Case No. 2018-2186

In the

United States Court of Appeals for the Tenth Circuit

NEW MEXICO HEALTH CONNECTIONS, a New Mexico non-profit corporation,
Plaintiff-Appellee,

v.

UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; CENTERS FOR MEDICARE AND MEDICAID SERVICES; ALEX M. AZAR, II, Secretary of the United States Department of Health and Human Services, in his official capacity; SEEMA VERMA, Administrator for the Centers for Medicare and Medicaid Services, in her official capacity,
Defendants-Appellants,

AMERICA'S HEALTH INSURANCE PLANS; BLUE CROSS BLUE SHIELD ASSOCIATION,
Amici-Curiae.

Appeal from a Decision of the United States District Court for the District of New Mexico, Case No. 1:16-cv-00878-JB-JHR · Honorable James O. Browning, U.S. District Judge

BRIEF OF APPELLEE NEW MEXICO HEALTH CONNECTIONS

Oral Argument Is Not Requested

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CORPORATE DISCLOSURE STATEMENT

New Mexico Health Connections is a New Mexico non-profit corporation and has no parent corporation. No publicly held company owns any stock in New Mexico Health Connections. There are no stockholders in New Mexico Health Connections, as it is a non-profit corporation.

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Counsel for Health Connections is not aware of any prior or related appeals pending in this Court.

GLOSSARY

ACA	Patient Protection and Affordable Care Act
AHIP	America's Health Insurance Plans
APA	Administrative Procedure Act
BCBSA	Blue Cross Blue Shield Association
CAA	Consolidated Appropriations Act
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
GAO	Government Accountability Office
HHS	U.S. Department of Health & Human Services
NBPP	Notice of Benefit and Payment Parameters
NMHC	Health Connections
PMA	Program Management Appropriation

COUNTER-STATEMENT OF ISSUES

1. Did the District Court correctly hold that HHS acted arbitrarily and capriciously when HHS issued Risk Adjustment regulations based upon a legal interpretation of the requirements of the ACA that was unsupported by any reasoning and that it has declined to defend on appeal?

2. Did the District Court correctly hold that HHS's decision to adopt the statewide average premium over each issuer's own premium was properly subject to judicial review because the agency had affirmatively considered this issue, as documented in the administrative record?

3. Did the District Court correctly enter the remedy of vacatur?

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

A. Introduction

The U.S. Department of Health and Human Services ("HHS") cannot defend its rules governing the Risk Adjustment program. Under the Affordable Care Act ("ACA"), HHS's rules should be designed to take money from insurers having enrollees with relatively low actuarial risk (healthier enrollees) and give money to insurers having enrollees with relatively high actuarial risk (sicker

enrollees). Yet HHS's rules have gone far beyond this basic structure. By using the statewide weighted average premium as a driving factor in its calculations, HHS's rules seize revenue from efficient insurers with relatively low premiums and provide payments to dominant, entrenched insurers with relatively high premiums.

From its inception, New Mexico Health Connections ("Health Connections") has offered lower than average premiums by actively managing its members' medical care to keep them healthier and out of hospitals and emergency rooms. But as a result of using these medical cost savings to lower premiums, Health Connections has been penalized by HHS's Risk Adjustment rules. Even in years when Health Connections' enrollees were no sicker than its competitors' enrollees, Health Connections paid millions of dollars in Risk Adjustment charges because its premiums were below the state average.

As the District Court correctly held, HHS presented no rational basis in the administrative record for using the statewide average premium. HHS's only explanation for its action was that the ACA mandated a Risk Adjustment formula in which charges and payments among insurers in a state would automatically net to zero (and thus be budget-neutral). But the statute contains no such requirement.

On appeal, HHS does not defend this rationale for using the statewide average premium, and implicitly concedes that the District Court correctly

interpreted the ACA as not imposing a statutory requirement of budget neutrality. Instead, HHS attempts to distract the Court by misidentifying the agency action on appeal and focusing on tangential issues related to appropriations. To the extent HHS does discuss its decision to use the statewide average premium, it does not identify any rational basis in the administrative record. Rather, HHS only offers a smattering of *post hoc* justifications for its actions cooked up by its litigation counsel. But it is a cardinal rule of judicial review under the Administrative Procedure Act ("APA") that this Court only reviews the agency's conduct set forth in the administrative record and disregards *post hoc* rationalizations. Moreover, even if this Court could consider these *post hoc* contentions (which it cannot), they fail on their own terms.

Sensing its weakness on the merits, HHS tries two other tacks. First, HHS argues that the decision to use the statewide average premium is not subject to judicial review because it was not challenged by commenters before the rulemaking for the 2017 benefit year. But the administrative record is clear that HHS actively considered this issue on its own. The APA does not require a commenter to ask the agency to engage in analysis of issues that it has already considered on its own initiative.

Second, HHS criticizes the District Court for vacating and setting aside the unlawful regulations, even though that is the remedy expressly stated in

the text of the APA. Rather than follow the APA's clear text, HHS asserts that the District Court should have remanded without vacatur to avoid unnecessary market disruption. Yet HHS points to no evidence of disruption in the fourteen months since the lower court ruled; nor did the agency seek a stay pending appeal.

The District Court's judgment should be affirmed.

B. The ACA and Its Premium Stabilization Programs

The ACA allowed millions of previously-uninsured Americans to obtain health care coverage. Under the ACA, insurers could no longer deny coverage based on preexisting conditions, or vary premiums based on an individual's health status. *See* 42 U.S.C. §§300gg-1-300gg-5.

The ACA's new coverage requirements made it difficult for insurers to accurately predict health care costs, as they were faced with an influx of new enrollees without established health care data. This inability to accurately predict costs posed a substantial risk of premium volatility. To mitigate this risk, Congress established three premium stabilization programs under the ACA: reinsurance, risk corridors, and, relevant here, Risk Adjustment.

The Risk Adjustment program was intended to protect issuers from the risk of enrolling a sicker-than-anticipated enrollee population by distributing funds to, and making assessments against, issuers based on the actuarial risk (the relative health or sickness) of their enrollees. *See e.g.,* Milliman, *Risk Adjustment:*

Overview and Opportunity, at SA83, attached to Health Connections 2018 Comment.[1] Specifically, the ACA provided as follows:

> each State shall assess a charge on health plans and health insurance issuers [in the individual or small group market within the state] . . . if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year. . . .
>
> each State shall provide a payment to health plans and health insurance issuers [in the individual or small group market within the state] . . . if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year. . . .

42 U.S.C. §18063(a).[2]

C. Health Connections Is Formed As a Nonprofit CO-OP

The ACA also aimed to enhance competition and consumer choice in the healthcare market. *See* U.S. H. of Reps., *Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program* (Sept. 13, 2016) ("House Rpt.") at 3, SA116. To help achieve this goal, Congress established the Consumer Operated and Oriented Plan ("CO-OP") program. 42 U.S.C. §18042(a). The CO-

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[1] Health Connections submits a supplemental appendix with this brief. Citations to the supplemental appendix are abbreviated "SA___".

[2] While HHS must establish the Risk Adjustment program in consultation with the states, HHS assumes this function for any state that declines to administer the program. HHS currently administers the program on behalf of every state. Only Massachusetts briefly operated its own program, but no longer does so. *See* 45 C.F.R. §§153.310-330.

OP program provided start-up loans to new nonprofit health insurers to invigorate competition, drive costs down, and increase the quality of health care. *See id.* at (a)-(c).

To qualify for funding, CO-OP's were required to offer plans on the ACA exchanges, and were encouraged to offer integrated models of care. 45 C.F.R. §156.515(c); 42 U.S.C. §18042(b)(2)(A)(ii). CO-OP's were required to use any profits "to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members." *Id.* at (c)(4).

Health Connections entered the New Mexico health insurance market through the CO-OP program and started providing coverage in January 2014, when the ACA exchanges launched. *See* Hickey Dec. (Oct. 5, 2016) at ¶27, SA103.

Health Connections has delivered on Congress' intent for the CO-OP program, offering an integrated care management approach that not only improves its members' health, but does so at an affordable price. Health Connections' care management strategies encourage adherence to preventative medical care that, in turn, improves health outcomes. For example, Health Connections offers:

- No co-payments for many chronic disease generic drugs and behavioral drugs, which reduces barriers to adherence for medications that control and stabilize health conditions;

- Personalized outreach to patients to ensure compliance with medication regimens;
- Care coordination, including follow-up visits with primary care providers after a hospitalization;
- Assistance of community health workers and social workers when needed; and
- Intense personalized medical management of high risk individuals.

See ECF 21, Am. Compl. at ¶82, SA38. Health Connections' focus on care management has worked. For example, in 2016, Health Connections' members had far fewer emergency department visits and hospital admissions than its competitors' populations. *See* Peterson Dec. (Apr. 20, 2018) at ¶¶20-21, SA567-SA568.

Strong health outcomes not only improve the quality of enrollees' lives, but also generate significant medical cost savings for Health Connections, which are used to lower premiums. *Id.* Health Connections has consistently offered among the lowest premiums in New Mexico. *See* Hickey Dec. at ¶31, SA104. But the Risk Adjustment program, as implemented by HHS, has threatened to bring this success to a grinding halt.

D. HHS's Risk Adjustment Formula

HHS issues a rulemaking for each calendar year (referred to as a benefit year) to govern the ACA exchange marketplaces, called the annual Notice of Benefit and Payment Parameters ("NBPP"). The NBPP is issued in advance of the relevant benefit year and includes the parameters and formula for the Risk Adjustment program. The first NBPP was promulgated for benefit year 2014; HHS has issued NBPP's for 2014-2020. This case concerns the Risk Adjustment formula for the NBPP's issued for 2014-2018.

While HHS's Risk Adjustment formula has varied somewhat over time, its core features have remained the same. Risk Adjustment transfers are driven by two calculations. First, HHS calculates a weighted average risk score for enrollees in the individual and small group markets in a state, based upon age, gender, and medical diagnosis. Each insurer's individual plan risk score, based upon its enrollees' data, is then compared to the weighted statewide average risk score to determine whether its population is healthier than average (and thus must pay a charge to HHS) or sicker than average (and thus receives a payment from HHS). *See generally* 78 Fed. Reg. 15,409, 15,430.

Once these relative risk scores are calculated, HHS converts them into dollar amounts of charges and payments by using a cost-scaling factor that is supposed to measure how much additional premium revenue was needed by

insurers with sicker members and how much excess premium was received by insurers that had healthier members.

In choosing a cost-scaling factor, HHS considered using either each issuer's own average premium or the statewide weighted average of all premiums charged. *See* CCIIO, *Risk Adjustment Implementation Issues* ("HHS White Paper") at 13-17, SA194-SA198; 77 Fed. Reg. 73,117, 73,139; 78 Fed. Reg. at 15,431-32. Believing itself to be under a legal obligation to develop a budget neutral formula, HHS opted to use the statewide average premium. As a matter of mathematical structure, this will always result in payments and charges netting to zero. *See infra* at 23-24.

E. The First Risk Adjustment Results

The first Risk Adjustment results, for benefit year 2014, were not published by HHS until June 30, 2015, after HHS had already promulgated regulations for benefit years 2015 and 2016. *See* Summary Report for 2014 Benefit Year (June 30, 2015), SA300. The results were shocking. The Risk Adjustment formula heavily penalized many new, small, and low-cost insurers, whose modest premiums were largely transferred by HHS to larger, higher-cost competitors. For example:

- Health Connections was assessed a charge representing 21.5% of its premiums.

- Preferred Medical in Florida was assessed a crippling $97.1M charge, equaling 38.4% of premiums, forcing it to shut down.

- Minuteman paid 71% of its premium revenues in Risk Adjustment charges.

- Health Republic Insurance of New York was charged over $80M.

- MetroPlus Health Plan of New York was charged $55M.

- Kentucky Health Cooperative and Louisiana Health Cooperative were both assessed nearly $8M.

- New York State Catholic Health Plan, Inc. was charged over $37.5M.

- Chinese Community Health Plan of California was assessed nearly $20M in charges.

- Health Net of Arizona, Inc. was assessed a $28M charge.

- Common Ground Health Cooperative was charged $23M.

- CoOportunity Health was assessed a $6.5M charge in Nebraska.
- Local Initiative Health Authority for Los Angeles County was charged over $31M.
- ConnectiCare Insurance Company, Inc. of Connecticut was charged over $18M.

See Summary Report for 2014 Benefit Year at 13-16, 23, 30, 32, 34, 35, 41, SA301-SA310; *see also Preferred Med. Plan, Inc. v. HHS et al.*, No. 17-20091 (S.D. Fl.), at ECF 24 (Am. Compl.), ¶¶77-78; CHOICES, *Technical Issues with ACA Risk Adjustment* ("CHOICES White Paper") at 11, SA135. Given that the health insurance industry targets operating margins of 2-5%, these charges were devastating, particularly to smaller insurers and new market entrants. *See* Hickey Dec. ¶19, SA102.

The same pattern continued in subsequent benefit years. Health Connections' experience is illustrative. For benefit year 2015, it was charged $14,569,495.74 (14.7% of its premiums). *Id*. at ¶18, SA102. Incredibly, in benefit year 2016, Health Connections' risk score was essentially identical to the state average for the small group market, yet it was assessed close to $9 million. *See* Peterson Dec. ¶¶18-19, SA567.

But Health Connections was one of the lucky ones; it has survived. The other CO-OP's have not fared so well, and massive Risk Adjustment assessments, often in excess of their capital reserves, have driven them to dissolution. *See* CHOICES White Paper at 11-13, SA135-SA137 (attributing CO-OP insolvencies largely to Risk Adjustment); House Rpt. at 19-22, SA119-SA122, attached to Health Connections 2018 Comment.[3]

One key driver of these extreme, destabilizing results was the use of the statewide average premium in the Risk Adjustment formula, which rewards issuers with high rates, but perversely penalizes efficient, low-cost issuers. This flawed result occurs because premium levels are not driven solely by the health or sickness of enrollees; rather, premiums are also impacted by whether an issuer can control its costs by, *inter alia*, doing a better job managing its members' medical care. If an issuer's premiums are lower because of medical cost savings arising from better care management, as opposed to having healthier members, the use of the statewide average premium punishes the carrier for using these operating efficiencies to price below the statewide average. The more a plan deviates from the statewide average premium, the higher the percentage of its Risk Adjustment assessment is attributable to lower premiums. *See* CHOICES White Paper at 5-6,

[3]Only four of 23 CO-OP's remain today.

9, SA129-SA130, SA133; CHOICES Comment re: Discussion Paper (Apr. 22, 2016) at 2-3, SA147-SA148; Hickey Dec. ¶¶58-72, SA107-SA111.

Health Connections and its fellow penalized issuers did not sit idly by in the face of these unfair assessments. Rather, they formed the CHOICES coalition and, with the technical assistance of HHS's former Chief Actuary, prepared and submitted to HHS a comprehensive white paper explaining the flaws in the agency's formula. That white paper explained how Risk Adjustment was perversely punishing innovations that improved health and lowered costs:

> The fundamental issue is that successful efforts to coordinate care and manage chronic conditions can help prevent further disease progression, reduce inpatient hospitalizations, and avoid other more intensive health care services. The improved health outcomes are highly beneficial for patients, but they also translate into lower risk scores . . . If the risk scores accurately reflected the plan's lower cost of care, then the risk adjustment and transfer programs would appropriately account for the relative risk profile of the enrollees. . . . however, the risk adjustment formula is 'tilted' in the direction of understating relative costs for lower-cost individuals and those without HCC diagnoses. . . . Consequently, the lower plan expenditures resulting from care coordination and management tend to be exaggerated in the risk score calculations, and the risk transfer amounts are biased against effective plans …. ***The net effect is an unintended cross-subsidization from plans that carefully manage care to ones that do not.***
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> ***
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> To the extent that a plan's actual premiums are significantly lower (or higher) than the market average,

> then its estimated premium difference will be significantly exaggerated. In particular, for efficient, high performing plans focusing on thorough care management, cost-efficient care, effective provider networks, low administrative costs, and, in some cases, low nonprofit margins, member premiums will generally be well below average in an area, for a given mix of enrollees.

CHOICES White Paper at 5-6, 9, SA129-SA130, SA133.

The first rulemaking after Risk Adjustment results were released was for benefit year 2017. Despite receiving a flood of comments about the program's destabilizing effects, the agency made only minor tweaks. HHS explicitly declined to address the many comments challenging the use of the statewide average premium. 81 Fed. Reg. 12,203, 12,230.

F. Health Connections Successfully Challenges the Risk Adjustment Regulations

Faced with HHS's indifference, Health Connections was forced to seek legal recourse. In 2016, Health Connections commenced the underlying action under the APA challenging, *inter alia*, the use of the statewide average premium as arbitrary and capricious.[4] After cross-motions for summary judgment and lengthy oral argument, the District Court held, in relevant part for this appeal,

[4] This was one of several actions challenging various aspects of the Risk Adjustment program. *See Evergreen Health Cooperative, Inc. v. HHS et al.,* No. 16-2039 (D. Md.); *Minuteman Health Inc. v. HHS et al.,* No. 16-1570 (D. Mass.); *Preferred Med. Plan, Inc. v. HHS et al.*, No. 17-20091 (S.D. Fl.); *Ommen v. United States,* No. 17-957 (Fed. Cl.).

that HHS's decision to use the statewide average premium was arbitrary and capricious. *N.M. Health Connections v. HHS et al.,* 312 F. Supp. 3d 1164, 1211-12 (D.N.M. 2018) ("*NMHC I*"). Specifically, the District Court noted HHS's flawed assumption that the ACA mandated a budget neutral formula and found that assumption "infect[ed] [HHS's] analysis of the relative merits of using a state's average premium . . . instead of using a plan's own premium." *Id.* at 1209. HHS failed to articulate an independent reason for requiring budget neutrality outside of its incorrect assumption that it was statutorily mandated (an assumption HHS has not defended in its Brief). With HHS's legal premise rebuffed and no other reason to fall back on, the District Court properly found that HHS's action in choosing to use the statewide average premium was arbitrary and capricious. Accordingly, for the challenged 2014-2018 benefit year regulations, the District Court "set[] aside and vacate[d] the agency action as to the statewide average premium rules and remand[ed] the case to the agency for further proceedings." *Id.* at 1211-12.

G. HHS Moves for Reconsideration

Rather than fix its flawed rules on remand, HHS moved for reconsideration under Fed. R. Civ. P. 59, making several new arguments. First, HHS claimed that Health Connections never challenged its decision to operate the Risk Adjustment in a budget neutral manner, and thus waived that challenge. Second, HHS argued that the District Court "misapprehended" its position on

budget neutrality, which caused it to overlook "fundamental" principles of constitutional and appropriations law. Finally, HHS argued that the Court should reconsider its remedy of vacatur because vacatur was manifestly unjust. *See generally* ECF 57, R59 Brief, SA480.[5]

The District Court rejected these new contentions and stood by its original decision. The District Court noted that the agency had flip-flopped its stance on whether it was legally required to design the program in a budget neutral manner. *N.M. Health Connections v. HHS et al.*, 340 F. Supp. 3d 1112, 1179-80 (D.N.M. 2018) ("*NMHC II*"). The District Court also rejected the notion that Health Connections' claim was precluded because Health Connections failed to raise its concerns in comments to the agency before the 2017 rulemaking. As is

[5] After the Rule 59 motion was fully briefed, the District Court conducted oral argument on June 21, 2018. During that hearing, the District Court indicated that it did not intend to issue a decision until after the 2017 Risk Adjustment transfers would have been due under the vacated rule. As a result, HHS suspended Risk Adjustment transfers pending the District Court's ruling. *See* Press Release, Aplt. App. 74. However, three weeks later, HHS reversed course and issued a new emergency Risk Adjustment regulation for the 2017 benefit year, allowing transfers to proceed. 83 Fed. Reg. 36,456, 36,457-59. HHS subsequently conducted notice and comment proceedings for a new, replacement Risk Adjustment regulation for 2018. *See* 83 Fed. Reg. 39,644, 39,646-48; 83 Fed. Reg. 63,419, 63,420-27. Nevertheless, HHS has not proposed new regulations to replace the vacated 2014-2016 regulations. Since the agency's new rules replace the original 2017 and 2018 rules, Health Connections asserted in the District Court that its challenge to the original 2017 and 2018 rules is now moot. *See* ECF 83, Health Connections' Response to Notice, at 1, SA627; ECF 85, Health Connections' Response to Notice, at 1, SA631. HHS has never responded to the mootness point nor did the District Court address it.

documented in the administrative record, HHS had independently considered the issue under review, whether to use the statewide average premium or each issuer's own premium. Since HHS had unquestionably addressed this issue, commenters were not independently required to raise the point. *NMHC II*, at 1168. Finally, the District Court rejected the challenge to its remedy of vacatur, noting that the evidence submitted by HHS of the purported disruptive impact of its Order – principally an Affidavit from HHS official Jeffrey Wu – consisted of predictions about market behavior and representations of HHS's position that largely turned out to be untrue. *NMHC II*, at 1180-82.

HHS's appeal followed.

SUMMARY OF ARGUMENT

1. The District Court correctly ruled that HHS's decision to use the statewide average premium instead of each issuer's own premium in the Risk Adjustment formula was arbitrary and capricious. In the administrative record, HHS based its decision on a supposed statutory requirement that payments and charges in the program net to zero, even though the ACA imposes no such requirement. HHS does not even purport to defend its reasoning in the administrative record, but rather offers a scattershot of *post hoc* justifications, none of which may be considered under the APA and each of which fails regardless on its own terms.

2. HHS cannot evade judicial review of its actions by arguing that they were not challenged by any commenter before the 2017 rulemaking. From the very first annual rulemaking, HHS affirmatively addressed whether to use the statewide average premium or each issuer's own premium in the Risk Adjustment formula, thus obviating the need for the point to be raised by commenters. Consequently, the agency's reasoning for the decision to use the statewide average premium is properly before this Court under the APA.

3. Finally, there is no reason to disturb the District Court's remedy. Vacatur is the standard remedy under the APA, as expressly provided in the statutory text. Given that (i) the agency's conduct was so seriously deficient that HHS is not defending its reasoning in the administrative record and (ii) HHS presents no evidence of disruption caused by the District Court's judgment in the fourteen months since it was entered (and has never sought a stay pending appellate review), there is no reason to depart from the typical remedy that Congress established in the APA.[6]

[6] Health Connections does not dispute HHS's position on the jurisdiction of this Court to hear this appeal.

ARGUMENT

A. HHS Acted Arbitrarily and Capriciously in Choosing to Use the Statewide Average Premium Over Each Issuer's Own Premium

1. Arbitrary and Capricious Review Under the APA

The issue on appeal is a narrow one: whether HHS's decision to use the statewide average premium, rather than an issuer's own premium, in the Risk Adjustment formula was arbitrary and capricious under the APA. Arbitrary and capricious review examines the rationality of agency action in light of the evidence before the agency at the time it made its decision. To pass muster, the agency must have "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Motor Vehicle Mfrs. Ass'n. of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.,* 463 U.S. 29, 43 (1983) (citations omitted). The Court's focus is on "the rationality of an agency's *decision making process* rather than on the rationality of the actual decision." *WildEarth Guardians v. U.S. Bureau of Land Mgmt.*, 870 F.3d 1222, 1233 (10th Cir. 2017) (emphasis added).

To that end, a court's review is limited to the facts and analysis as set forth in the *administrative record*. *See Olenhouse v. Commodity Credit Corp.*, 42 F.3d 1560, 1575 (10th Cir. 1994) ("[I]t is well-established that an agency's action must be upheld, if at all, on the basis articulated by the agency itself. Thus, the grounds upon which the agency acted must be clearly disclosed in, and sustained

by, the record."). A court can neither supply its own rationale for the agency's action, nor can it rely on *post hoc* justifications concocted by the agency's litigation counsel. *See SEC v. Chenery*, 318 U.S. 80, 87-88 (1943); *N.M. ex rel. Richardson v. BLM,* 565 F.3d 683, 688 (10th Cir. 2009) ("appellate courts consider only the agency's reasoning at the time of decisionmaking, excluding post-hoc rationalization concocted by counsel in briefs or argument"); *Christopher v. SmithKline Beecham Corp*., 567 U.S. 142, 155 (2012) (stating deference is unwarranted "when it appears that the interpretation is nothing more than a convenient litigating position or a *post hoc* rationalization advanced by an agency seeking to defend past agency action against attack"); *Motor Vehicle Mfrs*, 463 U.S. at 50 ("[C]ourts may not accept appellate counsel's post hoc rationalizations for agency action.").

2. **HHS Misrepresents the Agency Action Under Review**

The first step in any APA case is for the plaintiff to identify the final agency action it is challenging. *See* 5 U.S.C. §§702, 704; *Dine Citizens Against Ruining Our Env't v. Jewell,* 312 F. Supp. 3d. 1031, 1087 (D.N.M. 2018) ("Plaintiffs have the burden of identifying specific federal conduct and explaining how it is final agency action within the meaning of [the APA]."). The agency action at issue in this appeal is narrow: whether HHS's decision to use the

statewide average premium, as opposed to an insurer's own premium, in the Risk Adjustment transfer formula was arbitrary and capricious. *NMHC II*, at 1170-71.

Confusingly, HHS does not squarely address this issue in its Brief. Rather, in an attempt to obfuscate the issues, HHS tries to reframe the District Court's decision as focused on HHS's: (1) failure to consider the Program Management Appropriation ("PMA"); and (2) failure to explain its decision to operate the Risk Adjustment program in a budget neutral manner. But these are not final agency actions at all, much less the final agency actions that Health Connections actually challenged and the District Court reviewed.

The record below was clear as to what agency action was being challenged. As counsel for Health Connections explained at oral argument:

> *To be very clear*, the agency action we're challenging -- and the APA requires us when we come into federal court to identify the agency action being challenged that we're asking the Court to review -- was the decision to use the statewide average premium instead of each issuer's own premium.

R59 Tr. (July 3, 2018), at 12:16-21, SA617 (emphasis added); *see also id.* at 10:13-18, SA616 ("[H]ere, the agency action being challenged [is] the decision the agency made in setting the original formula to use the statewide average premium instead of each issuer's own premium, that is the specific agency action we challenged"); *id.* at 47:25-48:4, SA621-622 ("In terms of this lump sum appropriation issue, again, the agency action being challenged here is the decision

to use the statewide average premium instead of each issuer's own premium. That is the agency action.").

The District Court rightly focused its review on the agency action that Health Connections was challenging. In its first opinion, the District Court explained that, because "HHS has failed to provide a reasoned explanation for its action, it sets aside and vacates the agency action as to the statewide average premium rules." *NMHC I*, at 1211-12. And again in its second opinion: "HHS' Decision to Use the Statewide Average Premium in its Risk Adjustment Formula – Instead of Each Insurer's Own Average Premium – Was Arbitrary and Capricious." *NMHC II*, at 1164.

The District Court also admonished HHS for its similar attempts below to mischaracterize the agency action at issue, explicitly stating that it was neither reviewing HHS's consideration of the PMA nor an overarching concept of budget neutrality:

> [I]n its MOO, the Court reviews HHS' decision to use statewide average premiums rather than each insurer's own average premium in the agency's risk adjustment formula, and not a decision to spend the lump sum portion of the Program Management Appropriation on other priorities…. Far from reviewing an agency decision regarding budget priorities, the Court concluded that HHS made no such decision when crafting its risk adjustment formula.

NMHC II, at 1174-75 (emphasis in original).

> HHS argues, on the contrary, that the Court's holding is based on a claim . . . that HHS's budget-neutral approach was independently arbitrary and capricious for lack of a satisfactory explanation for the basis of that approach. That characterization of the MOO is not accurate, because the Court considered budget neutrality only insofar as HHS implicitly used budget neutrality to justify its decision to base its risk adjustment formula on statewide average premiums.

Id. at 1168-69.

3. The Administrative Record Demonstrates that HHS' Decision to Use the Statewide Average Premium Was Arbitrary and Capricious

The reason that HHS tries to distort the actual agency action being reviewed is because it cannot defend its conduct in the underlying rulemaking proceedings. HHS points to nothing in the administrative record to support its use of the statewide average premium, and instead relies on impermissible *post hoc* arguments from its litigation counsel. Such *post hoc* justifications cannot save HHS's failure to provide a reasoned basis in the administrative record for its decision to use the statewide average premium.

a. HHS's Justifications for Using the Statewide Average Premium Set Forth in the Administrative Record

HHS's first discussion of the statewide average premium was in a September 2011 white paper titled *Risk Adjustment Implementation Issues*. There, HHS stated transfers "will be calculated in a zero sum, budget-neutral manner." HHS White Paper at 13, SA194. The only explanation offered for this budget

neutral design was that "in contrast to some current risk adjustment methodologies, the Affordable Care Act's risk adjustment program is designed to be budget neutral." *Id.* at 4, SA193 (emphasis supplied). HHS articulated no policy reasons nor did it engage in any fact-finding related to its budget neutral design, but rather accepted budget neutrality as a mandate imposed by statute. HHS used the statewide average premium as a mathematical fix to guarantee that charges and payments in a state will always net to zero. Conversely, HHS considered and rejected use of each issuer's own premium in the formula because this could result in outcomes where payments and charges might not net to zero. *Id.* at 15, SA196.[7]

Slightly over a year later, on December 7, 2012, HHS issued its first proposed Risk Adjustment rule, for benefit year 2014. 77 Fed. Reg. 73,117. There, HHS described its reasons for selecting the statewide average premium over each issuer's own premium as assuring budget neutrality and "provid[ing] a straightforward and predictable benchmark for estimating transfers." *Id.* at 73,139. But the agency again articulated no rationale, nor found any facts, as to why budget neutrality was a good thing, other than taking it as a "given" under the statute.

[7] HHS expressly recognized, however, that it could maintain budget neutrality while using an issuer's own premium by reducing payments out on a *pro rata* basis to account for any shortfall of payments in – similar to how it operated the reinsurance and risk corridors programs. *See id.*

When HHS issued the final rule for 2014, in response to comments that the statewide average premium improperly sweeps in non-risk related administrative costs, HHS offered two additional unsupported, conclusory statements to justify its use of the statewide average premium: "use of a plan's own premium may cause unintended distortions in transfers" and "both claims and administrative costs include elements of risk selection, and therefore, that transfers should be based on the entire premium." 78 Fed. Reg. at 15,432.

The first point – "unintended distortions" – appears to be a restatement of HHS's desire for a mathematical formula guaranteeing that payments and charges net to zero, but again without any reasoning or fact-finding why the agency chose this path.

The second point does not address the agency's action in choosing the statewide average premium over each issuer's own premium, as both are "entire premiums." Rather, this point addressed whether HHS should use a measure other than a premium of some sort, such as medical claims costs.

The first Risk Adjustment results, for benefit year 2014, were published by HHS on June 30, 2015. *See* Summary Report for 2014 Benefit Year, SA300. By then, HHS had already promulgated Risk Adjustment regulations for 2015 and 2016, maintaining the use of the statewide average premium without further analysis. 79 Fed. Reg. 13,744, 13,754; 80 Fed. Reg. 10,750, 10,771.

Following publication of the first Risk Adjustment results, which, as discussed *supra* at 9-11, imposed massive surprise charges on many small insurers, the agency received comments from Health Connections and numerous others challenging the agency's use of the statewide average premium. *See e.g.,* Health Connections 2017 Comment at 1-3, SA171-SA173 (attaching CHOICES White Paper); Minuteman 2017 Comment at 5-7, SA160-SA162 (same); Evergreen 2017 Comment at 1-2, SA207-SA208; Land of Lincoln 2017 Comment at 4-5, SA202-SA203.

HHS, however, explicitly refused to address these comments: "We did not propose changes to the transfer formula, and therefore, are not addressing comments that are outside the scope of this rulemaking." 81 Fed. Reg. at 12,230.

Health Connections and other insurers again challenged HHS's use of the statewide average premium in the rulemaking for the 2018 benefit year. *See e.g.,* Health Connections 2018 Comment at Aplt. App. 23-25; Minuteman 2018 Comment at Aplt. App. 42-45; CHOICES 2018 Comment at 5, SA154; Axene Report at 8-14, SA94-SA100. This time HHS grudgingly responded with a one-sentence justification: "In the absence of additional funding for the HHS-operated risk adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner…." 81 Fed. Reg. 94,058, 94,101.

This threadbare explanation raises two problems. First, the agency did not state that it was changing its view, so presumably this was a continuation of the prior rationale that the ACA mandated a budget neutral structure. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2120 (2016) ("Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change."). Second, the phrase "in the absence of additional funding" implies, if anything, that HHS saw no policy reason to operate a budget-neutral program, but was rather concerned only about budgetary limits (although HHS engaged in no analysis of its appropriations).

b. **HHS's Justification in the Administrative Record is Without Basis**

In sum, the justification that HHS articulated in the administrative record for its decision to use the statewide average premium over each issuer's own premium was that the ACA mandated that the formula generate results where payments and charges net to zero. It is this reasoning that the District Court reviewed and found wanting in a detailed analysis of the ACA's text and structure. *See NMHC I*, at 1209-12. Because the ACA did not mandate a budget-neutral Risk

Adjustment formula, the District Court held that the agency's justification in the administrative record was arbitrary and capricious.[8] *Id.*

Nowhere in its Brief does HHS defend its reasoning in the administrative record that there was a legal mandate of an automatically budget neutral Risk Adjustment formula. This silence echoes how HHS floundered below when pushed by the District Court:

> The Court: [D]o you have anything in the record that says they explained [the budget neutral decision] from 2014 through 2017? . . just so I understand the position, without the affidavit, there is nothing in the record for 2014 to 2017 that explains any rationale for the budget neutrality?
>
> [HHS]: Nothing beyond the statements that the program was designed to be budget neutral.

R59 Tr. at 21:18-20 & 22:9-14, SA619-620.

Accordingly, HHS "failed to provide a reasoned explanation for its action," which is thus arbitrary and capricious. *Olenhouse*, 42 F.3d at 1575.

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[8] *Minuteman Health Inc. v. HHS*, 291 F. Supp. 3d 174 (D. Mass. 2018) also held that the ACA "does not require the [risk adjustment] program to be budget-neutral." Where *Minuteman* diverged from the District Court here was that it improperly offered its own justifications, outside the administrative record, for using a budget-neutral approach. But courts cannot substitute their own views to save an agency action. *See SEC v. Chenery*, 318 U.S. 80, 87-88 (1943). Where the agency's reasoning in the administrative record is deficient, the matter should be remanded to the agency to fix its errors. Crushed by its Risk Adjustment assessments, Minuteman went into receivership; it did not appeal the decision.

4. Counsel's *Post Hoc* Justifications Cannot Cure HHS's Error

a. The Court Must Disregard Counsel's *Post Hoc* Reasoning

Unable to defend the administrative record, HHS offers this Court only after-the-fact, counsel-made justifications for its use of the statewide average premium. But *post hoc* justifications concocted by litigation counsel cannot be considered under the APA. *Amerijet Int'l, Inc. v. Pistole*, 753 F.3d 1343, 1351 (D.C. Cir. 2014); *see also SEC v Chenery*, 332 U.S. 194, 196 (1974). On this basis alone, they should be disregarded. But even if the Court were to consider them (which would be improper), they still fall flat.

b. An Alleged Lack of Appropriation Does Not Necessitate Budget Neutrality

The central focus of HHS counsel's *post hoc* justifications for using the statewide average premium is that, in the absence of an appropriation expressly earmarked for the Risk Adjustment program, it was required to operate Risk Adjustment in a budget neutral manner. This justification appears nowhere in the administrative record for 2014-2017 (and likely not for 2018, as HHS did not indicate a change in position from past years) and, thus is not properly before the Court. It is also wrong.

Each year HHS receives an annual PMA from Congress. *See* Consol. Approp. Act ("CAA") 2014, 128 Stat. 5, 374-375; CAA 2015, 128 Stat. 2130,

2477; CAA 2016, 129 Stat. 2242, 2611; CAA 2017, 131 Stat. 135, 530; CAA 2018, H.R. 1625, 379-80. This appropriation has two relevant components.

First, the PMA authorizes HHS to spend "user fees" on HHS program functions. *See NMHC* II, at 1172. Without this appropriation of user fees paid by program participants, HHS would have no legal authority to use charges in the Risk Adjustment program (which are user fees) to fund payments out. *See id.* at 1171 (ACA does not contain "an appropriation, so it does not permit HHS to spend any federal money -- including the risk adjustment charges that HHS collects -- on risk adjustment payments" and "HHS must rely on the CMS program management appropriation to fund risk adjustment payments").

Second, the PMA provides a lump sum appropriation that HHS may spend on various matters, including a catchall category of "other responsibilities" of the agency. *See id.* at 1171-72. As the District Court pointed out, "other responsibilities" does not exclude the Risk Adjustment program, and thus the PMA was potentially available to HHS for Risk Adjustment. *See id.* at 1172.

In analyzing the availability of the PMA, the District Court was guided by persuasive authority that the lump sum appropriation could be applied to the closely related risk corridors program.[9] *See id.* at 1171-74. The GAO was

[9] Risk corridors was a three-year program in which HHS was required to reimburse insurer losses above certain thresholds and insurers in turn were

(continued...)

asked by certain members of Congress to evaluate what funding sources were available for the risk corridors program. The GAO opined that the PMA's lump sum would be available:

> Section 1342(b)(1) directs the Secretary to make payments to qualified health plans, but that section neither designates nor identifies a source of funds. *The CMS PM appropriation for FY 2014 made funds available to CMS to carry out its responsibilities, which, with the enactment of section 1342, include the risk corridors program.* Consequently, the CMS PM appropriation for FY 2014 would have been available for making the payments pursuant to section 1342(b)(1).

GAO, B-325630, HHS- Risk Corridors Program, at 3-4, SA298-SA299.[10] Notably, it is the GAO, and not HHS, that is the expert agency in the field of appropriations. *See Nevada v. DOE*, 400 F.3d 9, 16 (D.C. Cir. 2005).

Nevertheless, HHS contends that the PMA was unavailable because it was only an available source of funding for expenditures that were not "otherwise provided." Aplt. Br. at 31-32. According to HHS, "Congress 'otherwise

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(continued...)

required to disgorge profits in excess of certain other thresholds. *See Moda Health Plan, Inc. v. United States,* 892 F.3d 1311, 1314-16 (Fed. Cir. 2018) (describing risk corridors program).

[10] Congress later enacted appropriations riders to prohibit the use of the PMA lump sum for the risk corridors program. *See Moda,* 892 F.3d at 1318-19. There were no such restrictions placed on the Risk Adjustment program. *See NMHC II*, at 1173.

provided' for risk-adjustment payments by allowing the amounts collected from insurers to be used to fund those payments." *Id.* But it is the PMA that authorized both the use of charges into the program ("user fees") and appropriated the lump sum; both provisions follow after the "otherwise provided" language in the same appropriations act. As the District Court correctly noted, without the PMA, there were no funds – including charges paid into the program – available to be used for payments out under Risk Adjustment. *See NMHC II*, at 1171-74; *see also supra* at 29 (citing CAA's for 2014-2018).

c. **The Statewide Average Premium Does Not Ensure Predictability**

HHS's next *post hoc* justification is that relying on the annual appropriations cycle, in which Congress could change its mind from year to year, would render the purportedly stable Risk Adjustment program unpredictable and unreliable for purposes of setting premiums. Again, this argument is absent from the administrative record and should not be considered by the Court now. It is also wholly theoretical: HHS cites no fact-finding contemporaneous with its decision to use the statewide average premium to support its conclusory assertion that its formula is readily predictable for accurate premium-setting.

But there was evidence in the administrative record on the predictability of the formula, none of which supports HHS's theory. The 2017 rulemaking was the first rulemaking that occurred after actual Risk Adjustment

results had been released and insurers could test the accuracy of their Risk Adjustment assumptions made when setting their premiums. The results were a disaster: as numerous commenters noted in the 2017 and 2018 rulemakings, many small insurers were hit with huge Risk Adjustment charges, often well in excess of 20% of their total premium revenues (and in some cases leading to insolvencies), that they had not accounted for in their premiums. *See e.g.,* Health Connections 2017 Comment at 1-3, SA171-SA173; Minuteman 2017 Comment at 5-7, SA160-SA162; Land of Lincoln 2017 Comment at 4-5, SA202-SA203; CHOICES White Paper at 9, 11-13, SA133, SA135-SA137; Minuteman 2018 Comment at Aplt. App. 38-41; Health Connections 2018 Comment at Aplt. App. 14-18.

In its 2018 comments, Health Connections supplied even more systematic evidence of Risk Adjustment's unpredictability, attaching a study conducted by Milliman, a leading actuarial firm, measuring how well insurers predicted their Risk Adjustment outcomes. *See Financial Analysis of ACA Health Plan Issuers* (Feb. 2016) ("Milliman Paper"), SA139, attached to Health Connections 2018 Comment. Milliman made two key findings. First, over half of all issuers predicted Risk Adjustment payments/charges to be $0, a result Milliman attributed to plan actuaries throwing their hands up in the air at their inability to predict the formula's outcome. *Id.* at 3, SA141. Second, while the minority of issuers who did predict either a charge or payment tended to be directionally

correct as to whether they would be creditors or debtors, the predictions of the magnitude of payments and charges were wildly off. *Id*.

Health Connections' 2018 comments also showed that, in the State of New Mexico, every carrier assumed in its rate filings for 2017 that it would incur a Risk Adjustment charge and none predicted it would receive a payment. Yet that is mathematically impossible under the budget neutral formula (which equally balances charges and payments) and can only be explained by insurers' inability to predict the formula's outcome and need to price defensively. *See* Health Connections 2018 Comment at Aplt. App. 27, n.4 (*citing* BCBSNM Unified Rate Review (Jan. 1, 2017), http://www.osi.state.nm.us/serff/nmserff.aspx); *see also* Hickey Dec. ¶¶53-55, SA105-SA106.

None of this is surprising in light of the inherently unpredictable structure of HHS's Risk Adjustment program:

- Risk Adjustment results are not known until six months after the close of a relevant benefit year, and close to two years after premiums were set in advance of that benefit year.

- To predict Risk Adjustment results, insurers must predict who will enroll in the ACA marketplaces in a year and how healthy such individuals will be.

- Because risk scores are adjusted by geographic cost factor, insurers must predict where in their state consumers will buy insurance.

- Insurers must also predict which different insurance products consumers will buy, for two reasons. First, risk scores are adjusted by an "induced demand factor" that reflects different levels of consumer out-of-pocket costs (*e.g.*, copayments) in different insurance products. Second, the statewide average premium hinges largely on what types of differently priced insurance products consumers choose to buy.

- These uncertainties are compounded for small insurers, whose populations do not meaningfully impact the weighted average risk scores and weighted average premiums that drive Risk Adjustment results. Such small insurers are forced to guess about their larger competitors' enrollments and pricing strategies.

d. **There Is No Risk of Gaming Premiums**

In an argument spanning less than two pages, HHS halfheartedly claims that the use of an issuer's own premium would pose a gaming risk: "if risk-

adjustment payments were based on a plan's own premium, then higher-risk plans would have an incentive to raise premiums, so as to increase their risk-adjustment payments." Aplt. Br. at 35. But this argument ignores the realities of the premium-setting process, which is highly regulated. As HHS itself explained to the District Court: "[t]o the extent NMHC suggests that issuers can raise their rates solely to inflate risk adjustment payments (*i.e.,* in a manner untethered to actual costs), that outcome is foreclosed by the Medical Loss Ratio rules, rate-review provisions, state insurance law, and the laws of economics, all of which help ensure that issuers price to cost." ECF 35, HHS SJ Br. at 24, n. 5, SA344.

HHS further claims that using an issuer's own premium, instead of the statewide average premium, "could create disincentives for high-risk plans to operate efficiently or set lower prices." Aplt. Br. at 35. But this argument (made without citation to any evidence or actual analysis by HHS) ignores the fact that Risk Adjustment in its current design penalizes efficient, high-performing issuers.

As Health Connections has explained in its comments to HHS, use of the statewide average premium improperly penalizes any carrier that prices below the statewide average, as its charge will be artificially inflated to the extent that it is lowering prices below the statewide average. Because premiums are based not only upon whether an insured population is healthier or sicker, but also on whether an issuer can control its costs by, for example, doing a better job managing its

members' medical care, the use of the statewide average premium functions as a financial penalty for innovative efforts to reduce health care costs. *See e.g.,* Health Connections 2018 Comment at Aplt. App. 23; CHOICES White Paper at 9*,* SA133; CHOICES Comment (Apr. 22, 2016) at 2-3, SA147-SA148; Axene Report at 8-14, SA94-SA100; Health Connections 2017 Comment at 1-3, SA171-SA173.

e. **HHS Operates Risk Adjustment, Not the States**

In what is perhaps the agency's greatest departure from real world facts, HHS advances the *post hoc* argument that Risk Adjustment was designed to be administered by states and thus HHS was required to develop a program that was automatically budget neutral because HHS cannot commit state government funds. *See* Aplt. Br. at 33. But *no state* is administering the Risk Adjustment program. The only state that even tried – Massachusetts – abandoned the effort after the 2016 benefit year. As the states have declined to run their own Risk Adjustment programs, HHS exercised its authority to fill the void. Indeed, as the District Court pointed out, because states can (and uniformly do) opt to defer Risk Adjustment to HHS, there is no risk that HHS will attempt to commandeer state budgets. *See NMHC II*, at 1171, n. 22.

B. **HHS Cannot Evade Judicial Review by Claiming Issue Waiver**

No doubt recognizing that it cannot defend its conduct in the administrative record, HHS tries to evade judicial review by claiming that Health

Connections is precluded from challenging the "*budget-neutral design*" of the Risk Adjustment formula for 2014-2018 because no commenter "*urged HHS to treat the lump sum for CMS Program Management as a funding source.*" *See* Aplt. Br. at 20 (emphasis supplied). However, as explained *supra,* the final agency action challenged by Health Connections and reviewed by the District Court was HHS's decision to use the statewide average premium instead of issuers' own premiums. The agency's justification for its decision – budget neutrality – is not in and of itself an agency action subject to separate challenge under the APA. *See* 5 U.S.C. §702 (limiting judicial review to agency action); *Jewell,* 312 F. Supp. 3d. at 1087 ("Plaintiffs have the burden of identifying specific federal conduct and explaining how it is final agency action within the meaning of [the APA].").

That final agency action is properly before this Court. As the District Court noted, there is no issue waiver "when an agency, *for whatever reason*, considers a potential issue." *NMHC II,* at 1168 (emphasis supplied). This is because the concerns animating the issue exhaustion requirement are satisfied when "an agency addresses an issue – even if the agency does so on its own initiative – [as] an administrative record exists for the court to review [and] the agency had a fair opportunity to consider the issue." *Id.* Because (as discussed *supra* at 24-25) HHS actually considered whether to use the statewide average premium instead of an issuer's own premium as early as 2011, it was "appropriate

for the Court . . . to review whether HHS' reasoning underlying that decision passes muster under the APA." *Id.* Before the District Court, HHS did not even "contend there has been waiver with respect to challenging statewide average premium itself." *Id.* at 1137 (citing R59 Tr. at 16:08-10, SA618).

The District Court's decision is in accord with the law in the Tenth Circuit and elsewhere. *See e.g., Garcia-Carbajal v. Holder*, 625 F.3d 1233, 1238 (10th Cir. 2010); *Portland Gen. Elec. Co. v. Bonneville Power,* 501 F.3d 1009, 1024 (9th Cir. 2007); *Glacier Fish Co. LLC v. Pritzker,* 832 F.3d 1113, 1120, n.6 (9th Cir. 2016); *NRDC v. EPA,* 824 F.2d 1146, 1151 (D.C. Cir. 1987) ("This court has excused the exhaustion requirements for a particular issue when the agency has in fact considered the issue."); *Banner Health v. Burwell*, 126 F. Supp. 3d 28, 68, n. 24 (D.D.C. Sept. 2, 2015) ("the waiver rule would not bar a facial challenge if the agency has actually addressed the issue, either sua sponte or at the behest of another party.").

This Court has further held that issue waiver is inapplicable when the relevant concerns are "obvious" to the agency. *See Zen Magnets, LLC v. Consumer Prod. Safety Comm'n*, 841 F.3d 1141, 1151, n. 11 (10th Cir. 2016) ("Claims not raised before an agency are not waived if the problems underlying the claim are 'obvious.'"). As HHS addressed the issue under review –whether to use

the statewide weighted average premium or each issuer's own premium – the point must have been, at a minimum, "obvious."

Similarly, courts in other circuits have held that parties are not required to submit comments challenging "key assumptions" of an agency's rule. *See e.g., Hispanic Affairs Project v. Acosta*, 901 F.3d 378, 389 (D.C. Cir. 2018) ("Agencies always bear the affirmative burden of examin[ing] a key assumption when promulgating … a non-arbitrary, non-capricious rule … even if no one objects during the comment period."); *NRDC v. EPA,* 755 F.3d 1010, 1023 (D.C. Cir. 2014) ("even if a party may be deemed not to have raised a particular argument before the agency, EPA retains a duty to examine key assumptions as part of its affirmative burden of promulgating … a nonarbitrary, non-capricious rule"); *Am. Assoc. of Cosmetology Schools v. Devos,* 258 F. Supp. 3d 50, 72 (D.D.C. 2017) ("When an agency's reasoning involves a nonobvious essential factual assumption, the agency must justify that assumption notwithstanding a party's failure to challenge it as part of its affirmative duty to engage in rational decision making."). If budget neutrality were a key assumption underlying the design of the Risk Adjustment program (as HHS appears to argue), then HHS was under an independent obligation, as part of its duty under the APA to engage in rational decision-making, to explain and justify that assumption regardless of the comments it received.

Finally, there were no Risk Adjustment results available to Health Connections or other insurers before the rulemaking proceeding for benefit year 2017. But once insurers could see how the formula worked as applied, they submitted numerous comments in the 2017 and 2018 rulemakings challenging the agency's decision to use the statewide average premium. *See e.g.* CHOICES White Paper at 9, SA133 ("Use of a plan's *actual* average premium in the risk transfer formula, rather than the Statewide market average premium, would eliminate this significant source of estimation error and result in much fairer transfers among plans."); Health Connections 2017 Comment at 3, SA173 ("use of the statewide market average premium in the risk transfer formula again further punishes efficient and effective plans with lower premiums"); Minuteman 2017 Comment at 5-7, SA160-SA162; Evergreen 2017 Comment at 1-2, SA207-SA208; Land of Lincoln 2017 Comment at 5, SA203; Health Connections 2018 Comment at Aplt. App. 25 ("HHS and CMS cannot flout the Risk Adjustment statute to create a budget neutral formula. Instead, … HHS and CMS should adopt the recommendation of CHOICES and use a plan's own average premium in the transfer formula rather than the statewide average premium."); Minuteman 2018 Comment at Aplt. App. 42-45; CHOICES 2018 Comment at 5, SA154.

C. Vacatur was the Proper Remedy

HHS's final challenge to the decision below is that, even if the District Court were right on the merits (and it was), the District Court's remedy – vacating and setting aside the agency action it found to be arbitrary and capricious – was somehow improper. Once more, HHS's arguments fall flat.

The plain language of the APA expressly authorizes the District Court to vacate and set aside agency action that is arbitrary and capricious: "The reviewing court shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be—(A) arbitrary, capricious . . . ." 5 U.S.C. §706(2)(a). This is the standard remedy. *See e.g., Blue Water Navy Vietnam Veterans Ass'n v. McDonald*, 830 F.3d 570, 578 (D.C. Cir. 2016) ("[V]acatur is the 'normal remedy'" for "unsupported agency action"); *Jewell*, 312 F. Supp. 3d at 1110 ("Vacatur is the usual remedy for an agency action that is arbitrary, capricious, or contrary to law.").

"The decision whether to vacate depends on 'the seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed.'" *NMHC II*, at 1177. The District Court properly vacated the 2014-2018 rules as to the use of the statewide weighted average premium, because it determined that those rules suffered from serious deficiencies (*id.* at 1179-81), and

the record before the District Court did not establish that vacatur would cause significant disruption. *Id.* at 1180-82.

1. The District Court Properly Held that HHS's Rulemaking Suffered Serious Deficiencies

There can be little doubt that the agency's decision-making was seriously deficient. HHS chose to use the statewide weighted average premium because it assumed, without any analysis of statutory language or structure, that the ACA mandated a budget neutral Risk Adjustment formula. *See supra* at 23-25, 27. But HHS was unable to defend this reasoning in the District Court, nor did it even try. Similarly, it does not defend its own reasoning in the administrative record before this Court. That the agency is not willing to defend its own reasoning is sufficient by itself to establish the seriousness of the deficiencies in the agency action under review.

HHS tries to excuse its deficient reasoning by either passing it off as a mere failure to explain or by tossing about new, *post hoc* justifications that are not set forth in the administrative record. Yet this was not an instance where HHS failed to explain its reasoning; rather, the agency stated in its 2011 white paper that "the Affordable Care Act's risk adjustment program is designed to be budget neutral." HHS White Paper at 4, SA193 (emphasis supplied). HHS explained its reasoning, but now cannot muster an argument to defend it.

Likewise, the many *post hoc* explanations tossed up by HHS counsel both in this Court and in the District Court only highlight the seriousness of the deficiencies in the agency's decision-making when it created the Risk Adjustment formula in 2011 and 2012. For example, HHS argued in the underlying administrative record that Congress always intended for the program to be budget neutral (*NMHC II*, at 1178) but now contends that budget neutrality should be upheld as good policy. As the District Court explained: "[t]hese two arguments do not mesh and, rather, contradict each other," because there is no need to argue a good policy rationale if Congress mandated that the Risk Adjustment program be budget neutral. *NMHC II*, at 1178. In the lower court's words, HHS has engaged in an improper "*post hoc* rationalization for a decision it was not aware it made, which cannot withstand APA review." *Id.* at 1178-79; *see e.g.*, *SmithKline*, 567 U.S. at 155 (stating deference is unwarranted "when it appears that the interpretation is nothing more than a convenient litigating position or a *post hoc* rationalization advanced by an agency seeking to defend past agency action against attack.").

HHS argues that it has now provided sufficient explanations for its budget-neutral approach through the new rules issued in the summer of 2018 for the 2017 and 2018 benefit years. *See* Aplt. Br. at 38. To be clear, HHS partially implemented the District Court's remand by issuing new rules for the 2017 and

2018 benefit years. *See* 83 Fed. Reg. at 36,457-59; 83 Fed. Reg. at 39,646-48; 83 Fed. Reg. at 63,420-27. The agency now wants to use the new rules, issued to cure the defects identified in the District Court's judgment, as a basis to invalidate that judgment in the first instance. This circular, *Alice in Wonderland* logic fails on its face: that the agency issued new rules, with new reasoning, in response to the District Court's opinion has no bearing on whether the District Court was correct in its review of prior agency action. Indeed, such new rulemakings – which only occurred after the District Court held oral argument on HHS's fully briefed motion for reconsideration – were never part of the administrative record before the District Court.

Health Connections previously argued and remains of the view that, as a result of HHS' new rulemaking for the 2017 and 2018 benefit years, Health Connections' challenges to the old 2017 and 2018 regulations are moot (although not the challenge to the 2014-2016 rules, which were not replaced). *See* ECF 83, Health Connections' Response to HHS's Notice, at 1, SA627 ("Since the Final Rule supersedes the 2017 rule being litigated in this case, HHS's motion for reconsideration of the Court's findings on the 2017 rule is now moot"); ECF 85, Health Connections' Response to HHS's Notice, at 1, SA631 ("Given that HHS's Rule 59 motion seeks reconsideration of the Court's decision regarding a rule that

is shortly to be replaced, the motion is now entirely moot as to 2017 and 2018."). HHS has never responded to Health Connections' mootness argument.

Because the new rules for 2017 and 2018 were not before the District Court, Health Connections would need to bring a new action challenging them in order for their reasoning to be reviewed under the APA – which it did, filing an action on August 13, 2018 challenging the new 2017 Risk Adjustment regulation. *N.M. Health Connections v. HHS et al.*, No. 18-773 (D.N.M.). That new case has been stayed by agreement of the parties pending this appeal.[11]

2. HHS Has Failed to Establish that the Consequences of Vacatur Outweigh the Deficiencies in the Rulemaking

HHS also seeks to overturn the District Court's remedy of vacatur as unduly disruptive. But HHS's rhetoric bears little resemblance to the way that it has acted. To the extent that vacating the 2017 and 2018 regulations was disruptive, such disruption was cured by the agency itself issuing new regulations for those years. If HHS believes that the vacatur of the 2014-2016 rules is unduly disruptive, then it has had more than a year to promulgate new rules for those benefit years. That it has not bothered to do so is revealing of the true urgency

[11] Health Connections has not yet decided whether it will seek to amend its complaint in the second action to challenge the new 2018 rule. However, Health Connections did submit a 35-page comment, attaching 86 exhibits, in response to the proposed new 2018 rule.

here. Indeed, HHS never sought a stay of the District Court's judgment pending appeal.

While HHS now argues extensively the supposed consequences of the District Court's Order, it largely ignored the issue when the parties briefed summary judgment below, only making perfunctory arguments that vacatur would "introduce uncertainty in the market." ECF 35, HHS SJ Br. at 43, SA363. In the summary judgment proceedings, HHS did not provide the Court with any evidence of this anticipated disruption. Similarly, no amici appeared in support of HHS' motion for summary judgment providing any evidence of the claimed disruption. Accordingly, having determined that HHS engaged in arbitrary and capricious rulemaking, and without any proffered evidence of the alleged adverse consequences of vacatur, the District Court ordered the typical APA remedy and vacated the relevant regulations. *NMHC I,* at 1218-19.

After summary judgment, HHS moved for reconsideration and supplemented the record with the declaration of Jeffrey Wu, the Associate Deputy Director for Policy Coordination at the Center for Consumer Information and Insurance Oversight. *See* ECF 57, R59 Br., SA480 & ECF 57-1, Wu Dec., SA516. Even though HHS filed its motion for reconsideration a month after the District Court's judgment that would supposedly cause "significant uncertainty, financial hardship, and undue burden for hundreds of health insurance issuers and millions

of enrollees nationwide," again no amici filed any briefs in support of HHS's position or to bolster the points made by Mr. Wu. ECF 57 at 4, SA490.

In response, Health Connections presented rebuttal evidence and moved to strike the Wu Declaration. ECF 62, Health Connections Motion to Strike Brief, SA525, & ECF 63, R59 Opposition, SA533. Specifically, Health Connections presented evidence that unpredictable and excessive Risk Adjustment charges had forced numerous insurers to leave the market, including the closure of many of the CO-OP issuers the ACA established. *See* ECF 63, R59 Opposition, at 21-24, SA558-SA561. Far from being a program that enhanced market stability and predictability, Risk Adjustment was wreaking havoc and eliminating choices for consumers.

In resolving the motion for reconsideration, the District Court overruled Health Connections' objection to HHS' new evidence on disruption, but nevertheless found the Wu Declaration unconvincing for a variety of reasons. "The problem with Wu's predictions [of disruption] is that the Court issued its decision on February 28, 2018, and none of what Wu has predicted has come true. He has proven to be a poor prognosticator." *NMHC II,* at 1180. As the District Court explained, contrary to the Wu Declaration's predictions of uncertainty in the Risk Adjustment program driving higher premiums, insurance premiums for 2019 increased less than in past years. *Id.* at 1180-81.

Additionally, while the Wu Declaration averred that the District Court judgment would prevent HHS from collecting or making Risk Adjustment payments for 2017 and 2018 (ECF 57-1, Wu Dec. ¶13, SA520), shortly after filing the Wu Declaration HHS reversed course and decided not to suspend the payments for those years because it issued new rules for 2017 and 2018. *NMHC II*, at 1181. As the District Court observed: "Once again, HHS told the Court something that, like every time HHS speaks to the Court, reveals its new position. The Court's experience with HHS' changing positions has not been good. HHS' hyperbole does not appear to be an equity that weighs against vacatur." *Id.* at 1180.

In keeping with its pattern of *sub silentio* abandonment of its own positions, HHS made no attempt in its Brief to this Court to defend the Wu Declaration, even though that was the agency's principal evidence of alleged disruption before the District Court. Instead, pivoting yet again, HHS now relies upon events that occurred after the parties briefed and argued the motion for reconsideration.

HHS relies for its disruption argument on a four-page Amici Statement filed by America's Health Insurance Plans ("AHIP") and the Blue Cross Blue Shield Association ("BCBS") after the completion of briefing and oral argument on HHS's motion for reconsideration. ECF 80, Amici Motion at Aplt. App. 66 & ECF 80-1, Amici Statement at Aplt. App. 69. But the Amici Statement

only addressed the consequences resulting from HHS temporarily suspending Risk Adjustment transfers for the 2017 benefit year. ECF 80-1, Amici Statement at Aplt. App. 69-70; *see also* Amici Aplt. Br. at 7. That issue became moot shortly after the Amici Statement was filed because HHS reversed itself and issued a new rule for the 2017 benefit year, notifying issuers that the Risk Adjustment payments would resume in October of 2018. *See* ECF 81, HHS Notice, SA623. As the District Court explained:

> [B]ecause the Amici Statement came only after HHS suspended the program and does not discuss any harms to insurance companies resulting from vacatur of the prior years, it appears that insurance companies -- at least AHIP and Blue Cross -- do not seem to be concerned by this issue of remedies. The insurance companies did not file the Amici Statement after the Court issued its [Memorandum Opinion and Order] on February 28, 2018, but only after HHS suspended payments.

NMHC II, at 1182.

In the end, HHS points this Court to no evidence of disruption that provides a reason for this Court to disturb the remedy below.

3. The New AHIP/BCBS Amicus Brief Provides No Reason to Disturb the District Court's Remedy

AHIP/BCBS have appeared as amici again, now at the appellate level, to contest the District Court's remedy, offering new arguments that they failed to present to the District Court when they appeared below. *See generally* Amici Aplt. Br. That AHIP/BCBS could have, but chose not to, present their current disruption

arguments to the District Court makes one wonder whether these are legitimate concerns or rather gamesmanship by self-interested larger insurance companies, which have benefitted handsomely from hefty Risk Adjustment charges against smaller competitors like Health Connections, at times even putting those smaller, innovative competitors out of business altogether.[12]

Moreover, despite the fact that the District Court entered its judgment more than a year ago, AHIP/BCBS present no actual evidence of disruption beyond mere rhetoric and speculation. If disruption were to occur, it presumably should have reared its head in some concrete way by now.

Even on their own speculative terms, the disruption arguments presented by AHIP/BCBS are self-contradictory. On the one hand, the Amicus Brief states that HHS has cured the deficient rules for the 2017 and 2018 benefit years by issuing new rules. *See* Amici Aplt. Br. at 12. But in the very next paragraph, AHIP/BCBS argue that this Court should reinstate the old 2017 and

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[12] For example, the Connecticut, Illinois, and Maryland CO-OP insurers were rendered insolvent by being forced to pay massive and unexpected risk adjustment charges, which HHS then largely transferred to wealthy, dominant incumbent BCBS plans in those states. *See infra* at 53 (citing CO-OP declarations). Similarly, Preferred Medical, a small Florida insurer, was rendered insolvent by an excessive risk adjustment charge, which HHS largely transferred to the market dominant BCBS plan in Florida. *See Preferred Med.* at ECF 24 (Am. Compl.), ¶¶77-78.

2018 benefit year rules so as to moot Health Connections' challenge in a separate lawsuit to the new 2017 rule. *Id.* at 12-13.

In fact, the Amici's real dispute is with HHS. AHIP/BCBS's chief concern appears to be that HHS only issued new rules for 2017 and 2018 while offering no new rules for the 2014-2016 benefit years. But that was HHS's decision not to fully implement the District Court's remand for the past fourteen months. It is not an error by the District Court if the agency refuses to comply with its Order.

Given the lack of any evidentiary basis to take issue with the District Court's remedy, AHIP/BCBS argue that the APA does not permit arbitrary and capricious agency action to be vacated after implementation because remand without vacatur is the "most workable" result. *Id.* at 13. According to AHIP/BCBS, Health Connections cannot seek judicial review of HHS's actions once HHS implements its regulations – an extreme position that HHS does not advance in its Brief.

But the APA does not limit judicial review to temporary restraining orders or preliminary injunctions. The statute itself provides that "[a] person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof." 5 U.S.C. §702. The APA further provides that "[a]gency action

made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review." 5 U.S.C. §704. None of these provisions cut off judicial review once an agency has implemented its regulations; to the contrary, the term "agency action" demonstrates that Congress intended for judicial review to occur only after the agency has actually acted. AHIP/BCBS give no reason for this Court to depart from the straightforward text of the APA. *Lindsay v. Thiokol Corp.*, 112 F.3d 1068, 1070 (10th Cir. 1997) ("The exceptions to our obligation to interpret a statute according to its plain language are few and far between.").

Unsurprisingly, courts have not followed AHIP/BCBS's extreme position, but rather have, where appropriate, vacated and set aside past agency actions. *Lion Health Servs. Inc. v. Sebelius*, 635 F.3d 693 (5th Cir. 2011) (invalidating agency regulation for all years – prior, past, and future – and ordering a recalculation of refunds owed to plaintiffs); *Comm. for Fairness v. Kemp*, 791 F. Supp. 888 (D.D.C. 1992) (ordering recalculation of funds under a regulation for prior years); *AEP Tex. N. Co. v. Surface Transp. Bd.*, 609 F.3d 432, 444 (D.C. Cir. 2010) (vacating rule and remanding to agency "to reassess its decisionmaking for the 2005 cost of equity estimate.").

The AHIP/BCBS amicus brief also ignores two key points. First, the brief is silent regarding the victims of the arbitrary and capricious rules, including

Health Connections. Contrary to AHIP/BCBS's breezy assertions suggesting that all insurers have been able to rely on a supposedly predictable Risk Adjustment program, Health Connections presented substantial evidence to the District Court that insurers have been unable to predict Risk Adjustment results, leading to massive and unpredictable charges that have forced many smaller insurers to leave the ACA marketplaces altogether. *See* Peterson Dec. ¶7, SA564 ("Even though HHS has published the risk adjustment formula before our rates are finalized for the relevant benefit year, Health Connections and its actuaries have been unable to accurately predict risk adjustment costs when setting premiums."); Lalime Dec. ¶3, SA569-SA570 ("The risk adjustment program administered by [HHS] contributed to the demise of HealthyCT" because it was "unable to predict the magnitude" of its 2015 "risk adjustment penalty"); Beilinson Dec. ¶4, SA571-SA572 ("The risk adjustment program administered by [HHS] destroyed Evergreen" because "Evergreen was unable to predict" its risk adjustment penalty for the 2015 calendar year); Howell Dec. ¶7, SA575 ("due largely to the severity of its small group risk adjuster losses, CareConnect ceased writing new small and large group business … and new individual business on and off the New York State" exchange).

Second, AHIP/BCBS contend that they could not have anticipated that "a court might invalidate previously relied upon final rules setting forth the methodology for those transfer payments." Amici Aplt. Br. at 9. But the first

litigation challenging Risk Adjustment regulations was filed before the transfers for the 2015 benefit year occurred[13] (this case was filed shortly thereafter) and AHIP/BCBS have followed these cases closely, as evidenced by their filings. AHIP/BCBS's failure to take Health Connections' legal challenge seriously does not provide a legitimate reliance interest to justify reversal.

4. **The District Court Properly Vacated the 2014-2018 Rules Nationwide**

As a last gasp, HHS seeks to limit the judgment in this case to the State of New Mexico, on the theory that "the 'agency action' that aggrieved NMHC was the imposition of risk-adjustment charges *against it*." Aplt. Br. at 44 (emphasis in original). This is yet another argument that relies on misrepresenting the claims that Health Connections brought. If Health Connections were seeking to recover past charges, that claim would be a Tucker Act damages case in the Court of Federal Claims.[14] *See Normandy Apartments, Ltd. v. HUD*, 554 F.3d 1290, 1296 (10th Cir. 2009) ("The Tucker Act mandates that the Claims Court has exclusive jurisdiction over claims against government agencies founded on

[13] *See Evergreen*, No. 16-2039 (D. Md. filed June 13, 2016).

[14] The District Court expressly found that this is not a Tucker Act damages claim, a holding which HHS does not challenge on appeal. *NMHC I*, at 1203.

contract or federal law only when the action seeks monetary relief in excess of $10,000.") (internal quotations and citations omitted).

Rather, the agency action challenged was HHS's decision to use the statewide average premium in the Risk Adjustment formula instead of each issuer's own premium. Because that was the action challenged, it was the action that the District Court vacated and set aside. *See* 5 U.S.C. §706(2)(a); *NMHC I,* at 1211-12. As this agency action was not specific to New Mexico, the vacatur was not limited to New Mexico.

CONCLUSION

The judgment of the District Court should be affirmed.

Dated: April 22, 2019

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ADDENDUM OF
STATUTES AND REGULATIONS

5 USCS § 702

Current through PL 116-8, approved 3/8/19

United States Code Service - Titles 1 through 54 > TITLE 5. GOVERNMENT ORGANIZATION AND EMPLOYEES > PART I. THE AGENCIES GENERALLY > CHAPTER 7. JUDICIAL REVIEW

§ 702. Right of review

A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof. An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States: *Provided,* That any mandatory or injunctive decree shall specify the Federal officer or officers (by name or by title), and their successors in office, personally responsible for compliance. Nothing herein (1) affects other limitations on judicial review or the power or duty of the court to dismiss any action or deny relief on any other appropriate legal or equitable ground; or (2) confers authority to grant relief if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought.

History

(Sept. 6, 1966,P.L. 89-554, § 1, 80 Stat. 392; Oct. 21, 1976, P.L. 94-574, § 1, 90 Stat. 2721.)

Prior law and revision:

Derivation	U.S. Code	Revised Statutes and Statutes at Large
	5 USC Sec. 1009(a)	June 11, 1946, ch 324, Sec. 10(a), 60 Stat. 243.

Standard changes are made to conform with the definitions applicable and the style of this title as outlined in the preface to the report.

Annotations

Notes

Amendments:

1976 . Act Oct. 21, 1976, substituted this section for one which read: "A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof.".

Case Notes

5 USCS § 704

Current through PL 116-8, approved 3/8/19

United States Code Service - Titles 1 through 54 > TITLE 5. GOVERNMENT ORGANIZATION AND EMPLOYEES > PART I. THE AGENCIES GENERALLY > CHAPTER 7. JUDICIAL REVIEW

§ 704. Actions reviewable

Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review. A preliminary, procedural, or intermediate agency action or ruling not directly reviewable is subject to review on the review of the final agency action. Except as otherwise expressly required by statute, agency action otherwise final is final for the purposes of this section whether or not there has been presented or determined an application for a declaratory order, for any form of reconsideration, or, unless the agency otherwise requires by rule and provides that the action meanwhile is inoperative, for an appeal to superior agency authority.

History

(Sept. 6, 1966, *P.L. 89-554*, § 1, *80 Stat. 392*.)

Prior law and revision:

Derivation	U.S. Code	Revised Statutes and Statutes at Large
.....	*5 USC Sec. 1009(c)*	June 11, 1946, ch 324, Sec. 10(c), *60 Stat. 243*.

Standard changes are made to conform with the definitions applicable and the style of this title as outlined in the preface of this report.

Annotations

Case Notes

I. IN GENERAL
1. Generally
2. Purpose and effect
3. Construction
4. --With other statutes
5. --Civil Rights Acts
6. --Tucker Act
7. Presumption of reviewability
8. State administrative decisions
II. AGENCY ACTION AS MADE REVIEWABLE BY STATUTE; EFFECT OF REVIEW UNDER § 704
A. Environmental Protection
9. Clean Air Act

5 USCS § 706

Current through PL 116-8, approved 3/8/19

United States Code Service - Titles 1 through 54 > TITLE 5. GOVERNMENT ORGANIZATION AND EMPLOYEES > PART I. THE AGENCIES GENERALLY > CHAPTER 7. JUDICIAL REVIEW

Notice

Part 2 of 3. You are viewing a very large document that has been divided into parts.

§ 706. Scope of review

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall--

(1)compel agency action unlawfully withheld or unreasonably delayed; and

(2)hold unlawful and set aside agency action, findings, and conclusions found to be--

(A)arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B)contrary to constitutional right, power, privilege, or immunity;

(C)in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D)without observance of procedure required by law;

(E)unsupported by substantial evidence in a case subject to sections 556 and 557 of this *title [5 USCS §§ 556* and *557*] or otherwise reviewed on the record of an agency hearing provided by statute; or

(F)unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

History

(Sept. 6, 1966,*P.L. 89-554*, § 1, *80 Stat. 393*.)

Prior law and revision:

Derivation	U.S. Code	Revised Statutes and Statutes at Large
.....	*5 USC Sec. 1009(e)*	June 11, 1946, ch 324, Sec. 10(e), *60 Stat. 243*.

Warning – Negative Citing Cases
As of: September 7, 2017 8:19 PM Z

42 USCS § 300gg-1

Current through PL 115-51, approved 8/18/17

United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 6A. THE PUBLIC HEALTH SERVICE > REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE > INDIVIDUAL AND GROUP MARKET REFORMS > GENERAL REFORM

§ 300gg-1. Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market. Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) Enrollment.

(1) Restriction. A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) Establishment. A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974 [*29 USCS § 1163*]).

(3) Regulations. The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) Special rules for network plans.

(1) In general. In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may--

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that--

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals[,] employees and dependents.

(2) 180-day suspension upon denial of

coverage. An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits.

(1) In general. A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that--

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage. A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

History

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart I, § 2702, as added March 23, 2010,*P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(3), Subtitle G, § 1563(c)(8)(F) [1562(c)(8)(F)], Title X, Subtitle A, § 10107(b)(1), *124 Stat. 156*, 267, 911.)

Annotations

Notes

Explanatory notes:

The bracketed comma has been inserted in subsec. (c)(1)(B)(ii) to indicate the probable intent of Congress to include it.

This section, consisting of the heading and subsecs. (a) and (b), was added by § 1201(3) of Act March 23, 2010, *P.L. 111-148*, effective for plan years beginning on or after January 1, 2014, as provided by § 1255 of such Act. Section 1563(c)(8) of such Act amended former *42 USCS § 300gg-11* by deleting subsecs. (a), (b), (e), and (f), amending subsecs. (c) and (d), and transferring them to appear as subsecs. (c) and (d) of this section. No specific effective date or applicability provisions were associated with such amendments.

A prior § 300gg-1 (Act July 1, 1944, ch 373, Title XXVII, Part A, Subpart 1, § 2702, as added Aug. 21, 1996, *P.L. 104-191*, Title I, Subtitle A, Part 1, § 102(a), *110 Stat. 1961*; May 21, 2008, Title I, § 102(a)(1)-(3), *122 Stat. 888*; March 23, 2010, *P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(3)(A), *124 Stat. 154*) was transferred by Act March 23, 2010, *P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(3)(B), *124 Stat. 155* (effective for plan years beginning on or after 1/1/2014, as provided by §

1255 of such Act, which appears as *42 USCS § 300gg* note), and appears as subsecs. (b)-(f) of *42 USCS § 300gg-4*.

A prior § 2702 of Act July 1, 1944, ch 373, appeared as *42 USCS § 300aaa-1* prior to being redesignated and transferred by Act June 10, 1993, *P.L. 103-43*, Title XX, § 2010(a)(1)-(3), *107 Stat. 213*. Such section was reclassified to *42 USCS § 238a*.

Redesignation:

Section 1562 of Act March 23, 2010, *P.L. 111-148*, which amended this section, was redesignated § 1563 of such Act by § 10107(b)(1) of the Act.

Case Notes

1. Generally
2. Relationship with other laws

1. Generally

Court dismissed claim of village health and welfare fund against third-party against insurer and its agent alleging they violated provisions of Health Insurance Portability and Accountability Act (HIPAA), *42 USCS §§ 300gg* et seq., guaranteeing coverage renewability or, in alternative, limiting exclusions for preexisting conditions and prohibiting discrimination against individual participants based on their health status because HIPAA did not provide for private cause of action. *Northwestern Mem. Hosp. v Vill. of S. Chi. Heights Health & Welfare Fund (2004, ND Ill) 33 EBC 2046.*

2. Relationship with other laws

2000 version of *Kan. Stat. Ann. § 40-2254* did not determine which of two insurers, both of whom had coverage for health care costs in 31-day period, had primary duty to pay benefits; § 40-2254 was not coordination of benefits rule, and while plain reading of statute suggested that succeeding carrier was not obligated to provide coverage to hospitalized person receiving extension of benefits from prior carrier, if applied in that manner, statute would have directly conflicted with non-discrimination rule of *42 USCS § 300gg-1*; application of state statute would therefore have been preempted to extent of such conflict, notwithstanding narrow and "flexible" preemption rule of Health Insurance Portability and Accountability Act of 1996; as such, *Kan. Stat. Ann. § 40-2254* provided no basis for successor carrier to recover benefits from prior carrier. *MMA Ins. Co. v Blue Cross & Blue Shield of Kan., Inc. (2004, DC Kan) 552 F Supp 2d 1250.*

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42 USCS § 300gg-2

Current through PL 115-51, approved 8/18/17

United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 6A. THE PUBLIC HEALTH SERVICE > REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE > INDIVIDUAL AND GROUP MARKET REFORMS > GENERAL REFORM

§ 300gg-2. Guaranteed renewability of coverage

(a) In general. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

(b) General exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums. The plan sponsor, or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud. The plan sponsor, or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rates. In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.

(4) Termination of coverage. The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

(5) Movement outside service area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A) [*42 USCS § 300gg-11(c)(1)(A)*].

(6) Association membership ceases. In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for uniform termination of coverage.

(1) Particular type of coverage not offered. In any case in which an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if--

(A) the issuer provides notice to each plan sponsor, or individual, as applicable, provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each plan sponsor, or individual, as applicable, provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) Discontinuance of all coverage.

(A) In general. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual or group market, or all markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if--

(i) the issuer provides notice to the applicable State authority and to each plan sponsor, or individual, as applicable[,] (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) Prohibition on market reentry. In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for uniform modification of coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan--

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(e) Application to coverage offered only through associations. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

History

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart I, § 2703, as added March 23, 2010,*P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(4), Subtitle G, § 1563(c)(9)(D) [1562(c)(9)(D)], Title X, Subtitle A, § 10107(b)(1), *124 Stat. 156*, 268, 911.)

Annotations

Notes

Explanatory notes:

A comma has been enclosed in brackets in subsec. (c)(2)(A)(i) to indicate the probable intent of Congress to delete it.

This section, consisting of the heading and subsec. (a), was added by § 1201(4) of Act March 23, 2010, *P.L. 111-148*, effective for plan years beginning on or after January 1, 2014, as provided by § 1255 of such Act. Section 1563(c)(9) of such Act amended former *42 USCS § 300gg-11* by deleting subsec. (a), amending subsecs. (b) and (c), and transferring the section as amended to appear as subsecs. (b)-(e) of this section. No specific effective date or applicability provisions were associated with such amendments.

Effective date of section:

This section is effective for plan years beginning on or after January 1, 2014, as provided by § 1255 of Act March 23, 2010, *P.L. 111-148*, which appears as *42 USCS § 300gg* note.

Redesignation:

Section 1562 of Act March 23, 2010, *P.L. 111-148*, which amended this section, was redesignated § 1563 of such Act by § 10107(b)(1) of the Act.

Research References & Practice Aids

Am Jur:

44 Am Jur 2d, Insurance § 1053.

Law Review Articles:

Thompson. The Next Stage of Health Care Reform: Controlling Costs by Paying Health Plans Based on Health Outcomes. *44 Akron L Rev, 2011.*

Avraham. Clinical Practice Guidelines: The Warped Incentives in the U.S. Healthcare System. *37 Am J L and Med 7, 2011.*

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Dorf; Siegel. "Early-Bird Special" Indeed!: Why the Tax Anti-Injunction Act Permits the Present Challenges to the Minimum Coverage Provision. *121 Yale LJ Online 389,* January 19, 2012.

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42 USCS § 300gg-3

Current through PL 115-51, approved 8/18/17

United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 6A. THE PUBLIC HEALTH SERVICE > REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE > INDIVIDUAL AND GROUP MARKET REFORMS > GENERAL REFORM

§ 300gg-3. Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general. A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions. For purposes of this part [*42 USCS §§ 300gg* et seq.]--

(1) Preexisting condition exclusion.

(A) In general. The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information. Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date. The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee. The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during--

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) Waiting period. The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage.

(1) Creditable coverage defined. For purposes of this *title [42 USCS §§ 300gg* et seq.], the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [*42 USCS §§ 1395c* et seq. or *1395j* et seq.]

(D) Title XIX of the Social Security Act [*42 USCS §§ 1396* et seq.], other than coverage consisting solely of benefits under section 1928 [*42 USCS § 1396s*].

(E) Chapter 55 of title 10, United States Code [*10 USCS §§ 1071* et seq.].

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5, United States Code [*5 USCS §§ 8901* et seq.].

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 5(e) of the Peace Corps Act (*22 U.S.C. 2504(e)*).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 2791(c) [*42 USCS § 300gg-91(c)*]).

(2) Not counting periods before significant breaks in coverage.

(A) In general. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage. For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals. In the case of plan years beginning before January 1, 2014--

(i) TAA pre-certification period rule. In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of *section 7527 of the Internal Revenue Code of 1986* [26 USCS § 7627] shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions. The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 2205(b)(4) [*42 USCS § 300bb-5(b)(4)*].

(3) Method of crediting coverage.

(A) Standard method. Except as otherwise provided under subparagraph (B), for purposes of

applying subsection (a)(3), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method. A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice. In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall--

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice. In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the individual or group [group] market, the issuer--

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

(d) Exceptions.

(1) Exclusion not applicable to certain newborns. Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children. Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of

age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy. A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage. Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage.

(1) Requirement for certification of period of creditable coverage.

(A) In general. A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)--

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification. The certification described in this subparagraph is a written certification of--

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits. In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)--

(A) upon request of such plan or issuer, the entity which issued the

certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations. The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods.

(1) Individuals losing other coverage. A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)--

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries.

(A) In general. If--

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to

becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period. A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of--

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period. If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective--

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP.

(A) In general. A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage. The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act [*42 USCS §§ 1396* et seq.] or under a State child health plan under title XXI of such Act [*42 USCS §§ 1397aa* et seq.] and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not

later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP. The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP.

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage.

(I) In general. Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act [*42 USCS §§ 1396* et seq.], or child health assistance under a State child health plan under title XXI of such Act [*42 USCS §§ 1397aa* et seq.], in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (*29 U.S.C. 1181(f)(3)(B)(i)(II)*).

(II) Option to provide concurrent with provision of plan materials to employee. An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974 [*29 USCS § 1024(b)*].

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals. In the case of an enrollee in a group health plan

who is covered under a Medicaid plan of a State under title XIX of the Social Security Act [*42 USCS §§ 1396* et seq.] or under a State child health plan under title XXI of such Act [*42 USCS §§ 1397aa* et seq.], the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009 [*29 USCS § 1181* note], so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act [*42 USCS § 1397ee(c)*] or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion.

(1) In general. A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if--

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period.

(A) Defined. For purposes of this *title [42 USCS §§ 300gg* et seq.], the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning. Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the

requirements of this part for the State involved with respect to such issuer.

History

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart I[1], § 2704 [2701], as added Aug. 21, 1996,*P.L. 104-191*, Title I, Subtitle A, Part 1, § 102(a), *110 Stat. 1955*; Feb. 4, 2009, *P.L. 111-3*, Title III, Subtitle B, § 311(b)(2), *123 Stat. 70*; Feb. 17, 2009, *P.L. 111-5*, Div B, Title I, Subtitle I, Part VI, § 1899D(c), *123 Stat. 426*; March 23, 2010, *P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(2), Subtitle G, § 1563(c)(1) [1562(c)(1)], Title X, Subtitle A, § 10107(b)(1), *124 Stat. 154*, 264, 911; Dec. 29, 2010, *P.L. 111-344*, § 114(c), *124 Stat. 3615*.)

(As amended Oct. 21, 2011,*P.L. 112-40*, Title II, Subtitle B, § 242(a)(4), *125 Stat. 419*.)

Annotations

Notes

Explanatory notes:

The word "group" in subsec. (c)(3) has been enclosed in brackets to indicate the probable intent of Congress to delete such word.

This section formerly appeared as *42 USCS § 300gg*.

Amendments:

2009 . Act Feb. 4, 2009 (effective on 4/1/2009, and applicable to child health assistance and medical assistance provided on or after that date, as provided by § 3(a) of such Act, which appears as *42 USCS § 1396* note), in subsec. (f), added para. (3).

Act Feb. 17, 2009 (applicable to plan years beginning after enactment, as provided by § 1899D(d) of such Act, which appears as *26 USCS § 9801* note), added subsec. (c)(2)(C).

2010 . Act March 23, 2010 (effective for plan years beginning on or after 1/1/2014, as provided by § 1255 of such Act, which appears as *42 USCS § 300gg* note), substituted the section heading and subsec. (a) for ones which read:

"Increased portability through limitation on preexisting condition exclusions

"(a) Limitation on preexisting condition exclusion period; crediting for periods of previous coverage. Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if--

"(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

"(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

"(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.".

Such Act further, in subsec. (c), in para. (2), substituted "group or individual health plan" for "group health plan" wherever occurring, in para. (3), substituted "group or individual health insurance" for "group health insurance", wherever appearing, and, in subpara. (D), substituted "individual or group" for "small or large"; and, in subsecs. (d) and (e)(1)(A), substituted "group or individual health insurance" for "group health insurance", wherever appearing.

Act Dec. 29, 2010 (applicable to plan years beginning after 12/31/2010, as provided by § 114(d) of such Act, which appears as *26 USCS §*

9801 note), in subsec. (c)(2)(C), substituted "February 13, 2011" for "January 1, 2011". Such Act directed that the amendment be made to § 2701(c)(2)(C) of the Public Health Service Act as in effect for plan years beginning before January 1, 2014.

2011 . Act Oct. 21, 2011 (applicable to plan years beginning after 2/12/2011, as provided by § 242(a)(4) of such Act, which appears as 26 USCS § 9801 note), in subsec. (c)(2)(C), substituted "January 1, 2014" for "February 13, 2011".

Redesignation:

This section, enacted as § 2701 of subpart 1 of Part A of Title XXVII of Act July 1, 1944, ch 373, was redesignated § 2704 of subpart I of such Part by Act March 23, 2010, *P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(1), (2), *124 Stat. 154*, effective for plan years beginning on or after 1/1/2014, as provided by § 1255 of such Act, which appears as 42 USCS § 300gg note.

Section 1562 of Act March 23, 2010, *P.L. 111-148*, which amended this section, was redesignated § 1563 of such Act by § 10107(b)(1) of the Act.

Other provisions:

Application of section. The provisions of this section, as they apply to enrollees who are under 19 years of age, become effective for plan years beginning on or after the date that is 6 months after the date of enactment of Act March 23, 2010, *P.L. 111-148*, as provided by § 1255 of such Act, which appears as 42 USCS § 300gg note.

Research References & Practice Aids

Am Jur:

44 Am Jur 2d, Insurance § 1053.

44A Am Jur 2d, Insurance § 1840.

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42 USCS § 300gg-4

Current through PL 115-51, approved 8/18/17

United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 6A. THE PUBLIC HEALTH SERVICE > REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE > INDIVIDUAL AND GROUP MARKET REFORMS > GENERAL REFORM

§ 300gg-4. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In general. A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

(b) In premium contributions.

(1) In general. A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction. Nothing in paragraph (1) shall be construed--

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information.

(A) In general. For purposes of this section, a group health plan, and

health insurance issuer offering group or individual health insurance coverage, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction. Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) Genetic testing.

(1) Limitation on requesting or requiring genetic testing. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction. Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment.

(A) In general. Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act [*42 USCS §§ 1320d* et seq.] and *section 264* of the Health Insurance Portability and Accountability Act of 1996 [*42 USCS § 1320d-2* note], as may be revised from time to time) consistent with subsection (a).

(B) Limitation. For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception. Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made pursuant to research that complies with part *46 of title 45, Code of Federal R*egulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the

legal guardian of such beneficiary, to whom the request is made that--

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information.

(1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 2791 [*42 USCS § 300gg-91*]).

(2) Prohibition on collection of genetic information prior to enrollment. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) Incidental collection. If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans. The provisions of subsections (a)(6), (b)(3), (c) , and (d) and subsection (b)(1) and section 2704 [*42 USCS § 300gg-3*] with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 2735(a) [*42 USCS § 300gg-21(a)*].

(f) Genetic information of a fetus or embryo. Any reference in this part to genetic information concerning an individual or family member of an individual shall--

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(g)--(i) [Not enacted]

(j) Programs of health promotion or disease prevention.

(1) General provisions.

(A) General rule. For purposes of

subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

(B) No conditions based on health status factor. If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

(C) Conditions based on health status factor. If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

(2) Wellness programs not subject to requirements. If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

(A) A program that reimburses all or part of the cost for memberships in a fitness center.

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) A program that provides a reward to individuals for attending a periodic health education seminar.

(3) Wellness programs subject to requirements. If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

(A) The reward for the wellness

program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows--

(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

(k) Existing programs. Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

(l) Wellness program demonstration project.

(1) In general. Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

(2) Expansion of demonstration project. If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

(3) Requirements.

(A) Maintenance of coverage. The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that--

(i) will not result in any decrease in coverage; and

(ii) will not increase the cost to the Federal Government in providing credits under *section 36B of the Internal Revenue Code of 1986* [*26 USCS § 36B*] or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act [*42 USCS § 18071*].

(B) Other requirements. States that participate in the demonstration project under this subsection--

(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

(ii) shall ensure that requirements of consumer protection are met in

programs of health promotion in the individual market;

(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts--

(I) do not create undue burdens for individuals insured in the individual market;

(II) do not lead to cost shifting; and

(III) are not a subterfuge for discrimination;

(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (*42 U.S.C. 1320d-2* note); and

(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

(m) Report.

(1) In general. Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act [enacted March 23, 2010], the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning--

(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

(D) the effectiveness of different types of rewards.

(2) Data collection. In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

(n) Regulations. Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

History

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart I, § 2705, as added March 23, 2010,*P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(3)(A), (4), *124 Stat. 155*.)

Annotations

Notes

Explanatory notes:

Subsecs. (b)-(f) of this section formerly appeared as part of *42 USCS § 300gg-1*.

A prior § 300gg-4 was redesignated and transferred by Act March 23, 2010, *P.L. 111-148*, Title I, Subtitle A, § 1001(2), *124 Stat. 130*, and appears as *42 USCS § 300gg-25*.

A prior § 2704 of Act July 1, 1944, ch 373, appeared as *42 USCS § 300aaa-3* prior to being redesignated and transferred by Act June 10, 1993, *P.L. 103-43*, Title XX, § 2010(a)(1)-(3), *107 Stat. 213*. Such section was reclassified to *42 USCS § 238c*.

Effective date of section:

This section is effective for plan years beginning on or after January 1, 2014, as provided by § 1255 of Act March 23, 2010, *P.L. 111-148*, which appears as *42 USCS § 300gg* note.

Research References & Practice Aids

Am Jur:

43 Am Jur 2d, Insurance § 544.

Law Review Articles:

Thompson. The Next Stage of Health Care Reform: Controlling Costs by Paying Health Plans Based on Health Outcomes. *44 Akron L Rev, 2011.*

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Maher. The Benefits of Opt-In Federalism. *52 BC L Rev 1733,* November 2011.

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42 USCS § 300gg-5

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United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 6A. THE PUBLIC HEALTH SERVICE > REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE > INDIVIDUAL AND GROUP MARKET REFORMS > GENERAL REFORM

§ 300gg-5. Non-discrimination in health care

(a) Providers. A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

(b) Individuals. The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) [*29 USCS § 218c*] shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

History

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart I, § 2706, as added March 23, 2010,*P.L. 111-148*, Title I, Subtitle C, Part I, § 1201(4), *124 Stat. 160*.)

Annotations

Notes

Explanatory notes:

A prior § 300gg-5 was redesignated and transferred by Act March 23, 2010, *P.L. 111-148*, Title I, Subtitle A, § 1001(2), *124 Stat. 130*, and appears as *42 USCS § 300gg-26*.

Effective date of section:

This section is effective for plan years beginning on or after January 1, 2014, as provided by § 1255 of Act March 23, 2010, *P.L. 111-148*, which appears as *42 USCS § 300gg* note.

Research References & Practice Aids

Am Jur:

43 Am Jur 2d, Insurance § 544.

Law Review Articles:

Thompson. The Next Stage of Health Care Reform: Controlling Costs by Paying Health Plans Based on Health Outcomes. *44 Akron L Rev, 2011.*

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42 USCS § 18042

Current through PL 116-8, approved 3/8/19

United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 157. QUALITY AFFORDABLE HEALTH CARE FOR ALL AMERICANS > AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS > STATE FLEXIBILITY RELATING TO EXCHANGES

§ 18042. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers

(a) Establishment of program.

(1) In general. The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) Purpose. It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) Loans and grants under the CO-OP program.

(1) In general. The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of--

(A)loans to provide assistance to such person in meeting its start-up costs; and

(B)grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) Requirements for awarding loans and grants.

(A) In general. In awarding loans and grants under the CO-OP program, the Secretary shall--

(i)take into account the recommendations of the advisory board established under paragraph (3);

(ii)give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii)ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) States without issuers in program. If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) Agreement.

(i) In general. The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)--

(I)any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II)any requirements contained in the agreement for such person to receive such loan or grant.

(ii) Restrictions on use of Federal funds. The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used--

(I)for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II)for marketing. Nothing in this clause shall be construed to allow a person to take any action prohibited by *section 501(c)(29) of the Internal Revenue Code of 1986* [*26 USCS § 501(c)(29)*].

(iii) Failure to meet requirements. If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of--

(I)110 percent of the aggregate amount of loans and grants received under this section; plus

(II)interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding. The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code [*26 USCS § 501(c)(29)*].

(D) Time for awarding loans and grants. The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) Repayment of loans and grants. Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.

(4) Advisory board.

(A) In general. The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act [*42 USCS § 1395b-6(c)(2)*].

(B) Rules relating to appointments.

(i) Standards. Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) Original appointments. The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act [enacted March 23, 2010].

(C) Vacancy. Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) Pay and reimbursement.

(i) No compensation for members of advisory board. Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) Travel expenses. Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code [*5 USCS §§ 5701* et seq.].

(E) Application of FACA. The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) Termination. The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(c) Qualified nonprofit health insurance issuer. For purposes of this section--

(1) In general. The term "qualified nonprofit health insurance issuer" means a health insurance issuer that is an organization--

(A)that is organized under State law as a nonprofit, member corporation;

(B)substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and

(C)that meets the other requirements of this subsection.

(2) Certain organizations prohibited. An organization shall not be treated as a qualified nonprofit health insurance issuer if--

(A)the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

(B)the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

(3) Governance requirements. An organization shall not be treated as a qualified nonprofit health insurance issuer unless--

(A)the governance of the organization is subject to a majority vote of its members;

(B)its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

(C)as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(4) Profits inure to benefit of members. An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

(5) Compliance with State insurance laws. An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b) [*42 USCS § 18044(b)*].

(6) Coordination with State insurance reforms. An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act [*42 USCS §§ 300gg* et seq.] (as amended by subtitles A and C of this Act).

(d) Establishment of private purchasing council.

(1) In general. Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) Council may not set payment rates. The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) Continued application of antitrust laws.

(A) In general. Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) Antitrust laws. For purposes of this subparagraph, the term "antitrust laws" has the meaning given the term in subsection (a) of the first section of the Clayton Act (*15 U.S.C. 12(a)*). Such term also includes section 5 of the Federal Trade Commission Act (*15 U.S.C. 45*) to the extent that such section 5 applies to unfair methods of competition.

(e) Limitation on participation. No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) Limitations on Secretary.

(1) In general. The Secretary shall not--

(A)participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B)establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) Competition. Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) Appropriations. There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $ 6,000,000,000 to carry out this section.

(h)[Omitted]

(i)GAO study and report.

(1) Study. The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) Report. The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative

changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

History

(March 23, 2010,*P.L. 111-148*, Title I, Subtitle D, Part III, § 1322, Title X, Subtitle A, § 10104(l), *124 Stat. 187*, 902.)

Annotations

Notes

References in text:

"This Act", referred to in this section, is Act March 23, 2010, *P.L. 111-148*. For full classification of such Act, consult USCS Tables volumes.

"Subtitles A and C", referred to in this section, are Subtitles A and C of Title I of Act March 23, 2010, *P.L. 111-148*. For full classification of such Subtitles, consult USCS Tables volumes.

Explanatory notes:

Subsec. (h), which has been omitted, amended *26 USCS §§ 501*, *4958*, and *6033*.

Amendments:

2010 . Act March 23, 2010, § 10104(l), in subsec. (b), redesignated para. (3) as para. (4) and inserted new para. (3).

Other provisions:

Consumer operated and oriented plan program contingency fund. Act Jan. 2, 2013, *P.L. 112-240*, Title VI, Subtitle C, § 644, *126 Stat. 2362*, provides:

"(a) Establishment. The Secretary of Health and Human Services shall establish a fund to be used to provide assistance and oversight to qualified nonprofit health insurance issuers that have been awarded loans or grants under section 1322 of the Patient Protection and Affordable Care Act (*42 U.S.C. 18042*) prior to the date of enactment of this Act.

"(b) Transfer and rescission.

(1) Transfer. From the unobligated balance of funds appropriated under section 1322(g) of the Patient Protection and Affordable Care Act (*42 U.S.C. 18042(g)*), 10 percent of such sums are hereby transferred to the fund established under subsection (a) to remain available until expended.

"(2) Rescission. Except as provided for in paragraph (1), amounts appropriated under section 1322(g) of the Patient Protection and Affordable Care Act (*42 U.S.C. 18042(g)*) that are unobligated as of the date of enactment of this Act are rescinded.".

Research References & Practice Aids

Code of Federal Regulations:

Department of Health and Human Services--Exchange establishment standards and other related standards under the Affordable Care Act, *45 CFR 155.10* et seq.

Department of Health and Human Services--Health plan requirements under the Patient Protection and Affordable Care Act, including requirements related to exchanges, *45 CFR 156.10* et seq.

Law Review Articles:

Thompson. The Next Stage of Health Care Reform: Controlling Costs by Paying Health Plans Based on Health Outcomes. *44 Akron L Rev, 2011.*

Avraham. Clinical Practice Guidelines: The Warped Incentives in the U.S. Healthcare System. *37 Am J L and Med 7, 2011.*

Kinney. Comparative Effectiveness Research Under the Patient Protection and Affordable Care Act: Can New Bottles Accommodate Old Wine? *37 Am JL and Med 522, 2011.*

Maher. The Benefits of Opt-In Federalism. *52 BC L Rev 1733,* November 2011.

Smith. Federalism, Lochner, and the Individual Mandate. *91 BUL Rev 1723,* October 2011.

Cuello. How the Patient Protection and Affordable Care Act Shapes the Future of Home- and Community-Based Services. 45 Clearinghouse Rev 299, November-December 2011.

Skeel; Jackson. Transaction Consistency and the New Finance in Bankruptcy. *112 Colum L Rev 152,* Jan 2012.

Abbott. Treating the Health Care Crisis: Complementary and Alternative Medicine for PPACA. *14 DePaul J Health Care L 35,* Fall 2011.

Westfall. Ethically Economic: The Affordable Care Act's Impact on the Administration of Health Benefits. *14 DePaul J Health Care L 99,* Fall 2011.

Fox. Closing the Information Gap: Informing Better Medical Decisionmaking through the Use of Post-Market Safety and Comparative Effectiveness Information. *67 Food Drug LJ 83, 2012.*

Walsh. Everything but the Merits: Analyzing the Procedural Aspects of the Health Care Litigation: Essay: The Anti-Injunction Act, Congressional Inactivity, and Pre-Enforcement Challenges to § 5000A of the Tax Code. *46 U Rich L Rev 823,* March 2012.

Dorf; Siegel. "Early-Bird Special" Indeed!: Why the Tax Anti-Injunction Act Permits the Present Challenges to the Minimum Coverage Provision. *121 Yale LJ Online 389,* January 19, 2012.

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42 USCS § 18063

Current through PL 115-51, approved 8/18/17, with a gap of PL 115-50

United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 157. QUALITY AFFORDABLE HEALTH CARE FOR ALL AMERICANS > AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS > REINSURANCE AND RISK ADJUSTMENT

§ 18063. Risk adjustment

(a) In general.

(1) Low actuarial risk plans. Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(2) High actuarial risk plans. Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) Criteria and methods. The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act [*42 USCS §§ 1395w-21* et seq. or *1395w-101* et seq.]. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 1321 [*42 USCS § 18041*].

(c) Scope. A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

History

(March 23, 2010,*P.L. 111-148*, Title I, Subtitle D, Part V, § 1343, *124 Stat. 212*.)

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Public Law 113–76
113th Congress

An Act

Making consolidated appropriations for the fiscal year ending September 30, 2014, and for other purposes.

Jan. 17, 2014
[H.R. 3547]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Consolidated Appropriations Act, 2014.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated Appropriations Act, 2014".

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

CENTERS FOR MEDICARE AND MEDICAID SERVICES

GRANTS TO STATES FOR MEDICAID

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $177,872,985,000, to remain available until expended.

For making, after May 31, 2014, payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2014 for unanticipated costs incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the first quarter of fiscal year 2015, $103,472,323,000, to remain available until expended.

Payment under such title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

PAYMENTS TO HEALTH CARE TRUST FUNDS

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D–16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97–248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $255,185,000,000.

In addition, for making matching payments under section 1844 and benefit payments under section 1860D–16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2019: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further,* That the Secretary is directed to collect fees in fiscal year 2014 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts

under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act: *Provided further*, That $22,004,000 shall be available for the State high-risk health insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006.

HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT

In addition to amounts otherwise available for program integrity and program management, $293,588,000, to remain available through September 30, 2015, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $207,636,000 shall be for the Medicare Integrity Program at the Centers for Medicare and Medicaid Services, including administrative costs, to conduct oversight activities for Medicare Advantage under Part C and the Medicare Prescription Drug Program under Part D of the Social Security Act and for activities described in section 1893(b) of such Act, of which $28,122,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, of which $29,708,000 shall be for the Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities, and of which $28,122,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: *Provided,* That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2014 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation.

ADMINISTRATION FOR CHILDREN AND FAMILIES

PAYMENTS TO STATES FOR CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

For carrying out, except as otherwise provided under titles I, IV–D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960, $2,965,245,000, to remain available until expended; and for such purposes for the first quarter of fiscal year 2015, $1,250,000,000, to remain available until expended.

For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under titles I, IV–D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960, for the last 3 months of the current fiscal year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

LOW INCOME HOME ENERGY ASSISTANCE

For making payments under subsections (b) and (d) of section 2602 of the Low Income Home Energy Assistance Act of 1981, $3,424,549,000: *Provided*, That all but $491,000,000 of this amount shall be allocated as though the total appropriation for such payments for fiscal year 2014 was less than $1,975,000,000: *Provided further*, That notwithstanding section 2609A(a), of the amounts appropriated under section 2602(b), not more than $2,988,000 of

Public Law 113–235
113th Congress

An Act

Dec. 16, 2014
[H.R. 83]

Making consolidated appropriations for the fiscal year ending September 30, 2015, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Consolidated and Further Continuing Appropriations Act, 2015.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated and Further Continuing Appropriations Act, 2015".

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

fees, reimbursable and interagency agreements, and the sale of data shall be credited to this appropriation and shall remain available until September 30, 2016.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

GRANTS TO STATES FOR MEDICAID

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $234,608,916,000, to remain available until expended.

For making, after May 31, 2015, payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2015 for unanticipated costs incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the first quarter of fiscal year 2016, $113,272,140,000, to remain available until expended.

Payment under such title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

PAYMENTS TO HEALTH CARE TRUST FUNDS

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D–16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97–248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $259,212,000,000.

In addition, for making matching payments under section 1844 and benefit payments under section 1860D–16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2020: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes

Public Law 114–113
114th Congress

An Act

Dec. 18, 2015
[H.R. 2029]

Making appropriations for military construction, the Department of Veterans Affairs, and related agencies for the fiscal year ending September 30, 2016, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Consolidated Appropriations Act, 2016.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated Appropriations Act, 2016".

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

In addition, for making matching payments under section 1844 and benefit payments under section 1860D–16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2021: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further,* That the Secretary is directed to collect fees in fiscal year 2016 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT

In addition to amounts otherwise available for program integrity and program management, $681,000,000, to remain available through September 30, 2017, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $486,120,000 shall be for the Medicare Integrity Program at the Centers for Medicare and Medicaid Services, including administrative costs, to conduct oversight activities for Medicare Advantage under Part C and the Medicare Prescription Drug Program under Part D of the Social Security Act and for activities described in section 1893(b) of such Act, of which $67,200,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, of which $67,200,000 shall be for the Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities, and of which $60,480,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: *Provided,* That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2016 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation: *Provided further,* That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the

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* Public Law 115–31
115th Congress

An Act

Making appropriations for the fiscal year ending September 30, 2017, and for other purposes.

May 5, 2017
[H.R. 244]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Consolidated Appropriations Act, 2017.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated Appropriations Act, 2017".

SEC. 2. TABLE OF CONTENTS.

* See Endnote on 131 Stat. 842.

Act that were not anticipated in budget estimates, such sums as may be necessary.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2022: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further,* That the Secretary is directed to collect fees in fiscal year 2017 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

Fees.
Time period.

HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT

In addition to amounts otherwise available for program integrity and program management, $725,000,000, to remain available through September 30, 2018, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $486,936,000 shall be for the Medicare Integrity Program at the Centers for Medicare and Medicaid Services, including administrative costs, to conduct oversight activities for Medicare Advantage under Part C and the Medicare Prescription Drug Program under Part D of the Social Security Act and for activities described in section 1893(b) of such Act, of which $82,132,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, of which $82,132,000 shall be for the Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities, and of which $73,800,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: *Provided*, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2017 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation: *Provided further*, That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and $414,000,000 is additional new budget authority

Reports.
Time period.

AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

H. R. 1625

One Hundred Fifteenth Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Wednesday, the third day of January, two thousand and eighteen

An Act

To amend the State Department Basic Authorities Act of 1956 to include severe forms of trafficking in persons within the definition of transnational organized crime for purposes of the rewards program of the Department of State, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Consolidated Appropriations Act, 2018".

SEC. 2. TABLE OF CONTENTS.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

HEALTHCARE RESEARCH AND QUALITY

For carrying out titles III and IX of the PHS Act, part A of title XI of the Social Security Act, and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, $334,000,000: *Provided*, That section 947(c) of the PHS Act shall not apply in fiscal year 2018: *Provided further*, That in addition, amounts received from Freedom of Information Act fees, reimbursable and interagency agreements, and the sale of data shall be credited to this appropriation and shall remain available until September 30, 2019.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

GRANTS TO STATES FOR MEDICAID

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $284,798,384,000, to remain available until expended.

For making, after May 31, 2018, payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the last quarter of fiscal year 2018 for unanticipated costs incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the first quarter of fiscal year 2019, $134,847,759,000, to remain available until expended.

Payment under such title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

PAYMENTS TO HEALTH CARE TRUST FUNDS

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D–16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97–248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $323,497,300,000.

In addition, for making matching payments under section 1844 and benefit payments under section 1860D–16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the

Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 1893(h) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further,* That the Secretary is directed to collect fees in fiscal year 2018 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT

In addition to amounts otherwise available for program integrity and program management, $745,000,000, to remain available through September 30, 2019, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $500,368,000 shall be for the Medicare Integrity Program at the Centers for Medicare and Medicaid Services, including administrative costs, to conduct oversight activities for Medicare Advantage under Part C and the Medicare Prescription Drug Program under Part D of the Social Security Act and for activities described in section 1893(b) of such Act, of which $84,398,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, of which $84,398,000 shall be for the Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities, and of which $75,836,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: *Provided*, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year 2018 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation: *Provided further*, That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and $434,000,000 is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act: *Provided further*, That the Secretary shall provide not less than $17,621,000 for the Senior Medicare Patrol program to combat health care fraud and abuse from the funds provided to this account.

ADMINISTRATION FOR CHILDREN AND FAMILIES

PAYMENTS TO STATES FOR CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

For carrying out, except as otherwise provided, titles I, IV–D, X, XI, XIV, and XVI of the Social Security Act and the Act

45 CFR 153.310

This document is current through the August 28, 2017 issue of the Federal Register. Pursuant to 82 FR 8346 ("Regulatory Freeze Pending Review"), certain regulations will be delayed pending further review. See Publisher's Note under affected rules. Title 3 is current through August 4, 2017.

Code of Federal Regulations > TITLE 45 -- PUBLIC WELFARE > SUBTITLE A -- DEPARTMENT OF HEALTH AND HUMAN SERVICES > SUBCHAPTER B -- REQUIREMENTS RELATING TO HEALTH CARE ACCESS > PART 153--STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT > SUBPART D--STATE STANDARDS RELATED TO THE RISK ADJUSTMENT PROGRAM

§ 153.310 Risk adjustment administration.

(a) State eligibility to establish a risk adjustment program.

(1)A State that elects to operate an Exchange is eligible to establish a risk adjustment program.

(2) Any State that does not elect to operate an Exchange, or that HHS has not approved to operate an Exchange, will forgo implementation of all State functions in this subpart, and HHS will carry out all of the provisions of this subpart on behalf of the State.

(3) Any State that elects to operate an Exchange but does not elect to administer risk adjustment will forgo implementation of all State functions in this subpart, and HHS will carry out all of the provisions of this subpart on behalf of the State.

(4) Beginning in 2015, any State that is approved to operate an Exchange and elects to operate risk adjustment but has not been approved by HHS to operate risk adjustment prior to publication of its State notice of benefit and payment parameters for the applicable benefit year, will forgo implementation of all State functions in this subpart, and HHS will carry out all of the provisions of this subpart on behalf of the State.

(b) Entities eligible to carry out risk adjustment activities. If a State is operating a risk adjustment program, the State may elect to have an entity other than the Exchange perform the State functions of this subpart, provided that the entity meets the standards promulgated by HHS to be an entity eligible to carry out Exchange functions.

(c) State responsibility for risk adjustment. (1) A State operating a risk adjustment program for a benefit year must administer the applicable Federally certified risk adjustment methodology through an entity that--

(i) Is operationally ready to implement the applicable Federally certified risk adjustment methodology and process the resulting payments and charges; and

(ii) Has experience relevant to operating the risk adjustment program.

(2) The State must ensure that the risk adjustment entity complies with all applicable provisions of subpart D of this part in the administration of the applicable Federally certified risk adjustment methodology.

(3) The State must conduct oversight and monitoring of its risk adjustment program.

(4) Maintenance of records. A State operating a risk adjustment program must maintain documents and records relating to the risk adjustment program, whether paper, electronic, or in other media, for each benefit year for at least 10 years, and make them available upon request from HHS, the

OIG, the Comptroller General, or their designees, to any such entity. The documents and records must be sufficient to enable the evaluation of the State-operated risk adjustment program's compliance with Federal standards. A State operating a risk adjustment program must also ensure that its contractors, subcontractors, and agents similarly maintain and make relevant documents and records available upon request from HHS, the OIG, the Comptroller General, or their designees, to any such entity.

(d) Approval for a State to operate risk adjustment.

(1) To be approved by HHS to operate risk adjustment under a particular Federally certified risk adjustment methodology for a benefit year, a State must establish that it and its risk adjustment entity meet the standards set forth in paragraph (c) of this section.

(2) To obtain such approval, the State must submit to HHS, in a form and manner specified by HHS, evidence that its risk adjustment entity meets these standards.

(3) In addition to requirements set forth in paragraphs (d)(1) and (2) of this section, to obtain re-approval from HHS to operate risk adjustment for a third benefit year, the State must, in the first benefit year for which it operates risk adjustment, provide to HHS an interim report, in a manner specified by HHS, including a detailed summary of its risk adjustment activities in the first 10 months of the benefit year, no later than December 31 of the applicable benefit year.

(4) To obtain re-approval from HHS to operate risk adjustment for each benefit year after the third benefit year, each State operating a risk adjustment program must submit to HHS and make public a detailed summary of its risk adjustment program operations for the most recent benefit year for which risk adjustment operations have been completed, in the manner and timeframe specified by HHS.

(i) The summary must include the results of a programmatic and financial audit for each benefit year of the State-operated risk adjustment program conducted by an independent qualified auditing entity in accordance with generally accepted auditing standards (GAAS).

(ii) The summary must identify any material weakness or significant deficiency identified in the audit and address how the State intends to correct any such material weakness or significant deficiency.

(e) Timeframes. A State, or HHS on behalf of the State, must implement risk adjustment for the 2014 benefit year and every benefit year thereafter. For each benefit year, a State, or HHS on behalf of the State, must notify issuers of risk adjustment payments due or charges owed annually by June 30 of the year following the benefit year.

Statutory Authority

AUTHORITY NOTE APPLICABLE TO ENTIRE PART:

Secs. 1311, 1321, 1341-1343, Pub. L. 111-148, *24 Stat. 119.*

History

[77 FR 17220, 17245, Mar. 23, 2012; *78 FR 15410, 15527,* Mar. 11, 2013; *78 FR 65046, 65093,* Oct. 30, 2013]

Annotations

Notes

[EFFECTIVE DATE NOTE:

77 FR 17220, 17245, Mar. 23, 2012, added Part 153, effective May 22, 2012; *78 FR 15410, 15527,* Mar. 11, 2013, amended this section, effective Apr. 30, 2013; *78 FR 65046, 65093,* Oct. 30, 2013, amended this section, effective Dec. 30, 2013.]

Research References & Practice Aids

NOTES APPLICABLE TO ENTIRE SUBTITLE:

[PUBLISHER'S NOTE: Nomenclature changes to Subtitle A appear at *66 FR 39450, 39452,* July 31, 2001.]

[PUBLISHER'S NOTE: For Federal Register citations concerning Race to the Top--Early Learning Challenge (RTT-ELC) program, see: *78 FR 53964,* Aug. 30, 2013.]

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U.S. Code of Federal Regulations
TITLE 45 — Public Welfare
SUBTITLE A — DEPARTMENT OF HEALTH AND HUMAN SERVICES (§§ 2.1 to 170.599)
CHAPTER I — (§§ 2.1 to 170.599)
SUBCHAPTER B — REQUIREMENTS RELATING TO HEALTH CARE ACCESS (§§ 144.101 to 159.120)
PART 153 — STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT (§§ 153.10 to 153.740)
Subpart D — State Standards Related to the Risk Adjustment Program (§§ 153.300 to 153.365)

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45 C.F.R. § 153.320. Federally certified risk adjustment methodology.

(a) **General requirement.** — Any risk adjustment methodology used by a State, or HHS on behalf of the State, must be a Federally certified risk adjustment methodology. A risk adjustment methodology may become Federally certified by one of the following processes:

(1) The risk adjustment methodology is developed by HHS and published in advance of the benefit year in rulemaking; or

(2) An alternate risk adjustment methodology is submitted by a State in accordance with § 153.330, reviewed and certified by HHS, and published in the applicable annual HHS notice of benefit and payment parameters.

(b) **Publication of methodology in notices.** — The publication of a risk adjustment methodology by HHS in an annual HHS notice of benefit and payment parameters or by a State in an annual State notice of benefit and payment parameters described in subpart B of this part must include:

(1) A complete description of the risk adjustment model, including—

(i) Draft factors to be employed in the model, including but not limited to, demographic factors, diagnostic factors, and utilization factors, if any, the dataset(s) to be used to calculate final coefficients, and the date by which final coefficients will be released in guidance;

(ii) The qualifying criteria for establishing that an individual is eligible for a specific factor;

(iii) Weights assigned to each factor; and

(iv) The schedule for the calculation of individual risk scores.

(2) A complete description of the calculation of plan average actuarial risk.

(3) A complete description of the calculation of payments and charges.

(4) A complete description of the risk adjustment data collection approach.

(5) The schedule for the risk adjustment program.

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U.S. Code of Federal Regulations, 45 C.F.R. § 153.320. Federally certified risk adjustment methodology.

(c) **Use of methodology for States that do not operate a risk adjustment program.** — HHS will specify in the annual HHS notice of benefit and payment parameters for the applicable year the Federally certified risk adjustment methodology that will apply in States that do not operate a risk adjustment program.

[77 FR 17249, Mar. 23, 2012 , as amended at 78 FR 15528, Mar. 11, 2013; 81 FR 94174, Dec. 22, 2016]

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45 CFR 153.330

This document is current through the April 15, 2019 issue of the Federal Register. Title 3 is current through April 5, 2019.

Code of Federal Regulations > TITLE 45 -- PUBLIC WELFARE > SUBTITLE A -- DEPARTMENT OF HEALTH AND HUMAN SERVICES > SUBCHAPTER B -- REQUIREMENTS RELATING TO HEALTH CARE ACCESS > PART 153--STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT > SUBPART D--STATE STANDARDS RELATED TO THE RISK ADJUSTMENT PROGRAM

§ 153.330 State alternate risk adjustment methodology.

(a) State request for alternate methodology certification. (1) A State request to HHS for the certification of an alternate risk adjustment methodology must include:

(i) The elements specified in § 153.320(b);

(ii) The calibration methodology and frequency of calibration; and

(iii) The statistical performance metrics specified by HHS.

(2) The request must include the extent to which the methodology:

(i) Accurately explains the variation in health care costs of a given population;

(ii) Links risk factors to daily clinical practice and is clinically meaningful to providers;

(iii) Encourages favorable behavior among providers and health plans and discourages unfavorable behavior;

(iv) Uses data that is complete, high in quality, and available in a timely fashion;

(v) Is easy for stakeholders to understand and implement;

(vi) Provides stable risk scores over time and across plans; and

(vii) Minimizes administrative costs.

(b) Evaluation criteria for alternate risk adjustment methodology. An alternate risk adjustment methodology will be certified by HHS as a Federally certified risk adjustment methodology based on the following criteria:

(1) The criteria listed in paragraph (a)(2) of this section;

(2) Whether the methodology complies with the requirements of this subpart D;

(3) Whether the methodology accounts for risk selection across metal levels; and

(4) Whether each of the elements of the methodology are aligned.

(c) State renewal of alternate methodology. If a State is operating a risk adjustment program, the State may not implement a recalibrated risk adjustment model or otherwise alter its risk adjustment methodology without first obtaining HHS certification.

(1) Recalibration of the risk adjustment model must be performed at least as frequently as described in paragraph (a)(1)(ii) of this section;

(2)A State request to implement a recalibrated risk adjustment model or otherwise alter its risk adjustment methodology must include any changes to the parameters described in paragraph (a)(1) of this section.

Statutory Authority

AUTHORITY NOTE APPLICABLE TO ENTIRE PART:

Secs. 1311, 1321, 1341-1343, Pub. L. 111-148, *24 Stat. 119.*

History

[77 FR 17220, 17245, Mar. 23, 2012; *78 FR 15410, 15528,* Mar. 11, 2013]

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45 CFR 156.515

This document is current through the April 15, 2019 issue of the Federal Register. Title 3 is current through April 5, 2019.

Code of Federal Regulations > TITLE 45 -- PUBLIC WELFARE > SUBTITLE A -- DEPARTMENT OF HEALTH AND HUMAN SERVICES > SUBCHAPTER B -- REQUIREMENTS RELATING TO HEALTH CARE ACCESS > PART 156--HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES > SUBPART F--CONSUMER OPERATED AND ORIENTED PLAN PROGRAM

§ 156.515 CO-OP standards.

(a) General. A CO-OP must satisfy the standards in this section in addition to all other statutory, regulatory, or other requirements.

(b) Governance requirements. A CO-OP must meet the following governance requirements:

(1) Member control. A CO-OP must implement policies and procedures to foster and ensure member control of the organization. Accordingly, a CO-OP must meet the following requirements:

(i) The CO-OP must be governed by an operational board with a majority of directors elected by a majority vote of a quorum of the CO-OP's members that are age 18 or older;

(ii) All members age 18 or older must be eligible to vote for each of the directors on the organization's operational board subject to a vote of the members under paragraph (b)(1)(i) of this section;

(iii) Each member age 18 or older must have one vote in each election for each director subject to a vote of the members under paragraph (b)(1)(i) of this section in that election;

(iv) The first elected directors of the organization's operational board must be elected no later than one year after the effective date on which the organization provides coverage to its first member; the entire operational board must be elected or in place, and in full compliance with paragraph (b)(1)(i) of this section, no later than two years after the same date;

(v) Elections of the directors on the organization's operational board subject to a vote of the members under paragraph (b)(1)(i) of this section must be contested so that the total number of candidates for contested seats on the operational board exceeds the number of contested seats for such directors, except in cases where a seat is vacated mid- term due to death, resignation, or removal.

(2) Standards for board of directors. The operational board for a CO-OP must meet the following standards:

(i) Each director must meet ethical, conflict-of-interest, and disclosure standards;

(ii) Each director has one vote;

(iii) Positions on the board of directors may be designated for individuals with specialized expertise, experience, or affiliation (for example, providers, employers, and unions); and

(iv)[Reserved]

(v) Limitation on government and issuer participation. No representative of any Federal, State or local government (or of any political subdivision or instrumentality thereof) and no representative of

any organization described in § 156.510(b)(1)(i) (in the case of a representative of a State or local government or organization described in § 156.510(b)(1)(i), with respect to a State in which the CO-OP issues policies), may serve on the CO-OP's formation board or as a director on the organization's operational board.

(3) Ethics and conflict of interest protections. The CO-OP must have governing documents that incorporate ethics, conflict of interest, and disclosure standards. The standards must protect against insurance industry involvement and interference. In addition, the standards must ensure that each director acts in the sole interest of the CO-OP, its members, and its local geographic community as appropriate, avoids self dealing, and acts prudently and consistently with the terms of the CO-OP's governance documents and applicable State and Federal law. At a minimum, these standards must include:

(i)A mechanism to identify potential ethical or other conflicts of interest;

(ii)A duty on the CO-OP's executive officers and directors to disclose all potential conflicts of interest;

(iii)A process to determine the extent to which a conflict exists;

(iv)A process to address any conflict of interest; and

(v)A process to be followed in the event a director or executive officer of the CO-OP violates these standards.

(4) Consumer focus. The CO-OP must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(c) Standards for health plan issuance. A CO-OP must meet several standards for the issuance of health plans in the individual and small group market.

(1) At least two-thirds of the policies or contracts for health insurance coverage issued by a CO-OP in each State in which it is licensed must be CO-OP qualified health plans offered in the individual and small group markets.

(2) Loan recipients must offer a CO-OP qualified health plan at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in every individual market Exchange that serves the geographic regions in which the organization is licensed and intends to provide health care coverage. If offering at least one plan in the small group market, loan recipients must offer a CO-OP qualified health plan at both the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in each SHOP that serves the geographic regions in which the organization offers coverage in the small group market.

(3) Within the earlier of thirty-six months following the initial drawdown of the Start-up Loan or one year following the initial drawdown of the Solvency Loan, loan recipients must be licensed in a State and offer at least one CO-OP qualified health plan at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in the individual market Exchanges and if the loan recipient offers coverage in the small group market, at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in the SHOPs. Loan recipients may only begin offering plans and accepting enrollment in the Exchanges for new CO-OP qualified health plans during the open enrollment period for each applicable Exchange.

(d) Requirement to become a CO-OP. Loan recipients must meet the standards of § 156.515 no later than five years following initial drawdown of the Start-up Loan or three years following the initial drawdown of a Solvency Loan.

Statutory Authority

45 CFR 156.515

AUTHORITY NOTE APPLICABLE TO ENTIRE PART:

Title I of the Affordable Care Act, sections 1301-1304, 1311-1313, 1321-1322, 1324, 1334, 1342-1343, 1401-1402, 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).*

History

[76 FR 77392, 77411, Dec. 13, 2011; *81 FR 29146, 29155,* May 11, 2016; *81 FR 94058, 94182,* Dec. 22, 2016]

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AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

FEDERAL REGISTER

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Part II

Department of Health and Human Services

45 CFR Part 153, 155, 156, *et al.*
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 153, 155, 156, 157 and 158

[CMS–9964–P]

RIN 0938–AR51

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule provides further detail and parameters related to: the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for a Federally-facilitated Exchange; advance payments of the premium tax credit; a Federally-facilitated Small Business Health Option Program; and the medical loss ratio program. The cost-sharing reductions and advanced payments of the premium tax credit, combined with new insurance market reforms, will significantly increase the number of individuals with health insurance coverage, particularly in the individual market. The premium stabilization programs—risk adjustment, reinsurance, and risk corridors—will protect against adverse selection in the newly enrolled population. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue) protections and prohibiting the use of factors such as health status, medical history, gender, and industry of employment to set premium rates, will help to ensure that every American has access to high-quality, affordable health insurance.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 31, 2012.

ADDRESSES: In commenting, please refer to file code CMS–9964–P. 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–P, 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–P, 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 at (301) 492–4286, Laurie McWright at (301) 492–4311, or Jeff Wu at (301) 492–4305 for general information.

Adrianne Glasgow at (410) 786–0686 for matters related to reinsurance.

Michael Cohen at (301) 492–4277 for matters related to the methodology for determining the reinsurance contribution rate and payment parameters.

Grace Arnold at (301) 492–4272 for matters related to risk adjustment, the HHS risk adjustment methodology, or the distributed data collection approach for the HHS-operated risk adjustment and reinsurance programs.

Adam Shaw at (410) 786–1091 for matters related to risk corridors.

Johanna Lauer at (301) 492–4397 for matters related to cost-sharing reductions, advance payments of the premium tax credits, or user fees.

Rex Cowdry at (301) 492–4387 for matters related to the Small Business Health Options Program.

Carol Jimenez at (301) 492–4457 for matters related to the medical loss ratio program.

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 Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be 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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explained by a model, measures the predictive accuracy of the model overall. The predictive ratios measure the predictive accuracy of a model for different validation groups or subpopulations. The predictive ratio for each of the HHS risk adjustment models is the ratio of the weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The predictive ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0. For each of the HHS risk adjustment models, the R-squared statistic and the predictive ratio are in the range of published estimates for concurrent risk adjustment models.[20] The R-squared statistic for each model is shown in Table 8.

We welcome comment on these proposed risk adjustment models.

TABLE 8—R-SQUARED STATISTIC FOR HHS RISK ADJUSTMENT MODELS

Risk adjustment model	R-squared statistic
Platinum Adult	0.360
Platinum Child	0.307
Platinum Infant	0.292
Gold Adult	0.355
Gold Child	0.302
Gold Infant	0.289
Silver Adult	0.352
Silver Child	0.299
Silver Infant	0.288
Bronze Adult	0.351
Bronze Child	0.296
Bronze Infant	0.289
Catastrophic Adult	0.350
Catastrophic Child	0.295
Catastrophic Infant	0.289

c. Overview of the Payment Transfer Formula

Plan average risk scores are calculated as the member month-weighted average of individual enrollee risk scores, as shown in section III.B.3.b. of this proposed rule. We defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. Here, we combine these concepts into a risk adjustment payment transfer formula. In this section, we refer to payments and charges generically as transfers. Under § 153.310(e), as proposed to renumbered, HHS would invoice issuers of risk adjustment covered plans for transfers by June 30 of the year following the applicable benefit year.

We propose to calculate risk adjustment transfers after the close of the applicable benefit year, following the completion of issuer risk adjustment data reporting. As discussed in detail below, the payment transfer formula includes a set of cost adjustment terms that require transfers to be calculated at the geographic rating area level for each plan (thus, HHS would calculate two separate transfer amounts for a plan that operates in two rating areas). Payment transfer amounts would be aggregated at the issuer level (that is, at the level of the entity licensed by the State) such that each issuer would receive an invoice and a report detailing the basis for the net payment that would be made or the charge that would be owed. The invoice would also include plan-level risk adjustment information that may be used in the issuer's risk corridors calculations.

The proposed payment transfer formula is designed to provide a per member per month (PMPM) transfer amount. The PMPM transfer amount derived from the payment transfer formula would be multiplied by each plan's total member months for the benefit year to determine the total payment due or charge owed by the issuer for that plan in a rating area.

(1) Rationales for a Transfer Methodology Based on State Average Premiums

Risk adjustment transfers are intended to reduce the impact of risk selection on premiums while preserving premium differences related to other cost factors, such as the actuarial value, local patterns of utilization and care delivery, local differences in the cost of doing business, and, within limits established by the Affordable Care Act, the age of the enrollee. Risk adjustment payments would be fully funded by the charges that are collected from plans with lower risk enrollees (that is, transfers within a State would net to zero).

In the Risk Adjustment White Paper, we presented several approaches for calculating risk adjustment transfers using the State average premium and plans' own premiums. The approaches that used plans' own premiums resulted in unbalanced payment transfers, requiring a balancing adjustment to yield transfers that net to zero. These examples also demonstrated that the balancing adjustments could introduce differences in premiums across plans that were not consistent with features of the plan (for example, AV or differences in costs and utilization patterns across rating areas). A balancing adjustment would likely vary from year to year, and could add uncertainty to the rate development process (that is, plan actuaries would need to factor the uncertainty of the balancing adjustment into their transfer estimates).

Therefore, we propose a payment transfer formula that is based on the State average premium for the applicable market, as described in section III.B.3.a. of this proposed rule. The State average premium provides a straightforward and predictable benchmark for estimating transfers. As shown in the examples in the Risk Adjustment White Paper, transfers net to zero when the State average premium is used as the basis for calculating transfers.

Plan premiums differ from the State average premium due to a variety of factors, such as differences in cost-sharing structure or regional differences in utilization and unit costs. The proposed payment transfer formula applies a set of cost factor adjustments to the State average premium so that it will better reflect plan liability. These adjustments to the State average premium result in transfers that compensate plans for liability differences associated with risk selection, while preserving premium differences related to the other cost factors described above.

(2) Conceptual Overview of the Payment Transfer Formula

In this section, we provide a broad overview of the payment transfer formula that we propose to use when operating risk adjustment on behalf of a State. We discuss at a conceptual level our proposal to use the State average premium as the basis of the formula and the components of the formula.

(i) Calculating Transfers Using the State Average Premium

The payment transfer formula proposed for 2014 is based on the difference between two plan premium estimates: (1) A premium based on plan-specific risk selection; and (2) a premium without risk selection. Transfers are intended to bridge the gap between these two premium estimates:

[20] Winkleman, Ross and Syed Mehmud. ''A Comparative Analysis of Claims-Based Tools for Health Risk Assessment.'' Society of Actuaries. April 2007.

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Part II

Department of Health and Human Services

45 CFR Parts 153, 155, 156, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 153, 155, 156, 157 and 158

[CMS–9964–F]

RIN 0938–AR51

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

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

ACTION: Final rule.

SUMMARY: This final rule provides detail and parameters related to: the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for Federally-facilitated Exchanges; advance payments of the premium tax credit; the Federally-facilitated Small Business Health Option Program; and the medical loss ratio program. Cost-sharing reductions and advance payments of the premium tax credit, combined with new insurance market reforms, are expected to significantly increase the number of individuals with health insurance coverage, particularly in the individual market. In addition, we expect the premium stabilization programs—risk adjustment, reinsurance, and risk corridors—to protect against the effects of adverse selection. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue) and prohibiting the use of factors such as health status, medical history, gender, and industry of employment to set premium rates, will help to ensure that every American has access to high-quality, affordable health insurance.

DATES: This final rule is effective on April 30, 2013.

FOR FURTHER INFORMATION CONTACT:
Sharon Arnold, (301) 492–4286; Laurie McWright, (301) 492–4311; or Jeff Wu, (301) 492–4305, for general information.
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Michael Cohen, (301) 492–4277, for matters related to the risk adjustment methodology and the methodology for determining the reinsurance contribution rate and payment parameters.
Adrianne Glasgow, (410) 786–0686, for matters related to the reinsurance program.
Jaya Ghildiyal, (301) 492–5149, for matters related to the risk corridors program and user fees for Federally-facilitated Exchanges.
Johanna Lauer, (301) 492–4397, for matters related to cost-sharing reductions and advance payments of the premium tax credit.
Bobbie Knickman, (410) 786–4161, for matters related to the distributed data collection approach for the HHS-operated risk adjustment and reinsurance programs.
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SUPPLEMENTARY INFORMATION:

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Acronyms

Affordable Care Act The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act (Pub. L. 111–152))
APTC Advance payments of the premium tax credit
ASO Administrative services only contractor
AV Actuarial Value
CFR Code of Federal Regulations
CHIP Children's Health Insurance Program
CMS Centers for Medicare & Medicaid Services
COBRA Consolidated Omnibus Budget Reconciliation Act
EHB Essential health benefits
ERISA Employee Retirement Income Security Act
FFE Federally-facilitated Exchange

FF–SHOP Federally-facilitated Small Business Health Options Program Exchange
FPL Federal poverty level
HCC Hierarchical condition category
HHS United States Department of Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
IHS Indian Health Service
IRS Internal Revenue Service
MLR Medical loss ratio
NAIC National Association of Insurance Commissioners
OMB United States Office of Management and Budget
OPM United States Office of Personnel Management
PHS Act Public Health Service Act
PRA Paperwork Reduction Act of 1985
QHP Qualified health plan
SHOP Small Business Health Options Program
The Code Internal Revenue Code of 1986
TPA Third party administrator

I. Executive Summary

A. Purpose

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through competitive marketplaces called Affordable Insurance Exchanges, ''Exchanges,'' or ''Marketplaces.'' Individuals who enroll in qualified health plans through Exchanges may receive premium tax credits that make health insurance more affordable and financial assistance to cover some or all cost sharing for essential health benefits. We expect that the premium tax credits, combined with the new insurance reforms, will significantly increase the number of individuals with health insurance coverage, particularly in the individual market. Premium stabilization programs—risk adjustment, reinsurance, and risk corridors—are expected to protect against the effects of adverse selection. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue), and prohibiting the use of factors such as health status, medical history, gender, and industry of employment to set premium rates, will help to ensure that every American has access to high-quality, affordable health care.

Premium stabilization programs: The Affordable Care Act establishes a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers.

The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented and Exchanges facilitate increased enrollment. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' risk associated with high-cost enrollees. The risk corridors program will protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains. On an ongoing basis, the risk adjustment program is intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees. Under this program, funds are transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees.

In the Premium Stabilization Rule [1] we laid out a regulatory framework for these three programs. In that rule, we stated that the specific payment parameters for those programs would be published in this final rule. In this final rule, we describe these standards, and include payment parameters for these programs.

Advance payments of the premium tax credit and cost-sharing reductions: This final rule establishes standards for advance payments of the premium tax credit and for cost-sharing reductions. These programs assist eligible low- and moderate-income Americans in affording health insurance on an Exchange. Section 1401 of the Affordable Care Act amended the Internal Revenue Code (26 U.S.C.) to add section 36B, allowing an advance, refundable premium tax credit to help individuals and families afford health insurance coverage. Section 36B of the Code was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111–309) (124 Stat. 3285 (2010)); the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112–9) (125 Stat. 36 (2011)); and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112–10) (125 Stat. 38 (2011)). The section 36B credit is designed to make a qualified health plan (QHP) purchased on an Exchange affordable by reducing an eligible taxpayer's out-of-pocket premium cost.

[1] 77 FR 17220 (March 23, 2012).

Under sections 1401, 1411, and 1412 of the Affordable Care Act and 45 CFR part 155 subpart D, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in QHP coverage through the Exchange and seek financial assistance. Using information available at the time of enrollment, the Exchange determines whether the individual meets the income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. Advance payments are made periodically under section 1412 of the Affordable Care Act to the issuer of the QHP in which the individual enrolls.

Section 1402 of the Affordable Care Act provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 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 statute directs issuers to reduce cost sharing for essential health benefits for individuals with household incomes between 100 and 400 percent of the Federal poverty level (FPL) who are enrolled in a silver level QHP through an individual market Exchange and are eligible for advance payments of the premium tax credit. 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 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 prohibits issuers of QHPs from requiring 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.

HHS published a bulletin [2] outlining an intended regulatory approach to calculating actuarial value and implementing cost-sharing reductions on February 24, 2012 (AV/CSR Bulletin). The AV/CSR Bulletin outlined an intended regulatory approach governing the calculation of AV, de minimis variation standards, silver plan

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

TABLE 7—HHS HCCs INCLUDED IN INFANT MODEL SEVERITY CATEGORIES—Continued

Severity category	HCC
Severity Level 2	Drug Psychosis.
Severity Level 2	Drug Dependence.
Severity Level 2	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes.
Severity Level 2	Spina Bifida and Other Brain/Spinal/Nervous System Congenital Anomalies.
Severity Level 2	Seizure Disorders and Convulsions.
Severity Level 2	Monoplegia, Other Paralytic Syndromes.
Severity Level 2	Atherosclerosis of the Extremities with Ulceration or Gangrene.
Severity Level 2	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis.
Severity Level 2	Chronic Ulcer of Skin, Except Pressure.
Severity Level 1 (Lowest)	Chronic Hepatitis.
Severity Level 1	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption.
Severity Level 1	Thalassemia Major.
Severity Level 1	Autistic Disorder.
Severity Level 1	Pervasive Developmental Disorders, Except Autistic Disorder.
Severity Level 1	Multiple Sclerosis.
Severity Level 1	Asthma.
Severity Level 1	Chronic Kidney Disease, Severe (Stage 4).
Severity Level 1	Amputation Status, Lower Limb/Amputation Complications.
Severity Level 1	No Severity HCCs.

TABLE 8—R-SQUARED STATISTIC FOR HHS RISK ADJUSTMENT MODELS

Risk adjustment model	R-Squared statistic
Platinum Adult	0.360
Platinum Child	0.307
Platinum Infant	0.292
Gold Adult	0.355
Gold Child	0.302
Gold Infant	0.289
Silver Adult	0.352
Silver Child	0.299
Silver Infant	0.288
Bronze Adult	0.351
Bronze Child	0.296
Bronze Infant	0.289
Catastrophic Adult	0.350
Catastrophic Child	0.295

TABLE 8—R-SQUARED STATISTIC FOR HHS RISK ADJUSTMENT MODELS—Continued

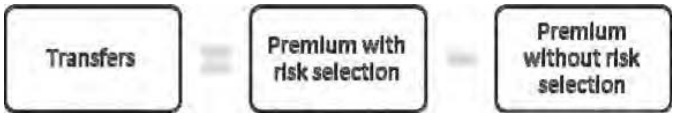
Risk adjustment model	R-Squared statistic
Catastrophic Infant	0.289

c. Overview of the Payment Transfer Formula

In the proposed rule, we proposed to calculate risk adjustment transfers after the close of the applicable benefit year, following the completion of issuer risk adjustment data reporting.

Transfers are calculated at the geographic rating area level for each plan (HHS would calculate two separate transfer amounts for a plan that operates in two rating areas). In other words, the payment transfer formula would treat each rating area segment of enrollment as a separate plan for the purposes of calculating transfers. Payment transfer amounts would be aggregated at the issuer level (that is, at the level of the entity licensed by the State) such that each issuer would receive an invoice and a report detailing the basis for the net payment that would be made or the charge that would be owed. The invoice would also include plan-level risk adjustment information.

The payment transfer formula is based on the difference between two plan premium estimates: (1) A premium based on plan-specific risk selection; and (2) a premium without risk selection. Transfers are intended to bridge the gap between these two premium estimates:



Conceptually, the goal of payment transfers is to provide plans with payments to help cover their actual risk exposure beyond the premiums the plans would charge reflecting allowable rating and their applicable cost factors. In other words, payments would help cover excess actuarial risk due to risk selection. Both of these premium estimates are based on the State average premium. The payment transfer formula includes the following premium adjustment terms:

- Plan average risk score: Multiplying the plan average risk score by the State average premium shows how a plan's premium would differ from the State average premium based on the risk selection experienced by the plan.
- Actuarial value (AV): A particular plan's premium may differ from the State average premium based on the plan's cost-sharing structure, or AV. An AV adjustment is applied to the State average premium to account for relative differences between a plan's AV and the market average AV.
- Permissible rating variation: Plan rates may differ based on allowable age rating factors. The rating adjustment accounts for the impact of allowable rating factors on the premium that would be realized by the plan.
- Geographic cost differences: Differences in unit costs and utilization

[11] This HCC also includes Breast (Age 50+) and Prostate Cancer.

000247

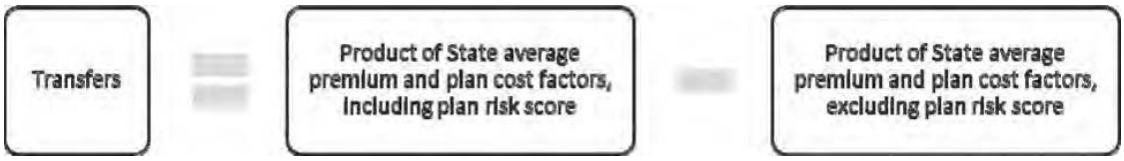
may lead to differences in the average premium between intra-State rating areas, holding other cost factors (for example, benefit design) constant. The geographic cost adjustment accounts for cost differences across rating areas.

• Induced demand: Enrollee spending patterns may vary based on the generosity of cost sharing. The induced demand adjustment accounts for greater utilization of health care services induced by lower enrollee cost sharing in higher metal level plans.

The State average premium is multiplied by these factors to develop the plan premium estimates used in the payment transfer formula. The factors are relative measures that compare how plans differ from the market average with respect to the cost factors (that is to say, the product of the adjustments is normalized to the market average product of the cost factors).

In the absence of these adjustments, transfers would reflect liability differences attributed to cost factors other than risk selection. For example, in the absence of the AV adjustment, a low AV plan with lower-risk enrollees would be overcharged because the State average premium would not be scaled down to reflect the fact that the plan's AV is lower than the average AV of plans operating in the market in the State.

The figure below shows how the State average premium, the plan average risk score, and other plan-specific cost factors are used to develop the two plan premium estimates that are used to calculate payment transfers:



We are finalizing the payment transfer formula as proposed, with several technical corrections. We clarify that IDF stands for induced demand factor in the equations, and modify the denominator of the plan average premium formula within the State average premium and geographic cost factor calculations to reflect the billable member calculation. Therefore, the 2014 HHS risk adjustment payment transfer formula is:

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \bar{P}_s$$

Where:
$\bar{P}_s$= State average premium;
$PLRS_i$ = plan i's plan liability risk score;
AV_i= plan i's metal level AV;
ARF_i= plan i's allowable rating factor;
IDF_i = plan i's induced demand factor;
GCF_i = plan i's geographic cost factor;
s_i = plan i's share of State enrollment;
and the denominator is summed across all plans in the risk pool in the market in the State.

Risk adjustment transfers will be calculated at the risk pool level. Each State will have a risk pool for all of its metal-level plans. Catastrophic plans will be treated as a separate risk pool for purposes of risk adjustment. Individual and small group market plans will either be pooled together or treated as separate risk pools, depending on how the State treats these pools under the single risk pool provisions.

The payment transfer formula provides a per member per month (PMPM) transfer amount for a plan within a rating area. The PMPM transfer amount derived from the payment transfer formula (T_{PMPM}) will be multiplied by each plan's rating area billable member months ($\Sigma_b M_b$) to calculate the plan's total risk adjustment payment for a given rating area (T_i).

$$T_i = T_{PMPM} * \sum_b M_b$$

Comment: We received a number of comments in support of the general approach to calculating payment transfers, including HHS's approach to adjusting for plan cost factors in the transfer equation.

Response: We are finalizing the payment transfer formula as proposed with minor technical corrections, specified below.

Comment: We received one comment requesting that HHS clarify the calculation of payment transfers at the plan level.

Response: Because we have proposed and are finalizing a geographic cost factor, transfers must be calculated for each rating area in which a plan operates. However, we note that, because the denominator of each term of the payment transfer equation is the Statewide average of the product of the terms, transfers occur within the risk pool within the market within the State.

Comment: We received one comment requesting that HHS provide detailed examples of the payment transfer formula.

Response: We anticipate working closely with issuers and other stakeholders to provide examples of the payment transfer formula and its application in a market.

(1) State Average Premium

We proposed a payment transfer formula that is based on the State average premium for the applicable market. Plan average premiums will be calculated from the actual premiums charged to their enrollees, weighted by the number of months enrolled. We make a technical correction to the formula to calculate PMPM plan average premiums, as described below. The equations for calculating State average premiums were proposed as:

$$\overline{P_S} = \sum_i s_i^S \overline{P_i}$$

and

$$\overline{P_i} = \frac{\sum_S (M_S \cdot P_S)}{\sum_S M_S}$$

The first equation calculates the State average premium $\overline{P_S}$ as the average of individual plan averages, $\overline{P_i}$ weighted by each plan's share of Statewide enrollment in the risk pool in the market, s_i^S (based on billable member months).

The second equation shows the proposed formula to calculate plan average premiums. The proposed formula, which we are modifying as described below, was the weighted mean over all subscribers *s* of subscriber premiums P_s, with M_s representing the number of billable member months of enrollment for each subscriber *s*. Due to a typographical error and to align with the calculation of plan average risk score, we have modified the denominator of the plan average premium equation from the proposed rule. The denominator in the revised formula is equal to the sum of the billable member months for all billable members *b* enrolled in the plan. The numerator of this formula remains unchanged from the proposed rule. The numerator is equal to the product of each subscriber's billable member months (the billable member months attributed to the individual that is the policy subscriber) and the average monthly premium for the subscriber, summed across all of the subscribers *s* in the plan. The calculation of each plan's total premium revenue—the numerator of this formula—uses subscriber-level premiums in order to align with the way that premium information will be captured in data on issuers' distributed data environments. The final formula is:

$$\overline{P_i} = \frac{\sum_s (M_s \cdot P_s)}{\sum_b M_b}$$

Billable member months are defined as the number of months during the risk adjustment period billable members are enrolled in the plan (billable members exclude children who do not count towards family rates). In non-community rated States, issuers are required to individually rate each member covered under a family policy and, in the case of large families, issuers are only allowed to include the three oldest children in the development of family rates. Therefore, for large families, only the three oldest children are counted as billable members in the risk adjustment transfer formula. In community rated States that require family tiering, the number of billable members under a family policy may vary based on the State's tiering structure. For example, if a State's largest family tier is set at two or more children, only the first two children under the family policy would count as billable members. HHS will assess each State's rating requirements and will provide community rated States with additional details on how billable members will be counted in the transfer formula.

Comment: We received a number of comments in support of our proposal to use the State average premium as the basis for risk adjustment transfers. One commenter suggested that use of a plan's own premium may cause unintended distortions in the transfer formula. One commenter suggested that we use net claims, or approximate net claims by using 90 percent of the State average premium, as the basis for risk adjustment transfers.

Response: The goal of the payment transfer formula is, to the extent possible, to promote risk-neutral premiums. We agree with commenters that use of a plan's own premium may cause unintended distortions in transfers. We also believe that both claims and administrative costs include elements of risk selection, and therefore, that transfers should be based on the entire premium. We are finalizing our proposal to base the payment transfer formula on the State average premium.

(2) Plan Average Risk Score

The proposed plan average risk score calculation included an adjustment to account for the family rating rules set forth in the Market Reform Rule, which limits the number of dependent children in non-community rated States that count toward the build-up of family rates to three. The formula below shows the final plan average risk score calculation including the risk of all members on the policy, including those children not included in the premium.

$$PLRS_i = \frac{\sum_e M_e \cdot PLRS_e}{\sum_b M_b}$$

Where:

$PLRS_i$ is plan *i*'s average plan liability risk score, the subscript *e* denotes each enrollee within the plan;

$PLRS_e$ is each enrollee's individual plan liability risk score;

M_e is the number of months during the risk adjustment period the enrollee is enrolled in the plan; and

M_b is the number of months during the risk adjustment period the billable member *b* is enrolled in the plan (billable members exclude children who do not count towards family rates).

We received the following comments regarding the calculation of the plan average risk score:

Comment: We received comments in support of this approach to calculating plan average risk score. We received one comment that calculating plan average risk score with an adjustment for billable members would be administratively burdensome for issuers.

Response: We are finalizing this term as proposed. We note that, when HHS is operating risk adjustment on behalf of the State, HHS will calculate the plan average risk score and so there will be no additional administrative burden for issuers.

(3) Actuarial Value (AV)

The proposed AV adjustment in the payment transfer formula accounts for relative differences in plan liability due to differences in AV. Table 9 shows the AV adjustment that will be used for

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Part II

Department of Health and Human Services

45 CFR Parts 144, 147, 153, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, 153, 155, 156 and 158

[CMS–9954–F]

RIN 0938–AR89

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth payment parameters and oversight provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also provides additional standards with respect to composite premiums, privacy and security of personally identifiable information, the annual open enrollment period for 2015, the actuarial value calculator, the annual limitation in cost sharing for stand-alone dental plans, the meaningful difference standard for qualified health plans offered through a Federally-facilitated Exchange, patient safety standards for issuers of qualified health plans, and the Small Business Health Options Program.

DATES: These regulations are effective on May 12, 2014.

FOR FURTHER INFORMATION CONTACT:

For general information: Sharon Arnold, (301) 492–4286; Laurie McWright, (301) 492–4311; or Jeff Wu, (301) 492–4305.
For matters related to student health insurance coverage and composite premiums: Jacob Ackerman, (301) 492–4179.
For matters related to the risk adjustment program: Kelly Horney, (410) 786–0558.
For general matters related to the reinsurance program: Adrianne Glasgow, (410) 786–0686.
For matters related to reinsurance contributions: Adam Shaw, (410) 786–1019.
For matters related to risk corridors: Jaya Ghildiyal, (301) 492–5149.
For matters related to medical loss ratio: Christina Pavlus, (301) 492–4172.
For matters related to cost-sharing reductions and netting of payments and charges: Pat Meisol, (410) 786–1917.
For matters related to the premium adjustment percentage: Johanna Lauer, (301) 492–4397.
For matters related to Federally-facilitated Exchange user fees: Michael Cohen, (301) 492–4277.
For matters related to the annual limitation on cost sharing for stand-alone dental plans, privacy and security of personally identifiable information, the annual open enrollment period for 2015, and the meaningful difference standard: Leigha Basini, (301) 492–4380.
For matters related to the Small Business Health Options Program: Christelle Jang, (410) 786–8438.
For matters related to the actuarial value calculator: Allison Yadsko, (410) 786–1740.
For matters related to patient safety standards for issuers of qualified health plans: Nidhi Singh Shah, (301) 492–5110.

SUPPLEMENTARY INFORMATION:

Table of Contents

Acronyms

Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)
AV Actuarial Value
CFR Code of Federal Regulations
CMS Centers for Medicare & Medicaid Services
EHB Essential Health Benefits
ERISA Employee Retirement Income Security Act of 1974 (Pub. L. 93–406)
FFE Federally-facilitated Exchange
FF–SHOP Federally-facilitated Small Business Health Options Program
FPL Federal poverty level
HCC Hierarchical condition category
HHS United States Department of Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
IRS Internal Revenue Service
MLR Medical Loss Ratio
OMB Office of Management and Budget
OPM United States Office of Personnel Management
PHS Act Public Health Service Act
PII Personally identifiable information
PSO Patient Safety Organization
PRA Paperwork Reduction Act of 1995
PSES Patient safety evaluation system
QHP Qualified health plan
SADP Stand-alone Dental Plan
SHOP Small Business Health Options Program
The Code Internal Revenue Code of 1986
TPA Third party administrator

I. Executive Summary

Qualified individuals and qualified employers are now able to purchase private health insurance coverage through competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges'' (also called Health Insurance Marketplaces, or ''Marketplaces'').[1] Individuals who enroll in qualified health plans (QHPs) through individual market Exchanges may be eligible to receive premium tax credits to make health insurance more affordable and reductions in cost-sharing payments to reduce out-of-pocket expenses for health care services. In 2014, HHS began operationalizing the premium stabilization programs established by the Affordable Care Act. These programs—the risk adjustment, reinsurance, and risk corridors programs—are intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. We believe that these programs, together with other reforms of the Affordable Care Act, will make high-quality health insurance affordable and accessible to millions of Americans.

HHS has previously outlined the major provisions and parameters related to the advance payments of the premium tax credit, cost-sharing reductions, and premium stabilization programs. This rule finalizes additional provisions related to the implementation of these programs, including certain oversight provisions for the premium stabilization programs, as well as key payment parameters for the 2015 benefit year.

The HHS Notice of Benefit and Payment Parameters for 2014 final rule (78 FR 15410) (2014 Payment Notice) finalized the risk adjustment methodology that HHS will use when it operates risk adjustment on behalf of a State. This final rule establishes updates to the risk adjustment methodology for 2014 to account for certain private market Medicaid expansion alternative plans. It also establishes the counting methods for determining small group size for participation in the risk adjustment and risk corridors programs.

Using the methodology set forth in the 2014 Payment Notice, we establish a 2015 uniform reinsurance contribution rate of $44 annually per capita, and the 2015 uniform reinsurance payment parameters—a $70,000 attachment point, a $250,000 reinsurance cap, and a 50 percent coinsurance rate. We are also finalizing our proposal to decrease the attachment point for 2014 from $60,000 to $45,000. Additionally, in order to maximize the financial effect of the transitional reinsurance program, we provide that if reinsurance contributions collected for a benefit year exceed total requests for reinsurance payments for the benefit year, we will increase the coinsurance rate on our reinsurance payments for that benefit year up to 100 percent, rolling over any remaining funds for use as reinsurance payments for the subsequent benefit year.

We also finalize several provisions related to cost sharing. First, we establish a methodology, with certain modifications described below, for estimating average per capita premium and for calculating the premium adjustment percentage for 2015, which is used to set the rate of increase for several parameters detailed in the Affordable Care Act, including the maximum annual limitation on cost sharing and the maximum annual limitation on deductibles for health plans in the small group market for 2015. We are establishing the reduced maximum annual limitations on cost sharing for the 2015 benefit year for cost-sharing reduction plan variations. We are relaxing the requirement that a QHP and its plan variations have the same out-of-pocket spending for non-EHBs. We are finalizing our proposal to modify the methodology for calculating advance payments for cost-sharing reductions for the 2015 benefit year. We are also finalizing parameters for updating the AV Calculator.

For 2015, we are finalizing the FFE user fee rate of 3.5 percent of premium. Additionally, with respect to the FFE user fee adjustment set forth under the Coverage of Certain Preventive Services Under the Affordable Care Act final rule, published in the July 2, 2013 **Federal Register** (78 FR 39870) (Preventive Services Rule), we are finalizing an allowance for administrative costs and margin associated with the payment for contraceptive services. We are also finalizing proposed modifications to the risk corridors program for the 2014 benefit year.

The success of the premium stabilization programs depends on a robust oversight program. This final rule expands on the provisions of the Premium Stabilization Rule (77 FR 17220), the 2014 Payment Notice (78 FR 15410), and the first and second final Program Integrity Rules (78 FR 54070 and 78 FR 65046). We are finalizing HHS's authority to audit State-operated reinsurance programs, contributing entities, and issuers of risk adjustment covered plans and reinsurance eligible-plans. We also finalize participation standards for the risk corridors program, and outline a process for validating risk corridors data submissions and enforcing compliance with the provisions of the risk corridors program.

We also finalize several aspects of our methodology for the HHS-operated risk adjustment data validation process. On June 22, 2013, we issued ''The Affordable Care Act HHS-operated Risk Adjustment Data Validation Process White Paper'' [2] and on June 25, 2013, we held a public meeting to discuss how to best ensure the accuracy and consistency of the data we will use when operating the risk adjustment program on behalf of a State. In this final rule, we establish certain standards for risk adjustment data validation, including a sampling methodology for the initial validation audit and detailed audit standards. These standards will be used and evaluated for 2 years before

[1] The word ''Exchanges'' refers to both State Exchanges, also called State-based Exchanges, and Federally-facilitated Exchanges (FFEs). In this rule, we use the terms ''State Exchange'' or ''FFE'' when we are referring to a particular type of Exchange. When we refer to ''FFEs,'' we are also referring to State Partnership Exchanges, which are a form of FFE.

[2] Available at: *https://www.regtap.info/uploads/library/ACA_HHS_OperatedRADVWhitePaper_062213_5CR_062213.pdf.*

they are used as a basis for payment adjustments.

This rule also includes a reduction in the time period for which a State electing to operate an Exchange after 2014 must have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment from at least 12 months to 6.5 months prior to the Exchange's first effective date of coverage. We also finalize certain provisions related to the privacy and security of personally identifiable information (PII) in the Exchange, the Exchange annual open enrollment period for 2015, the annual limitation on cost sharing for stand-alone dental plans, the meaningful difference standards for QHPs offered through an FFE, the SHOP, patient safety standards for QHP issuers, and composite premiums in the small group market.

II. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this rule, we refer to the two statutes collectively as the ''Affordable Care Act.''

Section 1201 of the Affordable Care Act added section 2701 of the Public Health Service Act (PHS Act) regarding fair health insurance premiums. Section 2701(a)(1) limits the variation in premium rates charged by a health insurance issuer for non-grandfathered health insurance coverage (including QHPs) in the individual or small group market to four factors: Family size; rating area; age; and tobacco use. Section 2701(a)(4) of the PHS Act requires that any family premium using age or tobacco rating may only apply those rates to the portion of the premium that is attributable to each family member.

Section 1302 of the Affordable Care Act directs the Secretary of Health and Human Services (referred to throughout this rule as the Secretary) to define essential health benefits (EHBs) and provides for cost-sharing limits and actuarial value (AV) requirements. Section 1302(d) of the Affordable Care Act describes the various levels of coverage based on AV. Consistent with section 1302(d)(2)(A) of the Affordable Care Act, AV is calculated based on the provision of EHB to a standard population. Section 1302(d)(3) of the Affordable Care Act directs the Secretary to develop guidelines that allow for *de minimis* variation in AV calculations.

Section 1311(b)(1)(B) of the Affordable Care Act directs that the SHOP assist qualified small employers in facilitating the enrollment of their employees in QHPs offered in the small group market. Under section 1312(f)(2)(B) of the Affordable Care Act, beginning in 2017, States will have the option to allow issuers to offer QHPs in the large group market through the SHOP.[3]

Section 1311(c)(6)(B) of the Affordable Care Act states that the Secretary is to set annual open enrollment periods for Exchanges for calendar years after the initial enrollment period.

Section 1311(h)(1) of the Affordable Care Act specifies that a QHP may contract with health care providers and hospitals with more than 50 beds only if they meet certain patient safety standards. For hospitals with more than 50 beds, this includes the use of a patient safety evaluation system and a comprehensive hospital discharge program. Section 1311(h)(2) of the Affordable Care Act also provides the Secretary flexibility to establish reasonable exceptions to these patient safety requirements, and section 1311(h)(3) of the Affordable Care Act allows the Secretary flexibility to issue regulations to modify the number of beds described in section 1311(h)(1)(A) of the Affordable Care Act.

Sections 1313 and 1321 of the Affordable Care Act provide the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1321(a) of the Affordable Care Act provides general authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of Title I of the Affordable Care Act.

When operating an FFE under section 1321(c)(1) of the Affordable Care Act, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the Affordable Care Act to collect and spend user fees. In addition, 31 U.S.C. 9701 permits a Federal agency to establish a charge for a service provided by the agency. Office of Management and Budget (OMB) Circular A–25 Revised establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.

Section 1341 of the Affordable Care Act requires the establishment of a transitional reinsurance program in each State to help pay the cost of treating high-cost enrollees in the individual market from 2014 through 2016. Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that provides for the sharing in gains or losses resulting from inaccurate rate setting from 2014 through 2016 between the Federal government and certain participating health plans. Section 1343 of the Affordable Care Act establishes a permanent risk adjustment program that is intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and thereby reduce incentives for issuers to avoid higher-risk enrollees. Sections 1402 and 1412 of the Affordable Care Act establish a program for reducing cost sharing for qualified individuals with lower household income and Indians.

Section 1411(g) of the Affordable Care Act requires that any person who receives information specified in section 1411(b) from an applicant or information specified in section 1411(c), (d), or (e) from a Federal agency must use the information only for the purpose of and to the extent necessary to ensure the efficient operation of the Exchange, and may not disclose the information to any other person except as provided in that section. Section 6103(l)(21)(C) of the Code additionally provides that return information disclosed under section 6103(l)(21)(A) or (B) may be used only for the purpose of and to the extent necessary in establishing eligibility for participation in the Exchange, verifying the appropriate amount of any premium tax credit or cost-sharing reduction, or determining eligibility for participation in a health insurance affordability program as described in that section.

Section 1560(c) of the Affordable Care Act provides that nothing in title I of the Affordable Care Act (or an amendment made by Title I of the Affordable Care Act) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is

[3] If a State elects this option, the rating rules in section 2701 of the PHS Act and its implementing regulations will apply to all coverage offered in such State's large group market (except for self-insured group health plans) pursuant to section 2701(a)(5) of the PHS Act.

conduct audits of issuers of risk adjustment covered plans.

a. Risk Adjustment User Fees

If a State is not approved to operate, or chooses to forgo operating, its own risk adjustment program, HHS will operate a risk adjustment program on the State's behalf. As described in the 2014 Payment Notice, HHS's operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that an issuer of a risk adjustment covered plan must remit a user fee to HHS for each month equal to the product of its monthly enrollment in the plan and the per-enrollee-per-month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. The risk adjustment program will provide special benefits as defined in section 6(a)(1)(b) of Circular No. A–25R to an issuer of a risk adjustment covered plan because it will mitigate the financial instability associated with risk selection as other market reforms go into effect. The risk adjustment program also will contribute to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual and small group health insurance markets.

For the 2015 benefit year, we proposed to use the same methodology that we used in the 2014 Payment Notice to estimate our administrative expenses to operate the risk adjustment program. That proposed methodology was based upon our contract costs in operating risk adjustment on behalf of States. The contract costs we considered cover development of the model and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. We proposed not to set the user fee to cover costs associated with Federal personnel. We proposed to calculate the user fee by dividing HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of enrollees in risk adjustment covered plans in HHS-operated risk adjustment programs for the benefit year (other than plans not subject to market reforms and student health plans, which are not subject to payments and charges under the risk adjustment methodology HHS uses when it operates risk adjustment on behalf of a State).

We estimated that the total cost for HHS to operate the risk adjustment program on behalf of States for 2015 would be approximately $27.3 million, and that the per capita risk adjustment user fee would be no more than $1.00 per enrollee per year. We are finalizing the proposed methodology for benefit year 2015, and are finalizing a per capita risk adjustment user fee of $0.96 per enrollee per year, which we will apply as a per-enrollee-per-month risk adjustment user fee of $0.08.

We received no comments on the risk adjustment user fee, and are therefore finalizing this proposal as proposed.

b. HHS Risk Adjustment Methodology Considerations

In the 2014 Payment Notice, we finalized the methodology that HHS will use when operating a risk adjustment program on behalf of a State in 2014. We proposed to use the same methodology in 2015, but proposed to amend the methodology by applying an adjustment for individuals enrolled in premium assistance Medicaid alternative plans. We proposed to apply the amended methodology beginning in 2014. We also sought comment on potential adjustments to the geographic cost factor to account for rating areas with low populations in the HHS risk adjustment methodology for future years.

We received a number of general comments regarding the HHS risk adjustment methodology.

Comment: Commenters requested that HHS provide additional guidance on the ICD–10 transition for risk adjustment, including the ICD–10 mappings, as soon as possible.

Response: We will publish updated ICD–9 instructions and software and then a combined set of ICD–9 and ICD–10 instructions and software on our Web site, as we did for the original ICD–9 software and instructions.[16] Because ICD–10 codes will be accepted for risk adjustment beginning October 1, 2014, we intend to publish these documents shortly.

Comment: One commenter requested that the risk adjustment model be calibrated for 2015 using the most current data possible. Other commenters suggested that HHS incorporate pharmacy utilization in the risk adjustment model. One commenter suggested that HHS include transitional plans' data in the risk adjustment model, but exclude them from payments and charges.

Response: We believe it is important to maintain model stability in implementing the risk adjustment methodology in the initial years of risk adjustment, and therefore do not intend to recalibrate the model in the initial years. Similarly, we do not intend to significantly change the model by including pharmacy utilization, though we continue to consider whether and how to include prescription drug data in future models. Finally, as we described in the 2014 Payment Notice (78 FR 15418), under our current methodology, plans not subject to the market reform rules are not subject to risk adjustment charges and do not receive risk adjustment payments. Because under the transitional policy, the Federal government will not consider certain health insurance coverage in the individual or small group market renewed after January 1, 2014, under certain conditions, to be out of compliance with specified 2014 market rules, and requested that States adopt a similar non-enforcement policy, transitional plans are able to set premiums and provide coverage as if they were not subject to market reform rules.[17] For this reason, transitional plans are not subject to risk adjustment payments and charges under our methodology at this time.

Comment: One commenter sought clarification on the risk scoring process. The commenter sought clarification on whether an enrollee's risk score is calculated monthly and aggregated to reflect changes in the receipt of cost-sharing reductions. The commenter also sought clarification on whether diagnoses carry through to the new plan if a qualifying event results in a special enrollment period and an enrollee changes plans, but stays with the same issuer. One commenter questioned whether an issuer would receive credit for the diagnoses on risk adjustment eligible claims paid by the issuer during a grace period if the issuer later processes a retroactive termination because the individual does not pay the premium.

Response: For each enrollee, HHS will use all risk adjustment eligible claims or encounters submitted from across all of the issuer's risk adjustment covered

[16] The HHS-Developed Risk Adjustment Model Algorithm Software is available at: *http://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html* under "Regulations & Guidance" (posted under "Guidance" on May 7, 2013).

[17] Letter to Insurance Commissioners, Center for Consumer Information and Insurance Oversight, November 14, 2013. Available at: *http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF*.

plans to calculate a risk score. The diagnoses would be associated with each of the issuer's plans in which the individual enrolls. This means that if the enrollee changes plans within the same issuer, then the claims data from all of the issuer's plans will be utilized to calculate the member's plan-specific risk scores for each of these plans. We note that in accordance with our methodology, the risk score value could change based on cost-sharing reductions received or plan AV. However, to align with our distributed data collection approach, which collects data by issuer, we will not link enrollee data across different issuers, even if the issuers are affiliated with the same insurance company. Diagnoses from risk adjustment eligible claims will only be accepted with dates of service that occur during active enrollment periods. Therefore, claims associated with months during a grace period will be counted toward risk adjustment, so long as the months are not later subject to a retroactive termination.

We are finalizing the use of the 2014 Federal risk adjustment methodology when HHS operates a risk adjustment program on behalf of a State, for 2015, with the modification for the treatment of Medicaid alternative plans discussed below, effective for 2014 risk adjustment.

(i) Incorporation of Premium Assistance Medicaid Alternative Plans in the HHS Risk Adjustment Methodology

Section 1343(c) of the Affordable Care Act provides that risk adjustment applies to non-grandfathered health insurance coverage offered in the individual and small group markets. In some States, expansion of Medicaid benefits under section 2001(a) of the Affordable Care Act may take the form of enrolling newly Medicaid-eligible enrollees into individual market plans. For example, these enrollees could be placed into silver plan variations—either the 94 percent silver plan variation or the zero cost sharing plan variation—with a portion of the premiums and cost sharing paid for by Medicaid on their behalf. Because individuals in these types of Medicaid alternative plans receive significant cost-sharing assistance, they may utilize medical services at a higher rate. To address this induced utilization in the context of cost-sharing reduction plan variations in the HHS risk adjustment methodology, our methodology increases the risk score for individuals in plan variations by a certain factor. We proposed to use the same factor that we use to adjust for induced utilization for individuals enrolled in cost-sharing plan variations to adjust for induced utilization for individuals enrolled in the corresponding Medicaid alternative plan variations, and to implement these adjustments in 2014. Table 1 shows the cost-sharing adjustments for both 94 percent silver plan variation enrollees and zero cost-sharing plan variation enrollees for silver QHPs as finalized in the 2014 Payment Notice.

TABLE 1—COST-SHARING REDUCTION ADJUSTMENTS

Plan variation	Induced utilization factor
94 Percent Plan Variation	1.12
Zero Cost-Sharing Plan Variation of Silver QHP	1.12

We are finalizing the application of the cost-sharing reduction adjustments to corresponding Medicaid alternative expansion plans as proposed. We plan to evaluate these adjustments in the future, after data from the initial years of risk adjustment is available.

Comment: Commenters agreed with our approach for accounting for Medicaid alternative plans under risk adjustment, with one commenter recommending that we monitor utilization patterns and consider evaluating States' Medicaid alternative plans separately in 2015 and beyond.

Response: We intend to examine the utilization patterns of current Medicaid alternative plans and the benefit structure of future Medicaid alternative plans, and may make appropriate adjustments in the future.

(ii) Adjustment to the Geographic Cost Factor

As finalized in the 2014 Payment Notice, the geographic cost factor is an adjustment in the payment transfer formula to account for plan costs, such as input prices, that vary by geography and are likely to affect plan premiums. For the metal-level risk pool, it is calculated based on the observed average silver plan premium in a geographic area relative to the Statewide average silver plan premium. It is separately calculated for catastrophic plans in a geographic area relative to the Statewide catastrophic pool. However, as we noted in the proposed rule, several States have defined a large number of rating areas, potentially leading to rating areas with low populations. Less populous rating areas raise concerns about the accuracy and stability of the calculation of the geographic cost factor, because in less populous rating areas, the geographic cost factor might be calculated based on a small number of plans. Inaccurate or unstable geographic cost factors could distort premiums and the stability of the risk adjustment model.

We sought comment in the proposed rule on how to best adjust the geographic cost factors or geographic rating areas in future years to address these potential premium distortions. We also sought comment on how this adjustment should be implemented for a separately risk adjusted pool of catastrophic plans. We stated that we did not intend to make this adjustment for 2014.

Based on comments received, we will continue to implement the geographic cost factor for each rating area established by the State under § 147.102(b) and calculated based on the observed average silver plan premium for the metal-level risk pool, as finalized in the 2014 Payment Notice (78 FR 15433).

Comment: Commenters did not support making additional adjustments to the geographic cost factor. Commenters stated that the time and resources needed to calculate and implement such an adjustment would be considerable, and that any such adjustment would be unlikely to have a material impact on final risk adjustment results.

Response: We will not adjust the geographic cost factors or geographic rating areas, but will monitor 2014 risk adjustment data for any potential premium distortions.

c. Small Group Determination for Risk Adjustment

For a plan to be subject to risk adjustment, according to section 1343(c) of the Affordable Care Act and the definition of a ''risk adjustment covered plan'' in § 153.20, a plan must be offered

in the ''individual or small group market.'' The definition of small group market in § 153.20 references the definition at section 1304(a)(3) of the Affordable Care Act.

Section 1304(a)(3) of the Affordable Care Act, in defining ''small group market,'' references the definition of a ''small employer'' in section 1304(b)(2) of the Affordable Care Act. That definition provides that an employer with an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year will be considered a ''small employer.'' However, section 1304(b)(3) of the Affordable Care Act provides that, for plan years beginning before January 1, 2016, a State may elect to define ''small employer'' to mean an employer with at least 1 but not more than 50 employees.

In the 2014 Payment Notice, we stated that we believe that the Affordable Care Act requires the use of a counting method that accounts for non-full-time employees, and that the full-time equivalent method described in section 4980H(c)(2)(E) of the Code is a reasonable method to apply (78 FR 15503). We stated that we believe that the risk adjustment program must also use a counting method that takes employees that are not full-time into account when determining whether a group health plan must participate in that program.

However, we also recognize that, because risk adjustment is intended to stabilize premiums by mitigating pricing uncertainty associated with the rating rules, it is important that the program be available to plans that are subject to the rating rules, to the extent permissible under the Affordable Care Act. We recognize that a number of States, which have primary enforcement jurisdiction over the market rules, may use counting methods that do not take non-full-time employees into account.

Thus, we are finalizing our proposal, with one modification—we are changing the cross-reference to the Code so that it references section 4980H(c)(2). In determining which group health plans participate as small group plans in the risk adjustment program, we will apply the applicable State counting method, unless the State counting method does not take into account employees that are non-full-time. In that circumstance, we will apply the counting method described in section 4980H(c)(2) of the Code and any implementing regulations.[18] We believe that this approach defers to State counting methods and aligns with State enforcement of rating rules, within the bounds of what is legally permissible under the Affordable Care Act.

Comment: One commenter supported our proposed counting method when a State counting method does not account for non-full-time employees. Some commenters urged us to maintain consistency with other counting methods, noting the administrative burden of having inconsistent counting methods across different Affordable Care Act programs. One commenter suggesting that we codify the average number of employees during the preceding calendar year as the single counting method across Affordable Care Act programs. Some commenters recommended deferring to the State counting method in the transitional years while collaborating with other Federal agencies to issue a uniform counting method in future rulemaking. One commenter recommended that if a group is required to be rated as a small group based on rating rules or SHOP requirements and is part of the single risk pool pricing, it should be included in the small group risk adjustment pool.

Response: We agree that risk adjustment should apply to plans subject to the market reform rating rules, to the extent permissible under the Affordable Care Act. We also agree with commenters that consistency in counting methods across Affordable Care Act programs is important, and we plan to collaborate with other Federal agencies to streamline counting methods in future rulemaking. To better address commenters' requests for consistency across Affordable Care Act programs, we have changed the Code reference from section 4980H(c)(2)(E) to 4980H(c)(2). This broader cross-reference will incorporate the limit in section 4980H(c)(2)(B) on how certain seasonal employees are counted, and will be consistent with the counting method used by the SHOP, as finalized in the 2014 Payment Notice (78 FR 15503). Prior to streamlining counting methods, because we interpret the employer size definitions in the Affordable Care Act to include non-full-time employees for purposes of determining small group status for purposes of risk adjustment, in States that do not account for non-full-time employees, we believe that requiring the large group counting method described in section 4980H(c)(2) of the Code (which accounts for non-full-time employees) is an appropriate standard because it is used by other Affordable Care Act programs and will reduce administrative burden for issuers.

d. Risk Adjustment Data Validation

The 2014 Payment Notice established a risk adjustment data validation program that HHS will use when operating risk adjustment on behalf of a State. In the 2014 Payment Notice (78 FR 15436), we specified a framework for this program that includes six stages: (1) Sample selection; (2) initial validation audit; (3) second validation audit; (4) error estimation; (5) appeals; and (6) payment adjustments.

To develop the details of the program, we sought the input of issuers, consumer advocates, providers, and other stakeholders. We issued the ''Affordable Care Act HHS-Operated Risk Adjustment Data Validation Process White Paper'' on June 22, 2013 (the ''white paper'').[19] That white paper discussed and sought comments on a number of potential considerations for the development of the risk adjustment data validation methodology. We received submissions from 53 commenters, including issuers, issuer trade groups, advocacy groups, and consultants. As we noted in the white paper, our overall goals are to promote consistency and a level playing field by establishing uniform audit requirements, and to protect private information by limiting data transfers during the data validation process.

In the proposed rule, we proposed provisions for the risk adjustment data validation process and methodology that reflect our analysis of the white paper comments and our discussions with stakeholders. We again note that a State operating a risk adjustment program is not required to adopt these standards.

We received some general comments about our proposed risk adjustment data validation methodology and process.

Comment: We received comments supporting the risk adjustment data validation methodology and process, noting that data validation is critical to issuer confidence and to encouraging the enrollment of individuals with significant health needs. Another commenter suggested that we model the HHS risk adjustment data validation program after the Medicare Advantage risk adjustment data validation program to the extent possible.

Response: We agree that a robust risk adjustment data validation program is

[18] We note that the IRS has published a final regulation that contains further details that would apply to this calculation (§ 54.4980H–2(c) (79 FR 8544).

[19] ''Affordable Care Act HHS-Operated Risk Adjustment Data Validation Process White Paper.'' 22 June 2013. *https://www.regtap.info/uploads/library/ACA_HHS_OperatedRADVWhitePaper_062213_5CR_062213.pdf.*

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Part II

Department of Health and Human Services

45 CFR Parts 144, 147, 153, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, 153, 154, 155, 156 and 158

[CMS–9944–F]

RIN 0938–AS19

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also finalizes additional standards for the individual market annual open enrollment period for the 2016 benefit year, essential health benefits, qualified health plans, network adequacy, quality improvement strategies, the Small Business Health Options Program, guaranteed availability, guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, and other related topics.

DATES: These regulations are effective on April 28, 2015 except the amendments to §§ 156.235, 156.285(d)(1)(ii), and 158.162 are effective on January 1, 2016.

FOR FURTHER INFORMATION CONTACT:

For general information: Jeff Wu, (301) 492–4305.

For matters related to guaranteed availability, guaranteed renewability, rate review, or the applicability of Title I of the Affordable Care Act in the U.S. Territories: Jacob Ackerman, (301) 492–4179.

For matters related to risk adjustment or the methodology for determining the reinsurance contribution rate and payment parameters: Kelly Horney, (410) 786–0558.

For matters related to reinsurance generally, distributed data collection good faith compliance policy, or administrative appeals: Adrianne Glasgow, (410) 786–0686.

For matters related to the definition of common ownership for purposes of reinsurance contributions: Adam Shaw, (410) 786–1019.

For matters related to risk corridors: Jaya Ghildiyal, (301) 492–5149.

For matters related to essential health benefits, network adequacy, essential community providers, or other standards for QHP issuers: Leigha Basini, (301) 492–4380.

For matters related to the qualified health plan good faith compliance policy: Cindy Yen, (301) 492–5142.

For matters related to the Small Business Health Options Program: Christelle Jang, (410) 786–8438.

For matters related to the Federally-facilitated Exchange user fee or minimum value: Krutika Amin, (301) 492–5153.

For matters related to cost-sharing reductions or the premium adjustment percentage: Pat Meisol, (410) 786–1917.

For matters related to re-enrollment, open enrollment periods, or exemptions from the individual shared responsibility payment: Christine Hammer, (301) 492–4431.

For matters related to special enrollment periods: Rachel Arguello, (301) 492–4263.

For matters related to minimum essential coverage: Cam Moultrie Clemmons, (206) 615–2338.

For matters related to quality improvement strategies: Marsha Smith, (410) 786–6614.

For matters related to the medical loss ratio program: Julie McCune, (301) 492–4196.

For matters related to meaningful access to QHP information, consumer assistance tools and programs of an Exchange, or cost-sharing reduction notices: Tricia Beckmann, (301) 492–4328.

SUPPLEMENTARY INFORMATION:

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g. Overview of the Payment Transfer Formula

We do not propose to alter our payment transfer methodology. Plan average risk scores would be calculated as the member month-weighted average of individual enrollee risk scores. We defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. In the 2014 Payment Notice, we combined those concepts into a risk adjustment payment transfer formula. Risk adjustment transfers (payments and charges) will be calculated following the completion of issuer risk adjustment data reporting. The payment transfer formula includes a set of cost adjustment terms that require transfers to be calculated at the geographic rating area level for each plan (that is, HHS will calculate two separate transfer amounts for a plan that operates in two rating areas).

The payment transfer formula is designed to provide a per member per month (PMPM) transfer amount. The PMPM transfer amount derived from the payment transfer formula will be multiplied by each plan's total member months for the benefit year to determine the total payment due or charge owed by the issuer for that plan in a rating area.

(1) Overview of the Payment Transfer Formula

Though we did not propose to change the payment transfer formula from what was finalized in the 2014 Payment Notice (78 FR 15430–15434), we believe it useful to republish the formula in its entirety, since we are finalizing recalibrated HHS risk adjustment models. Transfers (payments and charges) will be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection. As finalized in the 2014 Payment Notice, the HHS risk adjustment payment transfer formula is:

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \bar{P}_S$$

Where:

$\bar{P}_S$ = State average premium;
$PLRS_i$ = plan i's plan liability risk score;
AV_i = plan i's metal level AV;
ARF_i = allowable rating factor;
IDF_i = plan i's induced demand factor;
GCF_i = plan i's geographic cost factor;
s_i = plan i's share of State enrollment;

and the denominator is summed across all plans in the risk pool in the market in the State.

The difference between the two premium estimates in the payment transfer formula determines whether a plan pays a risk transfer charge or receives a risk transfer payment. Note that the value of the plan average risk score by itself does not determine whether a plan would be assessed a charge or receive a payment—even if the risk score is greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan may receive through its rating practices (as measured through the allowable rating factor) exceeds the plan's predicted liability associated with risk selection. Risk adjustment transfers are calculated at the risk pool level and catastrophic plans are treated as a separate risk pool for purposes of risk adjustment.

h. HHS Risk Adjustment Methodology Considerations

In the 2014 Payment Notice, we finalized the methodology that HHS will use when operating a risk adjustment program on behalf of a State. In the second Program Integrity Rule (78 FR 65046), we clarified the modification to the transfer formula to accommodate community rated States that utilize family tiering rating factors. We further clarified this formula in the proposed rule to ensure that the allowable rating factor (ARF) is appropriately applied in the transfer formula in community rated States for 2014 risk adjustment. In the second Program Integrity Rule, we stated that the ARF formula should be modified so that the numerator is a summation over all subscribers of the product of the family tiering factor and the subscriber member months, and the denominator the sum of billable member months. However, we do not believe the revised formula accurately reflects that description, as it does not distinguish between subscriber months (months attributed to the sole subscriber) and billable member months (months attributed to all allowable members of the family factored into the community rating). The calculation of ARF for family tiering States that was published in the second Program Integrity Rule that would be calculated at the level of the subscriber, was as follows:

$$ARF_i = \frac{\sum_s (ARF_s \cdot M_s)}{\sum_s (M_s)}$$

Where:

ARF_s is the rating factor for the subscriber(s) (based on family size/composition), and
M_s is the number of billed person-months that are counted in determining the premium(s) for the subscriber(s).

While the preamble description in the second Program Integrity Rule is correct, as we noted, the formula itself is incorrect in that it does not distinguish between billable member months and subscriber months by using the same variable for both. Therefore, we proposed a technical change to the ARF calculation for family tiering States, as follows:

$$ARF_i = \frac{\sum_s (ARF_s \cdot MS_s)}{\sum_s (MB_s)}$$

Where:

ARF_i is the allowable rating factor for plan i,
ARF_s is the allowable rating factor—also known as the family rating tier—for subscriber (family) s in plan i,
MS_s is the number of subscriber months for subscriber s, and
MB_s is the number of billable member months for subscriber (family) s.

The numerator is summed over the product of the allowable rating factor and the number of subscriber months (that is, months of family subscription), and the denominator is the sum over all billable members. Each family unit covered under a single contract is considered a single ''subscriber.'' Therefore, a family of four that purchases coverage for a period from January through December will accumulate 12 subscriber months (MS_s), although coverage is being provided for 48 member months (both billable and non-billable). Billable members are individuals who are counted for purposes of placing the subscriber in a family tier. For example, in a community rated State that rates based on two adults and one or more children with one full year of enrollment, the family of four would have 36 billable member months (MB_s), (12 billable member months for the subscriber, 12 billable member months for the second adult, and 12 billable months for the first child). We received no comments on this correction and are finalizing it as proposed.

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Part II

Department of Health and Human Services

45 CFR Parts 144, 147, 153, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, 153, 154, 155, 156, and 158

[CMS–9937–F]

RIN 0938–AS57

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also provides additional amendments regarding the annual open enrollment period for the individual market for the 2017 and 2018 benefit years; essential health benefits; cost sharing; qualified health plans; Exchange consumer assistance programs; network adequacy; patient safety; the Small Business Health Options Program; stand-alone dental plans; third-party payments to qualified health plans; the definitions of large employer and small employer; fair health insurance premiums; student health insurance coverage; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions and appeals; and other related topics.

DATES: These regulations are effective on May 9, 2016.

FOR FURTHER INFORMATION CONTACT: Jeff Wu, (301) 492–4305, Krutika Amin, (301) 492–5153, or Lindsey Murtagh (301) 492–4106, for general information.

David Mlawsky, (410) 786–6851, for matters related to fair health insurance premiums, student health insurance coverage, and the single risk pool.

Kelly Drury, (410) 786–0558, for matters related to risk adjustment.

Adrianne Glasgow, (410) 786–0686, for matters related to reinsurance, distributed data collection, and administrative appeals of financial transfers.

Melissa Jaffe, (301) 492–4129, for matters related to risk corridors.

Lisa Cuozzo, (410) 786–1746, for matters related to rate review.

Jennifer Stolbach, (301) 492–4350, for matters related to establishing a State Exchange, and State-based Exchanges on the Federal Platform.

Emily Ames, (301) 492–4246, and Michelle Koltov, (301) 492–4225, for matters related to Navigators, non-Navigator assistance personnel, and certified application counselors under part 155.

Briana Levine, (301) 492–4247, for matters related to agents and brokers.

Dana Krohn, (301) 492–4412, for matters related to employer notification and verification.

Rachel Arguello, (301) 492–4263, for matters related to open enrollment periods and special enrollment periods under part 155.

Anne Pesto, (410) 786–3492, for matters related to eligibility determinations and appeals of eligibility determinations for Exchange participation and insurance affordability programs, and eligibility determinations for exemptions.

Kate Ficke, (301) 492–4256, for matters related to exemptions from the shared responsibility payment.

Ryan Mooney, (301) 492–4405, for matters related to enrollment.

Terence Kane, (301) 492–4449, for matters related to the income threshold.

Christelle Jang, (410) 786–8438, for matters related to the SHOP.

Krutika Amin, (301) 492–5153, for matters related to the Federally-facilitated Exchange user fee.

Leigha Basini, (301) 492–4380, for matters related to essential health benefits, network adequacy, essential community providers, and other standards for QHP issuers.

Ielnaz Kashefipour, (301) 492–4376, for matters related to standardized options and third party payment of premiums and cost sharing.

Rebecca Zimmermann, (301) 492–4396, for matters related to stand-alone dental plans.

Cindy Chiou, (301) 492–5142, for matters related to QHP issuer oversight.

Pat Meisol, (410) 786–1917, for matters related to cost-sharing reductions and the premium adjustment percentage.

Nidhi Singh Shah, (301) 492–5110, for matters related to patient safety standards.

Christina Whitefield, (301) 492–4172, for matters related to the medical loss ratio program.

SUPPLEMENTARY INFORMATION:

Table of Contents

Acronyms and Abbreviations

Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended
AHRQ Agency for Healthcare Research and Quality
APTC Advance payments of the premium tax credit
AV Actuarial value
BBEDCA Balanced Budget and Emergency Deficit Control Act of 1985
CCN CMS Certification Number
CFR Code of Federal Regulations
CHIP Children's Health Insurance Program
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CSR Cost-sharing reduction
ECN Exemption certificate number
ECP Essential community provider
EHB Essential health benefits
FFE Federally-facilitated Exchange
FF–SHOP Federally-facilitated Small Business Health Options Program

FPL Federal poverty level
FR Federal Register
FTE Full-time equivalent
GDP Gross domestic product
HCC Hierarchical condition category
HEN Hospital engagement network
HHS United States Department of Health and Human Services
HICS Health Insurance Casework System
HIOS Health Insurance Oversight System
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HRSA Health Resources and Services Administration
HSA Health Savings Account
IRS Internal Revenue Service
MAGI Modified adjusted gross income
MAT Medication assisted treatment
MLR Medical loss ratio
MV Minimum value
NAIC National Association of Insurance Commissioners
NHEA National Health Expenditure Accounts
OMB Office of Management and Budget
OPM United States Office of Personnel Management
PBM Prescription benefit manager
PHS Act Public Health Service Act
PII Personally identifiable information
PMPM Per member per month
PRA Paperwork Reduction Act of 1995
PSO Patient safety organization
PSQIA Patient Safety and Quality Improvement Act (Pub. L. 109–41)
QHP Qualified health plan
QIO Quality improvement organizations
RADV Risk adjustment data validation
SADP Stand-alone dental plan
SBC Summary of benefits and coverage
SBE State-based Exchange
SBE–FP State-based Exchange on the Federal platform
SHOP Small Business Health Options Program
The Code Internal Revenue Code of 1986 (26 U.S.C. 1, *et seq.*)

I. Executive Summary

The Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended (the Affordable Care Act) enacted a set of reforms that are making high-quality health insurance coverage and care more affordable and accessible to millions of Americans. These reforms include the creation of competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges'' (in this final rule, we also call an Exchange a Health Insurance Marketplace℠,[1] or Marketplace℠) through which qualified individuals and qualified employers can purchase health insurance coverage. In addition, many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to receive a premium tax credit to make health insurance more affordable, and reductions in cost-sharing payments to reduce out-of-pocket expenses for health care services. These Affordable Care Act reforms also include the premium stabilization programs (risk adjustment, reinsurance and risk corridors) and rules that mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. In previous rulemaking, we have outlined the major provisions and parameters related to many Affordable Care Act programs.

In this rule, we seek to improve States' ability to operate efficient Exchanges by leveraging the economies of scale available through the Federal eligibility and enrollment platform and information technology infrastructure. We are finalizing a codification of a new Exchange model—the State-based Exchange using the Federal platform (SBE–FP). This Exchange model will enable State-based Exchanges (SBEs) to execute certain processes using the Federal eligibility enrollment infrastructure. The SBE–FP will be required to enter into a Federal platform agreement with HHS that will define a set of mutual obligations, including the set of Federal services upon which the SBE–FP agrees to rely. Under this Exchange model, certain requirements that were previously only applicable to QHPs offered on a Federally-facilitated Exchange (FFE) and their downstream and delegated entities will apply to QHPs offered on an SBE–FP and their downstream and delegated entities. For 2017, we are finalizing a mechanism through which SBE–FPs will offset some of the Federal costs of providing this infrastructure. In addition, we are finalizing rules requiring agents and brokers facilitating enrollments through SBE–FPs to comply with the FFE registration and training requirements.

We are also finalizing a number of amendments that will improve the stability of the Exchanges and support consumers' ability to make informed choices when purchasing health insurance. These include the introduction of ''standardized options'' in the individual market FFEs. Additional amendments will increase the accessibility of high-quality health insurance and improve competition, transparency, and affordability.

Our intent in offering standardized options is to simplify the consumer shopping experience and to allow consumers to more easily compare plans across issuers in the individual market FFEs. We are finalizing a standardized option with a specified cost-sharing structure at each of the bronze, silver (with cost-sharing reduction (CSR) plan variations), and gold metal levels. This policy does not restrict issuers' ability to offer non-standardized options. We anticipate differentially displaying these standardized options to allow consumers to compare plans based on differences in price and quality rather than cost-sharing structures.

We are also finalizing policies relating to network adequacy for QHPs on the FFEs. We proposed, but are not finalizing, a minimum quantitative network adequacy threshold for each State. As States continue their work to implement the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act (NAIC Network Adequacy Model Act), we will continue to use the same quantitative time-distance standards in our review of plans for QHP certification on the FFEs, which we will detail in the annual Letter to Issuers, which we are issuing in final form concurrently with this final rule. We are finalizing our proposed policy regarding standardized categorization of network breadth for QHPs on the FFEs on HealthCare.gov. We are also finalizing two provisions to address provider transitions in the FFE and a standard for all QHPs governing cost sharing that would apply in certain circumstances when an enrollee receives essential health benefit (EHB) provided by an out-of-network ancillary provider at an in-network setting.

We discuss the authority for FFEs to continue to select QHPs based on meeting the interests of qualified individuals and qualified employers. We will use this authority to strengthen oversight as needed in the short term.

We also seek to improve consumers' ability to make choices regarding health insurance coverage by ensuring they receive high-quality assistance in their interactions with the Exchange. For example, this final rule amends program requirements for Navigators, certain non-Navigator assistance personnel, and certified application counselors. These amendments will require FFE Navigators to assist consumers with certain post-enrollment and other issues beginning in 2018, require all Navigators to provide targeted assistance to underserved or vulnerable populations, and require Navigators and non-Navigator assistance personnel to complete training prior to conducting outreach and education activities. We are also amending our rules regarding the giving of gifts by Navigators, certain non-Navigator assistance personnel, and certified application counselors. In

[1] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.

addition, we are finalizing our proposal that certified application counselor designated organizations will be required to submit data and information related to the organization's certified application counselors, upon the request of the Exchanges in which they operate.

In addition, this final rule takes several steps to increase transparency. This rule finalizes provisions to enhance the transparency of rates in all States and the effectiveness of the rate review program.

This rule also establishes dates for the individual market annual open enrollment period for future benefit years. For 2017 and 2018, we will maintain the same open enrollment period we adopted for 2016—that is, November 1 of the year preceding the benefit year through January 31 of the benefit year, and for 2019 and later benefit years, we are establishing an open enrollment period of November 1 through December 15 of the year preceding the benefit year. The rule also finalizes two narrow changes to the Exchange re-enrollment hierarchy, prioritizing re-enrollment into silver plans, and providing Exchanges with the flexibility to re-enroll consumers into plans of other Exchange issuers if the consumer is enrolled in a plan from an issuer that does not have another plan available for re-enrollment through the Exchange.

We summarize input we have received on whether special enrollment periods are being appropriately provided, and discuss our plans to conduct an assessment of special enrollment periods granted to consumers through the FFEs. We are also codifying a number of Exchange policies relating to exemptions in order to provide certainty and transparency around these policies for all stakeholders.

We are finalizing our proposals for the risk adjustment program—in particular, we are finalizing our introduction of preventive services into the methodology, and our calculation of model coefficients based on the 2012, 2013, and 2014 MarketScan claims data. This final rule also amends the risk corridors provisions related to the reporting of allowable costs.

In addition to provisions aimed at stabilizing premiums, we are finalizing several provisions related to cost sharing. First, we are finalizing the premium adjustment percentage for 2017, which is used to set the rate of increase for several parameters detailed in the Affordable Care Act, including the maximum annual limitation on cost sharing for 2017. We are also finalizing the maximum annual limitations on cost sharing for the 2017 benefit year for cost-sharing reduction plan variations. We also finalize standards for stand-alone dental plans (SADPs) related to the annual limitation on cost sharing, and standards related to third party payments for premiums and cost sharing made on behalf of enrollees by Federal, State, and local governments; Ryan White HIV/AIDS programs; and Indian tribes, tribal organizations, or urban Indian organizations.

We finalize several improvements that seek to ensure consumers have access to affordable, high-quality health care coverage. We are amending requirements for QHPs, including essential community providers (ECPs) and meaningful difference requirements. This rule also contains technical amendments to QHP issuer oversight provisions. This rule includes amendments to further strengthen the patient safety requirements for QHP issuers offering coverage through Exchanges.

For consumers purchasing coverage through the Small Business Health Options Program (SHOP), we finalize a new ''vertical choice'' model for Federally-facilitated SHOPs for plan years beginning on or after January 1, 2017, under which employers would be able to offer qualified employees a choice of all plans across all available actuarial value levels of coverage from a single issuer. States with a Federally-facilitated Small Business Health Options Program (FF–SHOP) will have the opportunity to recommend that vertical choice not be implemented in their State, and SBEs relying on the FF–SHOP eligibility and enrollment platform will be able to choose not to have vertical choice implemented in their State.

We also finalize adjustments to our programs and rules, as we do each year, so that our rules and policies reflect the latest market developments. We finalize the following changes and clarifications to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Affordable Care Act health insurance reform requirements. We revise the definitions of small employer and large employer to bring them into conformance with the Protecting Affordable Coverage for Employees Act (Pub. L. 114–60). We also finalize provisions to ensure that a network plan in the small group market with a limited service area can be appropriately rated for sale based on geography. Lastly, we finalize some of the proposed provisions regarding the application of the actuarial value (AV) and single risk pool provisions to student health insurance coverage.

II. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the Affordable Care Act.

Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 2701 of the PHS Act, as added by the Affordable Care Act, restricts the variation in premium rates charged by a health insurance issuer for non-grandfathered health insurance coverage in the individual or small group market to certain specified factors. The factors are: Family size, rating area, age, and tobacco use.

Section 2701 of the PHS Act operates in coordination with section 1312(c) of the Affordable Care Act. Section 1312(c) of the Affordable Care Act generally requires a health insurance issuer to consider all enrollees in all health plans (except for grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets. States have the option to merge the individual market and small group market risk pools under section 1312(c)(3) of the Affordable Care Act.

Section 2702 of the PHS Act, as added by the Affordable Care Act, requires health insurance issuers that offer health insurance coverage in the group or individual market in a State to offer coverage to and accept every employer and individual in the State that applies for such coverage unless an exception applies.[2]

Section 2703 of the PHS Act, as added by the Affordable Care Act, and sections 2712 and 2741 of the PHS Act, as added by HIPAA and codified prior to the enactment of the Affordable Care Act, require health insurance issuers that offer health insurance coverage in the group or individual market to renew or

[2] Before enactment of the Affordable Care Act, the Health Insurance Portability and Accountability Act of 1996 amended the PHS Act (formerly section 2711) to generally require guaranteed availability of coverage for employers in the small group market.

TABLE 7—COST-SHARING REDUCTION ADJUSTMENT

Household income	Plan AV	Induced utilization factor
Silver Plan Variant Recipients		
100–150% of FPL	Plan Variation 94%	1.12
150–200% of FPL	Plan Variation 87%	1.12
200–250% of FPL	Plan Variation 73%	1.00
>250% of FPL	Standard Plan 70%	1.00
Zero Cost-Sharing Recipients		
<300% of FPL	Platinum (90%)	1.00
<300% of FPL	Gold (80%)	1.07
<300% of FPL	Silver (70%)	1.12
<300% of FPL	Bronze (60%)	1.15
Limited Cost-Sharing Recipients		
>300% of FPL	Platinum (90%)	1.00
>300% of FPL	Gold (80%)	1.07
>300% of FPL	Silver (70%)	1.12
>300% of FPL	Bronze (60%)	1.15

e. Model Performance Statistics (§ 153.320)

To evaluate the model's performance, we examined its R-squared and predictive ratios. The R-squared statistic, which calculates the percentage of individual variation explained by a model, measures the predictive accuracy of the model overall. The predictive ratios measure the predictive accuracy of a model for different validation groups or subpopulations. The predictive ratio for each of the HHS risk adjustment models is the ratio of the weighted mean predicted plan liability for the model sample population to the weighted mean actual plan liability for the model sample population. The predictive ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0. For each of the HHS risk adjustment models, the R-squared statistic and the predictive ratio are in the range of published estimates for concurrent risk adjustment models.[11] Because we are blending, that is to mean, averaging, the coefficients from separately solved models based on MarketScan 2012, 2013, and 2014 data, we are publishing the R-squared statistic for each model and year separately to verify their statistical validity. The R-squared statistic for each model is shown in Table 8.

TABLE 8—R-SQUARED STATISTIC FOR HHS RISK ADJUSTMENT MODELS

Risk adjustment model	R-Squared statistic		
	2012	2013	2014
Platinum Adult	0.3905	0.3790	0.3610
Platinum Child	0.2669	0.2518	0.2341
Platinum Infant	0.2848	0.3223	0.3089
Gold Adult	0.3865	0.3746	0.3558
Gold Child	0.2621	0.2467	0.2288
Gold Infant	0.2826	0.3204	0.3069
Silver Adult	0.3828	0.3707	0.3512
Silver Child	0.2576	0.2422	0.2241
Silver Infant	0.2812	0.3191	0.3054
Bronze Adult	0.3808	0.3686	0.3488
Bronze Child	0.2554	0.2400	0.2218
Bronze Infant	0.2812	0.3190	0.3052
Catastrophic Adult	0.3807	0.3685	0.3488
Catastrophic Child	0.2554	0.2400	0.2218
Catastrophic Infant	0.2812	0.3190	0.3052

f. Overview of the Payment Transfer Formula (§ 153.320)

We did not propose to alter our payment transfer methodology. Plan average risk scores will continue to be calculated as the member month-weighted average of individual enrollee risk scores. We defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. In the 2014 Payment Notice, we combined those concepts into a risk adjustment payment transfer formula. Risk

[11] Winkleman, Ross and Syed Mehmud. ''A Comparative Analysis of Claims-Based Tools for Health Risk Assessment.'' Society of Actuaries (Apr. 2007), available at *https://www.soa.org/research/research-projects/health/hlth-risk-assement.aspx.*

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adjustment transfers (payments and charges) will be calculated after issuers have completed risk adjustment data reporting. The payment transfer formula includes a set of cost adjustment terms that require transfers to be calculated at the geographic rating area level for each plan (that is, HHS will calculate two separate transfer amounts for a plan that operates in two rating areas).

The payment transfer formula is designed to provide a per member per month (PMPM) transfer amount. The PMPM transfer amount derived from the payment transfer formula would be multiplied by each plan's total member months for the benefit year to determine the total payment due or charge owed by the issuer for that plan in a rating area.

Comment: Commenters requested that administrative expenses be removed from the calculation of the statewide average premium. A commenter suggested that amending the transfer formula by eliminating administrative costs from the statewide average premium would make it ''benefit cost based.'' A commenter suggested that HHS consider basing the payment transfer on a portion of State average premium—namely, the portion representing the sum of claims, claims adjustment expenses, and taxes that are calculated on premium after risk adjustment transfers, by using a specified percentage of State average premiums. The commenter suggested the specified percentage could be determined based on data submitted by issuers on the Unified Rate Review Template (URRT) for the portion of premium needed for claims and on data from financial reporting statements for claim adjustment expenses and relevant taxes as a percent of premium and could vary by State or market. Some commenters opposed the use of the statewide average premium because it disadvantages issuers with below average premiums. Commenters requested that 2014 and later risk adjustment transfers for all plans with below average premiums in a State be calculated using the plans' own average premium amount or average claims cost, so that efficient plans are not penalized using the Statewide average premium. Commenters requested use of a ''care coordination factor'' in the risk transfer formula, and stated that risk adjustment results are distorted by regional biases, risks, and coding and demographic differences. One commenter recommended that risk scores be compared to other scores in the same geographic region, not to State averages, to avoid regional biases and to permit a fairer and more accurate comparison.

Response: We did not propose changes to the transfer formula, and therefore, are not addressing comments that are outside the scope of this rulemaking. We may be able to evaluate geographic differences in the future if we obtain enrollee-level data for future recalibrations—a topic that we also intend to discuss in the White Paper and at the March 31, 2016 risk adjustment conference.

(1) Overview of the Payment Transfer Formula

Although we did not propose to change the payment transfer formula from what was finalized in the 2014 Payment Notice (78 FR 15430 through 15434), we believe it is useful to republish the formula in its entirety, since, as noted above, we are recalibrating the HHS risk adjustment model. Transfers (payments and charges) will be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection. As finalized in the 2014 Payment Notice, the HHS risk adjustment payment transfer formula is:

$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \overline{P_s}$$

Where:
$P\bar{A}_s$ = State average premium;
$PLRS_i$ = plan *i*'s plan liability risk score;
AV_i = plan *i*'s metal level AV;
ARF_i = allowable rating factor;
IDF_i = plan *i*'s induced demand factor;
GCF_i = plan *i*'s geographic cost factor;
s_i = plan *i*'s share of State enrollment.

The denominator is summed across all plans in the risk pool in the market in the State.

The difference between the two premium estimates in the payment transfer formula determines whether a plan pays a risk transfer charge or receives a risk transfer payment. Note that the value of the plan average risk score by itself does not determine whether a plan would be assessed a charge or receive a payment—even if the risk score is greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan may receive through its rating practices (as measured through the allowable rating factor) exceeds the plan's predicted liability associated with risk selection. Risk adjustment transfers are calculated at the risk pool level, and catastrophic plans are treated as a separate risk pool for purposes of risk adjustment.

g. State-Submitted Alternate Risk Adjustment Methodology

We are not recertifying the alternate State methodology for use in Massachusetts for 2017 risk adjustment. Massachusetts and HHS will begin the transition that will allow HHS to operate risk adjustment in Massachusetts in 2017. HHS will operate risk adjustment in all States for the 2017 benefit year.

h. Risk Adjustment User Fee (§ 153.610(f))

As noted above, if a State is not approved to operate or chooses to forgo operating its own risk adjustment program, HHS will operate risk adjustment on the State's behalf. As described in the 2014 Payment Notice, HHS's operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that an issuer of a risk adjustment covered plan with the meaning of § 153.20 must remit a user fee to HHS equal to the product of its monthly enrollment in the plan and the per enrollee per month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. The risk adjustment program will provide special benefits as defined in section 6(a)(1)(b) of Circular No. A–25R to issuers of risk adjustment covered plans because it will mitigate the financial instability associated with potential adverse risk selection. The risk adjustment program also will contribute to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual and small group health insurance markets.

In the 2016 Payment Notice, we estimated Federal administrative

expenses of operating the risk adjustment program to be $1.75 per enrollee per year, based on our estimated contract costs for risk adjustment operations. For the 2017 benefit year, we proposed to use the same methodology to estimate our administrative expenses to operate the program. These contracts cover development of the model and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. To calculate the user fee, we divided HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of enrollees in risk adjustment covered plans (other than plans not subject to market reforms and student health plans, which are not subject to payments and charges under the risk adjustment methodology HHS uses when it operates risk adjustment on behalf of a State) in HHS-operated risk adjustment programs for the benefit year.

We estimated that the total cost for HHS to operate the risk adjustment program on behalf of States for 2017 would be approximately $52 million, and that the risk adjustment user fee would be $1.80 per enrollee per year. We stated that the risk adjustment user fee contract costs for 2017 include costs related to 2017 risk adjustment data validation, and are slightly higher than the 2016 contract costs because some contracts were rebid. We do not anticipate that Massachusetts' decision to use the Federal risk adjustment methodology will substantially affect the risk adjustment user fee rate for 2017.

Comment: One commenter strongly supported the assessment of a higher risk adjustment user fee to support the RADV program. Another commenter requested transparency for the user fee rate and that HHS consider less costly alternatives. One commenter expressed concern over the risk adjustment user fee proposal since HHS collected increased user fees accounting for 2014 risk adjustment data validation in 2016 but delayed 2014 risk adjustment data validation. This commenter recommended that HHS use those increased fees to pay for risk adjustment data validation in 2017 and decline to increase user fees for 2017 risk adjustment.

Response: In response to the comment regarding risk adjustment data validation costs, we re-examined all assumptions that went into the calculation of the risk adjustment user fee. First, we determined that our expected contract costs for 2017 risk adjustment are lower than anticipated, currently estimated at approximately $24 million. Then, we looked at the enrollment assumptions we were using to calculate the previous benefit year user fees. Because we now have actual 2014 risk adjustment enrollment, we were able to base expected 2017 enrollment on projected member month enrollment rather than total enrollees. We are revising the risk adjustment user fee to reflect lower contract costs for the 2017 benefit year and more accurate enrollment projections. Therefore, we are finalizing the 2017 risk adjustment user fee at $1.56 per enrollee per year, or $0.13 PMPM.

3. Provisions and Parameters for the Transitional Reinsurance Program

The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. In the 2014 Payment Notice, we expanded on the standards set forth in subparts C and E of the Premium Stabilization Rule and established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2014 benefit year. In the 2015 Payment Notice, we established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2015 benefit year and certain oversight provisions related to the operation of the reinsurance program. In the 2016 Payment Notice, we established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2016 benefit year and certain clarifying provisions related to the operation of the reinsurance program.

a. Decreasing the Reinsurance Attachment Point for the 2016 Benefit Year

Section 1341(b)(2)(B) of the Affordable Care Act directs the Secretary, in establishing standards for the transitional reinsurance program, to include a formula for determining the amount of reinsurance payments to be made to non-grandfathered, individual market issuers for high-risk claims that provides for the equitable allocation of funds. In the Premium Stabilization Rule (77 FR 17228), we provided that reinsurance payments to issuers of reinsurance-eligible plans will be made for a portion of an enrollee's claims costs paid by the issuer (the coinsurance rate) that exceeds an attachment point (when reinsurance would begin), subject to a reinsurance cap (when the reinsurance program stops paying claims for a high-cost individual). The coinsurance rate, attachment point, and reinsurance cap together constitute the uniform reinsurance payment parameters.

We provided in the 2015 Payment Notice (79 FR 13777) that HHS will use any excess contributions for reinsurance payments for a benefit year by increasing the coinsurance rate for that benefit year up to 100 percent before rolling over any remaining funds in the next year. In the proposed rule, we proposed that if any contribution amounts remain after calculating reinsurance payments for the 2016 benefit year (and after HHS increases the coinsurance rate to 100 percent for the 2016 benefit year), HHS would decrease the 2016 attachment point of $90,000 to pay out any remaining contribution amounts to issuers of reinsurance-eligible plans in an equitable manner for the 2016 benefit year.

We received numerous comments in support of this proposal and are finalizing this provision as proposed.

Comment: One commenter stated that changing the reinsurance payment parameters at the end of the program—instead of identifying and updating the parameters in earlier benefit years as current information is available—would be disruptive. The commenter stated that this proposal would cause disruption for States that exercised the option to create supplemental reinsurance programs and that need to set uniform reinsurance payment parameters.

Response: The final 2016 reinsurance coinsurance rate and attachment point, which would reflect a potential increase in coinsurance rate from 50 to 100 percent and a potential decrease in the attachment point from $90,000 to an amount that pays out remaining contributions in an equitable manner, will not be set until HHS confirms the total amount of contributions available and reinsurance payment requests for the 2016 benefit year. HHS understands that no State-operated reinsurance program established supplemental reinsurance payment parameters under §§ 153.220(d) and 153.232 and therefore no States will be affected by this provision. We believe that expending all remaining reinsurance contribution funds as payments for the 2016 benefit year will support the reinsurance program's goals of promoting nationwide premium stabilization and market stability in the early years of Exchange operations while providing issuers with incentives to continue to effectively manage enrollee costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, 147, 148, 153, 154, 155, 156, 157, and 158

[CMS–9934–F; CMS–9933–F]

RIN 0938–AS95, RIN 0938–AS87

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth payment parameters and provisions related to the risk adjustment program; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges and State-based Exchanges on the Federal platform. It also provides additional guidance relating to standardized options; qualified health plans; consumer assistance tools; network adequacy; the Small Business Health Options Programs; stand-alone dental plans; fair health insurance premiums; guaranteed availability and guaranteed renewability; the medical loss ratio program; eligibility and enrollment; appeals; consumer-operated and oriented plans; special enrollment periods; and other related topics.

DATES: These regulations are effective January 17, 2017.

FOR FURTHER INFORMATION CONTACT:

Jeff Wu, (301) 492–4305, Lindsey Murtagh, (301) 492–4106, or Michelle Koltov, (301) 492–4225 for general information.

Lisa Cuozzo, (410) 786–1746, for matters related to fair health insurance premiums, guaranteed renewability, and single risk pool.

Kelly Drury, (410) 786–0558, or Krutika Amin, (301) 492–5153, for matters related to risk adjustment.

Adrianne Patterson, (410) 786–0686, for matters related to sequestration, risk adjustment data validation discrepancies, and administrative appeals.

Emily Ames, (301) 492–4246, for matters related to language access.

Dana Krohn, (301) 492–4412, for matters related to periodic data matching, redeterminations of advance payments of the premium tax credit, and appeals.

Rachel Arguello, (301) 492–4263, for matters related to Exchange special enrollment periods.

Jack Lavelle, (202) 631–2971, for matters related to premium payment, billing, and terminations due to fraud.

Christelle Jang, (410) 786–8438, for matters related to the Small Business Health Options Program (SHOP).

Krutika Amin, (301) 492–5153, for matters related to the Federally-facilitated Exchange user fee.

Leigha Basini, (301) 492–4380, for matters related to mid-year withdrawals, and other standards for QHP issuers.

Ielnaz Kashefipour, (301) 492–4376, for matters related to standardized options.

Rebecca Zimmermann, (301) 492–4396, for matters related to stand-alone dental plans.

Jacob Schnur, (410) 786–7703, for matters related to QHP issuer oversight and direct enrollment.

Allison Yadsko, (410) 786–1740, for matters related to levels of coverage and actuarial value.

Pat Meisol, (410) 786–1917, for matters related to cost-sharing reductions, reconciliation of the cost-sharing reduction portion of advance payments discrepancies, and the premium adjustment percentage.

Kevin Kendrick, (301) 492–4134, for matters related to consumer-operated and oriented plans.

Christina Whitefield, (301) 492–4172, for matters related to the medical loss ratio program.

SUPPLEMENTARY INFORMATION:

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Acronyms and Abbreviations

The Act Social Security Act
Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended

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by 14 percent to account for the proportion of administrative costs that do not vary with claims beginning for the 2018 benefit year.

Comment: Numerous commenters supported removing a portion of administrative expenses from the Statewide average premium for the 2018 benefit year or for future benefit years. One commenter sought clarification regarding how the exclusion of these expenses would be operationalized across all issuers uniformly since each issuer has its own expense assumptions. Other commenters suggested approaches by which HHS could remove fixed administrative expenses from the Statewide average premium in the payment transfer formula, including reducing the portion of administrative expenses from the Statewide average premium by 20 percent, the amount of non-claims costs, profit and taxes, the administrative expense amount reported through the Unified Rate Review Templates (URRTs), or other categorization of fixed administrative costs that would result in only including claims, claims-related expenses and taxes in the Statewide average premiums. Other commenters generally supported reducing Statewide average premium by a flat percentage. As a way to reflect the elimination of administrative costs in the transfer formula, one commenter suggested that HHS multiply the transfer amount by the amount allowed as administrative costs in each State's MLR laws. One commenter requested that HHS consult the American Academy of Actuaries and move to an approach that relies on market average costs or claims experience and add-on a claims-related adjustment to account for administrative costs that can vary with the level of claims experience.

One commenter supported this proposal beginning with the 2016 benefit year and requested HHS to retroactively implement this policy for the 2014 and 2015 benefit year.

One commenter did not support such an adjustment to the Statewide average premium, noting that there is no easy way to make this adjustment without favoring some issuers and promoting gaming. Another commenter asked HHS to delay this proposal for further study, and accept public comment on the impact of the inclusion of certain administrative costs and profit in the Statewide average premium. One commenter suggested that an iterative or phased-in approach could mitigate concerns about the accuracy of administrative cost allocation.

Response: HHS will reduce the Statewide average premium in the risk adjustment transfer formula by a fixed rate of 14 percent beginning for the 2018 benefit year, which we believe reasonably reflects the proportion of administrative costs that do not vary with claims. To derive this parameter, we analyzed administrative and other non-claims expenses (for example quality improvement expenses) in the MLR Annual Reporting Form, and estimated, by category, the extent to which the expenses varied with claims. We compared those expenses to the total costs that issuers finance through premiums, including claims, administrative expenses, and taxes, netting out claims costs financed through cost-sharing reduction payments. We compared these expenses to total costs, rather than directly to premiums, to ensure that the estimated administrative cost percentage was not distorted by under- or over-pricing during the years for which MLR data are available. Using this methodology, we determined that the mean administrative cost percentage is 14 percent. We believe that this percentage represents the mean administrative cost percentage in the individual and small group markets, and represents a reasonable percentage of administrative costs on which risk adjustment transfers should not be calculated. Below, we amend the calculation of the Statewide average premium to reflect average premiums in a risk pool, less 14 percent. We have amended the definition of the State average premium below to reflect this change. We are finalizing this adjustment beginning for the 2018 benefit year. However, we are not making this change for 2017 because issuers would not have had an opportunity to incorporate it into their rates for 2017.

Comment: A few commenters requested that HHS use a plan's own actual average premium instead of the Statewide average premium in the transfer formula.

Response: We have considered the use of a plan's own premium instead of the Statewide average premium. However, our analysis determined that this approach is likely to lead to substantial volatility in transfer results and even higher transfer charges for low-risk low-premium plans. Under such an approach, high-risk, high-premium plans would require even greater transfer payments; thus, low-risk, low-premium plans would be required to pay in an even higher percentage of their plan-specific premiums in risk adjustment transfer charges. In other words, the use of a plan's own premium does not reduce risk adjustment charges for low-cost and low-risk issuers, given the budget neutrality of the risk adjustment program.

The revised formula for the calculation of Statewide average premium beginning for the 2018 benefit year risk adjustment is:

$$\bar{P}_S = \left(\sum_i (s_i \cdot P_i)\right) * 0.86$$

Where:

s_i = plan i's share of Statewide enrollment in the market in the risk pool;

P_i = Average premium per member month of plan i.

ii. The Payment Transfer Formula

The payment transfer formula is unchanged from what was finalized in the 2014 Payment Notice (78 FR 15430 through 15434), except with an adjustment to remove a portion of administrative costs from the Statewide average premium, as discussed above. Transfers (payments and charges) will be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection. As finalized in the 2014 Payment Notice, the HHS risk adjustment payment transfer formula is:

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$$T_i = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \overline{P}_s$$

Where:
$\overline{P}_s$ = Statewide average premium;
$PLRS_i$ = plan i's plan liability risk score;
AV_i = plan i's metal level AV;
ARF_i = allowable rating factor;
IDF_i = plan i's induced demand factor;
GCF_i = plan i's geographic cost factor;
s_i = plan i's share of Statewide enrollment.

The denominator is summed across all plans in the risk pool in the market in the State.

The difference between the two premium estimates in the payment transfer formula determines whether a plan pays a risk adjustment charge or receives a risk adjustment payment. Note that the value of the plan average risk score by itself does not determine whether a plan would be assessed a charge or receive a payment—even if the risk score is greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan may receive through its rating (as measured through the allowable rating factor) exceeds the plan's predicted liability associated with risk selection. Risk adjustment transfers are calculated at the risk pool level, and catastrophic plans are treated as a separate risk pool for purposes of risk adjustment.

This existing formula would be multiplied by the number of member months to determine the total payment or charge assessed with respect to plan average risk scores for a plan's geographic rating area for the market for the State and this payment or charge will be added to the transfer terms described above to account for the costs of high-risk enrollees.

Comment: A few commenters noted that the budget neutrality of the risk adjustment program leads to inadequate compensation for enrollees' risk and recommended a non-budget neutral risk adjustment program as with Medicare Advantage. Commenters also recommended capping risk adjustment charges if they exceed a certain percent of total premiums, applying issuer-specific caps with lower caps for smaller issuers, and also excluding carriers with experience and significant market share from risk adjustment as these carriers may have a sufficient scale to mitigate adverse selection. One commenter requested additional risk score information at the community- and State-level to allow them to make better decisions.

Response: In the absence of additional funding for the HHS-operated risk adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner and note that Medicare Part D risk adjustment transfers are also calculated in a budget neutral manner. We will not cap transfers as a percent of premiums or by issuer size, as this would also reduce the necessary risk adjustment payments for issuers with higher risk enrollees and thereby undermine the effectiveness of the risk adjustment program. We continue to evaluate additional information we may provide States and issuers that would not result in sharing issuers' proprietary information. Last year, we provided interim risk adjustment reports for credible States, as well as final State averages by risk pool, including risk scores, in an appendix to the June 30 Summary Report.[36]

(8) Risk Adjustment Issuer Data Requirements (§ 153.610)

In the 2014 Payment Notice, HHS established an approach for obtaining the necessary data for reinsurance and risk adjustment calculations through a distributed data collection model that prevented the transfer of individuals' personally identifiable information (PII). Under § 153.700, each issuer must establish an EDGE server through which it provides HHS access to enrollment, claims, and encounter data. To safeguard enrollees' privacy, each issuer must establish a unique masked enrollee identification number for each enrollee, and may not include PII in such masked enrollee identification number. Under the EDGE server approach issuers currently provide plan-level data to HHS.

The lack of more granular data under this approach limits HHS's ability to use data from risk adjustment covered plans to improve the risk adjustment model recalibration. As we discussed in the White Paper, access to enrollee-level data with masked enrollee IDs would permit HHS to recalibrate the risk adjustment model using actual data from issuers' individual and small group populations, as opposed to the MarketScan® commercial database that approximates individual and small group market populations, while continuing to safeguard the privacy and security of protected health information (PHI). Therefore, beginning as soon as the 2019 benefit year, while maintaining the underlying goals of the distributed data approach, including information privacy and security, we proposed to recalibrate the risk adjustment model using masked, enrollee-level EDGE server data from the 2016 benefit year. A separate report would be run on issuers' EDGE servers to access select data elements in the enrollee, medical claim, pharmacy claim and supplemental diagnosis files, with masked elements for each of enrollee ID, plan/issuer ID, rating area, and State. This approach would allow for the creation of a masked, enrollee-level dataset, avoiding, for example, the collection of information such as the enrollee ID, the plan ID, the issuer ID, rating area, State, or the EDGE server from which the data was extracted. HHS would provide additional information regarding the data elements it would collect and the related process considerations in future guidance.

HHS would use the dataset to recalibrate the risk adjustment model and inform development of the AV Calculator and Methodology, which HHS releases annually, to describe how issuers of non-grandfathered health plans in the individual and small group markets are to calculate AV for purposes of determining metal levels. We also believed the data could be a valuable source for calibrating other HHS programs in the individual and small group markets and creating a public use file to help governmental entities and independent researchers better understand these markets. After fully considering the comments received, we are finalizing our proposal to extract and use the EDGE server data in this manner to help update the risk adjustment methodology and the AV Calculator, which we aim to do for the 2019 benefit year. We will also consider using these data in the future for calibrating other HHS programs in the individual and small group markets and creating a public use file.

We believe that our approach described above, which minimizes the burden for issuers by only requiring them to execute a new EDGE command for the report to be run on their EDGE servers, permits important improvements to the HHS-operated risk adjustment program while continuing to safeguard privacy and security. We are finalizing the enrollee-level data collection as proposed.

[36] Appendix to the June 30 Summary Report. Available at *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx*.

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■ 25. Section 257.105 is amended by adding paragraph (h)(14) to read as follows:

§ 257.105 Recordkeeping requirements.

* * * * *

(h) * * *

(14) The demonstration, including long-term performance data, supporting the suspension of groundwater monitoring requirements as required by § 257.90(g).

* * * * *

■ 26. Section 257.106 is amended by adding paragraph (h)(11) to read as follows:

§ 257.106 Notification requirements.

* * * * *

(h) * * *

(11) Provide the demonstration supporting the suspension of groundwater monitoring requirements specified under § 257.105(h)(14).

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■ 27. Section 257.107 is amended by adding paragraph (h)(11) to read as follows:

§ 257.107 Publicly accessible internet site requirements.

* * * * *

(h) * * *

(11) The demonstration supporting the suspension of groundwater monitoring requirements specified under § 257.105(h)(14).

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[FR Doc. 2018-16262 Filed 7-27-18; 8:45 am]

BILLING CODE 6560-50-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS-9920-F]

RIN 0938-AT65

Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year

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

ACTION: Final rule.

SUMMARY: This final rule adopts the risk adjustment methodology that HHS previously established for the 2017 benefit year. In February 2018, a district court vacated the use of statewide average premium as a basis for the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. Accordingly, HHS is issuing this final rule to allow charges to be collected and payments to be made for the 2017 benefit year. We hereby adopt the final rules set out in the publication in the **Federal Register** on March 23, 2012 and the publication in the **Federal Register** on March 8, 2016.

DATES: These provisions of this final rule are effective on July 30, 2018.

FOR FURTHER INFORMATION CONTACT: Abigail Walker, (410) 786-1725; Adam Shaw, (410) 786-1091; Jaya Ghildiyal, (301) 492-5149; or Adrianne Patterson, (410) 786-0686.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111-148), was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) was enacted on March 30, 2010. These statutes are collectively referred to as "PPACA" in this final rule. Section 1343 of the PPACA established an annual permanent risk adjustment program under which payments are collected from health insurance issuers that enroll relatively low-risk populations, and payments are made to health insurance issuers that enroll relatively higher-risk populations. Consistent with section 1321(c)(1) of the PPACA, the Secretary is responsible for operating the risk adjustment program on behalf of any state that elected not to do so. For the 2017 benefit year, HHS is responsible for operation of the risk adjustment program in all 50 states and the District of Columbia.

HHS sets the risk adjustment methodology that it uses in states that elect not to operate the program in advance of each benefit year through a notice-and-comment rulemaking process with the intention that issuers will be able to rely on the methodology to price their plans appropriately (45 CFR 153.320; 76 FR 41930, 41932 through 41933; 81 FR 94058, 94702 (explaining the importance of setting rules ahead of time and describing comments supporting that practice)).

In the July 15, 2011 **Federal Register** (76 FR 41929), we published a proposed rule outlining the framework for the risk adjustment program. We implemented the risk adjustment program in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73117), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2014 benefit year and other parameters related to the risk adjustment program (proposed 2014 Payment Notice). We published the 2014 Payment Notice final rule in the March 11, 2013 **Federal Register** (78 FR 15409). In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed a modification to the HHS-operated methodology related to community rating states. In the October 30, 2013, **Federal Register** (78 FR 65046), we finalized the proposed modification to the HHS-operated methodology related to community rating states. We published a correcting amendment to the 2014 Payment Notice final rule in the November 6, 2013 **Federal Register** (78 FR 66653) to address how an enrollee's age for the risk score calculation would be determined under the HHS-operated risk adjustment methodology.

In the December 2, 2013 **Federal Register** (78 FR 72321), we published a proposed rule outlining the Federally certified risk adjustment methodologies for the 2015 benefit year and other parameters related to the risk adjustment program (proposed 2015 Payment Notice). We published the 2015 Payment Notice final rule in the March 11, 2014 **Federal Register** (79 FR 13743). In the May 27, 2014 **Federal Register** (79 FR 30240), the 2015 fiscal year sequestration rate for the risk adjustment program was announced.

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2016 benefit year and other parameters related to the risk adjustment program (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

In the December 2, 2015 **Federal Register** (80 FR 75487), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2017 benefit year and other parameters related to the risk adjustment program (proposed 2017 Payment Notice). We published the 2017 Payment Notice final rule in the March 8, 2016 **Federal Register** (81 FR 12204).

In the September 6, 2016 **Federal Register** (81 FR 61455), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2018 benefit year and other parameters related to the risk adjustment program (proposed 2018 Payment Notice). We published the 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058).

In the November 2, 2017 **Federal Register** (82 FR 51042), we published a proposed rule outlining the benefit and payment parameters for the 2019 benefit year, and to further promote stable premiums in the individual and small group markets. We proposed updates to the risk adjustment methodology and amendments to the risk adjustment data validation process (proposed 2019 Payment Notice). We published the 2019 Payment Notice final rule in the April 17, 2018 **Federal Register** (83 FR 16930). We published a correction to the 2019 risk adjustment coefficients in the 2019 Payment Notice final rule in the May 11, 2018 **Federal Register** (83 FR 21925).

B. The New Mexico Health Connections Court's Order

On February 28, 2018, in a suit brought by the health insurance issuer New Mexico Health Connections, the United States District Court for the District of New Mexico (the district court) vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. The district court reasoned that HHS had not adequately explained its decision to adopt a methodology that used the statewide average premium as the cost-scaling factor to ensure that amounts collected from issuers equal payments made to issuers for the applicable benefit year, that is, a methodology that maintains the budget neutrality of the program for the applicable benefit year.[1] The district court otherwise rejected New Mexico Health Connections' arguments. HHS's reconsideration motion remains pending with the district court.

HHS recently announced the collection and payment amounts for the 2017 benefit year as calculated under the HHS-operated risk adjustment methodology that uses the statewide average premium.[2] However, without this administrative action (that is, issuing this final rule), HHS would be unable to make those collections or distribute the payments for the 2017 benefit year, which total billions of dollars.[3] Uncertainty and delay in the distribution of those payments, which issuers anticipated when they set premiums for the 2017 benefit year, could add uncertainty to the market, as issuers are now in the process of determining the extent of their market participation and the rates and terms of plans they will offer for the 2019 benefit year.

II. Provisions of the Final Rule

This final rule adopts the HHS-operated risk adjustment methodology previously published at 81 FR 12204 for the 2017 benefit year with an additional explanation regarding the use of statewide average premium and the budget neutral nature of the program. This rule does not make any changes to the previously published HHS-operated risk adjustment methodology for the 2017 benefit year.

The risk adjustment program provides payments to health insurance issuers that enroll higher risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to structure their plan benefit designs or marketing strategies in order to avoid these enrollees and lessening the potential influence of risk selection on the premiums that issuers charge. Instead, issuers are expected to set rates based on average risk and compete based on plan features rather than selection of healthier enrollees. The program applies to any health insurance issuer offering plans in the individual or small group markets, with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.[4] In 45 CFR part 153, subparts A, B, D, G, and H, HHS established standards for the administration of the permanent risk adjustment program. In accordance with § 153.320, any risk adjustment methodology used by a state, or by HHS on behalf of the state, must be a Federally certified risk adjustment methodology.

As stated in the 2014 Payment Notice final rule, the Federally certified risk adjustment methodology developed and used by HHS in states that elect not to operate the program is based on the premise that premiums for this market should reflect the differences in plan benefits, quality, and efficiency—not the health status of the enrolled population.[5] HHS developed the risk adjustment payment transfer formula that calculates the difference between the revenues required by a plan based on the projected health risk of the plan's enrollees and the revenues that a plan can generate for those enrollees. These differences are then compared across plans in the state market risk pool and converted to a dollar amount based on the statewide average premium. HHS chose to use statewide average premium and normalize the risk adjustment transfer formula to reflect state average factors so that each plan's enrollment characteristics are compared to the state average and the total calculated payment amounts equal total calculated charges in each state market risk pool. Thus, each plan in the risk pool receives a risk adjustment payment or charge designed to compensate for risk for a plan with average risk in a budget neutral manner. This approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high risk enrollees. Such incentives could arise if HHS used each issuer's plan's own premium in the risk adjustment payment transfer formula, instead of statewide average premium.

As explained above, the district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years on the ground that HHS did not adequately explain its decision to adopt that aspect of the risk adjustment methodology. The district court recognized that use of statewide average premium maintained the budget neutrality of the program, but concluded that HHS had not adequately explained the underlying decision to adopt a methodology that kept the program budget neutral, that is, that ensured that amounts collected from issuers would equal payments made to issuers for the applicable benefit year. Accordingly, HHS is providing additional explanation herein.

[1] *New Mexico Health Connections* v. *United States Department of Health and Human Services et al.*, No. CIV 16-0878 JB/JHR (D.N.M. 2018).

[2] See, *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year*, available at *https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf*.

[3] See, July 7, 2018 *United States District Court Ruling Puts Risk Adjustment On Hold*, available at *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-07.html* and the July 9, 2018, *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year* *https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf*. Also see the CMS Memo: *Implications of the Decision by United States District Court for the District of New Mexico on the Risk Adjustment and Related Programs* (July 12, 2018), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Implications-of-the-Decision-by-United-States-District-Court-for-the-District-of-New-Mexico-on-the-Risk-Adjustment-and-Related-Programs.pdf*.

[4] See the definition for "risk adjustment covered plan" at 45 CFR 153.20.

[5] See 78 FR 15409 at 15417.

First, Congress designed the risk adjustment program to be implemented and operated by states if they choose to do so. Nothing in section 1343 of the PPACA requires a state to spend its own funds on risk adjustment payments or allows HHS to impose such a requirement. Thus, while section 1343 may have provided leeway for states to spend additional funding on the program if they voluntarily chose to do so, HHS could not have required additional funding within the HHS-operated risk adjustment methodology.

Second, while the PPACA did not include an explicit requirement that the risk adjustment program be operated in a budget-neutral manner, it also does not proscribe designing the program in a budget-neutral manner. In fact, although the statutory provisions for many other PPACA programs appropriated or authorized amounts to be appropriated from the U.S. Treasury, or provided budget authority in advance of appropriations,[6] the PPACA neither authorized nor appropriated additional funding for risk adjustment payments beyond the amount of charges paid in, nor authorized HHS to obligate itself for risk adjustment payments in excess of charges collected.[7] Indeed, unlike the Medicare Part D statute, which expressly authorizes the appropriation of funds and provides budget authority in advance of appropriations to make Part D risk-adjusted payments, the PPACA's risk adjustment statute makes no reference to additional appropriations whatsoever.[8] Because Congress omitted from the PPACA any provision appropriating independent funding or creating budget authority in advance of an appropriation for the risk adjustment program, HHS could not—absent another source of appropriations—have designed the risk adjustment program in a way that required payments in excess of collections consistent with binding appropriations law. Thus, as a practical matter, Congress did not give HHS discretion to implement a program that was not budget neutral.

Furthermore, if HHS had elected to adopt a HHS-operated risk adjustment methodology that was contingent on appropriations from Congress in the annual appropriations process that would have created uncertainty for issuers in the amount of risk adjustment payments they could expect. That uncertainty would undermine one of the central objectives of the risk adjustment program, which is to assure issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a high risk population compared to other issuers in the state market risk pool. The budget-neutral framework spreads the costs of covering higher-risk enrollees across issuers throughout a given state market risk pool, thereby reducing incentives for issuers to engage in risk-avoidance techniques such as designing or marketing their plans in ways that tend to attract healthier individuals, who cost less to insure. Moreover, relying on the possibility in each year's budget process for appropriation of additional funds to HHS that could be used to supplement risk adjustment transfers would have required HHS to delay setting the parameters for any risk adjustment payment proration rates until well after the plans were in effect for the applicable benefit year.[9] Without the adoption of a budget-neutral framework, HHS would have needed to assess a charge or otherwise collect additional funds, or prorate risk adjustment payments to balance the calculated risk adjustment transfer amounts. The resulting uncertainty would have conflicted with one of the overall goals of the risk adjustment program—to reduce incentives for issuers to avoid enrolling individuals with higher than average actuarial risk.

In light of the budget-neutral framework discussed above, HHS also chose not to use a different parameter for the payment transfer formula under the HHS-operated methodology, such as each plan's own premium, that would not have automatically achieved equality between risk adjustment payments and charges in each benefit year. As set forth in prior discussions,[10] use of the plan's own premium or some similar parameter would have required the application of a balancing adjustment in light of the program's budget neutrality—either reducing payments to issuers owed a payment, increasing charges on issuers due a charge, or splitting the difference in some fashion between issuers owed payments and issuers assessed charges. Such adjustments would have impaired the risk adjustment program's goals, discussed above, of encouraging issuers to rate for the average risk in the applicable risk pool and avoiding the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid higher-risk enrollees. Use of an after-the-fact balancing adjustment is also less predictable for issuers than a methodology that can be calculated in advance of a benefit year. Such predictability is important to serving the risk adjustment program's goals of premium stabilization and reducing issuer incentives to avoid enrolling higher-risk populations. Additionally, using a plan's own premium to scale transfers may provide additional incentive for plans with high-risk enrollees to increase premiums in order to receive additional risk adjustment payments. As noted by commenters to the 2014 Payment Notice proposed rule, transfers may be more volatile from year to year and sensitive to anomalous premiums if they were scaled to a plan's own premium instead of the statewide average premium. Scaling the risk adjustment transfers by the statewide average premium promotes premium stabilization by encouraging pricing to average risk in a risk pool, and results in a calculation of equal payments and charges.

In the risk adjustment methodologies applicable to the 2018 and 2019 benefit years, HHS has adjusted statewide average premium by reducing it by 14 percent to account for an estimated proportion of administrative costs that do not vary with claims. HHS is not applying this adjustment retroactively to the 2017 benefit year, but is instead

[6] For examples of PPACA provisions appropriating funds, *see* PPACA secs. 1101(g)(1), 1311(a)(1), 1322(g), 1323(c). For examples of PPACA provisions authorizing the appropriation of funds, *see* PPACA secs. 1002, 2705(f), 2706(e), 3013(c), 3015, 3504(b), 3505(a)(5), 3505(b), 3506, 3509(a)(1), 3509(b), 3509(e), 3509(f), 3509(g), 3511, 4003(a), 4003(b), 4004(j), 4101(b), 4102(a), 4102(c), 4102(d)(1)(C), 4102(d)(4), 4201(f), 4202(a)(5), 4204(b), 4206, 4302(a), 4304, 4305(a), 4305(c), 5101(b), 5102(e), 5103(a)(3), 5203, 5204, 5206(b), 5207, 5208(b), 5210, 5301, 5302, 5303, 5304, 5305(a), 5306(a), 5307(a), 5309(b).

[7] *See* 42 U.S.C. 18063.

[8] *Compare* 42 U.S.C. 18063 (failing to specify source of funding other than risk adjustment charges), *with* 42 U.S.C. 1395w–116(c)(3) (authorizing appropriations for Medicare Part D risk adjusted payments); 42 U.S.C. 1395w–115(a) (establishing "budget authority in advance of appropriations Acts" for risk adjusted payments under Medicare Part D).

[9] It has been suggested that the annual lump sum appropriation to CMS for program management was potentially available for risk adjustment payments. The lump sum appropriation for each year was not enacted until after the applicable rule announcing the methodology to calculate payments for the applicable benefit year. Moreover, HHS does not believe that the lump sum is legally available for risk adjustment payments. As the underlying budget requests reflect, the lump sum is for program management expenses, such as administrative costs for various CMS programs such as Medicaid, Medicare, the Children's Health Insurance Program, and the PPACA's insurance market reforms—not for the program payments themselves. CMS would have elected to use the lump sum for these important program management expenses even if CMS had discretion to use all or part of the lump sum for risk adjustment payments.

[10] See, *e.g.*, September 12, 2011, *Risk Adjustment Implementation Issues* White Paper, available at: *https://www.cms.gov/CCIIO/Resources/Files/Downloads/riskadjustment_whitepaper_web.pdf*

maintaining the definition of statewide average premium previously established for the 2017 benefit year. As discussed above, HHS has repeatedly stressed the importance of providing a risk adjustment methodology in advance of the benefit year to which it applies to provide issuers the opportunity to price their plans accordingly.[11] To protect the settled expectations of issuers that have structured their pricing and offering decisions in reliance on the previously promulgated 2017 benefit year methodology, this rule maintains for the 2017 benefit year the description of statewide average premium set forth in the 2017 Payment Notice.

Therefore, for the 2017 benefit year, we are issuing this final rule that adopts the HHS-operated risk adjustment methodology previously established for the 2017 benefit year in the **Federal Register** publications cited above, including use of statewide average premium. As set forth in reports previously issued, HHS has completed final risk adjustment calculations for the 2017 benefit year, but has not yet collected or paid risk adjustment amounts to issuers of risk adjustment covered plans. The provisions of this final rule adopt the methodology that applies to collection and payment of risk adjustment amounts for the 2017 benefit year. Because this final rule does not alter any previously announced risk adjustment methodology, the amounts previously calculated by HHS have not changed by virtue of this rule's issuance.

HHS will begin collection of the 2017 benefit year risk adjustment charge amounts announced in the *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year*[12] through netting pursuant to 45 CFR 156.1215(b) and subsequently issuing invoices if an amount remains outstanding in the September 2018 monthly payment cycle. HHS will begin making the 2017 benefit year risk adjustment payments outlined in the *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year* as part of the October 2018 monthly payment cycle, continuing on a monthly basis as collections are received. Under this timeline, issuers would receive invoices on or about September 11–13, 2018 and payments would begin to be made around October 22, 2018.

[11] See 76 FR 41930, 41932–33. Also see 81 FR 94058, 94702.

[12] *https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.*

III. Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act

This rule adopts the final rules set out in the publication in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and publication in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352). For the 2017 benefit year, in states where HHS is operating the risk adjustment program under section 1343 of the PPACA, HHS will use the criteria and methods as specified in the publication in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and publication in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352).

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

Under the Administrative Procedure Act (APA) (5 U.S.C. 553), a notice of proposed rulemaking and an opportunity for public comment are generally required before issuing a regulation. We also ordinarily provide a 30-day delay in the effective date of the provisions of a rule in accordance with the APA (5 U.S.C. 553(d)), unless the rule is a major rule and subject to the 60-day delayed effective date required by the Congressional Review Act (5 U.S.C. 801(a)(3)). However, these procedures can be waived if the agency, for good cause, finds that notice and public comment and delay in effective date are impracticable, unnecessary, or contrary to public interest and incorporates a statement of the finding and its reasons in the rule issued. See 5 U.S.C. 553(d)(3); 5 U.S.C. 808(2).

HHS has determined that issuing this rule in proposed form, such that it would not become effective until after public comments are submitted, considered, and responded to in a final rule, would be impracticable, unnecessary, and contrary to the public interest. As discussed above, immediate administrative action is imperative to maintain the stability and predictability in the individual and small group insurance markets. It is also consistent with settled expectations in that this rule adopts the risk adjustment methodology previously established for the 2017 benefit year.[13] Under normal operations, risk adjustment invoices for the 2017 benefit year would be issued beginning in August 2018 and risk adjustment payments for the 2017 benefit year would be made beginning in the September 2018 monthly payment cycle. Accordingly, it is now less than 2 months until risk adjustment payments for the 2017 benefit year, expected to total $5.2 billion, are due to begin. Immediate action is also necessary to maintain issuer confidence in the HHS-operated risk adjustment program. Issuers have already accounted for expected risk adjustment transfers in their rates for the 2017 benefit year and uncompensated payments for the 2017 benefit year could lead to higher premiums in future benefit years as issuers incorporate a risk premium into their rates. Issuers file rates for the 2019 benefit year in the summer of 2018, and if a projected $5.2 billion in risk adjustment payments is unavailable or there is uncertainty as to whether payments for the 2018 benefit year will be made, there is a serious risk issuers will substantially increase 2019 premiums to account for the uncompensated risk associated with high-risk enrollees. Consumers enrolled in certain plans could see a significant premium increase, which could make coverage in those plans particularly unaffordable for unsubsidized enrollees. Furthermore, issuers are currently making decisions on whether to offer qualified health plans (QHPs) through the Exchanges for the 2019 benefit year, and, for the Federally-facilitated Exchange (FFE), this decision must be made before the August 2018 deadline to finalize QHP agreements. In states with limited Exchange options, a QHP issuer exit would restrict consumer choice, and put additional upward pressure on Exchange premiums, thereby increasing the cost of coverage for unsubsidized individuals and federal spending for premium tax credits. The combination of these effects could lead to significant, involuntary coverage losses in certain state market risk pools.

Additionally, HHS's failure to make timely risk adjustment payments could impact the solvency of plans providing coverage to sicker (and costlier) than average enrollees that require the influx of risk adjustment payments to continue operations. When state regulators determine issuer solvency, any uncertainty surrounding risk adjustment transfers jeopardizes regulators' ability to make decisions that protect consumers and support the long-term health of insurance markets. Therefore, HHS has determined that delaying the effective date of the use of statewide average premium in the payment transfer calculation under the HHS-operated risk adjustment methodology for the 2017 benefit year to allow for

[13] The risk adjustment methodology for those benefit years was published at the February 27, 2015 **Federal Register** (80 FR 10749) and the March 8, 2016 **Federal Register** (81 FR 12203).

proposed rulemaking and comment is impracticable and contrary to the public interest because consumers would be negatively impacted by premium changes should risk adjustment payments be interrupted or confidence in the program undermined.

There is also good cause to proceed without notice and comment for the additional reason that such procedures are unnecessary here. HHS has received and considered comments in issuing the 2014 through 2017 Payment Notices. In each of these rulemaking processes, parties had the opportunity to comment on HHS's use of statewide average premium in the payment transfer formula under the HHS-operated risk adjustment methodology. Because this final rule adopts the same HHS-operated risk adjustment methodology issued in the 2017 Payment Notice final rule, the comments received in those rulemakings are sufficiently current to indicate a lack of necessity to engage in further notice and comment. In the 2014 Payment Notice final rule, we received a number of comments in support of our proposal to use the statewide average premium as the basis for risk adjustment transfers. In subsequent benefit year rulemakings, some commenters expressed a desire for HHS to use a plan's own premium. HHS addressed those comments by reiterating that we had considered the use of a plan's own premium instead of the statewide average premium and chose to use statewide average premium. As this approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high risk enrollees.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*).

VI. Regulatory Impact Analysis

A. Statement of Need

This final rule adopts the HHS-operated risk adjustment methodology for the 2017 benefit year set forth in the 2017 Payment Notice final rule to ensure that the risk adjustment program works as intended to protect consumers from the effects of adverse selection and premium increases due to issuer uncertainty. The Premium Stabilization Rule and previous Payment Notices noted above provided detail on the implementation of the risk adjustment program, including the specific parameters applicable for the 2017 benefit year.

B. Overall Impact

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), the Congressional Review Act (5 U.S.C. 804(2), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs. 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).

OMB has determined that this final rule is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any 1 year. In addition, for the reasons noted above, OMB has determined that this is a major rule under the Congressional Review Act.

This final rule offers a further explanation on budget neutrality and the use of statewide average premium in the risk adjustment payment transfer formula when HHS is operating the permanent risk adjustment program established in section 1343 of the PPACA on behalf of a state for the 2017 benefit year. We note that we previously estimated transfers associated with the risk adjustment program in the Premium Stabilization Rule and the 2017 Payment Notice, and that the provisions of this final rule do not change the risk adjustment transfers previously estimated under the HHS-operated risk adjustment methodology established in those final rules. The approximate risk adjustment transfers for the 2017 benefit year are $5.179 billion. As such, we also adopt the RIA in the 2017 Payment Notice proposed and final rules.

Dated: July 23, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–16190 Filed 7–25–18; 4:15 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[MD Docket Nos. 18–175; FCC 18–65]

Assessment and Collection of Regulatory Fees for Fiscal Year 2018

AGENCY: Federal Communications Commission.

ACTION: Final action.

SUMMARY: In this document, the Federal Communications Commission (Commission) makes decisions involving submarine cables, international bearer circuits, and the calculation of cable television subscribers.

DATES: This final action is effective August 29, 2018.

FOR FURTHER INFORMATION CONTACT: Roland Helvajian, Office of Managing Director at (202) 418–0444.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *FY 2018 Report and Order* (FY 2018 Report and Order), FCC 18–65, MD Docket No. 18–175 adopted on May 21, 2018 and released on May 22, 2018. The full text of this document is available for inspection and copying during normal business hours in the FCC Reference Center, 445 12th Street SW, Room CY–A257, Portals II, Washington, DC 20554, and may also be purchased from the Commission's copy contractor, BCPI, Inc., Portals II, 445 12th Street SW, Room CY–B402, Washington, DC 20554. Customers may contact BCPI, Inc. via their website, *http://www.bcpi.com*, or call 1–800–378–3160. This document is available in alternative formats (computer diskette, large print, audio record, and braille). Persons with disabilities who need documents in these formats may contact the FCC by email: *FCC504@fcc.gov* or phone: 202–418–0530 or TTY: 202–418–0432.

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receipt of the next NESHAP delegation request from ODEQ.[5]

XIII. Proposed Action

In today's action, the EPA is proposing to approve an update to the Oklahoma NESHAP delegation that would provide the ODEQ with the authority to implement and enforce certain newly incorporated NESHAP promulgated by the EPA and amendments to existing standards currently delegated, as they existed though September 1, 2016. As requested in ODEQ's June 25, 2018 letter, this proposed delegation to ODEQ does not extend to sources or activities located in Indian country, as defined in 18 U.S.C. 1151.

XIV. Statutory and Executive Order Reviews

Under the CAA, the Administrator has the authority to approve section 112(l) submissions that comply with the provisions of the Act and applicable Federal regulations. In reviewing section 112(l) submissions, the EPA's role is to approve state choices, provided that they meet the criteria and objectives of the CAA and of the EPA's implementing regulations. Accordingly, this proposed action would merely approve the State's request as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this proposed action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 13563 (76 FR 3821, January 21, 2011);
- does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

List of Subjects

40 CFR Part 61

Environmental protection, Administrative practice and procedure, Air pollution control, Arsenic, Benzene, Beryllium, Hazardous substances, Mercury, Intergovernmental relations, Reporting and recordkeeping requirements, Vinyl chloride.

40 CFR Part 63

Environmental protection, Administrative practice and procedure, Air pollution control, Hazardous substances, Intergovernmental relations, Reporting and recordkeeping requirements.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: July 25, 2018.

Wren Stenger,

Multimedia Division Director, Region 6.

[FR Doc. 2018–17139 Filed 8–9–18; 8:45 am]

BILLING CODE 6560–50–P

[5] A request from ODEQ that raises an issue not previously subject to comment, presents new data, requires EPA to examine its interpretation of the applicable law, or where EPA wishes to re-examine its present position on a matter will be processed through notice and comment rulemaking in the **Federal Register**.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS–9919–P]

RIN 0938–AT66

Patient Protection and Affordable Care Act; Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program for the 2018 Benefit Year Proposed Rule

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

ACTION: Proposed rule.

SUMMARY: This rule proposes to adopt the risk adjustment methodology that HHS previously established for the 2018 benefit year. In February 2018, a district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years. HHS is proposing to adopt the HHS-operated risk adjustment methodology for the 2018 benefit year as established in the final rules published in the March 23, 2012 **Federal Register** and the December 22, 2016 **Federal Register**.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5:00 p.m. on September 7, 2018.

ADDRESSES: In commenting, please refer to file code CMS–9919–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three 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–9919–P, 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–9919–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Krutika Amin, (301) 492–5153; Jaya Ghildiyal, (301) 492–5149; or Adrianne Patterson, (410) 786–0686.

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 also be 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.

I. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was enacted on March 30, 2010. These statutes are collectively referred to as "PPACA" in this document. Section 1343 of the PPACA established an annual permanent risk adjustment program under which payments are collected from health insurance issuers that enroll relatively low-risk populations, and payments are made to health insurance issuers that enroll relatively higher-risk populations. Consistent with section 1321(c)(1) of the PPACA, the Secretary is responsible for operating the risk adjustment program on behalf of any state that elected not to do so. For the 2018 benefit year, HHS is responsible for operation of the risk adjustment program in all 50 states and the District of Columbia.

HHS sets the risk adjustment methodology that it uses in states that elect not to operate the program in advance of each benefit year through a notice-and-comment rulemaking process with the intention that issuers will be able to rely on the methodology to price their plans appropriately (see 45 CFR 153.320; 76 FR 41930, 41932 through 41933; 81 FR 94058, 94702 (explaining the importance of setting rules ahead of time and describing comments supporting that practice)).

In the July 15, 2011 **Federal Register** (76 FR 41929), we published a proposed rule outlining the framework for the risk adjustment program. We implemented the risk adjustment program in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73117), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2014 benefit year and other parameters related to the risk adjustment program (proposed 2014 Payment Notice). We published the 2014 Payment Notice final rule in the March 11, 2013 **Federal Register** (78 FR 15409). In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed a modification to the HHS-operated methodology related to community rating states. In the October 30, 2013 **Federal Register** (78 FR 65046), we finalized the proposed modification to the HHS-operated methodology related to community rating states. We published a correcting amendment to the 2014 Payment Notice final rule in the November 6, 2013 **Federal Register** (78 FR 66653) to address how an enrollee's age for the risk score calculation would be determined under the HHS-operated risk adjustment methodology.

In the December 2, 2013 **Federal Register** (78 FR 72321), we published a proposed rule outlining the Federally certified risk adjustment methodologies for the 2015 benefit year and other parameters related to the risk adjustment program (proposed 2015 Payment Notice). We published the 2015 Payment Notice final rule in the March 11, 2014 **Federal Register** (79 FR 13743). In the May 27, 2014 **Federal Register** (79 FR 30240), the 2015 fiscal year sequestration rate for the risk adjustment program was announced.

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2016 benefit year and other parameters related to the risk adjustment program (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

In the December 2, 2015 **Federal Register** (80 FR 75487), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2017 benefit year and other parameters related to the risk adjustment program (proposed 2017 Payment Notice). We published the 2017 Payment Notice final rule in the March 8, 2016 **Federal Register** (81 FR 12204).

In the September 6, 2016 **Federal Register** (81 FR 61455), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2018 benefit year and other parameters related to the risk adjustment program (proposed 2018 Payment Notice). We published the 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058).

In the November 2, 2017 **Federal Register** (82 FR 51042), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2019 benefit year, and to further promote stable premiums in the individual and small group markets. We proposed updates to the risk adjustment methodology and amendments to the risk adjustment data validation process (proposed 2019 Payment Notice). We published the 2019 Payment Notice final rule in the April 17, 2018 **Federal Register** (83 FR 16930). We published a correction to the 2019 risk adjustment coefficients in the 2019 Payment Notice final rule in the May 11, 2018 **Federal Register** (83 FR 21925). On July 27, 2018, consistent with 45 CFR 153.320(b)(1)(i), we updated the 2019 benefit year final risk adjustment model coefficients to reflect an additional recalibration related to an update to the 2016 enrollee-level EDGE dataset.[1]

In the July 30, 2018 **Federal Register** (83 FR 36456), we published a final rule that adopted the 2017 benefit year risk adjustment methodology in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352). In light of the court order described below, this final rule sets forth additional explanation of the rationale supporting the use of statewide average premium in the HHS-operated risk adjustment payment transfer formula for the 2017 benefit year, including the reasons why the program is operated in a budget neutral manner. This final rule permitted HHS to resume 2017 benefit year program operations, including collection of risk adjustment charges and distribution of risk adjustment payments. HHS also provided guidance as to the operation of the HHS-operated risk adjustment program for the 2017 benefit year in light of publication of this final rule.[2]

B. The New Mexico Health Connections Court's Order

On February 28, 2018, in a suit brought by the health insurance issuer New Mexico Health Connections, the United States District Court for the District of New Mexico (the district court) vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. The district court reasoned that HHS had not adequately explained its decision to adopt a methodology that used statewide

[1] See, Updated 2019 Benefit Year Final HHS Risk Adjustment Model Coefficients, July 27, 2018. Available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Updtd-Final-HHS-RA-Model-Coefficients.pdf.*

[2] See, *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2017-RA-Final-Rule-Resumption-RAOps.pdf.*

average premium as the cost-scaling factor to ensure that amounts collected from issuers equal the amount of payments made to issuers for the applicable benefit year, that is, a methodology that maintains the budget neutrality of the program for the applicable benefit year.[3] The district court otherwise rejected New Mexico Health Connections' arguments. HHS's motion for reconsideration remains pending with the district court.

II. Provisions of the Proposed Rule

This rule proposes to adopt the HHS-operated risk adjustment methodology that was previously published at 81 FR 94058 for the 2018 benefit year with an additional explanation regarding the use of statewide average premium and the budget neutral nature of the risk adjustment program. This rule does not propose to make any changes to the previously published HHS-operated risk adjustment methodology for the 2018 benefit year.

The risk adjustment program provides payments to health insurance issuers that enroll higher-risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to structure their plan benefit designs or marketing strategies to avoid these enrollees and lessening the potential influence of risk selection on the premiums that issuers charge. Instead, issuers are expected to set rates based on average risk and compete based on plan features rather than selection of healthier enrollees. The program applies to any health insurance issuer offering plans in the individual or small group markets, with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.[4] In 45 CFR part 153, subparts A, B, D, G, and H, HHS established standards for the administration of the permanent risk adjustment program. In accordance with § 153.320, any risk adjustment methodology used by a state, or by HHS on behalf of the state, must be a Federally certified risk adjustment methodology.

As stated in the 2014 Payment Notice final rule, the Federally certified risk adjustment methodology developed and used by HHS in states that elect not to operate the program is based on the premise that premiums for that state market should reflect the differences in plan benefits, quality, and efficiency—not the health status of the enrolled population.[5] HHS developed the risk adjustment payment transfer formula that calculates the difference between the revenues required by a plan based on the projected health risk of the plan's enrollees and the revenues that a plan can generate for those enrollees. These differences are then compared across plans in the state market risk pool and converted to a dollar amount based on the statewide average premium. HHS chose to use statewide average premium and normalize the risk adjustment transfer formula to reflect state average factors so that each plan's enrollment characteristics are compared to the state average and the total calculated payment amounts equal total calculated charges in each state market risk pool. Thus, each plan in the risk pool receives a risk adjustment payment or charge designed to compensate for risk for a plan with average risk in a budget neutral manner. This approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high-risk enrollees. Such incentives could arise if HHS used each issuer's plan's own premium in the payment transfer formula, instead of statewide average premium.

As explained above, the district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years on the ground that HHS did not adequately explain its decision to adopt that aspect of the risk adjustment methodology. The district court recognized that use of statewide average premium maintained the budget neutrality of the program, but concluded that HHS had not adequately explained the underlying decision to adopt a methodology that kept the program budget neutral, that is, that ensured that amounts collected from issuers would equal payments made to issuers for the applicable benefit year. Accordingly, HHS is providing additional explanation herein.

First, Congress designed the risk adjustment program to be implemented and operated by states if they chose to do so. Nothing in section 1343 of the PPACA requires a state to spend its own funds on risk adjustment payments, or allows HHS to impose such a requirement. Thus, while section 1343 may have provided leeway for states to spend additional funds on the program if they voluntarily chose to do so, HHS could not have required such additional funding.

Second, while the PPACA did not include an explicit requirement that the risk adjustment program be operated in a budget neutral manner, it also did not prohibit HHS from designing the program in that manner. In fact, although the statutory provisions for many other PPACA programs appropriated or authorized amounts to be appropriated from the U.S. Treasury, or provided budget authority in advance of appropriations,[6] the PPACA neither authorized nor appropriated additional funding for risk adjustment payments beyond the amount of charges paid in, nor authorized HHS to obligate itself for risk adjustment payments in excess of charges collected.[7] Indeed, unlike the Medicare Part D statute, which expressly authorizes the appropriation of funds and provides budget authority in advance of appropriations to make Part D risk-adjusted payments, the PPACA's risk adjustment statute makes no reference to additional appropriations.[8] Because Congress omitted from the PPACA any provision appropriating independent funding or creating budget authority in advance of an appropriation for the risk adjustment program, HHS could not—absent another source of appropriations—have designed the program in a way that required payments in excess of collections consistent with binding appropriations law. Thus, as a practical matter, Congress did not give HHS discretion to implement a program that was not budget neutral.

Furthermore, if HHS elected to adopt a risk adjustment methodology that was contingent on appropriations from

[3] *New Mexico Health Connections* v. *United States Department of Health and Human Services et al.*, No. CIV 16–0878 JB/JHR (D.N.M. 2018).

[4] See the definition for "risk adjustment covered plan" at 45 CFR 153.20.

[5] See 78 FR 15409 at 15417.

[6] For examples of PPACA provisions appropriating funds, *see* PPACA secs. 1101(g)(1), 1311(a)(1), 1322(g), 1323(c). For examples of PPACA provisions authorizing the appropriation of funds, *see* PPACA secs. 1002, 2705(f), 2706(e), 3013(c), 3015, 3504(b), 3505(a)(5), 3505(b), 3506, 3509(a)(1), 3509(b), 3509(e), 3509(f), 3509(g), 3511, 4003(a), 4003(b), 4004(j), 4101(b), 4102(a), 4102(c), 4102(d)(1)(C), 4102(d)(4), 4201(f), 4202(a)(5), 4204(b), 4206, 4302(a), 4304, 4305(a), 4305(c), 5101(b), 5102(e), 5103(a)(3), 5203, 5204, 5206(b), 5207, 5208(b), 5210, 5301, 5302, 5303, 5304, 5305(a), 5306(a), 5307(a), and 5309(b).

[7] *See* 42 U.S.C. 18063.

[8] *Compare* 42 U.S.C. 18063 (failing to specify source of funding other than risk adjustment charges), *with* 42 U.S.C. 1395w–116(c)(3) (authorizing appropriations for Medicare Part D risk adjusted payments); 42 U.S.C. 1395w–115(a) (establishing "budget authority in advance of appropriations Acts" for risk adjusted payments under Medicare Part D).

Congress through the annual appropriations process, that would have created uncertainty for issuers regarding the amount of risk adjustment payments they could expect for a given benefit year. That uncertainty would have undermined one of the central objectives of the risk adjustment program, which is to assure issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a higher-risk population compared to other issuers in the state market risk pool. The budget-neutral framework spreads the costs of covering higher-risk enrollees across issuers throughout a given state market risk pool, thereby reducing incentives for issuers to engage in risk-avoidance techniques such as designing or marketing their plans in ways that tend to attract healthier individuals, who cost less to insure.

Moreover, relying on each year's budget process for appropriation of additional funds to HHS that could be used to supplement risk adjustment transfers would have required HHS to delay setting the parameters for any risk adjustment payment proration rates until well after the plans were in effect for the applicable benefit year. Any later-authorized program management appropriations made to CMS, moreover, were not intended to be used for supplementing risk adjustment payments, and were allocated by the agency for other, primarily administrative, purposes.[9] Without the adoption of a budget-neutral framework, HHS would have needed to assess a charge or otherwise collect additional funds, or prorate risk adjustment payments to balance the calculated risk adjustment transfer amounts. The resulting uncertainty would have conflicted with the overall goals of the risk adjustment program—to stabilize premiums and to reduce incentives for issuers to avoid enrolling individuals with higher than average actuarial risk.

In light of the budget neutral framework discussed above, HHS also chose not to use a different parameter for the payment transfer formula under the HHS-operated methodology, such as each plan's own premium, that would not have automatically achieved equality between risk adjustment payments and charges in each benefit year. As set forth in prior discussions,[10] use of the plan's own premium or a similar parameter would have required the application of a balancing adjustment in light of the program's budget neutrality—either reducing payments to issuers owed a payment, increasing charges on issuers due a charge, or splitting the difference in some fashion between issuers owed payments and issuers assessed charges. Such adjustments would have impaired the risk adjustment program's goals, as discussed above, of encouraging issuers to rate for the average risk in the applicable state market risk pool, and avoiding the creation of incentives for issuers to operate less efficiently, set higher prices, or develop benefit designs or create marketing strategies to avoid high-risk enrollees. Use of an after-the-fact balancing adjustment is also less predictable for issuers than a methodology that can be calculated in advance of a benefit year. Such predictability is important to serving the risk adjustment program's goals of premium stabilization and reducing issuer incentives to avoid enrolling higher-risk populations. Additionally, using a plan's own premium to scale transfers may provide additional incentive for plans with high-risk enrollees to increase premiums in order to receive additional risk adjustment payments. As noted by commenters to the 2014 Payment Notice proposed rule, transfers may be more volatile from year to year and sensitive to anomalous premiums if they were scaled to a plan's own premium instead of the statewide average premium. In the 2014 Payment Notice final rule, we noted that we received a number of comments in support of our proposal to use statewide average premium as the basis for risk adjustment transfers, while some commenters expressed a desire for HHS to use a plan's own premium. HHS addressed those comments by reiterating that we had considered the use of a plan's own premium instead of statewide average premium and chose to use statewide average premium, as this approach supports the overall goals of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to employ risk-avoidance techniques.

Although HHS has not yet calculated risk adjustment payments and charges for the 2018 benefit year, immediate administrative action is imperative to maintain the stability and predictability in the individual and small group insurance markets. This proposed rule would ensure that collections and payments may be made for the 2018 benefit year in a timely manner. Without this administrative action, the uncertainty related to the HHS-operated risk adjustment methodology for the 2018 benefit year could add uncertainty to the individual and small group markets, as issuers are now in the process of determining the extent of their market participation and the rates and benefit designs for plans they will offer for the 2019 benefit year. Issuers file rates for the 2019 benefit year during the summer of 2018, and if there is uncertainty as to whether payments for the 2018 benefit year will be made, there is a serious risk that issuers will substantially increase 2019 premiums to account for the uncompensated risk associated with high-risk enrollees. Consumers enrolled in certain plans could see a significant premium increase, which could make coverage in those plans particularly unaffordable for unsubsidized enrollees. Furthermore, issuers are currently making decisions on whether to offer qualified health plans (QHPs) through the Exchanges for the 2019 benefit year, and, for the Federally-facilitated Exchange (FFE), this decision must be made before the August 2018 deadline to finalize QHP agreements. In states with limited Exchange options, a QHP issuer exit would restrict consumer choice, and put additional upward pressure on Exchange premiums, thereby increasing the cost of coverage for unsubsidized individuals and federal spending for premium tax credits. The combination of these effects could lead to significant, involuntary coverage losses in certain state market risk pools.

Additionally, HHS's failure to make timely risk adjustment payments could impact the solvency of plans providing coverage to sicker (and costlier) than average enrollees that require the influx of risk adjustment payments to continue operations. When state regulators determine issuer solvency, any uncertainty surrounding risk adjustment transfers jeopardizes regulators' ability to make decisions that protect consumers and support the long-term health of insurance markets.

[9] It has been suggested that the annual lump sum appropriation to CMS for program management was potentially available for risk adjustment payments. The lump sum appropriation for each year was not enacted until after the applicable rule announcing payments for the applicable benefit year. Moreover, HHS does not believe that the lump sum is legally available for risk adjustment payments. As the underlying budget requests reflect, the annual lump sum was for program management expenses, such as administrative costs for various CMS programs such as Medicaid, Medicare, the Children's Health Insurance Program, and the PPACA's insurance market reforms—not for the program payments themselves. CMS would have elected to use the lump sum for these important program management expenses even if CMS had discretion to use all or part of the lump sum for risk adjustment payments.

[10] See for example, September 12, 2011, *Risk Adjustment Implementation Issues*, White Paper, available at: *https://www.cms.gov/CCIIO/Resources/Files/Downloads/riskadjustment_whitepaper_web.pdf*.

In light of the district court's decision to vacate the use of statewide average premium in the risk adjustment methodology on the ground that HHS did not adequately explain its decision to adopt that aspect of the methodology, we offer an additional explanation in this rule and are proposing to maintain the use of statewide average premium in the applicable state market risk pool for the payment transfer formula under the HHS-operated risk adjustment methodology for the 2018 benefit year. Therefore, HHS proposes to adopt the methodology previously established for the 2018 benefit year in the **Federal Register** publications cited above that applies to the calculation, collection and payment of risk adjustment transfers under the HHS-operated methodology for the 2018 benefit year. This includes the adjustment to the statewide average premium, reducing it by 14 percent, to account for an estimated proportion of administrative costs that do not vary with claims.[11] We seek comment on the proposal to use the statewide average premium. However, in order to protect the settled expectations of issuers that structured their pricing and offering decisions in reliance on the previously promulgated 2018 benefit year methodology, all other aspects of the risk adjustment methodology are outside of the scope of this rulemaking, and HHS does not seek comment on those finalized aspects.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*).

IV. Regulatory Impact Analysis

A. Statement of Need

This rule proposes to maintain statewide average premium as the cost-scaling factor in the HHS-operated risk adjustment methodology and continue the operation of the program in a budget neutral manner for the 2018 benefit year to protect consumers from the effects of adverse selection and premium increases due to issuer uncertainty. The Premium Stabilization Rule, previous Payment Notices, and other rulemakings noted above provided detail on the implementation of the risk adjustment program, including the specific parameters applicable for the 2018 benefit year.

B. Overall Impact

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), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs. 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).

OMB has determined that this proposed rule is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any 1 year. In addition, for the reasons noted above, OMB has determined that this is a major rule under the Congressional Review Act.

This proposed rule offers further explanation of budget neutrality and the use of statewide average premium in the risk adjustment payment transfer formula when HHS is operating the permanent risk adjustment program established in section 1343 of the PPACA on behalf of a state for the 2018 benefit year. We note that we previously estimated transfers associated with the risk adjustment program in the Premium Stabilization Rule and the 2018 Payment Notice, and that the provisions of this proposed rule do not change the risk adjustment transfers previously estimated under the HHS-operated risk adjustment methodology established in those final rules. The approximate estimated risk adjustment transfers for the 2018 benefit year are $4.8 billion. As such, we also incorporate into this proposed rule the RIA in the 2018 Payment Notice proposed and final rules.

V. 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 proposed rule, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Dated: July 30, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: August 2, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–17142 Filed 8–8–18; 4:15 pm]

BILLING CODE 4120–01–P

[11] See 81 FR 94058 at 94099.

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 11

[PS Docket Nos. 15–94, 15–91; FCC 18–94]

Emergency Alert System; Wireless Emergency Alerts

AGENCY: Federal Communications Commission.

ACTION: Further notice of proposed rulemaking.

SUMMARY: In this document, the Federal Communications Commission (FCC or Commission) seeks comment on whether additional alert reporting measures are needed; whether State EAS Plans should be required to include procedures to help prevent false alerts, or to swiftly mitigate their consequences should a false alert occur; and on factors that might delay or prevent delivery of Wireless Emergency Alerts (WEA) to members of the public and measures the Commission could take to address inconsistent WEA delivery.

DATES: Comments are due on or before September 10, 2018 and reply comments are due on or before October 9, 2018.

ADDRESSES: You may submit comments, identified by PS Docket Nos. 15–94, 15–91 by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Federal Communications Commission's Website: http://www.fcc.gov/ecfs/.* Follow the instructions for submitting comments.

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Final rule

§ 380.10 [Corrected]

■ 2. On page 61125, in the third column, in § 380.10, in paragraph (a)(2), "$0.0019" is corrected to read "$0.0018".

Dated: December 3, 2018.

David R. Strickler,

Copyright Royalty Judge.

[FR Doc. 2018-26606 Filed 12-7-18; 8:45 am]

BILLING CODE 1410-72-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS-9919-F]

RIN 0938-AT66

Patient Protection and Affordable Care Act; Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program for the 2018 Benefit Year Final Rule

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

ACTION: Final rule.

SUMMARY: This final rule adopts the HHS-operated risk adjustment methodology for the 2018 benefit year. In February 2018, a district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years. Following review of all submitted comments to the proposed rule, HHS is adopting for the 2018 benefit year an HHS-operated risk adjustment methodology that utilizes the statewide average premium and is operated in a budget-neutral manner, as established in the final rules published in the March 23, 2012 and the December 22, 2016 editions of the **Federal Register**.

DATES: The provisions of this final rule are effective on February 8, 2019.

FOR FURTHER INFORMATION CONTACT: Abigail Walker, (410) 786-1725; Adam Shaw, (410) 786-1091; Jaya Ghildiyal, (301) 492-5149; or Adrianne Patterson, (410) 786-0686.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) was enacted on March 30, 2010. These statutes are collectively referred to as "PPACA" in this final rule. Section 1343 of the PPACA established an annual permanent risk adjustment program under which payments are collected from health insurance issuers that enroll relatively low-risk populations, and payments are made to health insurance issuers that enroll relatively higher-risk populations. Consistent with section 1321(c)(1) of the PPACA, the Secretary is responsible for operating the risk adjustment program on behalf of any state that elects not to do so. For the 2018 benefit year, HHS is responsible for operation of the risk adjustment program in all 50 states and the District of Columbia.

HHS sets the risk adjustment methodology that it uses in states that elect not to operate risk adjustment in advance of each benefit year through a notice-and-comment rulemaking process with the intention that issuers will be able to rely on the methodology to price their plans appropriately (see 45 CFR 153.320; 76 FR 41930, 41932 through 41933; 81 FR 94058, 94702 (explaining the importance of setting rules ahead of time and describing comments supporting that practice)).

In the July 15, 2011 **Federal Register** (76 FR 41929), we published a proposed rule outlining the framework for the risk adjustment program. We implemented the risk adjustment program in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73117), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2014 benefit year and other parameters related to the risk adjustment program (proposed 2014 Payment Notice). We published the 2014 Payment Notice final rule in the March 11, 2013 **Federal Register** (78 FR 15409). In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed a modification to the HHS-operated risk adjustment methodology related to community rating states. In the October 30, 2013 **Federal Register** (78 FR 65046), we finalized this proposed modification related to community rating states. We published a correcting amendment to the 2014 Payment Notice final rule in the November 6, 2013 **Federal Register** (78 FR 66653) to address how an enrollee's age for the risk score calculation would be determined under the HHS-operated risk adjustment methodology.

In the December 2, 2013 **Federal Register** (78 FR 72321), we published a proposed rule outlining the Federally certified risk adjustment methodologies for the 2015 benefit year and other parameters related to the risk adjustment program (proposed 2015 Payment Notice). We published the 2015 Payment Notice final rule in the March 11, 2014 **Federal Register** (79 FR 13743). In the May 27, 2014 **Federal Register** (79 FR 30240), the 2015 fiscal year sequestration rate for the risk adjustment program was announced.

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2016 benefit year and other parameters related to the risk adjustment program (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

In the December 2, 2015 **Federal Register** (80 FR 75487), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2017 benefit year and other parameters related to the risk adjustment program (proposed 2017 Payment Notice). We published the 2017 Payment Notice final rule in the March 8, 2016 **Federal Register** (81 FR 12204).

In the September 6, 2016 **Federal Register** (81 FR 61455), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2018 benefit year and other parameters related to the risk adjustment program (proposed 2018 Payment Notice). We published the 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058).

In the November 2, 2017 **Federal Register** (82 FR 51042), we published a proposed rule outlining the federally certified risk adjustment methodology for the 2019 benefit year. In that proposed rule, we proposed updates to the risk adjustment methodology and amendments to the risk adjustment data validation process (proposed 2019 Payment Notice). We published the 2019 Payment Notice final rule in the April 17, 2018 **Federal Register** (83 FR 16930). We published a correction to the 2019 risk adjustment coefficients in the 2019 Payment Notice final rule in the May 11, 2018 **Federal Register** (83 FR 21925). On July 27, 2018, consistent with § 153.320(b)(1)(i), we updated the 2019 benefit year final risk adjustment model coefficients to reflect an additional recalibration related to an

update to the 2016 enrollee-level EDGE dataset.[1]

In the July 30, 2018 **Federal Register** (83 FR 36456), we published a final rule that adopted the 2017 benefit year HHS-operated risk adjustment methodology set forth in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352). The final rule provided an additional explanation of the rationale for use of statewide average premium in the HHS-operated risk adjustment state payment transfer formula for the 2017 benefit year, including why the program is operated in a budget-neutral manner. That final rule permitted HHS to resume 2017 benefit year program operations, including collection of risk adjustment charges and distribution of risk adjustment payments. HHS also provided guidance as to the operation of the HHS-operated risk adjustment program for the 2017 benefit year in light of publication of the final rule.[2]

In the August 10, 2018 **Federal Register** (83 FR 39644), we published the proposed rule concerning the adoption of the 2018 benefit year HHS-operated risk adjustment methodology set forth in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and in the December 22, 2016 **Federal Register** (81 FR 94058 through 94183).

B. The New Mexico Health Connections Court's Order

On February 28, 2018, in a suit brought by the health insurance issuer New Mexico Health Connections, the United States District Court for the District of New Mexico (the district court) vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. The district court reasoned that HHS had not adequately explained its decision to adopt a methodology that used statewide average premium as the cost-scaling factor to ensure that the amount collected from issuers equals the amount of payments made to issuers for the applicable benefit year, that is, a methodology that maintains the budget neutrality of the HHS-operated risk adjustment program for the applicable benefit year.[3] The district court otherwise rejected New Mexico Health Connections' arguments.

C. The PPACA Risk Adjustment Program

The risk adjustment program provides payments to health insurance plans that enroll populations with higher-than-average risk and collects charges from plans that enroll populations with lower-than-average risk. The program is intended to reduce incentives for issuers to structure their plan benefit designs or marketing strategies to avoid higher-risk enrollees and lessen the potential influence of risk selection on the premiums that plans charge. Instead, issuers are expected to set rates based on average risk and compete based on plan features rather than selection of healthier enrollees. The program applies to any health insurance issuer offering plans in the individual, small group and merged markets, with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.[4] In 45 CFR part 153, subparts A, B, D, G, and H, HHS established standards for the administration of the permanent risk adjustment program. In accordance with § 153.320, any risk adjustment methodology used by a state, or by HHS on behalf of the state, must be a federally certified risk adjustment methodology.

As stated in the 2014 Payment Notice final rule, the federally certified risk adjustment methodology developed and used by HHS in states that elect not to operate a risk adjustment program is based on the premise that premiums for that state market should reflect the differences in plan benefits and efficiency—not the health status of the enrolled population.[5] HHS developed the risk adjustment state payment transfer formula that calculates the difference between the revenues required by a plan based on the projected health risk of the plan's enrollees and the revenues that the plan can generate for those enrollees. These differences are then compared across plans in the state market risk pool and converted to a dollar amount based on the statewide average premium. HHS chose to use statewide average premium and normalize the risk adjustment state payment transfer formula to reflect state average factors so that each plan's enrollment characteristics are compared to the state average and the total calculated payment amounts equal total calculated charges in each state market risk pool. Thus, each plan in the state market risk pool receives a risk adjustment payment or charge designed to compensate for risk for a plan with average risk in a budget-neutral manner. This approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and mitigates incentives for issuers to operate less efficiently, set higher prices, or develop benefit designs or create marketing strategies to avoid high-risk enrollees. Such incentives could arise if HHS used each issuer's plan's own premium in the state payment transfer formula, instead of statewide average premium.

II. Provisions of the Proposed Rule and Analysis of and Responses to Public Comments

In the August 10, 2018 **Federal Register** (83 FR 39644), we published a proposed rule that proposed to adopt the HHS-operated risk adjustment methodology as previously established in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and the December 22, 2016 **Federal Register** (81 FR 94058 through 94183) for the 2018 benefit year, with an additional explanation regarding the use of statewide average premium and the budget-neutral nature of the HHS-operated risk adjustment program. We did not propose to make any changes to the previously published HHS-operated risk adjustment methodology for the 2018 benefit year.

As explained above, the district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years on the grounds that HHS did not adequately explain its decision to adopt that aspect of the risk adjustment methodology. The district court recognized that use of statewide average premium maintained the budget neutrality of the program, but concluded that HHS had not adequately explained the underlying decision to adopt a methodology that kept the program budget neutral, that is, a methodology that ensured that amounts

[1] See *Updated 2019 Benefit Year Final HHS Risk Adjustment Model Coefficients*. July 27, 2018. Available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Updtd-Final-HHS-RA-Model-Coefficients.pdf*.

[2] See *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2017-RA-Final-Rule-Resumption-RAOps.pdf*.

[3] *New Mexico Health Connections* v. *United States Department of Health and Human Services et al.*, No. CIV 16–0878 JB/JHR (D.N.M. Feb. 28, 2018). On March 28, 2018, HHS filed a motion requesting that the district court reconsider its decision. A hearing on the motion for reconsideration was held on June 21, 2018. On October 19, 2018, the court denied HHS's motion for reconsideration. See *New Mexico Health Connections* v. *United States Department of Health and Human Services et al.*, No. CIV 16–0878 JB/JHR (D.N.M. Oct. 19, 2018).

[4] See the definition for "risk adjustment covered plan" at § 153.20.

[5] See 78 FR at 15417.

collected from issuers would equal payments made to issuers for the applicable benefit year. Accordingly, HHS provided the additional explanation in the proposed rule.

As explained in the proposed rule, Congress designed the risk adjustment program to be implemented and operated by states if they chose to do so. Nothing in section 1343 of the PPACA requires a state to spend its own funds on risk adjustment payments, or allows HHS to impose such a requirement. Thus, while section 1343 may have provided leeway for states to spend additional funds on their programs if they voluntarily chose to do so, HHS could not have required such additional funding.

We also explained that while the PPACA did not include an explicit requirement that the risk adjustment program be operated in a budget-neutral manner, HHS was constrained by appropriations law to devise a risk adjustment methodology that could be implemented in a budget-neutral fashion. In fact, although the statutory provisions for many other PPACA programs appropriated or authorized amounts to be appropriated from the U.S. Treasury, or provided budget authority in advance of appropriations,[6] the PPACA neither authorized nor appropriated additional funding for risk adjustment payments beyond the amount of charges paid in, and did not authorize HHS to obligate itself for risk adjustment payments in excess of charges collected.[7] Indeed, unlike the Medicare Part D statute, which expressly authorized the appropriation of funds and provided budget authority in advance of appropriations to make Part D risk-adjusted payments, the PPACA's risk adjustment statute made no reference to additional appropriations.[8] Because Congress omitted from the PPACA any provision appropriating independent funding or creating budget authority in advance of an appropriation for the risk adjustment program, we explained that HHS could not—absent another source of appropriations—have designed the program in a way that required payments in excess of collections consistent with binding appropriations law. Thus, Congress did not give HHS discretion to implement a risk adjustment program that was not budget neutral.

Furthermore, the proposed rule explained that if HHS elected to adopt a risk adjustment methodology that was contingent on appropriations from Congress through the annual appropriations process, that would have created uncertainty for issuers regarding the amount of risk adjustment payments they could expect for a given benefit year. That uncertainty would have undermined one of the central objectives of the risk adjustment program, which is to stabilize premiums by assuring issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a higher-risk population compared to other issuers in the state market risk pool. The budget-neutral framework spreads the costs of covering higher-risk enrollees across issuers throughout a given state market risk pool, thereby reducing incentives for issuers to engage in risk-avoidance techniques such as designing or marketing their plans in ways that tend to attract healthier individuals, who cost less to insure.

Moreover, the proposed rule noted that relying on each year's budget process for appropriation of additional funds to HHS that could be used to supplement risk adjustment transfers would have required HHS to delay setting the parameters for any risk adjustment payment proration rates until well after the plans were in effect for the applicable benefit year. The proposed rule also explained that any later-authorized program management appropriations made to CMS were not intended to be used for supplementing risk adjustment payments, and were allocated by the agency for other, primarily administrative, purposes. Specifically, it has been suggested that the annual lump sum appropriation to CMS for program management (CMS Program Management account) was potentially available for risk adjustment payments. The lump sum appropriation for each year was not enacted until after the applicable rule announcing the HHS-operated methodology for the applicable benefit year, and therefore could not have been relied upon in promulgating that rule. Additionally, as the underlying budget requests reflect, the CMS Program Management account was intended for program management expenses, such as administrative costs for various CMS programs such as Medicaid, Medicare, the Children's Health Insurance Program, and the PPACA's insurance market reforms—not for the program payments under those programs. CMS would have elected to use the CMS Program Management account for these important program management expenses, rather than program payments for risk adjustment, even if CMS had discretion to use all or part of the lump sum for such program payments. Without the adoption of a budget-neutral framework, we explained that HHS would have needed to assess a charge or otherwise collect additional funds, or prorate risk adjustment payments to balance the calculated risk adjustment transfer amounts. The resulting uncertainty would have conflicted with the overall goals of the risk adjustment program—to stabilize premiums and to reduce incentives for issuers to avoid enrolling individuals with higher-than-average actuarial risk.

In light of the budget-neutral framework discussed above, the proposed rule explained that we also chose not to use a different parameter for the state payment transfer formula under the HHS-operated methodology, such as each plan's own premium, that would not have automatically achieved equality between risk adjustment payments and charges in each benefit year. As set forth in prior discussions,[9] use of the plan's own premium or a similar parameter would have required the application of a balancing adjustment in light of the program's budget neutrality—either reducing payments to issuers owed a payment, increasing charges on issuers due a charge, or splitting the difference in some fashion between issuers owed payments and issuers assessed charges. Using a plan's own premium would have frustrated the risk adjustment program's goals, as discussed above, of encouraging issuers to rate for the average risk in the applicable state market risk pool, and avoiding the creation of incentives for issuers to operate less efficiently, set higher prices, or develop benefit designs or create marketing strategies to avoid high-risk enrollees. Use of an after-the-fact balancing adjustment is also less predictable for issuers than a

[6] For examples of PPACA provisions appropriating funds, *see* PPACA secs. 1101(g)(1), 1311(a)(1), 1322(g), and 1323(c). For examples of PPACA provisions authorizing the appropriation of funds, *see* PPACA secs. 1002, 2705(f), 2706(e), 3013(c), 3015, 3504(b), 3505(a)(5), 3505(b), 3506, 3509(a)(1), 3509(b), 3509(e), 3509(f), 3509(g), 3511, 4003(a), 4003(b), 4004(j), 4101(b), 4102(a), 4102(c), 4102(d)(1)(C), 4102(d)(4), 4201(f), 4202(a)(5), 4204(b), 4206, 4302(a), 4304, 4305(a), 4305(c), 5101(h), 5102(e), 5103(a)(3), 5203, 5204, 5206(b), 5207, 5208(b), 5210, 5301, 5302, 5303, 5304, 5305(a), 5306(a), 5307(a), and 5309(b).

[7] *See* 42 U.S.C. 18063.

[8] *Compare* 42 U.S.C. 18063 (failing to specify source of funding other than risk adjustment charges), *with* 42 U.S.C. 1395w–116(c)(3) (authorizing appropriations for Medicare Part D risk adjusted payments); 42 U.S.C. 1395w–115(a) (establishing "budget authority in advance of appropriations Acts" for Medicare Part D risk adjusted payments).

[9] See for example, September 12, 2011, *Risk Adjustment Implementation Issues White Paper*, available at *https://www.cms.gov/CCIIO/Resources/Files/Downloads/riskadjustment_whitepaper_web.pdf*.

methodology that is established before the benefit year. We explained that such predictability is important to serving the risk adjustment program's goals of premium stabilization and reducing issuer incentives to avoid enrolling higher-risk populations.

Additionally, the proposed rule noted that using a plan's own premium to scale transfers may provide additional incentives for plans with high-risk enrollees to increase premiums in order to receive higher risk adjustment payments. As noted by commenters to the 2014 Payment Notice proposed rule, transfers also may be more volatile from year to year and sensitive to anomalous premiums if they were scaled to a plan's own premium instead of the statewide average premium. In the 2014 Payment Notice final rule, we noted that we received a number of comments in support of our proposal to use statewide average premium as the basis for risk adjustment transfers, while some commenters expressed a desire for HHS to use a plan's own premium.[10] HHS addressed those comments by reiterating that we had considered the use of a plan's own premium, but chose to use statewide average premium, as this approach supports the overall goals of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to employ risk-avoidance techniques.[11]

The proposed rule also explained that although HHS has not yet calculated risk adjustment payments and charges for the 2018 benefit year, immediate administrative action was imperative to maintain stability and predictability in the individual, small group and merged insurance markets. Without administrative action, the uncertainty related to the HHS-operated risk adjustment methodology for the 2018 benefit year could add uncertainty to the individual, small group and merged markets, as issuers determine the extent of their market participation and the rates and benefit designs for plans they will offer in future benefit years. Without certainty regarding the 2018 benefit year HHS-operated risk adjustment methodology, there was a serious risk that issuers would substantially increase future premiums to account for the potential of uncompensated risk associated with high-risk enrollees. Consumers enrolled in certain plans with benefit and network structures that appeal to higher risk enrollees could see a significant premium increase, which could make coverage in those plans particularly unaffordable for unsubsidized enrollees. In states with limited Exchange options, a qualified health plan issuer exit would restrict consumer choice, and could put additional upward pressure on premiums, thereby increasing the cost of coverage for unsubsidized individuals and federal spending for premium tax credits. The combination of these effects could lead to involuntary coverage losses in certain state market risk pools.

Additionally, the proposed rule explained that HHS's failure to make timely risk adjustment payments could impact the solvency of issuers providing coverage to sicker (and costlier) than average enrollees that require the influx of risk adjustment payments to continue operations. When state regulators evaluate issuer solvency, any uncertainty surrounding risk adjustment transfers hampers their ability to make decisions that protect consumers and support the long-term health of insurance markets.

In response to the district court's February 2018 decision that vacated the use of statewide average premium in the risk adjustment methodology on the grounds that HHS did not adequately explain its decision to adopt that aspect of the methodology, we offered the additional explanation outlined above in the proposed rule, and proposed to maintain the use of statewide average premium in the applicable state market risk pool for the state payment transfer formula under the HHS-operated risk adjustment methodology for the 2018 benefit year. HHS proposed to adopt the methodology previously established for the 2018 benefit year in the **Federal Register** publications cited above that apply to the calculation, collection, and payment of risk adjustment transfers under the HHS-operated methodology for the 2018 benefit year. This included the adjustment to the statewide average premium, reducing it by 14 percent, to account for an estimated proportion of administrative costs that do not vary with claims.[12] We sought comment on the proposal to use statewide average premium. However, in order to protect the settled expectations of issuers that structured their pricing, offering, and market participation decisions in reliance on the previously issued 2018 benefit year methodology, all other aspects of the risk adjustment methodology were outside of the scope of the proposed rule, and HHS did not seek comment on those finalized aspects.

We summarize and respond to the comments received to the proposed rule below. Given the volume of exhibits, court filings, white papers (including all corresponding exhibits), and comments on other rulemakings incorporated by reference in one commenter's letter, we are not able to separately address each of those documents. Instead, we summarize and respond to the significant comments and issues raised by the commenter that are within the scope of this rulemaking.

Comment: One commenter expressed general concerns about policymaking and implementation of the PPACA related to enrollment activity changes, cost-sharing reductions, and short-term, limited-duration plans.

Response: The use of statewide average premium in the HHS-operated risk adjustment methodology, including the operation of the program in a budget-neutral manner, which was the limited subject of the proposed rulemaking, was not addressed by this commenter. In fact, the commenter did not specifically address the risk adjustment program at all. Therefore, the concerns raised by this commenter are outside the scope of the proposed rule, and are not addressed in this final rule.

Comment: Commenters were overwhelmingly in favor of HHS finalizing the rule as proposed, and many encouraged HHS to do so as soon as possible. Many commenters stated that by finalizing this rule as proposed, HHS is providing an additional explanation regarding the operation of the program in a budget-neutral manner and the use of statewide average premium for the 2018 benefit year consistent with the decision of the district court, and is reducing the risk of substantial instability to the Exchanges and individual and small group and merged market risk pools. Many commenters stated that no changes should be made to the risk adjustment methodology for the 2018 benefit year because issuers' rates for the 2018 benefit year were set based on the previously finalized methodology.

Response: We agree that a prompt finalization of this rule is important to ensure the ongoing stability of the individual and small group and merged markets, and the ability of HHS to continue operations of the risk adjustment program normally for the 2018 benefit year. We also agree that finalizing the rule as proposed would maintain stability and ensure predictability of pricing in a budget-neutral framework because issuers relied on the 2018 HHS-operated risk adjustment methodology that used

[10] 78 FR 15410, 15432.

[11] *Id.*

[12] See 81 FR 94058 at 94099.

statewide average premium during rate setting and when deciding in calendar year 2017 whether to participate in the market(s) during the 2018 benefit year.

Comment: Several commenters agreed with HHS's interpretation of the statute as requiring the operation of the risk adjustment program in a budget-neutral manner; several cited the absence of additional funding which would cover any possible shortfall between risk adjustment transfers as supporting the operation of the program in a budget-neutral manner. One commenter highlighted that appropriations can vary from year to year, adding uncertainty and instability to the market(s) if the program relied on additional funding to cover potential shortfalls and was not operated in a budget-neutral manner, which in turn would affect issuer pricing decisions. These commenters noted that any uncertainty about whether Congress would fund risk adjustment payments would deprive issuers of the ability to make pricing and market participation decisions based on a legitimate expectation that risk adjustment transfers would occur as required in HHS regulations. Other commenters noted that without certainty of risk adjustment transfers, issuers would likely seek rate increases to account for this further uncertainty and the risk of enrolling a greater share of high-cost individuals. Alternatively, issuers seeking to avoid significant premium increases would be compelled to develop alternative coverage arrangements that fail to provide adequate coverage to people with chronic conditions or high health care costs (for example, narrow networks or formulary design changes). Another commenter pointed to the fact that risk adjustment was envisioned by Congress as being run by the states, and that if HHS were to require those states that run their own program to cover any shortfall between what they collect and what they must pay out, HHS would effectively be imposing an unfunded mandate on states. The commenter noted there is no indication that Congress intended risk adjustment to impose such an unfunded mandate. Another commenter expressed that a budget-neutral framework was the most natural reading of the PPACA, with a different commenter stating this framework is implied in the statute.

However, one commenter stated that risk adjustment does not need to operate as budget neutral, as section 1343 of the PPACA does not require that the program be budget neutral, and funds are available to HHS for the risk adjustment program from the CMS Program Management account to offset any potential shortfalls. The commenter also stated that the rationale for using statewide average premium to achieve budget neutrality is incorrect, and that even if budget neutrality is required, any risk adjustment payment shortfalls that may result from using a plan's own premium in the risk adjustment transfer formula could be addressed through pro rata adjustments to risk adjustment transfers. This commenter also stated that the use of statewide average premium is not predictable for issuers trying to set rates, especially for small issuers which do not have a large market share, as they do not have information about other issuers' rates at the time of rate setting. Conversely, many commenters noted that, absent an appropriation for risk adjustment payments, the prorated payments that would result from the use of a plan's own premium in the risk adjustment methodology would add an unnecessary layer of complexity for issuers when pricing and would reduce predictability, resulting in uncertainty and instability in the market(s).

Response: We acknowledged in the proposed rule that the PPACA did not include a provision that explicitly required the risk adjustment program be operated in a budget-neutral manner; however, HHS was constrained by appropriations law to devise a risk adjustment methodology that could be implemented in a budget-neutral fashion. In fact, Congress did not authorize or appropriate additional funding for risk adjustment beyond the amount of charges paid in, and did not authorize HHS to obligate itself for risk adjustment payments in excess of charges collected. In the absence of additional, independent funding or the creation of budget authority in advance of an appropriation, HHS could not make payments in excess of charges collected consistent with binding appropriations law. Furthermore, we agree with commenters that the creation of a methodology that was contingent on Congress agreeing to appropriate supplemental funding of unknown amounts through the annual appropriations process would create uncertainty. It would also delay the process for setting the parameters for any potential risk adjustment proration until well after rates were set and the plans were in effect for the applicable benefit year. In addition to proration of risk adjustment payments to balance risk adjustment transfer amounts, we considered the impact of assessing additional charges or otherwise collecting additional funds from issuers of risk adjustment covered plans as alternatives to the establishment of a budget-neutral framework. All of these after-the-fact balancing adjustments were ultimately rejected because they are less predictable for issuers than a budget-neutral methodology which does not require after-the-fact balancing adjustments, a conclusion supported by the vast majority of comments received. As detailed in the proposed rule, HHS determined it would not be appropriate to rely on the CMS Program Management account because those amounts are designated for administration and operational expenses, not program payments, nor would the CMS Program Management account be sufficient to fund both the payments under the risk adjustment program and those administrative and operational expenses. Furthermore, use of such funds would create the same uncertainty and other challenges described above, as it would require reliance on the annual appropriations process and would require after-the-fact balancing adjustments to address shortfalls. After extensive analysis and evaluation of alternatives, we determined that the best method consistent with legal requirements is to operate the risk adjustment program in a budget-neutral manner, using statewide average premium as the cost scaling factor and normalizing the risk adjustment payment transfer formula to reflect state average factors.

We agree with the commenters that calculating transfers based on a plan's own premium without an additional funding source to ensure full payment of risk adjustment payment amounts would create premium instability. If HHS implemented an approach based on a plan's own premium without an additional funding source, after-the-fact payment adjustments would be required. As explained above, the amount of these payment adjustments would vary from year to year, would delay the publication of final risk adjustment amounts, and would compel issuers with risk that is higher than the state average to speculate on the premium increase that would be necessary to cover an unknown risk adjustment payment shortfall amount. We considered and ultimately declined to adopt a methodology that required an after-the-fact balancing adjustment because such an approach is less predictable for issuers than a budget-neutral methodology that can be calculated in advance of a benefit year. This included consideration of a non-budget neutral HHS-operated risk adjustment methodology that used a plan's own premiums as the cost-scaling

factor, which we discuss in detail later in this preamble. Modifying the 2018 benefit year risk adjustment methodology to use a plan's own premium would reduce the predictability of risk adjustment payments and charges significantly. As commenters stated, the use of a plan's own premium would add an extra layer of complexity in estimating risk adjustment transfers because payments and charges would need to be prorated retrospectively based on the outcome of risk adjustment transfer calculations, but would need to be anticipated in advance of the applicable benefit year for use in issuers' pricing calculations. We do not agree with the commenter that statewide average premium is less predictable than a plan's own premium, as the use of statewide average premium under a budget-neutral framework makes risk adjustment transfers self-balancing, and provides payment certainty for issuers with higher-than-average risk.

After considering the comments submitted, we are finalizing a methodology that operates risk adjustment in a budget-neutral manner using statewide average premium as the cost scaling factor and normalizing the risk adjustment payment transfer formula to reflect state average factors for the 2018 benefit year.

Comment: The majority of the comments supported the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2018 benefit year. Some commenters stated that the risk adjustment program is working as intended, by compensating issuers based on their enrollees' health status, that is, transferring funds from issuers with predominately low-risk enrollees to those with a higher-than-average share of high-risk enrollees. One commenter stated that the program has been highly effective at reducing loss-ratios and ensuring that issuers can operate efficiently, without concern for significant swings in risk from year to year. Although some commenters requested refinements to ensure that the methodology does not unintentionally harm smaller, newer, or innovative issuers, a different commenter noted that the results for all prior benefit years of the risk adjustment program do not support the assertion that the risk adjustment methodology undermines small health plans. This commenter noted that the July 9, 2018 "Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year" found a very strong correlation between the amount of paid claims and the direction and scale of risk adjustment transfers.[13] It also pointed to the American Academy of Actuaries' analysis of 2014 benefit year risk adjustment results, in which 103 of 163 small health plans (those with less than 10 percent of market share) received risk adjustment payments and the average payment was 27 percent of premium.[14] This commenter cited these points as evidence that risk adjustment is working as intended for small issuers. This commenter also cited an Oliver Wyman study that analyzed risk adjustment receipts by health plan member months (that is, issuer size) and found no systematic bias in the 2014 risk adjustment model.[15]

A few commenters stated that use of statewide average premium to scale risk adjustment transfers tends to penalize issuers with efficient care management and lower premiums and rewards issuers for raising rates. One of the commenters also stated that the HHS-operated risk adjustment methodology does not reflect relative actuarial risk, that statewide average premium harms issuers that price below the statewide average, and that the program does not differentiate between an issuer that has lower premiums because of medical cost savings from better care coordination and an issuer that has lower premiums because of healthier-than-average enrollees. The commenter suggested that HHS add a Care Management Effectiveness index into the risk adjustment formula. This commenter also stated that use of a plan's own premium rather than statewide average premium could improve the risk adjustment formula, stating that issuers would not be able to inflate their premiums to "game" the risk adjustment system due to other PPACA requirements such as medical loss ratio, rate review, and essential health benefits, as well as state insurance regulations, including oversight of marketing practices intended to avoid sicker enrollees.

However, other commenters opposed the use of a plan's own premium in the risk adjustment formula based on a concern that it would undermine the risk adjustment program and create incentives for issuers to avoid enrolling high-cost individuals. Some commenters noted the difficulty of determining whether an issuer's low premium was the result of efficiency, mispricing, or a strategy to gain market share, and that the advantages of using statewide average premium outweigh the possibility that use of a plan's own premium could result in better reflection of cost management. One commenter noted that encouraging issuers to set premiums based on market averages in a state (that is, using statewide average premium) promotes market competition based on value, quality of care provided, and effective care management, not on the basis of risk selection. Other commenters strongly opposed the use of a plan's own premium, as doing so would introduce incentives for issuers to attract lower-risk enrollees because they would no longer have to pay their fair share, or because issuers that traditionally attract high-risk enrollees would be incentivized to increase premiums in order to receive larger risk adjustment payments. Others stated that the use of a plan's own premium would add an extra layer of complexity in estimating risk adjustment transfers, and therefore in premium rate setting, because payments and charges would need to be prorated retrospectively based on the outcome of risk adjustment transfer calculations, but would need to be anticipated prospectively as part of issuers' pricing calculations.

One commenter expressed concern that the risk adjustment payment transfer formula exaggerates plan differences in risk because it does not address plan coding differences.

Response: We agree with the majority of commenters that use of statewide average premium will maintain the integrity of the risk adjustment program by discouraging the creation of benefit designs and marketing strategies to avoid high-risk enrollees and promoting market stability and predictability. The benefits of using statewide average premium as the cost scaling factor in the risk adjustment state payment transfer formula extend beyond its role in maintaining the budget neutrality of the program. Consistent with the statute, under the HHS-operated risk adjustment program, each plan in the risk pool receives a risk adjustment payment or charge designed to take into account the plan's risk compared to a plan with average risk. The statewide average premium reflects the statewide average cost and efficiency level and acts as the cost scaling factor in the state payment transfer formula under the HHS-operated risk adjustment methodology. HHS chose to use statewide average premium to encourage issuers to rate for the average risk, to automatically

[13] Available at *https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf*.

[14] American Academy of Actuaries, "Insights on the ACA Risk Adjustment Program," April 2016. Available at *http://actuary.org/files/imce/Insights_on_the_ACA_Risk_Adjustment_Program.pdf*.

[15] Oliver Wyman, "A Story in 4 Charts, Risk Adjustment in the Non-Group Market in 2014," February 24, 2016. Available at *https://health.oliverwyman.com/2016/02/a_story_in_four_char.html*.

achieve equality between risk adjustment payments and charges in each benefit year, and to avoid the creation of incentives for issuers to operate less efficiently, set higher prices, or develop benefits designs or create marketing strategies to avoid high-risk enrollees.

HHS considered and again declined in the 2018 Payment Notice to adopt the use of each plan's own premium in the state payment transfer formula.[16] As we noted in the 2018 Payment Notice, use of a plan's own premium would likely lead to substantial volatility in transfer results and could result in even higher transfer charges for low-risk, low-premium plans because of the program's budget neutrality. Under such an approach, high-risk, high-premium plans would require even greater transfer payments. If HHS applied a balancing adjustment in favor of these plans to maintain the budget-neutral nature of the program after transfers have been calculated using a plan's own premium, low-risk, low-premium plans would be required to pay in an even higher percentage of their plan-specific premiums in risk adjustment transfer charges due to the need to maintain budget neutrality. Furthermore, payments to high-risk, low-premium plans that are presumably more efficient than high-risk, high-premium plans would be reduced, incentivizing such plans to inflate premiums. In other words, the use of a plan's own premium in this scenario would neither reduce risk adjustment charges for low-cost and low-risk issuers, nor would it incentivize issuers to operate at the average efficiency. Alternatively, application of a balancing adjustment in favor of low-risk, low-premium plans could have the effect of under-compensating high-risk plans, increasing the likelihood that such plans would raise premiums. In addition, if the application of a balancing adjustment was split equally between high-risk and low-risk plans, such an after-the-fact adjustment, would create uncertainty and instability in the market(s), and would incentivize issuers to increase premiums to receive additional risk adjustment payments or to employ risk-avoidance techniques. As such, we agree with the commenters that challenges associated with pricing for transfers based on a plan's own premium would create pricing instability in the market, and introduce incentives for issuers to attract lower-risk enrollees to avoid paying their fair share. We also agree that it is very difficult to determine the reason an issuer has lower premiums than the average, since an issuer's low premium could be the result of efficiency, mispricing, or a strategy to gain market share. In all, the advantages of using statewide average premium outweigh the possibility that the use of a plan's own premium could result in better reflection of care or cost management, given the overall disadvantages, outlined above, of using a plan's own premium. HHS does not agree that use of statewide average premium penalizes efficient issuers or that it rewards issuers for raising rates.

Consistent with the 2018 Payment Notice,[17] beginning with the 2018 benefit year, this final rule adopts the 14 percent reduction to the statewide average premium to account for administrative costs that are unrelated to the claims risk of the enrollee population. While low cost plans are not necessarily efficient plans,[18] we believe this adjustment differentiates between premiums that reflect savings resulting from administrative efficiency from premiums that reflect healthier-than-average enrollees. As detailed in the 2018 Payment Notice,[19] to derive this parameter, we analyzed administrative and other non-claims expenses in the Medical Loss Ratio (MLR) Annual Reporting Form and estimated, by category, the extent to which the expenses varied with claims. We compared those expenses to the total costs that issuers finance through premiums, including claims, administrative expenses, and taxes, and determined that the mean administrative cost percentage in the individual, small group and merged markets is approximately 14 percent. We believe this amount represents a reasonable percentage of administrative costs on which risk adjustment should not be calculated.

We disagree that the HHS-operated risk adjustment methodology does not reflect relative actuarial risk or that the use of statewide average premium indicates otherwise. In fact, the risk adjustment models estimate a plan's relative actuarial risk across actuarial value metal levels, also referred to as "simulated plan liability," by estimating the total costs a plan is expected to be liable for based on its enrollees' age, sex, hierarchical condition categories (HCCs), actuarial value, and cost-sharing structure. Therefore, this "simulated plan liability" reflects the actuarial risk relative to the average that can be assigned to each enrollee. We then use an enrollee's plan selection and diagnoses during the benefit year to assign a risk score. Although the HHS risk adjustment models are calibrated on national data, and average costs can vary between geographic areas, relative actuarial risk differences are generally similar nationally. The solved coefficients from the risk adjustment models are then used to evaluate actuarial risk differences between plans. The risk adjustment state payment transfer formula then further evaluates the plan's actuarial risk based on enrollees' health risk, after accounting for factors a plan could have rated for, including metal level, the prevailing level of expenditures in the geographic areas in which the enrollees live, the effect of coverage on utilization (induced demand), and the age and family structure of the subscribers. This relative plan actuarial risk difference compared to the state market risk pool average is then scaled to the statewide average premium. The use of statewide average premium as a cost-scaling factor requires plans to assess actuarial risk, and therefore scales transfers to actuarial differences between plans in state market risk pool(s), rather than differences in premium.

We have been continuously evaluating whether improvements are needed to the risk adjustment methodology, and will continue to do so as additional years' data become available. We decline to amend the risk adjustment methodology to include the Care Management Effectiveness index or a similar adjustment at this time. Doing so would be beyond the scope of this rulemaking, which addresses the use of statewide average premium and the operation of the risk adjustment program in a budget-neutral manner. A change of this magnitude would require significant study and evaluation. Although this type of change is not feasible at present, we will examine the feasibility, specificity, and sensitivity of measuring care management effectiveness through enrollee-level EDGE data for the individual, small group and merged markets, and the benefits of incorporating such measures in the risk adjustment methodology in future benefit years, either through rulemaking or other opportunities in which the public can submit comments. We believe that a robust risk adjustment program encourages issuers to adopt incentives to improve care management effectiveness, as doing so would reduce plans' medical costs. As we stated above, use of statewide average

[16] 81 FR 94100.

[17] 81 FR 94099.

[18] If a plan is a low-cost plan with low claims costs, it could be an indication of mispricing, as the issuer should be pricing for average risk.

[19] 81 FR 94100.

premium in the risk adjustment state payment transfer formula incentivizes plans to apply effective care management techniques to reduce losses, whereas use of a plan's own premium could be inflationary as it benefits plans with higher-than-average costs and higher-than-average premiums.

We are sympathetic to commenters' concerns about plan coding differences, and recognize that there is substantial variation in provider coding practices. We are continuing to strengthen the risk adjustment data validation program to ensure that conditions reported for risk adjustment are accurately coded and supported by medical records, and will adjust risk scores (and subsequently, risk adjustment transfers) beginning with 2017 benefit year data validation results to encourage issuers to continue to improve the accuracy of data used to compile risk scores and preserve confidence in the HHS-operated risk adjustment program.

Comment: Some commenters provided suggestions to improve the risk adjustment methodology, such as different weights for metal tiers, multiple mandatory data submission deadlines, reducing the magnitude of risk scores across the board, and fully removing administrative expenses from the statewide average premium. One commenter stated that, while it did not conceptually take issue with the use of statewide average premium, the payment transfer formula under the HHS-operated risk adjustment methodology creates market distortions and causes overstatement of relative risk differences among issuers. This commenter cited concerns with the use of the Truven MarketScan® data to calculate plan risk scores under the HHS risk adjustment models, and suggested incorporating an adjustment to the calculation of plan risk scores until the MarketScan® data is no longer used.

A few commenters stressed the importance of making changes thoughtfully and over time, and one encouraged HHS to actively seek improvements to avoid unnecessary litigation. Several commenters, while supportive of the proposed rule and its use for the 2018 benefit year, generally stated that the risk adjustment methodology should continue to be improved prospectively. Another commenter stated that the proposed rule did not do enough to improve the risk adjustment program, and encouraged HHS to review and consider suggestions to improve the risk adjustment methodology in order to promote stability and address the concerns raised in lawsuits other than the New Mexico case. One commenter further requested that HHS reopen rulemaking proceedings, reconsider, and revise the Payment Notices for the 2017 and 2019 benefit years under section 553(c) of the Administrative Procedure Act.

Response: We appreciate the feedback on potential improvements to the risk adjustment program, and will continue to consider the suggestions, analysis, and comments received from commenters for potential changes to future benefit years. This rulemaking is intended to provide additional explanation regarding the operation of the program in a budget-neutral manner and the use of statewide average premium for the 2018 benefit year, consistent with the February 2018 decision of the district court. It also requires an expedited timeframe to maintain stability in the health insurance markets following the district court's vacatur of the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2018 benefit year. We intend to continue to evaluate approaches to improve the risk adjustment models' calibration to reflect the individual, small group and merged markets actuarial risk and review additional years' data as they become available to evaluate all aspects of the HHS-operated risk adjustment methodology. We also continue to encourage issuers to submit EDGE server data earlier and more completely for future benefit years. However, the scope of the proposed rule was limited to the use of statewide average premium and the budget-neutral nature of the risk adjustment program for the 2018 benefit year, and consequently, we decline to adopt the various suggestions offered by commenters regarding potential improvements to the 2018 benefit year HHS-operated risk adjustment methodology as to other issues because they are outside the scope of this rule.

We reiterate that HHS is always considering possible ways to improve the risk adjustment methodology for future benefit years. For example, in the 2018 Payment Notice, based on comments received for the 2017 Payment Notice and the March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper,[20] HHS made multiple adjustments to the risk adjustment models and state payment transfer formula, including reducing the statewide average premium by 14 percent to account for the proportion of administrative costs that do not vary with claims, beginning with the 2018 benefit year.[21] HHS also modified the risk adjustment methodology by incorporating a high-cost risk pool calculation to mitigate residual incentive for risk selection to avoid high-cost enrollees, to better account for the average risk associated with the factors used in the HHS risk adjustment models, and to ensure that the actuarial risk of a plan with high-cost enrollees is better reflected in risk adjustment transfers to issuers with high actuarial risk.[22] Other recent changes made to the HHS-operated risk adjustment methodology include the incorporation of a partial year adjustment factor and prescription drug utilization factors.[23] Furthermore, as outlined above, HHS stated in the 2019 Payment Notice that it would recalibrate the risk adjustment model using 2016 enrollee-level EDGE data to better reflect individual, small group and merged market populations.[24] We also consistently seek methods to support states' authority and provide states with flexible options, while ensuring the success of the risk adjustment program.[25] We respond to comments regarding options available to states with respect to the risk adjustment program below. We appreciate the commenters' input and will continue to examine options for potential changes to the HHS-operated risk adjustment methodology in future notice with comment rulemaking.

The requests related to the 2017 and 2019 benefit year rulemakings are outside the scope of the proposed rule and this final rule, which is limited to the 2018 benefit year.

Comment: One commenter suggested that states should have broad authority to cap and limit risk adjustment transfers and charges as necessary, stating that the requirements associated with the flexibility HHS granted to states to request a reduction to risk adjustment transfers beginning in 2020 are too onerous and unclear. The commenter noted that state regulators know their markets best and should have the discretion and authority to implement their own remedial measures without seeking HHS's permission. Conversely, one commenter specifically supported the state flexibility policy set forth in § 153.320(d). A few commenters requested that states be allowed to establish alternatives to statewide

[20] *https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf*

[21] See 81 FR 94100.

[22] See 81 FR 94080.

[23] See 81 FR at 94071 and 94074.

[24] See 83 FR 16940.

[25] *Id.* and 81 FR 29146.

average premium, with one suggesting that this change begin with the 2020 benefit year, and providing as an example the idea that HHS could permit states to aggregate the average premiums of two or more distinct geographic markets within a state.

Response: HHS continually seeks to provide states with flexibility to determine what is best for their state markets. Section 1343 of the PPACA provides states authority to operate their own state risk adjustment programs. Under this authority, a state remains free to elect to operate the risk adjustment program and tailor it to its markets, which could include establishing alternatives to the statewide average premium methodology or aggregating the average premiums of two or more distinct geographic markets within a state. If a state does not elect to operate the risk adjustment program, HHS is required to do so.[26] No state elected to operate the risk adjustment program for the 2018 benefit year; therefore, HHS is responsible for operating the program in all 50 states and the District of Columbia.

In the 2019 Payment Notice, HHS adopted § 153.320(d) to provide states the flexibility, when HHS is operating the risk adjustment program, to request a reduction to the otherwise applicable risk adjustment transfers in the individual, small group, or merged markets by up to 50 percent.[27] This flexibility was established to provide states the opportunity to seek state-specific adjustments to the HHS-operated risk adjustment methodology without the necessity of operating their own risk adjustment programs. It is offered beginning with the 2020 benefit year risk adjustment transfers and, since it involves an adjustment to the transfers calculated by HHS, it will require review and approval by HHS. States requesting such reductions must substantiate the transfer reduction requested and demonstrate that the actuarial risk differences in plans in the applicable state market risk pool are attributable to factors other than systematic risk selection.[28] The process will give HHS the necessary information to evaluate the flexibility requests. We appreciate the comments offered on this flexibility, but note that they are outside the scope of the proposed rule, which was limited to the 2018 benefit year and did not propose any changes to the process established in § 153.320(d). However, we will continue to consider commenter feedback on the process, along with any lessons learned from 2020 benefit year requests.

HHS has consistently acknowledged the role of states as primary regulators[29] of their insurance markets, and we continue to encourage states to examine local approaches under state legal authority as they deem appropriate.

Comment: One commenter detailed the impact of the HHS-operated risk adjustment methodology on the commenter, the CO–OP program's general struggles, and the challenges faced by some non-CO–OP issuers, stating that this is evidence that the HHS-operated risk adjustment methodology is flawed. The commenter urged HHS to make changes discussed above to the methodology to address what it maintains are unintended financial impacts on small issuers that are required to pay large risk adjustment charges, and also challenged the assertion that the current risk adjustment methodology is predictable.

Response: HHS previously recognized and acknowledged that certain issuers, including a limited number of newer, rapidly growing, or smaller issuers, owed substantial risk adjustment charges that they did not anticipate in the initial years of the program. HHS has regularly discussed with issuers and state regulators ways to encourage new participation in the health insurance markets and to mitigate the effects of substantial risk adjustment charges. Program results discussed earlier have shown that the risk adjustment methodology has worked as intended, that risk adjustment transfers correlate with the amount of paid claims rather than issuer size, and that no systemic bias is found when risk adjustment receipts are analyzed by health plan member months. We created an interim risk adjustment reporting process, beginning with the 2015 benefit year, to provide issuers and states with preliminary information about the applicable benefit year's geographic cost factor, billable member months, and state averages such as monthly premiums, plan liability risk score, allowable rating factor, actuarial value, and induced demand factors by market. States may pursue local approaches under state legal authority to address concerns related to insolvencies and competition, including in instances where certain state laws or regulations differentially affect smaller or newer issuers. In addition, as detailed above, beginning with the 2020 benefit year, states may request a reduction in the transfer amounts calculated under the HHS-operated methodology to address state-specific rules or market dynamics to more precisely account for the expected cost of relative risk differences in the state's market risk pool(s).

Finally, HHS has consistently sought to increase the predictability and certainty of transfer amounts in order to promote the premium stabilization goal of the risk adjustment program. Statewide average premium provides greater predictability of an issuer's final risk adjustment receivables than use of a plan's own premium, and we disagree with comments stating that the use of a plan's own premium in the risk adjustment transfer formula would result in greater predictability in pricing. As discussed previously, if a plan's own premium is used as a scaling factor, risk adjustment transfers would not be budget neutral. After-the-fact adjustments would be necessary in order for issuers to receive the full amount of calculated payments, creating uncertainty and lack of predictability.

III. Provisions of the Final Regulations

After consideration of the comments received, this final rule adopts the HHS-operated risk adjustment methodology for the 2018 benefit year which utilizes statewide average premium and operates the program in a budget-neutral manner, as established in the final rules published in the March 23, 2012 and the December 22, 2016 editions of the **Federal Register**.

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*).

V. Regulatory Impact Analysis

A. Statement of Need

The proposed rule and this final rule were published in light of the February 2018 district court decision described above that vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014–2018 benefit years. This final rule adopts the HHS-operated risk adjustment methodology for the 2018 benefit year, maintaining the use of statewide average premium as the cost-scaling factor in the HHS-operated risk adjustment methodology and the

[26] See section 1321(c) of the PPACA.

[27] See 83 FR 16955.

[28] See § 153.320(d) and 83 FR 16960.

[29] See 83 FR 16955. Also see 81 FR 29146 at 29152 (May 11, 2016), available at *https://www.gpo.gov/fdsys/pkg/FR-2016-05-11/pdf/2016-11017.pdf*.

continued operation of the program in a budget-neutral manner, to protect consumers from the effects of adverse selection and premium increases that would result from issuer uncertainty. The Premium Stabilization Rule, previous Payment Notices, and other rulemakings noted above provided detail on the implementation of the risk adjustment program, including the specific parameters applicable for the 2018 benefit year.

B. Overall Impact

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), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs. 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).

OMB has determined that this final rule is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any 1 year. In addition, for the reasons noted above, OMB has determined that this final rule is a major rule under the Congressional Review Act.

This final rule offers further explanation of budget neutrality and the use of statewide average premium in the risk adjustment state payment transfer formula when HHS is operating the permanent risk adjustment program established by section 1343 of the PPACA on behalf of a state for the 2018 benefit year. We note that we previously estimated transfers associated with the risk adjustment program in the Premium Stabilization Rule and the 2018 Payment Notice, and that the provisions of this final rule do not change the risk adjustment transfers previously estimated under the HHS-operated risk adjustment methodology established in those final rules. The approximate estimated risk adjustment transfers for the 2018 benefit year are $4.8 billion. As such, we also incorporate into this final rule the RIA in the 2018 Payment Notice proposed and final rules.[30] This final rule is not subject to the requirements of Executive Order 13771 (82 FR 9339, February 3, 2017) because it is expected to result in no more than *de minimis* costs.

Dated: November 16, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 19, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–26591 Filed 12–7–18; 8:45 am]

BILLING CODE 4120–01–P

[30] 81 FR 61455 and 81 FR 94058.

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 665

RIN 0648–XG025

Pacific Island Pelagic Fisheries; 2018 U.S. Territorial Longline Bigeye Tuna Catch Limits for American Samoa

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Announcement of a valid specified fishing agreement.

SUMMARY: NMFS announces a valid specified fishing agreement that allocates up to 1,000 metric tons (t) of the 2018 bigeye tuna limit for the Territory of American Samoa to identified U.S. longline fishing vessels. The agreement supports the long-term sustainability of fishery resources of the U.S. Pacific Islands, and fisheries development in American Samoa.

DATES: December 7, 2018.

ADDRESSES: NMFS prepared environmental analyses that describe the potential impacts on the human environment that would result from the action. The analyses, identified by NOAA–NMFS–2018–0026, are available from *https://www.regulations.gov/docket?D=NOAA-NMFS-2018-0026*, or from Michael D. Tosatto, Regional Administrator, NMFS Pacific Islands Region (PIR), 1845 Wasp Blvd., Bldg. 176, Honolulu, HI 96818.

The Fishery Ecosystem Plan for Pelagic Fisheries of the Western Pacific (Pelagic FEP) is available from the Western Pacific Fishery Management Council (Council), 1164 Bishop St., Suite 1400, Honolulu, HI 96813, tel 808–522–8220, fax 808–522–8226, or *http://www.wpcouncil.org.*

FOR FURTHER INFORMATION CONTACT: Rebecca Walker, NMFS PIRO Sustainable Fisheries, 808–725–5184.

SUPPLEMENTARY INFORMATION: In a final rule published on October 23, 2018, NMFS specified a 2018 limit of 2,000 t of longline-caught bigeye tuna for the U.S. Pacific Island territories of American Samoa, Guam, and the CNMI (83 FR 53399). NMFS allows each territory to allocate up to 1,000 t of the 2,000 t limit to U.S. longline fishing vessels identified in a valid specified fishing agreement.

On November 19, 2018, NMFS received from the Council a specified fishing agreement between the government of American Samoa and Quota Management, Inc. (QMI). The Council's Executive Director advised that the specified fishing agreement was consistent with the criteria set forth in 50 CFR 665.819(c)(1). NMFS reviewed the agreement and determined that it is consistent with the Pelagic FEP, the Magnuson-Stevens Fishery Conservation and Management Act, implementing regulations, and other applicable laws.

In accordance with 50 CFR 300.224(d) and 50 CFR 665.819(c)(9), vessels identified in the agreement may retain and land bigeye tuna in the western and central Pacific Ocean under the American Samoa limit. NMFS will begin attributing bigeye tuna caught by vessels identified in the agreement to American Samoa starting on December 10, 2018. This is seven days before December 17, 2018, which is the date NMFS forecasted the fishery would reach the CNMI bigeye tuna allocation limit. If NMFS determines that the fishery will reach the American Samoa 1,000-t attribution, we would restrict the retention of bigeye tuna caught by vessels identified in the agreement, unless the vessels are included in a subsequent specified fishing agreement with another U.S. territory, and we would publish a notice to that effect in the **Federal Register**.

Authority: 16 U.S.C. 1801 *et seq.*

CERTIFICATE OF COMPLIANCE WITH RULE 32(a)(7)

In accordance with Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned counsel certifies that this brief complies with the type-volume limitation set forth in Rule 32(a)(7)(B), because this brief, exclusive of the items listed in Rule 32(a)(7)(B)(iii), contains 12,519 words.

Dated: April 22, 2019

/s/ Nancy R. Long
Nancy R. Long
Attorney for Appellee

CERTIFICATE OF DIGITAL SUBMISSION

Counsel for Appellee hereby certifies that all required privacy redactions have been made, which complies with the requirements of Federal Rule of Appellate Procedure 25(a)(5).

Counsel also certifies that the hard copies submitted to the Court are exact copies of the ECF filing from April 22, 2019.

Counsel further certifies that the ECF submission was scanned for viruses with the most recent version of a commercial virus scanning program (Vipre software version 10.1.7359; Definitions version 74532 – 7.80471 [April 22, 2019]; Vipre engine version 3.9.2671.2 – 3.0), and, according to the program, is free of viruses.

Dated: April 22, 2019

/s/ Nancy R. Long
Nancy R. Long
Attorney for Appellee

CERTIFICATE OF SERVICE

I hereby certify that on April 22, 2019, I electronically filed the foregoing Brief of Appellee New Mexico Health Connections with the Clerk of the Court for the United States Court of Appeals for the Tenth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

I further certify that seven (7) printed copies of the Brief of Appellee will be shipped via Federal Express overnight delivery to the Clerk, United States Court of Appeals for the Tenth Circuit, Byron White U.S. Courthouse, 1823 Stout Street, Denver, Colorado 80257-1823, for delivery to the Court within two (2) business days of the above date.

/s/ Nancy R. Long
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