Subpart H—Distributed Data Collection for HHS-Operated Programs

AUTHORITY: Secs. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

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—

(1) A health insurance issuer; or

(2) For the 2014 benefit year, a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage), whether or not it uses a third party administrator; and for the 2015 and 2016 benefit years, a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third party administrator in connection with claims processing or adjudication (including the management of internal appeals) or plan enrollment for services other than for pharmacy benefits or excepted benefits within the meaning of section 2791(c) of the PHS

Act. Notwithstanding the foregoing, a self-insured group health plan that uses an unrelated third party to obtain provider network and related claim repricing services, or uses an unrelated third party for up to 5 percent of claims processing or adjudication or plan enrollment, will not be deemed to use a third party administrator, based on either the number of transactions processed by the third party, or the value of the claims processing and adjudication and plan enrollment services provided by the third party. A self-insured group health plan that is a contributing entity is responsible for the reinsurance contributions, although it may elect to use a third party administrator or administrative services-only contractor for transfer of the reinsurance contributions.

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 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.

Major medical coverage means, for purposes only of the requirements related to reinsurance contributions under section 1341 of the Affordable Care Act, a catastrophic plan, an individual or a small group market plan subject to the actuarial value requirements under §156.140 of this subchapter, or health coverage for a broad range of services and treatments provided in various settings that provides minimum value as defined in §156.145 of this subchapter.

Qualified employer 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 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 plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.

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, and validated 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.

[77 FR 17245, Mar. 23, 2012, as amended at 78 FR 15525, Mar. 11, 2013; 78 FR 54133, Aug. 30, 2013; 78 FR 65093, Oct. 30, 2013; 79 FR 13834, Mar. 11, 2014; 79 FR 36432, June 27, 2014]

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 for health insurance issuers to receive reinsurance payments from those specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year;

(2) Collect additional reinsurance contributions under §153.220(d)(1) or use additional funds for reinsurance payments under §153.220(d)(2); or

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

(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 for health insurance issuers to receive reinsurance payments that are specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year;

(2) Forgo the collection of additional reinsurance contributions under §153.220(d)(1) and the use of additional funds for reinsurance payments under §153.220(d)(2);

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

(4) 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.

[77 FR 17245, Mar. 23, 2012, as amended at 78 FR 15525, Mar. 11, 2013]

§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 for health insurance issuers to receive reinsurance payments 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) *Additional collections.* If a State that establishes a reinsurance program elects to collect additional funds under §153.220(d)(1) or use additional funds for reinsurance payments under §153.220(d)(2), the State must publish in