DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 153 and 156

[CMS-9964-IFC]

RIN 0938-AR74

Patient Protection and Affordable Care Act; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Interim final rule with comment.

SUMMARY: This interim final rule with comment builds upon standards set forth in the HHS Notice of Benefit and Payment Parameters for 2014, published elsewhere in this issue of the **Federal Register**. This document will adjust risk corridors calculations that would align the calculations with the single risk pool provision, and set standards permitting issuers of qualified health plans the option of using an alternate methodology for calculating the value of cost-sharing reductions provided for the purpose of reconciliation of advance payments of cost-sharing reductions.

DATES: Effective date*:* These regulations are effective on [OFR-insert date 60 days after the date of filing for public inspection at OFR].

Comment date*:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **[**OFR--insert date 60 days after the date of filing for public inspection at OFR**]**.

ADDRESSES: In commenting, please refer to file code CMS-9964-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX)

transmission.

You may submit comments in one of four ways (please choose only one of the ways listed)

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9964-IFC,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9964-IFC,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Sharon Arnold, (301) 492-4286; Laurie McWright, (301) 492-4311; or Jeff Wu, (301) 492-4305, for general information.

Jaya Ghildiyal, (301) 492-5149 for matters relating to risk corridors.

Johanna Lauer, (301) 492-4397 for matters relating to cost-sharing reductions.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that website to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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I. Executive Summary

A. Purpose

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance – qualified health plans – through competitive marketplaces, called Affordable Insurance Exchanges, "Exchanges," or "Marketplaces."

Section 1342 of the Affordable Care Act provides for a temporary risk corridors program. The program, which is Federally administered and in effect from 2014 through 2016, is intended to protect against uncertainty in rate setting for qualified health plans (QHPs) by limiting the extent of issuer losses and gains. In the rule entitled "Standards Related to

Reinsurance, Risk Adjustment and Risk Corridors" (77 FR 17220) (Premium Stabilization Rule), we set forth a regulatory framework for this program. In the HHS Notice of Benefit and Payment Parameters for 2014 (2014 Payment Notice) published elsewhere in this issue of the **Federal Register**, we expanded upon these standards, and stated that we are publishing this interim final rule with comment. In this interim final rule with comment, we will amend the requirements governing the risk corridors program to better align it with the single risk pool requirement we established in the rule entitled "Health Insurance Market Reforms; Rate Review," which was made available for public inspection at the Office of the Federal Register on February 22, 2013. The Market Reform Rule sets forth standards at §156.80 to implement section 1312(c) of the Affordable Care Act, which directs an issuer to use a single risk pool for a market (the individual market, small group market, or merged individual and small group market) when developing rates and premiums for coverage effective beginning in 2014. Under the single risk pool provision, an issuer will develop a market-wide index rate (average rate) based on the total combined essential health benefits (EHB) claims experience of all enrollees in all non-grandfathered plans in the market. After setting the index rate, the issuer will make a market-wide adjustment based on the expected aggregated payments and charges under the risk adjustment and reinsurance programs in a State. The premium rate for any given plan may not vary from the resulting adjusted market-wide index rate, except for plan specific adjustments specified under §156.80. To address a potential incongruity between the current risk corridors calculation methodology and the single risk pool requirement in section 1312(c) of the Affordable Care Act, we are modifying

our interpretation of the definition of "allowable costs" found in section 1342(c)(1)(A) of the Affordable Care Act and are changing the corresponding regulatory definition accordingly. We are also making certain conforming changes to the risk corridors attribution and allocation rules in §153.520.

This interim final rule with comment establishes alternate standards for the administration and payment to issuers of the value of cost-sharing reductions provided to eligible individuals. Section 1402 of the Affordable Care Act provides for reductions in cost sharing for certain individuals enrolled in QHPs purchased on the Exchanges, and section 1412(c) of the Affordable Care Act provides for the advance payment of these reductions to issuers. This assistance will help eligible low- and moderate-income qualified individuals and families afford the out-of-pocket spending associated with health care services provided through Exchange-based QHP coverage. The Affordable Care Act directs issuers to reduce cost sharing for EHB for low- and moderate-income individuals who are enrolled in a silver level QHP through an individual market Exchange and are eligible for advance payments of the premium tax credit under Section 36B of the Internal Revenue Code. The statute also directs issuers to eliminate cost sharing for Indians (as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income at or below 300 percent of the Federal poverty level (FPL) who are enrolled in a QHP of any "metal" level (that is, bronze, silver, gold, or platinum) through the individual market in the Exchange, and does not allow issuers of QHPs to require cost sharing for Indians, regardless of household income, for items or services furnished directly by the Indian Health Service,

an Indian Tribe, a Tribal Organization, or an Urban Indian Organization, or through referral under contract health services.

To implement these cost-sharing reductions, we published a rule entitled "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers" (77 FR 18310) (Exchange Establishment Rule), which established eligibility standards for these cost-sharing reductions. We published a bulletin outlining an intended regulatory approach to calculating actuarial value and implementing cost-sharing reductions on February 24, 2012 (the AV/CSR Bulletin).[1] The AV/CSR Bulletin specifically outlined an intended regulatory approach for de minimis variation standards, silver plan variations for individuals eligible for cost-sharing reductions, and advance payments of cost-sharing reductions to issuers, among other topics. The HHS Notice of Benefit and Payment Parameters for 2014 (the 2014 Payment Notice), published concurrently with this interim final rule with comment, establishes standards governing the administration of cost-sharing reductions and provided specific payment parameters for the program. In this interim final rule with comment, we establish an alternate, optional methodology for calculating the value of cost-sharing reductions provided for the purpose of reconciliation of advance payments of cost-sharing reductions.

B. Summary of Provisions

This interim final rule with comment amends the standards established by the Premium Stabilization Rule and the 2014 Payment Notice for the risk corridors and cost-sharing reductions programs.

[1] Available at: http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

Risk Corridors: The temporary risk corridors program provides for the Federal government to share a QHP's profits or losses resulting from inaccurate rate setting from 2014 to 2016. In this interim final rule with comment, we are modifying our interpretation of the definition of "allowable costs" in section 1342(c)(1)(A) of the Affordable Care Act, as reflected in §153.500, so that a QHP's allowable costs are determined on the basis of its pro-rata share of a pooled claims cost amount. This approach is consistent with the single risk pool provision established in §156.80, which directs each issuer to develop its premiums based on its pooled claim experience for all of its non-grandfathered health plans in a market within a State.

Cost-Sharing Reductions: Section 1402(c)(3) of the Affordable Care Act directs a QHP issuer to notify the Secretary of HHS of cost-sharing reductions made under the statute for qualified individuals, and directs the Secretary to make periodic and timely payments to the QHP issuer equal to the value of those reductions. Section 1402(c)(3)(B) of the Affordable Care Act also permits the Secretary to establish a capitated payment system to carry out these payments. Similarly, section 1402(d)(3) of the Affordable Care Act requires the Secretary to pay the QHP issuer an amount necessary to reflect the increase in actuarial value of the plan due to the reduction in cost sharing provided to Indians. Further, section 1412(c)(3) of the Affordable Care Act permits advance payments of cost-sharing reduction amounts to QHP issuers based upon amounts specified by the Secretary.

Under these authorities, the 2014 Payment Notice finalizes a payment approach under which we will make monthly advance payments to QHP issuers to cover projected

cost-sharing reduction amounts, and then reconcile those advance payments to the actual cost-sharing reduction amounts provided during the benefit year. In the 2014 Payment Notice, we explained that the reconciliation will happen after the close of the 2014 benefit year. As part of the notice and comment process for the 2014 Payment Notice, we received comments suggesting alternatives for the reconciliation and identifying drawbacks to the use of actual cost-sharing reduction amounts. Those comments led us to finalize here additional subparagraphs in §156.430(c) to include an alternate methodology for calculating the amounts of cost-sharing reductions provided, against which the advanced payments to QHP issuers will be reconciled. We believe that this alternate methodology will provide QHP issuers with additional flexibility, and reduce the administrative burden for some issuers of participating in the cost-sharing reductions program. Under this regulation, issuers of QHPs will be permitted to choose one of two methodologies for calculating the amount of cost-sharing reductions provided. The first methodology (referred to as the "standard methodology") was finalized in the 2014 Payment Notice. Under the standard methodology, QHP issuers calculate the cost sharing that an enrollee would have paid under the standard plan without cost-sharing reductions by applying the cost-sharing requirements for the standard plan to the allowed costs for each policy; in effect, each claim would be processed twice: using the cost-sharing structure that would have been in place if the individual were not eligible for cost-sharing reductions, and using the reduced cost-sharing structure in the applicable plan variation for which the individual is eligible. Under the second methodology established here (referred to as the "simplified methodology"), QHP issuers calculate the

value of the cost-sharing reductions provided by using a formula based on certain summary cost-sharing parameters of the standard plan, applied to the total allowed costs for each policy.

C. Costs and Benefits

The provisions of this interim final rule with comment, combined with other provisions in the Affordable Care Act and related rules, will make health insurance more affordable and accessible to millions of Americans who currently do not have affordable options available to them. The shortcomings of the individual market today have been widely documented.[2]

We believe that this interim final rule with comment, combined with other provisions of the Affordable Care Act, will improve the functioning of both the individual and the small group markets while stabilizing premiums. The risk corridors program is intended to protect QHP issuers in the individual and small group markets against inaccurate rate setting, and to permit issuers to offer lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets.

Provisions addressing cost-sharing reductions will help provide for the reduction or elimination of cost sharing for certain individuals enrolled in individual market QHPs offered through the Exchanges. This assistance is expected to help many low-and moderate-income individuals and families, as well as Indians, obtain health care. For

[2] Michelle M. Doty et al., Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2007, The Commonwealth Fund, July 2009; Sara R. Collins, Invited Testimony: Premium Tax Credits Under The Affordable Care Act: How They Will Help Millions Of Uninsured And Underinsured Americans Gain Affordable, Comprehensive Health Insurance, The Commonwealth Fund, October 27, 2011.

many people, cost sharing is a barrier to obtaining needed health care.[3]

II. Background

The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act (Pub. L. 111-152) was enacted on March 30, 2010. We refer to the two statutes collectively as the Affordable Care Act in this interim final rule with comment.

Premium Stabilization: The Premium Stabilization Rule, (77 FR 17220), which implemented the health insurance premium stabilization programs (that is, risk adjustment, reinsurance, and risk corridors), was published in the **Federal Register** on March 23, 2012.

Cost-Sharing Reductions and Actuarial Value: The AV/CSR Bulletin, published on February 24, 2012, outlined an intended regulatory approach for the design of plan variations for individuals eligible for cost-sharing reductions and advance payments and reimbursement of cost-sharing reductions to issuers, among other issues. A notice of proposed rulemaking relating to EHB and actuarial value was published in a November 26, 2012 **Federal Register** proposed rule entitled "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" (77 FR 70644). The final version of that rule was published by the Office of the Federal Register on February 25, 2013 (78 FR 12834). A notice of proposed rulemaking relating to parameters and provisions governing the risk adjustment, reinsurance, and risk corridors programs; cost-sharing

[3] Brook, Robert H., John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patricia Camp and Joseph P. Newhouse. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment.* Santa Monica, CA: RAND Corporation, 1984. Available at: http://www.rand.org/pubs/reports/R3055.

reductions; user fees for Federally-facilitated Exchanges; advance payments of the premium tax credit; and the medical loss ratio program was published in a December 7, 2012 **Federal Register** proposed rule entitled "HHS Notice of Benefit and Payment Parameters for 2014" (77 FR 73118). The final version of that rule is published elsewhere in this issue of the **Federal Register**.

Market Reform Rules: A notice of proposed rulemaking relating to market reforms and effective rate review was published in a November 26, 2012 **Federal Register** proposed rule entitled "Health Insurance Market Reforms; Rate Review" (78 FR 70584). The final version of that rule was made available for public inspection at the Office of the Federal Register on February 22, 2013.

Tribal Consultations: This interim final rule with comment may be of interest to, and affect, American Indians/Alaska natives. Therefore, we plan to consult with Tribes during the comment period and prior to adopting the final rule.

III. Provisions of the Interim Final Rule

A. Calculation of Allowable Costs for the Risk Corridors Program

The Affordable Care Act established the temporary risk corridors program to help stabilize premiums in the early years of the Exchanges and the market reform rules. The risk corridors program compares a plan's allowable costs (claims costs with certain adjustments) against a plan's target amount (total premiums reduced by administrative costs), and is designed to share the risk of inaccurate rate-setting between QHP issuers and the Federal government. Issuers must establish their premiums based on the single risk pool requirement set forth at §156.80, which directs each issuer to develop its

premiums based on its pooled claim experience for all of its non-grandfathered health plans in a market (that is, the individual market, the small group market, or the merged market) within a State, as adjusted for the pooled amount of net risk adjustment transfers and reinsurance payments it expects. Therefore, under the current risk corridors and single risk pool regulations, risk corridors would compare plan-specific allowable costs based on plan-specific claims costs against a target amount that reflects the issuer's market-wide premiums.

We received a number of comments to our draft 2014 Payment Notice noting the discrepancy. One commenter indicated that the current policy of calculating risk corridors at the plan level was inconsistent with the single risk pool requirement because, as noted above, it would require a comparison of plan-specific claims costs to market-wide premiums. We agree that a risk corridors calculation based on unpooled claims costs may create an incongruity with the single risk pool requirement that could lessen the premium stabilizing effect of the risk corridors program. We recognize that in the Premium Stabilization Rule (77 FR 17220), in response to a comment similarly recommending that risk corridors be calculated at the issuer level, we stated that the statute did not afford the necessary flexibility. However, in light of the comments we have received on this issue, we have concluded that section 1342 of the Affordable Care Act provides the flexibility to calculate risk corridors payments and charges based on pooled claims and premiums.

We believe the approach to the risk corridors calculation that we describe here is consistent with section 1342(a) of the Affordable Care Act, which requires QHPs to

"participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." We further believe that we can interpret the statutory definition of "allowable costs," which refers to total costs other than administrative costs "of the plan" in providing benefits "under the plan," to mean the plan's proportional share of total claims costs.

As a result of our proposed modification of our interpretation of the statute, we are amending the regulatory definition of allowable costs so that allowable costs for a QHP are equal to the pro rata portion of the QHP issuer's incurred claims (subject to adjustments for any direct or indirect remuneration as described in §158.40, costs related to improving health care quality set forth in §158.150, health information technology expenditures set forth in §158.151, and other applicable adjustments consistent with §153.530(b)) for all of its non-grandfathered health plans in a market within a State, allocated to the QHP based on premiums earned by the issuer in the applicable market. We are retaining the adjustments and costs described in §158.40, §158.150, §158.151, and §153.530(b) within the regulatory definition of allowable costs in order to maintain consistency with the MLR formula.

Below, we describe an example of the manner in which we will allocate allowable costs to and among an issuer's QHPs in proportion to the amount of the QHP's premiums. Assume that Issuer I has three plans in the individual market within the State, QHP A and QHP B which are QHPs, and Plan X which is a non-grandfathered health plan. QHP A earns 50 percent of the issuer's premiums in the market, QHP B earns 20 percent, and Plan X earns 30 percent. Assume total allowable costs across all three of I's

plans of $10 million. On these facts, $5 million of allowable costs would be allocated to QHP A, $2 million to QHP B, and $3 million to Plan X. The risk corridors calculation would compare those allowable costs to the QHPs' target amounts.

Finally, we are modifying the rule related to attribution and allocation of revenue and expense items in §153.520 to conform to the changes above for the risk corridors calculation. We are clarifying that these rules, which require that each item of revenue and expense in the risk corridors calculation be reasonably attributable to the operation of the QHP based on a generally accepted accounting method, will apply to the target amount (and therefore allowable administrative expenses), but not to allowable costs. This modification aligns with the approach described above, which requires a QHP issuer to pool allowable costs across all its plans and allocate these costs to each QHP based on the QHP's premiums earned as a share of the premiums earned of all non-grandfathered plans in the relevant market. A number of commenters to the proposed 2014 Payment Notice requested that risk corridors be conducted at the issuer level. We note that under the approach implemented in this interim final rule with comments an issuer may reasonably allocate, in accordance with §153.520, allowable administrative costs across its business pro rata by premiums earned, leading to an issuer-level risk corridors calculation for its QHP business.

As noted above, we believe the approach to the risk corridors calculation that we describe here is consistent with section 1342(a) of the Affordable Care Act and implements the statutory intent of the risk corridors program. In addition, we believe it is

comprehensible to stakeholders, and is administratively straightforward to implement. We seek comments on this approach.

B. Submission of Actual Amounts of Cost-Sharing Reductions

As described in the 2014 Payment Notice, HHS will make monthly advance payments to QHP issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments after the end of the benefit year to the cost-sharing reductions provided. This approach is similar to the one employed for the low-income subsidy under Medicare Part D. To implement this payment approach, §156.430(c) directs QHP issuers to report to HHS the amount of cost-sharing reductions provided during the benefit year. This submission must be made on the timeframe and in the manner identified by HHS. We anticipate collecting this information after the end of the benefit year.

In response to the proposed 2014 Payment Notice, we received a number of comments suggesting that the reporting requirements for QHP issuers under the proposed §156.430(c) would be operationally challenging, in large part due to the short timeframe for implementation and other information technology challenges facing issuers in 2013 and 2014. Commenters noted that although the reporting and reconciliation process is appropriate for the Medicare Part D Low-Income Subsidy Program, medical benefits are more complex than pharmaceutical benefits and often have a longer time lag between submission and adjudication. Commenters stated that to meet the reporting requirements under proposed §156.430(c), QHP issuers could need to re-adjudicate each claim for enrollees receiving cost-sharing reductions in order to determine the difference in cost

sharing between the applicable plan variation and standard plan. This process could require the development of new information systems in a short period of time.

As an alternative, several commenters suggested that HHS should allow QHP issuers to estimate the value of the cost-sharing reductions provided using a formula similar to that used for the advance payments, but based on the actual claims experience of the enrollees. These calculated amounts could be used as part of cost-sharing reduction reconciliation, lessening the administrative burden on issuers.

Considering those comments, we modified §156.430(c) in the 2014 Payment Notice, and establish additional standards in this interim final rule with comment to allow QHP issuers greater flexibility in the manner in which cost-sharing reduction amounts are calculated. With this policy, we seek to balance the need to safeguard Federal funds with the goal of lessening the administrative burden on QHP issuers.

Under §156.430(c)(1) and (2), finalized in the 2014 Payment Notice, a QHP issuer must submit to HHS, for each policy of each plan variation offered on an Exchange, the total allowed costs for EHB charged for the policy for the benefit year, broken down by: (i) the amount the issuer paid; (ii) the amount the enrollee(s) paid; and (iii) the amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions, which must be calculated using the standard methodology, by applying the actual cost-sharing requirements for the standard plan to the allowed costs for essential health benefits under the enrollee's policy for the benefit year. HHS will use this information to calculate the difference between the amount the enrollee(s) paid and the amount that the enrollee(s) would have paid under the standard plan without cost-

sharing reductions, and reconcile this amount against the advance payments provided to the QHP issuer pursuant to §156.430(a) and (b). We noted in the 2014 Payment Notice, that we anticipate that QHP issuers will submit this information several months after the close of the benefit year. We also clarified that the amount the enrollee paid should include any cost sharing paid by a third party, including a State, on behalf of the enrollee.

In this interim final rule with comment, we build on the standards finalized in the 2014 Payment Notice and add paragraphs (c)(3) and (4). In §156.430(c)(3), we establish new standards to permit QHP issuers greater flexibility in the manner in which cost-sharing reduction amounts are calculated. We specify that QHP issuers may choose to calculate the amounts that would have been paid under the standard plan without cost-sharing reductions using a simplified methodology, as an alternative to the standard methodology. We anticipate that after an appropriate transition period, all QHP issuers will be required to use the standard methodology. We seek comment on the appropriate length of a transition period permitting the use of the simplified methodology for consideration when we finalize this rule.

In paragraph (3)(i), we provide that the QHP issuer must notify HHS prior to the start of each benefit year whether or not it selects the simplified methodology for the benefit year. We will provide guidance in the future on the manner and timeframe for this submission. In paragraph (3)(ii), we specify that if the QHP issuer selects the simplified methodology, it must apply the simplified methodology to all plan variations it offers on the Exchange for a benefit year. Since the simplified methodology is intended to be used by issuers whose systems are not yet capable of implementing the standard

methodology, in paragraph (3)(iii) we specify that the QHP issuer may not select the simplified methodology if it did not select the simplified methodology for the prior benefit year. We also set forth standards for selecting a methodology if a QHP issuer merges with or acquires another issuer of QHPs on the Exchange, or acquires a QHP offered on the Exchange from another issuer. In paragraph (c)(3)(iv), we provide that if each of the affected parties had selected a different methodology for the benefit year, then notwithstanding paragraphs (3)(ii) and (3)(iii), for the benefit year in which the merger or acquisition took place, the QHP issuer must continue to use the methodology selected prior to the start of the benefit year for each plan variation (whether or not the selection was made by that issuer), and for the next benefit year, the QHP issuer may select either methodology subject to the requirement in paragraph (3)(ii) that a QHP issuer select the same methodology for all plan variations it offers on the Exchange for the benefit year. We seek comment on these provisions, and in particular, the administrative implications for QHP issuers.

We believe that the approach described above will allow QHP issuers to choose the methodology that best aligns with their operational practices, which should reduce the administrative burden on issuers in the initial years of the Exchanges and provide additional time for systems implementation. In later years, we will consider alternative approaches for reimbursing QHP issuers. For example, once more data is available, we could change to a capitated payment system as permitted in section 1402(c)(3)(B) of the Affordable Care Act. However, such a change would require access to data on the utilization and cost-sharing patterns of individuals eligible for cost-sharing reductions.

We believe that providing a transition period on an interim basis now addresses issuers' operational needs and will permit us to explore a capitated payment approach for future implementation. We will provide QHP issuers with sufficient notice and seek comment prior to proposing any such changes.

In §156.430(c)(4), we set forth a methodology for calculating the value of the amount that the enrollee(s) would have paid under the standard plan without cost-sharing reductions. We believe this methodology will reduce the administrative burden for certain QHP issuers, yet continue to provide a relatively accurate accounting of the cost-sharing reductions provided. Specifically, §156.430(c)(4) provides, subject to §156.430(c)(4)(iv) as described below, that a QHP issuer selecting the simplified methodology will calculates the amount that the enrollee(s) would have paid under the standard plan by applying certain summary, or "effective," cost-sharing parameters for the standard plan – the effective deductible, the effective pre-deductible coinsurance rate, the effective post-deductible coinsurance rate, and the effective claims ceiling – to the total allowed costs paid for EHB under the policy (that is, the policy with cost-sharing reductions) for the benefit year. In §156.430(c)(4)(i), we detail the process for calculating the amount that the enrollee(s) would have paid under the standard plan under the simplified methodology, depending on the utilization pattern under the policy. We describe these calculations here using Formulas A, B, and C, which build upon each other and use common terms. In §156.430(c)(4)(ii) we define the effective cost-sharing parameters for the standard plan, which must be calculated separately for both self-only

coverage and other than self-only coverage. Below we provide instructions for determining these effective parameters.

Under the simplified methodology, QHP issuers will calculate the amount that the enrollee(s) would have paid under the standard plan for policies with total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible in accordance with paragraph (c)(4)(i)(A), and illustrated below with Formula A. The definitions for all of the terms used in the formula are defined below.

Formula A: $C = TAC_i * PreD$

Where,

C = the amount that the enrollee(s) in a particular policy would have paid under the standard plan without cost-sharing reductions;

TAC_i = the total allowed costs for EHB under the policy with cost-sharing reductions for the benefit year; and

PreD = the effective pre-deductible coinsurance rate.

Secondly, QHP issuers must calculate the amount that the enrollee(s) would have paid under the standard plan for policies with cost-sharing reductions with total allowed costs for EHB for the benefit year that are greater than the effective deductible but less than the effective claims ceiling (that is, the estimated amount of total allowed claims for a policy that results in enrollee cost sharing that meets the annual limitation on cost sharing) in accordance with paragraph (c)(4)(i)(B), and illustrated below with Formula B. The method for calculating the effective claims ceiling is described below.

Formula B: $C = D + ((TAC_i – D) * PostD)$

Where,

D = the effective deductible; and

PostD = the effective post-deductible coinsurance rate.

Lastly, QHP issuers must calculate the amount that the enrollee(s) would have paid under the standard plan for policies with cost-sharing reductions with total allowed costs for EHB for the benefit year that are greater than the effective claims ceiling in accordance with paragraph (c)(4)(i)(C), and illustrated below with Formula C.

Formula C: $C = D + ((EC - D) * PostD)$

Where,

EC = the effective claims ceiling.

We request comment on these formulas for calculating the amount that the enrollee(s) would have paid under the standard plan, and whether this methodology appropriately divides policies based on utilization patterns. We welcome suggestions for alternative methodologies, which may provide a more accurate approach to estimating the amount that the enrollee(s) would have paid under the standard plan, while balancing the administrative burden on QHP issuers.

In §156.430(c)(4)(ii), we set forth instructions for determining the effective cost-sharing parameters for the standard plan. These parameters are similar to the actual cost-sharing requirements for the standard plan, but are simplified and adjusted based on the utilization of the enrollees in the standard plan. This adjustment allows QHP issuers to calculate enrollee liability under the standard plan in a simple, standardized format. We also specify that QHP issuers must develop separate effective cost-sharing parameters for

self-only coverage and other than self-only coverage, though we group together coverage for different size families under the category "other than self-only coverage." However, we seek comment on whether utilization patterns differ for self-only coverage and other than self-only coverage such that separate effective cost-sharing parameters would yield more accurate calculations, and whether different family sizes should also be analyzed separately. We also note that if a QHP issuer has entirely separate cost-sharing parameters for pharmaceutical and medical services, the QHP issuer may elect to develop separate sets of effective cost-sharing parameters for pharmaceutical and medical services.

Effective Deductible: In §156.430(c)(4)(ii)(A), we provide instructions for determining the effective deductible for the standard plan. If the standard plan has no deductible (and only copays or coinsurance), the effective deductible is zero. If the standard plan has only one deductible, the effective deductible is that deductible. If the standard plan has more than one deductible (for example, one deductible for certain or all in-network services, and another deductible for certain or all out-of-network services), the effective deductible is the weighted average deductible, weighted by allowed claims for EHB for either self-only or other than self-only coverage, as appropriate, under the plan for the benefit year that fall within each deductible category. For example, if a standard plan has a $500 deductible for certain in-network services and a $1,000 deductible for certain out-of-network services, and 65 percent of allowed costs under the standard plan were for the certain in-network services subject to the in-network deductible and 30 percent were for the certain out-of-network services subject to the out-

of-network deductible, the weighted average deductible would be equal to approximately $658 (that is, (0.65*500+0.3*1000)/0.95).

We note that services that are not subject to any deductible (including services subject to copays or coinsurance but not subject to the deductible) should not be incorporated into the weighted average calculation of the effective deductible. The estimated cost sharing liability for such services is captured in the effective pre-deductible coinsurance rate, discussed below. Similarly, services that are subject to the deductible only to a limited extent, for example a service for which the first three instances are subject to a copay instead of the deductible, but for which the fourth and each instance thereafter are subject to the deductible, should be incorporated into the weighted average calculation of the effective deductible to the extent the service is subject to the deductible (that is, the fourth and each later instance should be so incorporated), and should be incorporated into the calculation of the pre-deductible coinsurance rate (as calculated as described below) to the extent the service is not (that is, the first three instances should be so incorporated).

Effective Pre-Deductible Coinsurance Rate: In §156.430(c)(4)(ii)(B), we provide instructions for determining the effective pre-deductible coinsurance rate for the standard plan. We specify that the effective pre-deductible coinsurance rate must be calculated using the cost data from those standard plan policies that have total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible. The effective pre-deductible coinsurance rate would be calculated as the proportion of the total allowed costs for EHB under the standard plan for the benefit year incurred for those

standard plan enrollees and payable as cost sharing (including as copays or coinsurance on services with such cost sharing but not subject to the deductible, as discussed above). The effective pre-deductible coinsurance rate for the standard plan without cost-sharing reductions must be calculated separately for both self-only coverage and other than self-only coverage. We note that although the pre-deductible coinsurance rate may be high, it will likely not be 100 percent as certain services, including those preventative services described in §147.130, will have no cost-sharing requirements. The higher the utilization is for these services, the lower the effective pre-deductible coinsurance rate.

Effective Post-Deductible Coinsurance Rate: In §156.430(c)(4)(ii)(C), we provide instructions for determining the effective post-deductible coinsurance rate for the standard plan. We specify that the effective post-deductible coinsurance rate must be calculated using the cost data from those standard plan policies that have total allowed costs for EHB for the benefit year that are above the effective deductible, but for which associated cost sharing is less than the annual limitation on cost sharing. The effective post-deductible coinsurance rate for the standard plan without cost-sharing reductions must be calculated separately for both self-only coverage and other than self-only coverage. The effective post-deductible coinsurance rate will then be calculated using the following formula:

$PostD = (CS_p)/(TAC_p - D)$

Where,

PostD = the effective post-deductible coinsurance rate;

CS_p = the average allowed costs for EHB for the benefit year incurred for those enrollee(s) on the policies and payable as cost sharing other than through a deductible (for example, coinsurance and copayments on services not subject to a deductible or for services after the applicable deductible has been met);

D = the effective deductible; and

TAC_p = the average total allowed costs for EHB for the policies of the standard plan for the benefit year (we distinguish TAC_p from the TAC_i; TAC_p refers to the average of total allowed costs for EHB for all the policies in the population that is part of the calculation – which in this case, are the standard plan policies with total allowed costs for EHB for the benefit year that are above the effective deductible, but for which associated cost sharing is less than the annual limitation on cost sharing – while TAC_i refers to the total allowed costs for EHB for a particular policy).

For example, a standard plan has one deductible of $1,000, and therefore, an effective deductible of $1,000. The average total allowed costs for EHB for the policies included in this calculation (that is, standard plan policies, for either self-only or other than self-only coverage, as appropriate, with total allowed costs for EHB for the benefit year that are above the effective deductible but for which associated cost sharing is less than the annual limitation on cost sharing) is $2,000, and the average total allowed cost payable by the enrollees as cost sharing other than through a deductible is $290. Therefore, the effective post-deductible coinsurance rate is equal to approximately 29 percent (that is, (290)/(2,000-1,000)).

Effective Claims Ceiling: In §156.430(c)(4)(ii)(D), we provide instructions for determining the effective claims ceiling for the standard plan (that is, the estimated amount of total allowed claims for a policy that results in enrollee cost sharing that meets the annual limitation on cost sharing). We specify that the effective claims ceiling is to be calculated using the following formula:

EC = D + ((AL – D)/PostD)

Where,

EC = the effective claims ceiling;

AL = the standard plan's annual limitation on cost sharing;

PostD = the effective post-deductible coinsurance rate; and

D = the effective deductible.

Therefore, continuing the example from above, where a standard plan has an effective deductible of $1,000 and an effective post-deductible coinsurance rate of 29 percent, assume the standard plan also has an annual limitation on cost sharing of $6,000. The effective claims ceiling would be $18,241 (that is, 1,000+((6,000-1,000)/0.29)).

We request comment on these instructions for determining the effective cost-sharing parameters of a standard plan, including their ability to accurately characterize the experience of an enrollee in the standard plan, and the potential administrative burden associated with the calculations. We also welcome comment on alternative methods for estimating the cost sharing required under the standard plan. For example, we also considered whether simply using the proportion of total allowed costs that were payable as cost sharing under the standard plan would be an appropriate estimate of the amount

the enrollee(s) would have paid under the standard plan. We seek comment on this alternative approach, as well as other alternatives.

In §156.430(c)(4)(iii), we establish additional standards for QHP issuers that elect to use the simplified methodology. These provisions will allow HHS to ensure that QHP issuers are appropriately developing the effective cost-sharing parameters based on the actual experience of the enrollees in the standard plan. Specifically, we specify that QHP issuers submit to HHS, in the manner and timeframe established by HHS, the following information for each standard plan, for both self-only coverage and other than self-only coverage offered by the QHP issuer in the individual market through the Exchange: the effective deductible; the effective pre-deductible coinsurance rate; the effective post-deductible coinsurance rate; the effective claims ceiling; and a memorandum developed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies that describes how the QHP issuer calculated the effective cost-sharing parameters for the standard plan. We seek comment on whether HHS should require any other data submissions or establish any additional standards to oversee these provisions.

We recognize that because the effective pre- and post-deductible coinsurance rates are calculated based on the average experience of the enrollees in the standard plan, low enrollment in the standard plan could lead to inaccurate effective coinsurance rates. Therefore, we provide additional standards related to the simplified methodology in §156.430(c)(4)(iv) to address credibility concerns that may result from low enrollment in the standard plan. We establish that if a standard plan has an enrollment during the

benefit year of fewer than 12,000 member months (that is, the sum of the months that each enrollee is covered by the plan) in any of the four subgroups delineated below, and the QHP issuer has selected the simplified methodology, then the QHP issuer must calculate the amount that the enrollee(s) would have paid under the standard plan for enrollees in all subgroups by applying the standard plan's actuarial value, as calculated under §156.135, to the allowed costs for EHB for the enrollee(s) for the benefit year. We establish four subgroups to align with the policy implemented in §156.430(c)(4)(iii), which requires that the effective cost-sharing parameters be calculated separately for self-only and other than self-only coverage. The subgroups are enrollees in the standard plan with: (1) self-only coverage with total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible; (2) other than self-only coverage with total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible; (3) self-only coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but below the effective claims ceiling; and (4) other than self-only coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but below the effective claims ceiling. A subgroup is not necessary for the enrollees with total allowed costs for EHB for the benefit year that are greater than the effective claims ceiling because the experience of this population is not used to calculate the effective cost-sharing parameters.

The credibility standard of 12,000 member months aligns with a similar standard used by the Medicare Part D program; however, we seek comment on the appropriate amount of member months to achieve credible use of the simplified methodology. We

believe that a population with member months below this standard would not provide adequate data on which to base the effective cost-sharing parameters. If a QHP issuer does not have adequate enrollment in any of the four subgroups, we believe the standard plan's actuarial value will provide an adequate substitute for the effective cost-sharing parameters if applied to all policies in all four subgroups. We seek comment on the credibility standard of 12,000 member months, and whether the standard plan's actuarial value applied to the allowed costs for EHB for the enrollee(s) for the benefit year will provide an appropriate estimate of the amount of cost sharing that the enrollee(s) would have paid under the standard plan without cost-sharing reductions. We seek comment on alternative approaches for QHP issuers with low enrollment for estimating the amount of cost sharing that the enrollee(s) would have paid under the standard plan. We also seek comment on the composition of these subgroups and whether they appropriately divide enrollees based on their utilization patterns, or whether any subgroups are required at all. We seek comment on whether low enrollment in one subgroup should prompt the QHP issuer to use the actuarial value for enrollees in all subgroups or just the subgroup with low enrollment.

We appreciate the possibility that, for a very small number of plans with unique cost-sharing structures, the amounts that enrollees would have been paid under the plan cannot fairly be estimated using the simplified methodology described in paragraph (c). We are considering a process in which a QHP issuer of such a plan may notify HHS if it believes that such is the case for one or more of its plans. We are considering requiring such a notification within ninety days of the beginning of the applicable benefit year, and

we are considering requiring the QHP issuer to provide information on the unique plan design supporting the QHP issuer's assessment.

Under this approach, if HHS were to agree with the assessment, we are considering requiring that the QHP issuer calculate the amount that the enrollee(s) would have paid under the standard plan without cost-sharing reductions by applying the standard plan's actuarial value, as calculated pursuant to §156.135, to the allowed costs for essential health benefits for the enrollee(s) for the benefit year. If HHS were to disagree with the issuer's assessment, the QHP issuer would calculate such amounts using the effective cost-sharing parameters under the approach described in paragraphs (4)(i) through (4)(iii) (or (4)(iv), if applicable, of §156.430.

We seek comment on whether we should adopt such an approach, and on the specifics outlined above. In particular, we seek comment on the types of plans, if any, for which it will be difficult to fairly calculate the amount that the enrollee(s) would have paid under the standard plan without cost-sharing reductions using the simplified methodology, and their prevalence. We seek comment on the standard that should apply for determining whether the plan will be exempted from using the simplified methodology, and how HHS should make that determination. Finally, we seek comment on what estimation methodology should be used if the plan is determined to be exempt, and if it is not. Section 156.430(c)(5), finalized in the 2014 Payment Notice, provides that in the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid

under the standard plan without cost-sharing reductions only to the extent the amount was either payable by the enrollee(s) as cost sharing under the plan variation or was reimbursed to the provider by the QHP issuer. We note that this provision applies to calculations using either the standard methodology or the simplified methodology.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the Federal Register and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. However, under section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 et seq.), a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule issued. The Secretary has determined that it would be impracticable to delay finalizing the provisions of this regulation until a public notice and comment process is complete.

Section 1321(b) of the Affordable Care Act directs that Exchanges be operational by January 1, 2014, and section 1311(b)(6) of the Affordable Care Act directs that the Exchanges permit individuals to apply for coverage during annual open enrollment periods. Accordingly, §155.410(b) establishes that Exchanges must be available to enroll individuals in QHPs beginning October 1, 2013. In order to meet this enrollment deadline and offer QHPs on the Exchange, QHP issuers must develop premium rates and

plan offerings for QHPs to be offered on the Exchanges. Issuers must then seek and obtain approval of their rates and plan offerings from the applicable State Departments of Insurance, and submit their rates and plan offerings to the Exchange beginning April 1, 2013. In order to meet these statutorily driven deadlines, final rulemaking relating to the risk corridors program and the cost-sharing reduction program must be in effect so that QHP issuers can take these programs appropriately into account when developing their rates. The temporary risk corridors program will protect against uncertainty in rates for QHPs by limiting the extent of issuer losses and gains and will permit issuers to offer lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets. If the provisions of this regulation were proposed under a standard 60-day notice and comment process, QHP issuers would not have the information needed to develop rates and products for the Exchanges and meet the October 1, 2013 deadline for open enrollment.

Additionally, because the cost-sharing reduction provisions implemented in this regulation provide issuers with information that will affect how they prepare their information systems to process cost-sharing reductions, any delay in the effective date of those provisions would adversely affect issuers' operational readiness. For the reasons described above, we believe that issuing this regulation on an interim final basis is necessary in order to avoid regulatory confusion for the affected industry and to ensure effective compliance with existing regulations.

HHS solicited public comment on the risk corridors program in the proposed Premium Stabilization Rule and the proposed Payment Notice. HHS solicited public

comment on the cost-sharing reductions program in the AV/CSR Bulletin, and in the proposed Payment Notice. Comments in response to these documents were considered in the development of this regulation. In light of these comments and based on the Secretary's determination that a delay of these rules would be impracticable , the Secretary finds good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. As a result of the timing constraints, we are providing a 60-day public comment period, and intend to address comments received.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a control number assigned by OMB.

This interim final rule with comment modifies some of the information collections listed in the 2014 Payment Notice, and adds one additional information collection. We plan to seek OMB approval at a later date for these information collections. HHS will issue future **Federal Register** notices to seek comments on those information collections, as required by 3506(c)(2)(A) of the Paperwork Reduction Act. Included among such information collections for which HHS plans to seek later approval are those described below.

The amendments we make for the risk corridors program in this interim final rule with comment will not increase the information collection burden of the program established by and described in the Premium Stabilization Rule and the HHS Notice of Benefit and Payment Parameters for 2014. This interim final rule with comment modifies the calculation of allowable costs in the risk corridors calculation, but does not establish any information collection requirements beyond those already established in §153.530. The information collection process and instruments associated with the risk corridors program data submission requirements under §153.530 are currently under development. We will seek OMB approval and solicit public comments upon their completion.

In this interim final rule with comment, we build on the standards finalized in the 2014 Payment Notice related to the administration of cost-sharing reductions and add provisions to paragraphs (c)(3) and (4) of §156.430. We provide standards to permit QHP issuers greater flexibility in the manner in which the value of cost-sharing reduction amounts are calculated. In paragraph (c)(3), we specify that QHP issuers may choose to calculate the amounts that would have been paid under the standard plan without cost-sharing reductions using a simplified methodology, as an alternative to the standard methodology described in the 2014 Payment Notice final rule at §156.430(c)(2). In addition, we establish a new information collection requirement in paragraph (3)(i), under which a QHP issuer must notify HHS prior to the start of each benefit year whether or not it selects the simplified methodology for the benefit year. While this information collection requirement is subject to the Paperwork Reduction Act, the information

collection process and instruments associated with this requirement are currently under development. We will seek OMB approval and solicit public comments upon their completion. We estimate that the burden associated with the information collection requirement will be no more than one million dollars (assuming 1,200 issuers participate in an Exchange nationally, and each issuer has a reporting burden of approximately $700, which primarily represents the cost of the analysis performed by the QHP issuer to determine whether or not to use the simplified methodology).

In §156.430(c)(4) we set forth a simplified methodology for calculating the value of the amount that the enrollee(s) would have paid under the standard plan without cost-sharing reductions. We believe this methodology will reduce the administrative burden for certain QHP issuers, yet continue to provide a relatively accurate accounting of the cost-sharing reductions provided. If a QHP issuer uses the simplified methodology, the QHP issuer must also submit estimated cost-sharing parameters and an actuarial memorandum, as described in §156.430(c)(4)(iii); however, we expect this information collection to require a limited amount of analysis by a QHP issuer's actuaries. These information collections associated with these provisions are subject to the Paperwork Reduction Act; however, the information collection process and instruments associated with this requirement are currently under development. We will seek OMB approval and solicit public comments upon their completion. Below we provide an initial estimate of the incremental burden associated with the provisions in §156.430(c)(4). Under the provisions finalized in the 2014 Payment Notice, all QHP issuers must use the standard methodology; however, the provisions in this interim final rule with comment provide a

choice of methodologies. To estimate the incremental effect of the simplified methodology, we compare the burden of the standard methodology to the simplified methodology for those issuers that we assume select the simplified methodology.

As discussed in the Collection of Information section in the 2014 Payment Notice, we estimate that 1,200 issuers will participate in an Exchange nationally and will incur total costs of approximately $138 million using the standard methodology. In contrast, we estimate that each issuer using the simplified methodology set forth in this interim final rule with comment will incur labor costs of 40 hours of work by an actuary and (at a wage rate of $56.89) and 20 hours of work by an insurance manager (at a wage rate of $67.44) to develop the effective cost-sharing parameters and actuarial memorandum, and calculate the amount of cost-sharing reductions provided, resulting in a cost of approximately $3,624 per issuer.[4] Although we cannot predict the precise number of issuers that will select either the standard or simplified methodology, we estimate that approximately half of QHP issuers (600 issuers) will implement the simplified methodology. Therefore, we estimate that the provisions of this rule will result in an incremental savings of approximately $57,825,600 ($60 million that would have been incurred by these issuers under the standard methodology, minus 600 multiplied by $3,624) by reducing the overall administrative costs that issuers incur.

[4] HHS relied on the Bureau of Labor Statistics, U.S. Department of Labor, *National Compensation Survey Occupational Earnings in the United States, 2011,* for estimates of job descriptions and wages.

VI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

This interim final rule with comment implements amendments to the calculation of allowable costs under the risk corridors program and to the methodology for calculating the amounts of cost-sharing reductions provided. The amendments to the risk corridors program are needed to align that program with the single risk pool requirements at §156.80 so that both allowable costs and the target amount in that calculation are calculated based on a QHP's share of total amounts pooled across an issuer's non-grandfathered plans in a market. This change will permit the program to have its intended effect – to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016. Without these changes, pooled premiums would be compared against unpooled claims costs, which we believe was not the intent of the statute because it would lessen the effect of the risk corridors program on stabilizing premiums. The amendments to the cost-sharing reduction standards are needed to lessen the burden of participating in that program for QHP issuers who cannot easily alter their information technology systems to calculate the amount of cost-sharing reductions provided according to the methodology specified in the 2014 Payment Notice.

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). As discussed in the Collection of Information Requirements section, we believe that §156.430(c)(3) will add approximately $1 million in reporting burden. We also believe that the addition of paragraph (c)(4) to §156.430 will reduce the administrative burden associated with complying with §156.430(c)(1) in the specified timeframe, particularly for smaller issuers, by approximately $66,825,600.

In addition, although this interim final rule with comment amends §153.500 to modify the manner in which QHP issuers will calculate allowable costs for the purposes of the risk corridors calculation, we do not believe that this change to the risk corridors calculation method will have a significant effect on the aggregate amount of risk corridors payments made in any one year. Additionally, we do not believe that these

amendments will substantially alter the analysis provided in previous impact analyses of the risk corridors program in the Premium Stabilization Rule and the 2014 Payment Notice.

We conclude that this interim final rule with comment does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7 million to $35.5 million in any one year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this interim final rule with comment would not have a significant economic impact on a substantial number of small entities.

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq*.) (RFA) requires agencies to prepare a final regulatory flexibility analysis to describe the impact of the final rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." HHS uses a change in revenues of more than three to five percent as its measure of significant

economic impact on a substantial number of small entities.

This final rule contains rules for health plan issuers regarding the temporary risk corridors program and the cost-sharing reduction program. We believe that health insurance issuers and plan sponsors would be classified under the North American Industry Classification System (NAICS) code 524114. According to SBA size standards, an entity with average annual receipts of $7 million or less would be considered small entities for this NAICS code. We believe that few insurance firms offering comprehensive health insurance policies fall below this size threshold for "small entities" established by the SBA. Therefore, we are not preparing a regulatory flexibility analysis because we have determined, and the Secretary certifies, that this interim final rule with comment will not have a significant impact on the operations of a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year by State, local, or Tribal governments, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately $141 million. Since the impact on State, local, and Tribal governments, and the private sector is below this threshold, no analysis under UMRA is required.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism

implications. This interim final rule with comment does not impose any costs on State or local governments and does not preempt State law. The amendments to the cost-sharing reduction program set forth in this rule have no Federalism implications, but the amendments to the risk corridors program have the effect of complementing a State's authority to regulate and enforce the single risk pool requirement. Thus, we believe this interim final rule with comment has positive Federalism implications.

This interim final rule with comment is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects

45 CFR Part 153

Administrative practice and procedure, Adverse selection, Health care, Health insurance, Health records, Organization and functions (Government agencies), Premium stabilization, Reporting and recordkeeping requirements, Reinsurance, Risk adjustment, Risk corridors, Risk mitigation, State and local governments.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory Committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, American Indian/Alaska Natives, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 153 and 156 as set forth below:

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

1. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1321, 1341-1343, Pub. L. 111-148, 24 Stat. 119.

2. Section 153.500 is amended by revising the definition of "Allowable costs" to read as follows:

§153.500 Definitions.

* * * * *

Allowable costs means, with respect to a QHP, an amount equal to the pro rata portion of the sum of incurred claims 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); in each case for all of the QHP issuer's non-grandfathered health plans in a market within a State, allocated to the QHP based on premiums earned.

* * * * *

3. Section 153.520 is amended by revising paragraphs (a) and (b) to read as follows:

§ 153.520 Attribution and allocation of revenue and expense items.

(a) Attribution to QHP. Each item of revenue or expense in 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 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.

* * * * *

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

4. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, and 1412, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

5. Section 156.430 is amended by adding paragraphs (c)(3) and (c)(4) to read as

follows:

§156.430 Payment for cost-sharing reductions.

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(c) * * *

(3) Selection of methodology. Notwithstanding paragraph (c)(2) of this section, a QHP issuer may choose to calculate the amounts that would have been paid under the standard plan without cost-sharing reductions using a simplified methodology specified in paragraph (c)(4) of this section.

(i) The QHP issuer must notify HHS prior to the start of each benefit year, in the manner and timeframe established by HHS, whether or not it selects the simplified methodology for the benefit year.

(ii) If the QHP issuer selects the simplified methodology, it must apply the simplified methodology to all plan variations it offers on the Exchange for a benefit year.

(iii) The QHP issuer may not select the simplified methodology described in paragraph (c)(4) of this section for a benefit year if the QHP issuer did not select the simplified methodology for the prior benefit year.

(iv) Notwithstanding paragraphs (c)(3)(ii) and (c)(3)(iii) of this section, if a QHP issuer merges with or acquires another issuer of QHPs on the Exchange, or acquires a QHP offered on the Exchange from another QHP issuer, and if one, but not all, of the merging, acquiring, or acquired parties had selected the simplified methodology for the benefit year, then for the benefit year in which the merger or acquisition took place, the QHP issuer must calculate the amounts that would have been paid using the standard

methodology described in paragraph (c)(2) of this section, or as calculated under the simplified methodology, as applicable, if selected prior to the start of the benefit year for each plan variation (even if the selection was not made by that QHP issuer). For the next benefit year, the QHP issuer may select the simplified methodology (subject to paragraph (c)(3)(ii) of this section but, for that benefit year, not paragraph (c)(3)(iii) of this section) or the methodology specified in paragraph (c)(2) of this section.

(4) Simplified methodology. Subject to paragraph (c)(4)(iv) of this section, a QHP issuer that selects the simplified methodology described in this paragraph (c)(4) must calculate the amount that the enrollee(s) would have paid under the standard plan without cost-sharing reductions by applying the standard plan's effective cost-sharing parameters (as calculated under paragraph (c)(4)(ii) of this section) to the total allowed costs for essential health benefits under each policy for the benefit year (as described in paragraph (c)(4)(i) of this section).

(i) For policies with total allowed costs for essential health benefits for the benefit year that are –

(A) Less than or equal to the effective deductible, the amount that the enrollee(s) would have paid under the standard plan is equal to the total allowed costs for essential health benefits under the policy for the benefit year multiplied by the effective pre-deductible coinsurance rate.

(B) Greater than the effective deductible but less than the effective claims ceiling, the amount that the enrollee(s) would have paid under the standard plan is equal to the sum of (x) the effective deductible, plus (y) the product of the allowed costs for essential

health benefits under the policy for the benefit year above the effective deductible, multiplied by the effective post-deductible coinsurance rate.

(C) Greater than the effective claims ceiling, the amount that the enrollee(s) would have paid under the standard plan is equal to the sum of (x) the effective deductible, plus (y) the product of the allowed costs for essential health benefits between the effective deductible and the effective claims ceiling, multiplied by the effective post-deductible coinsurance rate.

(ii) The effective cost-sharing parameters for the standard plan without cost-sharing reductions must be calculated separately for both self-only coverage and other than self-only coverage as follows–

(A) If the standard plan has no deductible, the effective deductible of the standard plan is zero. If the standard plan has only one deductible, the effective deductible of the standard plan is that deductible amount. If the standard plan has more than one deductible, the effective deductible is the weighted average deductible, weighted by allowed claims for essential health benefits under the plan for the benefit year that are subject to each separate deductible. Services that are not subject to any deductible (including services subject to copays or coinsurance but not subject to the deductible) are not to be incorporated into the weighted average calculation of the effective deductible.

(B) The effective pre-deductible coinsurance rate is based on standard plan policies with total allowed costs for essential health benefits for the benefit year that are less than or equal to the effective deductible, and calculated as the proportion of the total allowed costs for essential health benefits under the standard plan for the benefit year

incurred for those standard plan enrollees and payable as cost sharing.

(C) The effective post-deductible coinsurance rate is based on standard plan policies with total allowed costs for essential health benefits for the benefit year that are above the effective deductible but for which associated cost sharing is less than the annual limitation on cost sharing, and calculated as the quotient of (x) the portion of average allowed costs for essential health benefits for the benefit year incurred for those enrollee(s) and payable by the enrollees as cost sharing other than through a deductible, divided by (y) the average allowed costs for essential health benefits for the benefit year above the effective deductible.

(D) The effective claims ceiling is calculated as the effective deductible plus the quotient of (x) the difference between the annual limitation on cost sharing and the effective deductible, divided by (y) the effective post-deductible coinsurance rate.

(iii) Submission of effective cost-sharing parameters. If a QHP issuer uses the simplified methodology described in this paragraph (c)(4), the QHP issuer must also submit to HHS, in the manner and timeframe established by HHS, the following information for each standard plan, for both self-only coverage and other than self-only coverage, offered by the QHP issuer in the individual market through the Exchange—

(A) The effective deductible.

(B) The effective pre-deductible coinsurance rate.

(C) The effective post-deductible coinsurance rate.

(D) The effective claims ceiling.

(E) A memorandum developed by a member of the American Academy of

Actuaries in accordance with generally accepted actuarial principles and methodologies that describes how the QHP issuer calculated the effective cost-sharing parameters for the standard plan.

(iv) Minimum credibility. Notwithstanding paragraphs (c)(4)(i) through (c)(4)(iii) of this section, if the standard plan without cost-sharing reductions has an enrollment during the benefit year of fewer than 12,000 member months in any of the following four subgroups, and the QHP issuer has selected the simplified methodology described in this paragraph (c)(4), then the QHP issuer must calculate the amount that the enrollee(s) would have paid under the standard plan without cost-sharing reductions for all subgroups by applying the standard plan's actuarial value, as calculated under §156.135, to the allowed costs for essential health benefits for the enrollee(s) for the benefit year. For purposes of this paragraph (c)(4)(iv), the four subgroups are:

(A) Enrollees in the standard plan with self-only coverage with total allowed costs for essential health benefits for the benefit year that are less than or equal to the effective deductible.

(B) Enrollees in the standard plan with other than self-only coverage with total allowed costs for essential health benefits for the benefit year that are less than or equal to the effective deductible.

(C) Enrollees in the standard plan with self-only coverage with total allowed costs for essential health benefits for the benefit year that are greater than the effective deductible, but below the effective claims ceiling.

(D) Enrollees in the standard plan with other than self-only coverage with total

allowed costs for essential health benefits for the benefit year that are greater than the effective deductible, but below the effective claims ceiling.

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Dated: February 25, 13.

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Marilyn Tavenner,

Acting Administrator,

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Approved: February 27, 2013.

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Kathleen Sebelius,

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