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.

§ 153.360 Application of risk adjustment to the small group market.

Enrollees in a risk adjustment covered plan must be assigned to the applicable risk pool in the State in which the employer's policy was filed and approved.

[78 FR 15528, Mar. 11, 2013]

§ 153.365 General oversight requirements for State-operated risk adjustment programs.

If a State is operating a risk adjustment program, it must keep an accounting of all receipts and expenditures related to risk adjustment payments and charges and the administration of risk adjustment-related functions and activities for each benefit year.

[78 FR 65094, Oct. 30, 2013]

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 annually: at the national contribution rate for all reinsurance contribution enrollees, in a manner specified by HHS; and at the additional State supplemental contribution rate if the State has elected to collect additional contributions under §153.220(d)(1), in a manner specified by the State.

(1) In general, reinsurance contributions are required for major medical coverage that is considered to be part of a commercial book of business, but are not required to be paid more than once with respect to the same covered life. In order to effectuate that principle, a contributing entity must make reinsurance contributions for lives covered by its self-insured group health plans and health insurance coverage except to the extent that:

(i) Such plan or coverage is not major medical coverage, subject to paragraph (a)(3) of this section.

(ii) In the case of health insurance coverage, such coverage is not considered to be part of an issuer's commercial book of business;

(iii) Such plan or coverage is expatriate health coverage, as defined by the Secretary; or

(iv) In the case of employer-provided health coverage, such coverage applies to individuals with respect to which benefits under Title XVIII of the Act (Medicare) are primary under the Medicare Secondary Payor rules under section 1862(b) of the Act and the regulations issued thereunder.

(v) Such plan or coverage applies to individuals with primary residence in a territory that does not operate a reinsurance program.

(vi) In the case of employer-provided group health coverage:

(A) Such coverage applies to individuals with individual market health insurance coverage for which reinsurance contributions are required; or

(B) Such coverage is supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives.

(2) Accordingly, as specified in paragraph (a)(1) of this section, a contributing entity is not required to make contributions on behalf of the following:

(i) A self-insured group health plan or health insurance coverage that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act;

(ii) Coverage offered by an issuer under contract to provide benefits under any of the following titles of the Act:

(A) Title XVIII (Medicare);

(B) Title XIX (Medicaid); or

(C) Title XXI (Children's Health Insurance Program);

(iii) A Federal or State high-risk pool, including the Pre-Existing Condition Insurance Plan Program;

(iv) Basic health plan coverage offered by issuers under contract with a State as described in section 1331 of the Affordable Care Act;

(v) A health reimbursement arrangement within the meaning of IRS Notice 2002–45 (2002–2 CB 93) or any subsequent applicable guidance, that is integrated with a self-insured group health plan or health insurance coverage;

(vi) A health savings account within the meaning of section 223(d) of the Code;

(vii) A health flexible spending arrangement within the meaning of section 125 of the Code;

(viii) An employee assistance plan, disease management program, or wellness program that does not provide major medical coverage;

(ix) A stop-loss policy or an indemnity reinsurance policy;

(x) TRICARE and other military health benefits for active and retired uniformed services personnel and their dependents;

(xi) A plan or coverage provided by an Indian Tribe to Tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the Tribe), in the capacity of the Tribal members as Tribal members (and not in their capacity as current or former employees of the Tribe or their dependents);

(xii) Health programs operated under the authority of the Indian Health Service; or

(xiii) A self-insured group health plan or health insurance coverage that consists solely of benefits for prescription drugs.

(3) Notwithstanding paragraph (a)(1)(i) of this section, a health insurance issuer must make reinsurance contributions for lives covered by its group health insurance coverage whether or not the insurance coverage constitutes major medical coverage, if—

(i) The group health plan provides health insurance coverage for those covered lives through more than one insurance policy that in combination constitute major medical coverage;

(ii) The lives are not covered by self-insured coverage of the group health plan (except for self-insured coverage limited to excepted benefits); and

(iii) The health insurance coverage under the policy offered by the health insurance issuer constitutes the greatest portion of inpatient hospitalization benefits under the group health plan.

(b) *Data requirements.* Each contributing entity must submit to HHS data required to substantiate the contribution amounts for the contributing entity, in the manner and timeframe specified by HHS.

[78 FR 15528, Mar. 11, 2013, as amended at 78 FR 65094, Oct. 30, 2013; 79 FR 13835, Mar. 11, 2014]

§ 153.405 Calculation of reinsurance contributions.

(a) *In general.* The reinsurance contribution required from a contributing entity for its reinsurance contribution enrollees during a benefit year is calculated by multiplying:

(1) The number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all plans and coverage described in § 153.400(a)(1) of the contributing entity; by

(2) The contribution rate for the applicable benefit year.

(b) *Annual enrollment count.* No later than November 15 of benefit year 2014, 2015, or 2016, as applicable, a contributing entity must submit an annual enrollment count of the number of covered lives of reinsurance contribution enrollees for the applicable benefit year to HHS. The count must be determined as specified in paragraphs (d) through (g) of this section, as applicable.

(c) *Notification and payment.* (1) Following submission of the annual enrollment count described in paragraph (b) of this section, HHS will notify the contributing entity of the reinsurance contribution amount allocated to reinsurance payments and administrative expenses to be paid for the applicable benefit year.

(2) In the fourth quarter of the calendar year following the applicable benefit year, HHS will notify the contributing entity of the portion of the reinsurance contribution amount allocated for payments to the U.S. Treasury for the applicable benefit year.

(3) A contributing entity must remit reinsurance contributions to HHS