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Overview of the March 1, 2013 Final Rules on Benefits and Payment Parameters, Multi-State Plan Program, and Risk Corridor Calculation

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Introduction

On March 1, 2013, the U.S. Department of Health and Human Services (HHS) released three sets of final rules:

- A final rule on the benefits and payment parameters for the risk adjustment, reinsurance and risk corridors programs; cost-sharing reductions (CSRs); user fees for the federal exchanges; advances premium tax credit payments (APTCs); the Small Business Health Options Program (SHOP); and the medical loss ratio (MLR) program. http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf
- A final rule on the multi-state plan program (MSPP). http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04954.pdf
- An interim final rule adjusting the final risk corridor calculation and offering qualified health plans an alternative methodology for calculating cost-sharing reductions. http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04904.pdf

This document provides a high-level summary of these rules and highlights key changes.

Final Rule: Risk Adjustment, Reinsurance, Risk Corridors, APTCS, SHOP, and MLR (Title 45 of the Code of Federal Regulations)

Overview

The Affordable Care Act (ACA) established three premium stabilization programs to mitigate adverse selection and evenly spread the financial risk. The transitional reinsurance program reduces the uncertainty of risk associated with higher-risk enrollees. The temporary risk corridors program limits the extent of an issuer's financial losses and gains, which protects against the uncertainty in rate setting. The permanent risk adjustment program provides increased payments to issuers that attract and enroll higher-risk enrollees (notably individuals with chronic conditions). The purpose of this final rule is to complete the framework associated with these premium stabilization programs, establish provisions that govern APTCs, and amend provisions related SHOP and MLR. This final rule adopts most of the methodologies in the proposed rule with only minor technical amendments.

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

For benefit year 2014 only, a state is required to publish its notice of benefit and payment parameters by Mach 1, 2013, or within 30 days of the publication of the final *HHS Notice of Benefit and Payment Parameters*. HHS finalized this provision as proposed.

B. Provisions and Parameters for the Permanent Risk Adjustment Program

1. Approval of State-Operated Risk Adjustment §153.100(c)

The Notice of Proposed Rule Making (NPRM) established §153.310(c) to describe "state responsibility for risk adjustment," establishing standards for states that choose to operate risk adjustment such that the state system performs in line with the federal risk adjustment methodology. These requirements go into effect in 2015. During 2014, a "consultative process" rather than federal approval of the state programs would be in place. So far, only Massachusetts has elected to operate its own risk adjustment program in 2014.[1] This will be a transitional policy which will not extend into 2015. Formal certification policies will begin in 2015. HHS is accepting this section of the rule as final, with no changes.

2. Risk Adjustment User Fees §153.610

The final rule adds §153.610(f), codifying the methodology for assessing user fees for the risk adjustment program, for states that allow the HHS to calculate and operate a risk Adjustment system, to be collected annually in July on the basis of per member monthly enrollment. The per-enrollee-per-month risk adjusted user fee will be $0.08 in 2014. The risk adjustment user fee is the sole purpose of funding HHS's costs for operating the federal risk adjustment program, and HHS intends to keep the user fee amount as low as possible. The user fee is based on total contract costs for risk adjustment operations in the applicable benefit year divided by the expected annual enrollment in risk adjustment covered plans for that benefit year. HHS is accepting this section of the rule as final, with no changes.

3. Risk Adjustment Methodology §153.20

The methodology HHS will use when operating the risk adjustment program is the same as in the proposed rule, with the exception of mostly technical adjustments. These include:

[1] http://healthaffairs.org/blog/2013/03/03/implementing-health-reform-the-benefit-and-payment-parameters-final-rule/

1. Excluding individuals over 64 in the demographic factors categorizing individuals because of data for estimating costs for 65 and older were not available in the data set used for constructing the risk adjustment factors.
2. Updating the CSR adjustment factors for zero cost-sharing plans. It is assumed that members joining Exchange plans with subsidies and zero cost sharing will use more services because of the absence of cost-sharing incentives.
3. Making technical corrections to the risk adjustment payment transfer formula. A typographical error in the NPRM miscalculated the average premium per plan, which should have been based on billable members (i.e., the number in a family on which a premium is based).
4. Clarifying that geographic cost factors will be calculated for each risk pool in each market (small group, individual, or catastrophic) in a state.
5. Clarifying how the risk adjustment payment transfers will be calculated at the plan level. The state average premium is multiplied by factors to develop the plan premium estimates used in the payment transfer formula. The factors are relative measures that compare how plans differ from the market average with respect to the cost factors (that is to say, the product of the adjustments is normalized to the market average product of the cost factors). The factors include: plan average risk score, actuarial value of the benefits and cost sharing structure of a particular plan, rating variation based on allowable age rating factors, geographic cost differences, and induced demand from lower cost sharing levels in more generous plans.

The risk adjustment system used criteria and methods from Medicare when appropriate, but also customized this methodology to best mitigate adverse selection based on projections of the 2014 marketplace. HHS anticipates making future adjustments to the model, seeking to balance stakeholders' desire for a stable model in the initial years with introducing model improvements as additional data become available. HHS will engage with stakeholders throughout this process.

4. State Alternate Methodology §153.310 -340

The premium stabilization rule established standards for states that establish their own risk adjustment programs. A state may establish a risk adjustment program if it elects to operate an Exchange and is approved to operate risk adjustment in the state. If a state does not meet the requirements to operate risk adjustment, HHS will carry out all functions of risk adjustment on behalf of the state. Federally certified methodologies must be used in the operation of the risk management program, and the process by which a methodology may become federally certified was also defined. It was proposed that these methodologies must be published in "the applicable annual" notice of benefit and payment parameters, and must be certified for use each year. HHS finalized these provisions as proposed.

State Alternate Risk Adjustment Methodology Evaluation Criteria

The elements required to be included with the request to HHS for certification of an alternate methodology are: (1) the risk adjustment model, (2) the calculation of plan average actuarial risk, (3) the calculation of payments and charges, (4) the risk adjustment data collection approach, and (5) the schedule for the risk adjustment program. The request should also include certain descriptive and explanatory information relating to the alternate methodology.

HHS proposed additional evaluation criteria to certify alternate risk adjustment methodologies in a new paragraph. Specifically, HHS stated that they should be evaluating 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.
- Use data that is complete, high in quality, and available at a timely fashion.
- Provides stable risk scores over time and across plans.
- Minimizes administrative costs.

The alternate methodologies are required 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. The provision also sets forth a number of minimum requirements for data collection under risk adjustment, including standards relating to data privacy and security. 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.

According to HHS, sharing risk across metal levels (i.e. bronze, silver, gold, and platinum plan levels of coverage) is a critical part of a risk adjustment methodology as new market reforms are implemented because of the need to mitigate adverse selection across metal levels, as well as within metal levels. The proposed HHS risk adjustment methodology transfers funds between plans across metal levels, and under this proposal, state alternate methodologies would do as well.

Under the proposed risk adjustment methodology, risk will be adjusted to catastrophic plans in their own risk pool. In other words, funds will be transferred between catastrophic plans, but not between catastrophic plans and metal plans. For a number of plans, such as student health plans and plans not subject to the market reform rules, HHS will not transfer payments under the HHS risk adjustment methodology. States should have the flexibility to submit a methodology that

transfers funds between these types of plans (either in their own risk pool or with the other metal levels).

HHS proposed to consider whether the elements of the alternate methodology align with each other. For example, the data collected through the data collection approach should align with the data required by the risk adjustment model to calculate individual risk scores. HHS finalized these provisions as proposed.

HHS noted that it will publish approved state alternate methodologies in the annual HHS notice of benefit and payment parameters.

Payment and Charges

HHS noted that they plan on establishing a national method for calculation of payments and charges. In the proposed rule, they expanded on this approach by designating areas of state flexibility within the general approach to payment transfers. HHS finalized these provisions as proposed.

5. Risk Adjustment Data Validation §153.630

Beginning in 2014, HHS proposed to 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. States are not required to adopt this HHS data validation methodology. HHS is finalizing these provisions as proposed.

Data Validation Process When HHS Operates Risk Adjustment

It was proposed that HHS would choose an adequate sample size of enrollees such that the estimated payment errors would be statistically sound and enrollee-level risk score distributions would reflect enrollee characteristics for each insurer. Additionally, the sample would cover applicable subpopulations for each issuer, such as enrollees with and without risk adjustment diagnoses. HHS anticipates providing more detailed information on the sampling methodology in future rulemaking and guidance, including sample sizes and expected tolerances and confidence intervals.

Individuals without risk adjustment diagnoses will be subject to audits of their demographic information as well as medical record reviews during both the initial and second valuation audits to determine whether any risk adjustment hierarchical condition categories should have been assigned that were not.

HHS anticipates revisiting this policy after the first year of the program to assess the utility of performing medical record reviews on enrollees with no Hierarchical Condition Categories. Over

time, HHS anticipates that issuers will utilize the front-end HHS-operated data submission processes to ensure they are providing all relevant risk adjustment diagnosis for enrollees as opposed to relying on back-end audit processes to reveal this information.

In §153.630(b), it was proposed that once the audit samples are selected by HHS, issuers would conduct independent audits of the risk adjustment data for their initial validation audit sample enrollees. In §153.630(b) (1), HHS proposed that issuers of risk adjustment covered plans engage one or more auditors to conduct these independent initial validation audits. Further, it was proposed that issuers ensure that the initial validation auditors are reasonably capable of performing the audit, the audit is completed, the auditor is free from conflicts of interest, and the auditor submits information regarding the initial validation audit to HHS in the manner and timeframe specified by HHS. HHS is finalizing these provisions as proposed.

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

HHS considered prospectively certifying entities prior to acting as validation auditors. This approach is utilized before performing audits on organizations collecting and reporting performance measures through HEDIS. HHS will monitor the performance of validation auditors to determine whether certifications of the auditors or additional safeguards are necessary in the future.

Second Validation Audit

It was proposed that HHS retain an independent second validation auditor to verify the accuracy of the findings of the initial validation audit using a sub-sample of the initial validation audit sample enrollees for review. Issuers would submit (or ensure their initial validation auditor submits) data validation information, as specified by HHS, from their initial validation audit for each enrollee included in the second validation audit subsample. HHS is finalizing these provisions as proposed.

Some HHS comments of note include:

- HHS does not have access to the underlying medical records necessary to perform a comparison of a plan's diagnosis reporting accuracy to the calibration data set for the risk adjustment models' diagnosis accuracy. HHS will consider performing similar analyses in future years, as more data becomes available.
- HHS anticipates applying any error rate determined by the second validation audit to the error rate calculated by the initial validation audit. This reconciled error rate will be extrapolated to an issuer's entire risk adjusted population, not just the subsample under §153.630(c).

- HHS also believes that limiting the review of the second validation audit to only that information made available during the initial validation will help to ensure the entire validation process is completed in a timely manner and will provide incentives for making all relevant information available to the initial validation auditor.

HHS would estimate risk score error rates based on the findings from the data validation process. HHS has plans to conduct further analysis to determine the most effective methodology for adjusting plan risk scores for calculating risk adjustment payment transfers. HHS is finalizing these provisions as proposed, and intends to consult with stakeholders on the details of the methodology for error rate calculation to inform future rulemaking.

Pursuant to §153.350(d), HHS or a state operating risk adjustment must provide an administrative process to appeal data validation findings. HHS proposed in §153.630(d) that issuers may appeal the findings of a second validation audit or the application of a risk score error rate to its risk adjustment payments and charges. HHS anticipates that appeals would be limited to instances in which the audit was not conducted in accordance with the second validation audit standards established by HHS. HHS is finalizing this provision as proposed.

Payment Adjustments

HHS proposed using a prospective approach when making payment adjustments based on findings from the data validation process. Specifically, an insurer's data validation error estimates from the prior year would be used to adjust the issuer's average risk score in the current transfer year. Additionally, because the credibility of the system is important, for the success of the program, it was proposed that HHS may also adjust payments and charges for issuers that do not comply with the initial or second validation audit standards set forth in §153.630(b) and (c). HHS is finalizing this provision as proposed and anticipates conducting stakeholder consultations prior to further rulemaking on data validation.

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

HHS proposed that issuers of risk adjustment covered plans adhere to the data validation process beginning with data for the 2014 benefit year. However, due to the complexity of the risk adjustment program and the data validation process, and the uncertainty in the market that will exist in 2014, there is a concern that adjusting payments and charges without first gathering information on the prevalence of error could lead to a costly and potentially ineffective audit program. Hence, it was proposed that the issuers conduct an initial validation audit, and that HHS conduct a second validation audit for benefit years 2014 and 2015, but the payments and charges would not be adjusted based on the validation findings during these first two years of the program. Although payments and charges would not be adjusted based on error estimates, other remedies, such as prosecution under the False Claims Act, may be applicable to issuers not in compliance with the risk adjustment program requirements.

HHS may study the extent to which errors at the auditor level contribute to risk score error rate findings during the initial validation audits. HHS does not anticipate that the report will identify providers, but it may identify issuers. HHS will issue further guidance and rulemaking on these matters.

Data Security and Transmission

It was proposed that issuers submit any risk adjustment data and source documentation specified by HHS for the initial and second validation audits, and any appeals, to HHS in the manner and timeframe established by HHS. HHS did not receive any comments on these provisions and is finalizing them as proposed.

6. State-Submitted Alternate Risk Adjustment Methodology

HHS received an alternate risk adjustment methodology from one state, Massachusetts. HHS is certifying this methodology as a federally certified methodology for use in Massachusetts. A detailed example has been provided in the report. More detailed information about this methodology can be obtained from Massachusetts upon request.

C. Provisions and Parameters for the Traditional Reinsurance Program

The ACA requires a traditional reinsurance program in each state to help stabilize premiums in the individual market in 2014-2016. This final rule establishes the standards for implementing the reinsurance program.

1. State Standards Related to the Reinsurance Program

State-Operated Reinsurance Programs, Generally §153.100, 153.210, 153.222

A state electing to operate reinsurance cannot, via state notice of benefit and payment parameters, modify the data collection frequency for issuers to receive reinsurance payments. If a state chooses to collect additional reinsurance contributions (or use additional funds from elsewhere) for purposes of making supplemental reinsurance payments, it must publish supplemental state reinsurance payment parameters in its state notice of benefit and payment parameters.HHS will collect reinsurance contributions from all states from health insurance issuers and self-insured group health plans. After collecting in the aggregate, HHS will disburse reinsurance payments based on the state's need for reinsurance payments. Additional contributions collected for administrative expenses must be collected by the state operating reinsurance. HHS finalized these provisions as proposed, with the following technical amendments:

- HHS clarifies that it is the state's responsibility to ensure each applicable reinsurance entity operates in a distinct geographic area with no overlap of jurisdiction with any other

applicable reinsurance entity. This responsibility applies regardless of whether the state contracts with or establishes such applicable reinsurance entity.

- Governmental entities may serve as applicable reinsurance entities.

HHS notes that a state should have the flexibility to collect the data it deems necessary and in the manner most appropriate for calculating reinsurance payments for issuers of non-grandfathered individual market plans in the state.

Reporting to HHS §153.210, 153.232, 153.240

States establishing the reinsurance program will be required to provide information on all requests for reinsurance payments received from all reinsurance-eligible plans to HHS. HHS requires this information for each quarter during the state's benefit year. The information will be used to provide issuers of reinsurance-eligible plans with quarterly updates of such request under the uniform payment parameters and any state supplemental payment parameters. These quarterly reports will be conducted by the state or by HHS (operating on the reinsurance program on a state's behalf). HHS finalized these provisions as proposed, with the following technical amendments

- A state is required to provide an issuer of a reinsurance-eligible plan the calculation of the total reinsurance payments requests under the national reinsurance payment parameters and any state supplemental reinsurance payment parameters. This must be done on a quarterly basis during the applicable benefit year in a "timeframe and manner" determined by HHS.

HHS anticipates issuing further guidance to states with regard to quarterly reporting on the amount of reinsurance requests submitted.

Additional State Collections §153.220

A state has the option of collecting more than the amounts based on the national contribution rate established by HHS for administrative expenses of the applicable reinsurance entity or for additional reinsurance payments. HHS finalized these provisions as proposed, with the following technical amendments:

- Deleting the requirement that a state notify HHS within 30 days after publication of the draft annual *HHS Notice of Benefit and Payment Parameters* for the applicable benefit year of any additional contribution rate. HHS deleted this requirement because these finalize that it will no longer collect additional contributions on behalf of a state and will therefore not need this information.

Some HHS comments of note include:

- HHS emphasizes that nothing in ACA §1341 or this final rule gives states the authority to collect any funds—whether under the national contribution rate or under the additional state contribution rate—from self-insured group health plans covered by ERISA.
- HHS does not interpret ACA §1341 to grant states additional authority to collect from contributing entities, such as the federal employees health benefit program (FEHB).
- Only a state operating reinsurance is permitted to collect additional administrative expenses.

State Collections §153.220

For states establishing a reinsurance program, HHS will collect all reinsurance contributions from all contributing entities for that state under the national contribution rate. A state has the option of collecting additional funds, not collected as additional reinsurance contributions, in order to make supplemental reinsurance payments under the state supplemental reinsurance payment parameters. Additional revenue sources can include funds from the state high-risk pools. HHS notes that all provisions are finalized as proposed.

High-Risk Pools §153.400

State high-risk pools are excluded from making reinsurance contributions and will not receive reinsurance payments. HHS clarifies that nothing in the Premium Stabilization Rule or this final rule prevents a state that establishes the reinsurance program from using state money designated for the state's high-risk pool towards the reinsurance program. A state may not use funds collected for the ACA reinsurance program for its high-risk pool. A state has the authority to designate its high-risk pool as an applicable reinsurance entity, providing that it meets all criteria.

HHS notes that a state has flexibility in deciding to maintain, phase-out, or eliminate their high-risk pools. It notes that because high-risk pools and the reinsurance program both target high-cost enrollees, high-risk pools can operate alongside reinsurance serving a distinct subset of the target population.

2. Contributing and Excluded Entities §153.20

This section identifies entities that are required to make reinsurance contribution payments (contributing entities), as well as the entities that are excluded from the reinsurance contribution. HHS modifies the definition of "contributing entity" to clarify that such entity is a health insurance issuer or a self-insured group health plan.

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

Exceptions

Major Medical Coverage §153.400

A contributing entity is required to make contributions for its health coverage except to the extent that such coverage is not "major medical coverage." HHS finalizes this provision as proposed. HHS notes that for the purposes of the reinsurance program only, it views major medical coverage as health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings (including inpatient, outpatient, and emergency room settings). Coverage limited in scope (stand-alone vision or dental) or extent (coverage that is not subject to §2711 of the PHS Act and its implementing regulations) would not be considered "major medical coverage." Technical amendments include:

- To the extent a plan or coverage applies to individuals with respect to which benefits under Title XVIII of the SSA (Medicare) are primary under the multi-state plan (MSP) rules, reinsurance contributions are not required on behalf of those enrollees under that plan or coverage.
- Modifying the exception to exclude from reinsurance contributions expatriate health coverage, as defined by the Secretary.
- Adding language to codify the Medicare coordination rule.
- Adding language to exclude self-insured group health plans or health insurance coverage this is limited to prescription drug benefits from reinsurance contributions.

Commercial Book of Business §153.400

Health insurance coverage that is not part of an issuer's "commercial book of business" is exempt from the reinsurance contribution requirement. HHS defines this term as to include large and small group health insurance policies and individual market health insurance policies. Products offered by an issuer under Medicare Part C or D are considered to be under the "governmental" book of business. Similarly, coverage offered to tribal members and their spouses and dependents as a result of their affiliation is excluded. However, plan or coverage offered by the federal government, a state government, or a tribe to employees (or retirees and dependents) because a current or former employment relationship would be part of a commercial book of business. HHS finalized this provision as proposed.

Policy Filed and Approved by a State §153.400)

Insurance coverage not filed or approved by the state is excluded from the reinsurance contribution requirement. HHS finalized this provision as proposed, with the following modification:

- Expatriate health coverage, as defined by the Secretary, is excluded from the reinsurance contribution requirement.

General Exclusions from Reinsurance Contribution Requirement

In addition to previously mentioned exceptions, HHS explicitly excludes the following plans and coverage from the reinsurance contribution requirement:

- *Excepted Benefits* – HHS reiterates that there is no change in policy with respect to plans or health insurance coverage that consist solely of excepted benefits (such as stand-alone dental or vision coverage, as defined by §2791(C) of the PHS Act.
- *Private Medicare, Medicaid, CHIP, State High-Risk Pools, and Basic Health Plans* – Private Medicare and Medicaid plans, Children's Health Insurance Programs (CHIP), federal and state high-risk pools, and basic health plans are excluded from the reinsurance contribution requirement.
- *Health Reimbursement Arrangements (HRAs) Integrated with a Group Health Plan* – HRAs integrated with a group health plan are excluded from the reinsurance contribution requirement. However, the reinsurance contribution requirement does apply to the group health plan.
- *Health Savings Accounts (HSAs)* – HSAs are excluded from the reinsurance contribution requirement. HHS doesn't believe an HSA is "major medical coverage" as it consists of a fixed amount of funds available for both medical and non-medical purposes. **High deductible health plans are not excluded** from the reinsurance contribution requirement, as HHS considers it major medical coverage.
- *Health Flexible Spending Arrangements (FSAs)* – HHS notes that because ACA §9005 limits the annual amount that may be contributed by an employee to a health FSA; it is not to be considered major medical coverage. Therefore, it is excluded from the reinsurance contribution requirement.
- *Employee Assistance Plans, Disease Management Programs, and Wellness Programs* – HHS excludes these services because they do not constitute major medical coverage.
- *Stop-loss and Indemnity Reinsurance Policies* – HHS believes such policies are not intended to be subject to the reinsurance program. Therefore, they are excluded.
- *Military Health Benefits* – Although provided by private insurers, TRICARE is not part of a commercial book of business due to the relationship between uniformed services and service members, compared with a traditional employer-employee relationship. Therefore, it is excluded from the reinsurance contribution requirement.
- *Tribal Coverage* – Tribal coverage is generally excluded from the reinsurance contribution requirement. HHS emphasizes that a plan or coverage offered by a Tribe or

its employees (or retirees or dependents) on account of a *current or former employment relationship* would be required to make reinsurance contribution.

3. National Contribution Rate §153.220

2014 Rate

HHS plans to publish, in the annual HHS notice of benefit and payment parameters, the national per capita reinsurance contribution rate for the upcoming benefit year. HHS created a table detailing the proportion of contributions under the national contribution rate (NCR) (below):

Proportion of Contributions under the NCR for Reinsurance Payments, Payments to the U.S. Treasury, and Administrative Expenses

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

HHS finalized these provisions as proposed and notes that further information on the tax status of reinsurance contributions pursuant to the ACA can be found at http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs.

Federal Administrative Fees

If a state operates reinsurance, HHS will retain $0.055 to offset the costs of contributions collection, and will allocate $0.055 towards administrative expenses for reinsurance payments. Total amounts allocated towards administrative expenses for reinsurance payments will be distributed to states operating reinsurance (or retained by HHS where it is operating on a state's behalf) in proportion to the state-by-state total requests for reinsurance payments made under the uniform payment parameters. HHS notes these provisions are finalized as proposed.

4. Calculation and Collection of Reinsurance Contributions §153.240, 153.400, 153.405

Calculation of Reinsurance Contribution Amount and Timeframe for Collections

HHS will collect and pay out reinsurance funds annually to mitigate (1) the costs of administering the reinsurance program and (2) the burden on contributing entities. The reinsurance contribution of a contributing entity will be calculated by multiplying (1) the average number of covered lives of reinsurance contribution enrollees during the benefit year for all the contributing entity's plans and coverage that must pay reinsurance contributions by (2) the national contribution rate for the applicable benefit year. A contributing entity is required to submit to HHS an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees not later than November 15 of benefit year 2014, 2015, and 2016 as applicable. Each contributing entity is required to make annual reinsurance contributions at the national contribution rate, and under any additional applicable state supplemental contribution rate (should a state choose to collect additional contributions for administrative expenses or supplemental reinsurance payments). HHS finalized these provisions as proposed, with the following technical corrections:

- Each contributing entity must make reinsurance contributions annually at the national contribution rate.
- Within 30 days of the state's annual enrollment count submission (or by December 15, whichever is later), HHS will notify each contributing entity of the reinsurance contribution amounts to be paid based the enrollment count.
- HHS deletes "average" to clarify that the reinsurance contributions are calculated by multiplying the number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all contributing entities by the national contribution rate.

Counting Methods for Health Insurance Issuers

HHS identified the following methods a health insurance issuer may use to assess the number of covered lives for determining the reinsurance contribution:

- Actual Count Method – An issuer may determine the number of lives covered under the plan for the plan year by calculating (1) the sum of the lives covered for each day of the plan year and (2) dividing that sum by the number of days in the plan year. Such issuer would add the total number of lives covered for each day of the first nine months of the benefit year and divide that total by the number of days in those nine months of the benefit year.
- Snapshot Count Method – An issuer may determine the number of lives by (1) adding the total number of lives covered on a certain data during the same corresponding month in each quarter, or an equal number of dates for each quarter, and (2) dividing the total by the number of dates on which a count was made. With regard to reinsurance

contributions, an issuer would add the totals of lives covered on a date during the same corresponding month in each of the first three quarters of the benefit year.

- Member Months Method or State Form Method – An issuer may determine the number of lives by using data from the NAIC supplemental health exhibit or similar data from other state forms. HHS notes that data from these forms may be out of date at the time of the annual enrollment count submission.

Counting Methods for Self-Insured Group Health Plans

A self-insured plan may use the "actual count" or "snapshot count" method that is previously described. In addition, such plan can use the "Annual Return/Report of Employee Benefit Plan" that is filed with the Department of Labor by using the data from the Form 5500 for the last applicable plan year.

Counting Methods for Plans with Self-Insured and Insured Options

A group health plan with both self-insured and insured options for a benefit year must use the "actual count" or "snapshot count" method for determining the number of covered lives of reinsurance contribution enrollees.

Aggregation of Self-Insured Group Health Plans and Health Insurance Plans

HHS requires that if a plan sponsor maintains two or more group health plans or health insurance plans that collectively provide major medical coverage for the same covered lives, which we refer to as "multiple plans" for purposes of the reinsurance program, then these multiple plans must be treated as single self-insured group health plan for purposes of calculating any reinsurance contribution amount. HHS defines plan sponsor as:

- The employer, in the case of a plan established or maintained by a single employer.
- The employee organization, in the case of a plan established or maintained by an employee organization.
- The joint board of trustees, in the case of a multiemployer plan.
- The committee, in the case of a multiple employer welfare arrangement.
- The cooperative or association that establishes or maintains a plan established or maintained by a rural electric cooperative or rural cooperative.
- The trustee, in the case of a plan established or maintained by a voluntary employees' beneficiary association (which means that the association is not merely serving as a funding vehicle for a plan that is established or maintained by an employer or other person.

- In the case of a plan, the plan sponsor of which is not previously described, the person identified or designated by the terms of the document under which the plan is operated as the plan sponsor.
- Moreover, each employer or employee organization that maintains the plan (with regard to employees of that employer or employee organization), and each board of trustees, cooperative or association that maintains the plan.

HHS notes two exceptions to the aggregation rule:

- Any group health plan that consists solely of excepted benefits (such as stand-alone dental or vision benefits).
- Benefits related to prescription drug coverage.

Treatment of Multiple Plans

For multiple plans in which at least one of the plans is an insured plan, the plan sponsor must use one of the methods applicable to health insurance plans or self-insured group health plans.

Multiple Group Health Plans Including an Insured Plan

HHS prohibits the use of the "Form 5500 Method" to count covered lives across multiple self-insured plans because that method would not easily permit aggregate counting, since the identifies of the covered lives are not available on that form. Such plans must report to HHS: (1) the average number of covered lives calculated; (2) the counting method used; and (3) the names of the multiple plans being treated as a single group health plan as determined by the plan sponsor.HHS is finalizing all provisions as proposed, with only the following technical amendments:

- Previously mentioned adjustments to the aggregation rule.
- Providing plan sponsors with the option to count any coverage options within a single group health plan separately if the coverage options are treated as offering major medical coverage.
- Providing plan sponsors with the option not to aggregate group health plans for purposes of counting covered lives if each group health plan is treated as offering major medical coverage.
- Including HRAs, HSAs, and FSAs in the categories of group health plans that are excluded from the counting rules.

State Use of Contributions Attributed to Administrative Expenses

- HHS intends to apply the prohibitions of the reinsurance program that prevents an Exchange from using funds intended for administrative and operational expenses of the Exchange for such purposes as staff retreats, promotional giveaways, and excessive executive compensation.
- HHS intends to propose that reinsurance funds intended for administrative expenses may not be used for any expense not necessary to the operation or administration of the reinsurance program.
- HHS intends to propose that an applicable reinsurance entity must allocate any share, indirect, or overheard costs between reinsurance-related and other state expenses based on generally accepted accounting principles, consistently applied.
- HHS intends to issue further guidance that will include these proposed rules.

5. Eligibility for Reinsurance Payments §153.234

- HHS notes that a reinsurance-eligible plan's covered claims costs for an enrollee incurred prior to the application of 2014 market reform rules will not count toward either the uniform or state supplemental attachment points, reinsurance caps, or coinsurance. As a result, such claims would not be eligible for reinsurance payments.
- HHS will operate the reinsurance program on a calendar year basis. It believes this method is most feasible from policy and administrative standpoints.

6. Reinsurance Payment Parameters §153.230

Uniform reinsurance payment parameters apply to the reinsurance program for each state, regardless of whether it is operated by the state. HHS proposed the 2014 uniform reinsurance payment parameters be established at (a) an attachment point of $60,000, when reinsurance payments would begin, (b) a national reinsurance cap of $250,000, when the reinsurance program stops paying claims for a high-cost individual, and (c) a uniform coinsurance rate of 80 percent, which is the reimbursement percentage applied to the issuer's aggregated paid claims amounts on behalf of an enrollee while giving issuers an incentive to contain costs between the attachment point and reinsurance cap. HHS finalizes the provisions as proposed, with the following technical revisions:

- Changing "non-grandfathered individual market plan" to "reinsurance eligible plan."
- Clarifying that national reinsurance payments are calculated as the product of (1) the national coinsurance rate multiplied by (2) the health insurance issuer's claims costs for an individual enrollee's covered benefits that the health insurance issuer incurs in the applicable benefit year.

7. Uniform Adjustment to Reinsurance Payments §153.230

Reinsurance payments will be adjusted by a uniform, pro rata adjustment rate if HHS determines that the total requests for reinsurance payments under the reinsurance payment parameters will exceed the reinsurance contributions collected under the national contribution rate during a given benefit year. HHS finalized this provision as proposed.

8. Supplemental State Reinsurance Contributions §153.220, 153.232

- A state establishing the reinsurance program may modify the uniform reinsurance payment parameters only by establishing states supplemental payment parameters that cover an issuer's claims costs beyond the uniform reinsurance payment parameters.
- HHS requires that reinsurance payments under state supplemental payments parameters be made only with the additional funds that the state collects for reinsurance payments or state funds applied to the reinsurance program.
- A state choosing to establish state supplemental reinsurance payment parameters must set those parameters through adjusting the uniform reinsurance payment parameters in one or more of the following ways: (1) decreasing the national attachment point, (2) increasing the national reinsurance cap, or (3) increasing the national coinsurance rate.

9. Allocation and Distribution of Reinsurance Contributions §153.220, 153.235

HHS will allocate and distribute the reinsurance contributions collected under the national contribution rate based on the need for reinsurance payments, regardless of where the contributions are collected. Even if a state establishes the reinsurance program, HHS will directly collect the reinsurance contributions for enrollees who reside in that state from both health insurance issuers and self-insured group health plans. HHS is finalizing these provisions as proposed, with the following revisions:

- HHS will allocate and disburse to each state operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of the state), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The disbursed funds would be based on the total requests for reinsurance payments made under the national reinsurance payment parameters in all states.
- An issuer of a reinsurance-eligible plan may make requests for reinsurance payments when an issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payments (42 CFR Part B and this final rule) and, where applicable, the state notice of benefit and payment parameters.

10. Reinsurance Data Collection Standards

Data Collection Standards for Reinsurance Payments §153.230, 153.240, 153.420

HHS requires states to ensure that their applicable reinsurance entities collect or provide access to the data necessary to determine reinsurance payments from an issuer of a reinsurance-eligible plan. HHS directs states to provide a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims in the normal course of business, such as a capitated plan, may request reinsurance payments or submit data to be considered for reinsurance payments based on estimated costs of encounters for the plan. States are required to ensure that such requests (or subset of such requests) are subject to, to the extent required by the state, a data validation program. This allows certain reinsurance-eligible plans, like 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. A capitated plan is required to use its principal internal methodology for pricing encounters for reinsurance purposes. HHS finalized these provisions as proposed.

Notification of Reinsurance Payments §153.240

A state, or HHS on behalf of the state, is required to notify issuers of the total amount of reinsurance payments that will be made no later than June 30 of the year following the applicable benefit year. A state is required to provide quarterly notifications of estimates to each reinsurance-eligible plan of the expected requests for reinsurance payments. HHS finalized these provisions as proposed and notes its intention to collaborate with issuers and states to develop these early notifications.

Privacy and Security Standards §153.240

A state establishing the reinsurance program is required to ensure that any 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. An applicable reinsurance entity is required to implement specific privacy and security standards to ensure enrollee privacy and to protect sensitive information. HHS finalized these provisions as proposed.

Data Collection §153.420

An issuer of a reinsurance-eligible plan seeking reinsurance payments is required to submit or make accessible data, in accordance with the reinsurance data collection approach established by the state, or HHS on behalf of the state. An issuer of a reinsurance-eligible plan must 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. This deadline applies to all issuers of

reinsurance-eligible plans, regardless of whether the state or HHS is operating reinsurance. HHS is finalized these provisions as proposed.

D. Provisions for the Temporary Risk Corridors Program

1. Definitions

HHS is finalizing the proposed definitions with the following modifications:

- HHS made a minor correction to the calculation or profits in the example illustrating the proposed operation of the risk corridors calculation. This was made in response to comments noting that the proposed rule states that the risk corridors profits calculation was based on after-tax premiums, but the example in the proposed rule calculated based on a pre-tax premium amount.
- Deleting §153.530(b)(1)(ii) to eliminate the adjustment to allowable costs for reinsurance contributions made by an issuer and clarifying the repayment of community benefit expenditures within the risk corridors calculation.
- Modifying the definition of taxes by replacing the term "taxes" with "taxes and regulatory fee."

2. Establishment and Payment Methodology

This section requires issuers to remit risk corridors charges to HHS within 30 days of notification of the charges, and the due date for qualified health plan (QHP) issuers to submit all information is July 31 of the year following the applicable benefit year. The applicable MLR reporting deadline is revised to align with this schedule. HHS is finalizing this provision as proposed. HHS is publishing another interim final rule to address the alignment of the risk corridors calculations with the single risk pool requirement.

3. Data Requirements

This section requires QHP issuers to submit data related to actual premium amounts collected, including premium amounts paid by parties other than the enrollee. HHS further specified that risk adjustment and reinsurance payments are regarded as after-the-fact adjustments to allowable costs for purposes of determining risk corridors amounts, and that allowable costs be reduced by the amount of any CSRs received from HHS. HHS received no comments on this section and is finalizing the provision as proposed.

4. Manner of Data Collection

This section notes that HHS will provide more information on the manner of submitting the required risk corridors data in future guidance. HHS received no comments on this section and is finalizing the provision as proposed.

E. Provisions for APTCs and CSR Programs

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

Special Rule for Family Policies §155.305

HHS proposed amending §155.305(g)(3), which added a category for qualified individuals who are not eligible for any cost-sharing reductions, and revised the introductory text to address situations in which Indians (as defined in §155.300(a)) and non-Indians enroll in a family policy. The proposed amendment also extended the current policy such that individuals on a family policy would be eligible to be assigned to the most generous plan variation for which all members of the family are eligible. HHS finalized these provisions as proposed.

Some comments of note include:

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

Recalculation of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions §155.330

HHS proposed §155.330(g) that clarified how an Exchange would re-determine the eligibility of an enrollee during a benefit year if an Exchange receives new information that affects eligibility for advance payments of the premium tax credit and cost-sharing reductions. Retroactive payments were proposed for changes resulting in an increased credit. HHS finalized these provisions as proposed, with the following modification:

- Added clarifying language to reiterate that HHS is not implementing the retroactive payment approach.

While some comments raised concerns about the operational and administrative challenges associated with retroactive payments, HHS expects QHP issuers to provide guidance to enrollees regarding the importance of reporting changes.

Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions §155.340

HHS proposed §155.340(e) that states that if those eligible for advance payment of the premium tax credit enroll in more than one policy, the advance payments be allocated first to QHP policies, and any remainder be allocated to stand-alone dental policies in a reasonable and consistent manner specified by the Exchange. HHS finalized these provisions as proposed with the following modification:

- In granting greater flexibility in the allocation of advance payments of the premium tax credit, state-based Exchanges may choose to adopt the federal methodology or another reasonable methodology under this final rule.

2. Exchange Functions: Certification of QHPs §155.1030, 156.470, 156.210

HHS proposed §155.1030 that establishes standards for Exchanges to ensure that QHPs in the individual market on the Exchange meet requirements to advance payments of the premium tax credit and cost-sharing reductions. In §156.470(a), HHS proposed that an issuer of a metal level health plan in the individual market also submit to the Exchange annually an actuarial memorandum with a detailed description of the methods and specific bases used to perform the allocations of the premium and the premium tax credit to Essential Health Benefits and other covered services. In §156.470(b), HHS proposed somewhat similar standards for the allocation of premiums for stand-alone dental plans. HHS expects that the Exchange will review the allocation information in conjunction with the rate and benefit information that the issuer submits under §156.210 as finalized in the Exchange Establishment Rule. HHS finalized these provisions as proposed, with the following modification:

- The allocation standard of dental premiums is modified such that it only needs to be performed by a member of the American Academy of Actuaries. HHS believes this to be a sufficient standard.

HHS created a unified data template for the submission, as well as detailed instructions for completing the actuarial memorandum. HHS suggest that Exchanges require issuers to use similar reporting processes in order to submit the rate and claims cost allocation information to the Exchange under §156.470.

3. QHP Minimum Certification Standards Relating to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions §156.215

HHS proposed to amend §156.215, the QHP minimum certification standards, to specify that an issuer seeking to offer a health plan on the individual market in the Exchange meet the requirements described in subpart E of part 156 related to the administration of advance payments of the premium tax credit and cost-sharing reductions. HHS finalized this provision as proposed.

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

Definitions §156.400

This section provided proposed definitions for:

- *Standard plan* – a QHP offered at one of the four levels of coverage.
- *Silver plan variation* – With regard to a standard silver plan, any of the variations of such plan.
- *Zero cost-sharing variation* – With regard to a QHP at any level of coverage, the variation of such QHP which provides for the elimination of cost-sharing for Indians based on household income level.
- *Limited cost-sharing variation* – With regard to a QHP at any level of coverage, the variation of such QHP which provides for the prohibition on cost-sharing applicable to the receipt of benefits from the Indian Health Service (IHS) or certain other providers, regardless of income.
- *Plan variation* – Defined as zero cost-sharing plan variation, limited cost-sharing plan variation, or silver plan variation. HHS emphasizes that plan variations of QHPs are not separate plans. Rather, it is only a variation in how the cost-sharing is required under a QHP that is to be shared between the enrollee and the federal government.
- *"de minimus variation for a silver plan variation"* – defined as a single percentage point. HHS intends this to mean that a 1 percentage point variation in the actuarial value of a

silver plan variation would not result in a "material difference" in the true dollar value of the silver plan variation. HHS notes that this differs from the 2 percentage point *de minimus* variation standard for health plans finalized in the Essential Health Benefits/Actuarial Value final rule.

- *Annual limitation on cost*-sharing – The annual dollar limit on cost-sharing required to be paid by an enrollee that is established by a QHP.
- *Reduced maximum annual limitation on cost*-sharing – The dollar value of the maximum annual limitation on cost-sharing for a silver plan variation that remains after applying the reduction in the maximum annual limitation on cost-sharing required by ACA §1402, as announcement in the annual HHS *Notice of Benefit and Payment Parameters*.

HHS finalized these definitions as proposed.

CSRs for Enrollees §156.410

HHS proposed in §156.410(a) that a QHP issuer must ensure that an individual eligible for cost-sharing reductions, pay only the cost sharing required of an eligible individual for the applicable covered service. The QHP issuer would ensure that the enrollee is not charged any type of cost sharing after the applicable annual limitation on cost sharing has been met. HHS finalized these provisions as proposed.

Plan Variations §156.420

In §156.420, HHS proposed that issuers submit to the Exchange for certification and approval the variations of the health plans that they offer in the individual market on the Exchange as QHPs that include required levels of cost-sharing reductions. Under the proposal, multi-state plans, as defined in §155.1000(a), and CO–OP QHPs, as defined in §156.505, would be subject to the provisions of this subpart. This proposed policy is finalized; with the modification of adding a new paragraph (g) to clarify that Office of Personnel Management (OPM), rather than the Exchange, will determine the time and manner for multi-state plans to submit silver plan variations and zero and limited cost sharing plan variations for the purpose of certification.

HHS estimated that the maximum annual limitation on cost sharing for self-only coverage for 2014 will be approximately $6,400 (the maximum annual limitation on cost sharing for other than self-only coverage for 2014 would be twice that amount, or $12,800). A QHP issuer offering coverage in the individual market on an Exchange would be required to develop three variations of its standard silver plan—one each for individuals with household income between 100 and 150 percent of the FPL, 150 and 200 percent of the FPL, and 200 and 250 percent of the FPL—with each variation having an annual limitation on cost sharing that does not exceed the applicable reduced maximum annual limitation on cost sharing published in the annual HHS Notice of Benefit and Payment Parameters. If the application of the reduced annual limitation on cost sharing results in an actuarial value for a particular silver plan variation that differs from the

required 73, 87, or 94 percent AV level by more than the permitted 1 percent de minimis amount for silver plan variations, the QHP issuer would adjust the cost-sharing structure in that silver plan variation to achieve the applicable AV level.

HHS will provide future guidance to clarify how silver plan variations could be designed to be compatible with HSAs.

Changes in Eligibility for Cost-Sharing Reductions §156.425

In §156.425(a), HHS proposed that if the Exchange notifies a QHP issuer of a change in an enrollee's eligibility for cost-sharing reductions (including a change following which the enrollee will not be eligible for cost-sharing reductions), then the QHP issuer must change the individual's assignment so that the individual is assigned to the applicable standard plan or plan variation. It also proposed that the QHP issuer effectuate the change in eligibility in accordance with the effective date of eligibility established by the Exchange. HHS finalized these provisions as proposed.

One commenter asked HHS to consider instituting safe harbors if the enrollee already met the annual limit on cost sharing, but due to lags in data the QHP is not informed. HHS anticipates consulting with stakeholders to provide guidance on these sorts of operational issues.

Payment for Cost-Sharing Reductions §156.430

HHS proposed monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconciling those advance payments at the end of the benefit year. HHS finalized these provisions as proposed with the following modifications:

- Two modifications relating to reimbursement for cost-sharing reductions for Indians.
- Adding §156.430(a)(4), clarifying that issuers of multi-state plans must provide the estimates of cost sharing reduction payments to OPM, rather than the Exchange, in the time and manner established by OPM.
- HHS is authorized to adjust the advance payments if the QHP issuer provides evidence, certified a certified actuary in accordance with generally accepted actuarial principles and methodologies, that the advance payments for a particular QHP are likely to be substantially different than the cost-sharing reduction amounts provided by the issuer that will be reimbursed by HHS after the end of the year during the reconciliation process.
- A QHP issuer is permitted to calculate the value of the cost-sharing reductions provided under the methodology described at §156.430(c)(2), or to use an alternative, simplified methodology, under which the QHP issuer would calculate the value of the cost-sharing reductions provided using certain summary cost sharing parameters.

The issuer must provide to the Exchange annually prior to the benefit year, for approval by HHS, an estimate of the dollar value of the cost-sharing reductions to be provided over the benefit year. Exchanges will collect this information from issuers through the QHP certification process or an annual submission process, and then send the information to HHS for review.

Plans Eligible for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions §156.440

In §156.440, HHS clarified the applicability of advance payments of the premium tax credit and cost-sharing reductions to certain QHPs. HHS proposed that the provisions of part 156 subpart E generally apply to QHPs offered in the individual market on the Exchange. However the provisions do not apply to catastrophic plans. For stand-alone dental plans, cost sharing reductions do not apply but premium tax credits do. All the provisions apply to child-only plans. HHS finalized these provisions as proposed.

Reduction of Enrollee's Share of Premium to Account for Advance Payments of Premium Tax Credit §155.340, 156.460

HHS finalized the following provisions as proposed:

- QHP issuers are required to reduce the portion of the premium charged to the enrollee by the amount of the advance payment of the premium tax credit for the applicable month(s).
- QHP issuers are required to notify the Exchange of any reduction in the portion of the premium charged to the individual. The Exchange would receive such notification through the standard enrollment acknowledgement. At that point, the Exchange would send this information to HHS.
- QHP issuers are required to display the amount of the advance payment of the premium tax credit for the applicable month(s) on an enrollee's billing statement.
- QHP issuers are prohibited from terminating or refusing to commence coverage in the event of any delay in payment of an advance premium tax credit for an enrollee if the issuer has been notified by the Exchange it will receive the advance payment.
- The following standards relating to an Exchange when it is facilitating the collection and payment of premiums to QHP issuers and stand-alone dental plans on behalf of enrollees: **(1)** Exchanges are to reduce to reduce the portion of the premium for the policy collected from the enrollee by the amount of the advance payment of the premium tax credit for the applicable month(s) and **(2)** Exchange are required to display the amount of the advance payment on an enrollee's billing statement.

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

HHS proposed in §156.470 that issuers allocate the rate or expected premium for each metal level health plan and stand-alone dental plan offered, or proposed to be offered in the individual market on the Exchange, and the expected allowed claims costs for the metal level health plans, among essential health benefits (EHB) and additional benefits. Furthermore, issuers are required to submit these allocations annually to the Exchange, along with an actuarial memorandum describing the methods and specific bases used to perform the allocations

HHS finalized these provisions as proposed with technical amendments that apply these requirements to multi-state plans.

Special Cost-Sharing Reduction Rules for Indians Interpretation of ACA §1402

HHS reiterates its interpretation of ACA §1402 that cost-sharing reductions be available to Indians regardless of their eligibility for premium tax credits. Furthermore, reductions in cost-sharing must be provided to Indians who purchase Exchange coverage only in the individual market. HHS does not believe Congress intended for cost-sharing reductions to be available outside individual market Exchanges. HHS finalizes this interpretation of statute.

With regard to 45 CFR Part 156, "*Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Relating to Exchange*" HHS proposed the following policy with respect to cost-sharing reductions for Indians:

- A QHP issuer is required to assign an Indian determined by the Exchange to have an expected household income not exceeding 300 percent FPL to a zero cost sharing plan variation of the selected QHP (regardless of the level of coverage) with no cost sharing, based on the enrollment and eligibility information provided by the Exchange.
- A QHP issuer is required to assign an Indian determined eligible by the Exchange for cost-sharing reductions to a limited cost sharing plan variation of the selected QHP (regardless of the level of coverage) with no cost sharing required on benefits received from the IHS and certain other providers.

HHS finalized this policy as proposed.

Some comments of note include:

- HHS is continuing to review this policy and anticipates issuing further guidance to address operational concerns raised by comments.
- HHS recognizes that there is no practical need to ensure eligible Indians have access to higher metal level plans if a lower metal level plan offers identical benefits and networks,

at a lower premium with no cost sharing. Therefore, HHS will deem an Exchange to be adequately enforcing these requirements if, within a set standard plans offered by an issuer differing only by the cost sharing or premiums, the Exchange allows the issuer to submit one zero cost sharing plan variation for only the standard plan within the set with the lowest premium.

    - HHS notes that for operational reasons in 2014, the federally facilitated Exchange (FFE) will still require QHP issuers to submit a zero cost sharing plan variation for any level of coverage that the QHP issuer seeks certification. HHS will consider changing this approach in later benefit years.

- HHS requires QHP issuers to use the same methodology for estimating advance payments for cost sharing reductions with regard to cost sharing reductions under the zero cost sharing plan variation. That is, the formula is modified as follows:
    - Per Enrollee Per Month Advance Payment **equals** Monthly Expected Allowed Claims Costs for Zero Cost Sharing Plan Variation **multiplied by** (Zero Cost Sharing Plan Variation Actuarial Value **minus** Standard Plan Actuarial Value).
- The Exchange would review this allocation and submit approved allocation to HHS. In turn, HHS would multiply this estimated amount by a modified induced utilization table.
- HHS notes that future notices of benefits and payment parameters may include different methodologies.
- With regard to the prohibition on cost sharing under the limited cost sharing plan variation for services or items provided through referral under a contract health services program, HHS plans to issue guidance in the future.

F. Provisions on User Fees for the FFE §156.50

Participating issuers must pay a user fee to support the operation of FFEs. An issuer's monthly user fee amount is equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy offered through an FFE.

- Circular No. A-25R states that user charges should generally be set at a level so that they are sufficient to recover the full cost of the federal government of providing the service when the government is acting in its capacity as sovereign.
    - HHS is seeking an exception to this policy in 2014 and instead would like to set the monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan. This would apply to plans offered through FF-SHOPs and FFEs.
        - Exception must be approved by the Office of Management and Budget (OMB).

- HHS will collect user fees monthly by deducting the user fee from FFE-related program payments. If a QHP issuer does not receive any Exchange-related program payments, the issuer would be invoiced for the user fee on a monthly basis.
- The user fee rate is applied directly to the premium set by the issuer for a policy and is charged on each policy with enrollment through the FFE.

G. Distribution Data Collection for the HHS-Operated Risk Adjustment and Reinsurance Programs – Part 153

When operating a risk adjustment or reinsurance program on behalf of a state, HHS will use a distributed approach, one in which each issuer formats its own enrollee-level and claims-level data in a manner consistent with the applicable database, and then passes the relevant information to the entity responsible for making payments and charges for the program.

1. Distributed Data Environments

- An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a state where HHS is operating the risk adjustment or reinsurance program on behalf of the state should establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for risk adjustment and reinsurance operations.
    - Issuers should establish secure, dedicated, electronic server environments to house medical and pharmacy claims, encounter data, and enrollment information.
- HHS will store aggregate plan summary data and reports based on activities performed on each issuer's dedicated server environment in a private and secure HHS computing environment.
- HHS will provide future guidance on:
    - Data formats, definitions, and technical standards applicable to the HHS-operated distributed data approach, including standards relating to data from chart reviews.
    - The uses of data collected through the distributed data approach.
    - Recalibration of the HHS risk adjustment models.

2. Timeline

Issuers must establish the dedicated data environment and confirm proper establishment through successfully testing the environment to conform with HHS standards for such testing three months prior to the first date of full operation.

- Issuers will have the opportunity to submit data files to a test environment.
- Further details and specifications for such testing will be provided in future guidance.

3. Enrollment, Claims, and Encounter Data

An issuer of a risk adjustment covered plan or reinsurance-eligible plan in a state in which HHS is operating the risk adjustment or reinsurance program should provide to HHS, by April 30 of the applicable benefit year, through the dedicated data environment, access to the enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data specified by HHS. Applicable benefit year is determined by discharge date.

HHS will provide future guidance on:

- Data storage requirements for reinsurance-eligible plans and risk adjustment covered plans.
- Full list of acceptable provider types and criteria.

4. Claims Data

All claims data submitted by an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a state in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer (payment of cost sharing by the enrollee). Enrollee-level data must include information from claims and encounter data 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.

HHS will provide each issuer with a periodic report on data functions performed in each issuer's distributed data environment, and to identify reinsurance-eligible claims. If an error is identified in HHS-provided reports, issuers need to provide corrected files and data to address the errors. HHS will provide future guidance on timeframes for these reports, including for receipt of corrected files and discrepancy resolution.

5. Claims Data from Capitated Plans

An issuer that does not generate claims in the normal course of business must derive costs on all applicable provider encounters using their principal internal methodology for pricing those encounters. If no such methodology exists, the plan is permitted to implement a methodology in a manner that yields derived claims that are reasonable in light of the specific market that the plan is serving. Capitated plans are subject to validation and audit. Validation language is in §153.240(a)(3) for state-operated reinsurance programs, and in §§153.350 and 153.630 for state- and HHS-operated risk adjustment programs, respectively.

6. Establishment and Usage of Masked Enrollee Identification Numbers

An issuer of a risk adjustment covered plan or reinsurance-eligible plan in a state in which HHS operates risk adjustment or reinsurance must establish a unique masked enrollee identification number for each enrollee, in accordance with HHS-defined requirements, and maintain the same masked enrollee identification number for an enrollee across enrollments or plans within the issuer, within the state, during a benefit year. HHS will be releasing compliance standards for privacy and security standards in forthcoming rulemaking.

7. Deadline for Submission of Data

An issuer of a risk adjustment covered plan or reinsurance-eligible plan in a state in which HHS operates risk adjustment or reinsurance, should submit data to be considered for risk adjustment payments and changes and reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year. HHS recommends issuers submit data at least quarterly throughout the benefit year to support the calculation of reinsurance payments and risk adjustment payments and charges. Compliance requirements will be forthcoming.

H. Small Business Health Options Program §155.705

1. Employee Choice in the Federally Facilitated SHOP (FF-SHOP)

Each FF-SHOP should provide employers the option of offering a single qualified health plan (QHP) to participate in an FF-SHOP and retain potential eligibility for the small business tax credit, which is only available through a SHOP Exchange beginning in 2014. The effective implementation of employee choice in the FF-SHOP will not be possible in 2014 because of operational challenges; therefore, a separate proposal published elsewhere in the Federal Register proposes the following:

- The effective date of the employee choice requirements and the premium aggregation requirements will be January 1, 2015.
- SHOP Exchanges may offer employee choice and perform premium aggregation for plan years beginning on or after January 1, 2014.
- An FF-SHOP will not offer employee choice and premium aggregation until plan years beginning on or after January 1, 2015.

2. Methods for Employer Contributions in an FF-SHOP

Each SHOP can define a standard method by which employers will contribute toward the employee coverage. Employers should choose whether to use a calculated composite premium. The choice must be consistent with applicable state law. Per commenter request, HHS will

provide future guidance on mid-year changes in group composition and how a SHOP might address the resulting changes in the average premium group.

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

An FFE may certify a QHP in the individual market of an FFE only if the QHP issuer, or an issuer member of the same issuer group, has a 20percent share of the small group market in the state, based on the most recent earned premium data reported under §158.110, and meets one of the following conditions:

- The QHP issuer offers through the FF-SHOP serving that state at least one small group market QHP at the silver level of coverage and one at the gold level of coverage.
- The QHP issuer does not offer small group market plans in that state, but another issuer in the same issuer group offers through the FF-SHOP serving that state at least one small group market QHP at the silver level of coverage and one at the gold level of coverage.
- Neither the issuer nor any issuer in the same issuer group offers a small group market product in the state.
- "Issuer Group" includes both issuers affiliated by common ownership and control, and issuers affiliated by the common use of a nationally licensed service mark.

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

QHP certification by an FFE and an FF-SHOP is conditioned on the QHP issuer paying broker compensation for QHPs offered through an FFE or FF-SHOP that are similar to broker compensation for similar QHPs offered outside an FFE and an FF-SHOP. HHS will provide future guidance as to what constitutes similar QHPs.

5. Minimum Participation Rate in FF-SHOPs

A SHOP is permitted to authorize minimum participation requirements for qualified employers participating in the SHOP so long as the participation is measured at the SHOP level and not based on enrollment in a single QHP. The minimum participation rate for an FF-SHOP is 70 percent, calculated at the level of the participation of the employees of the qualified employer in the FF-SHOP and not enrollment in a single QHP. An FF-SHOP may adopt its own minimum participation rate in a state with an FF-SHOP if there is evidence that: (1) a state law sets the rate; or (2) a higher or lower rate is customarily used by the majority of QHP issuers in that state for products in the state's small group market outside the SHOP. Employees with the following types of alternative coverage are excluded from the calculation of the minimum participation rate: (1) a group health plan offered by another employer; or (2) a governmental program such as Medicare, Medicaid, or TRICARE.

6. Determining Employer Size for Purposes of SHOP Participation

To determine whether an employer is a small employer for purposes related to the SHOP, use the full-time equivalent method used in section 4980H(c)(2) of the IRC, as added by section 1513 of the ACA.

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

The definition of full-time employee cross-references section 4980H(c)(4) of the IRC and provides that a full-time employee with respect to any month is generally an employee who is employed an average at least 30 hours of service per week, subject to transitional policies (see 8).

8. Transitional Policies

In 2014 and 2015, HHS will not take any enforcement actions against a state-operated SHOP for including a group in the small group market based on a state definition that does not include part-time employees when the group should have been classified as part of the large group marked based on the federal definition. To define "full-time employee," "small employer," and "large employer" in order to determine whether an employer has met the SHOP requirement to offer coverage to all full-time employees:

- In 2014 and 2015, an employer and a state-operated SHOP may adopt a reasonable basis for their definition of full-time employee. Examples include:
    - From the state's small group market definition.
    - From the federal definition from section 4980H of Chapter 43 of the Code.
    - For plan years beginning on or after January 1, 2016, use a full-time equivalent methodology referenced in the definitions.

To define "full-time employee," "small employer," and "large employer" in the FF-SHOPs for plan years beginning on or after January 1, 2014, and in connection with open enrollment activities beginning October 1, 2013, definitions will be based on the full-time equivalent method referenced in the definitions.

9. Website Disclosures Relating to Agents and Brokers

The Exchange or SHOP is allowed to limit the display of agent and broker information to include only those licensed agents and brokers who are registered with the Exchange or SHOP, including an FFE and FF-SHOP.

10. QHP Issuer Standards Specific to SHOP

QHP issuers participating in the SHOP must enroll qualified employees if they are eligible for coverage.

I. Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act

1. Treatment of Premium Stabilization Payments, and Timing of Annual MLR Reports and Distribution of Rebates §158.110, 158.130, 158.140, 158.221, 158.240, 158.241

HHS proposed to account for all premium stabilization amounts in a way that would not have a net impact on the adjusted earned premium used for the purposes of calculating MLR denominator and rebates. Furthermore, HHS proposed to include all premium stabilization amounts (positive or negative) as adjustments to incurred claims in calculating the MLR numerator. HHS proposed changes to the MLR reporting and rebate deadlines, starting with the 2014 MLR reporting year, to coordinate them with the reporting cycles of the premium stabilization programs. HHS finalized these provisions as proposed, but modified them to address concern that reinsurance contributions could "reasonably be characterized" as fees or assessments that are deducted from premium in MLR and rebate calculations. HHS adopted the approach that, with regard to premium stabilization amounts other than reinsurance contributions—such as risk adjustment, risk corridor amounts, and reinsurance payments—will have a net impact on the MLR numerator.

2. Deduction of Community Benefit Expenditures §158.162

HHS proposed to allow an issuer exempt from federal income tax to deduct state premium taxes and community benefit expenditures from earned premium in MLR and rebate calculations. HHS limits the community benefit expenditure deduction to the higher of (1) the highest premium tax rate in issuer's state or (2) three percent of premium. The community benefit expenditure deduction is also available to issuers that are not exempt from federal income tax. Such issuers are allowed to deduct the higher of (1) their state premium taxes or (2) their community benefit expenditures limited to the higher premium tax rate charged to an issuer in their state. These provisions were finalized as proposed.

3. Summary of Errors in the MLR Regulations

HHS proposed corrections to the following errors in the 2010 interim final rule:

- The date by which issuers must define the formula for its blended rate adjustment is prior to January 1 of the MLR reporting year.

- The date after which partially credible issuers that consistently fail to meet MLR standards will be prohibited from using the credibility adjustment.
    - Beginning with the 2013 MLR reporting year.
- The calculation of the per-person deductible will be the lesser of (1) the deductible applicable to each of the individual family members or (2) the overall family deductible for the subscriber and his/her family divided by two—regardless of the total number of family members covered through the subscriber.

Final Rule: Multi-State Plans (Title 5 of the Code of Federal Regulations)

Overview

Section 1334 of the ACA directs OPM to establish the MSPP to foster competition among plans in the individual and small group markets on Exchanges. It directs OPM to contract with private health insurance issuers (one must be non-profit) to offer at least two MSPs on each Exchange in each state. An MSP issuer may phase in the states in which it offers coverage over four years, but it must offer MSPs on Exchanges in all states and D.C. by the fourth year. This regulation outlines the process by which OPM will establish and administer the MSPP. Overall, the proposed rules were adopted as final with few changes.

Basis, Scope, and Definitions §800.10-.20

These sections of the regulations define the basis, scope, and key terms for part 800. OPM received no comment on the basis and scope section and are adopting these as final with no changes. OPM received some comments on the definitions, but there were no major changes. OPM slightly revised the definition of MSP to clarify than an MSP is offered under contract with OPM through an MSSPP issuer.

MSPP Issuer Requirements §800.101

This section sets forth general requirements, including licensure, contracting with OPM, required levels of coverage, eligibility and enrollment, compliance with OPM direction and other legal requirements, and compliance with applicable non-discrimination statutes. OPM is adopting the proposed rule as final with a revision to §800.101(i) of the final rule to ensure consistency with the prohibition on discrimination with respect to the EHB.

OPM notes that if there are specific consumer protections and regulatory procedures for state Exchanges that go above and beyond the federal standards, OPM encourages states to identify them so OPM can consider and address them through a memorandum of understanding with the state, and, if appropriate, in its contracts with issuers.

Compliance with Federal Law §800.102

This section specifies the federal laws with which MSPP issuers must comply as a condition of participation. OPM is adopting this rule as final with the following changes with a minor technical correction to remove references to appendices.

Authority to Contract with Issuers §800.103

This section proposed that OPM may enter into an MSPP contract with a group of issuers affiliated either by ownership and control or by the use of a nationally licensed service mark, or an affiliation of health insurance issuers and an entity that is not an issuer but owns a nationally licensed service mark. OPM received no substantive comments on this section and is adopting the proposed rules as final.

Phased Expansion §800.104

This section proposed phased expansion into states and that MSP issuers may provide partial coverage within a state in the initial years. OPM also proposed that MSP issuers must be licensed in the state where they offer coverage, and OPM may enter into a contract with an issuer that is not licensed in all states. MSPP issuers may offer coverage in part of a state and do not have to offer coverage statewide. OPM will require MSSP issuers to provide plans for state wideness if offering only partial state coverage. OPM is adopting as proposed with a revision to remove the regulatory text on the number of states that an issuer must phase into. Instead, an MSPP issuer must have a plan available in 60 percent of states in the initial year, phasing in to all states by the fourth year.

OPM also proposed that by the end of the phase-in period, MSPP issuers should be required to offer coverage on the SHOP. OPM is finalizing the regulation to require MSPP issuers to comply with 45 CFR 156.200(g). They are adopting policies that mirror the standards set forth by the FF-SHOP: MSPs only have to offer SHOP coverage if they are required to by state or FFE law. The rules also clarify that an MSP issuer must offer coverage for individual and small groups in states with merged markets.

Benefits §800.105

This section implements ACA section 1334(c)(1)(A), which directs the MSP to offer a uniform benefit package in each state that consists of the EHB. OPM proposed that an MSP issuer must offer a uniform benefit package for each MSP and that the benefits for each MSP must be uniform within a state, but not necessarily among states. OPM also proposed to allow MSP issuers to offer a benefit package that is substantially equal to either (1) each state's EHB benchmark plan in each state in which it operates; or (2) any EHB benchmark plan selected by OPM. OPM is adopting these rules as proposed.

OPM also proposed that even if an issuer chooses to use the EHB benchmark plan selected by OPM in all states, the MSP issuer must still use a state-selected benchmark in states that do not allow substitution for services within the benchmark benefits. OPM is revising this rule to include a paragraph clarifying that an MSPP issuer must comply with any state standards relating to substitution of benchmark benefits or standard benefit design. Therefore, if a state does not

allow substitution or has standard benefit designs, an MSP issuer must use the state's EHB benchmark plan.

OMB proposed selecting the three largest FEHB plan options as the EHB benchmark plans. An MSP issuer that selects one of these benchmarks must offer this benefit package in all states in which it operates an MSP. OPM also proposed that any OPM-selected benchmark plan lacking coverage for pediatric oral health or pediatric vision services must be supplemented by the addition of the entire category of benefits from the largest federal Employee Dental and Vision Insurance Program.OPM is adopting these as proposed and is not promulgating further regulations regarding provision of pediatric oral health services. Instead, it will keep in mind comments offered about stand alone dental plans during MSPP contract negotiations.

Regarding habilitative services, OPM proposed than an MSPP issuer must follow state definitions for habilitative services and devices when a state specifically chooses to define this category. When a state does not choose a definition, and any OPM-selected benchmark lacks coverage of habilitative services, OPM may determine what to include in this category. OPM is adopting this rule as proposed with one technical correction to refer to both habilitative "services and devices" throughout.

OPM also proposed that, at least for 2014 and 2015, OPM's benchmark plans would also include any state-required benefits enacted by December 31, 2011, that are included in a state's EHB benchmark plan. OPM is adopting these requirements as proposed.

OPM had solicited comment on whether an MSPP issuer should submit evidence of actuarial equivalence of substituted benefits to OPM is lieu of or in addition to submission to a state. OPM is adopting the rule as proposed and will work with states during the MSPP application process to ensure that they receive necessary actuarial evidence of substituted benefits.

In summary, OPM is adopting proposed §800.105 as final with the one change relating to standardized benefit design and minor technical corrections.

Cost-Sharing Limits, APTCs, and CSRs §800.106

This section requires MSPP issuers to comply with ACA standards for cost-sharing and APTCs. OPM is adopting these as final with minor technical clarification that MSPP issuers must comply with the same standards as QHP issuers.

Levels of Coverage §800.107

OPM proposed that an MSPP issuer, like a QHP issuer, must offer at least one plan at the silver level of coverage and one plan at the gold level in each Exchange in which the issuer is certified to offer an MSP. MSPP issuers may offer bronze or platinum plans. MSPP issuers must also

offer a child-only plan for each level of coverage. OPM is adopting the proposed rules as final with no changes.

Assessments and User Fess §800.108

In this section, OPM has the discretion to collect an assessment or user fee from MSP issuers to cover administrative costs. OPM is adopting the proposed rule as final, but adds the clarification that it may begin collecting the user fee in 2015. OPM estimates that any future fees or assessments would be no more than 0.2 percent of premiums. OPM notes that its user fee would not be a substitute for any user fee or assessment imposed by a state-based Exchange or FFE. OPM will issue further guidance in advance of collecting any user fees in 2015.

Network Adequacy §800.109

OPM proposed that the network adequacy standard for MSPPs mirror HHS's standard:

- Include sufficient numbers and types of providers to ensure that all services will be accessible without unreasonable delay.
- Meet guaranteed availability network plan requirements.
- Include essential community providers.

OPM is adopting this rule as final. While it is not stated in the regulation, OPM notes that it will adopt the time and distance standards for network adequacy published by CMS for Medicare Advantage Plans and Medicare Part D. In the first year, OPM will only apply the MSPP standard for MSPP issuer networks and, in future years, may require an MSPP issuer to meet state network standards.

Service Area §800.110

OPM proposed that MSPP issuers comply with the service areas defined by Exchanges, but this does not necessarily require that an MSP be offered in all defined service areas. OPM is adopting as proposed with one change-removing the requirement that for each state in which the MSPP issuer does not offer coverage in all service areas, the MSPP issuer would submit a plan on expanding coverage.

Accreditation Requirement §800.111

OPM proposed that MSPP issuers be accredited consistent with the standards for QHP issuers and that the MSPP issuer must authorize the accrediting entity to release the most recent accreditation survey and to OPM and Exchanges. If an issuer is not accredited as of the date it enters into a contract with OPM, it must become accredited within the time frame established by OPM. OPM is adopting the proposed rule as final.

Reporting Requirements §800.112

This section gives OPM the authority to collect data and information as it determines necessary for the administration and oversight of the program. It also specifies quality and quality improvement standards to be reported. The rule does not address the specifics of how OPM will collect data, and their method of data collection will be developed in future policy guidance. OPM is adopting the proposed rule as final.

Benefit Plan Material or Information §800.113

Under 5 C.F.R. §800.20, the definition of "benefit plan material or information" includes general information on a carriers products, and not a policy or contract for health insurance coverage, though OPM will review both the plan material and policy forms. Under benefit plan material section, MSPP issuers are required to comply with federal and state laws related to benefit plan material and information, in addition to OPM standards, process, and approval timelines. Further, all MSP enrollee notices must meet minimum standards access standards for individuals with limited English proficiency (LEP) and for individuals with disabilities. In addition to this requirement, MSPP issuers must also comply with any qualified health plan (QHP) summary and benefit coverage (SBC) requirements issued by HHS. Fourth, OPM has the authority to review and approve certain benefit plan materials, and that the focus of its review will be on MSPP issuers' compliance with the OPM standards. Nevertheless, OPM will work with states concerning the review of the benefit plan material and information through Memoranda of Understanding (MOUs). While OPM will review policy forms and state approval of forms is not a precondition of OPM approval, OPM still expects MSPP issuers to comply with state laws regarding form review. Finally, MSPP issuers will be allowed to state that, as applicable, their plans have been certified by OPM as MSPs.

Compliance with Applicable State Law §800.114

Generally, MSPP issuers must comply with state law. This section defines and explains the standards for determining when MSPP issuers do not have to comply with state law. There are three categories of state law with which MSPP issuers do not have comply: (1) state laws that are inconsistent with section 1334 of the ACA (the MSP provision of the ACA); (2) state laws that prevent the application of a requirement of part A of XXVII of the Public Health Service (PHS) Act (ACA reforms to group and individual health plans); and (3) state laws that prevent the application of a requirement of title I of the ACA. OPM reserves the right to determine whether the above standards are satisfied with respect to a particular state law.

The proposed rule listed four factors that OPM would use in determining consistency of a particular state law with the three categories of state laws described above: (1) whether the law in question imposes a requirement that differs from those applicable to QHPs and QHP issuers on one or more Exchanges in the state; (2) whether the law creates responsibilities, administrative

burdens, or costs that would significantly deter or impede the MSPP issuer from offering a viable product on one or more Exchanges; (3) whether the law creates responsibilities, administrative burdens, or costs that significantly deter or impede OPM's effective implementation of the MSPP; or (4) whether the law prevents an MSPP issuer from offering an MSP on one or more Exchanges in the state. These have been removed in the final rule. The four factors were removed because many comments thought they were too broad and vague. Nevertheless, OPM explains that the factors are relevant considerations in evaluating a particular state law against the three preemption categories. Further, the rule explains that OPM will consult and work in conjunction with states in determining the consistency of a state law. The framework for MSPP compliance with state law sets standards similar to those used in the FEHB, and a determination of inconsistency of state law would be applicable only in the state in question and not all states.

Level Playing Field §800.115

This section explains that OPM expects MSPP issuers to comply with federal and state laws regarding guaranteed renewal, rating, preexisting conditions, non-discrimination, quality abuse, licensure, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, and benefit plan material and information.

Process for Dispute Resolution §800.116

This section addresses a process by which a state may request OPM for a reconsideration of a determination that a state law does not apply to a MSPP issuer. The burden of proving that the state law does apply to the MSPP issuer lays on the state, which in particular must show that the law does not fall into one of the three categories of state laws described under §800.114. Also, OPM will issue a written decision within 60 calendar days after receiving the written request for reconsideration or after a state responds with more information as requested by OPM. The written decision constitutes final agency decision under the federal Administrative Procedure Act. One item of note here is that a different OPM official than the one who made the determination of the applicability of state law would review the determination.

General Requirements – Rating Standards §800.201

This section provides a number of rate setting standards in the MSPP. First, OPM will negotiate premiums and issue rate guidance for the MSPP, similar to the FEHBP, and the rates will remain in effect for 12 months. Further, MSPP issuers must comply with HHS standards for calculating actuarial value as related to QHPs, and state rating standards with respect to rating factors generally applicable in a state. Finally, an MSPP must issuer must consider all MSP enrollees in all non-grandfathered health plans in the individual market to be members of a single risk pool, and all MSP enrollees in grandfathered health plans in the individual market to be members of a single risk pool. In this final regulation, OPM has clarified that while it has discretion to make the final decision to approve rates for a MSP, it will exercise this discretion only in the event that

the state's action with regards to approving a rate would impede OPM's ability to operate the MSPP. The rule explains that OPM expects that it will rarely, if ever, have to exercise its authority to approve rates. Also, while OPM will review rates for each MSPP issuer, states can also review rates independent of OPM's review

Rating Factors §800.202

This section explains that MSPP issuers must comply with rating requirements under the PHS Act as amended by the ACA. Specifically, it lines up the rating factor standards for MSPs with the standards explained in the market reform regulations issued by HHS. Rating for age, geographic areas, tobacco, and wellness programs must be aligned with the standards specified for these rating factors in HHS market rules regulations. This final regulation clarifies that MSPP issuers must comply with any age curve established by a state under 45 C.F.R. §147.103(e) (market rules regulation section pertaining to age rating). Also, where a state does not establish an age curve, the MSPP issuer should use the standard age curve established by HHS. Finally, while OPM will not specify categories of family members for purposes of rating, it "encourages MSPs to provide the same benefits for all family compositions, including but not limited to same-sex domestic partners and their children."

Medical Loss Ratio §800.203

This section requires MSPP issuers to comply with the MLR requirements of section 2718 of the PHS Act (the MLR requirements and calculation methodology specified in the ACA). Though OPM has the authority to set MSP-specific MLRs, it does not foresee using this authority excerpt in rare circumstances. This section also explains that if an MSPP issuer fails to attain the MLR specified in the above-noted PHS Act section, OPM may take appropriate action, including intermediate sanctions or decertification of an MSP in one or more states. With regards to decertification, OPM will decertify a MSP mid-year only under unusual circumstances, such as "widespread and repeated failure to comply with legal or contractual requirements." OPM will also consult states before decertifying an MSP.

Reinsurance, Risk Corridors, and Risk Adjustment §800.204

This section states that MSPP issuers must participate in all three risk-mitigation programs and must do so in accordance with the ACA and pursuant federal regulations, as well as any applicable state regulations.

Application and Contracting Procedures §800.301 and Review of Applications §800.302

These sections explain that a health insurance issuer may submit an application to OPM to participate in the MSPP, and explain OPM's authority to review the application, including requesting additional information and entering into contract negotiations with the issuer.

MSPP Contracting §800.303

This section addresses the standards related to contracting between MSPP issuers and OPM. Specifically, this section explains that an issuer must execute a contract with OPM to become a MSPP issuer; OPM will establish a standard contract for the MSPP; OPM and the issuer will negotiate premiums every year; OPM will review for approval the benefit packages; OPM can negotiate additional contractual terms with issuers; and OPM can certify MSPs to be offered on Exchanges. Finally, the rule explains that OPM will measure performance using standards similar to those it uses in the FEHBP.

Terms of the Contract §800.304

This section explains that the term of a contract will be for a consecutive 12-month period and that a plan year may be a calendar year or any other 12-month period. This final rule clarifies that the definitions section explains that a "plan year" is the same plan year that is used for QHPs offered on the Exchange.

Contract Renewal Process §800.305 and Nonrenewal §800.306

These sections provide the process for contract renewal, explaining that even if new premiums are not negotiated between the issuer and OPM, a MSP contract may still be renewed with the same premiums in effect the year prior. The nonrenewal section explains that either OPM or the issuer may decline renewal at the end of the plan year, with timely notification to the other party and the plan's enrollees (but not less than 90 days, unless a different notice period is required by an Exchange).

Contract Performance §800.401 and Contract Quality Assurance §800.402

These sections explain that an issuer must meet all applicable ACA sections and MSPP regulations, shall engage in "prudent business practices" (e.g., timely compliance with OPM instructions and directives, maintaining accurate accounting reports of costs, accurately and fairly disclosing data in all reports required by OPM), must not engage in specified "poor business practices" (e.g., using fraudulent or unethical business or health care practices or otherwise displaying lack of honesty, failing to comply with OPM instructions and directives, failing to assure that the MSP properly pays or denies claims or provides medical services that

are inconsistent with standards of good medical practice), and that OPM can collect an assessment to a performance escrow account. These sections next provide procedures that OPM will follow to determine compliance of MSPP contracts with quality assurance standards to be set by OPM.

Fraud and Abuse §800.403; Compliance Actions §800.404; and Reconsiderations of Compliance Actions §800.405

Under these sections, MSPP issuers are first required to maintain a fraud and abuse program and to provide information on certain operational areas to OPM. Second, these sections allow OPM to impose compliance actions on the issuer, explain the notices that OPM will send issuers when imposing such an action, and explain the notices that MSPP issuers must send their enrollees regarding the imposition of such an action. OPM will also notify state insurance and Exchange officials of compliance actions. The final rule clarifies that Exchange and state insurance officials will also receive notices from OPM when it is imposing a compliance action on a MSPP issuer. This rule also explains that when OPM decertifies a MSP, the MSPP issuer must follow applicable state Exchanges' QHP termination procedures when terminating the MSP enrollment.

Appeals – General Requirements §800.501; MSPP Issuer Internal Claims, Appeals Processes, Appeals Timeframes and Notice of Determinations §800.502

These sections first explain that a person acting on behalf of an MSP enrollee may seek review of an adverse determination. The sections then provide MSPP issuers with the ability to have an internal appeals process and require them to provide notices as specified under HHS regulations related to group health plans.

External Review §800.503 and Judicial Review §800.504

The external review section explains the process by which OPM will conduct a review of adverse benefit determinations; this process is set to follow the FEHBP external review process. The judicial review section provides that OPM's written decision serves as a final agency decision under the APA and review of the written decision in a U.S. District Court will be limited to the record OPM had when it made its decision.

Interim Final Rule: Risk Corridors Calculations and Standards for Alternate Methodology for CSRs (Title 45 of the Code of Federal Regulations)

Overview

This interim final rule builds upon the framework established in the *HHS Notice of Benefit and Payment Parameters for 2014* final rule. Specifically, this interim final rule adjusts the calculations for the temporary risk corridors program and establishes standards that permit

issuers of QHPs the option of using an alternate methodology for calculating cost-sharing reductions for the purposes of advance payment of such reductions.

A. Calculation of Allowable Costs for the Risk Corridors Program §153.520, 153.530, 158.150, 158.151

The temporary risk corridors program compares a plan's allowable costs against a plan's target amount, which is designed to share the risk of inaccurate rate-setting between QHP issuers and the federal government. HHS proposed to amend the regulatory definition of allowable costs so that such costs for a QHP are equal to the pro rata portion of the QHP issuer's incurred claims (subject to adjustments) for all of their non-grandfathered health plans in a state's market. HHS provides an example to show how the modified definition is applied.

HHS seeks comment on this approach.

B. Submission of Actual Amounts of Cost-Sharing Reductions §156.430

As stated in the *HHS Notice of Benefit and Payment Parameters for 2014 final rule*, HHS will make monthly advance payments to QHP issuers to cover projected cost-sharing reduction amounts. These advance payments will then be reconciled at the end of each benefit year with the actual CSRs. HHS proposes new standards to permit QHP issuers to choose a simplified methodology calculate the amounts that would have been paid under the standard plan without cost-sharing reductions. Under the simplified methodology QHP issuers would perform the following calculations:

- The amount that the enrollee would have paid under the standard plan for policies with total allowed costs for EHBs for the benefit year that *are less than or equal to the effective deductible*.
- The amount that the enrollee would have paid under the standard plan for policies with cost-sharing reductions with total allowed costs for EHB for the benefit year *that are greater than the effective deductible but less than the effective claims ceiling*. The effective claims ceiling is the estimated amount of total allowed claims for a policy would require enrollee cost-sharing (ensuring annual cost-sharing limitation is met).
- The amount the enrollee would have paid under the standard plan for policies with cost-sharing reductions with total allowed costs for EHB for the benefit year *that are greater than the effective claims ceiling*.

HHS proposed the following definitions:

- Effective Pre-Deductible Coinsurance – This is the proportion of the total allowed costs for EHB under the standard plan for the benefit year incurred for those standard plan

enrollees and payable as cost-sharing. It includes copayments or coinsurance on services with such cost-sharing but not subject to the deductible.

- Effective Post-Deductible Coinsurance – This is calculated using the cost data from those standard plan policies that have total allowed costs for EHB for the benefit year that are above the effective deductible, but for which associated cost sharing is less than the annual limitation on cost-sharing.
    - The effective post-deductible coinsurance rate for the standard plan must be calculated separately for both *self-only and other than self-only coverage*.

To align with the requirement that effective cost-sharing parameters be calculated separately for self-only and other than self-only coverage, HHS establishes the following subgroups:

- Self-only coverage with total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible.
- Other than self-only coverage with total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible.
- Self-only coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but below the effective claims ceiling.
- Other than self-only coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but below the effective claims ceiling.

Items for Comment:

HHS seeks comment on the following:

- These formulas and their instructions.
- The standard that should apply for determining whether a plan will be exempted from using the simplified methodology and how HHS should make such determination.
- The types of plans for which it will be difficult to calculate such amounts using the simplified methodology.
- The appropriate amount of member months to achieve credible use of the simplified methodology.
- The credibility standard of 12,000 member months and whether the standard plan's actuarial value (AV) applied to the allowable costs for EHB will provide an appropriate estimate of the cost-sharing amount enrollees would have to pay without cost-sharing reductions.
- Alternative approaches for QHP issuers with low enrollment for estimating the cost-sharing amount enrollees would have to pay under the standard plan.

- The composition of the subgroups and whether they appropriately divide enrollees based on their utilization patterns, or whether any subgroups are required at all.
- Whether low enrollment in one subgroup should prompt the QHP issuer to use the AV for enrollees in all subgroups or just the subgroup with low enrollment.
- Whether it should require any other data submissions or establish additional standards relating to these provisions.

HHS also welcomes suggestions for other alternative methodologies.

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