

§ 153.100

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;