.07
<300% of FPL	Bronze (60%)	1.00
Table 7. 77 FR 73138		

These adjustments would be multiplicative, and applied after demographic, diagnosis, and interaction factors are summed. CMS plans to evaluate this adjustment in the future, once data from the first few years of risk adjustment are available. **CMS seeks comment on this approach.**

CMS notes that adjusting for the ACA's reinsurance payments in the HHS risk adjustment model would address concerns that reinsurance and risk adjustment could compensate twice for the same high-risk individuals. It rejects such an adjustment, however, because: (1) removing reinsurance payments would reduce protections for issuers of reinsurance-eligible plans that enroll high-cost individuals: (2) it would be difficult to determine what portion of reinsurance payments were made for conditions included in each HHS risk adjustment model, and the appropriate model adjustment for these payments; and (3) the size of the reinsurance pool declines over its three-year duration and this would require the methodology to account for reinsurance payments to be modified each year for the HHS risk adjustment model.

(14) Model Performance Statistics

The standard way to evaluate whether a risk adjustment model performs well is to assess its predictive accuracy. The statistic (R-Squared or R^2) calculates the percentage of individual variation explained by a model overall. Predictive ratios are used to measure the predictive accuracy of a model for different validation groups or subpopulations. The ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0.

For each of the HHS risk adjustment models, the R^2 and the predictive ratio are in the range of published estimates for concurrent risk adjustment models. The R-squared statistic for each model is shown in Table 8 at 77 FR 73139. They range from a low of .288 for the silver infant risk adjustment model to a high of .360 for the platinum adult model.

CMS welcomes comment on these proposed risk adjustment models.

c. Overview of the Payment Transfer Formula

CMS begins with a high level explanation of its approach to making payments to issuers with above average actuarial risk and collecting payments from plans with below average actuarial risk as measured by the HHS risk adjustment models. Payments and charges are referred to as "transfers." CMS defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. In this proposed rule's preamble, CMS combines these concepts into a risk adjustment payment transfer formula.

CMS would calculate risk adjustment transfers after the close of the applicable benefit year, following the completion of issuer risk adjustment data reporting. Under §153.310(e), as proposed to be renumbered, HHS would invoice issuers of risk adjustment covered plans for transfers by June 30 of the year following the applicable benefit year.

The CMS payment transfer formula includes a set of cost adjustment terms that require transfers to be calculated at the geographic rating area level for each plan (thus, two separate transfer amounts would be calculated for a plan that operates in two rating areas). Payment transfer amounts would be aggregated at the issuer level (i.e., at the level of the entity licensed by the state) such that each issuer would receive an invoice and a report detailing the basis for the net payment that would be made or the charge that would be owed. The invoice would also include plan-level risk adjustment information that may be used in the issuer's risk corridors calculations.

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

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

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

CMS discusses the two approaches that it presented in its Risk Adjustment White Paper for calculating risk adjustment transfers: (1) using state average premiums and (2) using the plans' own premiums. CMS found that the plan premium approach resulted in unbalanced payment transfers (i.e., they did not net to zero) whereas state average premiums net to zero, and that balancing adjustments could introduce differences in premiums across plans that were not consistent with features of the plan. Moreover, a balancing adjustment would likely vary from year to year, adding to uncertainty for issuers in developing their rates. As a result, CMS is proposing to use the state average premium for the applicable market for the plan transfer

formula. CMS explains that plan premiums differ from the state average premium due to factors such as differences in cost- sharing structure or regional differences in utilization and unit costs.

(2) Conceptual Overview of the Payment Transfer Formula

CMS provides in the preamble both a narrative explanation and the mathematical formulae for its proposed payment transfer calculations (see 77 FR 73140).

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.

The payment transfer formula proposed for 2014 is based on the difference between two plan premium estimates: (1) a premium based on plan-specific risk selection; and (2) a premium without risk selection. Transfers are intended to bridge the gap between these two premium estimates.
Both of these premium estimates would be based on the state average premium, defined as the average premium requirement for providing insurance to the applicable market population.

The proposed payment transfer formula develops plan premium estimates by adjusting the state average premium to account for plan specific characteristics such as benefit differences. This approach also assumes that all plans have premiums that can be decomposed into the state average premium and a set of adjustment factors (identified below), and that all plans would have the same premium if the adjustment factors were held constant across plans.

The derivation of the payment transfers also assumes that plans "price to cost," that is, that competition among plans for enrollees drives plans' premiums to their premium requirements. Therefore, "premiums" are considered to be "costs" or "premium requirements."

The CMS payment transfer formula includes certain premium adjustment terms (such as plan average risk score and actuarial value (AV)) which are described in greater detail in the more technical discussion that follows the overview.

The state average premium is then multiplied by these adjustment 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. This means that the product of the adjustments is normalized to the market average product of the cost factors.

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:

Calculating Payment Transfers

In the subsequent technical description in the preamble, CMS explains the formulae (and the component variables) for estimating plan premiums with and without risk selection and calculating the amount of transfers. Again, transfers would be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection. The difference between the two premium estimates in the payment transfer formula would determine whether a plan would pay a risk transfer charge or receive a risk transfer payment. The value of the plan average risk score by itself would not determine whether a plan would be assessed a charge or receive a payment. Even if the risk score is greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan may receive through its rating practices (as measured through the allowable rating factor) exceeds the plan's predicted liability associated with risk selection.

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

Finally, CMS notes that transfers are calculated at the risk pool level. Each state will have a risk pool for all of its metal-level plans. Catastrophic plans will be treated as a separate risk pool for purposes of risk adjustment. Individual and small group market plans will either be pooled together or treated as separate risk pools, depending on the state.

Normalization and Budget Neutral Transfers. Each of the two premium terms in the payment transfer formula would be divided by its average, (normalized to 1.0). Thus, the average of the difference between these terms would be zero. This ensures that transfers across a risk pool would net to zero.[10]

Calculation of Transfer Formula Inputs. CMS next explains in greater detail each component of the proposed payment transfer formula, how it is computed (including the mathematical formulae) and how the component affects transfers. The components include:

[10] CMS further explains that the individual factors in the proposed payment transfer formula do not need to independently average to 1.0 (see 77 FR 73141.

- Plan average risk score – an adjustment is included to account for the family rating rules proposed in the Market Reform Rule.
- Billable members – with the exception of the plan average risk score, all other calculations are based on billable members (i.e., children are not counted toward the family premium are excluded).
- State average premium.
- Actuarial value – each metal level has an AV (e.g., bronze = .60) and that AV would be included in the transfer model. Note that CMS assigns an AV of .57 to catastrophic plans.
- Allowable rating variation – only the age factor (3:1) would be accounted for in the payment transfer model.[11] The other allowable rating factors of tobacco use and wellness discounts are not included because they are discretionary and CMS wants to maintain issuer flexibility with respect to their use in rating. Family size differences are counted for in the "billable members" variable.[12]
- Induced demand – an adjustment is needed so that plans are not paid for the effect of induced demand on enrollee spending attributable to the different metal levels. CMS proposes adjustments of 1.00 for catastrophic and bonze metal levels; 1.03 for silver; 1.08 for gold and 1.15 for platinum, based on the expenditure data underlying the AV calculator.
- Geographic area cost variation – this adjustment is needed to account for some plan costs, such as input prices or utilization rates, which vary geographically and are likely to affect plan premiums. By including the adjustment, these costs would be reflected in premiums, rather than being offset by transfers.[13] A geographic cost factor (GCF) would be calculated for each rating area, based on the observed average silver plan premiums in a geographic area relative to the statewide average silver plan premium. (See 77 FR 73144) for the steps used to compute the geographic cost factor.) Using the formulae described by CMS, the enrollment-weighted statewide average of plan geographic cost factor values would equal 1.0. Thus, a GCF equal to 1.15 indicates that the plan operates in a geographic area where costs are, on average, 15% higher than the statewide average.

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

[11] CMS includes in the preamble an illustration of how the Allowable Rating Factor adjustment in the payment transfer formula works (see Table 10, 77 FR 73143).

[12] Each plan's allowable rating factor would be calculated as the enrollment-weighted average of the age factor, based on the applicable standard age curve, across all of a plan's enrollees. In operation, for the age rating factor included in the payment transfer formula, age would be calculated as the enrollee's age at the time of enrollment, as outlined in the proposed Market Reform Rule.

[13] CMS explains that excluding this adjustment would cause transfers to subsidize high-risk plans in high-cost areas at the expense of low-risk plans in low-cost areas. At the same time, the payment received by higher-than-average risk plans would be larger than necessary to compensate for the plan's excess risk. This would disadvantage low-risk plans relative to high-risk plans in the low-cost area. The opposite would be true in high-cost areas.

CMS welcomes comment on this proposed payment transfer formula.

d. Overview of the Data Collection Approach

In §153.20, CMS proposes a technical correction to the definition of risk adjustment data collection approach. CMS would delete "audited" so that the 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." Thus auditing is not part of the data collection approach but is part of the data validation process.

CMS also proposes 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)." CMS says this addition will further ensure the privacy and security of potentially sensitive data by limiting the use or disclosure of any personally identifiable information collected as a part of this program.

The distributed data collection approach HHS proposes to use when operating risk adjustment on behalf of the state is described below (see c. Data Validation Process When HHS Operates Risk Adjustment). **CMS welcomes comment on this proposed data collection approach.**

e. Schedule for Risk Adjustment (§153.730)

Under existing §153.610(a), issuers of risk adjustment covered plans are required to 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 this proposed rule (see III.G.) for benefit year 2014 beginning January 1, 2014. Enrollee risk scores will be calculated based on enrollment periods and claims dates of service that occur between January 1, 2014 and December 31, 2014. Enrollee risk scores for subsequent benefit years will be calculated based on claims and enrollment periods for that same benefit year. Under proposed §153.730, claims to be used in the risk score calculation would have to be made available to HHS by April 30 of the year following the benefit year. CMS believes this date provides for ample claims runout to ensure that diagnoses for the benefit year are captured, while providing HHS sufficient time to run enrollee risk score, plan average risk, and payments and charges calculations and meet the June 30 deadline described at the redesignated §153.310(e). **CMS welcomes comment on this proposed schedule for risk adjustment.**

4. State Alternate Methodology

a. Technical Correction

CMS proposes a technical correction to the regulatory language at §153.320(a)(1) and (a)(2) to make clear that federally certified risk adjustment methodologies must be certified for use each year.

b. State Alternate Risk Adjustment Methodology Evaluation Criteria (§153.330(b)

CMS also proposes modifications to its criteria for a state alternate risk adjustment methodology that were specified in the Premium Stabilization Rule.

CMS proposes additional criteria to §153.330 to certify such methodologies. CMS notes in the preamble that requests for state alternate methodologies will be accepted up to 30 days after publication of this proposed rule. CMS will review a state's request only if it has submitted an Exchange Blueprint application and has indicated on that application its intent to operate a risk adjustment program (or, in later years, if it is operating or has been approved to operate an Exchange). CMS expects to work with states as they develop their alternate methodologies.

Under the revised criteria, CMS would evaluate the extent to which an alternate risk adjustment methodology:

- Explains the variation in health care costs of a given population;
- Links risk factors to daily clinical practices and is clinically meaningful to providers;
- Encourages favorable behavior among providers and health plans and discourages unfavorable behavior;
- Uses data that are complete, high in quality, and available in a timely fashion;
- Is easy for stakeholders to understand and implement;
- Provides stable risk scores over time and across plans; and
- Minimizes administrative costs.

In the preamble, CMS gives the example that to determine the extent to which an alternate methodology meets the first criterion of explaining the variation in health care costs of a given population, it would consider whether the 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, CMS 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 would have to provide a rationale for the methodology's approach to the plans subject to risk adjustment.

As summarized in the preamble, a state alternate methodology would further be evaluated for the following;

- It must not discriminate against individuals because of age, disability, or expected length of life, and should take into account the health care needs of diverse segments of the risk adjustment population, including women, children, persons with disabilities, and other vulnerable groups.
- It must comply with the federal requirements 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.

- It must meet minimum requirements for data collection under risk adjustment, including standards relating to data privacy and security. CMS notes that while the federal approach will not directly collect data from insurers, but instead will use a distributed approach that will not include personally identifiable information, the Premium Stabilization Rule gives states the flexibility to design their own data collection approach, provided privacy and security standards are met. CMS considers the privacy and security of enrollees' data is of paramount importance and the state's data collection approach 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.
- It accounts for payment transfers across metal levels so as to mitigate adverse selection across as well as within metal levels.
- The elements of the methodology should align with each other. For example, does the data collection approach result in the collection of data required by the risk adjustment model to calculate individual risk scores?

CMS proposes to gives states flexibility with respect to whether their alternate methodology applies risk adjustment to catastrophic plans in their own risk pool and/or includes plans not subject to the federal market reform rules in the state risk adjustment program.

Alternate methodologies submitted by states that are approved as federally certified risk adjustment methodologies for 2014 will be published in the final 2014 HHS notice of benefit and payment parameters. CMS envisions working closely with states during the development of their alternate methodologies to ensure that they meet the criteria described above. CMS is "committed to working with states in a collaborative fashion on these matters."

c. Payment and Charges

In the preamble, CMS references the payment transfer formula proposed in this rule (III.B.3.10) and reiterates that this formula utilizes the plan average risk score and the state average premium and is based on a plan liability model. CMS advises that states can adapt this formula to a total expenditure model by replacing the plan liability risk score in the formula with the total expenditure risk score of a plan, and multiplying the total expenditure risk score by an adjustment for AV. CMS proposes to give states the flexibility to select the adjustments used for the calculation of payments and charges in their alternate methodologies. While the proposed HHS payment transfer formula will make adjustments for AV, age rating factor, geographic cost differences, and induced demand, states have the option of including or excluding any of these adjustments. States may also include other adjustments in the calculation of payments and charges under their alternate methodologies. Adjustments can be added to or removed from the basic payment transfer formula as long as these factors are normalized, so that transfers net to zero. CMS will work with states on a one-on-one basis in developing their payment transfer formulae for their alternative methodologies.

5. Risk Adjustment Data Validation

CMS explains in the preamble that existing §153.350 specifies standards applicable to states, or HHS on behalf of states, in validating risk adjustment data. States operating their own program and HHS are required to establish a process to appeal findings from data validation and allow the state, or HHS on behalf of the state, to adjust risk adjustment payments and charges based on data validation findings. These requirements are important to ensure credibility of risk adjustment data and establish issuer confidence in the risk adjustment program. Moreover, as error rates derived from the results of data validation may be used to make adjustments to the plan average actuarial risk calculated for a risk adjustment covered plan, the data validation process will ensure that such transfers accurately reflect each plan's average enrollee risk.

In this proposed rule, CMS builds upon guidance released in the Risk Adjustment Bulletin and in discussions held with stakeholders at the Risk Adjustment Spring Meeting to define data validation standards applicable to issuers of risk adjustment covered plans when HHS operates risk adjustment on behalf of a state.

CMS proposes that, beginning in 2014, HHS conduct a six-stage data validation program when operating risk adjustment on behalf of a state: (1) sample selection; (2) initial validation audit; (3) second validation audit; (4) error estimation; (5) appeals; and (6) payment adjustments. However, states are not required to adopt this HHS data validation methodology. More detail follows:

a. Data Validation Standards When HHS Operates Risk Adjustment (§153.630)

Proposed new §153.630 would set forth risk adjustment data validation standards applicable to all issuers of risk adjustment covered plans when HHS is operating risk adjustment for a state. In general, issuers of risk adjustment covered plans have an initial and second validation audit of risk adjustment data (these are the second and third stages of the six-stage data validation program described below.

b. Data Validation Process When HHS Operates Risk Adjustment

(1) Sample Selection

In the preamble, CMS reiterate the requirement under the Premium Stabilization Rule for HHS to validate a statistically valid sample from each issuer that submits data for risk adjustment every year. Such sample selection is the first stage of HHS' six-stage risk adjustment data validation process. The sample would be selected for each issuer in accordance with standards described in this section and would have to be adequate such that the estimated payment errors will be statistically sound and so that enrollee-level risk score distributions reflect enrollee characteristics for each issuer. CMS will seek to balance the need to ensure statistical soundness of the sample and minimizing operational burden on issuers, providers and HHS.

CMS expects that each issuer's initial validation audit sample within a state will consist of approximately 300 enrollees, with up to two-thirds of the sample consisting of enrollees with

HCCs. Its assumptions about sample size and the population distributions may be updated as the agency gains experience. **CMS seeks comment on this approach to sample selection, particularly on use of existing data validation program results that could be used to derive comparable estimates under this program.**

(2) Initial Validation Audit

Once HHS selects the audit samples, issuers would be required to conduct independent audits of the risk adjustment data for their initial validation audit sample enrollees. Issuers would be required to engage one or more auditors to conduct these independent initial validation audits. Auditors would have to be reasonably capable of performing the audit and free from conflicts of interest. The audit would have to be completed and the information regarding the initial validation audit sent to HHS in the manner and timeframe specified by HHS.

CMS notes that for enrollees included in the HHS-specified audit sample, issuers of risk adjustment covered plans would be required to provide enrollment and medical record documentation to the initial validation auditor to validate the demographic and health status data of each enrollee. Issuers would be given considerable autonomy in selecting their initial validation auditors so long as they conduct data validation audits in accordance with HHS' audit standards. CMS has identified three methods for establishing these standards: (1) HHS or an HHS-designated entity could prospectively certify auditors for these audits; (2) HHS could develop standards that issuers and initial validation auditors would follow, without any requirement of prior HHS certification or approval of auditors; or HHS could issue non-binding, "best practice" guidelines for issuers and auditors.

CMS requests comment on these approaches and on any standards or best practices that should be applicable.

(3) Second Validation Audit

CMS proposes to select a subsample of the risk adjustment data validated by the initial validation audit for a second validation audit. All standards for such audits would have to be met and the issuer would have to cooperate with and ensure that the initial auditor cooperated with HHS and the second validation auditor. Issuers would be required to submit the data for the audit to HHS or its auditor in an electronic format to be determined by HHS. The second validation auditor would inform the issuers of error findings based on its review.

(4) Error Estimation

CMS proposes to estimate risk score error rates based on the findings from the data validation process and describes it approach to doing this. CMS plans to conduct analyses to determine the most effective methodology for adjusting plan risk scores for calculating risk adjustment payment transfers. Upon completion of the second validation audit and error estimation stages of HHS's data validation process, the agency plans to provide each issuer with enrollee-level audit results and error estimates at the issuer level. **CMS is requesting comments on these proposed error estimation concepts.**

c. Appeals (§153.630(d))

In accordance with existing §153.350(b), newly proposed §153.603(d) would provide 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. CMS advises in the preamble that it anticipates that appeals would be limited to instances in which the audit was not conducted in accordance with second validation audit standards established by HHS. It will provide further detail on this process in future guidance or regulation, as appropriate.

d. Payment Adjustments (§153.630(e))

In accordance with existing §153.350(d), HHS may adjust payments and charges for issuers that do not comply with the specified audit requirements and standards. CMS advises in the preamble that it anticipates using a prospective approach when making such payment adjustments and explains why this approach should be pursued. CMS would use an issuer's data validation error estimates from the prior year to adjust the issuer's average risk score in current year for transfers and **requests comment on this approach.** Under new proposed §153.630(e), HHS may adjust payments and charges for issuers that do not comply with the initial or second audit standards. **Comment is requested on the types of adjustments that may be assessed on issuers that do not comply with the initial or second validation audit standards proposed in this rule.**

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

In the preamble, CMS proposes that issuers of risk adjustment covered plans adhere to the data validation process outlined above beginning with data for the 2014 benefit year. But given the complexity of the risk adjustment program and the data validation process, and the uncertainty in the market that will exist in 2014, CMS is 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." CMS, therefore, proposes to still require that issuers conduct the initial validation audit and for the agency to conduct a second validation audit for benefit years 2014 and 2015. However, no adjustment will be made to payments and charges based on validation results on data from the 2014 and 2015 benefit years. CMS believes that the data validation conducted during the first two years of the program will serve an important educational purpose for issuers and providers. That said, other remedies, such as prosecution under the False Claims Act, may be applicable to issuers not in compliance with the risk adjustment program requirements.

CMS notes that this approach was taken with the Medicare Part C risk adjustment program – the data validation audit process was observed for several years before payment adjustments were made. CMS plans to work with issuers during the first two years of the data validation program, and will seek additional input on how to improve the process. **CMS requests 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 it should adopt, and what methods it should adopt to ensure data integrity in the first two years of the program.**

CMS is considering publishing a report on the error rates discovered during 2014 and 2015 to inform its audit program. For this report, CMS may conduct special studies of the second validation audits aimed at comparing the error rate results of the initial validation auditors and second validation audits, looking at discrepancies that may result between the two audits. CMS elaborates on the error rate analysis. CMS anticipates that a small number of audit firms will perform the majority of initial audits. **Comment is requested including on what CMS is proposing as well as additional approaches to data validation for risk adjustment.**

f. Data Security and Transmission §153.630(f),

Under proposed §153.630(f), issuers must 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. In addition, an issuer must ensure that it and its initial validation auditor comply with the security standards described in §164.308, §164.310, and §164.312.

C. Provisions and Parameters for the Transitional Reinsurance Program

The ACA directs that a transitional reinsurance program be established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. The intent is for reinsurance to alleviate the need by issuers to build into their health insurance premiums the risk of enrolling individuals with significant unmet medical needs.

In an overview section of the preamble, CMS describes ways in which it proposes to modify the reinsurance program requirements (as set forth in the Premium Stabilization Rule). These modifications are intended to "provide reinsurance payments in an efficient, fair, and accurate manner, where they are needed most, to effectively stabilize premiums nationally . . . and to implement the reinsurance program in a manner that minimizes the administrative burden of collecting contributions and making reinsurance payments." In addition, for the HHS-operated reinsurance program, reinsurance payments would be calculated using the same distributed approach for data collection proposed for operating risk adjustment on behalf of states (III.G.) 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.

CMS identifies the proposed changes in this proposed rule from the policies in the Premium Stabilization Rule:

- Uniform reinsurance payment parameters to be used by all states;
- A uniform reinsurance contribution collection and payment calendar;
- A one-time annual reinsurance contribution collection, instead of quarterly collections in a benefit year;
- Collection of reinsurance contributions by HHS under the national contribution rate from both health insurance issuers and self-insured group health plans;
- A limitation on states' ability to change reinsurance payment parameters from those that HHS establishes in the annual HHS notice of benefit and payment parameters. A state

may only propose supplemental reinsurance payment parameters if the state elects to collect additional funds for reinsurance payments or use additional state funds for reinsurance payments; and

- A limitation on states that seek additional reinsurance funds for administrative expenses, such that the state must have its applicable reinsurance entity collect those additional funds.

A more detailed summary of these and additional proposed changes to the reinsurance program follow.

1. State Standards Related to the Reinsurance Program

a. State Notice of Benefit and Payment Parameters (§153.100, 153.110, §153.210)

Under proposed modifications to §153.100, all states would be required to use the annual payment schedule set forth in this proposed rule. This is instead of the current language allowing a state establishing its own reinsurance program to modify, via a state notice of benefit and payment parameters, the data collection frequency for issuers to receive reinsurance payments. Under the modified language, the frequency with which data must be submitted for reinsurance payments would follow a national schedule. HHS would, however, continue to allow a state establishing a reinsurance program to modify the data requirements for health insurance issuers to receive reinsurance payments, provided that the state publishes a state notice of benefit and payment parameters and specifies these modifications in that notice.

A further change would direct a state that elects to collect additional reinsurance contributions for purposes of making additional reinsurance payments or use additional funds for reinsurance payments under §153.220(d) to publish supplemental state reinsurance payment parameters in its state notice of benefit and payment parameters.

In the preamble, CMS explains that under the Premium Stabilization Rule, a state that established a reinsurance program may either directly collect additional reinsurance contributions for administrative expenses and reinsurance payments or elect to have HHS do this. CMS now proposes to change this such that a state operating its own reinsurance program would no longer be permitted to have HHS collect additional funds for administrative expenses. Aiming for the most effective program, CMS proposes to collect reinsurance contributions on behalf of all states from both health insurance issuers and self-insured group health plans in the aggregate, and 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. Section 153.100(a)(3) would be amended to clarify that these additional contributions may only be collected by a state operating its own reinsurance program in that state. Related changes would also be made to enable CMS to disperse reinsurance contributions in proportion to the need for reinsurance payments (see proposed changes to §153.110(d)(5) and §153.210(a)(2)(iii) as well as deletion of §153.110(d)(2)).

Finally, CMS proposes that HHS collect all contributions under a national contribution rate from all health insurance issuers in all states. This requires deleting all requirements regarding the state collection of reinsurance contributions from issuers under the national contribution rate, including §153.100(a)(2) and §153.110(b), and removing the requirement that a state publish a state notice of benefit and payment parameters to announce its intention to collect reinsurance contributions from issuers. Also deleted would be §153.110(d)(4) requiring states to publish in their notices an estimate of the reinsurance contributions to be collected by each applicable reinsurance entity.

b. Reporting to HHS (§153.210; §153.240)

Under the proposed modification to §153.210, a new section (e) would be added to require each state that establishes a reinsurance program to ensure that each applicable reinsurance entity provide information regarding requests for reinsurance payments under the national contribution rate for all reinsurance-eligible plans for each quarter during the applicable benefit year in a manner and timeframe established by HHS. CMS proposes in the preamble to use this information to monitor requests for reinsurance payments and contribution amounts throughout the benefit year, to ensure equitable reinsurance payments in all states.

Under proposed §153.240(b)(2), a state, or HHS on behalf of the state, would be required to provide issuers of reinsurance-eligible plans with quarterly estimates of the expected requests for reinsurance payments for the reinsurance-eligible plan under both the national payment parameters and any state supplemental payments parameters, as determined by HHS or the state's reinsurance entity, as applicable. These quarterly estimates would provide issuers of individual coverage with the timely information needed to support the calculation of expected claims assumptions that are key to rate development and ultimately, premium stabilization. CMS notes its expectation that reinsurance payments will be used in the rate setting process by issuers to reduce premiums.

CMS notes in the preamble that the national reinsurance payment parameters are calculated to expend all reinsurance contributions collected under the national contribution rate. Similarly, the additional funds collected by the state for reinsurance payments or additional state funds are to be reasonably calculated, under proposed §153.232(a)(2), to cover all additional reinsurance payments projected to be made under the state supplemental payment parameters. Given the two separate funds, CMS believes it is important for a state to distinguish between reinsurance payments made under the two different sets of parameters so that reinsurance-eligible plans can understand how each reinsurance program will likely affect claims costs. (HHS intends to collaborate with issuers and states to develop these early notifications.) Therefore, proposed §153.240(b) would require each state, or HHS on behalf of the state, to ensure that each applicable reinsurance entity provides to issuers the expected requests for reinsurance payments for all reinsurance-eligible plans in the state within 60 days of the end of each quarter, with a final report for a benefit year sent to issuers no later than June 30 of the year following the applicable benefit year. CMS intends to obtain reports regarding reinsurance payments and administrative expenses from states that establish a reinsurance program; details of these reports will be spelled out in future regulation and guidance.

c. Additional State Collections and d. State Collections (§153.220)

Under proposed (renumbered) §153.220(d), 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: funding for administrative expenses of the applicable reinsurance entity; or additional funds for reinsurance payments. (2) The state must notify HHS within 30 days after publication of the draft annual HHS notice of benefit and payment parameters for the applicable benefit year of the additional contribution rate that it elects to collect for any additional contributions. (3) A state may use additional funds which were not collected as additional reinsurance contributions for reinsurance payments under the state supplemental payment parameters under §153.232. (CMS explains that this would allow states to use other revenue sources, including funds for their high-risk pools (see below), for supplemental reinsurance payments. Additional conforming changes would be made. As noted in the preamble, a state cannot collect from self-insured group health plans covered by ERISA.

e. High-Risk Pools

CMS is not proposing further requirements for state high-risk pools beyond those currently provided at §153.250. Under that provision, a state must eliminate or modify its high-risk pool to the extent necessary to carry out the transitional reinsurance program but such changes must comply with the terms and conditions of federal grants to states for operation of qualified high-risk pools. Further, the ACA permits a state to coordinate its high-risk pool with the reinsurance program "to the extent not inconsistent" with the statute. Thus, a state may coordinate the entry of the state's high-risk pool enrollees into the Exchange. CMS advises that it is examining ways in which a state could continue its high-risk pool program to complement Exchange coverage. CMS clarifies that nothing in the Premium Stabilization Rule prevents a state that establishes its own reinsurance program from using state money designated for its own high-risk pool towards the reinsurance program. However, a state may not use funds collected for the reinsurance program for its high-risk pool. Finally, a state could designate its high-risk pool as its applicable reinsurance entity, provided that the high-risk pool meets all applicable criteria for being an applicable reinsurance entity.

2. Contributing Entities and Excluded Entities (§153.400)

Under §1341 of the ACA, health insurance issuers and third party administrators on behalf of group health plans must make payments to an applicable reinsurance entity. Thus, with respect to insured coverage, issuers are liable for making reinsurance contributions. With respect to self-insured group health plans, the plan is liable (and pays directly), although a third-party administrator or administrative-services-only (ASO) contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion. Contribution amounts for reinsurance are to reflect, in part, an issuer's "fully insured commercial book of business for all major medical products." CMS holds that it is implicit in the ACA that contributions are not required for health insurance coverage that is not regulated by a state department of insurance and written on a policy form filed with and approved by a state department of insurance (but contributions are generally required for self-insured plans even

though they are not regulated by a state department of insurance). In this section, CMS describes its intent to exclude certain types of plans and proposes in §153.400(a)(1) that the following types are excluded:

- *Coverage that is not major medical coverage (i.e., limited scope coverage)* -- Examples include dread disease coverage, hospital indemnity, coverage, stand-alone vision coverage, or stand-alone dental coverage or coverage that is not subject to the Public Health Service Act section 2711 and its implementing regulations.

- *Group health coverage that is not the primary payer* (consistent with Medicare Secondary Payer (MSP) rules).

- *Coverage not included in a "commercial book of business"* – CMS interprets this ACA reference to mean large and small employer group policies and individual market policies. Other coverage, such as Medicare Part C or Part D or coverage offered by a Tribe to Tribal members (and specified family and dependents), would not be part of a commercial book of business. However, a plan or coverage offered by the federal government, a state government or a Tribe to employees (or retirees or dependents) because of a current or former employment relationship, would be part of a commercial book of business. **CMS seeks comment on this interpretation.**

- *Policy that is not filed and approved in a state* – For example, if group coverage for employees substantially all of whom work outside the United States – "expatriate coverage" – is not written on a form filed with and approved by a state department of insurance, it would be excluded from reinsurance contributions.

Comments are requested on these proposals.

In addition, CMS proposes in §153.400(a)(1), and for clarity, in §153.400(a)(2), to explicitly exclude the following types of plans and coverage from reinsurance contributions: Medicare; Medicaid, CHIP, federal or state high-risk pool, including the Pre-existing Condition Insurance Plan Program; ACA Basic health plan coverage; a Health Reimbursement Arrangement (HRA); a Health Savings Account (HSA); a flexible spending arrangement (under section 125 of IRC); and other plans as specified (see §153.400(a)(2)).

3. National Contribution Rate

a. 2014 Contribution Rate

CMS reiterates its intent to publish in the annual HHS notice of benefit and payment parameters the national per capita reinsurance contribution rate for the upcoming benefit year. Total contribution amounts required to be collected by the ACA (i.e., the reinsurance pool) are: $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. Out of these amounts, $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016 are payable to the U.S. Treasury (the same amount appropriated by the ACA for the Early Retiree Reinsurance Program). CMS notes that it has been suggested that the collection of the $2 billion in funds payable to the U.S. Treasury for

2014 should be deferred until 2016, thereby lowering the contribution rate in 2014, while ensuring that the total amount specified by law is returned to the U.S. Treasury by the end of this temporary program. **CMS seeks comment on whether such a delayed collection would be consistent with the statutory requirements and whether other steps could be taken to reduce the burden of these collections on contributing entities.**

The ACA also allows for the collection of additional amounts for reinsurance program 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.

CMS proposes that the national per capita contribution rate 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. The *national per capita reinsurance contribution rate =*

$$\frac{\textit{National reinsurance pool} + \textit{Treasury contribution} + \textit{administrative costs}}{\textit{Estimate of enrollees in plans required to make reinsurance contributions}}$$

The following example is provided for 2014—

> National reinsurance pool = $10 billion
> Contribution to the U.S. Treasury = $2 billion.
> Collection for administrative expenses = $20.3 million (0.2% of the $10 billion dispersed) (see below)
> Total = $12.023 billion
> For the HHS estimated number of enrollees in plans required to make reinsurance contributions = the per capita per month contribution is $5.25

CMS seeks comment on this calculation.

As required under 153.220(c) (previously designated as §153.220(e)), CMS provides in this proposed rule (see table 12 as reproduced below) the national contribution rate and the proportion of contributions collected under the national contribution rate to be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses. (See section III.C.6 relating to CMS' proposed methodology for developing enrollment estimates for the national per capita contribution rate.)

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% ($10 billion/$12.02 billion)	The difference between total national collections and those contributions allocated to the US Treasury and administrative expenses
Payments to the U.S. Treasury	16.6% ($2 billion/$12.02 billion	$2 billion
Administrative expenses	0.2% ($20.3 million/$12.012 billion	$20.3 million
Table 12, 77 FR 73155.		

b. Federal Administrative Fees

CMS proposes a national per capita contribution rate of $0.11 annually for HHS administrative expenses. It expects to apportion that sum as shown in Table 13, reproduced below:

Breakdown of Administrative Expenses (annual, per capita)	
Item	**Estimated Cost**
Collecting contributions from health insurance issuers and self-insured plans	$0.055
Payment activities	$0.055
Total annual per capita fee for HHS to perform all reinsurance functions	$0.11
Table 13, 77 FR 73155	

CMS explains that if it operates the reinsurance program on behalf of a state, it would retain the annual per capita administrative fee. If a state operates its own program, HHS would transfer $0.055 (half) of the per capita fee to the state so that it could be used for the state's administrative expenses; HHS would retain the remaining $0.055 to offset the costs of contribution collection. The administrative expenses for reinsurance payments will be distributed in proportion to the state-by-state total requests for reinsurance payments made under the national payment parameters. **CMS seeks comment on this approach and other reasonable, administratively simple approaches that may be used to calculate administrative costs.**

4. Calculation and Collection of Reinsurance Contributions

a. Calculation of Reinsurance Contribution Amounts and Timeframe for Collection (§153.405)

CMS seeks to administer the reinsurance program so as to minimize the administrative burden on issuers and self-insured group health plans, while ensuring that contributions are calculated accurately. Thus, under proposed §153.400(a) and §153.240(b)(1), CMS would collect and pay out reinsurance funds annually as opposed to throughout the benefit year. CMS notes that this

approach would delay the receipt of some reinsurance payments for individual market issuers, and **solicits comment on the benefits and burdens for issuers, states, and other stakeholders of a more frequent collections and payment cycle.**

To clarify how issuers and self-insured group health plans would be assessed for reinsurance contributions, CMS proposes to add §153.405. The contribution would be calculated by multiplying the average number of covered lives of reinsurance contribution enrollees during the benefit year for all of the entity's plans and coverage that must pay reinsurance contributions, by the national contribution rate for the applicable benefit year.

In addition, CMS would amend §153.405(b) to require that, no later than November 15 of benefit year 2014, 2015, and 2016, as applicable, a contributing entity must submit to HHS an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees for each benefit year. The count must be determined as specified in proposed §153.405(d), (e), (f), or (g) as applicable. Section 153.400(a) would be amended so that each contributing entity would be required to make reinsurance contributions at the national contribution rate annually and in a manner specified by HHS. Additional regulation text would be added to implement the requirement that entities make contributions annually and in a manner specified by HHS. If a state elects to collect additional contributions, the entity would be required to make the contributions annual and in a manner specified by the state.

Under proposed §153.405(c)(1), 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 that annual enrollment count. The contributing entity would be required to remit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year.

Counting Methods for Health Insurance Issuers. In §153.405(d), CMS proposes three distinct methods that an issuer may use to determine the average number of covered lives of reinsurance contribution enrollees under a plan for a benefit year for purposes of the annual enrollment count. "These methods promote administrative efficiencies by building on the methods permitted for purposes of the fee to fund the Patient-Centered Outcomes Research Trust Fund (the PCORTF Rule), modified so that a health insurance issuer may determine an annual enrollment count during the fourth quarter of the benefit year. Thus, under each of these methods, the number of covered lives will be determined based on the first nine months of the benefit year." More information on each method is presented in the preamble.

Counting Methods for Self-Insured Group Health Plans. In §153.405(e), CMS proposes three 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. More information on each method is presented in the preamble.

Counting Methods for Plans with Self-insured and Insured Options. CMS notes that 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), it proposes 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, the plan must use the "actual count" method or "snapshot count" for health insurance issuers, both of which are defined in the proposed rule and discussed in the preamble.

Aggregation of self-insured group health plans and health insurance plans. In §153.405(g)(1), CMS proposes that if a plan sponsor maintains two or more group health plans or health insurance plans (or a group health plan with both insured and self-insured components) that collectively provide major medical coverage for the same covered lives, ("multiple plans"), then these plans must be treated as a single self-insured group health plan for purposes of calculating any reinsurance contribution amount due. The plan sponsor would be responsible for paying the applicable fee. The term "plan sponsor" is defined for different types of entities (e.g., single employer, employee organization, multiple employer welfare arrangement, etc.).

Exceptions. CMS proposes two exceptions to this aggregation rule in §153.405(g)(3). (1) If the benefits provided by any health insurance or self-insured group health plans are limited to excepted benefits (such as stand-alone dental or vision benefits), the excepted benefits coverage need not be aggregated with other plans for purposes of this section. (2) If benefits provided by any health insurance or self-insured group health plan are limited to prescription drug coverage, that coverage need not be aggregated so as to reduce the burden on sponsors who have chosen to structure their coverage in that manner. Thus, if enrollees have major medical coverage and separate coverage consisting of prescription drug or excepted benefits, reinsurance contributions only would be required with respect to the major medical coverage.

Other plan configurations. CMS proposes counting requirements for: multiple plans in which at least one of the plans is an insured plan and there are also multiple self-insured group health plans not including an insured plan; multiple group health plans including an insured plan; and multiple self-insured group health plans not including an insured plan.

Consistency with PCORTF Rule Not Required. CMS advises that it intends to allow a reinsurance contributing entity to use a different counting method for the annual enrollment count of covered lives for purposes of reinsurance contributions from that used for purposes of the return that is required in connection with the PCORTF Rule.

CMS welcomes comments on its approach to counting covered lives for reinsurance contributions.

b. State Use of Contributions Attributed to Administrative Expenses

CMS outlines three restrictions that it intends to propose on the use of reinsurance contributions for administrative expenses in order to permit states that participate in the reinsurance program to accurately estimate the cost of administrative expenses. Details of these standards will be provided in future regulation and guidance. (1) Such funds could not be used for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications. (2) Such funds could not be used for any expense not necessary to the operation and administration of the reinsurance program. (3) An applicable reinsurance entity must allocate any shared, indirect, or overhead costs between reinsurance-

related and other state expenses based on generally accepted accounting principles, consistently applied. An applicable entity would be required to provide HHS, in a timeframe and manner specified by HHS, a report setting forth and justifying its allocation of administrative costs. **Comments are welcomed on these intended proposals.**

5. Eligibility for Reinsurance Payments under Health Insurance Market Rules (§153.234)

CMS proposes to add §153.234 to clarify that, under either the reinsurance national payment parameters or the state supplemental reinsurance payment parameters, if applicable, a reinsurance-eligible plan's covered claims costs for an enrollee incurred prior to the application of the ACA's 2014 market reform rules[14] do not count toward either the national or state supplemental attachment points, reinsurance caps, or coinsurance rates. The market reform rules will be effective for the individual market for policy years beginning on or after January 1, 2014, and as a result, policies that are issued in 2013 will be subject to these rules at the time of renewal in 2014, and therefore, become eligible for reinsurance payments at the time of renewal in 2014.

CMS also proposes that state-operated reinsurance programs similarly limit eligibility for reinsurance payments. CMS notes that this policy contrasts with its proposed approach for state-operated risk adjustment programs, under which states would be permitted to choose to risk adjust plans not subject to the 2014 market reform rules. This is because 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 but state flexibility for eligibility for reinsurance payments would not further the goal of the reinsurance program.

CMS notes too its intent to operate the reinsurance program on a calendar year basis, drawing its policy from its reading of the ACA. The rationale for this decision is explained.

Comments are welcome on these proposals.

6. Reinsurance Payment Parameters

CMS restates the requirement in the Premium Stabilization Rule that reinsurance payments to eligible issuers be made for a portion of an enrollee's claims costs paid by the issuer that exceeds an attachment point, subject to a reinsurance cap. The coinsurance rate, attachment point, and reinsurance cap are the reinsurance "payment parameters." The ACA directs the Secretary, in establishing transitional reinsurance program standards to include a formula for determining the amount of reinsurance payments to be made to issuers for high-risk individuals that provides for the equitable allocation funds. Using the Secretary's authority under this provision, CMS proposes to amend its policy by establishing uniform "national" reinsurance payment parameters that will be applicable to the reinsurance program for each state, whether or not operated by a state. The rationale is that such national parameters will provide for equitable access to the

[14] These are: §147.102 (fair health insurance premiums), §147.104 (guaranteed availability of coverage, subject to the student health insurance provisions at §147.145), §147.106 (guaranteed renewability of coverage, subject to the student health insurance provisions at §147.145), §156.80 (single risk pool), and Subpart B 156 (essential health benefits package).

reinsurance funds across states, while furthering the goal of premium stabilization across all states by disbursing reinsurance contributions where they are most needed.

CMS proposes the following 2014 national payment parameters:

- Reinsurance to begin at an attachment point of $60,000
- Reinsurance program stops paying claims for a high-cost individual at $250,000 (i.e., the reinsurance cap)
- 80% uniform coinsurance rate (meant to reimburse a proportion of claims between the attachment point and reinsurance cap while giving issuers an incentive to contain costs).

CMS says that these proposed payment parameters would help offset high-cost enrollees, without interfering with traditional commercial reinsurance, which typically has attachment points in the $250,000 range.

CMS estimates that these national payment parameters will result in total requests for reinsurance payments of approximately $10 billion.

CMS intends to continue to monitor individual market enrollment and claims patterns to appropriately disburse reinsurance payments throughout each of the benefit years.

CMS explains how it developed a model that estimates market enrollment incorporating the effects of state and federal policy choices and accounting for the behavior of individuals and employers (the Affordable Care Act Health Insurance Model (ACAHIM). The outputs of the ACAHIM, especially the estimated enrollment and expenditure distributions, were used to analyze a number of policy choices relating to benefit and payment parameters, including the national reinsurance contribution rate and national reinsurance payment parameters. The ACAHIM (including the data and assumptions used about key variables such as take-up of insurance) is briefly described in the preamble in two sections: (1) the approach for estimating 2014 enrollment and (2) the approach for estimating 2014 expenditures (77 FR 73160).

7. Uniform Adjustment to Reinsurance Payments (§153.230)

CMS proposes to amend §153.230 by specifying in subparagraph (d) that HHS will adjust reinsurance payments by a uniform, pro rata adjustment rate in the event that HHS determines that the amount of total requests for reinsurance payments under the national reinsurance payment parameters will exceed the amount of reinsurance contributions collected under the national contribution rate during a given benefit year. The total amount of contributions considered for this purpose would include any contributions collected but unused under the national contribution rate during any previous benefit year. If HHS determines that the total reinsurance contributions collected under the national contribution rate for the applicable benefit year are equal to or more than the total requests for reinsurance payments calculated using the national reinsurance payment parameters, then no such adjustment will be applied, and all requests for reinsurance payments will be paid in full under the national payment parameters. **CMS invites comment on this policy.**

8. Supplemental State Reinsurance Parameters (§153.232)

CMS proposes in a new §153.232(a) that a state that establishes its own reinsurance program may only modify the national reinsurance parameters by establishing state supplemental payment parameters that cover an issuer's claims costs beyond the national reinsurance payment parameters. In addition, reinsurance payments under these supplemental payments parameters may only be made with additional funds the state collects for reinsurance payments under §153.220(d)(1)(ii) or state funds applied to the reinsurance program under §153.220(d)(3). A state may set its supplemental reinsurance payments parameters by adjusting the national reinsurance payment parameters in one or more of the following ways: (1) decreasing the national attachment point; (2) increasing the national reinsurance cap; or (3) increasing the national coinsurance rate. In other words, a state may not alter the national reinsurance payment parameters in a manner that could result in reduced reinsurance payments. **CMS seeks comment on this approach, including whether there should be any limitations as to how a state may supplement the national reinsurance payment parameters.**

"To provide issuers with greater certainty for premium rate setting purposes," CMS further proposes that a state ensure that any additional funds for reinsurance payments it collects or state funds (otherwise collected) are reasonably calculated to cover additional reinsurance payments that are projected to be made under the state's supplemental reinsurance payment parameters for a given benefit year. The state must also ensure that such parameters are applied to all reinsurance eligible plans in that state in the same manner. CMS further proposes that contributions collected or additional funds, 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.

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

To ensure that reinsurance payments under state supplemental payment parameters do not overlap with the national parameters, CMS proposes in §153.232(d) a method for calculating state supplemental reinsurance payments. The method is explained, with an example, in the preamble at 77 FR 73161.

CMS also proposes in §153.232(e) that if all requested reinsurance payments under the state parameters calculated in a state for a benefit year will exceed all the additional funds a state collects for reinsurance payments, 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 by that adjustment.

Under proposed §153.232(f), a state must ensure that reinsurance payments made to issuers under the state parameters do not exceed the issuer's total paid amount for the reinsurance-eligible claim(s) and any remaining additional funds collected must be used for reinsurance payments under the state supplemental parameters in subsequent benefit years.

CMS seeks comment on this proposal, including other areas of flexibility that could be provided to state-operated reinsurance programs.

9. Allocation and Distribution of Reinsurance Collections (§153.220(a), §153.235(a))

Under §153.220(d) of the Premium Stabilization Rule, HHS would distribute reinsurance contributions collected for reinsurance payments from a state to the applicable reinsurance entity for that state. CMS proposes to replace this with proposed §153.235(a). It would provide that HHS allocate and distribute the reinsurance contributions collected under the national contribution rate based on the need for reinsurance payments, regardless of where the contribution was collected. As noted earlier, HHS would then 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. Consistent with this proposal, §153.220(a) would be amended to clarify that even if a state establishes a reinsurance program, HHS would directly collect from health insurance issuers, as well as self-insured group health plans, the reinsurance contributions for enrollees who reside in that state.

10. Reinsurance Data Collection Standards for Reinsurance Payments

a. Data Collection Standards for Reinsurance Payments (§153.240(a))

Under current §153.240(a), a state's applicable reinsurance entity is directed to collect data needed to determine reinsurance payments. CMS proposes to add a new subparagraph to direct a state to ensure that its applicable reinsurance entity either collect or be provided access to the data necessary to determine reinsurance payments from an issuer of a reinsurance-eligible plan. This proposed amendment would clarify that an applicable reinsurance entity may either use a distributed data collection approach (see III.G.) for its reinsurance program or directly collect privacy-protected data from issuers to determine an issuer's reinsurance payments. Additional language would be added to direct states to provide a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims may use estimated claims costs to make a request for payment. Such requests for reinsurance payment would be subject to validation. CMS explains that 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.

b. Notification of Reinsurance Payments (§153.240(b)

Under new §153.240(b)(1) a state, or HHS on behalf of the state, would be directed to notify issuers of the total amount of reinsurance payments that will be made no later than June 30 of the year following the benefit year (the same date on which a state or HHS must notify issuers of risk adjustment payments and charges). In other words, by June 30 of the year following the applicable benefit year, issuers will be notified of both reinsurance payments and risk adjustment payments and charges. This will allow issuers to account for their total reinsurance payments and risk adjustment payments and charges when submitting data for the risk corridors and minimum medical loss ratio (MLR) programs. To provide individual market issuers with information to assist in development of premiums and rates in subsequent benefit years, proposed §153.240(b)(2) directs a state to provide quarterly notifications of estimates to each reinsurance-eligible plan of the expected requests for reinsurance payments for each quarter. HHS intends to collaborate with issuers and states to develop these early notifications. **Comments are welcome.**

c. Privacy and Security Standards (§153.240(d))

CMS proposes to amend §153.240 by adding paragraph (d)(1), to require a state operating its own reinsurance program to ensure that the applicable reinsurance entity's collection of personally identifiable information is limited to information reasonably necessary for use in the calculation of reinsurance payments and that use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected (including for purposes of data validation). CMS explains that this proposal aligns with corresponding language for the risk adjustment program.[15] Further, proposed new paragraph (d)(2) would require that an applicable reinsurance entity 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.[16]

d. Data Collection (§153.420(a) and(b))

Proposed new §153.420(a) requires that issuers of plans eligible for and seeking reinsurance payments submit or make accessible data (including data on cost-sharing reductions to permit the calculation of enrollees' claims costs incurred by the issuer), in accordance with the reinsurance data collection approach established by the state, or HHS on behalf of the State. Proposed §153.420(b) directs an issuer of a reinsurance-eligible plan to 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. **Comments are welcome on this proposal.**

[15] 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).
[16] These standards are at §164.308, §164.310, and §164.312.

D. Provisions for the Temporary Risk Corridor Program

Background

Section 1342 of the ACA, previously codified in subpart F of 45 CFR 153, sets out a temporary three-year risk corridor program designed to protect against uncertainty in rates by limiting the extent of issuer gains and losses. It provides, in general, for shared savings and losses when a QHP's allowable costs are higher or lower than a target amount. The following summarizes the thresholds and basic approach.

QHP's allowable costs compared with target amount	Risk Corridor Payment
>108%	HHS pays amount equal to 2.5% of target amount + 80% of allowable costs in excess of 108% of target amount
>103% to ≤108%	HHS pays amount equal to 50% of target amount in excess of 103% of target amount
97% to103%	No risk corridor payment
≥92% to <97%	QHP issuer pays HHS amount equal to 50% of difference between 97% of target amount and allowable costs
< 92%	QHP issuer pays HHS amount = 2.5% of target amount + 80% of difference between 92% of target amount and allowable costs
Source: Health Policy Alternatives based on §1342(b) of the ACA and §153.510 of the July 15, 2011 Notice of Proposed Rulemaking.	

CMS proposes several changes in the rules to reflect its previously stated intent to account for taxes and profits in the risk corridors calculation in the same manner as they are dealt with in the Medical Loss Ratio (MLR) program. In addition, CMS proposes changes to the charge submission deadline and data requirements.

1. Definitions (§153.500)

CMS proposes changes to the definitions necessary to account for taxes and profits in the risk corridors calculation.

Taxes: CMS proposes a new definition of "taxes", with respect to a QHP: it proposes that taxes are Federal and State licensing, regulatory fees, taxes and assessments paid with respect to a QHP as described in the MLR regulations (§158.161 and §158.162).

After-tax premium earned: CMS proposes a new definition of premiums minus taxes as after-tax premium earned.

Administrative costs: CMS proposes to broaden the current definition of administrative costs to reflect this new recognition of taxes: administrative costs would be total non-claims costs, including taxes.

Profits: CMS proposes a definition of profits to be the greater of:

- Three percent of after-tax premiums earned; or
- Premiums earned minus allowable costs and administrative costs.

CMS notes that this minimum three percent profit margin is intended so that the risk corridor program will protect a reasonable margin (subject to the 20 percent cap on administrative costs). CMS says that permitting issuers to retain a reasonable margin will afford them greater assurance of achieving reasonable financial results given expected changes in the market over this three year period, and encourage them to reduce the risk premium built into their rates. CMS cites data on average long-term industry underwriting margins of 2 percent, but notes that that result includes plans with significant losses. MLR data suggest an average margin of 3 percent once the negative results are removed, which CMS believes better reflects reasonable issuer projections. **CMS welcomes comments.**

Allowable administrative costs: CMS proposes to revise the definition of allowable administrative costs to reflect the changes above. The new definition of allowable administrative costs is the sum of administrative costs, other than taxes plus profits, but limited to 20 percent of after-tax premiums earned, plus taxes. A summary of CMS' example of a calculation of a risk corridor payment is provided in the following summary table.

Summary of HHS example of calculation of risk corridor payment	
Assumptions	
1. Premiums earned	$200
2. Allowable costs (defined in prior rule, including claims and allowed expenses for quality, information technology, and other applicable adjustments, and net of reinsurance and risk adjustment payments, and net of any cost-sharing reduction payment received by the issuer)	$140
3. Non-claims costs, total	$50
a. Taxes	$15
b. Other than taxes	$35
Calculations	
4. After tax premiums earned: premiums earned minus taxes: ($200-$15)	$185
5. Profits: greater of 3% of premiums earned (3% * $200=$6) or premiums earned minus allowable and administrative costs ($200-($140+$50)=$10)	$10
6. Allowable administrative costs: sum of administrative costs other than taxes plus profits ($35+$10=$45), limited to 20% of after tax premiums earned (20% of $185=$37), plus taxes ($15) = $37 + $15 = $52	$52
7. Target amount: premiums earned minus allowable administrative costs: ($200 - $52 = $148)	$148
8. Risk corridor ratio: ratio of allowable costs to the target amount ($140/$148=94.6%).	
9. Based on risk corridor table above, issuer would be required to remit to HHS 50% of difference between 97% and 94.6% (50% of 2.4% =1.2%) times the target amount of $148 (1.2%*$148 =$1.78)	

CMS notes that it proposes the changes to align MLR and risk corridor calculations where practicable, and **welcomes comments on the proposal.**

2. Risk corridor establishment and payment methodology (§153.510)

CMS proposes in §153.510 that QHP issuers must remit charges to HHS within 30 days of notification of the charges. CMS notes that it **welcomes comments on the proposal**

CMS notes that the schedule would align with risk adjustment, reinsurance, and MLR deadlines. By June 30 of the year following an applicable benefit year, issuers will have been notified of risk adjustment payments and charges, and all reinsurance arrangements. CMS proposes in §153.530(d) that QHP issuers submit all information by July 31 of the year following an applicable benefit year.

3. Risk corridors data requirements (§153.530)

CMS proposes that allowable costs be reduced by the amount of any cost-sharing reduction payment received by the issuer to the extent it is not reimbursed to the provider providing the services. CMS notes that this provision links the data requirements to the requirement in section III.E of the proposed rule (in proposed §156.430(c) related to cost-sharing requirements).

CMS proposes that it will address the manner of submitting required risk corridor data in future guidance, rather than in in this proposed notice of benefit and payment parameters (as specified in the current rule).

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

Background

The Exchange Final Rule published March 27, 2012 set out in 45 CFR Part 155 Subpart D Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs. CMS also set out, on February 24, 2012, an Actuarial Value and Cost-Sharing Reduction Bulletin (AV/CSR Bulletin) indicating its potential policy directions, for comment.

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

a. Special Rule for Family Policies (§155.305(g)(3))

Current §155.305(g)(3) sets out policy for determining eligibility for cost-sharing reductions for individuals in different tax households but enrolled in the same family QHP policy. It sets out a hierarchy under which the lowest level of cost sharing subsidy that any one individual in the family QHP policy is eligible for would apply to the combined household QHP. For example, if one family member is in a taxable household with income of 140 percent of the FPL which would qualify for a silver plan AV of 94 percent, and another is in a taxable household with income of 160 percent of the FPL, which would qualify for a silver plan variation with AV of 87 percent, the lower 87 percent AV level would be the applicable cost-sharing subsidy for the family in the QHP in the Exchange.

CMS proposes to add to the hierarchy to deal with the situation where one individual is not eligible for any AV subsidy (member of a taxable household with income above 250 percent of the FPL), in which case the family in the QHP would be eligible for no AV subsidy to the silver policy as this would be the lowest applicable level of cost sharing. In addition, CMS proposes to add in to the hierarchy the special determinations for Indians and non-Indians enrolled in a family policy (see §155.300).

CMS notes that current §155.305(g)(3) and this proposed change may limit cost-sharing reductions that members of a family might receive, but that section 1402 of the ACA precludes any individual from receiving benefits for which the individual is ineligible. CMS notes the difficulty of applying different AVs, deductibles and copayments and OOP limits within the same family policy, but that nothing precludes qualified individuals from enrolling in separate policies rather than one family policy in order to secure the highest cost-sharing subsidy for which they are eligible**. CMS welcomes comments.**

b. Recalculation of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§155.330(g))

Current §155.330 sets out Exchange standards for redetermination of eligibility during a benefit year, including requirements for individuals to report changes, verification processes, periodic examination of data sources by Exchanges to identify potential changes, and redetermination and notification standards.

Redetermination of advance payment of premium tax credits: CMS proposes to add a new §155.330(g)(1) to clarify how eligibility redeterminations affect eligibility for advance payments of the premium tax credit. CMS notes that, under the Internal Revenue Code (IRC) rules at 26 CFR 1.36B-4(a)(1), it is important when calculating advance payments that the Exchange act to minimize any potential discrepancies between the advance payments and the final premium tax credit amount, which is reconciled to actual income on the filer's end-of-year tax return. CMS proposes that when making such a recalculation during the year, the Exchange account for any advance payments already made during the year, so that the recalculated advance payment is projected to result in total advance payments that correspond to the tax filer's projected premium tax credit for the benefit year. CMS provides the following example:

- At the beginning of 2014, a tax filer is determined to be eligible for a tax credit of $35 per month ($420 for the year), based on expected income and QHP rating in the rating area, and an advance payment of the premium tax credit of that monthly amount is made to the QHP.
- In June, the tax filer reports and the Exchange verifies a reduction in expected household income for the year, and the Exchange determines that the filer would be eligible for a tax credit of $1,356 for the year which would be $113 per month if spread over the 12 months.
- In determining the advance payment for the remaining 6 months of the year, CMS would first determine the total amount already paid ($35 * 6 = $210) and subtract it from the $1,356 amount that is the new projected tax credit for the year ($1,356 - $210 = $1,146).
- It then divides that amount by the remaining 6 months to determine the advance payment due for each of the final six months of the year ($1,146 / 6 = $191).

CMS proposes that, in the case of such a redetermination, the advance payment would be greater than or equal to zero. That means that in the case of a redetermination based on an increase in income, the advance payment could decrease for the remainder of the year, but any recovery of a net overpayment over the course of the year would be reconciled on the filer's tax return for the year.

CMS notes that it considered proposing retroactive payments to the QHP issuer in the case of a reduction in income, instead of making the full adjustment over the remaining months of the benefit year. In the example above, it would proceed as follows:

- The Exchange would calculate the difference between:
  - the $35 per month, or $210 actually paid for the first six months; and
  - the $113/month, or $678 it would have paid under the recalculation for the year;
  - the difference is $438
- The Exchange would make that payment of $438 to the QHP as a retroactive payment for the first six months, and the Exchange would then make a monthly advance payment to the QHP of $113 for the remaining six months of the year.

CMS notes that such an approach would permit it to pay more of the full premium tax credit amount owed prior to the end of the year in the case of a redetermination late in the year with a substantial reduction in income. The reason is that the monthly advance payment cannot exceed the monthly premium for the QHP. CMS also notes that a retroactive payment may help address outstanding premium amounts owed to a QHP. **CMS seeks comments on this alternative, and how QHP issuers would be required to provide such a retroactive payment to enrollees.**

Redetermination of cost-sharing reductions: CMS proposes to add a new §155.330(g)(2) to clarify how eligibility redeterminations affect eligibility for cost-sharing reductions. CMS proposes that the Exchange must determine an individual eligible for the category of cost-sharing reductions that corresponds to his or her expected household income for the benefit year.

CMS notes that, unlike premium tax credits, cost-sharing reductions are not reconciled at the end of the year. As a result, redeterminations of eligibility during a year should not take into account cost-sharing reductions already provided during the year. CMS provides an example in the case of a redetermination of eligibility. The tax filer is reassigned (within the silver plan) to the AV subsidy level to which they are newly eligible (either a higher or lower AV level) based on their expected annual income, and deductible limits, copayments and maximum OOP limits would be determined under the new AV structure of that plan for the remainder of the year (taking into account previous deductible and cost-sharing payments made by the individual during the benefit year).

c. Administration of Advance Payment of the Premium Tax Credit and Cost-Sharing Reductions (§155.340)

Current §155.340 sets out information reporting requirements for Exchanges for administration of the advance payment premium tax credits and cost-sharing reductions.

CMS proposes two new paragraphs. It proposes a new paragraph (e), Allocation of Advance Payments of the Premium Tax Credit Between Policies, to deal with a situation in which individuals in a tax filer's household who are eligible for advance payment of a premium tax credit are enrolled in more than one QHP or stand-alone dental plan.

- The Exchange must first allocate the portion of the advance payment tax credit that is less than or equal to the aggregate adjusted monthly premiums for the QHP policies in proportion to the respective portions of the premiums of those QHP policies properly allocated to the EHB.
- The Exchange must allocate any remaining advance payment to the stand-alone dental policies, if any, in proportion to the respective portions of the adjusted monthly premiums for the stand-alone dental policies properly allocated to the pediatric dental benefit.

CMS notes the following example of this pro rata allocation:

- A family eligible for an advance payment premium tax credit is enrolled in two QHPs, one with a premium of $500 and a second with a premium of $400 allocated to EHB, and a stand-alone dental plan with a $100 premium for the pediatric dental EHB.
- The Exchange would allocate 5/9 ($500/$900) of the tax credit, up to a maximum of $500, to the first QHP and 4/9 ($400/$900), up to a maximum of $400, of the tax credit to the second QHP. If there is any remaining premium tax credit it would be allocated to the stand-alone dental plan.

CMS also proposes to add a paragraph (f) to set out standards for an Exchange when it is facilitating the collection and payment of premiums to QHP issuers. CMS proposes that in that situation the Exchange must:

- Reduce the portion of the premium collected from the enrollee by the amount of the advance payment premium tax credit; and
- Display in each billing statement for the enrollee the amount of the advance payment premium tax credit, and the remaining premium owed for the policy.

CMS notes that this is equivalent to the proposed §156.460(b) requirement for QHP issuers when the issuer submits the billing statement to the enrollee, and is designed to ensure that an enrollee is aware of both the total cost of the premium and the amount of the advance payment premium tax credit. **CMS solicits comment on this approach.**

2. Exchange Functions: Certification of Qualified Health Plans

Current Subpart K of Part 155 sets out the standards for Exchange Functions for Certification of Qualified Health Plans.

CMS proposes to add a new §155.1030 to include certification standards related to advance payments of the premium tax credit and cost-sharing reductions. CMS notes that it is appropriate to incorporate these as QHP certification criteria because Exchanges are the primary entities that interact with and oversee QHPs.

CMS proposes in §155.1030(a) that an Exchange must ensure that each issuer submit the required plan variations in AV and cost-sharing set out in proposed §156.420, certify that the

variations meet those requirements, and report the AVs of the QHPs and silver plan variations to HHS. CMS notes that it expects an Exchange to collect information necessary, including cost-sharing requirements for the plan variations, such as the annual limitation on cost-sharing and any reductions in deductibles, copayments or coinsurance. The Exchange would also collect or calculate the AV of each QHP and silver plan variation.

CMS proposes in §155.1030(b) that an Exchange must collect and review annually the information that an issuer must submit under proposed §156.470 that would allow for the calculation of premium tax credits and cost-sharing reductions. CMS notes that it expects that the Exchange will review the information in conjunction with the rate and benefit information submitted by an issuer under §156.210, and notes that it proposed revisions to the reporting requirements for the Effective Rate Review Program in the Market Reform rule to include rate allocation and expected claims cost allocation information from issuers of metal level health plans. CMS expects that the alignment between the provisions can streamline reporting by issuers and review by the Exchange. CMS notes that it is the Exchange's responsibility to ensure that each issuer performs the allocations appropriately, including those that are not reported as part of the Effective Rate Review Program.

CMS notes that the information would be used by the Exchange to calculate the dollar amounts of the advance payments of premium tax credits and cost-sharing reductions as described in proposed §156.430.

CMS proposes that the Exchange must submit to HHS the approved allocations for each health plan at any level of coverage, or stand-alone dental plan, offered or proposed to be offered in the individual market in the Exchange. CMS also proposes that an Exchange collect annually any estimates and supporting documentation from a QHP issuer to receive advance payments of the value of cost-sharing reductions under §156.430(a), and submit the estimates and supporting documentation to HHS. CMS intends to provide further detail on the manner and timeframe of the submission of information to HHS, but expects that an Exchange will be required to submit prior to the start of the benefit year.

Finally, CMS proposes authority for HHS to use the information submitted for the approval and oversight of advance payments of premium tax credits and cost-sharing reductions.

Information Collection Requirements

CMS, in its review of Information Collection Requirements in the proposed rule, sets out the following estimates for new §155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions. It estimates:

- An incremental cost of approximately $181/year for each partnership or State Exchange to collect, validate and submit to HHS required information on required plan variations, for a total costs of $9,240.
- An incremental cost of approximately $19 per year for Exchange collection and submission of required information for stand-alone dental plans, with an assumption of 20 stand-alone dental plans, for a total cost of $385.

- An incremental cost of approximately $3.08 for Exchanges to collect and submit required documentation for advance payment of certain cost-sharing reductions, for a total cost of $158.

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

Current Part 156 sets out Health Insurance Issuer Standards Under the ACA, Including Standards Related to Exchanges. CMS proposes a new subpart E – Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions, to clarify that meeting these standards is a requirement of QHP certification. Failure to comply would result in decertification of the QHP and other enforcement actions.

a. Definitions (§156.400)

CMS proposes definitions that would apply only to subpart E. CMS notes that some cross-reference definitions elsewhere in parts 155 and 156, and **seeks comments.**

CMS proposes five related definitions required under subpart E:

- "Standard plan" is a QHP offered at one of the four "metals" levels of coverage, with an annual limit on cost-sharing that conforms to §156.130(a). Standard plans are referred to as standard bronze, standard silver, standard, gold, and standard platinum plans.
- "Silver plan variation" is with respect to a standard silver plan, any of the variations of that plan described in proposed §156.420(a) (which are the income-related reductions in annual limits, and reductions in cost-sharing associated with income-related increases in AV).
- "Zero cost-sharing variation" is, with respect to a QHP at any level of coverage, the variation of the QHP that provides for the elimination of cost-sharing for Indians based on household income level under proposed §156.420(b)(1).
- "Limited cost-sharing variation" is, with respect to a QHP at any level of coverage, the variation of the QHP that provides for the elimination of cost-sharing for the receipt of benefits from the Indian Health Service and certain other providers, irrespective of income levels.
- "Plan variation" is a zero cost-sharing, limited cost sharing, or silver plan variation.

CMS emphasizes 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 and the Federal government. CMS proposes that each plan variation will reflect the enrollee's portion of the cost sharing requirements. CMS refers to "assigning" enrollees to the applicable plan variation, and reiterates that these variations are not different QHPs.

CMS proposes additional definitions as follows:

- "De minimus variation for a silver plan variation" means a single percentage point variation in AV. CMS notes that this differs from the 2 percentage point variation

proposed for the standard plans in the EHB/AV proposed rule. CMS notes that the cost-sharing reductions are reimbursed by the Federal government, so the degree of flexibility afforded to issuers for silver plan variations should be somewhat less. CMS seeks to balance the need to ensure that individuals receive full value of the cost-sharing reductions for which they are eligible with issuers' ability to set reasonable cost-sharing.

- "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 QHP. CMS notes that under the proposed EHB/AV rule, the annual limit would not include cost-sharing for benefits provide outside of a QHP's network, and if a state requires benefits in addition to EHB, the provisions related to cost-sharing reductions do not apply to those additional benefits.
- "Maximum annual limitation on cost-sharing" means the uniform maximum that would apply to all QHPs for a particular year.
- "Reduced maximum annual limitation on cost-sharing" is the dollar value of the maximum annual limitation on cost-sharing for a silver plan variation after applying the reduction in the maximum annual limitation for each silver plan variation. CMS notes again that annual limitation applies only for cost-sharing with respect to EHB, and does not apply to cost-sharing for out-of-network services.

CMS seeks comments on all of the definitions proposed in §156.400.

b. Cost-sharing reductions for enrollees (§156.410)

CMS proposes in §156.140(a) that a QHP must ensure that an individual eligible for cost-sharing reduction and assigned to a particular plan variation pay only the required cost sharing for the applicable covered service for that plan variation. Further, CMS proposes that the cost-sharing reduction must be applied when the cost-sharing is collected. CMS notes that an issuer may not create a system in which an individual pays the full cost-sharing (for example, for the standard silver plan) and then apply for a refund to reflect the cost-sharing reduction for the applicable plan variation. Further, the issuer must ensure that the enrollee is not charged any type of cost-sharing after the applicable annual limitation on cost-sharing has been met. CMS notes, however, that an individual is not eligible for cost-sharing reductions until any applicable (and potentially reduced) deductible is met. **CMS seeks comment on these policies.**

CMS proposes in §156.140(b) a process by which a QHP issuer assigns a qualified individual to the applicable plan variation.

- If the individual is eligible for cost-sharing reductions, the QHP issuer must assign the individual to the silver plan variation of the selected silver plan based on the individual's income-based eligibility under §156.420. CMS notes that it chose not to allow the individual to opt out of the most generous silver plan for which the individual is eligible, because it would cause confusion without policy benefit. Further, CMS notes that an individual may choose not to apply for cost-sharing reductions. CMS invites comments on this approach.

- If the individual is eligible for cost-sharing reductions for Indians with lower house income (under proposed §155.350), the QHP issuer must assign the individual to the zero cost-sharing plan variation of the selected QHP.
- If the individual is eligible for cost-sharing reductions for Indians regardless of household income 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 no cost-sharing for benefits received from the Indian Health Service and certain other providers.
- If the individual is not eligible for cost-sharing reductions and chooses to enroll in a QHP, the QHP issuer must assign the individual to the selected QHP with no cost-sharing reduction.

c. Plan variations (§156.420)

CMS proposes regulatory language on plan variations and then provides an extensive discussion of its implementation for the2014 benefit year.

CMS proposes in §156.420(a) an annual process by which QHP issuers would submit for certification, prior to each benefit year, for the standard silver plan and each silver plan variation for which individuals are eligible on the basis of income:

- The reduced annual limitation on cost sharing for that silver plan variation complying with the limits set by HHS in the annual notice of benefit and payment parameters;
- Other cost-sharing reductions such that the AV of the silver plan variation reaches the required AV levels of 94, 87 and 73 percent (for the appropriate income tier).

CMS proposes in §156.420(b) a comparable process for QHP issuers to submit for certification prior to each benefit year the zero cost-sharing and limited cost-sharing plans for which Indians are eligible.

CMs proposes in §156.420(c) that a standard silver plan and each silver plan variation must cover the same benefits and providers and require the same out-of-pocket spending for benefits other than EHB. CMS proposes in §156.420(d) comparable requirements for zero cost-sharing and limited cost-sharing plans, and notes that issuers must meet all other QHP requirements in these plan variations.

CMS proposes in §156.420(e) that cost-sharing under any silver plan variation for an EHB may not exceed the corresponding cost-sharing required under the standard silver plan or a silver plan variation with a lower AV. CMS notes that commenters on the AV/CSR Bulletin suggested that HHS adopt more restrictive requirements on cost-sharing structures in silver plan variations, including concern about the effect of deductibles on those with low incomes. CMS responds that it believes that the proposal strikes the appropriate balance between protecting consumers and preserving QHP issuer flexibility, and **seeks comment**.

CMS proposes in §156.420(f) that, notwithstanding the de minimus variation standards, the minimum AV difference between the standard silver plan and the silver plan for those with income between 200 and 250 percent of the FPL cannot be less than 2 percentage points.

CMS reviews the statutory standard for reductions in the maximum annual limit and increases in AV level in Table 14 in the proposed rule, repeated below.

From Table 14 in NPRM: Statutory Reductions in Cost Sharing		
Household income	**AV Level**	**Reductions in maximum annual limit on cost-sharing, subject to revision by the Secretary**
100-150% of FPL	94%	2/3 reduction
150-200% of FPL	87%	2/3 reduction
200-250% of FPL	73%	½ reduction
250-300% of FPL	70%	½ reduction
300-400% of FPL	70%	1/3 reduction

CMS notes that the law first directs issuers to reduce the maximum annual limit on cost-sharing, and then adjust cost-sharing to reach the required AV. However, CMS notes that the Secretary may adjust the reduction in the annual limit if necessary to ensure that it is possible to achieve the required AV with other cost-sharing provisions.

CMS proposes for 2014 in this annual notice of benefit and payment parameters, as it had suggested in the AV/CSR Bulletin, not to reduce the maximum annual limit on cost-sharing for those with income between 250 and 400 percent of the FPL, because such a reduction would require a significant increase in deductibles and copayments in order to retain the AV at 70 percent in the standard silver plan. CMS notes that the majority of commenters on the Bulletin supported this proposal.

For those with household income of 100-250 percent of the FPL, CMS proposes an annual three-step process for design of silver plan variations.

Step 1: First, CMS would identify in the annual HHS notice of benefit and payment parameters the maximum annual limitation on cost-sharing applicable to all plans. CMS proceeds to propose that limit for 2014.

The statutory maximum annual limit on cost-sharing for 2014 is the dollar limit on cost-sharing for high deductible health plans that will be set by the IRS for 2014. The IRS will not publish this amount until the spring of 2013, so CMS proceeds with a methodology replicating the IRS methodology, and using projected CPI data from the Office of Management and Budget. CMS estimates that the maximum OOP limit will be approximately $6,400 for self-only coverage and $12,800 (double that amount) for other than self-only coverage. CMS welcomes comment.

Step 2: CMS would analyze the effect on AV of the reductions in the maximum annual limits on cost sharing for those eligible for reduced cost-sharing (see table derived from Table 14 in the proposed rule.) CMS would adjust the limits on cost-sharing, if necessary, to ensure that the AV would not exceed the AV set under the law. CMS proceeds with that analysis for benefit year 2014.

CMS developed three model standard silver QHP cost-sharing packages that included the proposed $6,400/$12,800 annual limits:

- PPO: $1,675 deductible, 20% in-network coinsurance, $6.400/$12,800 annual limit.
- PPO: $575 deductible, 40% in-network coinsurance, $6,400/$12,800 annual limit.
- HMO: $2,100 deductible, 20% coinsurance, several special deductible and copay provisions, $6,400/$12,800 annual limit.

CMS then observed how the required reduction in the maximum annual limit would affect the AV of silver plan variations with those cost-sharing packages:

- For those with income between 100-150 percent of FPL, the required 2/3 reduction did not cause AV to exceed the 94 percent statutory level.
- For those with income between 150-200 percent of FPL, the required 2/3 reduction did not cause AV to exceed the 87 percent statutory level.
- However, for those with income between 200-250 percent of FPL, the required ½ statutory reduction did cause the AV of the modeled plans to exceed the statutory AV of 73 percent.

Based on this analysis, CMS proposes that for 2014, the maximum annual limit for those with income between 200-250% of the FPL would be reduced by about 1/5, rather than ½, and further proposes to moderate the reductions for all three income categories to account for any potential inaccuracies. When combined with the previous proposal to not reduce the maximum OOP limit for those with income between 250-400 percent of the FPL, CMS proposes the following maximum allowable limitations on cost-sharing for 2014. The table below presents both the statutory standard and the CMS proposed adjustment.

CMS' Proposed Maximum Annual Limits on Cost-Sharing for 2014			
	AV Level	**Statutory reduction**	**CMS proposed annual limit for self only/non-self only and estimated reduction**
Standard silver plan	70%		$6,400/$12,800
Household Income			
100-150% of FPL	94%	2/3 reduction	$2,250/$4,500 (65% reduction)
150-200% of FPL	87%	2/3 reduction	$2,250/$4,500 (65% reduction)
200-250% of FPL	73%	½ reduction	$5,200/$10,400 (19% reduction)
250-300% of FPL	70%	½ reduction	$6,400/$12,800 (no reduction)
300-400% of FPL	70%	1/3 reduction	$6,400/$12,800 (no reduction)

CMS notes that it does not believe it will be necessary to revise its analysis once the IRS publishes its dollar limit for high deductible plans, and proposes that QHP issuers may rely on the limits in the final HHS notice of benefit and payment parameters.

CMS welcomes comments on this approach.

Step 3: CMS proposes that a QHP issuer would develop three variations of its standard silver plan (reflecting the income-related tiers with AVs of 94 percent, 87 percent, and 73 percent), with the annual limits noted above. If the reduced annual limit on cost-sharing results in a change in the AV of the plan by more than the required de minimus amount of 1 percentage

point, the QHP issuer would adjust the cost-sharing (not the proposed annual limits) to reach the desired AV level. **CMS welcomes comments on the proposals.**

Information Collection Requirements

CMS, in its review of Information Collection Requirements in the proposed rule, sets out the following estimates for new §156.420, plan variations. It estimates:

- 1,200 issuers will participate in an exchange nationally;
- Each issuer will offer one QHP per metal level, with four zero cost-sharing variations and four limited cost-sharing variations (one per metal level) and three variations of the standard silver plan for low-income populations, for a total of four standard plans and 11 plan variations.
- CMS estimates it would cost an issuer $866.47 to submit the information on plan variations, for total cost for 1,200 issuers of $1,039,698.

d. Changes in Eligibility for Cost-Sharing Reductions (§156.425)

CMS proposes that if an Exchange notifies a QHP issuer of a change in eligibility 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 in accordance with the Exchange effective date of eligibility.

CMS proposes that, in the case of a change in assignment to a different standard plan or plan variation in the course of a benefit year, the QHP issuer must ensure that any deductible and cost sharing paid under the previous plan variation or standard plan is accounted for in the calculation of the deductibles and annual limits in the new plan variation for the remainder of the benefit year. CMS notes that a change from or to an individual or family policy of a QHP during a year does not constitute a change in plan, so individuals would not be penalized by changes in eligibility for cost-sharing reductions during the benefit year or the additional or removal of family members. They would not be eligible for any refund on cost-sharing to the extent that newly applied deductible or annual limitation on cost-sharing is exceeded by prior cost-sharing. A QHP issuer is not prohibited from or required to extend this policy to situations in which the individual changes QHPs, including enrollment at a different metal level, but would be permitted to extend the policy provided it is applied across all enrollees in a uniform manner. **CMS seeks comments on this proposal.**

e. Payment for Cost-Sharing Reductions (§156.430)

CMS reviews the statutory authorities for payment to QHP issuers to pay for the cost-sharing reductions, and says that it proposes to implement a payment approach under which it would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts and reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts. CMS notes that this is similar to the process employed for the low-income subsidy under Medicare Part D, and **welcomes comments on the approach and alternative approaches, and whether the approach should change over time.**

CMS proposes in §156.430(a) that for each health plan that an issuer offers or intends to offer in the individual market in an Exchange, the issuer must provide 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 plan, it must include the per member per month (PM/PM) dollar value of the cost-sharing reductions under each silver plan variation.
- All QHPs must provide the PM/PM dollar value of cost-sharing reductions under the zero cost sharing plan variation.
- If an issuer seeks advance payments for the limited cost-sharing plan, it must provide the PM/PM dollar value of cost-sharing reductions under that plan.
- All submissions must be developed using the methodology specified by HHS in the annual HHS notice of benefit and payment parameters, and must be accompanied by supporting documentation.
- HHS' approval is based on whether the estimate is made consistent with HHS' methodology.

In this proposed notice of benefit and payment parameters for 2014, CMS proposes a simplified methodology for estimating the value of the cost-sharing reductions. CMS believes that a lack of data will make it difficult to accurately predict the value of the cost-sharing reductions, even if a complex methodology is used, and it intends to review the methodology in future years, once more data are available. CMS also notes that the payment reconciliation process described in proposed §156.430(c) through (e) below ensure that a QHP issuer is made whole for the value of cost-sharing reductions during the year, which may not be equal to the advance payments.

CMS proposes that for 2014, advance payments for cost-sharing reductions for silver plan variations be computed as follows:

Monthly PMPM advance payment =

Monthly expected allowed claims for the standard silver plan (AV 70%),
multiplied by
An induced utilization factor for the increased use at a higher AV (see table below)
multiplied by
The difference between the silver plan variation AV and the standard silver plan AV.

The induced utilization factors proposed by HHS are as follows, as presented in Table 16 in the proposed rule.

From Table 16: Proposed Induced Utilization Factors for Computing Cost-Sharing Reduction Advance Payments		
Household income	**Silver Plan AV**	**Induced utilization factor**
100-150% of FPL	Plan variation 94%	1.12
150-200% of FPL	Plan variation 87%	1.12
200-250% of FPL	Plan variation 73%	1.00

Health Policy Alternatives provides the following example of how the calculation appears to work. The example starts with several assumptions:

- A silver plan QHP with an actual AV of 70%, and PM/PM expected allowed claims costs of $500.
- Silver plan variations with an actual AV of 94%, 86% (within the de minimus 1% variation from 87%) and 73%.

The assumptions and calculations are presented in the table below.

Example of Calculation of Advance Payment to a particular QHP for Cost-Sharing subsidies				
	Standard Silver Plan	**Silver Plan Variations**		
Income tier		**100-150% of FPL**	**150-200% of FPL**	**200-250% of FPL**
1. Actual AV* (assumption)	70%	94%	86%*	73%
2. PM/PM expected allowed claims costs (assumption)	$500			
3. Induced utilization factor		1.12	1.12	1.00
4. PM/PM expected allowed claims * induced utilization (2 * 3)		$560	$560	$500
5. Difference between AV of standard silver plan and AV of silver plan variation (differences in columns on line 1)		24%	16%	3%
6. Advanced payment PM/PM to the QHP for cost-sharing subsidy (5 * 4)		$134.40	$89.60	$3.00
'* Note: the AV for this calculation is the actual approved AV of the particular plan, which can differ from the statutory target. For example, the silver plan variation in this example for those with income between 150-200% of the FPL has an AV of 86%, which is within the +/- 1% de minimus variation from the statutory target of 87%.				

CMS believes that this will limit the estimating burden, **and welcomes comment on the methodology and proposed induced utilization factors, as well as the tradeoff in the value of increased complexity of the methodology versus the value of operational efficiency.**

CMS proposes a similar process for advanced payment of cost-sharing reductions for zero cost sharing plans for Indians, and proposes that QHP issuers have the option to forego submitting an estimate for advance payment for the limited cost-sharing plan variation for Indians if they believe the operational cost of developing the estimate is not worth the value of the advance payment. If the issuer does seek advance payments, it must submit an estimate meeting standards set out in HHS' annual notice of benefit and payment parameters. For 2014, CMS simply proposes that issuers submit a reasonable estimate for the limited cost-sharing plan variation developed by a member of the American Academy of Actuaries.

CMS proposes in §156.430(b) to make periodic advance payments to issuers based on the approved advance estimates, determined above, and confirmed enrollment information.

CMS proposes in §156.430(c) that QHP issuers report to HHS the actual amount of cost-sharing reductions provided. CMS proposes that, in the case of payment for EHB paid in whole or in part on a fee-for-service basis, the issuer report total allowed costs for EHB, broken down by what the issuer paid, what the enrollee paid, and the amount paid by the issuer to account for the amount that the enrollee would have paid under the standard QHP. In the case of payment for EHB in any other manner (such as per member per month payments) the QHP issuer must submit total allowed costs for EHB, broken down by what the issuer paid, what the enrollee paid, and the amount that the enrollee would have paid under the standard QHP. CMS notes that it expects that QHP issuers will make available to providers in non-fee-for-service arrangements compensation for the cost-sharing reductions through negotiated capitated arrangements. CMS seeks comments on this assumption and other payment approaches for QHPs that use a capitated system to pay providers.

CMS proposes in §156.430(d) to periodically reconcile advance payments against actual cost-sharing reduction amounts reported under (c) above.

CMS proposes in §156.430(e) that if the advance payments are higher (or lower) than the actual cost-sharing amounts, the issuer (or HHS) would be responsible for reimbursement of the other party.

CMS proposes in §156.430(f) that a QHP issuer remains eligible for payment of cost-sharing reductions provided prior to termination of coverage, including during any grace period for non-payment of premiums. A QHP issuer would be required to repay any advance payments made with respect to any month after any termination of coverage effective date. CMS proposes that if any other retroactive termination, or late determination of the termination, is the fault of the QHP issuer, as reasonably determined by the Exchange, the issuer would not be eligible for advance payments and reimbursements of cost-sharing reductions provided during the period following the termination of coverage effective data. If the termination, or late determination of the termination, 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 of cost-sharing reductions during such a period.

CMS proposes that a QHP issuer would 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 under §155.315(f).

CMS welcomes comment on the proposal, and the relative equities of, and incentives created by, and consequences of this and other approaches, including costs to HHS.

Information Collection Requirements

CMS, in its review of Information Collection Requirements in the proposed rule, sets out the following estimates for new §156.430. It estimates:

- A total of 1,200 issuers.
- A cost of approximately $47.69 for an issuer to submit a response for each of the plan variations.
- Four submissions per issuer, for a total cost for the 1,200 issuers of $228,912.

f. Plans eligible for advance payments of the premium tax credit and cost-sharing reduction (§156.440)

CMS proposes that the provisions of subpart E apply to QHPs offered in the individual market in the Exchange. They do not apply to catastrophic plans described in §156.155 (to conform with previous definitions and policies) and the provisions for cost-sharing reductions do not apply to stand-alone dental plans, as that would entail significant operational complexities. The provisions related to advance payment of premium tax credits do apply to stand-alone dental plans. The provisions apply to child-only plans.

g. Reduction of an Enrollee's Share of Premium to Account for Advance Payments of the Premium Tax Credit (§156.460)

CMS proposes that a QHP issuer that receives notice from the Exchange of an individual's eligibility for an advance payment premium tax credit must:

- Reduce the portion of the premium charged the individual for the applicable months by the amount of the advance payment premium tax credit;
- Notify the Exchange of the reduction as part of its standard acknowledgment (that information will in turn be submitted to the Secretary via enrollment information); and
- Include in each billing statement the amount of the advance payment of the premium tax credit for the applicable month and the remaining premium owed.

CMS proposes that an issuer may not refuse to commence coverage or terminate coverage on account of any delay in the advance payment of a premium tax credit if the issuer has been notified by an Exchange that it will receive such a payment. CMS expects that advance payments will be paid in the middle of the month. **CMS welcomes comments on these proposals.**

Information Collection Requirements

CMS, in its review of Information Collection Requirements in the proposed rule, sets out the following estimates for new §156.460, reduction of an enrollee's share of premium to account for advance payment of the premium tax credit. It estimates:

- A total of 1,200 issuers.
- An incremental cost of $3.30 for each issuer to notify the Exchange (as part of standard enrollment acknowledgment).
- A total cost for the 1,200 issuers of $3,849.

h. Allocation of Rates and Claims Costs for Advance Payments of Cost-Sharing Reductions and the Premium Tax Credit (§156.470)

CMS proposes that issuers provide to the Exchange annually for approval for each metal level health plan and stand-alone dental plan, an allocation of the rate and expected allowed claims costs for the plan, in each case to: EHB (other than abortion services for which federal funding is precluded) and to any other services or benefits offered by the health plan. In the case of a stand-alone dental plan, the issuer must report the allocation to the pediatric dental EHB for an individual under the age of 19 and to any other benefits that are not the pediatric dental EHB.

The allocation must be performed by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles, meet other technical standards, be calculated across all enrollees in all plans in the relevant risk pool and not across a standardized population or plan-specific population, and be accompanied by an actuarial memorandum with a detailed description of the methods and specific bases used to perform the calculations.

CMS notes that these proposals allow for the removal of additional, non-EHB benefits from the calculation of advance payments of the premium tax credit, and seeks comments on the proposal.

Information Collection Requirements

CMS, in its review of Information Collection Requirements in the proposed rule, sets out the following estimates for new §156.470, allocation of rates and claims costs for advance payments of the premium tax credit and cost-sharing reductions. It estimates:

- No burden on the issuers that submit their rates through the Effective Rate Review Program.
- An estimated cost of about $230 for each of an estimated 20 stand-alone dental plans, for a total cost of $4,585.

i. Special Cost-Sharing Reduction Rules for Indians

General: CMS reviews in detail a number of provisions throughout subpart E implementing section 1402 of the ACA, which governs cost-sharing for Indians.

Section 1402(d)(2) directs a QHP issuer to treat an Indian with household income of not more than 300 percent of the FPL as an "eligible insured" and to eliminate all cost-sharing. CMS

interprets this definition to include only months in which the individual is eligible for premium tax credits in the Exchange.

Section 1402(d)(2) prohibits cost-sharing under a QHP for items and services provided directly by the IHS, an Indian Tribe, Tribal Organization, Urban Indian Organization or through referral under contract for health services. CMS notes that that section does not direct the issuer to treat the Indian as an "eligible insured," and interprets this to mean that the limited cost-sharing reductions for designated providers are not limited to Indians eligible for a premium tax credit. CMS welcomes comments on this interpretation. CMS also interprets this section to apply only to the individual market inside the Exchanges, and **welcomes comment.**

Section 1402(d)(2)(B) of the ACA states that QHP issuers are not to reduce payments to the relevant facility or provider by the amount of any cost-sharing that would be due from an Indian but for the prohibition on cost-sharing. CMS proposes not to codify this provision as it is clear and self-enforcing, and because CMS believes it is impermissible for an issuer to reduce payments for any provider for any cost-sharing reductions required under the ACA, particularly because these cost-sharing reductions are to be reimbursed by HHS.

Proposed provisions of part 156 related to Indians

CMS proposes, as noted in earlier sections of this summary, to use the concept of plan variations proposed for cost-sharing reductions for non-Indians to describe how Indians would pay none, or a portion, of the cost-sharing required under a plan, with the Federal government bearing the remainder of the cost-sharing burden.

CMS proposes in the definitions and eligibility proposals the previously described "zero cost sharing plan variation" of the expected QHP for those Indians with income at or below 300 percent of the FPL, and the previously described "limited cost-sharing plan variation" for all Indians for items and services provided by the IHS and other designated providers.

CMS notes that, rather than requiring QHP issuers to assign Indians to zero and limited cost-sharing variations (as is proposed in this NPRM), CMS considered an alternative under which QHP issuers assign Indians to the standard plan (or silver plan variation, if appropriate) and waive the cost-sharing requirements as appropriate. CMS notes that this would allow an Indian and non-Indian in a family to enroll in the same plan, and for each to receive the cost-sharing reductions to which they are individually entitled. Because of technical constraints, CMS believes this alternative approach would be nearly impossible for many issuers for benefit year 2014. **However, CMS seeks comment on which approach it should adopt beginning January 1, 2016.**

CMS reviews other policies proposed in part 156 and previously described in this summary and their applicability to QHPs serving Indians.

CMS sets out a formula for computing the monthly advance payment for cost-sharing reductions for the zero cost-sharing plan variation in a manner similar to that noted above for the silver plan variations.

Monthly PMPM advance payment =

Monthly expected allowed claims for the standard plan QHP in which the Indian is enrolled (Bronze, Silver, Gold, or Platinum),
multiplied by
An induced utilization factor for the increased use at a higher AV with no cost-sharing (see table below)
multiplied by
The difference between the zero cost-sharing plan AV and the standard plan AV.

The induced utilization factors proposed by HHS are as follows, as presented in Table 17 in the proposed rule.

From Table 17: Proposed Induced Utilization Factors for Computing Cost-Sharing Reduction Advance Payments for Indians	
Zero Cost Sharing Plan Variation	**Induced utilization factor**
Zero cost-sharing variation of Bronze QHP	1.15
Zero cost-sharing variation of Silver QHP	1.12
Zero cost-sharing variation of Gold QHP	1.07
Zero cost-sharing variation of Platinum QHP	1.00

CMS, as noted in the summary of §156.430, does not propose a standardized methodology for 2014 for advance payment for QHPs for limited cost-sharing plans variations for the benefit year. QHPs have the option to forego the advance payment (and still receive reimbursement for cost-sharing subsidies in the reconciliation process) or to submit, for 2014, a reasonable estimate developed by a member of the American Academy of Actuaries.

CMS welcomes comment on these approaches.

Regulatory Impact Analysis

CMS includes in its regulatory impact analysis a review of the impact of the proposals related to advance payments of the premium tax credit and cost-sharing reductions. CMS expects that the proposed provisions will not alter CBO's March 2012 baseline budget estimates of the budget impact of the two programs, as the proposals are well within the parameters of the modeling for the ACA. CMS notes that CBO estimated that there will be approximately 20 million individuals in Exchange coverage by 2016, including approximately 16 million Exchange enrollees receiving subsidies.

CMS anticipates that the provisions will result in transfers from the general fund of the treasury to people receiving cost-sharing reductions and advance payments of the premium tax credit. In table 19 in the proposed rule, it estimates that the annualized value of those transfers over the 2013-2017 period, in 2013 dollars, of $6.5 to $6.8 billion.

F. Provisions on User Fees for a Federally-facilitated Exchange (FFE) (§156.50)

CMS reviews the ACA provisions for assessments or user fees to finance the activities of an Exchange in 2015 and subsequent years, along with existing federal policies regarding imposition of user fees.

CMS proposes in §156.50(b) to require a participating issuer to make payments for user fees or other payments charges, or fees, if assessed by the state Exchanges.

CMS proposes in §156.50(c) that participating issuers operating through a federally-facilitated Exchange (FFE) must remit a user fee to HHS each month, equal to the product of the number of billable members enrolled through the Exchange and the monthly user fee established by HHS in the annual notice of benefit and payment parameters.

CMS reviews the benefits to issuers of participating in the FFE. CMS proposes for the 2014 benefit year a monthly user fee rate for the FFE equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan. CMS seeks to align this with rates charged by state-based Exchanges, and may adjust it in the final payment notice.

G. Distributed Data Collection for the HHS-Operated Risk Adjustment and Reinsurance Programs (Subpart H)

1. Background

The Premium Stabilization Rule specifies at §153.20 that a risk adjustment methodology (which is described in this newly proposed rule) must include a risk adjustment data collection approach. As discussed above, CMS has proposed a new §153.420(a) to establish that an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the state, or by HHS on behalf of the state. CMS is proposing to amend Part 153 by adding Subpart H, entitled "Distributed Data Collection for HHS-Operated Programs," in which it would clarify the data collection process that HHS would use when operating a risk adjustment or reinsurance program on behalf of a state.

CMS reiterates from the Premium Stabilization Rule's preamble that a distributed approach is one in which each issuer formats its own data in a manner consistent with the risk assessment database, and then passes risk scores to the entity responsible for assessing risk adjustment charges and payments. This approach will be used to collect data for the HHS-operated risk adjustment program and for the HHS-operated reinsurance program. The goal is to minimize issuer burden while protecting enrollees' privacy.

2. Issuer Data Collection and Submission Requirements

CMS notes that under the HHS-operated risk adjustment and reinsurance programs, HHS will use a distributed data collection approach to run software on enrollee-level and claims-level data

that reside on an issuer's dedicated data environment. Close technological coordination between issuers and HHS will be needed.

The following proposed requirements would all apply to issuers of a risk adjustment covered plan or a reinsurance-eligible plan where HHS operates the risk adjustment program or reinsurance program on behalf of a state.

Distributed data environment (§153.700). For each benefit year in which HHS operates the risk adjustment or reinsurance program on behalf of a state, an issuer of the plan in the state would have to establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS. Such issuer would be required to establish secure, dedicated, electronic server environments to house medical and pharmacy claims, encounter data and enrollment information. The issuer would send the data to HHS in HHS-specified electronic formats and provide HHS with access to the data environment to install, update, and operate common software and specific reference tables to enable it to execute risk adjustment and program operations. Additional details will be specified in the future.

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

An issuer would have to 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 (e.g., for benefit year 2014, implementation, including testing, will begin in March 2013, and continue through October 2013, in preparation for the commencement of risk adjustment and reinsurance program operations on January 1, 2014). HHS plans to schedule technical assistance training for issuers in 2013.

Data Requirements (§153.710). An issuer would have to 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. In addition, all claims data submitted by an issuer in the state would have to have resulted in payment by the insurer. The enrollee-level data would have to 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. (Additional specifications relate to reporting of encounters by capitated plans.) All data would have to be provided at the level of aggregation specified by HHS.[17]

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

Establishment and Usage of Masked Enrollee Identification Numbers (§153.720). An issuer would be required to establish a unique masked enrollee identification number for each enrollee, in accordance with certain HHS-defined requirements and maintain the same masked number for an enrollee across enrollments or plans within the issuer, within the state, during a benefit year. Such an issuer would be prohibited from including an enrollee's personally identifiable information in the masked enrollee identification number or use the same identification number for different enrollees enrolled with the issuer.

Deadline for Submission of Data (§155.730). An issuer would be required to 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.

CMS notes that states administering their own reinsurance program would have to notify issuers of reinsurance-eligible plans of their expected requests for reinsurance payments on a quarterly basis.

3. Risk Adjustment Data Requirements

CMS notes in the preamble that HHS's data collection approach is aligned with the HHS risk adjustment model and its calculation of payments and charges. Certain types of data will be acceptable for risk adjustment. The data collection period will encompass enrollment and services for the applicable benefit year. Institutional and medical claims and encounter data where the discharge data or "though date" of service occurs in the applicable benefit year will be allowed if: the types of claims,[18] providers and diagnoses are acceptable. Issuers would be responsible for correcting errors and problems identified by HHS in the distributed data environment.

4. Reinsurance Data Requirements

a. Data Collection Period

CMS notes in the preamble that HHS would use the same distributed data collection approach as used for risk adjustment; however, only data elements necessary for reinsurance claim selection would be considered for the purpose of determining a reinsurance payment. Criteria for acceptable data are specified and the collection period would be claims incurred in the benefit year beginning on or after January 1 of the applicable benefit year and paid before the applicable data submission deadline (provided all other criteria are met).

b. Acceptable Reinsurance Data

Data to identify eligible reinsurance paid claims would include medical and pharmacy claims. Claims that resulted in payment by the issuer as the final action and encounters priced in accordance with issuer pricing methodologies would be considered for payment. Replacement claims for the purposes of adjusting data elements submitted on prior claim submissions,

[18] The specific criteria for capturing a complete inpatient stay or single hospital admission will be provided in future guidance.

including, but not limited to changes in payment amounts, services rendered and diagnosis, would be accepted, but interim bills and late charges would not be accepted. The specific criteria for submitting complete data for inpatient stays and specific information related to the assessment and application of encounter claims for reinsurance calculations will be provided in future guidance.

c. Reinsurance Processing and Reporting

CMS notes in the preamble HHS' plans to provide each issuer with a periodic report on data functions performed in each issuer's distributed data environment, including the identification of reinsurance eligible claims by state. The reports would indicate whether HHS accepted or rejected submitted files and data, and errors detected by HHS. Issuers would be required to provide corrected files and data to address the identified errors. Timeframes for the processing and reporting of these reports, including receipt of corrected files or discrepancy resolution, will be provided in future guidance.

Information Collection Requirements for Reinsurance and Risk Adjustment

CMS estimates that fewer than 9 states will choose to operate their own risk adjustment and/or reinsurance programs. Collections from fewer than 10 persons are exempt from the PRA; thus CMS does not plan to seek OMB approval for the related collections that it identifies. However, in the event that, by the time of the final Payment Notice, CMS believes that the number of states will be greater than 9, a PRA approval will be sought based on the burden estimates outlined in the Collection of Information Requirement section of the NPRM.

CMS estimates the aggregate costs for an estimated 2,000 contributing entities (issuers, self-insured group health plans or their TPAs) of calculating covered lives for purpose of the reinsurance contributions to be $110,000.

CMS estimates that the cost to each of the estimated 1,800 issuers of submitting risk adjustment and reinsurance data will be about $327,600 in total labor and capital costs (including the average cost of $15,000 for a data processing server) during the start-up year. This cost will be lower in future years when fixed costs decrease. Therefore, CMS estimates an aggregate burden of $589,680,000 for all issuers as a result of these requirements.

CMS estimates that the cost to each of 1,800 issuers to meet the data validation requirements when HHS operates risk adjustment will be about $45,000, with the burden overall costing $81 million.

Regulatory Impact Analysis for Risk Adjustment and Reinsurance

The impact analysis for the premium stabilization programs references estimates from CBO and CMS. It concludes that the provisions of this proposed rule will not significantly alter CBO's estimates of the budget impact of these ACA risk mitigation programs.

CMS has updated estimates for the reinsurance and risk adjustment programs to reflect the five-year period from fiscal years (FYs) 2013 through 2017. Table 20, reproduced below, includes the CBO estimates for outlays and receipts for the reinsurance and risk adjustment programs from FYs 2013 through 2017. Unlike the current policy, however, CBO assumed risk adjustment payments and charges would begin to be made in 2014, when in fact they will begin in 2015. Also, CBO's estimates do not reflect the $5 billion in reinsurance contributions that are submitted to the U.S. Treasury. No outlays and receipts for reinsurance and risk adjustment occur in 2013 because the provisions do not take effect until 2014.

Estimated Federal Government Outlays and Receipts for the Reinsurance and Risk Adjustment Programs from 2013-2017, in billions of dollars						
Year	**2013**	**2014**	**2015**	**2016**	**2017**	**2013-2017**
Reinsurance and risk adjustment program payments	--	11	18	18	18	65
Reinsurance and risk adjustment program receipts*	--	12	16	18	18	64
*Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time. Source: Congressional Budget Office. 2011. *Letter to Hon. Nancy Pelosi.* March 20, 2010. Table 20, 77 FR 73196						

CMS further notes that risk adjustment, which transfers dollars from health plans with lower-risk enrollees to health plans with higher-risk enrollees, will result in a total of $27 billion being transferred between issuers. From 2014 through 2017, an estimated $45 billion will be transferred between issuers.

CMS anticipates that the cost of reinsurance contributions will be roughly equal to one percent of premiums in the total market in 2014, less in 2015 and 2016 (and ends in 2017)). It is anticipated that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent.

H. Small Business Health Options Program

CMS proposes rules with respect to operations of the federally-facilitated Small Business Health Options Program (FF-SHOP) and also proposes to expand on rules previously adopted for the SHOP. Those rules were included in the final Exchange establishment rule published in the *Federal Register* on March 27, 2012 (77 FR 18310).

1. Employee Choice in the FF-SHOP

Under the previously adopted rules, the SHOP must allow an employer to select a level of coverage—bronze, silver, gold or platinum – and then provide for employee choice of QHPs within that level. A SHOP may provide for another method that allows employers to make one or more QHPs available to employees.

CMS proposes that a FF-SHOP would only permit the employer to select a level of coverage, but **seeks comments on two other possible options for employer and employee choice**. Under the first, employees could choose any plan within the metal level selected by the employer with the option to "buy up" to any QHPs in the next higher level of coverage that the issuer agrees to make available for this purpose. Describing earlier comments received on this issue, CMS notes both support for allowing employee choice across metal levels of coverage and concerns about the risk segmentation that might occur. The "buy up" alternative for which comments are sought is intended to offer a broader range of choice while allowing issuers to decide whether to make such coverage available.

The second option for which comments are sought is described as a "transitional policy" that would allow or direct employers in a FF-SHOP to make available a single QHP available to employees rather than all QHPs in a metal group. CMS presents this option in the context of the need, especially in the early years of implementation, to balance goals of employer and employee choice with concerns about risk selection, achieving broad participation of issuers and plan designs, and effective competition in the small group market.

2. Methods for Employer Contributions in the FF-SHOP

In order for employees choosing coverage in the SHOP to know the net cost of each QHP to them after the employer contribution, the employer will need to choose a contribution level prior to the employee QHP selection process. CMS proposes that a SHOP may establish one or more standard methods for employers to use in defining their contribution toward employee and dependent coverage.

With respect to the FF-SHOP, CMS proposes to apply methods established in section III.G of IRS Notice 2010-82 pertaining to the small business premium tax credit as the initial methods available to employers in determining contribution amounts. These methods are referred to as "safe harbor" methods providing meaningful employer choice and conforming to federal law. Under the proposed methods, the employer would choose a reference plan from among the QHPs offered in the level of coverage the employer is making available to its employees. The employer would then choose a percentage contribution toward employee-only premiums under the reference plan, and if dependent coverage is offered, a percentage contribution toward dependent coverage under the reference plan. The employer would be able to choose different percentages for different employee categories to the extent permitted under federal and state law. State law or the employer could require that the FF-SHOP base contributions on a calculated composite reference plan premium for employees, adult dependents and dependents under age 21. The amounts calculated using the reference plan and contribution percentages then become the employer contribution applied to the QHPs available to an employee.

As described in the preamble discussion, under this method employers could, except where prohibited under state law, vary contributions by employee age (or other permissible rating factor). Where state laws permit, employers would be asked whether they want each employee to contribute the same amount toward the reference plan premium, or whether they want the employee contribution to vary by age within the allowed (3 to 1) limits. CMS notes that with

respect to tobacco use, the adjustment would always be applied as a surcharge to the employee premium.

In a case where the employer chooses to vary employee contributions by age, the employer contribution would be fixed and unaffected by employee decisions about participation. If however, an employer chooses to provide that each employee pay a fixed amount (and the employer contribution vary by age) the composite premium for the reference plan and the employer contribution would change based on which employees participate. In that case, once employee choices were made the composite premium for the reference plan would be recalculated and the employer and employees notified of any changes. CMS also notes that the proposed safe harbor approach for a FF-SHOP includes rating methods that are part of the IRS Notice including "list billing", "composite billing" and "employer-computer composite rate." IRS Notice 2010-82 is available at http://www.irs.gov/irb/2010-51_IRB/ar09.html#d0e533

3. Linking Issuer Participation in an FFE to Participation in an FF-SHOP

Noting that a state operated SHOP has more choices to ensure a choice of QHPs and issuers, CMS proposes requirements for certification of a QHP by the FFE linked to offering of coverage through the FF-SHOP. Specifically, under the proposed rule an FFE could certify a QHP for participation only if: 1) the QHP issuer offers through the FF-SHOP at least one small group QHP each at the silver and gold levels of coverage, or 2) the QHP issuer does not offer any small group plans in the state, but another issuer in the same issuer group offers at least one silver and one gold plan through the FF-SHOP, or 3) neither the issuer or any issuer in the same issuer group offers small group coverage in the state. An issuer group would be defined to include issuers affiliated by common ownership and control and those affiliated by the common use of a nationally licensed service mark. **CMS seeks comments on whether the proposed policy meets three intended goals: enhancing employer and employee choice, assuring similar effects on single issuers and issuer groups and not requiring any issuer not already offering coverage in the small group coverage to begin to do so.**

4. Broker Compensation for Coverage Sold Through an FFE or FF-SHOP

QHP certification for the FFE and FF-SHOP would be conditioned on the QHP issuer paying similar broker compensation in the FFE and FF-SHOP to that paid for similar health plans outside the FFE and FF-SHOP. **CMS specifically seeks comments on whether "similar health plans" is a sufficient standard and if not, what factors should be considered in developing a standard. In addition, comments are sought on how the standard might apply when commissions are calculated on a basis other than an amount per employee/covered life or a percentage of premium.**

5. Minimum Participation Rate in the FF-SHOP

Under previously adopted rules, a SHOP may establish a uniform minimum participation rate for employee participation across QHPs offered in the SHOP, and in this rule, CMS proposes a minimum participation rate for the FF-SHOP of 70 percent. The rate would be calculated as the number of qualified employees accepting coverage in the employer's group health plan divided

by the number of qualified employees offered coverage, excluding employees covered by a group health plan offered by another employer or a government program such as Medicare, Medicaid or TRICARE

This proposal reflects CMS' view that risk selection based on employee participation decisions is likely without a minimum participation rate. CMS notes that the ability of a SHOP to adopt a minimum participation rates is dependent on adoption of the proposal (at §147.104) in the Health Insurance Market Rule published in the *Federal Register* on November 26, 2012 that conditions employer eligibility for year-round open enrollment in the SHOP on meeting any minimum participation rate established by the SHOP.

Under the proposal, the FF-SHOP could adopt a different uniform percentage for a state where the rate is set by state law, or a higher or lower rate is customarily used by the majority of QHP issuers in the state for products in the state's small group market outside the SHOP.

6. Determining Employer Size for Purposes of SHOP Participation

CMS proposes to amend the definitions of small employer and large employer previously adopted to specify the method for determining employer size using the definitions adopted for the employer shared responsibility requirements. Specifically, the definitions would be amended to say that the number of employees shall be determined using the full-time equivalent method set forth in section 4980H (c)(2)(E) of the [Internal Revenue] Code, effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which the method shall be used for plan years beginning on or after October 1, 2013. The specified full-time equivalent method states that an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

CMS believes this proposal would provide greater clarity and simplicity for employers and states seeking to reconcile state methods of determining group size with federal methods for operating Exchanges and determining employer eligibility for the SHOP.

Under the previously adopted definitions, a small employer is one who, in connection with a group health plan with respect to a calendar year and a plan year, 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." A large employer means one who employs 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."

7. Definition of a Full-Time Employee for Purposes of Exchanges and SHOPs

CMS notes that the ACA defines a qualified employer as one that elects to make all full-time employees eligible for QHPs in the small group market through an Exchange, it does not define a full-time employee for this purpose. In this rule, CMS proposes to cross reference section 4980(H)(c)(4) of the Internal Revenue Code which defines a full-time employee with respect to a month generally as one who is employed an average of 30 hours of service per week. (Additional rules apply, including those with respect to employees who are not compensated on an hourly basis.) This definition would be effective for plan years beginning on or after January 1, 2016 except for the operations of an FF-SHOP, for which it would be effective for plan years beginning on or after October 1, 2013.

8. Transitional Policies

With respect to the proposed definitions of small employer and full-time employee discussed above, CMS recognizes that states employ definitions and methods of counting employees that differ from those proposed, and that the ACA gives states discretion in defining the small group market in 2014 and 2015. Therefore, while CMS proposes to use the definitions for the FF-SHOP effective October 1, 2013, they would be effective on January 1, 2016 for purposes of Exchange and SHOP administration. No enforcement action would be taken by HHS against a state-operated SHOP for including a small employer based on a state definition if the group would have been a large employer under the federal definition, and during 2014 and 2015 an employer and a state-operated SHOP may adopt a reasonable basis for determining whether coverage has been offered to all full-time employees.

CMS notes that because the FF-SHOP would use the proposed federal definitions including full-time equivalent employees, there may be a few employers who could purchase small group coverage outside the FF-SHOP under state definitions yet be ineligible for the FF-SHOP.

9. Web site Disclosures Relating to Agents and Brokers

Previously adopted rules allowing Exchanges to elect to provide for website disclosure of information regarding licensed agents and brokers would be modified to allow an Exchange or SHOP to limit the display to include only those agents and brokers who have completed an Exchange or SHOP registration or training process. FFEs and FF-SHOPs would limit disclosure to agents and brokers who have completed registration and training. CMS believes that listing only those brokers that have registered with the Exchange is in the best interest of consumers, because the registration and training would help ensure that the agent or broker is familiar with Exchange policies and application procedures. In addition, it would avoid the website listing large numbers of inactive agents and brokers.

10. QHP Issuer Standards Specific to SHOP

CMS proposes to modify the standards at §156.285 to require that QHP issuers participating in a SHOP must enroll qualified employees if they are eligible for coverage. This proposed change is intended to align SHOP enrollment standards with those for the Exchange.

11. Information Collection Requirements, Regulatory Impact Analysis and Other Requirements

The proposed rule linking issuer Participation in an FFE to Participation in an FF-SHOP could require issuers to prepare a QHP certification application for a SHOP for at least one silver and one gold level plan. CMS published a Notice for Initial Plan Data Collection in the *Federal Register* on November 21, 2012 (77 FR 69846) requesting comment on proposed paperwork collections for this purpose. Comments are due to OMB no later than December 21, 2012. CMS notes that QHP issuers may face additional user fees for participating in the SHOP; these costs are not estimated.

The regulatory impact analysis estimates that the proposed requirement for a 70 percent uniform minimum participation rate for the FF-SHOP, with exceptions based on state law and issuer practices, would not change market dynamics or place any additional costs on employers or issuers.

Under the Regulatory Flexibility Act, CMS provides an analysis of the potential effect of the proposed rule on small entities. CMS does not believe the proposed rules impose requirements on employers offering coverage through the SHOP that are more restrictive than current requirements on employers offering employer-sponsored health insurance coverage.

I. Medical Loss Ratio Requirements

Under the Medical Loss Ratio (MLR) requirements, issuers must rebate a portion of premiums for a year if their MLR does not meet the minimum standard for that year. The MLR is calculated as claims plus quality improvement activities divided by premium revenue. Revenue is adjusted for taxes, regulatory fees and the premium stabilization programs.

CMS proposes to modify and correct MLR regulations that were adopted in a final rule with comment period published in the *Federal Register* on December 7, 2011 (76 FR 76574). The proposed changes would modify the MLR calculations to take into account payments to and receipts from the premium stabilization programs, change the reporting and rebate deadlines beginning with 2014, and limit the deduction from premium for community benefit expenditures. In addition, errors in previously adopted regulations are corrected.

Treatment of Premium Stabilization Payments

CMS proposes to modify the definitions used in calculating the MLR beginning with the 2014 MLR reporting year to take into account premium stabilization payments. Specifically, premium stabilization amounts would be considered as part of total premium revenue reported to the Secretary, but removed from the adjusted earned premium so that they do not have a net impact on the calculation of the MLR denominator and rebate amounts. The premium stabilization amounts would also be an adjustment to incurred claims in calculating the MLR numerator. CMS believes this approach 1) addresses stakeholder concerns that netting the premium stabilization amounts directly against the adjusted earned premium would have a differential

effect on issuers depending on whether the net premium stabilization obligation was a payment or a receipt, and 2) is consistent with the treatment of reinsurance and risk adjustment amounts in risk corridor calculations. CMS believes the statutory requirement that premium revenue "account for" collections or receipts from the premium stabilization program provides flexibility for this approach. **Comments are invited on this proposal and an alternative which would instead net premium stabilization payments or receipts against revenue.**

Taking into account the proposed changes, the MLR formula would be modified to read as follows:

Adjusted MLR = [(i + q + n – r) / {(p + n – r) – t – f – n + r}] + c

Where,

i = incurred claims

q = expenditures on quality improving activities

p = earned premiums

t = Federal and State taxes

f = licensing and regulatory fees

n = reinsurance, risk corridors, and risk adjustment payments made by issuer

r = issuer's reinsurance, risk corridors, and risk adjustment related receipts

c = credibility adjustment, if any.

Rebates for a company whose adjusted MLR value for a market in a State falls below the minimum standard would be calculated using the following formula, reflecting proposed changes:

Rebates = (m – a) * [(p + n – r) – t – f – n + r]

Where,

m = the applicable minimum MLR standard for a particular State and market

a = issuer's adjusted MLR for a particular State and market.

Reporting deadlines

CMS proposes to change the deadlines for MLR reporting and rebates in order to conform to the premium stabilization program reporting cycles. Amounts associated with the premium

stabilization programs would not be known until after the current June 1 MLR reporting deadline. Therefore, CMS proposes, that beginning with the 2014 MLR reporting year, the deadline for MLR reporting to the Secretary would be changed from June 1 to July 31, and the rebate due date would be moved from August 1 to September 30. Rebates would apply to the first month's premium that is due on or after September 30 following the MLR reporting year. CMS notes that, as discussed earlier in this rule, it must provide issuers with any reconciliation of their risk corridor calculations by August 31, but it believes there will be few changes to the risk corridor calculations submitted to issuers by July 31. Giving issuers one month from the reconciliation to disburse any rebates owed is sufficient time, in CMS' view.

Deduction of Community Benefits

CMS proposes to make changes with respect to the treatment of community benefit payments made by tax exempt issuers in the MLR calculation. First, an issuer exempt from federal taxes could deduct both State premium taxes and community benefit expenditures from earned premium in the MLR calculation. In proposing this change, CMS agrees with commenters that community benefit expenditures are a requirement for maintaining federal tax exempt status and therefore should be treated in the same manner as the federal income tax payments made by for-profit issuers, which are deducted from earned premium. The previously adopted rules allow a deduction for community benefit expenditures in lieu of state premium taxes, but not federal income taxes. Second, the limit on community benefit expenditures would be modified to be either 3 percent of the issuer's earned premium or the highest premium tax rate charged in the state multiplied by the issuer's earned premium in the applicable state market, whichever is greater. The limit adopted in the 2011 final rule allows deduction of community benefit expenditures up to the state premium tax rate. In discussing this proposal, CMS reports that the 3 percent limit was suggested by commenters and would be sufficient to allow tax exempt issuers to maintain their current community benefit expenditures, which in the 2011 MLR data averaged 1.6 percent of premium among the not-for-profit issuers that reported any expenditure.

CMS also makes technical changes to correct several errors in previously adopted MLR rules and earlier corrections. These amend sections 158.140 and 158.232.

Information Collection Requirements

Prior to the deadline for issuer submission of the annual MLR report for the 2014 MLR reporting year, public comment would be solicited and OMB approval sought for an updated annual form that would include reporting of the premium stabilization payments and reflect the proposed changes in the deduction for community benefit expenditures for federal income tax-exempt issuers.

Regulatory Impact Analysis

The proposed adjustments in the MLR calculations would increase or decrease insurers' MLRs and could therefore also increase or decrease consumer rebates. CMS does not have data to estimate which issuers have high-risk enrollees and therefore would be expected to have positive net premium stabilization payments and higher MLRs under the proposed changes. CMS

estimates that, based on data from the 2011 MLR reporting year, 466 issuers offering coverage in the individual and small group markets to almost 80 million enrollees would be affected by the proposed changes. Reported rebate payments made in 2012 are shown in the table below. Again, no estimates are available on how rebates may be affected by the proposed changes in the MLR calculation. The administrative costs of reporting premium stabilization amounts in the MLR report as proposed are considered to be minimal.

MLR Rebates Made in 2012 (for 2011 MLR reporting year)			
Market	**Number of issuers**	**Total rebates (in millions)**	**Number of enrollees (in millions)**
Individual	54	$396	4 million
Small group	59	$289	3 million
Large group	47	$403	6 million

With respect to the proposed changes to deductibility of community benefit expenditures, CMS estimates that, based on data for the 2011 MLR reporting year, 132 issuers would be affected. Because community benefit expenditures are estimated to be below the current limit as well as the proposed limit, the proposed change is estimated to have minimal effect on MLRs and rebates.

IV. Collection of Information Requirements

A summary of the estimated fiscal year reporting recordkeeping and cost burdens is presented in Table 18 (77 FR 73194). For more on the implications of the Paperwork Reduction Act requirements for the major sections of the proposed rule, see the discussions of Collection of Information Requirements in each of the above summary sections.

V. Regulatory Impact Analysis (RIA)

OMB has determined that this Payment Notice is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any one year. Accordingly, CMS has prepared an RIA that presents the costs and benefits of this proposed rule. The major findings of the RIA are incorporated in the above summary for each of the major sections of the proposed rule.