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

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.

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