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State, HHS may reallocate unused funds to other States, as needed.

§ 152.35 Insufficient funds.

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

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

Subpart G—Relationship to Existing Laws and Programs

§ 152.39 Maintenance of effort.

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

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

§ 152.40 Relation to State laws.

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

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Subpart H—Transition to Exchanges

§ 152.44 End of PCIP program coverage.

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

§ 152.45 Transition to the exchanges.

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

PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

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SOURCE: 77 FR 17245, Mar. 23, 2012, unless otherwise noted.

Subpart A—General Provisions

§ 153.10 Basis and scope.

(a) *Basis.* This part is based on the following sections of title I of the Affordable Care Act (Pub. L. 111–148, 24 Stat. 119):

(1) Section 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(2) Section 1341. Transitional reinsurance program for individual market in each State.

(3) Section 1342. Establishment of risk corridors for plans in individual and small group markets.

(4) Section 1343. Risk adjustment.

(b) *Scope.* This part establishes standards for the establishment and operation of a transitional reinsurance program, temporary risk corridors program, and a permanent risk adjustment program.

§ 153.20 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Alternate risk adjustment methodology means a risk adjustment methodology proposed by a State for use instead of a Federally certified risk adjustment methodology that has not yet been certified by HHS.

Applicable reinsurance entity means a not-for-profit organization that is exempt from taxation under Chapter 1 of the Internal Revenue Code of 1986 that carries out reinsurance functions under this part on behalf of the State. An entity is not an applicable reinsurance entity to the extent it is carrying out reinsurance functions under subpart C of this part on behalf of HHS.

Attachment point means the threshold dollar amount for claims costs incurred by a health insurance issuer for an enrolled individual’s covered benefits in a benefit year, after which threshold the claims costs for such benefits are eligible for reinsurance payments.

Benefit year has the meaning given to the term in §155.20 of this subchapter.

Calculation of payments and charges means the methodology applied to plan average actuarial risk to determine risk adjustment payments and charges for a risk adjustment covered plan.

Calculation of plan average actuarial risk means the specific procedures used to determine plan average actuarial risk from individual risk scores for a risk adjustment covered plan, including adjustments for variable rating and the specification of the risk pool from which average actuarial risk is to be calculated.

Coinsurance rate means the rate at which the applicable reinsurance entity will reimburse the health insurance issuer for claims costs incurred for an enrolled individual’s covered benefits in a benefit year after the attachment point and before the reinsurance cap.

Contributing entity means a health insurance issuer or a third party administrator on behalf a self-insured group health plan.

Contribution rate means, with respect to a benefit year, the per capita amount each contributing entity must pay for a reinsurance program established under this part with respect to

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each reinsurance contribution enrollee who resides in that State.

Exchange has the meaning given to the term in § 155.20 of this subchapter.

Federally certified risk adjustment methodology means a risk adjustment methodology that either has been developed and promulgated by HHS, or has been certified by HHS.

Grandfathered health plan has the meaning given to the term in § 147.140(a) of this subchapter.

Group health plan has the meaning given to the term in § 144.103 of this subchapter.

Health insurance coverage has the meaning given to the term in § 144.103 of this subchapter.

Health insurance issuer or *issuer* has the meaning given to the term in § 144.103 of this subchapter.

Health plan has the meaning given to the term in section 1301(b)(1) of the Affordable Care Act.

Individual market has the meaning given to the term in § 144.103 of this subchapter.

Individual risk score means a relative measure of predicted health care costs for a particular enrollee that is the result of a risk adjustment model.

Large employer has the meaning given to the term in § 155.20 of this subchapter.

Qualified employer has the meaning given to the term in § 155.20 of this subchapter.

Qualified health plan or *QHP* has the meaning given to the term in § 155.20 of this subchapter.

Qualified individual has the meaning given to the term in § 155.20 of this subchapter.

Reinsurance cap means the threshold dollar amount for claims costs incurred by a health insurance issuer for an enrolled individual's covered benefits, after which threshold, the claims costs for such benefits are no longer eligible for reinsurance payments.

Reinsurance contribution enrollee means an individual covered by a plan for which reinsurance contributions must be made pursuant to § 153.400.

Reinsurance-eligible plan means, for the purpose of the reinsurance program, any health insurance coverage offered in the individual market, except for grandfathered plans and health

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insurance coverage not required to submit reinsurance contributions under § 153.400(a).

Risk adjustment covered plan means, for the purpose of the risk adjustment program, any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, group health insurance coverage described in § 146.145(c) of this subchapter, individual health insurance coverage described in § 148.220 of this subchapter, and any other plan determined not to be a risk adjustment covered plan in the annual HHS notice of benefit and payment parameters.

Risk adjustment data means all data that are used in a risk adjustment model, the calculation of plan average actuarial risk, or the calculation of payments and charges, or that are used for validation or audit of such data.

Risk adjustment data collection approach means the specific procedures by which risk adjustment data is to be stored, collected, accessed, transmitted, validated and audited and the applicable timeframes, data formats, and privacy and security standards.

Risk adjustment methodology means the risk adjustment model, the calculation of plan average actuarial risk, the calculation of payments and charges, the risk adjustment data collection approach, and the schedule for the risk adjustment program.

Risk adjustment model means an actuarial tool used to predict health care costs based on the relative actuarial risk of enrollees in risk adjustment covered plans.

Risk pool means the State-wide population across which risk is distributed.

Small group market has the meaning given to the term in section 1304(a)(3) of the Affordable Care Act.

State has the meaning given to the term in § 155.20 of this subchapter.

Subpart B—State Notice of Benefit and Payment Parameters

§ 153.100 State notice of benefit and payment parameters.

(a) *General requirement for reinsurance.* A State establishing a reinsurance program must issue an annual notice of

benefit and payment parameters specific to that State if that State elects to:

(1) Modify the data requirements or data collection frequency for health insurance issuers to receive reinsurance payment from those specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year;

(2) Collect reinsurance contributions pursuant to §153.220(a)(1);

(3) Collect additional reinsurance contributions pursuant to §153.220(g);

(4) Use more than one applicable reinsurance entity; or

(5) Modify any reinsurance payment parameters from those specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

(b) *Risk adjustment requirements.* A State operating a risk adjustment program must issue an annual notice of benefit and payment parameters specific to that State setting forth the risk adjustment methodology and data validation standards it will use.

(c) *State notice deadlines.* If a State is required to publish an annual State notice of benefit and payment parameters, it must do so by March 1 of the calendar year prior to the benefit year for which the notice applies.

(d) *State failure to publish notice.* Any State establishing a reinsurance program or operating a risk adjustment program that fails to publish a State notice of benefit and payment parameters within the period specified in paragraph (c) of this section must—

(1) Adhere to the data requirements and data collection frequency for health insurance issuers to receive reinsurance payments that are specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year;

(2) Forgo the collection of reinsurance contributions pursuant to §153.220(a);

(3) Forgo the collection of additional reinsurance contributions pursuant to §153.220(g);

(4) Forgo the use of more than one applicable reinsurance entity;

(5) Adhere to the reinsurance parameters specified in the annual HHS notice

of benefit and payment parameters for the applicable benefit year; and

(6) Adhere to the risk adjustment methodology and data validation standards published in the annual HHS notice of benefit and payment parameters for use by HHS when operating risk adjustment on behalf of a State.

§ 153.110 Standards for the State notice of benefit and payment parameters.

(a) *Data requirements.* If a State that establishes a reinsurance program elects to modify the data requirements or data collection frequency for health insurance issuers to receive reinsurance payment from those specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year, the State notice of benefit and payment parameters must specify those modifications.

(b) *Reinsurance collection.* If a State that establishes a reinsurance program elects to collect reinsurance contributions pursuant to §153.220(a), then the State must announce its intention to do so in the State notice of benefit and payment parameters.

(c) *Additional collections.* If a State that establishes a reinsurance program elects to collect additional funds pursuant to §153.220(g), the State must publish the following:

(1) A description of the purpose of the additional collection, including whether it will be used to cover reinsurance payments, administrative costs, or both; and

(2) The additional contribution rate at which the funds will be collected.

(d) *Multiple reinsurance entities.* If a State plans to use more than one applicable reinsurance entity, the State must publish in the State notice of benefit and payment parameters, for each applicable reinsurance entity—

(1) The geographic boundaries for that entity;

(2) An estimate of the number of enrollees in fully insured plans within those boundaries;

(3) An estimate of the number of enrollees in the individual market within those boundaries;

(4) An estimate of the reinsurance contributions that will be collected by the applicable reinsurance entity;

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(5) The percentage of reinsurance contributions received from HHS for the State to be allocated to the applicable reinsurance entity; and

(6) An estimate of the amount of reinsurance payments that will be made to issuers with respect to enrollees within those boundaries.

(e) *Reinsurance payment.* If a State that establishes a reinsurance program intends to modify the attachment point, reinsurance cap, or coinsurance rate from the corresponding parameters specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year, the State must—

(1) Describe those modified parameters in the State notice of benefit and payment parameters; and

(2) Apply the modified parameters uniformly throughout the State.

(f) *Risk adjustment content.* A State operating a risk adjustment program must provide the information set forth in §153.330(a) and the data validation standards set forth pursuant to §153.350 in the State notice of benefit and payment parameters.

Subpart C—State Standards Related to the Reinsurance Program

§ 153.200 [Reserved]

§ 153.210 State establishment of a reinsurance program.

(a) *General requirement.* Each State is eligible to establish a reinsurance program for the years 2014 through 2016.

(1) If a State establishes a reinsurance program, the State must enter into a contract with one or more applicable reinsurance entities to carry out the provisions of this subpart.

(2) If a State contracts with more than one applicable reinsurance entity, the State must:

(i) Ensure that each applicable reinsurance entity operates in a distinct geographic area with no overlap of jurisdiction with any other applicable reinsurance entity;

(ii) Use the same payment parameters with respect to each applicable reinsurance entity; and

(iii) Notify HHS in the manner and timeframe specified by HHS of the per-

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centage of reinsurance contributions received from HHS for the State to be allocated to each applicable reinsurance entity.

(3) A State may permit an applicable reinsurance entity to subcontract specific administrative functions required under this subpart and subpart E of this part.

(4) A State must review and approve subcontracting arrangements to ensure efficient and appropriate expenditures of administrative funds collected under this subpart.

(5) A State must ensure that the applicable reinsurance entity completes all reinsurance-related activities for benefit years 2014 through 2016 and any activities required to be undertaken in subsequent periods.

(b) *Multi-State reinsurance arrangements.* Multiple States may contract with a single entity to serve as an applicable reinsurance entity for each State. In such a case, the reinsurance programs for those States must be operated as separate programs.

(c) *Non-electing States.* HHS will establish a reinsurance program for each State that does not elect to establish its own reinsurance program.

(d) *Oversight.* Each State that establishes a reinsurance program must ensure that the applicable reinsurance entity complies with all provisions of this subpart and subpart E of this part throughout the duration of its contract.

§ 153.220 Collection of reinsurance contribution funds.

(a) *Collections.* If a State establishes a reinsurance program, then—

(1) The State may elect to—

(i) Have the applicable reinsurance entity collect contributions for reinsurance contribution enrollees who reside in that State directly from issuers of health plans; or

(ii) Ensure that the applicable reinsurance entity accepts contributions for reinsurance contribution enrollees who reside in that State with respect to issuers of health plans from HHS.

(2) The State must ensure that the applicable reinsurance entity accepts contributions for reinsurance contribution enrollees who reside in that State

with respect to all contributing entities other than issuers of health plans from HHS.

(b) *Notification of election to collect.* If a State establishes a reinsurance program, then that State must notify HHS by December 1, 2012, if the State elects to collect reinsurance contributions from fully insured plans for the 2014 benefit year, and by September 1 of the calendar year that is two years prior to the applicable benefit year if the State elects to collect reinsurance contributions from fully insured plans for any benefit year after 2014, in each case pursuant to paragraph (a)(1)(i) of this section. The State's notification will be effective for the applicable benefit year and each subsequent benefit year during which activities related to the transitional reinsurance program continue.

(c) *Contribution funding.* Reinsurance contributions collected must fund the following:

(1) Reinsurance payments that will total, on a national basis, \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016;

(2) U.S. Treasury contributions that will total, on a national basis, \$2 billion in 2014, \$2 billion in 2015, and \$1 billion in 2016; and

(3) Administrative expenses of the applicable reinsurance entity or HHS when performing reinsurance functions under this subpart.

(d) *Distribution of reinsurance contributions.* If a State establishes a reinsurance program, HHS will distribute funds collected for reinsurance contribution enrollees who reside in a State to the applicable reinsurance entity for that State (or the applicable reinsurance entities, if more than one, in accordance with the allocation specified by the State pursuant to § 153.210(a)(2)(iii)), less:

(1) The State's pro rata share of the U.S. Treasury contribution described in paragraph (c)(2) of this section; and

(2) The State's pro rata share of administrative expenses incurred by HHS when performing reinsurance functions under this subpart.

(e) *National contribution rate.* HHS will set in the annual HHS notice of benefit and payment parameters for the applicable benefit year the na-

tional contribution rate and the proportion of contributions collected under the national contribution rate to be allocated to:

(1) Reinsurance payments;

(2) Payments to the U.S. Treasury as described in paragraph (c)(2) of this section; and

(3) Administrative expenses of the applicable reinsurance entity or HHS when performing reinsurance functions under this subpart.

(f) *State collections.* If a State elects to have the applicable reinsurance entity collect contributions pursuant to paragraph (a)(1)(i) of this section, the State must ensure that:

(1) The applicable reinsurance entity for the State collects contributions for reinsurance contribution enrollees who reside in that State directly from issuers of health plans in the amounts required under the national contribution rate.

(2) Reinsurance contributions are allocated as required in the annual HHS notice of benefit and payment parameters for the applicable benefit year, such that:

(i) Contributions allocated for reinsurance payments are only used for reinsurance payments; and

(ii) Contributions allocated for payments to the U.S. Treasury are paid to the U.S. Treasury in a timeframe to be established by HHS.

(g) *Additional State collections.* If a State establishes a reinsurance program, it may elect to collect more than the amounts that would be collected based on the national contribution rate set forth in the annual HHS notice of benefit and payment parameters for the applicable benefit year to provide:

(1) Funding for administrative expenses of the applicable reinsurance entity; or

(2) Additional funding for reinsurance payments.

(h) *Administration of additional State collections.* If a State elects to collect additional amounts pursuant to paragraph (g) of this section for administrative expenses or reinsurance payments, then:

(1) The State must notify HHS within 30 days after publication of the draft annual HHS notice of benefit and payment parameters for the applicable

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benefit year of the additional contribution rate that it elects to collect for additional administrative expenses. The State must ensure that the State's applicable reinsurance entity—

(i) Collects these additional amounts for additional administrative expenses from issuers of health plans when the State elects to collect contributions from such issuers under paragraph (a)(1) of this section; and

(ii) Accepts additional amounts for additional administrative expenses from HHS from all contributing entities from which HHS collects in accordance with the State's election under paragraph (a)(1) of this section.

(2) Notwithstanding paragraphs (a)(1) and (a)(2) of this section, the State must ensure that the applicable reinsurance entity collects all additional reinsurance contributions for the purpose of reinsurance payments from all contributing entities.

[77 FR 17245, Mar. 23, 2012, as amended at 77 FR 29236, May, 17, 2012]

§ 153.230 Calculation of reinsurance payments.

(a) *General requirement.* A health insurance issuer of a non-grandfathered individual market plan becomes eligible for reinsurance payments when its claims costs for an individual enrollee's covered benefits in a benefit year exceed the attachment point.

(b) *Reinsurance payment parameters.* If a State establishes a reinsurance program, the State must use, subject to any modifications made pursuant to paragraph (d) of this section, the payment formula and values for the attachment point, reinsurance cap, and coinsurance rate for each year commencing in 2014 and ending in 2016 established in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

(c) *Reinsurance payments.* If a State establishes a reinsurance program, the State must ensure, subject to § 153.240(b)(1), that the reinsurance payment represents the product of the coinsurance rate multiplied by the health insurance issuer's claims costs for an individual enrollee's covered benefits that the health insurance issuer incurs between the attachment point and the reinsurance cap.

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(d) *State modification of reinsurance payment formula.* If a State establishes a reinsurance program, the State may modify the reinsurance payment formula in accordance with the following:

(1) The State may only use one or more of the following methods to modify the reinsurance payment formula:

(i) Increasing or decreasing the attachment point;

(ii) Increasing, decreasing, or eliminating the reinsurance cap; or

(iii) Increasing or decreasing the coinsurance rate.

(2) The State must publish any such modification to the reinsurance payment formula and parameters in a State notice of benefit and payment parameters as described in subpart B of this part.

(3) Any State modification to the reinsurance payment formula pursuant to paragraph (d)(1) of this section must be reasonably calculated to ensure that reinsurance contributions received toward reinsurance are sufficient to cover payments that the applicable reinsurance entity is obligated to make under that State formula for the given benefit year for the reinsurance program.

(4) The State must use a uniform attachment point, coinsurance rate, and reinsurance cap throughout the State.

§ 153.240 Disbursement of reinsurance payments.

(a) *Data collection.* If a State establishes a reinsurance program, the State must ensure that the applicable reinsurance entity collects from health insurance issuers of reinsurance-eligible plans data required to calculate payments described in § 153.230, according to the data requirements and data collection frequency specified by the State in the notice of benefit and payment parameters described in subpart B of this part.

(b) *Reinsurance entity payments.* If a State establishes a reinsurance program, the State must ensure that each applicable reinsurance entity does not make payments to health insurance issuers that exceed contributions received to date by the applicable reinsurance entity.

(1) If a State, or HHS on behalf of the State, determines that reinsurance

payments requested for a benefit year will likely exceed the reinsurance contributions that will be received for the year, the State may require that the applicable reinsurance entity reduce (or HHS on behalf of the State may reduce) reinsurance payments, so long as the manner in which payments are reduced is fair and equitable for all health insurance issuers in the individual market.

(2) The State must ensure that an applicable reinsurance entity makes payment to the health insurance issuer of a reinsurance-eligible plan after receiving a valid claim for payment from that health insurance issuer in accordance with the requirements of § 153.410.

(c) *Maintenance of records.* If a State establishes a reinsurance program, the State must maintain books, records, documents, and other evidence of accounting procedures and practices of the reinsurance program for each benefit year for at least 10 years.

§ 153.250 Coordination with high-risk pools.

(a) *General requirement.* The State must eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this subpart.

(b) *Coordination with high-risk pools.* The State may coordinate the State high-risk pool with the reinsurance program to the extent that the State high-risk pool conforms to the provisions of this subpart.

Subpart D—State Standards Related to the Risk Adjustment Program

§ 153.300 [Reserved]

§ 153.310 Risk adjustment administration.

(a) *State eligibility to establish a risk adjustment program.* (1) A State that elects to operate an Exchange is eligible to establish a risk adjustment program.

(2) Any State that does not elect to operate an Exchange, or that HHS has not approved to operate an Exchange, will forgo implementation of all State functions in this subpart, and HHS will

carry out all of the provisions of this subpart on behalf of the State.

(3) Any State that elects to operate an Exchange but does not elect to administer risk adjustment will forgo implementation of all State functions in this subpart, and HHS will carry out all of the provisions of this subpart on behalf of the State.

(b) *Entities eligible to carry out risk adjustment activities.* If a State is operating a risk adjustment program, the State may elect to have an entity other than the Exchange perform the State functions of this subpart, provided that the entity meets the standards promulgated by HHS to be an entity eligible to carry out Exchange functions.

(c) *Timeframes.* A State, or HHS on behalf of the State, must implement risk adjustment for the 2014 benefit year and every benefit year thereafter. For each benefit year, a State, or HHS on behalf of the State, must notify issuers of risk adjustment payments due or charges owed annually by June 30 of the year following the benefit year.

(d) *State summary reports.* Each State operating a risk adjustment program must submit to HHS an annual summary of risk adjustment program operations in the manner and timeframe specified by HHS.

§ 153.320 Federally certified risk adjustment methodology.

(a) *General requirement.* Any risk adjustment methodology used by a State, or HHS on behalf of the State, must be a Federally certified risk adjustment methodology. A risk adjustment methodology may become Federally certified by one of the following processes:

(1) The risk adjustment methodology is developed by HHS and published in an annual HHS notice of benefit and payment parameters; or

(2) An alternate risk adjustment methodology is submitted by a State in accordance with § 153.330, reviewed and certified by HHS, and published in an annual HHS notice of benefit and payment parameters.

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(b) *Publication of methodology in notices.* The publication of a risk adjustment methodology by HHS in an annual HHS notice of benefit and payment parameters or by a State in an annual State notice of benefit and payment parameters described in subpart B of this part must include:

(1) A complete description of the risk adjustment model, including—

(i) Factors to be employed in the model, including but not limited to demographic factors, diagnostic factors, and utilization factors, if any;

(ii) The qualifying criteria for establishing that an individual is eligible for a specific factor;

(iii) Weights assigned to each factor; and

(iv) The schedule for the calculation of individual risk scores.

(2) A complete description of the calculation of plan average actuarial risk.

(3) A complete description of the calculation of payments and charges.

(4) A complete description of the risk adjustment data collection approach.

(5) The schedule for the risk adjustment program.

(c) *Use of methodology for States that do not operate a risk adjustment program.* HHS will specify in the annual HHS notice of benefit and payment parameters for the applicable year the Federally certified risk adjustment methodology that will apply in States that do not operate a risk adjustment program.

§ 153.330 State alternate risk adjustment methodology.

(a) *State request for alternate methodology certification.* (1) A State request to HHS for the certification of an alternate risk adjustment methodology must include:

(i) The elements specified in § 153.320(b);

(ii) The calibration methodology and frequency of calibration; and

(iii) The statistical performance metrics specified by HHS.

(2) The request must include the extent to which the methodology:

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

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

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

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

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

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

(vii) Minimizes administrative costs.

(b) *State renewal of alternate methodology.* If a State is operating a risk adjustment program, the State may not implement a recalibrated risk adjustment model or otherwise alter its risk adjustment methodology without first obtaining HHS certification.

(1) Recalibration of the risk adjustment model must be performed at least as frequently as described in paragraph (a)(1)(ii) of this section;

(2) A State request to implement a recalibrated risk adjustment model or otherwise alter its risk adjustment methodology must include any changes to the parameters described in paragraph (a)(1) of this section.

§ 153.340 Data collection under risk adjustment.

(a) *Data collection requirements.* If a State is operating a risk adjustment program, the State must collect risk adjustment data.

(b) *Minimum standards.* (1) If a State is operating a risk adjustment program, the State may vary the amount and type of data collected, but the State must collect or calculate individual risk scores generated by the risk adjustment model in the applicable Federally certified risk adjustment methodology;

(2) If a State is operating a risk adjustment program, the State must require that issuers offering risk adjustment covered plans in the State comply with data privacy and security standards set forth in the applicable risk adjustment data collection approach; and

(3) If a State is operating a risk adjustment program, the State must ensure that any collection of personally identifiable information is limited to information reasonably necessary for use in the applicable risk adjustment

model, calculation of plan average actuarial risk, or calculation of payments and charges. Except for purposes of data validation, the State may not collect or store any personally identifiable information for use as a unique identifier for an enrollee's data, unless such information is masked or encrypted by the issuer, with the key to that masking or encryption withheld from the State.

(4) If a State is operating a risk adjustment program, the State must implement security standards that provide administrative, physical, and technical safeguards for the individually identifiable information consistent with the security standards described at 45 CFR 164.308, 164.310, and 164.312.

§ 153.350 Risk adjustment data validation standards.

(a) *General requirement.* The State, or HHS on behalf of the State, must ensure proper implementation of any risk adjustment software and ensure proper validation of a statistically valid sample of risk adjustment data from each issuer that offers at least one risk adjustment covered plan in that State.

(b) *Adjustment to plan average actuarial risk.* The State, or HHS on behalf of the State, may adjust the plan average actuarial risk for a risk adjustment covered plan based on errors discovered with respect to implementation of risk adjustment software or as a result of data validation conducted pursuant to paragraph (a) of this section.

(c) *Adjustment to charges and payments.* The State, or HHS on behalf of the State, may adjust charges and payments to all risk adjustment covered plan issuers based on the adjustments calculated in paragraph (b) of this section.

(d) *Appeals.* The State, or HHS on behalf of the State, must provide an administrative process to appeal findings with respect to the implementation of risk adjustment software or data validation.

Subpart E—Health Insurance Issuer and Group Health Plan Standards Related to the Reinsurance Program

§ 153.400 Reinsurance contribution funds.

(a) *General requirement.* Each contributing entity must make reinsurance contributions at the national contribution rate (and any additional contribution rate if the State has elected to collect additional contributions pursuant to § 153.220(g)) for the reinsurance program for all reinsurance contribution enrollees who reside in a State, in a frequency and manner determined by HHS or the State, to HHS or the applicable reinsurance entity, as applicable.

(1) A contributing entity must make reinsurance contributions on behalf of its group health plans and health insurance coverage, except as set forth in paragraph (a)(2) of this section.

(2) A contributing entity is not required to make contributions on behalf of plans or health insurance coverage that consist solely of excepted benefits as defined by section 2791(c) of the PHS Act.

(b) *Multiple reinsurance entities.* If the State establishes or contracts with more than one applicable reinsurance entity, the contributing entity must make reinsurance contributions to each applicable reinsurance entity for the reinsurance contribution enrollees who reside in the applicable geographic area.

(c) *Timeframe for Federal collections.* Each contributing entity must submit contributions to HHS on a quarterly basis beginning January 15, 2014.

(d) *Data requirements.* Each contributing entity must submit to HHS and each applicable reinsurance entity, if the State elects to collect reinsurance contributions, data required to substantiate the contribution amounts for the contributing entity, in the manner and timeframe specified by the State or HHS.

§ 153.410 Requests for reinsurance payment.

(a) *General requirement.* An issuer of a reinsurance-eligible plan may make a request for payment when an enrollee of that reinsurance-eligible plan has

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met the criteria for reinsurance payment set forth in the annual HHS notice of benefit and payment parameters for the applicable year or the State notice of benefit and payment parameters described in subpart B of this part, as applicable.

(b) *Manner of request.* An issuer of a reinsurance-eligible plan must make requests for payment in accordance with the requirements of the annual HHS notice of benefit and payment parameters for the applicable benefit year or the State notice of benefit and payment parameters described in subpart B of this part, as applicable.

Subpart F—Health Insurance Issuer Standards Related to the Risk Corridors Program

§ 153.500 Definitions.

The following definitions apply to this subpart:

Administrative costs mean, with respect to a QHP, total non-claims costs incurred by the QHP issuer for the QHP, as described in § 158.160(b) of this subchapter.

Allowable administrative costs mean, with respect to a QHP, administrative costs of the QHP, up to 20 percent of the premiums earned with respect to the QHP (including any premium tax credit under any governmental program).

Allowable costs mean, with respect to a QHP, an amount equal to the sum of incurred claims of the QHP issuer for the QHP, within the meaning of § 158.140 of this subchapter (including adjustments for any direct and indirect remuneration); expenditures by the QHP issuer for the QHP for activities that improve health care quality as set forth in § 158.150 of this subchapter; expenditures by the QHP issuer for the QHP related to health information technology and meaningful use requirements as set forth in § 158.151 of this subchapter; and the adjustments set forth in § 153.530(b).

Charge means the flow of funds from QHP issuers to HHS.

Direct and indirect remuneration means prescription drug rebates received by a QHP issuer within the meaning of § 158.140(b)(1)(i) of this subchapter.

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Payment means the flow of funds from HHS to QHP issuers.

Premiums earned mean, with respect to a QHP, all monies paid by or for enrollees with respect to that plan as a condition of receiving coverage, including any fees or other contributions paid by or for enrollees, within the meaning of § 158.130 of this subchapter.

Risk corridors means any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount.

Target amount means, with respect to a QHP, an amount equal to the total premiums earned with respect to a QHP, including any premium tax credit under any governmental program, reduced by the allowable administrative costs of the plan.

§ 153.510 Risk corridors establishment and payment methodology.

(a) *General requirement.* A QHP issuer must adhere to the requirements set by HHS in this subpart and in the annual HHS notice of benefit and payment parameters for the establishment and administration of a program of risk corridors for calendar years 2014, 2015, and 2016.

(b) *HHS payments to health insurance issuers.* QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:

(1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and

(2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(c) *Health insurance issuers' remittance of charges.* QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:

(1) If a QHP's allowable costs for any benefit year are less than 97 percent

but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and

(2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

§ 153.520 Attribution and allocation of revenue and expense items.

(a) *Attribution to QHP.* Each item of revenue or expense in allowable costs or the target amount with respect to a QHP must be reasonably attributable to the operation of the QHP, with the attribution based on a generally accepted accounting method, consistently applied. To the extent that an issuer utilizes a specific method for allocating expenses for purposes of § 158.170 of this subchapter, the method used for purposes of this paragraph must be consistent.

(b) *Allocation across plans.* Each item of revenue or expense in allowable costs or the target amount must be reasonably allocated across a QHP issuer's plans, with the allocation based on a generally accepted accounting method, consistently applied. To the extent that an issuer utilizes a specific method for allocating expenses for purposes of § 158.170 of this subchapter, the method used for purposes of this paragraph must be consistent.

(c) *Disclosure of attribution and allocation methods.* A QHP issuer must submit to HHS a report, in the manner and timeframe specified in the annual HHS notice of benefit and payment parameters, with a detailed description of the methods and specific bases used to perform the attributions and allocations set forth in paragraphs (a) and (b) of this section.

(d) *Attribution of reinsurance and risk adjustment to benefit year.* A QHP issuer must attribute reinsurance payments and contributions and risk adjustment payments and charges to allowable costs for the benefit year with respect to which the reinsurance payments or

contributions or risk adjustment calculations apply.

(e) *Maintenance of records.* A QHP issuer must maintain for 10 years and make available to HHS upon request the data used to make the attributions and allocations set forth in paragraphs (a) and (b) of this section, together with all supporting information required to determine that these methods and bases were accurately implemented.

§ 153.530 Risk corridors data requirements.

(a) *Premium data.* A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters.

(b) *Allowable costs.* A QHP issuer must submit to HHS data on the allowable costs incurred with respect to each QHP that the QHP issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters. For purposes of this subpart, allowable costs must be—

(1) Increased by—

(i) Any risk adjustment charges paid by the issuer for the QHP under the risk adjustment program established pursuant to subpart D of this part; and

(ii) Any reinsurance contributions made by the issuer for the QHP under the transitional reinsurance program established pursuant to subpart C of this part.

(2) Reduced by—

(i) Any risk adjustment payments received by the issuer for the QHP under the risk adjustment program established pursuant to subpart D of this part;

(ii) Any reinsurance payments received by the issuer for the QHP under the transitional reinsurance program established pursuant to subpart C of this part; and

(iii) Any cost-sharing reduction payments received by the issuer for the QHP.

(c) *Allowable administrative costs.* A QHP issuer must submit to HHS data on the allowable administrative costs incurred with respect to each QHP that the QHP issuer offers in the manner

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and timeframe set forth in the annual HHS notice of benefit and payment parameters.

Subpart G—Health Insurance Issuer Standards Related to the Risk Adjustment Program

§ 153.600 [Reserved]

§ 153.610 Risk adjustment issuer requirements.

(a) *Data requirements.* An issuer that offers risk adjustment covered plans must submit or make accessible all required risk adjustment data for those risk adjustment covered plans in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State.

(b) *Risk adjustment data storage.* An issuer that offers risk adjustment covered plans must store all required risk adjustment data in accordance with the risk adjustment data collection approach established by the State, or by HHS on behalf of the State.

(c) *Issuer contracts.* An issuer that offers risk adjustment covered plans may include in its contract with a provider, supplier, physician, or other practitioner, provisions that require such contractor's submission of complete and accurate risk adjustment data in the manner and timeframe established by the State, or HHS on behalf of the State. These provisions may include financial penalties for failure to submit complete, timely, or accurate data.

(d) *Assessment of charges.* An issuer that offers risk adjustment covered plans that has a net balance of risk adjustment charges payable, including adjustments made pursuant to §153.350(c), will be notified by the State, or by HHS on behalf of the State, of those net charges, and must remit those risk adjustment charges to the State, or to HHS on behalf of the State, as applicable.

(e) *Charge submission deadline.* An issuer must remit net charges to the State, or HHS on behalf of the State, within 30 days of notification of net charges payable by the State, or HHS on behalf of the State.

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§ 153.620 Compliance with risk adjustment standards.

(a) *Issuer support of data validation.* An issuer that offers risk adjustment covered plans must comply with any data validation requests by the State or HHS on behalf of the State.

(b) *Issuer records maintenance requirements.* An issuer that offers risk adjustment covered plans must retain any information requested to support risk adjustment data validation for a period of at least ten years after the date of the report.

PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

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Subpart C—Effective Rate Review Programs

- 154.301 CMS's determinations of Effective Rate Review Programs.

AUTHORITY: Section 2794 of the Public Health Service Act (42 USC 300gg–94).

SOURCE: 76 FR 29985, May 23, 2011, unless otherwise noted.

Subpart A—General Provisions

§ 154.101 Basis and scope.

(a) *Basis.* This part implements section 2794 of the Public Health Service (PHS) Act.