IN THE UNITED STATES COURT OF FEDERAL CLAIMS

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 16-651 C Judge Griggsby

AMENDED COMPLAINT

Plaintiff Blue Cross and Blue Shield of North Carolina ("Plaintiff" or "BCBSNC"), by and through its undersigned counsel, brings this action against Defendant, the United States of America ("Defendant," "United States," or "Government"), and alleges the following:

INTRODUCTION

1. BCBSNC brings this action to recover damages owed by Defendant for violations of the mandatory risk corridor payment obligations prescribed in Section 1342 of the Patient Protection and Affordable Care Act ("ACA"), and its implementing federal regulations.

2. Congress's enactment in 2010 of the ACA marked a major reform in the United States health care market.

3. The market reform extended guaranteed availability of health care to all Americans, and prohibited health insurers from using factors such as health status, medical history, gender, and industry of employment to set premium rates or deny coverage.

4. The ACA introduced scores of previously uninsured or underinsured citizens into the health care marketplace, creating great uncertainty to health insurers, including Plaintiff, that had no previous experience or reliable data to meaningfully assess the risks and set the premiums

for this new population of insureds under the ACA.

5. Congress, recognizing such uncertainty for health insurers, included three premium-stabilization programs in the ACA to help protect health insurers against risk selection and market uncertainty, including the temporary risk corridors program, which mandated that health insurers be paid annual risk corridor payments based on a statutorily prescribed formula to provide health insurers with stability as insurance market reforms began.

6. Under the statutory parameters of the risk corridors program, Qualified Health Plans ("QHPs") – such as Plaintiff – and the federal government share in the risk associated with the new marketplace's uncertainty for each of the temporary program's three years: 2014, 2015 and 2016. If the amount a QHP collects in premiums in any one of these years exceeds its medical expenses by a certain target amount, the QHP will make a payment to the Government. If annual premiums fall short of this target, however, Congress required the Government to make risk corridor payments to the QHP under a formula prescribed in Section 1342.

7. The temporary risk corridors program was designed to ease the transition between the old and new health insurance marketplaces and help stabilize premiums for consumers, and was modeled on a similar program in Medicare Part D signed into law by President George W. Bush.

8. The United States has specifically admitted in writing its statutory and regulatory obligations to pay the full amount of risk corridor payments owed to BCBSNC for calendar years 2014 ("CY 2014"), 2015 ("CY 2015") and 2016 ("CY 2016"), but Defendant has failed to pay the full amount due. Instead, the Government arbitrarily has paid Plaintiff only a pro-rata share of the total amount due, asserting that full payment to BCBSNC is limited by available appropriations, even though no such limits appear anywhere in the ACA or its implementing

regulations.

9. This action seeks damages from the Government of at least $356,251,839.67, which represents the amount of risk corridor payments owed to Plaintiff for CY 2014, CY 2015 and CY 2016.

10. The Supreme Court recently decided in favor of BCBSNC and three other appellee-health insurers in their consolidated appeal in *Maine Community Health Options v. United States.* No. 18-1023, 140 S. Ct. 1308 (2020). In *Maine Community Health Options*, the Supreme Court reversed the Federal Circuit's ruling in *Moda Health Plan, Inc. v. United States*, 892 F. 3d 1311 (Fed. Cir. 2018) and held that: (1) "The Risk Corridors Statute created a government obligation to pay insurers the full amount set out in §1342's [statutory] formula" based on the statute's "express terms and context" (*Maine Cmty.,* 140 S. Ct. at 1319-20); (2) the "shall pay" mandate in §1342, on its "plain terms," was a legally binding "obligation neither contingent on nor limited by the availability of appropriations or other funds" (*id*. at 1321, 1323); (3) Congress did not impliedly repeal the statutory payment obligation through later-enacted appropriations riders (*id*. at 1323-27-); and (4) this Court has jurisdiction under the Tucker Act to award monetary damages against the government based on the "money-mandating" nature of the "shall pay" statutory payment obligation in §1342 (*id*. at 1327-31). The Supreme Court's decision in *Maine Community Health Options* is dispositive of the legal issues in this case.

11. Following the Supreme Court's decision, on June 24, 2020 the Federal Circuit vacated the April 18, 2017 judgment of this Court, which had dismissed Plaintiff's Complaint (*see* Doc. No. 36), and remanded to this Court "for further proceedings consistent with the U.S. Supreme Court's opinion in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020)."

JURISDICTION AND VENUE

12. This Court has jurisdiction over this action and venue is proper in this Court pursuant to the Tucker Act, 28 U.S.C. § 1491(a)(1), because Plaintiff brings claims for damages over $10,000 against the United States founded upon the Government's violations of a money-mandating Act of Congress, a money-mandating regulation of an executive department.

13. The actions and/or decisions of the Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS") at issue in this lawsuit were conducted on behalf of the Defendant United States within the District of Columbia.

PARTIES

14. Plaintiff BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA ("BCBSNC"), an independent licensee of the Blue Cross and Blue Shield Association, is a fully taxed, not-for-profit North Carolina company with headquarters located in Durham, North Carolina, serving nearly 3.9 million customers. BCBSNC was a QHP issuer on the North Carolina Health Insurance Marketplace for CY 2014, CY 2015, and CY 2016.

15. Defendant is THE UNITED STATES OF AMERICA. The Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS") are agencies of the Defendant United States of America.

FACTUAL ALLEGATIONS

Congress Enacts the Patient Protection and Affordable Care Act

16. In 2010, Congress enacted the ACA, Public Law 111-148, 124 Stat. 119.

17. The ACA aimed to increase the number of Americans covered by health insurance and decrease the cost of health care in the U.S.

18. The ACA provides that "each health insurance issuer that offers health insurance

coverage in the individual . . . market in a State must accept every . . . individual in the State that applies for such coverage." 42 U.S.C. § 300gg–1(a).

19. The ACA also bars insurers from charging higher premiums on the basis of a person's health. 42 U.S.C. § 300gg.

20. Beginning on January 1, 2014, individuals and small businesses were permitted to purchase private health insurance through competitive statewide marketplaces called Affordable Insurance Exchanges, Health Benefit Exchanges, "Exchanges," or "Marketplaces." ACA Section 1311 establishes the framework for the Exchanges. *See* 42 U.S.C. § 18031.

21. BCBSNC participated in the ACA Marketplace in North Carolina in CY 2014, CY 2015, and CY 2016.

The ACA's Premium-Stabilization Programs

22. To help protect health insurers against risk selection and market uncertainty, the ACA established three premium-stabilization programs, which began in 2014: temporary reinsurance and risk corridor programs to give insurers payment stability as insurance market reforms began, and an ongoing risk adjustment program that makes payments to health insurance issuers that cover higher-risk populations (*e.g.*, those with chronic conditions) to more evenly spread the financial risk borne by issuers.

23. This action only addresses the temporary, three-year risk corridors program, which began in CY 2014 and expires at the end of CY 2016.

24. Congress's overarching goal of the premium-stabilization programs, along with other Exchange-related provisions and policies in the ACA, was to make affordable health insurance available to individuals who previously did not have access to such coverage, and to help to ensure that every American has access to high-quality, affordable health care by

protecting consumers from increases in premiums due to health insurer uncertainty.

25. Congress also strived to provide certainty and protect against adverse selection in the health care market (when a health insurance purchaser understands his or her own potential health risk better than the health insurance issuer does) while stabilizing premiums in the individual and small group markets as the ACA's market reforms and Exchanges began in 2014.

26. The financial protections that Congress provided in the statutory premium-stabilization programs, including the mandatory risk corridor payments, provided QHPs with the security – backed by federal law and the full faith and credit of the United States – to become participating health insurers in their respective states' ACA markets, at considerable cost to the QHPs, despite the significant financial risks posed by the uncertainty in the new health care markets.

27. Since the ACA's rollout, BCBSNC has worked in partnership with the federal government to make the ACA Exchanges successful in BCBSNC's market by agreeing to participate as a QHP on the North Carolina ACA Exchanges, rolling out competitive rates, and offering a broad spectrum of health insurance products.

28. In CY 2014, BCBSNC was the largest of the two QHPs participating in the North Carolina ACA market, enrolling the majority of insureds in the North Carolina ACA Exchanges. BCBSNC was the only QHP in CY 2014 to offer ACA health insurance plans in all 100 counties in North Carolina.

29. BCBSNC has demonstrated its willingness to be a meaningful partner in the ACA program, and has done so in good faith, with the understanding that the United States would honor its statutory and regulatory commitments regarding the premium-stabilization programs, including the temporary risk corridors program.

The ACA's Risk Corridors Program

30. Section 1342 of the ACA expressly requires the Secretary of HHS to establish a temporary risk corridors program that provides for the sharing in gains or losses resulting from inaccurate rate setting from CY 2014 through CY 2016 between the Government and certain participating health plans in the individual and small group markets. *See* 42 U.S.C. § 18062, attached hereto at Exhibit 01.

31. Congress required the ACA risk corridors program established in Section 1342 to be modeled after a similar program implemented as part of the Medicare Part D prescription drug benefit program that was signed into law by President George W. Bush. *See* 42 U.S.C. § 18062(a), Ex. 01 (mandating that the risk corridors "program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act").

32. The risk corridors program applies only to participating plans that agreed to accept the responsibilities and obligations of QHPs. All insurers that elect to enter into agreements to become QHPs are required by Section 1342(a) of the ACA to participate in the risk corridors program.

33. By enacting Section 1342 of the ACA, Congress recognized that, due to uncertainty about the population entering the Exchanges during the first few years, health insurers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted.

34. Congress intended the ACA's temporary risk corridors provision as an important safety valve for consumers and insurers as millions of Americans would transition to new coverage in a brand new Marketplace, protecting against the uncertainty that health insurers, like

BCBSNC, would face when estimating enrollments and costs resulting from the market reforms by creating a mechanism for sharing risk between the federal government and issuers of QHPs in each of the first three years of the Marketplace.

BCBSNC was a QHP

35. Based on Congress' statutory commitments set forth in the ACA, including, but not limited to, Section 1342 and the risk corridors program, BCBSNC agreed to become a QHP, and to enter into QHP Agreements with CMS, a federal agency within HHS, which QHP Agreements are attached to this Complaint at Exhibits 02 to 04.

36. BCBSNC executed a QHP Agreement on September 11, 2013, which is referred to herein as the "CY 2014 QHP Agreement." *See* Exhibit 02.

37. The CY 2014 QHP Agreement was executed by representatives of the Government who had actual authority to bind the United States, and was entered into with mutual assent and consideration by both parties.

38. Pursuant to Section III.a. of the CY 2014 QHP Agreement, the CY 2014 QHP Agreement had effective dates from the date of execution by the last of the two parties until December 31, 2014, the last day of CY 2014.

39. Section II.d. of the CY 2014 QHP Agreement states that CMS is obligated to "undertake all reasonable efforts to implement systems and processes that will support [QHP] functions."

40. On October 30, 2014, BCBSNC executed a QHP Agreement with terms that were materially and substantially identical to those found in the CY 2014 QHP Agreement, which is referred to herein as the "CY 2015 QHP Agreement." *See* Exhibit 03.

41. The CY 2015 QHP Agreement was executed by representatives of the

Government who had actual authority to bind the United States, and was entered into with mutual assent and consideration by both parties.

42. Pursuant to Section IV.a. of the CY 2015 QHP Agreement, the CY 2015 QHP Agreement had effective dates from the date of execution by the last of the two parties until December 31, 2015, the last day of CY 2015.

43. On September 24, 2015, BCBSNC executed a QHP Agreement with terms that were materially and substantially identical to those found in the CY 2015 QHP Agreement, which is referred to herein as the "CY 2016 QHP Agreement." *See* Exhibit 04.

44. The CY 2016 QHP Agreement was executed by representatives of the Government who had actual authority to bind the United States, and was entered into with mutual assent and consideration by both parties.

45. Pursuant to Section IV.a. of the CY 2016 QHP Agreement, the CY 2016 QHP Agreement has effective dates from the date of execution by the last of the two parties until December 31, 2016, the last day of CY 2016.

46. Guidance from HHS and CMS to Issuers on Federally-Facilitated Exchanges ("FFE") and State Partnership Exchanges on April 5, 2013, stated that, "A signed QHP Agreement with CMS will complete the certification process in an FFE or State Partnership Exchange. The Agreement will highlight and memorialize many of the QHP issuer's statutory and regulatory requirements and will serve as an important reminder of the relationship between the QHP issuer and CMS." Letter from CMS to Issuers on Federally-Facilitated Exchanges and State Partnership Exchanges at 23 (Apr. 5, 2013), attached hereto at Exhibit 05.

47. Before BCBSNC executed the CY 2014, CY 2015, and CY 2016 QHP Agreements, BCBSNC executed dozens of attestations certifying its compliance with the

obligations it was undertaking by agreeing to become, or continuing to act as, a QHP on the ACA Exchanges in North Carolina. Plaintiff submitted its executed attestations for CY 2014 to CMS on April 30, 2013, and Plaintiff's CY 2015 and CY 2016 attestations were submitted via CMS's web-based system on, respectively, June 27, 2014, and May 15, 2015. *See* Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses (Apr. 30, 2013), attached hereto at Exhibit 06.

48. The financial risk sharing that Congress mandated through the risk corridors program was a significant factor in BCBSNC's decision to agree to become a QHP and undertake the many responsibilities and obligations required for BCBSNC to participate in the ACA Exchanges.

The Risk Corridors Payment Methodology

49. Under the risk corridors program, the federal government shares risk with QHP health insurers by collecting charges from a health insurer if the insurer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and by making payments to the insurer if the insurer's QHP premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments.

50. Congress, through Sections 1342(b)(1) and (2) of the ACA, established the payment methodology and formula for the payments in and the payments out to determine the amounts the QHPs must pay to the Secretary of HHS and the amounts the Secretary must pay to the QHPs if the risk corridors threshold is met.

51. The text of Section 1342(b) states:

> **(b) Payment methodology**
>
> **(1) Payments out**
>
> The Secretary shall provide under the program established

> under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> **(2) Payments in**
>
> The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062(b), Ex. 01.

52. To determine whether a QHP pays into, or receives payments from, the risk corridors program, HHS compares allowable costs (essentially, claims costs subject to adjustments for health care quality, health IT, risk adjustment payments and charges and reinsurance payments) and the target amount – the difference between a QHP's earned premiums and allowable administrative costs.

53. Pursuant to the Section 1342(b) formula, each year from CY 2014 through CY 2016, QHPs with allowable costs that are less than 97 percent of the QHP's target amount are required to remit charges for a percentage of those cost savings to HHS, while QHPs with allowable costs greater than 103 percent of the QHP's target amount will receive payments from

HHS to offset a percentage of those losses.

54. Section 1342(b)(1) provides the specific payment formula from HHS to QHPs whose costs in a calendar year exceed their original target amounts by more than three percent.

55. Section 1342(b)(1)(A) requires that if a QHP's allowable costs in a calendar year are more than 103 percent, but not more than 108 percent, of the target amount, then "the Secretary [of HHS] shall pay" to the QHP an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount.

56. Section 1342(b)(1)(B) further requires that if a QHP's allowable costs in a calendar year are more than 108 percent of the target amount, then "the Secretary [of HHS] shall pay" to the QHP an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the allowable costs in excess of 108 percent of the target amount.

57. Alternatively, Section 1342(b)(2) sets forth the amount of charges that must be remitted to HHS by QHPs whose costs in a calendar year are more than three percent below their original target amounts.

58. Section 1342(b)(2)(A) requires that if a QHP's allowable costs in a calendar year are less than 97 percent, but not less than 92 percent, of the target amount, then "the plan shall pay to the Secretary [of HHS]" an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs.

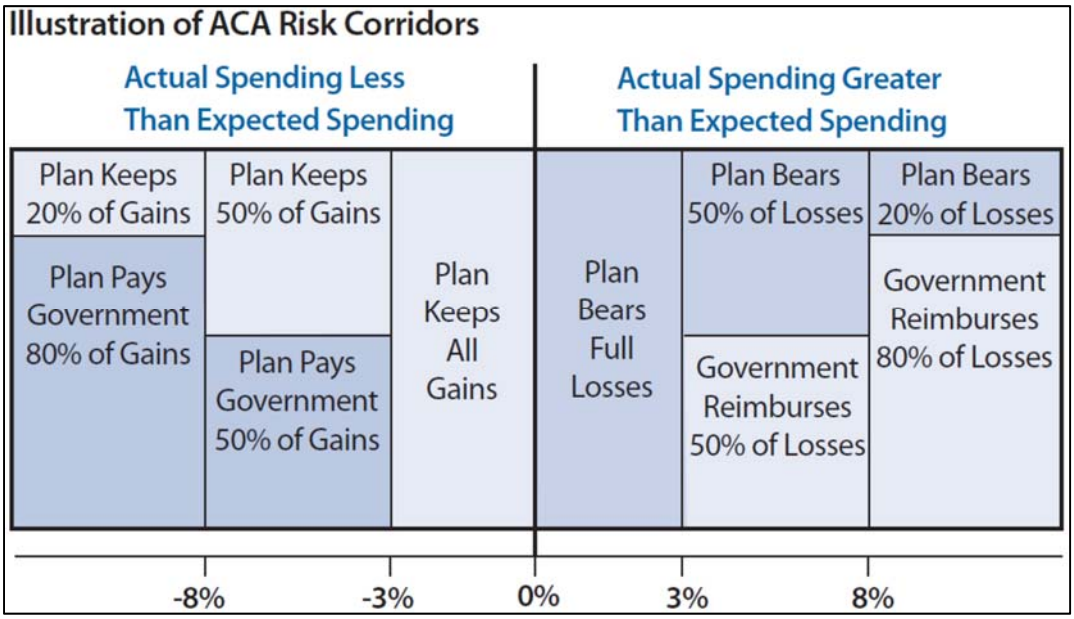
59. Section 1342(b)(2)(B) requires that if a QHP's allowable costs in a calendar year are less than 92 percent of the target amount, then "the plan shall pay to the Secretary [of HHS]" an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

60. Through this risk corridors payment methodology, QHPs keep all gains and bear

all losses that they experience within three percent of their target amount for a calendar year. For example, a QHP that has a target amount of $10 million in a given calendar year will not pay a risk corridors charge or receive a risk corridors payment if its allowable charges range between $9.7 million and $10.3 million for that calendar year.

61. HHS and CMS provided specific examples of risk corridors payment and charge calculations beyond the three percent threshold – published in the Federal Register dated July 15, 2011, at 76 FR 41929, 41943 – which illustrate risk corridor payments the Government must pay under different allowable cost, target amount, and gain and loss scenarios. *See* 76 FR 41929, 41943 (July 15, 2011), attached hereto at Exhibit 07.

62. The American Academy of Actuaries provided an approximate illustration of the risk corridors payment methodology – excluding the charge or payment of 2.5 percent of the target amount for gains or losses greater than eight percent – as follows:



Source: American Academy of Actuaries, *Fact Sheet: ACA Risk-Sharing Mechanisms* (2013), *available at* http://actuary.org/files/ACA_Risk_Share_Fact_Sheet_FINAL120413.pdf, attached hereto at Exhibit 08.

63. As detailed below, in CY 2014, BCBSNC experienced allowable-cost losses of more than three percent of its target amounts in the North Carolina ACA Individual and Small Group Markets, making BCBSNC eligible to receive mandatory risk corridor payments required under Section 1342.

64. Congress did not impose any financial limits or restraints on the Government's mandatory risk corridor payments to QHPs in either Section 1342 or any other section of the ACA.

65. Congress also did not limit in any way the Secretary of HHS's obligation to make full risk corridor payments owed to QHPs, due to appropriations, restriction on the use of funds, or otherwise in Section 1342 or anywhere else in the ACA.

66. Congress has not amended Section 1342 since enactment of the ACA.

67. Congress has not repealed Section 1342.

68. HHS and CMS thus lack statutory authority to pay anything less than 100% of the risk corridor payments due to Plaintiff for CY 2014.

69. On March 11, 2013, HHS publicly affirmed – while health insurers, including BCBSNC, were contemplating whether to agree to participate in the new Exchanges that were opening on January 1, 2014 – that the risk corridors program is not statutorily required to be budget neutral. HHS further confirmed that, "Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 FR 15409, 15473 (Mar. 11, 2013), attached hereto at Exhibit 09.

70. In deciding to become a QHP, BCBSNC relied upon HHS's commitments to make full risk corridor payments annually to it as required in Section 1342 of the ACA regardless of whether risk corridor payments to QHPs are actually greater than risk corridor

charges collected from QHPs for a particular calendar year.

71. The United States, however, has refused to make full and timely risk corridor payments to BCBSNC for CY 2014, CY 2015 and CY 2016 as required by Section 1342.

HHS's Risk Corridors Regulations

72. Congress directed HHS to administer the risk corridors program enacted in Section 1342. *See* 42 U.S.C. § 18062(a), Ex. 01. Accordingly, CMS issued implementing regulations for the risk corridors program at 45 C.F.R. Part 153.

73. In 45 C.F.R. § 153.510, CMS adopted a risk corridors calculation that is mathematically identical to the statutory formulation in Section 1342 of the ACA, using the identical thresholds and risk-sharing levels specified in the statute. *See* 45 C.F.R. § 153.510, attached hereto at Exhibit 10.

74. Specifically, 45 C.F.R. § 153.510(b) prescribes the method for determining risk corridor payment amounts that QHPs "will receive":

> (b) *HHS payments to health insurance issuers*. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:
>
> > (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
> >
> > (2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

75. Furthermore, 45 C.F.R. § 153.510(c) prescribes the circumstances under which QHPs "must remit" charges to HHS, as well as the means by which HHS will determine those

charge amounts:

> (c) *Health insurance issuers' remittance of charges.* QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:
>
> > (1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and
> >
> > (2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

76. Additionally, 45 C.F.R. § 153.510(d) imposes a 30-day deadline for a QHP to fully remit charge payments to HHS when the QHP's allowable costs in a calendar year are less than 97 percent of the QHP's target amount, specifically stating that:

> (d) *Charge submission deadline.* A QHP issuer must remit charges to HHS within 30 days after notification of such charges.

77. CMS did not impose a deadline for HHS to tender full risk corridor payments to QHPs whose allowable costs in a calendar year are greater than 103 percent of the QHP's target amount.

78. During the proposed rulemaking that ultimately resulted in adoption of the 30-day charge-remittance deadline for QHPs at 45 C.F.R. § 153.510(d), however, CMS and HHS stated that the deadline for the Government's payment of risk corridor payments to QHPs should be identical to the deadline for a QHP's remittance of charges to the Government. *See* 76 FR 41929, 41943 (July 15, 2011), Ex. 07; 77 FR 17219, 17238 (Mar. 23, 2012), attached hereto at Exhibit 11.

79. On July 15, 2011, CMS and HHS printed the following in its proposed rule in the

Federal Register:

> HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS within a 30-day period after HHS determines that a payment should be made to the QHP issuer. We believe that QHP issuers who are owed these amounts will want prompt payment, and also believe that the payment deadlines should be the same for HHS and QHP issuers.

76 FR 41929, 41943 (July 15, 2011), Ex. 07.

80. On March 23, 2012, CMS and HHS printed the following in its final rule in the Federal Register:

> While we did not propose deadlines in the proposed rule, we … suggested … that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. *QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers*.

77 FR 17219, 17238 (Mar. 23, 2012), Ex. 11 (emphasis added).

81. Nothing in 45 C.F.R. Part 153 limits CMS's obligation to pay QHPs the full amount of risk corridor payments due based on appropriations, restrictions on the use of funds, or otherwise.

82. BCBSNC relied upon these statements by HHS and CMS in the Federal Register in deciding to agree to become a QHP in North Carolina and accept the obligations and responsibilities of a QHP, believing that the Government would pay the full risk corridor payments owed to it within 30 days after it had been determined that Plaintiff experienced losses sufficient to qualify for risk corridor payments under Section 1342 of the ACA and 45 C.F.R. § 153.510.

83. The United States should have paid BCBSNC the full CY 2014 risk corridor payments due by the end of CY 2015, paid the full CY 2015 risk corridors payments due by the end of CY 2016, and paid the full CY 2016 risk corridors payments due by the end of CY 2017,

but failed to do so.

84. The United States has failed or refused to make full and timely risk corridor payments to BCBSNC for CY 2014, CY 2015 and CY 2016 as required under Section 1342 of the ACA and 45 C.F.R. § 153.510.

HHS and CMS's Recognition of Risk Corridors Payment Obligations

85. Since Congress's enactment of the ACA in 2010, HHS and CMS have repeatedly publicly acknowledged and confirmed to BCBSNC and other QHPs their statutory and regulatory obligations to make full and timely risk corridor payments to qualifying QHPs.

86. These public statements by HHS and CMS were made by representatives of the Government who had actual authority to bind the United States.

87. BCBSNC relied on these public statements by HHS and CMS to assume and continue its QHP status, including its continued participation in the North Carolina ACA Exchanges.

88. On July 11, 2011, HHS issued a fact sheet on HealthCare.gov, "Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment," stating that under the risk corridors program, "qualified health plan issuers with costs greater than three percent of cost projections will receive payments from HHS to offset a percentage of those losses." HealthCare.gov, "Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" (July 11, 2011), attached hereto at Exhibit 12.

89. On March 23, 2012, HHS implemented a final rule regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (77 FR 17219). Although HHS recognized that it did not propose deadlines for making risk corridor payments, HHS stated that "QHP

issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers." 77 FR 17219, 17238 (Mar. 23, 2012), Ex. 11.

90. When HHS implemented a final rule on March 11, 2013, regarding HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15409), HHS confirmed, "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 FR 15409, 15473 (Mar. 11, 2013), Ex. 09.

91. In September 2013, in reliance on the Government's statutory, regulatory and contractual obligations and inducements described above, BCBSNC executed the CY 2014 QHP Agreement and became a QHP. *See* Ex. 02.

92. In HHS's response letter to the U.S. Government Accountability Office ("GAO") dated May 20, 2014, HHS again admitted that "Section 1342(b)(1) … establishes … the formula to determine … the amounts the Secretary must pay to the QHPs if the risk corridors threshold is met." Letter from William B. Schulz, General Counsel, HHS, to Julia C. Matta, Assistant General Counsel, GAO (May 20, 2014), attached hereto at Exhibit 13.

93. On June 18, 2014, HHS sent to U.S. Senator Sessions and U.S. Representative Upton identical letters stating that, "As established in statute, … [QHP] plans with allowable costs at least three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses." Letter from Sylvia M. Burwell, Secretary, HHS, to U.S. Senator Jeff Sessions (June 18, 2014), attached hereto at Exhibit 14.

94. In October 2014, in reliance on the Government's statutory and regulatory obligations and inducements described above, BCBSNC executed the CY 2015 QHP Agreement. *See* Ex. 03.

95. On February 27, 2015, HHS's implementation of a final rule regarding HHS Notice of Benefit and Payment Parameters for 2016 (80 FR 10749), further confirmed that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." 80 FR 10749, 10779 (Feb. 27, 2015), attached hereto at Exhibit 15.

96. CMS's letter to state insurance commissioners on July 21, 2015, stated in boldface text that "**CMS remains committed to the risk corridor program.**" Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to State Insurance Commissioners (July 21, 2015), attached hereto at Exhibit 16.

97. In September 2015, in reliance on the Government's statutory and regulatory obligations and inducements described above, BCBSNC executed the CY 2016 QHP Agreement. *See* Ex. 04.

98. On November 19, 2015, CMS issued a public announcement further confirming that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." Bulletin, CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015), attached hereto at Exhibit 17.

99. HHS and CMS's direct statements to BCBSNC also have unequivocally confirmed the agencies' position that risk corridor payments owed to Plaintiff are a binding obligation of the United States.

100. CMS's letter to BCBSNC on November 2, 2015 stated, "I wish to reiterate to you that the Department of Health and Human Services (HHS) recognizes that the Affordable Care Act *requires* the Secretary to make full payments to issuers." Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to J. Bradley Wilson, President and CEO, BCBSNC (Nov. 2, 2015) (emphasis added), attached hereto at Exhibit 18.

101. Moreover, CMS stated in an email transmitting its November 2, 2015 letter to BCBSNC that the "letter from CMS reiterat[es] that risk corridors payments *are an obligation of the U.S. Government*." Email from Counihan, CMS, to Wilson, BCBSNC (Nov. 2, 2015) (emphasis added), Ex. 18.

The United States' Failure to Honor its Obligations

102. Beginning in 2014, after BCBSNC (which had executed the CY 2014 QHP Agreement in September 2013) had already agreed to participate in the CY 2014 North Carolina ACA Exchanges in reliance upon the Government's risk corridor payment obligations, the Government announced that the United States would not honor those payment obligations.

103. On March 11, 2014, HHS stated in the Federal Register that "HHS intends to implement this [risk corridors] program in a budget neutral manner." 79 FR 13743, 13829 (Mar. 11, 2014), Exhibit 19.

104. This announcement was inconsistent with HHS's prior statement – made exactly one year earlier in the Federal Register, March 11, 2013 – which stated: "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 FR 15409, 15473 (Mar. 11, 2013), Ex. 09.

105. On April 11, 2014, HHS and CMS issued a bulletin entitled "Risk Corridors and Budget Neutrality," which contained HHS and CMS's statement that:

> We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. ***However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall.*** Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund

> current year payments. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Bulletin, CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) (emphasis added), attached hereto at Exhibit 20.

106. The bulletin of April 11, 2014, was the first instance in which HHS and CMS publicly suggested that risk corridor charges collected from QHPs would be less than the Government's full mandatory risk corridor payment obligations owed to QHPs.

107. Only one month earlier, on March 11, 2014, HHS and CMS had publicly announced that "we believe that the risk corridors program as a whole will be budget neutral or, [sic] will result in net revenue to the Federal government in FY 2015 for the 2014 benefit year." 79 FR 13743, 13829 (Mar. 11, 2014), Ex. 19.

108. On December 16, 2014, Congress enacted the Cromnibus appropriations bill for fiscal year 2015, the "Consolidated and Further Continuing Appropriations Act, 2015" (the "2015 Appropriations Act"). Pub. L. 113-235.

109. In the 2015 Appropriations Act, Congress specifically targeted the Government's existing, mandatory risk corridors payment obligations owed to QHPs, including Plaintiff, under Section 1342 of the ACA, limiting appropriations for those payment obligations from three large funding sources by including the following text at Section 227 of the 2015 Appropriations Act:

> ***None of the funds*** made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, ***may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors)***.

128 Stat. 2491 (emphasis added), attached hereto at Exhibit 21.

110. Section 1342(b)(1) of Public Law 111-148 – referenced immediately above – is the ACA's prescribed methodology for the Government's mandatory risk corridor payments to QHPs.

111. Congress's failure to appropriate sufficient funds for risk corridor payments due for CY 2014, without modifying or repealing Section 1342 of the ACA, did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridor payments to QHPs, including Plaintiff.

112. On October 1, 2015, after collecting risk corridors data from QHPs for CY 2014, HHS and CMS announced that it intended to prorate the risk corridors payments owed to QHPs, including Plaintiff, for CY 2014, stating that:

> Based on current data from QHP issuers' risk corridors submissions, issuers will pay $362 million in risk corridors charges, and have submitted for $2.87 billion in risk corridors payments for 2014. **At this time, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent.**

Bulletin, CMS, "Risk Corridors Payment Proration Rate for 2014" (Oct. 1, 2015), attached hereto at Exhibit 22.

113. HHS and CMS further announced on October 1, 2015, that they would be collecting full risk corridors charges from QHPs in November 2015, and would begin making the prorated risk corridor payments to QHPs starting in December 2015. *See id.*

114. HHS and CMS also advised BCBSNC by letter on October 1, 2015, that the Government "will not know the total loss or gain for the [temporary risk corridors] program until the fall of 2017 …. In the event of a shortfall for the 2016 program year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This

includes working with Congress on the necessary funding for outstanding risk corridors payments." Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to J. Bradley Wilson, President and CEO, BCBSNC (Oct. 1, 2015).

115. On April 1, 2016, CMS reaffirmed in a letter to another QHP that – although "remaining risk corridor claims will be paid" – the amounts owed would be delayed and contingent upon the Government's receipt of sufficient risk corridor charges/collections for CY 2015 and/or CY 2016. Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to Highmark Health (Apr. 1, 2016), attached hereto at Exhibit 23. The Government has thus left BCBSNC, and other QHPs owed past-due risk corridor payments, to guess when—if ever—the United States will make the CY 2014 risk corridor payments owed to Plaintiff.

116. HHS and CMS failed to provide Plaintiff with any statutory authority for their unilateral decision to make only partial, prorated risk corridor payments for CY 2014, and to withhold delivery of full risk corridor payments for CY 2014 beyond 2015.

117. Recognizing that the United States was acting in contravention of its statutory and regulatory payment obligations, on November 2, 2015, HHS and CMS sent an email to Mr. Wilson expressly "reiterating that risk corridors payments are an obligation of the U.S. Government," which also included as an attachment a letter to Mr. Wilson stating that:

> I wish to reiterate to you that the Department of Health and Human Services (HHS) recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligations of the United States government for which full payment is required.

Email and Letter from Counihan, CMS, to Wilson, BCBSNC (Nov. 2, 2015), Ex. 18.

118. HHS and CMS made the same acknowledgement in a public bulletin on November 19, 2015, regarding CY 2014 risk corridor payments:

> HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation [sic] of the United States Government for which full payment is required.

Bulletin, CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015), Ex. 17.

119. The Government's written acknowledgement of its risk corridors payment obligation for CY 2014, however, is an insufficient substitute for full and timely payment of the amounts owed as required by statute, regulation and HHS and CMS's previous statements.

120. On December 18, 2015, Congress enacted the Omnibus appropriations bill for fiscal year 2016, the "Consolidated Appropriations Act, 2016" (the "2016 Appropriations Act"). Pub. L. 114-113.

121. In the 2016 Appropriations Act, Congress again specifically targeted the Government's existing, mandatory risk corridor payment obligations owed to QHPs, including Plaintiff, under Section 1342 of the ACA, limiting appropriations for those payment obligations from three large funding sources by including the following text at Section 225 of the 2016 Appropriations Act:

> ***None of the funds*** made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, ***may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors)***.

129 Stat. 2624 (emphasis added), attached hereto at Exhibit 24.

122. Again, Section 1342(b)(1) of Public Law 111-148 is the ACA's prescribed methodology for the Government's mandatory risk corridor payments to QHPs.

123. Congress's failure to appropriate sufficient funds for risk corridor payments due for CY 2014, CY 2015, and CY 2016, without modifying or repealing Section 1342 of the ACA,

did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridor payments to QHPs, including Plaintiff.

BCBSNC's Risk Corridors Payment Amounts for CY 2014

124. In a report released on November 19, 2015, HHS and CMS publicly announced QHPs' risk corridor charges and payments for CY 2014, and emphasized that "**Risk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated.**" Bulletin, CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) ("CY 2014 Risk Corridors Report"), attached hereto at Exhibit 25.

125. BCBSNC's losses in the ACA North Carolina Individual Market for CY 2014 resulted in the Government being required to pay BCBSNC a risk corridors payment of $147,421,876.38. *See* CY 2014 Risk Corridors Report at Table 34 – North Carolina, Ex. 25.

126. BCBSNC's losses in the ACA North Carolina Small Group Market for CY 2014 resulted in the Government being required to pay BCBSNC a risk corridors payment of $53,091.97. *See id.*

127. Unlike some other QHPs, BCBSNC did not have gains in the ACA Individual or Small Group Markets for CY 2014 that resulted in BCBSNC being required to remit risk corridors charges to the Secretary of HHS. *See generally* CY 2014 Risk Corridors Report, Ex. 25.

128. Had BCBSNC been required to remit a risk corridors charge to the Secretary of HHS, then BCBSNC would have been required to remit 100% of the amount of the charge to HHS before the close of calendar year 2015, as it had affirmatively attested it would do. *See id.*; Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation

Responses at 8-9 (Apr. 30, 2013), Ex. 06.

129. In total, the Government is required to pay BCBSNC risk corridor payments for CY 2014 of $147,474,968.35, but to date has only paid a small pro rata fraction thereof.

130. Had BCBSNC been required to remit a risk corridors charge to the Secretary of HHS, then BCBSNC would have been required to pay the Government 100% of its CY 2014 North Carolina Individual or Small Group market risk corridor charges – not some unilaterally determined fraction thereof – and to do so promptly. BCBSNC was ready, willing, and able to satisfy this obligation to which it had attested, had BCBSNC been required to do so.

131. The Government has made some prorated risk corridor payments to Plaintiff totaling $24,695,348.87, as of the date of the filing of this Amended Complaint. This amount represents only approximately 16.8% of CY 2014 risk corridor payments that the Government owes to Plaintiff.

132. HHS lacks the authority, under statute, regulation or contract, to unilaterally withhold full and timely CY 2014 risk corridor payments from QHPs such as BCBSNC.

BCBSNC'S Risk Corridors Payment Amounts for CY 2015

133. In a report released on November 18, 2016, HHS and CMS publicly announced QHPs' risk corridors charges and payments for CY 2015, stating that "all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments," and that "HHS intends to collect the full 2015 risk corridors charge amounts indicated in the tables" printed in the report. Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year* (Nov. 18, 2016) ("CY 2015 Risk Corridors Report"), attached hereto at Exhibit 26.

134. BCBSNC's losses in the ACA North Carolina Individual Market for CY 2015

resulted in the Government being required to pay BCBSNC a risk corridors payment of $214,485,108.80. *See id*. at 8. BCBSNC's losses in the ACA North Carolina Small Group Market for CY 2015 resulted in the Government being required to pay BCBSNC a risk corridors payment of $827,984.90. *See id*. at 8. In total, the Government is required to pay BCBSNC risk corridor payments for CY 2015 of $215,313,093.70. The Government, however, did not make any payments to Plaintiff for the CY 2015 risk corridors amounts owed.

135. The Government lacks the authority, under statute, regulation or contract, to unilaterally withhold full and timely CY 2015 risk corridors payments from QHPs such as BCBSNC.

BCBSNC'S Risk Corridors Payment Amounts for CY 2016

136. In a report released on November 13, 2017, HHS and CMS publicly announced the amount of risk corridors payments the Government owes to QHPs, and the amount of risk corridors charges the Government will collect from QHPs, for the CY 2016 plan year. CMS announced that "HHS will use 2016 benefit year risk corridors collection to make additional payments toward 2014 benefit year balances," indicating that the Government will not make any payments to QHPs, including Independent Health's, toward the Government's CY 2015 or CY 2016 risk corridors amounts still owed. Bulletin, CMS, *Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year* at 1 (Nov. 13, 2017) ("CY 2016 Risk Corridors Report"), attached hereto at Exhibit 27.

137. BCBSNC's losses in the ACA North Carolina Individual Market for CY 2016 resulted in the Government being required to pay BCBSNC a risk corridors payment of $18,159,126.49. *See id*. at 12. The Government, however, did not make any payments to Plaintiff for the CY 2016 risk corridors amounts owed.

138. The Government lacks the authority, under statute, regulation or contract, to unilaterally withhold full and timely CY 2016 risk corridors payments from QHPs such as BCBSNC.

139. In total, the Government owes Plaintiff $356,251,839.67 in unpaid risk corridors payments for CY 2014, CY 2015 and CY 2016 combined (consisting of the total $380,947,188.54 owed less $24,695,348.87 paid to date). The Defendant agrees that amount is the total risk corridors damages owed to Plaintiff. BCBSNC is entitled to receive, and demands, full and immediate payment from the United States.

COUNT I
Violation of Federal Statute and Regulation

140. Plaintiff realleges and incorporates by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

141. Section 1342(b)(1) of the ACA mandates compensation, expressly stating that the Secretary of HHS "shall pay" risk corridor payments to QHPs in accordance with the payment formula set forth in the statute.

142. HHS and CMS's implementing regulation at 45 C.F.R. § 153.510(b) also mandates compensation, expressly stating that HHS "will pay" risk corridor payments to QHPs in accordance with the payment formula set forth in the regulation, which formula is mathematically identical to the formula in Section 1342(b)(1) of the ACA.

143. HHS and CMS's regulation at 45 C.F.R. § 153.510(d) requires a QHP to remit charges to HHS within 30 days after notification of such charges.

144. HHS and CMS's statements in the Federal Register on July 15, 2011, and March 23, 2012, state that risk corridor "payment deadlines should be the same for HHS and QHP issuers." 76 FR 41929, 41943 (July 15, 2011), Ex. 07; 77 FR 17219, 17238 (Mar. 23, 2012), Ex.

11.

145. BCBSNC was a QHP in CY 2014, CY 2015 and CY 2016, *see* Ex. 02-04, and was qualified for and entitled to receive mandated risk corridor payments from the Government.

146. BCBSNC is entitled under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b) to recover full and timely mandated risk corridor payments from the Government for CY 2014.

147. In the CY 2014 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling $147,474,968.35, that the Government concedes it owes BCBSNC for CY 2014. *See* Ex. 25.

148. In the CY 2015 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling $215,313,093.70, that the Government concedes it owes BCBSNC for CY 2015. *See* Ex. 26.

149. In the CY 2016 Risk Corridors Report, HHS and CMS acknowledged and published the full risk corridors payment amount, totaling $18,159,126.49, that the Government concedes it owes BCBSNC for CY 2016. *See* Ex. 27.

150. The United States has failed to make full and timely risk corridor payments to BCBSNC for CY 2014, CY 2015 and CY 2016, despite the Government repeatedly confirming in writing that Section 1342 mandates that the Government make risk corridor payments.

151. Congress's failure to appropriate sufficient funds for risk corridor payments due for CY 2014, CY 2015 and CY 2016, without modifying or repealing Section 1342 of the ACA, did not defeat or otherwise abrogate the United States' statutory obligation created by Section 1342 to make full and timely risk corridor payments to QHPs, including Plaintiff.

152. The Government's failure to make full and timely risk corridor payments to

BCBSNC for CY 2014, CY 2015 and CY 2016 constitutes a violation and breach of the Government's mandatory payment obligations under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b).

153. As a result of the United States' violation of Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b), BCBSNC has been damaged in the amount of at least $356,251,839.67, in unpaid risk corridors payments for CY 2014, CY 2015 and CY 2016 combined.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff demands judgment against the Defendant, the United States of America, as follows:

(1) For Count I, awarding damages sustained by Plaintiff, in the amount of $356,251,839.67, as a result of the Defendant's violation of Section 1342(b)(1) of the ACA and of 45 C.F.R. § 153.510(b) regarding the CY 2014, CY 2015 and CY 2016 risk corridor payments;

(2) Awarding all available interest, including, but not limited to, post-judgment interest, to Plaintiff.

Dated: July 8, 2020

Respectfully Submitted,

s/ Lawrence S. Sher
Lawrence S. Sher (D.C. Bar No. 430469)
REED SMITH LLP
1301 K Street NW
Suite 1000-East Tower
Washington, DC 20005
Telephone: 202.414.9200
Facsimile: 202.414.9299
Email: lsher@reedsmith.com

Of Counsel:

Conor M. Shaffer (PA Bar No. 314474)
REED SMITH LLP

Reed Smith Centre
225 Fifth Avenue, Suite 1200
Pittsburgh, PA 15222
Telephone: 412.288.3131
Facsimile: 412.288.3063
Email: cshaffer@reedsmith.com

Counsel for Plaintiff Blue Cross and Blue Shield of North Carolina

CERTIFICATE OF SERVICE

I hereby certify that on July 8th, 2020, a copy of the foregoing Amended Complaint and accompanying Exhibits were filed electronically with the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing with be sent to all parties by operation of the Court's ECF system.

s/ Lawrence S. Sher
Lawrence S. Sher
Counsel for Plaintiff

EXHIBIT 1

ation under chapter 1 of title 26. The preceding sentence shall not apply to the tax imposed by section 511 such[3] title (relating to tax on unrelated business taxable income of an exempt organization).

(d) Coordination with State high-risk pools

The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

(Pub. L. 111–148, title I, §1341, title X, §10104(r), Mar. 23, 2010, 124 Stat. 208, 906.)

AMENDMENTS

2010—Pub. L. 111–148, §10104(r)(1), substituted ''market'' for ''and small group markets'' in section catchline.

Subsec. (b)(2)(B). Pub. L. 111–148, §10104(r)(2), substituted ''paragraph (1)(B)'' for ''paragraph (1)(A)'' in introductory provisions.

Subsec. (c)(1)(A). Pub. L. 111–148, §10104(r)(3), substituted ''individual market'' for ''individual and small group markets''.

§ 18062. Establishment of risk corridors for plans in individual and small group markets

(a) In general

The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.].

(b) Payment methodology

(1) Payments out

The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) Payments in

The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment and reinsurance payments

Allowable costs shall[1] reduced by any risk adjustment and reinsurance payments received under section[2] 18061 and 18063 of this title.

(2) Target amount

The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

(Pub. L. 111–148, title I, §1342, Mar. 23, 2010, 124 Stat. 211.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part D of title XVIII of the Act is classified generally to part D (§1395w–101 et seq.) of subchapter XVIII of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

§ 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 [29 U.S.C. 1001 et seq.]).

(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 ac-

[3] So in original. Probably should be preceded by ''of''.

[1] So in original. Probably should be followed by ''be''.

[2] So in original. Probably should be ''sections''.

EXHIBIT 2

BlueCross BlueShield of North Carolina

September 10, 2013

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Re: Executed Agreement between Qualified Health Plan Issuer and the Centers for Medicare and Medicaid Services

Dear Sir or Madam:

Blue Cross and Blue Shield of North Carolina ("BCBSNC") submits the attached executed Agreement between Qualified Health Plan Issuer ("QHPI") and the Centers for Medicare and Medicaid Services ("CMS") (the "Agreement").

BCBSNC has been involved with CMS and multiple industry trade groups regarding health care reform and, in particular, this agreement. We, like others in the industry, have expressed concern about the permitted uses, access, and disclosure of personally identifiable information ("PII") under the Agreement, as well as the privacy and security obligations of the QHPI in terms of "affiliated entities," agents and brokers (some of whom may be captive), among others. From communications between CMS and these trade groups, we understand that CMS has heard our collective concerns and intends to issue formal clarifying guidance, whether through additional or revised FAQs or other guidance, that address more definitively these and other issues. At present, we understand and have relied upon the following:

- The Minimum Acceptable Risk Standards for Exchanges ("MARS-E") suite of security requirements do not apply to a QHPI who is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), with respect to the information that the QHPI creates, collects, discloses, accesses, maintains, uses, or stores that has been received from the CMS Data Services Hub Web Services.
- A QHPI must require its employees, officers, directors, contractors, agents, and representatives to strictly adhere to the terms of the Agreement, including applicable law (namely HIPAA and Section 1411(g) of the Affordable Care Act for purposes of confidentiality of applicant information).
- There will be no separate privacy or security agreements for QHPIs participating in Direct Enrollment at the company level, only at the level of an individual broker or agent.

In addition to reliance on the above understanding, we are aware of our obligation to act in good faith to comply with applicable standards. We look forward to the opportunity to provide our Members, current and prospective, with benefits through this new marketplace and to continued dialogue with you to encourage the greatest level of success and collaboration in this new marketplace.

Sincerely,
Blue Cross and Blue Shield of North Carolina

Gerald Petkau, SVP and Chief Financial Officer

AGREEMENT BETWEEN QUALIFIED HEALTH PLAN ISSUER AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THIS QUALIFIED HEALTH PLAN ("QHP") ISSUER AGREEMENT ("Agreement") is entered into by and between THE CENTERS FOR MEDICARE & MEDICAID SERVICES "(CMS"), as the Party (as defined below) responsible for the management and oversight of the Federally-facilitated Exchange ("FFE"), including the Federally-facilitated Small Business Health Options Program ("FF-SHOP") and CMS Data Services Hub ("Hub"), and Blue Cross and Blue Shield of NC ("QHPI"), an Issuer that provides Health Insurance Coverage through QHPs offered through the FFE and FF-SHOP to Enrollees; and provides customer service. CMS and QHPI each are hereinafter referred to as a "Party" or, collectively, the "Parties."

WHEREAS:

1. Section 1301(a) of the Affordable Care Act ("ACA") provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish.

2. QHPI is an entity licensed by an applicable State Department of Insurance ("DOI") as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs.

3. QHPI will not, without signing another agreement specified by CMS, assist Consumers, Applicants, Qualified Individuals, Enrollees, Qualified Employers, and Qualified Employees, as applicable, in applying for a determination or redetermination of eligibility for coverage through the FFE or for insurance affordability programs;

4. It is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and QHPI.

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, QHPI and CMS agree as follows:

I. Definitions.

a. **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which are referred to collectively as the Affordable Care Act.

b. **Advance Payments of the Premium Tax Credit (APTC)** has the meaning set forth in 45 CFR 155.20.

c. **Applicant** has the meaning set forth in 45 CFR 155.20.

d. **CMS Companion Guides** means a CMS-authored guide, available on the CMS web site, which is meant to be used in conjunction with and supplement relevant implementation guides published by the Accredited Standards Committee.

e. **CMS Data Services Hub (Hub)** is the CMS Federally-managed service to interface data among connecting entities, including HHS, certain other Federal agencies, and State Medicaid agencies.

f. **CMS Data Services Hub Web Services (Hub Web Services)** means business and technical services made available by CMS to enable the determination of certain eligibility and enrollment or Federal financial payment data through the Federally-facilitated Exchange web site, including the collection of personal and financial information necessary for Consumer, Applicant, Qualified Individual, Qualified Employer, Qualified Employee, or Enrollee account creations; Qualified Health Plan (QHP) application submissions; and Insurance Affordability Program eligibility determinations.

g. **Consumer** means a person who, for himself or herself, or on behalf of another individual, seeks information related to eligibility or coverage through a Qualified Health Plan (QHP) or other Insurance Affordability Program, or whom an agent or broker (including Web-brokers), Navigator, Issuer, Certified Application Counselor, or other entity assists in applying for a coverage through QHP, applying for APTCs and CSRs, and/or completing enrollment in a QHP through its web site for individual market coverage.

h. **Cost-sharing Reduction (CSR)** has the meaning set forth in 45 CFR 155.20.

i. **Day or Days** means calendar days unless otherwise expressly indicated in this Agreement.

j. **Enrollee** has the meaning set forth in 45 CFR 155.20.

k. **Federally-facilitated Exchange (FFE)** means an **Exchange** (or **Marketplace**) established by HHS and operated by CMS under Section 1321(c)(1) of the ACA for individual or small group market coverage, including the Federally-facilitated Small Business Health Options Program (**FF-SHOP**).

l. **Health Insurance Coverage** has the meaning set forth in 45 CFR 155.20.

m. **Health Insurance Portability and Accountability Act (HIPAA)** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and its implementing regulations.

n. **Issuer** has the meaning set forth in 45 CFR 144.103.

o. **Personally Identifiable Information (PII)** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007) and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, *etc.*, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, *etc.*

p. **Qualified Employee** has the meaning set forth in 45 CFR 155.20.

q. **Qualified Employer** has the meaning set forth in 45 CFR 155.20.

r. **Qualified Health Plan (QHP)** has the meaning set forth in 45 CFR 155.20.

s. **Qualified Individual** has the meaning set forth in 45 CFR 155.20.

t. **State** means the State that has licensed the Agent, Broker, or Issuer that is a party to this Agreement or the State where the Certified Application Counselor, Navigator, or Non-Navigator that is a party to this Agreement is operating.

II. Acceptance of Standard Rules of Conduct.

a. QHPI hereby acknowledges and agrees to accept and abide by the standard rules of conduct set forth below, and to require that its employees, officers, directors, contractors, agents, and representatives strictly adhere to the same, in order to gain and maintain access to the CMS Data Services Hub Web Services ("Hub Web Services"). QHPI agrees that it will create, collect, disclose, access, maintain, use, or store PII that it receives from Hub Web Services only in accordance with all laws as applicable, including HIPAA and section 1411(g) of the ACA.

b. Standards for Communication with the Hub.

(1) QHPI must complete testing for each type of transaction it will implement and shall not be allowed to exchange data with CMS in production mode until testing is satisfactorily passed as determined by CMS in its sole discretion. Satisfactorily passed testing generally means the ability to pass all HIPAA compliance standards, and to process electronic healthcare information transmitted by QHPI to the Hub. This capability to submit test transactions will be maintained by QHPI throughout the term of this Agreement.

(2) As applicable, all transactions must be formatted in accordance with the Accredited Standards Committee Implementation Guides, adopted under HIPAA, available at http://store.x12.org/store/. CMS will make available Companion Guides for all applicable transactions, which specify certain situational data elements necessary.

(3) QHPI agrees to abide by the Standard Companion Guide Transaction Information Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Exchange (FFE) Companion Guide Version 1.5, released March 22, 2013, and the CMS Instructions related to the ASC X12 820 transaction as specified in the ASC X12 005010X306 Health Insurance Exchange Related Payments (820) Implementation Guide.

(4) QHPI agrees to submit test transactions to the Hub prior to the submission of any transactions to the FFE production system, to determine that the transactions and responses comply with all requirements and specifications approved by the CMS and/or the CMS contractor.[1]

(5) QHPI agrees that prior to the submission of any additional transaction types to the FFE production system, or as a result of making changes to an existing transaction type or system, it will submit test transactions to the Hub in accordance with paragraph (1) above.

(6) If QHPI enters into relationships with other affiliated entities, or their authorized designees, for submitting and receiving FFE data, it must execute contracts with such entities that stipulate that such entities and any subcontractors or affiliates of

[1] While CMS owns data in the FFE, other contractors operate the FFE system in which the enrollment and financial management data flow. Contractors provide the pipeline network for the transmission of electronic data, including the transport of Exchange data to and from the Hub and QHPI so that QHPI may discern the activity related to enrollment functions of persons they serve. QHPI may also use the transported data to receive descriptions of financial transactions from CMS.

such entities, must be bound by the terms of this Agreement, test software, and receive QHPI's approval of software as being in the proper format and compatible with the FFE system.

c. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

d. CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

III. Effective Date; Term; Renewal.

a. Effective Date and Term. This Agreement becomes effective on the date the last of the two Parties executes this Agreement and ends December 31, 2014.

b. Renewal. This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

IV. Termination.

a. This Agreement shall terminate automatically upon QHPI's ceasing to provide all coverage under any QHPs that were offered through an FFE in the State(s) QHPI offered them.

b. Termination with Cause.

1. Termination with Notice by CMS. CMS may terminate this Agreement for cause upon sixty (60) Days' written notice to QHPI if QHPI materially breaches any term of this Agreement as determined at the sole but reasonable discretion of CMS, unless QHPI commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of CMS in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. A QHPI's inability to perform due to a CMS error will not be considered a material breach. The 60-Day notice from CMS shall contain a description of the material breach and any suggested options for curing the breach(es), whereupon QHPI shall have seven (7) Days from the date of the

notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame may be rejected, approved, or amended in CMS' sole but reasonable discretion. The Agreement shall not be terminated if QHPI cures the cause for termination within 30 Days' of the written notice to the satisfaction of CMS, which satisfaction shall be in CMS' sole discretion but shall not be unreasonably withheld. Notwithstanding the foregoing, QHPI shall be considered in "Habitual Default" of this Agreement in the event that it has been served with a 60-Day notice under this subsection more than three (3) times in any calendar year, whereupon CMS may, in its sole discretion, immediately thereafter terminate this Agreement upon notice to QHPI without any further opportunity to cure or propose cure.

2. Termination with Notice by QHPI. At any time prior to midnight on October 31, 2013, QHPI may terminate this Agreement upon sixty (60) Days' written notice to CMS if CMS materially breaches any term of this Agreement, unless CMS commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of QHPI in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. The 60-Day notice shall contain a description of the material breach(es) and any suggested options for curing the breach(es), whereupon CMS shall have fifteen (15) Days from the date of the notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame shall be accepted by QHPI unless the same is substantially unreasonable on its face, in which case the Parties shall thereafter use good faith efforts to come to an agreement of reasonable cure terms.

c. QHPI acknowledges that termination of this Agreement 1) may affect its ability to continue to offer QHPs through the FFE; 2) does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year. This Agreement does not impose any independent obligation on QHPI, after termination of this Agreement, to continue enrollment or treat those enrolled as being contracted for coverage.

V. Miscellaneous.

a. Notice. All notices specifically required under this Agreement shall be given in writing and shall be delivered as follows:

If to QHPI: To the contact identified in QHPI's QHP Application using the contact information provided in QHPI's QHP Application.

If to CMS:

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received, provided that notices not given on a business day (i.e., Monday – Friday excluding Federal holidays) between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next business day for the recipient. QHPI or CMS to this Agreement may change its contact information for notices and other communications by providing thirty (30) Days' written notice of such change in accordance with this provision.

b. Assignment and Subcontracting. QHPI shall assume ultimate responsibility for all services and functions includes those that are assigned or subcontracted or other entities and must ensure that subcontractor and assigns will perform all functions in accordance with all applicable requirements. QHPI shall further be thereafter subject to such compliance actions for functions assigned to subcontractors or assignees as may otherwise be provided for under applicable law. Notwithstanding any assignment of this Agreement or subcontracting of any responsibility hereunder, QHPI shall not be released from any of its performance or compliance obligations hereunder, and shall remain fully bound to the terms and conditions of this Agreement as unaltered and unaffected by such assignment or subcontracting.

c. Amendment. CMS may amend this Agreement for purposes of reflecting changes in applicable law or regulations, with such amendments taking effect upon sixty (60) Days' written notice to QHPI ("CMS notice period"). Any amendments made under this provision will only have prospective effect and will not be applied retrospectively. QHPI may reject such amendment, by providing to CMS, during the CMS notice period, sixty (60) Days' written notice of its intent to reject the amendment ("rejection notice period"). Any such rejection of an amendment made by CMS shall result in the termination of this Agreement upon expiration of the rejection notice period.

d. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid,

unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

e. Disclaimer of Joint Venture. Neither this Agreement nor the activities of the QHPI contemplated by and under this Agreement shall be deemed or construed to create in any way any partnership, joint venture or agency relationship between CMS and QHPI. Neither QHPI nor CMS is, nor shall either QHPI or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in ACA and the regulations codified thereunder, including as codified at 45 CFR part 155.

f. Remedies Cumulative. No remedy herein conferred upon or reserved to CMS under this Agreement is intended to be exclusive of any other remedy or remedies available to CMS under operative law and regulation, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy now or hereafter existing at law or in equity or otherwise.

g. Governing Law. This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules. QHPI further agrees and consents to the jurisdiction of the Federal Courts located within the District of Columbia and the courts of appeal therefrom, and waives any claim of lack of jurisdiction or forum *non conveniens*.

h. Audit. QHPI agrees that CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of QHPI's compliance with the requirements of this Agreement, upon reasonable notice to QHPI and during QHPI's regular business hours and at QHPI's regular business location. QHPI further agrees to allow reasonable access to the information and facilities requested by CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees for the purpose of such an audit.

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date indicated by each signature.

FOR QHPI

Signature of Person Authorized to Enter Agreement on behalf of QHPI

Gerald Petkau, SVP and Chief Financial Officer
Typed or printed Name and Title of Person Authorized to Enter into Agreement for QHPI

Blue Cross and Blue Shield of NC
Issuer Name

11512
Issuer HIOS ID

1830 Chapel Hill Rd, Chapel Hill, NC 27517
Entity Address mailing: P.O. Box 2291 Durham, NC 27702-2291

September 11, 2013
Date

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement.

_____ _____

James Kerr **Date**
Acting Deputy Director, Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

_____ _____

Tony Trenkle **Date**
Director and CMS Chief Information Officer
Office of Information Services
Centers for Medicare & Medicaid Services

EXHIBIT 3

QUALIFIED HEALTH PLAN CERTIFICATION AGREEMENT AND PRIVACY AND SECURITY AGREEMENT BETWEEN QUALIFIED HEALTH PLAN ISSUER AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THIS QUALIFIED HEALTH PLAN ("QHP") ISSUER AGREEMENT ("Agreement") is entered into by and between THE CENTERS FOR MEDICARE & MEDICAID SERVICES "(CMS"), as the party responsible for the management and oversight of the Federally-facilitated Exchange ("FFE"), including the Federally-facilitated Small Business Health Options Program ("FF-SHOP") and CMS Data Services Hub ("Hub"), and Blue Cross and Blue Shield of North Carolina ("QHPI"), an Issuer that provides Health Insurance Coverage through QHPs offered through the FFE and FF-SHOP to Enrollees; and provides customer service. CMS and QHPI each are hereinafter referred to as a "Party" or, collectively, the "Parties."

WHEREAS:

1. Section 1301(a) of the Affordable Care Act ("ACA") provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish.

2. QHPI is an entity licensed by an applicable State Department of Insurance ("DOI") as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs.

3. It is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and QHPI.

4. QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, QHPI and CMS agree as follows:

I. Definitions

a. **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which are referred to collectively as the Affordable Care Act.

b. **Advance Payments of the Premium Tax Credit (APTC)** has the meaning set forth in 45 CFR 155.20.

c. **Applicant** has the meaning set forth in 45 CFR 155.20.

d. **Breach** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than authorized uses or for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII), whether physical or electronic.

e. **CMS Companion Guides** means a CMS-authored guide, available on the CMS web site, which is meant to be used in conjunction with and supplement relevant implementation guides published by the Accredited Standards Committee.

f. **CMS Data Services Hub (Hub)** is the CMS Federally-managed service to interface data among connecting entities, including HHS, certain other Federal agencies, and State Medicaid agencies.

g. **CMS Data Services Hub Web Services (Hub Web Services)** means business and technical services made available by CMS to enable the determination of certain eligibility and enrollment or Federal financial payment data through the Federally-facilitated Exchange web site, including the collection of personal and financial information necessary for Consumer, Applicant, Qualified Individual, Qualified Employer, Qualified Employee, or Enrollee account creations; Qualified Health Plan (QHP) application submissions; and Insurance Affordability Program eligibility determinations.

h. **Consumer** means a person who, for himself or herself, or on behalf of another individual, seeks information related to eligibility or coverage through a Qualified Health Plan (QHP) or other Insurance Affordability Program, or whom an agent or broker (including Web-brokers), Navigator, Issuer, Certified Application Counselor, or other entity assists in applying for a coverage through QHP, applying for APTCs and CSRs, and/or completing enrollment in a QHP through its web site for individual market coverage.

i. **Cost-sharing Reduction (CSR)** has the meaning set forth in 45 CFR 155.20.

j. **Day or Days** means calendar days unless otherwise expressly indicated in this Agreement.

k. **Enrollee** has the meaning set forth in 45 CFR 155.20.

l. **Federally-facilitated Exchange (FFE)** means an **Exchange** (or **Marketplace**) established by HHS and operated by CMS under Section 1321(c)(1) of the ACA for individual or small group market coverage, including the Federally-facilitated Small Business Health Options Program (**FF-SHOP**).

m. **Health Insurance Coverage** has the meaning set forth in 45 CFR 155.20.

n. **Health Insurance Portability and Accountability Act (HIPAA)** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and its implementing regulations.

o. **Incident**, or **Security Incident**, means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.

p. **Issuer** has the meaning set forth in 45 CFR 144.103.

q. **Personally Identifiable Information (PII)** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, *etc.*, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, *etc.*

r. **Qualified Employee** has the meaning set forth in 45 CFR 155.20.

s. **Qualified Employer** has the meaning set forth in 45 CFR 155.20.

t. **Qualified Health Plan (QHP)** has the meaning set forth in 45 CFR 155.20.

u. **Qualified Individual** has the meaning set forth in 45 CFR 155.20.

v. **State** means the State that has licensed the Issuer that is a party to this Agreement.

II. Acceptance of Standard Rules of Conduct

a. Standards regarding Personally Identifiable Information

QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2). QHPI hereby acknowledges and agrees to accept and abide by the standard rules of conduct set forth herein, and to require that its employees, officers, directors, contractors, agents, and representatives strictly adhere to the same, in order to gain and maintain access to the CMS Data Services Hub Web Services ("Hub Web Services"). QHPI agrees that it will create, collect, disclose, access, maintain, use, or store PII that it receives directly from Exchange applicants and from Hub Web Services only in accordance with all laws as applicable, including HIPAA and section 1411(g) of the ACA.

(1) Safeguards. QHPI agrees to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 155.260(a)(5); and to inform the Exchange of any material change in its administrative, technical, or operational environments, or

that would require an alteration of the privacy and security standards within this Agreement.

(2) Downstream Entities. QHPI will satisfy the requirement in 45 CFR 155.260(b)(2)(v) to bind downstream entities by entering into written agreements, including where appropriate, Business Associate Agreements (as such term is defined under HIPAA), with any downstream entities that will have access to PII as defined in this Agreement.

b. Standards for Communication with the Hub

(1) QHPI must complete testing for each type of transaction it will implement and shall not be allowed to exchange data with CMS in production mode until testing is satisfactorily passed as determined by CMS in its sole discretion. Satisfactorily passed testing generally means the ability to pass all HIPAA compliance standards, and to process electronic healthcare information transmitted by QHPI to the Hub. This capability to submit test transactions will be maintained by QHPI throughout the term of this Agreement.

(2) As applicable, all transactions must be formatted in accordance with the Accredited Standards Committee Implementation Guides, adopted under HIPAA, available at http://store.x12.org/store/. CMS will make available Companion Guides for all applicable transactions, which specify certain situational data elements necessary.

(3) QHPI agrees to abide by the Standard Companion Guide Transaction Information Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Marketplace (FFM) Companion Guide Version most recently released by CMS and in effect at the time the transactions are sent, and the CMS Instructions related to the ASC X12 820 transaction as specified in the ASC X12 005010X306 Health Insurance Exchange Related Payments (820) Implementation Guide.

(4) QHPI agrees to submit test transactions to the Hub prior to the submission of any transactions to the FFE production system, to determine that the transactions and responses comply with all requirements and specifications approved by the CMS and/or the CMS contractor.[1]

[1] While CMS owns data in the FFE, other contractors operate the FFE system in which the enrollment and financial management data flow. Contractors provide the pipeline network for the transmission of electronic data, including

(5) QHPI agrees that prior to the submission of any additional transaction types to the FFE production system, or as a result of making changes to an existing transaction type or system, it will submit test transactions to the Hub in accordance with paragraph (1) above.

(6) If QHPI enters into relationships with other affiliated entities, or their authorized designees, for submitting and receiving FFE data, it must execute contracts with such entities that stipulate that such entities and any subcontractors or affiliates of such entities, must be bound by the terms of this Agreement, test software, and receive QHPI's approval of software as being in the proper format and compatible with the FFE system.

(7) Incident and Breach Reporting Policies and Procedures. QHPI agrees to report any Incident or Breach of PII to the CMS IT Service Desk by telephone at (410)786-2580 or 1-800-562-1963 or via email notification at cms_it_service_desk@cms.hhs.gov within seventy-two (72) to ninety-six (96) hours after discovery of the Incident or Breach.

III. CMS Obligations

a. CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and/or processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

IV. Effective Date; Term; Renewal.

a. Effective Date and Term. This Agreement becomes effective on the date the last of the two Parties executes this Agreement and terminates on December 31, 2015.

b. Renewal. This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

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the transport of Exchange data to and from the Hub and QHPI so that QHPI may discern the activity related to enrollment functions of persons they serve. QHPI may also use the transported data to receive descriptions of financial transactions from CMS.

IV. Termination.

a. This Agreement shall terminate automatically upon QHPI's ceasing to provide all coverage under any QHPs that were offered through an FFE in the State(s) QHPI offered them.

b. CMS acknowledges that QHPI has developed its products for the FFE based on the assumption that APTCs and CSRs will be available to qualifying Enrollees. In the event that this assumption ceases to be valid during the term of this Agreement, CMS acknowledges that Issuer could have cause to terminate this Agreement subject to applicable state and federal law.

c. Termination with Notice by CMS. CMS may terminate this Agreement for cause upon sixty (60) Days' written notice to QHPI if QHPI materially breaches any term of this Agreement as determined at the sole but reasonable discretion of CMS, unless QHPI commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of CMS in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. A QHPI's inability to perform due to a CMS error will not be considered a material breach. The 60-Day notice from CMS shall contain a description of the material breach and any suggested options for curing the breach(es), whereupon QHPI shall have seven (7) Days from the date of the notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame may be rejected, approved, or amended in CMS' sole but reasonable discretion. The Agreement shall not be terminated if QHPI cures the cause for termination within 30 Days of the written notice to the satisfaction of CMS, which satisfaction shall be in CMS' sole discretion but shall not be unreasonably withheld. Notwithstanding the foregoing, QHPI shall be considered in "Habitual Default" of this Agreement in the event that it has been served with a 60-Day notice under this subsection more than three (3) times in any calendar year, whereupon CMS may, in its sole discretion, immediately thereafter terminate this Agreement upon notice to QHPI without any further opportunity to cure or propose cure.

d. QHPI acknowledges that termination of this Agreement 1) may affect its ability to continue to offer QHPs through the FFE; 2) does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year. This Agreement does not impose any independent obligation on QHPI, after termination of this Agreement, to continue enrollment or treat those enrolled as being contracted for coverage.

V. Miscellaneous.

a. Notice. All notices specifically required under this Agreement shall be given in writing and shall be delivered as follows:

If to QHPI: To the contact identified in QHPI's QHP Application using the contact information provided in QHPI's QHP Application.

If to CMS:

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received, provided that notices not given on a business day (i.e., Monday – Friday excluding Federal holidays) between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next business day for the recipient. QHPI or CMS to this Agreement may change its contact information for notices and other communications by providing thirty (30) Days' written notice of such change in accordance with this provision.

b. Assignment and Subcontracting. QHPI shall assume ultimate responsibility for all services and functions including those that are assigned or subcontracted to other entities and must ensure that subcontractors and assignees will perform all functions in accordance with all applicable requirements. QHPI shall further be subject to such compliance actions for functions assigned to subcontractors or assignees as may otherwise be provided for under applicable law. Notwithstanding any assignment of this Agreement or subcontracting of any responsibility hereunder, QHPI shall not be released from any of its performance or compliance obligations hereunder, and shall remain fully bound to the terms and conditions of this Agreement as unaltered and unaffected by such assignment or subcontracting.

c. Amendment. CMS may amend this Agreement for purposes of reflecting changes in applicable law or regulations, with such amendments taking effect upon sixty (60) Days' written notice to QHPI ("CMS notice period"), unless a different effective date is required by law. Any amendments made under this provision will only have

prospective effect and will not be applied retrospectively unless required by law. QHPI may reject such amendment, by providing to CMS, during the CMS notice period, thirty (30) Days' written notice of its intent to reject the amendment ("rejection notice period"). Any such rejection of an amendment made by CMS shall result in the termination of this Agreement upon expiration of the rejection notice period.

d. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid, unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

e. Disclaimer of Joint Venture. Neither this Agreement nor the activities of the QHPI contemplated by and under this Agreement shall be deemed or construed to create in any way any partnership, joint venture or agency relationship between CMS and QHPI. Neither QHPI nor CMS is, nor shall either QHPI or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in ACA and the regulations codified thereunder, including as codified at 45 CFR part 155.

f. Remedies Cumulative. No remedy herein conferred upon or reserved to CMS under this Agreement is intended to be exclusive of any other remedy or remedies available to CMS under operative law and regulation, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy now or hereafter existing at law or in equity or otherwise.

g. Governing Law. This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules. QHPI further agrees and consents to the jurisdiction of the Federal Courts located within the District of Columbia and the courts of appeal therefrom, and waives any claim of lack of jurisdiction or forum *non conveniens*.

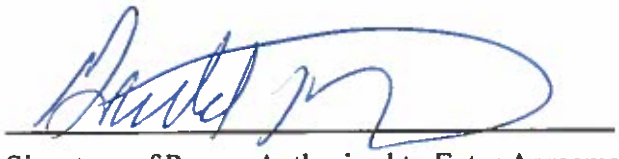
h. Audit. QHPI agrees that CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of QHPI's compliance with the requirements of this Agreement, upon

reasonable notice to QHPI and during QHPI's regular business hours and at QHPI's regular business location. QHPI further agrees to allow reasonable access to the information and facilities requested by CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees for the purpose of such an audit.

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date indicated by each signature.

FOR QHPI



Signature of Person Authorized to Enter Agreement on behalf of QHPI

Gerald A. Petkau, Senior Vice President, Chief Financial Officer

Type or printed Name and Title of Person Authorized to Enter into Agreement for QHPI

Blue Cross and Blue Shield of North Carolina

Issuer Name

11512

Issuer HIOS ID

5901 Chapel Hill Blvd., Durham, NC 27707-3346

Entity Address

10-30-14

Date

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement.

10/29/14

Kevin J. Counihan — **Date**
Marketplace Chief Executive Officer and Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

10/28/14

David J. Nelson — **Date**
Deputy Chief Operating Officer and Chief Information Officer
Centers for Medicare & Medicaid Services

10-29-14

Todd A. Lawson — **Date**
Acting Director, Office of E-Health Standards and Services
and Acting Senior Official for Privacy
Centers for Medicare & Medicaid Services

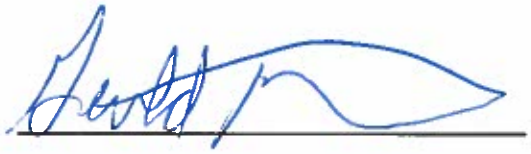
2015 Qualified Health Plan Senior Officer Acknowledgment Form

I, Gerald A. Petkau, am the signatory of the Qualified Health Plan Issuer Agreement on behalf of [QHP Legal Name]. I, along with compliance officer(s) and other members of the senior leadership team at Blue Cross and Blue Shield of North Carolina, am responsible for the implementation and performance of my company's Qualified Health Plans (QHPs) and/or Stand Alone Dental Plans (SADPs) in the Federally-Facilitated Marketplace (FFM). As such, I acknowledge that I have been briefed on what is included in my company's offerings of Qualified Health Plans (QHPs) and/or Stand Alone Dental Plans (SADPs) in the Federally-Facilitated Marketplace (FFM). I have also been briefed on and understand the following requirements, guidance, and provisions, for participation in the FFM, including:

- The provisions in the 2015 Qualified Health Plan Issuer (QHPI) Agreement;
- The attestations and QHP/SADP certification requirements in the 2015 QHP Application; and
- The provisions and requirements described in the 2015 Annual Letter to Issuers.

Additionally, I acknowledge that my company has or is in the process of implementing appropriate structures and processes to comply with the aforementioned requirements, and will endeavor to implement them in time before the 2015 Open Enrollment Period.

ON BEHALF OF: Blue Cross and Blue Shield of North Carolina

Signature: 

(Name of Person Authorized to Sign on Behalf of QHP Issuer)
Gerald A. Petkau

Senior Vice President, Chief Financial Officer

(Title of Person Authorized to Sign on Behalf of QHP Issuer)

Date: 10-21-14

EXHIBIT 4

QUALIFIED HEALTH PLAN CERTIFICATION AGREEMENT AND PRIVACY AND SECURITY AGREEMENT BETWEEN QUALIFIED HEALTH PLAN ISSUER AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THIS QUALIFIED HEALTH PLAN ("QHP") ISSUER AGREEMENT ("Agreement") is entered into by and between THE CENTERS FOR MEDICARE & MEDICAID SERVICES "(CMS"), as the party responsible for the management and oversight of the Federally-facilitated Exchange ("FFE"), including the Federally-facilitated Small Business Health Options Program ("FF-SHOP") and CMS Data Services Hub ("Hub"), and Blue Cross and Blue Shield of North Carolina ("QHPI"), an Issuer that provides Health Insurance Coverage through QHPs offered through the FFE and FF-SHOP to Enrollees; and provides customer service. CMS and QHPI each are hereinafter referred to as a "Party" or, collectively, the "Parties."

WHEREAS:

1. Section 1301(a) of the Affordable Care Act ("ACA") provides that QHPs are health plans that are certified by an Exchange and, among other things, comply with the regulations developed by the Secretary of the Department of Health and Human Services under section 1311(d) and other requirements that an applicable Exchange may establish.

2. QHPI is an entity licensed by an applicable State Department of Insurance ("DOI") as an Issuer and seeks to offer through the FFE in such State one or more plans that are certified to be QHPs.

3. It is anticipated that periodic APTCs, advance payments of CSRs, and payments of FFE user fees will be due between CMS and QHPI.

4. QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2).

Now, therefore, in consideration of the promises and covenants herein contained, the adequacy of which the Parties acknowledge, QHPI and CMS agree as follows:

I. Definitions

a. **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which are referred to collectively as the Affordable Care Act.

b. **Advance Payments of the Premium Tax Credit (APTC)** has the meaning set forth in 45 CFR 155.20.

c. **Applicant** has the meaning set forth in 45 CFR 155.20.

d. **Breach** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than authorized uses or for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII), whether physical or electronic.

e. **CMS Companion Guides** means a CMS-authored guide, available on the CMS web site, which is meant to be used in conjunction with and supplement relevant implementation guides published by the Accredited Standards Committee.

f. **CMS Data Services Hub (Hub)** is the CMS Federally-managed service to interface data among connecting entities, including HHS, certain other Federal agencies, and State Medicaid agencies.

g. **CMS Data Services Hub Web Services (Hub Web Services)** means business and technical services made available by CMS to enable the determination of certain eligibility and enrollment or Federal financial payment data through the Federally-facilitated Exchange web site, including the collection of personal and financial information necessary for Consumer, Applicant, Qualified Individual, Qualified Employer, Qualified Employee, or Enrollee account creations; Qualified Health Plan (QHP) application submissions; and Insurance Affordability Program eligibility determinations.

h. **Consumer** means a person who, for himself or herself, or on behalf of another individual, seeks information related to eligibility or coverage through a Qualified Health Plan (QHP) or other Insurance Affordability Program, or whom an agent or broker (including Web-brokers), Navigator, Issuer, Certified Application Counselor, or other entity assists in applying for a coverage through QHP, applying for APTCs and CSRs, and/or completing enrollment in a QHP through its web site for individual market coverage.

i. **Cost-sharing Reduction (CSR)** has the meaning set forth in 45 CFR 155.20.

j. **Day or Days** means calendar days unless otherwise expressly indicated in this Agreement.

k. **Enrollee** has the meaning set forth in 45 CFR 155.20.

l. **Federally-facilitated Exchange (FFE)** means an **Exchange** (or **Marketplace**) established by HHS and operated by CMS under Section 1321(c)(1) of the ACA for individual or small group market coverage, including the Federally-facilitated Small Business Health Options Program (**FF-SHOP**).

m. **Health Insurance Coverage** has the meaning set forth in 45 CFR 155.20.

n. **Health Insurance Portability and Accountability Act (HIPAA)** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended, and its implementing regulations.

o. **Incident**, or **Security Incident**, means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.

p. **Issuer** has the meaning set forth in 45 CFR 144.103.

q. **Personally Identifiable Information (PII)** has the meaning contained in OMB Memoranda M-07-16 (May 22, 2007), and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, *etc.*, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, *etc.*

r. **Qualified Employee** has the meaning set forth in 45 CFR 155.20.

s. **Qualified Employer** has the meaning set forth in 45 CFR 155.20.

t. **Qualified Health Plan (QHP)** has the meaning set forth in 45 CFR 155.20.

u. **Qualified Individual** has the meaning set forth in 45 CFR 155.20.

v. **State** means the State that has licensed the Issuer that is a party to this Agreement.

II. Acceptance of Standard Rules of Conduct

a. Standards regarding Personally Identifiable Information

QHPI and CMS are entering into this Agreement to satisfy the requirements under 45 CFR 155.260(b)(2). QHPI hereby acknowledges and agrees to accept and abide by the standard rules of conduct set forth herein, and to require that its employees, officers, directors, contractors, agents, and representatives strictly adhere to the same, in order to gain and maintain access to the CMS Data Services Hub Web Services ("Hub Web Services"). QHPI agrees that it will create, collect, disclose, access, maintain, use, or store PII that it receives directly from Exchange applicants and from Hub Web Services only in accordance with all laws as applicable, including HIPAA and section 1411(g) of the ACA.

(1) Safeguards. QHPI agrees to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with 155.260(a)(5); and to inform the Exchange of any material change in its administrative, technical, or operational environments, or

that would require an alteration of the privacy and security standards within this Agreement.

(2) Downstream Entities. QHPI will satisfy the requirement in 45 CFR 155.260(b)(2)(v) to bind downstream entities by entering into written agreements, including where appropriate, Business Associate Agreements (as such term is defined under HIPAA), with any downstream entities that will have access to PII as defined in this Agreement.

b. Standards for Communication with the Hub

(1) QHPI must complete testing for each type of transaction it will implement and shall not be allowed to exchange data with CMS in production mode until testing is satisfactorily passed as determined by CMS in its sole discretion. Satisfactorily passed testing generally means the ability to pass all HIPAA compliance standards, and to process electronic healthcare information transmitted by QHPI to the Hub. This capability to submit test transactions will be maintained by QHPI throughout the term of this Agreement.

(2) As applicable, all transactions must be formatted in accordance with the Accredited Standards Committee Implementation Guides, adopted under HIPAA, available at http://store.x12.org/store/. CMS will make available Companion Guides for all applicable transactions, which specify certain situational data elements necessary.

(3) QHPI agrees to abide by the Standard Companion Guide Transaction Information Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Marketplace (FFM) Companion Guide Version most recently released by CMS and in effect at the time the transactions are sent, and the CMS Instructions related to the ASC X12 820 transaction as specified in the ASC X12 005010X306 Health Insurance Exchange Related Payments (820) Implementation Guide.

(4) QHPI agrees to submit test transactions to the Hub prior to the submission of any transactions to the FFE production system, to determine that the transactions and responses comply with all requirements and specifications approved by the CMS and/or the CMS contractor.[1]

[1] While CMS owns data in the FFE, other contractors operate the FFE system in which the enrollment and financial management data flow. Contractors provide the pipeline network for the transmission of electronic data, including

(5) QHPI agrees that prior to the submission of any additional transaction types to the FFE production system, or as a result of making changes to an existing transaction type or system, it will submit test transactions to the Hub in accordance with paragraph (1) above.

(6) If QHPI enters into relationships with other affiliated entities, or their authorized designees, for submitting and receiving FFE data, it must execute contracts with such entities that stipulate that such entities and any subcontractors or affiliates of such entities, must be bound by the terms of this Agreement, test software, and receive QHPI's approval of software as being in the proper format and compatible with the FFE system.

(7) Incident and Breach Reporting Policies and Procedures. QHPI agrees to report any Incident or Breach of PII to the CMS IT Service Desk by telephone at (410)786-2580 or 1-800-562-1963 or via email notification at cms_it_service_desk@cms.hhs.gov within seventy-two (72) to ninety-six (96) hours after discovery of the Incident or Breach.

III. CMS Obligations

a. CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and/or processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

b. As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to QHPI against amounts owed to CMS by QHPI or any entity operating under the same tax identification number as QHPI (including overpayments previously made) with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment of Federally-facilitated Exchange user fees.

IV. Effective Date; Term; Renewal.

a. Effective Date and Term. This Agreement becomes effective on the date the last of the two Parties executes this Agreement and terminates on December 31, 2016.

b. Renewal. This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

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the transport of Exchange data to and from the Hub and QHPI so that QHPI may discern the activity related to enrollment functions of persons they serve. QHPI may also use the transported data to receive descriptions of financial transactions from CMS.

IV. Termination.

a. This Agreement shall terminate automatically upon QHPI's ceasing to provide all coverage under any QHPs that were offered through an FFE in the State(s) QHPI offered them.

b. CMS acknowledges that QHPI has developed its products for the FFE based on the assumption that APTCs and CSRs will be available to qualifying Enrollees. In the event that this assumption ceases to be valid during the term of this Agreement, CMS acknowledges that Issuer could have cause to terminate this Agreement subject to applicable state and federal law.

c. Termination with Notice by CMS. CMS may terminate this Agreement for cause upon sixty (60) Days' written notice to QHPI if QHPI materially breaches any term of this Agreement as determined at the sole but reasonable discretion of CMS, unless QHPI commences curing such breach(es) within such 60-Day period to the reasonable satisfaction of CMS in the manner hereafter described in this subsection, and thereafter diligently prosecutes such cure to completion. A QHPI's inability to perform due to a CMS error will not be considered a material breach. The 60-Day notice from CMS shall contain a description of the material breach and any suggested options for curing the breach(es), whereupon QHPI shall have seven (7) Days from the date of the notice in which to propose a plan and a time frame to cure the material breach(es), which plan and time frame may be rejected, approved, or amended in CMS' sole but reasonable discretion. The Agreement shall not be terminated if QHPI cures the cause for termination within 30 Days of the written notice to the satisfaction of CMS, which satisfaction shall be in CMS' sole discretion but shall not be unreasonably withheld. Notwithstanding the foregoing, QHPI shall be considered in "Habitual Default" of this Agreement in the event that it has been served with a 60-Day notice under this subsection more than three (3) times in any calendar year, whereupon CMS may, in its sole discretion, immediately thereafter terminate this Agreement upon notice to QHPI without any further opportunity to cure or propose cure.

d. QHPI acknowledges that termination of this Agreement 1) may affect its ability to continue to offer QHPs through the FFE; 2) does not relieve QHPI of applicable obligations to continue providing coverage to enrollees; and 3) specifically does not relieve QHPI of any obligation under applicable State law to continue to offer coverage for a full plan year. This Agreement does not impose any independent obligation on QHPI, after termination of this Agreement, to continue enrollment or treat those enrolled as being contracted for coverage.

V. Miscellaneous.

a. Notice. All notices specifically required under this Agreement shall be given in writing and shall be delivered as follows:

If to QHPI: To the contact identified in QHPI's QHP Application using the contact information provided in QHPI's QHP Application.

If to CMS:

Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information & Insurance Oversight (CCIIO)
Attn: Office of the Director – Issuer Agreement
Room 739H
200 Independence Avenue, SW
Washington, DC 20201

Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received, provided that notices not given on a business day (i.e., Monday – Friday excluding Federal holidays) between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next business day for the recipient. QHPI or CMS to this Agreement may change its contact information for notices and other communications by providing thirty (30) Days' written notice of such change in accordance with this provision.

b. Assignment and Subcontracting. QHPI shall assume ultimate responsibility for all services and functions including those that are assigned or subcontracted to other entities and must ensure that subcontractors and assignees will perform all functions in accordance with all applicable requirements. QHPI shall further be subject to such compliance actions for functions assigned to subcontractors or assignees as may otherwise be provided for under applicable law. Notwithstanding any assignment of this Agreement or subcontracting of any responsibility hereunder, QHPI shall not be released from any of its performance or compliance obligations hereunder, and shall remain fully bound to the terms and conditions of this Agreement as unaltered and unaffected by such assignment or subcontracting.

c. Amendment. CMS may amend this Agreement for purposes of reflecting changes in applicable law or regulations, with such amendments taking effect upon sixty (60) Days' written notice to QHPI ("CMS notice period"), unless a different effective date is required by law. Any amendments made under this provision will only have

prospective effect and will not be applied retrospectively unless required by law. QHPI may reject such amendment, by providing to CMS, during the CMS notice period, thirty (30) Days' written notice of its intent to reject the amendment ("rejection notice period"). Any such rejection of an amendment made by CMS shall result in the termination of this Agreement upon expiration of the rejection notice period.

d. Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid, unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

e. Disclaimer of Joint Venture. Neither this Agreement nor the activities of the QHPI contemplated by and under this Agreement shall be deemed or construed to create in any way any partnership, joint venture or agency relationship between CMS and QHPI. Neither QHPI nor CMS is, nor shall either QHPI or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in ACA and the regulations codified thereunder, including as codified at 45 CFR part 155.

f. Remedies Cumulative. No remedy herein conferred upon or reserved to CMS under this Agreement is intended to be exclusive of any other remedy or remedies available to CMS under operative law and regulation, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy now or hereafter existing at law or in equity or otherwise.

g. Governing Law. This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules. QHPI further agrees and consents to the jurisdiction of the Federal Courts located within the District of Columbia and the courts of appeal therefrom, and waives any claim of lack of jurisdiction or forum *non conveniens*.

h. Audit. QHPI agrees that CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of QHPI's compliance with the requirements of this Agreement, upon

reasonable notice to QHPI and during QHPI's regular business hours and at QHPI's regular business location. QHPI further agrees to allow reasonable access to the information and facilities requested by CMS, the Comptroller General, the Office of the Inspector General of HHS or their designees for the purpose of such an audit.

[remainder of page intentionally blank]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date indicated by each signature.

FOR QHPI

Signature of Person Authorized to Enter Agreement on behalf of QHPI

Gerald A. Petkau, SVP/Chief Financial Officer

Typed or printed Name and Title of Person Authorized to Enter into Agreement for QHPI

Blue Cross and Blue Shield of North Carolina

Issuer Name

11512

Issuer HIOS ID

5901 Chapel Hill Blvd. Durham, NC 27707

Entity Address

09/24/2015

Date

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The undersigned are officials of CMS who are authorized to represent CMS for purposes of this Agreement.

Kevin J. Counihan
Marketplace Chief Executive Officer and Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

August 30, 2015
Date

David J. Nelson
Deputy Chief Operating Officer and Chief Information Officer
Centers for Medicare & Medicaid Services

10.8.15
Date

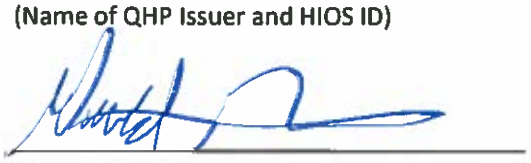
2016 Qualified Health Plan Senior Officer Acknowledgment Form

I, Gerald A. Petkau, am the signatory of the Qualified Health Plan Issuer Agreement on behalf of Blue Cross Blue Shield of NC (QHP Legal Name). I, along with compliance officer(s) and other members of the senior leadership team at Blue Cross Blue Shield of NC, am responsible for the implementation and performance of my company's Qualified Health Plans (QHPs) and/or Stand Alone Dental Plans (SADPs) in the Federally-Facilitated Marketplace (FFM). As such, I acknowledge that I have been briefed on what is included in my company's offerings of Qualified Health Plans (QHPs) and/or Stand Alone Dental Plans (SADPs) in the Federally-Facilitated Marketplace (FFM). I have also been briefed on and understand the following requirements, guidance, and provisions, for participation in the FFM, including:

- The provisions in the 2016 Qualified Health Plan Issuer (QHPI) Agreement;
- The attestations and QHP/SADP certification requirements in the 2016 QHP Application; and
- The provisions and requirements described in the 2016 Annual Letter to Issuers.

Additionally, I acknowledge that my company has or is in the process of implementing appropriate structures and processes to comply with the aforementioned requirements, and will endeavor to implement them in time before the 2016 Open Enrollment Period.

ON BEHALF OF: Blue Cross and Blue Shield of North Carolina Issuer 11512
(Name of QHP Issuer and HIOS ID)

Signature: 

Gerald A. Petkau
(Name of Person Authorized to Sign on Behalf of QHP Issuer)

Senior Vice President, Chief Financial Officer
(Title of Person Authorized to Sign on Behalf of QHP Issuer)

Date: 09/24/2015

EXHIBIT 5

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

Date: April 5, 2013

From: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

Title: Affordable Exchanges Guidance

Subject: Letter to Issuers on Federally-facilitated and State Partnership Exchanges

The Centers for Medicare & Medicaid Services (CMS) is issuing this Letter to Issuers on Federally-facilitated and State Partnership Exchanges (Letter). This Letter provides issuers seeking to offer Qualified Health Plans (QHPs) in Federally-facilitated Exchanges (FFE) and Federally-facilitated SHOPs (FF-SHOP), including State Partnership Exchanges, with operational and technical guidance to help them successfully participate in Exchanges. Unless otherwise specified, references to the Exchange or FFE also refer to the SHOP or FF-SHOP.

As indicated in previous guidance, State Plan Management Partnership Exchanges have some flexibility to apply certification standards and adjust processes. Throughout the Letter we identify the areas in which states participating in a State Plan Management Partnership Exchange have flexibility to follow a different approach from the approach articulated in this guidance. For purposes of this Letter, references to State Plan Management Partnership Exchanges also apply to states performing plan management functions in an FFE. We note that the policies articulated in this Letter apply to the 2014 coverage year and beyond. In the future, CMS will issue similar letters to provide operational updates to QHP issuers, but we do not intend to issue these letters more than annually.

CMS has previously provided guidance on market-wide and QHP certification standards, eligibility and enrollment procedures, and other Exchange-related topics in several phases. A list of the most relevant regulations and guidance documents is included in Appendix A. These materials provide the basis for much of the operational guidance included in this Letter. Issuers are advised to consult these materials in conjunction with the Letter to ensure full compliance with the requirements of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (together referred to as the Affordable Care Act), as implemented. These and other regulatory and guidance materials are available at http://cciio.cms.gov/resources/regulations/index.html.

CMS received a number of comments on the draft Letter. Commenters represented a variety of stakeholders including issuers, health and patient advocacy organizations, agents and brokers, and consumer groups. Changes to address these comments are included, as appropriate, throughout the Letter.

Contents

Chapter 1: Certification Standards for Qualified Health Plans

The Affordable Care Act and the applicable Exchange regulations establish that health plans must meet a number of standards to be certified as qualified health plans (QHPs). Several of these certification standards apply to plans offered in the individual and small group markets that are not QHPs; the remaining standards are specific to QHPs seeking certification from an Exchange. In the Guidance on State Partnership Exchanges,[1] CMS stated its intent not to duplicate state review of potential QHPs conducted under state authority or as part of a state's enforcement of 2014 market reforms (e.g., essential health benefits and actuarial value standards). CMS expects that states will enforce 2014 market reforms; accordingly, CMS expects to rely on states' reviews of market reforms as part of its QHP certification process, provided that such state reviews are consistent with federal regulatory standards and operational timelines.[2] Issuers should follow state guidance regarding the review processes and criteria for state-conducted reviews.

The following sections describe CMS's approach to reviewing plans against standards that apply only to QHPs seeking certification from an Exchange. The reviews described in these sections will be conducted either by a state participating in a State Partnership Exchange in plan management as a part of the state's recommendation to CMS, or by CMS as a part of the process of certifying a QHP in the applicable FFE. Each section describes CMS's planned approach to evaluating QHPs against a certification standard in a non-Partnership FFE. As noted in previously released guidance, State Partnership Exchanges have some flexibility in their application of QHP certification standards, provided that the state's application is consistent with the parameters outlined in CMS regulations and guidance. States where a State Partnership Exchange is operating may use CMS's planned approach to conduct QHP certification reviews and arrive at certification recommendations, or adopt another approach to developing a recommendation that is consistent with the federal regulatory standards in consultation with CMS. More information on the QHP certification process in State Partnership Exchanges is included in Chapter 2. Issuers seeking certification in State Partnership Exchanges should refer to state direction in addition to this guidance. State-based Exchanges will conduct their own reviews for QHP-specific standards.

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[1] Guidance on the State Partnership Exchange (January 3, 2013), *available at* http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf.

[2] States are the primary regulators of health insurers and are responsible for enforcing the market reform provisions in title XXVII of the Public Health Service (PHS) Act both inside and outside the Exchanges. Under §§ 2723 and 2761 of the PHS Act and existing regulations, codified at 45 C.F.R. Part 150, CMS is responsible for enforcing the provisions of Parts A and B of title XXVII of the PHS Act in a state if a state notifies CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the provisions, or if CMS determines that the state is not substantially enforcing the requirements. As necessary, CMS will provide additional information on enforcement.

SECTION 1. NETWORK ADEQUACY AND INCLUSION OF ESSENTIAL COMMUNITY PROVIDERS

This section addresses how CMS will review health plans applying to be QHPs for compliance with network adequacy and Essential Community Provider (ECP) standards. States participating in a State Partnership Exchange may use a similar approach.

In collaboration with states, CMS will monitor QHPs for network adequacy and ECP sufficiency. Issuers seeking certification of their health plans as QHPs and issuers offering QHPs are encouraged to review the network adequacy and ECP standards set forth in 45 C.F.R. §§ 156.230 and 156.235 and explained in this Letter as the minimum requirements; CMS urges issuers to offer provider networks with robust ECP participation.

i. Network Adequacy

45 C.F.R. § 156.230(a)(2) requires a QHP issuer to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay. CMS recognizes that many states conduct network adequacy reviews as part of the issuer licensure process under their existing authority. As a result, for the 2014 coverage year, when CMS is evaluating applications for QHP certification, CMS will rely on state analyses and recommendations when the state has the authority and means to assess issuer network adequacy. CMS's approach to reviewing network adequacy will vary based on whether the state assesses network adequacy in a sufficient manner and uses standards at least as stringent as those identified in 45 C.F.R. § 156.230(a).

In states with sufficient network adequacy reviews, CMS will use a state's reviews as part of its evaluation.

In states without sufficient network adequacy reviews, CMS will rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. Unaccredited issuers will be required to submit an access plan as part of the QHP Application.[3] The access plan must demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with § 156.235(a).

CMS will further monitor network adequacy, for example, via complaint tracking or gathering network data from any QHP issuer at any time to determine whether the QHP's network(s) continues to meet these certification standards.

[3] The access plan in the QHP Application was developed based on the National Association of Insurance Commissioners' (NAIC) Managed Care Plan Network Adequacy Model Act. The Model Act is available at: http://www.naic.org/.

ii. Essential Community Providers

45 C.F.R. § 156.235 establishes requirements for inclusion of ECPs in provider networks and provides an alternate standard for issuers that provide a majority of covered services through employed physicians or a single contracted medical group.

As defined in the statute and regulation, ECPs include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Because the number and types of ECPs available varies significantly by location, CMS will use the following approach to evaluate QHP applications for sufficient inclusion of ECPs for the 2014 coverage year. CMS interprets the sufficiency standard found in 45 C.F.R. § 156.235 as being met by the safe harbor standard or minimum expectation described in the following paragraphs. CMS notes that contracted ECPs are subject to applicable issuer credentialing standards for network providers.

- **Safe Harbor Standard**: An application for QHP certification that demonstrates compliance with the standards outlined in this paragraph will be determined to meet the regulatory standard established by 45 C.F.R. § 156.235(a) without further documentation. First, the application demonstrates that at least 20 percent of available ECPs in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation of available ECPs, the issuer offers contracts prior to the coverage year to:
    - All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and
    - At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.

  CMS may verify the offering of contracts after certification.
- **Minimum Expectation**: An issuer application that demonstrates that at least 10 percent of available ECPs in the plan's service area participate in the issuer's provider network(s) for that plan will be determined to meet the regulatory standard, provided that the issuer includes as part of its application a satisfactory narrative justification describing how the issuer's provider network(s), as currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees.
- **Examples**:
    - Issuer A proposes a service area in which 80 ECPs are available. Issuer A's network includes 16 ECPs, and Issuer A attests in its narrative justification that it has offered contracts to available Indian providers and one ECP in each major ECP category per county, where an ECP in that category is available. Issuer A meets the safe harbor standard; no additional documentation is required.

- Issuer B also proposes a service area in which 80 ECPs are available. Issuer B's network includes 8 ECPs. Issuer B meets the minimum expectation by providing a narrative justification explaining why its network includes only 8 ECPs and how it will ensure service for low-income and medically underserved enrollees.

For an issuer that does not meet either the safe harbor standard or the minimum expectation, CMS will expect the application to include a narrative justification describing how the issuer's provider network(s) will provide access for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network(s) in future years.

To assist issuers in identifying these providers, CMS published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies, which issuers may use to calculate the safe harbor and/or minimum expectation thresholds. This non-exhaustive list is available at: http://cciio.cms.gov/programs/exchanges/qhp.html.

Issuers will indicate which ECPs are included in their provider network(s) by populating a template as part of the QHP Application. CMS will provide detailed instructions to support issuers in completing the template. Issuers that submit a narrative justification will do so as part of the issuer application for QHP certification.

Issuers will be permitted to write in ECPs not on the CMS-developed list for consideration as part of CMS's certification review (that is, allowable write-ins will count toward the satisfaction of the minimum expectation or safe harbor standard). For example, issuers may write in any providers that are currently eligible to participate in 340B programs that are not included on the CMS-developed list, or not-for-profit or state-owned providers that would be entities described in section 340B but do not receive federal funding under the relevant section of law referred to in section 340B. Such providers include not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act.

Table 1.1: ECP Categories and Types in FFEs

Major ECP Category	**ECP Provider Types**
Federally Qualified Health Center (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Native Hawaiian Health Centers
Ryan White Provider	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Providers	Tribal and Urban Indian Organization Providers
Hospitals	DSH and DSH-eligible Hospitals, Children's Hospitals, Rural

	Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

iii. Alternate ECP Standard for Integrated Issuers

Issuers that qualify for the alternate ECP standard articulated in 45 C.F.R. § 156.235(a)(2) and (b)[4] must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. CMS interprets this standard as being met if the issuer complies with the safe harbor or minimum expectation described above, based on employed or contracted providers located in or contiguous to Health Professional Shortage Areas (HPSA)[5] and 5-digit zip codes in which 30 percent or more of the population falls below 200 percent of the federal poverty level (FPL). For example, if an issuer's service area includes 50 available ECPs, the issuer would need10 providers (20 percent of 50) in the service area that are also in or contiguous to a HPSA or low-income zip code to meet the safe harbor, and 5 providers in the service area that are in or contiguous to a HPSA or low-income zip code to meet the minimum expectation.

As with the general safe harbor, an application that does not meet the safe harbor standard must include a narrative justification describing how the issuer's provider network(s) complies with the regulatory standard. In this context, an issuer's explanation should address how the issuer intends to ensure coverage in HPSAs or low-income zip codes in the service area(s). The explanation should describe the extent to which the issuer's provider sites are accessible to, and have services that meet the needs of, specific underserved populations, including:

- Individuals with HIV/AIDS (including those with co-morbid behavioral health conditions);
- American Indians/Alaska Natives (AI/AN); and
- Low-income and underserved individuals seeking women's health and reproductive health services.

[4] To qualify for the alternate standard, an issuer must provide a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group.

[5] More information on Health Professional Shortage Areas is available at: http://bhpr.hrsa.gov/shortage/.

To the extent that issuers subject to the alternate standard cannot meet the safe harbor or minimum expectation levels, CMS will take into account factors and circumstances identified in the supplemental response,[6] along with an explanation of how the issuer will provide access to low-income and underserved populations.

CMS is providing issuers with a database of zip codes listed as HPSAs or where more than 30 percent of the population falls below 200 percent of the FPL. The database is available at http://cciio.cms.gov/resources/regulations/index.html#pm. Issuers that qualify for the alternate standard will use the same data template as other issuers to complete this section of the application.

CMS will continue to assess QHP provider networks, including ECPs, and may revise its approach to reviewing for compliance with network adequacy and ECPs in later years.

SECTION 2. ACCREDITATION

This section provides additional guidance on accreditation requirements for issuers seeking certification of a QHP in an FFE, including a State Partnership Exchange.

45 C.F.R. § 155.1045 establishes the timeline by which QHP issuers offering coverage in an FFE must be accredited. An issuer's accreditation status will be displayed to consumers on the Exchange website.[7] As stated in the preamble to the Essential Health Benefits (EHB)/Accreditation final rule,[8] CMS is implementing a phased approach to accreditation for QHP issuers in FFEs.

As part of the application for QHP certification, issuers will be asked to provide some information about their accreditation status to determine if the standard in § 155.1045(b) is met. Issuers will be asked if they have any existing health plan accreditation in the commercial, Medicaid, or Exchange markets (i.e., accredited with respect to the product type at issue under the same legal entity as the one that is applying to offer products in the Exchange). If so, they will be asked to provide information about that accreditation and identify the recognized accrediting entity that issued the accreditation. For certification in 2013 for the 2014 plan year, the National Committee for Quality Assurance (NCQA) and URAC have been recognized as

[6] More information on the supplementary response can be found on the CCIIO website at: http://cciio.cms.gov/programs/Files/ecp_supplemental_response_Form_03_08_13.pdf.
[7] CMS will be responsible for the Exchange website in FFEs, including State Partnership Exchanges.
[8] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834 (Feb. 25, 2013) (to be codified at 45 C.F.R. parts 147, 155, & 156).

accrediting entities.[9] The issuer will be asked to enter information for accredited products within the commercial, Medicaid, or Exchange markets, such as accredited product type(s), expiration date(s), and accrediting entity-specific identification information numbers, such as the NCQA Organization Identification Number and Sub-Identification Number(s), and/or the URAC application number(s). Issuers should verify with the applicable accrediting entity before completing the application if they are unsure about their identification numbers. This is important for displaying the appropriate accreditation-related data for the issuer. For certification in future years, the timeline in § 155.1045(b) will be applied by looking at the issuer's accreditation status 90 days prior to open enrollment.

To verify the accreditation information, issuers will also be asked to upload their current and relevant accreditation certificates issued by either NCQA or URAC, or both of these recognized accrediting entities, if applicable. Only data that can be validated will be displayed. All issuers will be required to complete attestations about the accreditation data that will be displayed on the Exchange website in order to demonstrate how the issuer and health plan meet the applicable certification requirements. In addition, information about the issuer's Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[10] surveys and other data will be requested for CMS to use in determining whether it is in the interest of qualified individuals and qualified employers to certify the health plan as a QHP. Consistent with 45 C.F.R. § 156.275(a)(2), issuers will be asked as part of the application to authorize the release of their accreditation survey data from the recognized accrediting entity to the Exchange, if available.

For open enrollment beginning on October 1, 2013, an Exchange website will display selected CAHPS® survey results from an issuer's accredited commercial product lines when these existing CAHPS® data are available for the same QHP product types and adult/child populations. CMS will display the two CAHPS® Global Ratings for the health plan[11] and health care,[12] and results from one access to care measure.[13]

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[9] NCQA and URAC were established as recognized as accrediting entities on an interim basis in Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42658 (Jul. 20, 2012) (to be codified at 45 C.F.R. part 156). They were formally recognized in a final notice published on November 23, 2012 (77 Fed. Reg. 70163). CMS may recognize additional accrediting entities in the future. See 45 C.F.R. § 156.275(a).

[10] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) of HHS.

[11] Using any number from 0 to 10 where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

[12] Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care (excluding dental and hospital) in the last 12 months?

[13] In the last 12 months, how often was it easy to get the care, tests, or treatment you needed? [Never/Sometimes/Usually/Always]

If CAHPS® commercial data are not available through existing accreditation for an issuer's same QHP product types (e.g., HMO, PPO) and adult/child populations, CMS will display CAHPS® survey results available from an issuer's accredited Medicaid product lines if these data are available for the same QHP product types and adult/child populations. If applicable CAHPS® data are not available through existing accreditation, the Exchange website will display a neutral statement such as "No data available." For issuers with relevant Medicaid CAHPS® data to be displayed, the Exchange website will display Medicaid CAHPS® 2012 data at the beginning of open enrollment until Medicaid CAHPS® 2013 data are available (anticipated in mid-November 2013).

For the 2014 coverage year, the Exchange website will also display the accreditation status of a QHP issuer's HMO, PPO, POS, or EPO product ("Accredited by NCQA," "Accredited by URAC," "Accredited by NCQA and URAC," or "Not yet accredited") if an issuer is accredited on its applicable, existing products in the commercial, Medicaid, or Exchange markets by one of the currently recognized accrediting entities. If the QHP issuer is accredited by NCQA with "Excellent," "Commendable," "Accredited," and /or "Interim" status, the Exchange website will display the issuer as accredited. If the QHP issuer is accredited by URAC with "Full," "Provisional," and/ or "Conditional," status, the Exchange website will display the issuer as "Accredited." An issuer will not be displayed as accredited if the accreditation review is scheduled or in process. If the issuer does not have this existing accreditation from a currently recognized accrediting entity, neutral language such as "Not yet accredited" will be displayed.

In addition to displaying CAHPS® data attained through accreditation and accreditation status as explained above, all states participating in an FFE (including a State Partnership Exchange) have the option of requesting that the Exchange website display a link to existing quality data available for the commercial and/or Medicaid market in that state. We interpret 45 C.F.R. § 155.205(c) to apply to such linked websites and materials when the linked sites are provided as part of the FFE provision of comparable data about QHPs and QHP issuers.

SECTION 3. REVIEW OF RATES

This section addresses how CMS will work with states to review rate increases for QHPs. States participating in a State Partnership Exchange may use a similar approach.

i. Consideration of Rate Increases

45 C.F.R. § 155.1020 requires an Exchange to consider all rate increases when certifying plans as QHPs. For the 2014 plan year, CMS will take into consideration issuers' data and actuarial justifications provided in the Unified Rate Review Template, other information submitted as part of the Effective Rate Review program and any recommendations provided to CMS by the applicable state regulator about patterns or practices of excessive or unjustified rate increases and

whether or not particular issuers should be excluded from participation in the Exchange. In future years, CMS may also take into account other factors such as rate growth inside and outside the Exchange market.

As discussed above and in the Guidance on State Partnership Exchanges, CMS does not plan to duplicate reviews that a state is already conducting as a matter of state law, and will take into consideration reviews conducted on behalf of a state under the Effective Rate Review program as described in the Final Market Rules.[14] CMS anticipates integrating state and other CMS rate reviews into its QHP certification processes, provided that states provide information to CMS consistent with federal standards and agreed-upon timelines.

For rate increases not being reviewed by an Effective Rate Review program or by CMS on behalf of a state:

- The QHP issuers' justification for all rate increases will be captured in the submission of Part I of the rate filing justification (Unified Rate Review Template).

- To ensure consumer transparency, issuers must publish information from Part I of the rate filing justification by either: (1) posting a link on the issuer's website to the Exchange's website (or HealthCare.gov), or (2) posting the information on the issuer's website.[15]

i. Review of QHP Rates

Rates that are too high or too low could have undesirable consequences for consumers. If rates are too high, consumers may be overpaying for services. If rates are too low, consumers may purchase a plan in which the pricing is not sustainable over time, potentially leading to significant rate increases in future years. Such increases could be disruptive to consumers who remain in the plan and to consumers who switch to more effectively priced plans but experience changes in covered benefits or provider networks. In addition, QHP rates – specifically, the rate for the second lowest cost silver plan in an Exchange – directly impact the value of tax credits for health insurance as well as other federal outlays.

As detailed above, CMS does not plan to duplicate reviews that a state is already conducting as a matter of state law. CMS intends to implement a process that, in collaboration with existing state rate review processes, will help ensure that QHP rates are reasonable. Specifically, CMS will

[14] Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13406 (Feb. 27, 2013) (to be codified at 45 C.F.R. parts 144, 147, 150, 154, & 156).

[15] Section 1311(e)(2) of the Affordable Care Act directs issuers to "prominently post" justifications for any rate increases. CMS notes that information that is not part of the justification that is protected by the Freedom of Information Act or the Trade Secrets Act (such as trade secrets or confidential financial information) will not be publicly posted by CMS.

conduct outlier identification on QHP rates to identify rates that are relatively high or low compared to other QHP rates in the same rating area.

CMS recognizes that identification of a QHP rate as an outlier does not necessarily indicate inappropriate rate development. CMS will notify the appropriate state entity of the results of its outlier identification process. If the state confirms that the rate is justified, CMS expects to certify the QHP if the QHP meets all other standards.

SECTION 4. BENEFIT DESIGN REVIEW

This section addresses how CMS will review health plans applying for QHP certification. States participating in a State Partnership Exchange may use a similar approach.

i. Non-discrimination

The law directs that, as a condition of participating in Exchanges, QHPs must not employ cost-sharing designs that will have the effect of discouraging the enrollment of individuals with significant health needs (45 C.F.R. § 156.225).[16] To ensure non-discrimination in benefit design, CMS will identify outliers with regards to QHP cost sharing (e.g., co-payments and coinsurance) as part of its QHP certification reviews. Identification as an outlier does not necessarily indicate that a QHP benefit design is discriminatory; rather, CMS will use the outlier identification to target QHPs for more in-depth reviews.

CMS's outlier will array and compare QHPs with comparable cost-sharing structures to identify outliers. For example, CMS will array and compare silver level QHPs with coinsurance-based benefit designs. In 2014, CMS's analysis will identify cost-sharing outliers for specific benefits, including:

i. Inpatient hospital stays,
ii. Inpatient mental/behavioral health stays,
iii. Specialist visits,
iv. Pregnancy and newborn care,
v. Specific conditions including behavioral health conditions such as mental health disorders and substance abuse, and
vi. Prescription drugs.

[16] Non-discrimination in benefit design with respect to EHB and marketing are market-wide consumer protections that apply inside and outside of Exchanges.

Issuers of QHPs flagged as outliers may be asked to modify benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.

CMS will also review information contained in the "explanations" and "exclusions" sections of the plans and benefits template with the objective of identifying discriminatory practices or wording. As part of this review, CMS expects to flag any language that indicates a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices (e.g., language indicating that the coinsurance rate for a particular benefit is higher for enrollees with certain health issues).

Finally, CMS will collect attestations that issuers' QHPs will not discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation, consistent with 45 C.F.R. § 156.200(e).

ii. Supporting Informed Consumer Choice

CMS has previously stated its intention to certify as a QHP any plan that meets all certification standards. CMS believes that this approach has important benefits, including increased consumer choice and competition. However, CMS also wishes to ensure that consumers can make an informed selection among plan choices that the consumer can readily differentiate and compare,[17] and that one issuer does not impede competition by submitting a number of very similar QHPs that monopolize virtual "shelf space."

To balance these priorities, CMS will conduct a benefit package review for all QHPs offered by an issuer. The goal of this review is to identify QHPs that are not meaningfully different from other QHPs offered by the same issuer and with the same plan characteristics. As in other areas, CMS will use this review to target QHPs for additional review and discussion with the issuer.

CMS anticipates implementing this review in the following manner for 2014:

- First, an issuer's plans from a given state will be organized into subgroups based on plan type, metal level and overlapping counties/service areas.
- Second, CMS will review each subgroup to determine whether the potential QHPs in that subgroup differ from each other on least any one of the following criteria:
    - Different network;
    - Different formulary;
    - $50 or more difference in both individual and family in-network deductibles;

[17] Research suggests that consumers may prefer more limited arrays of choices. See Iyengar, S.; Lepper, M. *Journal of Personality and Social Psychology*, Vol 79(6), Dec 2000, 995-1006.

  - $100 or more difference in both individual and family in-network maximum-out-of-pocket; and
  - Difference in covered EHB.
- If CMS finds that two or more plans within a subgroup do not differ based on any of the above criteria (that is, the two or more QHPs are of the same plan type and metal level; have overlapping service areas; have the same provider network, formulary, and EHB coverage; and have less than a $50 difference in deductibles and less than a $100 difference in maximum out-of-pocket), then those QHPs will be flagged for follow-up.

If CMS flags a potential QHP for follow-up based on this review, we anticipate that the issuer will be given the opportunity to amend or withdraw its submission for one or more of the identified health plans. Alternatively, the issuer may submit supporting documentation to CMS explaining how the potential QHP is substantially different from others offered by the issuer for QHP certification and, thus, is in the interest of consumers to certify as a QHP. For example, an issuer may make the case that one QHP is an Accountable Care Organization. This additional information will factor into the determination of whether it is in the interest of the qualified individuals and qualified employers to certify the plan as a QHP (*see* 45 C.F.R. § 155.1000).

Given the uniqueness of the stand-alone dental plan market, CMS will not perform such a review of stand-alone dental plans as part of the certification of those plans.

CMS anticipates its approach related to meaningful difference may be updated in future years.

iii. Annual Limitation on Cost Sharing

Section 1302(c)(1) of the Affordable Care Act sets an annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) as part of the EHB package that non-grandfathered policies sold in the individual and small group markets must offer. As provided in 45 C.F.R. § 156.130(c), cost sharing for benefits provided outside of a health plan's network do not count towards the annual limitation on cost sharing when the health plan uses a provider network. For plan or policy years beginning after January 1, 2014, this limit will be the out-of-pocket limit for high deductible health plans (HDHP), adjusted by the Consumer Price Index (CPI-U), and set by the Internal Revenue Service (IRS) pursuant to section 223(c)(2)(A)(ii) of the Internal Revenue Code.[18] Issuers of stand-alone dental plans should consult Chapter 4 of this Letter for more information on stand-alone dental plans.

[18] Beginning in 2015, a different methodology set by CMS will be used as set forth in section 1302(c)(1)(B) of the Affordable Care Act. This methodology will be discussed in the Notice of Benefit and Payment Parameters for 2015. 45 C.F.R. § 1 56.130(a)(2).

CMS anticipates that the IRS will publish the HDHP limit for 2014 in the spring of 2013. IRS's publication of these limits cannot occur earlier because of the statutorily required method for computing and adjusting the HDHP limit. To assist issuers in designing health plans for the 2014 plan year, CMS has estimated that the annual limitation on cost sharing for the 2014 plan year will be approximately $6,400 for self-only coverage and $12,800 for family coverage.[19] These are estimates only, though we think it is unlikely that the actual numbers will differ.

In the FFE, if IRS-published limits are below $6,400/$12,800, CMS will flag QHP applications with out-of-pocket maximums above the allowed amount. Affected issuers will be permitted to revise their out-of-pocket maximums during the resubmission window built into the QHP certification process. CMS will allow issuers to adjust other associated data elements for affected plans if necessary. For example, issuers will be permitted to modify other cost-sharing parameters in order to maintain an actuarial value (AV) consistent with the standards of 45 C.F.R. § 156.140.

CMS encourages states, particularly those participating in a State Partnership Exchange, to use this approach to allow updates during the revision window. States may instruct issuers to follow an alternate process to correct deficiencies of this type of issue.

Where an issuer uses multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization), new coordination processes may be required to ensure compliance with the maximum out-of-pocket limits. This may be necessary where, for example, the plan's service providers impose different levels of out-of-pocket limitations and/or use different methods for crediting participants' expenses against any out-of-pocket maximums.

For the first plan year beginning on or after January 1, 2014, a small group market health plan issuer[20] using more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section 1302(c)(1), will be considered to satisfy those limitations.[21] These conditions are as follows:

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[19] For reference, the limit set by the IRS for the 2013 calendar year is $6,250 for self-only coverage or $12,500 for family coverage. IRS Rev. Proc. 2012-26, *available at* http://www.irs.gov/pub/irs-drop/rp-12-26.pdf. This $6,400/$12,800 estimate is approximately a 2 percent increase from the limit set by IRS for the 2013 benefit year ($6,250). By way of comparison, a 0 percent increase in the limit would result in an annual limit for 2014 of $6,250, and a 6 percent increase would result in an annual limit of $6,650. Over the past 20 years, CPI has always been below 6 percent.

[20] Section 2707(b) of the PHS Act applies to "group health plans," which include small group, large group, and self-insured plans, but do not include individual market plans. Therefore, the administrative flexibility in the application of section 2707(b) applies only to small group, large group, and self-insured market plans.

[21] The Actuarial Value Calculator cannot accommodate the inputs for and will not accurately compute the AV of a plan with multiple out-of-pocket maximums that in total exceed the statutory maximum. Accordingly, small group

a. The QHP complies with the annual out-of-pocket maximums with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
b. To the extent the QHP includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1).

Once CMS's QHP certification determinations are complete, CMS's Health Insurance Oversight System (HIOS) will send all final QHP application data to the NAIC's System for Electronic Rate and Form Filing (SERFF) for use as a final state record.

SECTION 5. COST-SHARING REDUCTION PLAN VARIATIONS AND ADVANCE PAYMENT ESTIMATES

This section addresses how CMS will review plans for QHP certification. States participating in a State Partnership Exchange may use a similar approach.

CMS plans to review the estimated advance payment amounts for QHP issuers in all Exchanges – whether or not operated by CMS – to ensure that these payments are consistent with the methodology identified in § 156.430, and set forth in the Final Payment Notice[22] for the 2014 benefit year. If any estimates are identified as inconsistent with the methodology, issuers will be notified, and advance payment amounts may be modified. Finalized advance payment amounts will be identified for Exchanges to include enrollment information transferred to QHPs.

market QHPs using multiple service providers to administer benefits that are subject to the maximum out-of-pocket limits and who meet the defined requirements for being considered to have satisfied the maximum out-of-pocket limitations must use one of the alternate methods provided for in 45 CFR 156.135(b) to calculate actuarial value.

[22] Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410 (Mar. 11, 2013) (to be codified at 45 C.F.R. parts 153, 155, 156, 157, & 158).

Chapter 2: Qualified Health Plan Certification Process in FFEs, including State Partnership Exchanges

This Chapter provides an overview of the QHP certification process in FFEs, including State Partnership Exchanges, and describes the timing, data submission by issuers, and communication processes. High-level graphics summarizing the certification process in non-Partnership FFEs and State Partnership Exchanges are included in Appendix B.

As described in the Guidance on State Partnership Exchanges, states participating in a State Partnership Exchange will evaluate health plans against QHP certification standards as part of the state's traditional regulatory role for the insurance industry and/or enforcement of Title XXVII of the PHS Act, or otherwise for state purposes. Based upon the state's analysis and review, the state will recommend plans for QHP certification to CMS, and CMS will decide whether to certify the plans as QHPs. Similarly, CMS anticipates integrating state regulatory activities conducted independently of a Partnership Exchange into its decision-making for QHP certification recommendations in the FFE, provided that states make these determinations and provide information to HHS consistent with federal standards and FFE timelines. These principles underlie the discussion in this Letter about the QHP certification process.

CMS will review the state's recommendations or findings to confirm that they are consistent with federal regulatory standards, and will communicate to the state any concerns that would preclude CMS's implementation of the state's recommendations or findings according to the process and timeline outlined in the State Partnership Exchange guidance. CMS will be responsible for QHP certification decisions in each FFE or State Partnership Exchange.

SECTION 1. QHP APPLICATION AND CERTIFICATION PROCESS IN NON-PARTNERSHIP FFES

This section describes how CMS will conduct QHP certification. States and issuers participating in a State Partnership Exchange should refer to Section 2.

In accordance with 45 C.F.R. part 155 subpart K, CMS will review and approve or deny applications from issuers that are applying to offer QHPs in a non-Partnership FFE. Table 2.1 presents a high-level overview of key dates in the certification process. Each major component of the process is described in greater detail in the subsections that follow.

Table 2.1 Key Dates: QHP Certification in an FFE (Non-Partnership)[23]
Note: All dates are subject to minor changes.

[23] Note that stand-alone dental plan issuers will apply for certification on a modified timeline – see Chapter 4.

Expected Date (all dates in 2013)	Activity
Already in process	Issuers Submit Requests for Plan IDs (for plans intended for the Exchange) to HIOS
April 1 – April 30	Issuers Submit QHP Applications in HIOS
May 1 – June 16	CMS Reviews QHP Applications
June 17	CMS Releases QHP Application Results to Issuers
June 17 – June 21[24]	Issuers Revise QHP Applications Based on any Identified Deficiencies and Resubmit to HIOS
June 21 – mid-August	CMS Reviews Revised QHP Data
August 22 – August 26	Issuers Review Data During Plan Preview Period and Submit Data Corrections
September 4	CMS Notifies all Issuers of QHP Certification Decisions for the FFEs
September 5 – September 9	Issuers Sign Agreements with CMS
October 1	Open Enrollment Begins

i. Registration and Application

To offer QHPs in non-Partnership FFEs for the 2014 plan year, health insurance issuers will complete QHP Applications electronically through HIOS. Before submitting an application, issuers must gain access to HIOS and define user roles (such as data submitter, data validator, and attestor), and obtain HIOS user IDs.

We expect that between April 1 and April 30, 2013, the issuers will access the QHP Application in HIOS to submit all information necessary for certification of health plans as QHPs. The QHP Application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 C.F.R. parts 155 and 156 and other programmatic requirements necessary for the operational success of an Exchange, and provide requested supporting documentation. These attestations will also apply to vendors and contractors of the issuer or company.

ii. Issuer Data Collection and Coordination with States

CMS expects that states will review potential QHPs for compliance with EHB and AV standards under state regulatory authority consistent with the PHS Act. To the extent permissible by law, CMS intends to utilize state results from reviews conducted under state authority in these and

[24] CMS is working to provide issuers with additional time during this period.

other areas (including network adequacy), and will review and incorporate these results into its certification decisions. Issuers that wish to prohibit CMS from sharing QHP Application information with the relevant state department of insurance should do so by notifying CMS in writing (email is permitted). Regardless of whether a state conducts reviews under its own authority, issuers will submit a complete copy of the QHP Application and any supporting data in HIOS.

We expect that states will establish the timeline, communication process, and resubmission window for any reviews under state authority. Issuers should defer to any state-specific guidelines for review and resubmission of state-reviewed standards. CMS notes that issuers may be required to submit additional data to state regulators, if required by a state, and must comply with any requests for resubmissions from the state or from CMS in order to be certified. CMS will coordinate with states to ensure that any state-specific review guidelines and procedures are consistent with applicable federal law and operational deadlines. We note that all QHP issuers must be licensed and in good standing to offer health insurance coverage in each state where the issuer offers health insurance coverage.

iii. FFE review of QHP Applications

Between May 1 and June 16, 2013, CMS expects to review QHP Applications. On or around June 17, 2013, CMS expects to notify issuers of the results of all reviews conducted in this initial period by CMS, including any deficiencies or requests for additional documentation. During a single resubmission window, issuers will submit corrections or clarifications into HIOS in response to CMS's notification. During this period, issuers may also receive requests for resubmission or other communications from states conducting reviews under state authority. Issuers will be able to alter only data explicitly identified as deficient in CMS's notice or by a state. CMS expects to review the revised data, verify and confirm findings and results submitted by a state, and inform issuers of its final certification determination by September 4, 2013.

iv. Plan Preview

The Plan Preview period will allow issuers to review their QHP data before the data become public and to correct any discrepancies between the issuer's Application data and the data for display, as appropriate. Plan Preview will occur concurrently with CMS's final certification reviews; therefore, display during Plan Preview is not a guarantee that a QHP will be certified. After receiving final QHP data from issuers, CMS will load QHP data into a plan preview portal for issuer review. Accreditation status and CAHPS® survey data will also be part of Plan Preview on the FFE website, as applicable. Issuers will review plan data as the data will appear to consumers on the Exchange website, and will have an opportunity to submit corrections if necessary. Issuers will not have an opportunity to submit substantive changes (that is, changes that would require CMS to re-evaluate an issuer's Application) to 2014 QHP Applications during

the Plan Preview period. At a later date, issuers will also have the opportunity to review the updated Medicaid CAHPS® 2013 data when these data become available and prior to posting on the FFE website. More information about CAHPS® data is included in Chapter 1, Section 2 of this Letter.

SECTION 2. QHP CERTIFICATION PROCESS IN A PLAN MANAGEMENT STATE PARTNERSHIP EXCHANGE

This section describes how states participating in a State Partnership Exchange will conduct QHP certification. Issuers participating in a non-Partnership FFE should refer to Section 1.

In a Plan Management State Partnership Exchange, issuers will work directly with the state to submit all QHP issuer application data in accordance with state guidance.[25] CMS anticipates that states will choose to use the SERFF system to collect and review QHP data. The state will review issuer applications for QHP certification for compliance with the standards described above and will provide a certification recommendation for each plan to CMS. CMS will review and confirm the state's recommendations, coordinate Plan Preview, make final certification decisions, and load certified QHP plans on the Exchange website for the relevant State Partnership Exchange. CMS will work closely with states in State Partnership Exchanges to coordinate this process.

As indicated in Table 2.2, the certification process in State Partnership Exchanges will align with the process for issuers in states without State Partnership Exchanges, particularly beginning in August. Each major component of the process is described in greater detail in the subsections that follow.

Table 2.2 Key Dates: QHP Certification in a State Partnership Exchange[26]
Note: All dates are subject to minor changes.

Expected Dates (all dates in 2013)	Activities
Already in progress	Issuers Submit Requests for Plan IDs (for plans intended for the Exchange) to HIOS
Beginning approx. April 1	Issuers Submit QHP Applications into State's Application system
July 31	CMS Receives State Certification Recommendation and Final

[25] CMS will work with states participating in State Partnership Exchanges to ensure that such guidance is consistent with federal regulatory standards and operational timelines.
[26] Note that stand-alone dental plan issuers will apply for certification on a modified timeline – see Chapter 4.

	Reviewed Plan Data from Partner States
August	CMS Review of State Certification Recommendations
August 22 – August 26	Issuers Review Data During Plan Preview Period and Submit Data Corrections
September 4	CMS Notifies all Issuers of QHP Certification Decisions

i. Registration, Application, and State Review

An issuer's HIOS user ID will be used to link the state and federal records for a given issuer or QHP. Therefore, like an issuer applying in an FFE, an issuer applying in a State Partnership Exchange must access HIOS between March 1, 2013 and the beginning of the state's QHP certification process to obtain a HIOS user ID, as described in Section 1 above.

Issuers are to submit QHP Applications, typically in SERFF, according to the timeline set by the state. Each state will define the relevant submission window as well as dates and processes for deficiency notices, corrections, and resubmissions. Issuers are to refer to state guidance on this process. We expect that the state will review the QHP Applications and provide final data and recommendations for certification to CMS no later than July 31, 2013.

i. Plan Preview

As described in Section 1 above, CMS will offer a plan preview period for issuers seeking certification in a State Partnership Exchange. The plan preview period will follow the process outlined in Section 1, except that issuers that submitted QHP Applications into SERFF will also submit any data corrections into SERFF.

SECTION 3. QHP AGREEMENT

This section describes how CMS will conclude QHP certification in all FFEs, including State Partnership Exchanges.

A signed QHP Agreement with CMS will complete the certification process in an FFE or State Partnership Exchange. The Agreement will highlight and memorialize many of the QHP issuer's statutory and regulatory requirements and will serve as an important reminder of the relationship between the QHP issuer and CMS. A single QHP Agreement will cover all of the QHPs offered by a single issuer in an FFE and FF-SHOP (i.e., the state area served by the FFE and FF-SHOP) CMS plans to release a copy of the QHP Agreement in the spring of 2013. In order for QHPs to be displayed in the Exchange to potential enrollees during the initial open enrollment period, we anticipate issuers should submit the signed agreement to CMS by approximately September 9. The QHP Application and agreement should be signed by a representative of the issuer who has the authority to commit the issuer to upholding all statutory and regulatory requirements.

SECTION 4. FFE QHP ANNUAL REVIEW AND RECERTIFICATION

This section describes how CMS will conduct QHP recertification. States participating in a State Partnership Exchange may use a similar approach.

QHP certification in an FFE is valid for one year. Issuers wishing to continue participating in FFEs will be required to apply for recertification. CMS's annual review and recertification process, including the associated data and/or document needs, will be outlined in future guidance. Issues that emerge through issuer audits, monitoring, consumer complaints, and/or concerns raised by states or consumers during the 2014 coverage year will factor into CMS's future certification decisions.

Consistent with a state's role in State Partnership Exchange certification activities, CMS expects that states participating in State Partnership Exchanges will establish their own QHP recertification processes that are consistent with FFE policies and guidance. CMS will articulate a process for working with states to complete recertification in future guidance.

SECTION 5. CERTIFICATION OF STAND-ALONE DENTAL PLANS

This section provides additional guidance for stand-alone dental plans seeking certification in FFEs, including State Partnership Exchanges.

CMS and states participating in a State Partnership Exchange will use the QHP certification process, with necessary adjustments, to certify stand-alone dental plans. As provided in the Exchange Final Rule,[27] stand-alone dental plans seeking Exchange certification must meet all applicable QHP certification standards. Chapter 4 identifies which QHP certification standards will apply to stand-alone dental plans in FFEs, including State Partnership Exchanges, for the 2014 coverage year. CMS anticipates verifying compliance with those requirements by having stand-alone dental plan issuers attest to meeting the applicable certification requirements as part of their QHP Applications. More information on stand-alone dental plans is included in Chapter 4.

SECTION 6. CERTIFICATION OF CO-OPS FOR ALL EXCHANGES

This section provides additional guidance for CO-OPs seeking certification in FFEs, including State Partnership Exchanges, and State-based Exchanges.

[27] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 C.F.R. parts 155, 156, & 157).

Section 1322 of the Affordable Care Act establishes the Consumer Operated and Oriented Plan (CO-OP) Program to provide additional health plan options for consumers in Exchanges. Consistent with this goal, QHPs offered by CO-OPs may be deemed certified to participate in the Exchanges by CMS pursuant to section 1301(a)(2) of the Affordable Care Act.

Under 45 C.F.R. § 156.520(e) of the final rule Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan Program,[28] to be deemed certified to participate in an Exchange, a CO-OP plan must meet the terms of the CO-OP Program, federal standards for Exchanges, and any state-specific Exchange standards.[29] CO-OP plans may be deemed certified to participate in the Exchanges for two years by CMS. CMS will work closely with State-based Exchanges and states participating in State Partnership Exchanges to assess whether plans offered by a CO-OP meet all certification standards. A State-based Exchange's or state's recommendation regarding whether a CO-OP plan meets Exchange certification standards will be given consideration in CMS's determination to deem a CO-OP's plan to be certified to be offered through an Exchange, though the final decision will remain with CMS under the CO-OP rule.

To apply to have a plan deemed certified to participate in FFEs, including State Partnership Exchanges, a CO-OP issuer must generally follow the same application process as other QHP issuers. When registering in HIOS, CO-OPs must select the CO-OP indicator on the QHP Application to be considered for deeming. CMS does not expect to collect information beyond the QHP Application from CO-OPs in order to complete the deeming process in FFEs, including State Partnership Exchanges.

SECTION 7. OPM CERTIFICATION OF MULTI-STATE PLANS FOR ALL EXCHANGES

This section provides additional guidance for multi-State plans seeking certification in FFEs, including State Partnership Exchanges, and State-based Exchanges.

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan Program (MSPP) as required under section 1334 of the Affordable Care Act. Specifically, OPM is responsible for contracting with at least two health insurance issuers to offer individual and small group coverage through multi-State plans (MSPs) made available on Exchanges. In accordance with section 1334(d) of the Affordable Care Act, MSPs offered by MSPP issuers under contract with OPM are deemed to be certified by an Exchange.

[28] Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan Program, 76 Fed. Reg. 77392 (Dec. 13, 2011) (to be codified at 45 C.F.R. 156).

[29] CO-OPs are not required to meet state-specific Exchange standards that operate to exclude CO-OPs due to being new issuers or other characteristics inherent in the design of a CO–OP.

Issuers seeking to offer MSPs must apply to participate via OPM's online application portal.[30] OPM will evaluate issuer applications and determine which issuers are qualified to become MSPP issuers. OPM plans to work closely with states in reviewing benefits and rates to achieve a viable MSPP and a level playing field for all issuers within a state. In accordance with section 1334(d) of the Affordable Care Act, the contracts between MSPP issuers and OPM will specify each MSP that the issuer will offer and in what state it will be offered. The MSP will thereby be deemed to be certified by OPM to be offered on the Exchange(s) operating in those states. In order to be deemed certified to be offered on an Exchange, an MSP must be offered in the relevant state under contract with OPM.

OPM will provide further information to MSPP issuers on a number of issues, including data transmissions to Exchanges, reporting requirements, and other matters. In addition, the MSPP contract will set forth performance requirements for MSPP issuers. MSPs offered under contract with OPM will be displayed on the FFE website and included in the display of QHPs made available through consumer tools. CMS plans to display accreditation status, CAHPS® data (if applicable), and a link to existing quality data provided by OPM, though OPM will communicate quality requirements for MSPs.

[30] For more information about the MSPP, including the MSPP application and MSPP regulations, visit http://www.opm.gov/healthcare-insurance/multi-state-plan-program/. The MSPP final rule is Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges, 78 Fed, Reg, 15559 (Mar. 11, 2013) (to be codified at 45 C.F.R. part 800). For the MSPP application, OPM is requiring applicants to submit information in phases. On March 29, applicants were required to submit information relating to the first section of the application. By April 15, applicants must submit information all other information, except for information relating to rates and benefits. By April 29, applicants must submit information relating to rates and benefits.

Chapter 3: Qualified Health Plan Performance and Oversight

Section 1311 of the Affordable Care Act establishes minimum standards that health plans must meet in order to be certified as QHPs. CMS, in operation of FFEs, is responsible for the ongoing compliance of issuers offering QHPs in all states where FFEs, including State Partnership Exchanges, are operating.

SECTION 1. ACCOUNT MANAGEMENT

This section describes how CMS will monitor QHP performance during the coverage year in all FFEs, including State Partnership Exchanges.

As described in previously released guidance, all issuers participating in FFEs, including State Partnership Exchanges, will be assigned a federal Account Manager. Account Managers will serve as the QHP issuer's primary point of contact with the Exchange and will provide QHP issuers with clarification and other assistance related to issuers' responsibilities and requirements for participating in the Exchange. Particularly in State Partnership Exchanges, the Account Manager will focus on issues that are unique to Exchange participation, such as assisting issuers with questions regarding the Exchange website, enrollment transaction files, and other operational matters. CMS expects that states, regardless of Exchange type, will take the lead in addressing market-wide issues, such as complaints related to market conduct.

SECTION 2. QHP ISSUER COMPLIANCE AND OVERSIGHT

This section describes how CMS will monitor QHP performance during the coverage year in all FFEs, including State Partnership Exchanges.

QHP issuers will be asked to submit a Compliance Plan as part of the QHP Application. The Compliance Plan is largely intended as a means for each issuer to document its efforts to ensure that appropriate processes are in place to maintain adherence with applicable regulations and guidelines, as well as to prevent fraud, waste, and abuse. CMS believes that compliance plans are a key part of an issuer's overall performance. While submission of a compliance plan is not a requirement for QHP certification, we encourage issuers to submit a plan and we anticipate using the plan as part of determining whether a certifying a particular QHP is in the interests of the qualified individuals and qualified employers who are served by the applicable FFE.

CMS will generally look to existing state compliance oversight and enforcement efforts for issues that fall under the state's regulatory and enforcement authority (e.g., standards that apply to all non-grandfathered individual and small-group market products). CMS will also investigate compliance concerns that are Exchange-specific in nature. CMS intends to use a risk-based approach to monitoring compliance, focusing first on issuers that show signs of potential

performance issues or non-compliance. CMS will consider whether to perform periodic compliance reviews to address evident or suspected performance issues or non-compliance, consistent with oversight and enforcement authority.

SECTION 3. QHP MARKETING

This section describes how CMS will monitor QHP performance during the coverage year in all FFEs, including State Partnership Exchanges.

45 C.F.R. § 156.225 requires that in order to have a plan certified as a QHP, a QHP issuer must comply with all applicable state laws regarding health plan marketing. In addition, a QHP issuer must not employ marketing practices that could discourage the enrollment of individuals with significant health needs.

Because states generally already regulate health plan marketing materials and other documents under state law, CMS does not intend to review QHP marketing materials for compliance with state standards as described at 45 C.F.R. § 156.225. However, to assist consumers in identifying plans that have been certified by an Exchange, we recommend that all marketing materials distributed to enrollees and to potential enrollees, contain the following disclaimer: "[Insert plan's legal or marketing name] is a Qualified Health Plan issuer in the [Health Insurance Marketplace]." A logo for the Health Insurance Marketplace will also be made available for use on marketing materials.[31] Marketing materials should include communications to consumers and enrollees, such as advertising materials, consumer notices, and brochures. We note that consumer-facing materials will refer to the Exchange as the "Health Insurance Marketplace."

In addition to complying with state marketing standards that apply to all issuers, QHP issuers must ensure that all marketing products and materials meet the meaningful access standards described in Chapter 6, Section 6 of this Letter to ensure access for individuals with limited English proficiency and individuals with disabilities (*See* 45 C.F.R. §§ 155.205, 155.230, and 156.250).

[31] Information on the logo and how issuers can obtain it for official use is available at http://marketplace.cms.gov/GetOfficialResources/marketplace-brand-guide.pdf.

Chapter 4: Stand-alone Dental Plans

Stand-alone dental plans are treated uniquely in the Affordable Care Act, particularly with respect to stand-alone dental plan participation in Exchanges. Thus, various statutory and regulatory standards apply differently to stand-alone dental plans from how they apply to other QHPs. To provide states, issuers, and other stakeholders with additional clarity on this issue, the following sections cover a number of policy issues unique to stand-alone dental plans.

SECTION 1. REGULATION OF STAND-ALONE DENTAL PLANS

This section clarifies which federal statutory and regulatory standards related to the Affordable Care Act apply to stand-alone dental plans participating in any Exchange.

i. Affordable Care Act Provisions that Do Not Apply to Stand-alone Dental Plans

When provided under a separate policy, certificate, or contract of insurance, or when they are otherwise not an integral part of the plan,[32] limited scope dental benefits are excepted benefits, as defined by PHS Act section 2791(and its implementing regulations at 45 C.F.R. § 146.145(c)), and thus not subject to the requirements of Parts A and B of Title XXVII of the PHS Act. This means that stand-alone dental plans are not subject to the insurance market reform provisions of the Affordable Care Act that amend the PHS Act and generally apply to non-grandfathered health plans in the individual and group markets inside and outside the Exchange, such as guaranteed availability and renewability of coverage.[33]

There are other provisions of the Affordable Care Act that generally apply to QHPs offered through an Exchange that are not applicable to stand-alone dental plans because of the unique nature of the limited benefits stand-alone dental plans provide. As stated in 45 C.F.R. § 155.1065, issuers of stand-alone dental plans and stand-alone dental plans must meet QHP certification standards, except for any certification requirement that cannot be met because the plan only covers dental benefits.

Additionally, section 1402(c)(5) of the Affordable Care Act, implemented in 45 C.F.R. § 156.440(b), excludes stand-alone dental plans from the cost-sharing reduction (CSR) requirements placed on medical QHP issuers. The Affordable Care Act provision generally states that any CSRs that would be applied to the pediatric dental EHB in a comprehensive

[32] 45 C.F.R. § 146.145(c)(3)(i).
[33] Examples of PHS Act reforms that do not apply to stand-alone dental plans include but are not limited to section 2718 medical loss ratio standards, section 2701 rating standards related to age, family size, rating area, and tobacco, section 2702 guaranteed availability standards, and section 2703 guaranteed renewability standards.

medical QHP will not be applied if the pediatric dental benefit is provided through a stand-alone plan.

ii. Affordable Care Act Provisions that Apply to Stand-alone Dental Plans

Some market-wide and Exchange-specific provisions in the Affordable Care Act do apply to stand-alone dental plans that are seeking certification as a QHP, including but not limited to:

- **Prohibition on Annual and Lifetime Dollar Limits**: Section 2711 of the PHS Act (and its implementing regulations at 45 C.F.R. § 147.126) generally prohibits group health plans and health insurance issuers in the individual and group markets from placing annual or lifetime limits on the dollar value of EHB for any beneficiary.[34] Under 45 C.F.R. § 155.1065(a)(2), the pediatric dental EHB offered by stand-alone dental plans certified to be offered in the Exchanges must be offered without annual and lifetime limits.
- **Annual Limits on Cost-sharing:** Under 45 C.F.R. § 156.150(a), rather than meeting the specific dollar limits that apply to cost sharing for comprehensive medical QHPs, stand-alone dental plans certified to be offered inside an Exchange will be required to demonstrate to the Exchange (FFE or otherwise) that they have a reasonable annual limitation on cost-sharing in place. The EHB/Accreditation final rule also clarified that the Exchange is responsible for determining the level for "reasonable."

SECTION 2. OFFERING STAND-ALONE DENTAL PLANS

This section describes how stand-alone dental plans will be treated in FFEs, including State Partnership Exchanges.

i. Certification of Stand-alone Dental Plans

Stand-alone dental plans must meet the applicable standards for certification and to comply with requirements related to coverage of the EHB package, as articulated in 45 C.F.R. §§ 155.1065 and 156.150. The following chart outlines some of the certification standards that do and do not apply to stand-alone dental plans seeking certification in the FFEs for the 2014 coverage year. We note that in addition to the applicable certification standards, issuers of stand-alone dental plans will need to comply with operational processes and standards.

[34] The prohibition on lifetime limits is applicable for plan years (in the individual market, policy years) beginning on or after September 23, 2010, and the prohibition on annual limits is applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2014. Restricted annual limits are permissible with respect to plan years beginning prior to January 1, 2014, in accordance with the requirements at 45 C.F.R. § 147.126(d).

Table 4.1: Certification Standards Applicable to Stand-alone Dental Plans

Certification Standard Applies (* denotes modified standard)		**Certification Standard Does Not Apply**
Essential Health Benefits*	Actuarial Value*	Accreditation
Maximum Out-of-Pocket Limits*	Licensure	Cost-sharing Reduction Plan Variations
Network Adequacy	Inclusion of ECPs	Unified Rate Review Template
Marketing	Service Area	
Non-discrimination		

Stand-alone dental plans will generally use the same QHP Application, but will complete and submit the application on an adjusted timeline. Some portions of the QHP certification application require modifications to accommodate the limited scope of stand-alone dental plans. For the 2013 QHP certification cycle, CMS anticipates that the draft plan benefits template will be ready for stand-alone dental plans by May 1. Issuers of stand-alone dental plans can begin to work on completing the other QHP templates in advance of May; however, final submission of stand-alone dental plan applications will need to occur between May 15 and May 31.

One modified standard is the limit on out-of-pocket costs. In 45 C.F.R. § 156.150, stand-alone dental plans are directed to demonstrate that they have a reasonable annual limitation on cost-sharing, as determined by the Exchange. For the 2014 coverage year in the FFE, CMS interprets the word "reasonable" to mean any annual limit on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees.

ii. Displaying Stand-alone Dental Plan Rates

As articulated in 45 C.F.R. § 155.205(b), the Exchange is required to collect and display premium rate information for all QHPs, including stand-alone dental plans, in a standardized and comparable way. In addition, 45 C.F.R. § 156.210 requires QHP and stand-alone dental plan issuers to submit rate and benefit information to the Exchange as a standard for certification by the Exchange. To the extent that stand-alone dental plans qualify as excepted benefits, they are not required to meet the rating rules of PHS Act section 2701(a) that underlie the QHP Rating Tables and business rules template. However, stand-alone dental plans will still need to complete these tables, and based on that information, CMS will display basic, comparable rate information for stand-alone dental plans on the web portal. CMS will also calculate the advance payment of the premium tax credit for stand-alone dental plans using the pediatric dental EHB premium allocation.

When a consumer is directed to the stand-alone dental plan issuer to make the initial premium payment to effectuate enrollment, the stand-alone dental plan issuers would have the ability to make any premium adjustments beyond those accounted for in the Rating Tables and based on additional rating factors available to issuers of stand-alone dental plans.

In order to provide the maximum amount of information to consumers during plan selection, stand-alone dental plans will need to indicate whether they are committing to the rates reported in the Rating Tables or if they are reserving the option to charge additional premium amounts. Issuers of stand-alone dental plans would indicate in the templates included in the issuer application for QHP certification whether they are guaranteeing the rate that is completed in the templates. If the issuer indicates that the rates are guaranteed, then the issuer would not charge additional rates beyond what is reported in the rating templates. If the issuer indicates that the rates are not guaranteed, the issuer could charge additional premiums to the consumer. The plan compare function of the FFE website will inform consumers what the different indications mean.

If an issuer of stand-alone dental plans elects to charge an additional premium, CMS would collect that information for the individual market from the issuer during the transmission of enrollment information and acknowledgement process. As with QHPs in the individual market, the enrollee will be billed by and make payments directly to the stand-alone dental plan issuer.

iii. Separately Offering and Pricing Stand-alone Dental Plans

In the discussion of stand-alone dental plans in the preamble to the Exchange Final Rule, it is noted that each Exchange can require, as a condition of certification, comprehensive medical QHPs to offer and price the pediatric dental EHB (if covered) separately, if doing so would be in the best interest of consumers.

For the 2014 coverage year, CMS will not require comprehensive medical QHP issuers that provide pediatric dental coverage to offer and price the pediatric dental EHB separately from the rest of the plan in connection with certification by an FFE.

Additionally, the FFE will not have the capacity to display dental benefits of a QHP as a separate or severable benefit, for example where an issuer offers both health plans and stand-alone dental plans and wishes to "bundle" them in the plan compare website. In order to be displayed on the Exchange website, dental benefits must either be offered as part of a comprehensive medical QHP (either directly by the health insurance issuer or through contract with a dental plan issuer) or offered separately through a stand-alone dental plan.

iv. Data Collected through the Stand-alone Dental Plan Voluntary Reporting Program

In order to allow QHP issuers to exercise the statutory option to omit the pediatric dental EHB in an Exchange where a stand-alone dental plan is also offered, CMS established a voluntary reporting program[35] to determine in which Exchanges dental issuers are likely to offer stand-alone plans. The voluntary reporting encouraged dental issuers that intend to seek certification of one or more stand-alone plans in an Exchange to communicate their intent to CMS by state, service area, and market (individual or group). The data were published for the FFE states on February 11, 2013 on the CCIIO website. [36] The data show that a stand-alone dental plan is expected to be offered in each state in which an FFE, including a State Partnership Exchange, will be operating; therefore, QHP issuers participating in FFEs, including State Partnership Exchanges, can expect to have the option to omit the pediatric dental EHB. In future years, CMS expects to publish these data in the Letter.

[35] *See* Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42,658 (July 20, 2012) (to be codified at 45 C.F.R. part 156) and OMB control number 0938-1174.

[36] Issuers of Stand-alone Dental Plans: Intent to Offer in FFE States (Jan. 23, 2013), *available at* http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf.

Chapter 5: Consumer Enrollment and Premium Payment[37]

In the General Guidance on Federally-facilitated Exchanges,[38] CMS outlined a high-level approach for implementation of the enrollment process in FFEs. This Chapter provides updated policy, operational, and technical information to assist issuers in their preparations to offer health insurance coverage through the FFE. Specifically, this Chapter addresses the enrollment process, the enrollment transaction and accompanying Companion Guide for issuers, related transactions, enrollment periods, effective dates, changes, terminations, and enrollment reconciliation. Because eligibility and enrollment functions will be conducted by CMS in State Partnership Exchanges, all processes related to eligibility and enrollment described in this Chapter will apply in all FFEs, including State Partnership Exchanges. Some of the standards and practices outlined in this Chapter will also apply to State-based Exchanges. However, given the complexity of state laws in this area and additional flexibility authorized for State-based Exchanges, CMS intends to provide similarly detailed guidance to State-based Exchanges and participating issuers in those Exchanges in the future.

Sections 1 – 3 provide a high-level overview of the enrollment process, including premium payment. The policies and procedures outlined in these sections are consistent with the Exchange Final Rule, and are intended to promote issuer readiness to receive and transmit necessary data and process premium payments. If deemed necessary, CMS will publish future guidance addressing nuances associated with applying for coverage via a paper application.

SECTION 1. OVERVIEW OF THE ENROLLMENT PROCESS FOR QUALIFIED INDIVIDUALS

When a qualified individual wishes to purchase health insurance in a qualified health plan or stand-alone dental plan through the FFE, the individual will:

1. Complete the eligibility application for coverage and, if desired, insurance affordability programs through the Exchange;
2. Evaluate available QHPs to compare the options;
3. Make a plan selection;
4. Select the desired amount of APTC, if eligible; and
5. After being re-directed by the Exchange to the appropriate issuer's website, follow instructions provided by the issuer to determine how to make the first premium payment (unless the APTC is greater than the premium) and provide any additional information required by the QHP issuer to process the enrollment, such as a selection of primary care

[37] In this chapter, sections 1, 2, 6, 7, and 9 generally do not apply to the FF-SHOP.
[38] General Guidance on Federally-facilitated Exchanges (May 16, 2012), available at http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf.

provider. More information about the initial premium payment is provided later in this document.

At least once daily, the Exchange and QHP issuers will exchange electronic files containing information about new enrollments, updates for existing enrollees (e.g., address changes), cancellations, and terminations. The enrollment transactions will also include the APTC and CSR amounts for those who are eligible for that assistance. QHP issuers are expected to update their internal records promptly to match the Exchange's records.

SECTION 2. PAYMENT OF PREMIUMS

i. Premium Payments

Enrollees in all FFEs (including State Partnership Exchanges) will make premium payments directly to the QHP issuer; the Exchange will not accept premium payment on behalf of issuers. The mechanism of payment must comply with the issuer's payment policies. When a qualified individual makes a QHP selection online, the Exchange will direct the individual to the issuer's website. If the issuer accepts payment electronically, we anticipate that the individual will be able to make the first premium payment on-line using that link to the issuer's website. We expect that QHP issuers will also provide a telephone number that individuals can call to make payment or ask questions. If payment must be made by other means, instructions should be provided on the issuer's website. QHP issuers must be able to accept payment in ways that are non-discriminatory.

In the event that the payment information submitted by the individual is inconsistent with the issuer's payment policies (for example, because the payment does not clear the issuer's financial institution), QHP issuers are permitted to follow their standard cancellation procedures (for initial premium payments) or termination procedures (for existing enrollees), subject to applicable federal law and regulations, including section 2703 of the PHS Act, as implemented in 45 C.F.R. § 147.106. For existing enrollees, coverage may be terminated in accordance with the allowable grace periods set forth at 45 C.F.R. §§ 155.430(b) and 156.270(c). Issuers must develop a process for notifying an enrollee of the termination, communicating the reason for the termination. CMS believes that also providing an explanation of any associated liability for medical claims that may have been incurred would be a best practice for QHP Issuers.

ii. Initial Premium Payment Cut-off Dates and Cancellations

CMS recommends but does not require that issuers establish the following best practices regarding payment cut-off dates and coverage cancellations. The cut-off date set by issuers for premium payment by the enrollee would be no later than the day before the effective date of coverage and would not be earlier than the last possible date of plan selection. For example, if a

qualified individual selects a QHP on December 14, 2013, for coverage on January 1, 2014, the premium payment cut-off date would be no earlier than December 15, 2013, and no later than December 31, 2013. Issuers could choose to *cancel* coverage of any qualified individual who does not make timely payment of the initial premium. Requiring initial premium payment before the effective date of coverage would prevent an individual from using the insurance benefit of covered services without first having made a premium payment, so CMS recommends that issuers follow that practice. If the qualified individual is still in an enrollment period at the time the coverage is cancelled, he or she could go through the plan selection process again and may select the same or another QHP, should the individual be eligible to enroll in coverage at that future date.

If a qualified individual makes a QHP selection but later selects a new QHP before the coverage effective date, the initial QHP selection will be automatically cancelled by the Exchange as part of the transmission of updated enrollment information to QHP issuers. If any premiums were paid to the initial QHP, the issuer would be responsible for refunding the premium. In some instances, such as when cancellation requests are received immediately before the coverage effective date, the process might result in a retroactive cancellation and issuers should ensure their systems can accommodate such transactions.

iii. APTCs and Premium Payments from Qualified Individuals and Enrollees

In order for the Exchange to appropriately administer APTCs, the QHP issuer must report current and accurate information on the status of qualified individual and enrollee premium payments. QHP issuers will provide up-to-date information on the last premium payment date for every enrollee. In accordance with 45 C.F.R. §§ 155.270, 162.925 and 162.1502, QHP issuers will use Version 5010 Technical Report Type 3 Benefit Enrollment and Maintenance Transaction (ASC X12 834), adopted by the Secretary of Health and Human Services on January 23, 2009.

SECTION 3. EFFECTIVE DATE OF COVERAGE

When a qualified individual enrolls in a QHP, enrollment effective dates follow the rules established by 45 C.F.R. §§155.410(c)(1) and 155.420(b)(1)–(2); CMS will not attempt to negotiate alternative (earlier) effective dates for QHPs offered through FFEs. Although most coverage effective dates are either the first of the following month or the first of the second following month, there are exceptions for certain special enrollments (such as those for birth, adoption, placement of adoption, marriage and loss of minimum essential coverage), which allow a qualified individual or enrollee to make a plan selection outside of the initial or annual open enrollment period.

Special enrollment period coverage effective dates depend on the type of event, the date of request for a special enrollment period, and the date of plan selection. CMS will determine

enrollee eligibility for all special enrollment periods in the FFEs, including the State Partnership Exchanges, in accordance with 45 C.F.R. § 155.420.[39] Table 5.1 depicts certain triggering events and their corresponding effective enrollment dates, assuming the individual selects a plan and makes a timely premium payment.

Table 5.1: Examples of Effective Dates of Coverage for Individuals

Triggering Event	**Triggering Event Date**	**Eligibility Determination Date**	**Enrollment Period**		**Plan Selection Date Examples**	**Enrollment Effective Dates (first available date depending on the plan selection date)**
			Start	**End**		
Initial Open Enrollment Period		10/1/13	10/1/13	3/31/14	10/1/13	1/1/2014
					3/16/14	5/1/2014
Annual Open Enrollment Period (example for years subsequent to 1/1/2015)		9/10/15	10/15/15	12/7/15	12/7/15	1/1/16
Special Enrollment Periods last 60 days from the triggering event per 45 C.F.R. § 155.420(c).[40] Enrollment Period start dates below indicate the earliest date an individual could select a plan.						
Relocation	4/1	4/10	4/10	5/30	4/15	5/1
	4/10			6/10	4/16	6/1
	3/20			5/20	5/16	7/1
Birth	6/1	7/20	7/20	7/30	7/29	6/1
Loss of Minimum Essential Coverage	4/28	4/28	4/28	6/28	4/29	5/1
	4/15			6/15	5/2	6/1

[39] 45 C.F.R. §155.725 sets standards for special enrollment periods in the SHOP, including the FF-SHOP.
[40] In Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program; Proposed Rule; 78 Fed. Reg. 15553 (Mar. 11, 2013) (to be codified at 45 C.F.R. parts 155 & 156), we propose amending the duration of certain special enrollment periods for the SHOP.

Triggering Event	Triggering Event Date	Eligibility Determination Date	Enrollment Period		Plan Selection Date Examples	Enrollment Effective Dates (first available date depending on the plan selection date)
Marriage	4/12	5/28	5/28	6/12	5/28	5/1
Loss of employer-sponsored insurance	8/30	8/5	8/5	10/30	8/5	9/1

SECTION 4. TRANSMISSION OF ENROLLMENT INFORMATION BETWEEN THE FFE AND QUALIFIED HEALTH PLANS

45 C.F.R. § 155.270 requires Exchanges to use standards, implementation specifications, operating rules, and code sets adopted by the Secretary under the HIPAA and the Affordable Care Act when conducting certain electronic transactions with a covered entity, such as an issuer.

The transaction standard CMS and issuers will use to exchange electronic enrollment files will be the ASC X12 834, adopted by the Secretary of CMS on January 23, 2009, and required for use by HIPAA covered entities – like issuers and health plans – on January 1, 2012. CMS released a Companion Guide[41] for certain fields and data elements for use by Exchanges and issuers to include data elements not otherwise provided in the ASC X12 834 standard transaction, such as APTCs. Most issuers currently use Companion Guides to provide direction to their trading partners when conducting any type of HIPAA-compliant data exchange such as enrollment, claims processing, eligibility inquiries, and claim status inquiries. Issuers offering QHPs through an FFE, including a State Partnership Exchange, must use ASC X12 834 with the CMS Companion Guide for purposes of QHP enrollment transactions. The CMS Companion Guide is available for use by issuers and Exchanges to begin programming and internal testing.

In some situations (e.g., natural disaster or serious technical problems), it may be necessary to accept an enrollment file in a non-electronic data interface (EDI) format. CMS will work with QHP issuers to evaluate and determine appropriate alternate paths to transmit enrollment data, which may include CD, tapes, or online processes, as necessary under those circumstances.

[41] Standard Companion Guide Transaction Information Companion Guide Version Number: 1.0 (January 31, 2013). Available at: http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf.http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf.

The ASC X12 Version 5010 834 Benefit Enrollment and Maintenance Transaction TR3 may be purchased from ASC X12, at http://store.x12.org/store/.

i. Enrollment Transaction Acknowledgement Files (ASC X12 999)

When the issuer receives the daily enrollment file, in accordance with 45 C.F.R. § 155.400(b)(2), it must acknowledge receipt of information to the FFE by transmitting an ASC X12 Version 5010 999 Implementation Acknowledgement for Health Care Insurance transaction (ASC X12 999 Acknowledgement). This transaction informs the submitter that the file (the ASC X12 Version 5010 834 Benefit Enrollment and Maintenance Transaction TR3) arrived at the destination and can be processed. The ASC X12 999 Acknowledgement may include the number of transactions received, the number of transactions processed, and any errors detected. CMS will provide future guidance as to the other content required in the ASC X12 999 Acknowledgement.

ii. Enrollment Confirmation Transaction

Issuers will use the ASC X12 834 as a confirmation transaction for certain enrollment actions. For example, when a qualified individual submits full payment to the issuer for any applicable initial premium due, the issuer will send the Exchange a full ASC X12 834 "confirmation" record. The confirmation file provides CMS, in operation of the FFEs, assurance that the issuer has effectuated enrollment consistent with the information received from the Exchange and also provides the Exchange with the data necessary to reconcile any pending transactions.

iii. Identifiers within the Enrollment Transaction

Both CMS and issuers will utilize several identifiers in the enrollment transaction, including unique identifiers designating the subscriber, enrollee, issuer, and Exchange. Some of these identifiers will be created and provided to the issuer by the Exchange, and some will be created by the issuer and sent to the Exchange. The identifiers, their sources, and definitions will be included in the CMS Companion Guide to include information about the qualifiers that will be used with each identifier, where they will be found in the transaction, and how they will be defined. The key identifiers for the enrollment transaction are the subscriber identifier, which is the identifier for the person with the primary coverage, and the member identifier, which is associated with the other individuals who are insured with the subscriber.

iv. Unique Identifiers for the Subscriber

Issuers use unique numbers to identify subscribers and members, and these numbers are often associated with the individual for as long as such individual maintains coverage through a group or health plan with that issuer. The ASC X12 834 standard requires the use of an individual

identifier in each transaction to ensure the accuracy of an exchange of data between two trading partners, and the consistency of that information over time.

CMS will assign a unique identifier to each qualified individual enrolled in a QHP. The unique identifier will be associated with the specific issuer and will not "travel" with the qualified individual if the individual changes QHPs. If the qualified individual changes to a QHP with another issuer, he or she will receive a new identifier. However, if the qualified individual returns to a QHP issuer from whom he or she previously held coverage through the Exchange, the same identifier will be reassigned to that person.

For non-FF-SHOP enrollees, because CMS will be redirecting qualified individuals to QHP issuers to make initial premium payments rather than aggregating premiums in the FFEs serving the individual market, the FFE will provide QHP issuers with a unique transaction ID during redirect to aid issuers in matching initial premium payments made by qualified individuals to the ASC X12 834 transactions sent by the Exchange which will also contain the transaction ID.

SECTION 5. TERMINATION OF COVERAGE AND CANCELLATION OPTIONS

The FFE will initiate all enrollee terminations of coverage and enrollment, except that the QHP issuer may initiate terminations in cases of non-payment of premium to the issuer by the enrollee and situations covered by 45 C.F.R. § 147.128 (e.g., fraudulent activity by the enrollee). When enrollees wish to terminate coverage, they should provide reasonable notice. Issuers will receive termination information from the Exchange through an ASC X12 834 transaction, and guidance on the data elements to be used in the transaction will be provided in the Companion Guide.

SECTION 6. GRACE PERIODS FOR NON-PAYMENT OF PREMIUMS

In accordance with the Exchange Final Rule, issuers will be permitted to terminate coverage for enrollees who fail to pay premiums. However, 45 C.F.R. § 156.270(d) requires issuers to observe a three month grace period before terminating coverage for those enrollees who are receiving APTCs. The grace period only applies to enrollees who have already paid their share of one month's premium in full; for enrollees who meet this initial requirement, the grace period is triggered once the enrollee subsequently misses a premium payment. The final rule outlines a process for addressing such instances of non-payment, including issuer responsibilities with respect to provider notification and claims payment.

If an enrollee makes all outstanding premium payments before the end of the grace period, the enrollee's enrollment with the same QHP remains intact. However, if an enrollee exhausts the

grace period without making all outstanding premium payments, the issuer may terminate coverage with notice to the enrollee. An enrollee may not extend the grace period by paying only a portion of the outstanding premium (e.g., by paying the first outstanding month's premium). If coverage is terminated for non-payment of premiums, the last day of coverage may be as soon as the last day of the first month of the grace period; thus, coverage may be terminated retroactively, if permitted by state law. If an enrollee exhausts the grace period and coverage is then terminated, the issuer must return APTCs for the second and third months to the Treasury Department. CMS intends to provide additional information about this process in the future.

If an enrollee's coverage in a QHP is terminated for non-payment of premiums, as indicated on the 834 transaction via the disenrollment code, he or she may not enroll in another QHP with any issuer through a special enrollment period. 45 C.F.R. § 155.420(d)(1) and (e). However, he or she may have other opportunities to enroll under the enrollment periods provided for under the guaranteed availability requirement, implemented in 45 C.F.R. § 147.104. We anticipate that all Exchanges will have access to this information as part of the enrollment information sent by QHP issuers in the ASC X12 834 standard. If a QHP issuer terminates the enrollee's coverage for non-payment, all individuals covered by the policy also lose coverage. Applicable state law will govern any applicable grace periods for enrollees not receiving APTCs within the Exchange.

SECTION 7 NOTICE REQUIREMENTS

i. Notice of Premium Non-payment— to Enrollees

Issuers must notify enrollees who are receiving APTCs and who have failed to make a premium payment that they are delinquent in such payment, as described in 45 C.F.R. § 156.270(f). The notice should be written in plain language and comply with the standards provided herein under Chapter 6, Section 6 with regard to the provision of notice to people with limited English proficiency or to people with disabilities. Issuers should include the following information:

- Purpose of the notice;
- An identification/reference number unique to the notice;
- The name of the QHP and affiliated issuer;
- Primary subscriber and relevant contact information;
- Names of all enrollees affected by the unpaid premium;
- Explanation about the three-month grace period, including applicable dates;
- The telephone number for the QHP customer service; and
- Consequences of losing coverage, including:
    - Repayment of premium tax credits provided for months of coverage that is retro-actively terminated,

- Inability to participate in a special enrollment period, and
- Individual responsibility for paying any medical claims incurred during the period of the retroactively terminated coverage.

ii. Notice of Pending Claims—to Providers

In accordance with 45 C.F.R. § 1 56.270(d)(3), issuers must notify providers that may be affected (meaning at least providers that submit claims for services rendered during the grace period) that an enrollee has lapsed in his or her payment of premiums. Issuers may utilize automated electronic processes to convey such notices. The notice must indicate there is a possibility that the issuer may deny payment of claims incurred during the second and third months of the grace period if the enrollee exhausts the grace period without paying the premiums in full. Issuers should notify all potentially affected providers as soon as is practicable when an enrollee enters the grace period, since the risk and burden are greatest on the provider. Issuers should include the following information in the provider notification:

- Purpose of the notice;
- A notice-unique identification number;
- The name of the QHP and affiliated issuer;
- Names of all individuals affected under the policy and possibly under the care of this provider;
- An explanation of the three month grace period, including applicable dates, including:
  - Whether the enrollee is in the second or third month of the grace period,
  - Consequences of grace period exhaustion for the enrollee and provider, and
  - Options for the provider; and
- The QHP customer service telephone number specifically for use by providers, if available.

SECTION 8. ENROLLMENT RECONCILIATION

On at least a monthly basis, as determined by CMS, the Exchange and issuers will exchange full enrollment files to identify and resolve discrepancies between the enrollment records and to ensure information in each system (Exchange and issuer) is consistent.

i. Reconciliation Process

To operationalize the requirements in 45 C.F.R. § 155.400(d) and 45 C.F.R. § 156.265(f), in an FFE, including a State Partnership Exchange, CMS will conduct a reconciliation process electronically and in a bi-directional flow between the Exchange and the issuer, meaning that each party will send the other a full file of data for comparison. At a scheduled time each month, each issuer will compile an ASC X12 834 audit file comprised of all enrollments for a specified period of time (e.g., one quarter), and will transmit this file to the FFE through the Data Services

Hub (Hub). CMS will compare the issuer records with the internal enrollment records for the Exchange for that same period of time. The files will be transmitted through the Hub and will be processed based on evaluation criteria to be established for the reconciliation processes. At the same time CMS is comparing its files to those of the issuers, CMS will compile and send an ASC X12 834 audit file to each issuer for the same time period, comprised of all individuals enrolled in that issuer's QHPs. QHP issuers may use this file for their own comparison and analysis.

The data exchange will allow the issuers and the Exchanges to run comparisons to identify discrepancies using key data elements including name, date of birth, issuer ID numbers, plan/level, effective and termination dates, cancellations, and APTC and CSR amounts. CMS will create discrepancy reports specific to each QHP issuer, and analyze the discrepancy reports and conduct appropriate research to understand and resolve discrepancies so that ultimately the issuer and CMS will have the same enrollment data. This may involve some manual effort and discussions on the part of both CMS and/or QHP issuers to obtain correct information from enrollees.

ii. Enrollment and Mid-year Changes

Issuers will receive from the Exchange electronic transactions containing enrollment changes and updates due to enrollees reporting changes in circumstances throughout the benefit year and as part of the eligibility redetermination process. The Exchange will send transactions in sequential order and should be applied sequentially in order to ensure that issuers have the most up-to-date mid-year change data. Issuers will also periodically receive an update from the Exchange with retroactive changes. The most common instances in which this will occur include birth, death, errors, QHP material provision violations, and exceptional circumstances. The process for how APTC and CSR will be handled is outlined in the Final Payment Notice.

SECTION 9. DIRECT ENROLLMENT WITH THE QHP ISSUER

As provided in 45 C.F.R. § 156.265(b)(2), a QHP issuer may treat an enrollee as enrolled in a QHP through the Exchange if the issuer directs the individual to the Exchange, or ensures that the individual receives an eligibility determination for coverage through the Exchange.

Where an FFE or State Partnership Exchange is operating, CMS intends to make available a technical solution that allows a consumer to enroll through the Exchange using an issuer's website or web-broker to initiate the enrollment process and complete plan comparison and selection. All consumers, including those who approach QHP issuers directly seeking to enroll through the Exchange, will complete the single, streamlined application described in 45 C.F.R. §155.405 and receive an eligibility determination from the Exchange. In addition, the Exchange will continue to serve as the system of record for all enrollment transactions. Consumers will be

able to complete an initial enrollment and to report changes, including changes that impact eligibility, through this process. CMS intends to provide additional guidance about this process, including technical specifications for issuers, in the near future.

SECTION 10. AGENTS AND BROKERS

Section 1312(e) of the Affordable Care Act and 45 C.F.R. § 155.220 permit states to allow agents and brokers to enroll qualified individuals, employers, and employees in QHPs through an Exchange. Where permitted by the state, agents and brokers (including web-brokers) may assist with the eligibility application and enrollment processes, including plan selection, as well as in applying for insurance affordability programs, including APTCs and CSRs, subject to the standards outlined in 45 C.F.R. § 155.220.

All agents and brokers, including web-brokers, seeking to enroll individuals through an FFE or FF-SHOP must be licensed by the relevant state and adhere to all applicable state laws. States are expected to maintain their current roles of overseeing agents and brokers in their insurance markets, including licensure requirements, appointments with issuers, and any compensation standards.[42]

CMS will work with agents and brokers, including web-brokers, to facilitate enrollment in FFEs or FF-SHOPs, including State Partnership Exchanges, to the extent permitted by state law. CMS expects that agents and brokers will leverage existing processes to assist consumers, and plans to provide additional information on this process in the near future.

Issuers must ensure that marketing activities conducted on their behalf by agents and brokers, including web-brokers, participating in FFEs and FF-SHOPs comply with applicable federal and state requirements. Any marketing materials related to an issuer's QHPs and used by an agent or broker must conform to requirements in the QHP issuer's Agreement with the Exchange.

[42] However, we expect that a QHP issuer participating in an FFE or FF-SHOP would pay the same commission for a QHP sold inside and outside of an Exchange.

Chapter 6: Consumer Support

SECTION 1. CALL CENTER AND WEBSITE

Issuers should have their own call centers and websites to support consumers' customer service needs. CMS believes that issuer websites should provide information about QHP offerings, benefits, and coverage information; how to contact the issuer regarding premium payment; and where to seek information on eligibility determinations and learning more about the FFE and financial assistance (i.e., FFE website). CMS also expects issuers to have a toll-free call center available for consumers post-enrollment. Issuers will want to have customer service channels available to assist with consumer questions. Following is an overview of the kinds of customer service CMS will be providing for the FFE; we encourage issuers to use this information as a guide in how they implement their customer service channels to serve their enrollees and prospective enrollees.

CMS will also provide customer support and is responsible for the operation of the FFE Call Center, to support consumers in states that do not have a State-based Exchange, including states where a State Partnership Exchange is operating. The Call Center will provide an unbiased central point of contact for consumers and employees.

Where possible, the customer service representatives at the Call Center will be able to provide referrals to the appropriate state or federal agencies or assistance programs (such as Navigators and other in-person assisters), or issuers.

The Call Center will be established so that all customer service representatives are able to address requests for general information, consumer eligibility, plan comparisons, and enrollment.

CMS will also operate a website to support consumers in states that do not have a State-based Exchange. CMS expects that states participating in State Consumer Partnership Exchanges will promote the FFE website by including the Health Insurance Marketplace URL on their state website beginning on June 1, 2013. The website supporting FFEs and State Partnership Exchanges will be compliant with section 508 of the Rehabilitation Act of 1973, designed to accommodate people with disabilities according to federal requirements, and will support the following key program topics in both English and Spanish:

- Consumer education,
- Customer self-service,
- Exchange, Medicaid and CHIP program support (e.g., eligibility determinations, enabling successful plan selection, and enrollments), and
- Information about available consumer support (such as customer service representatives, in-person assisters, Navigators, agents, etc.).

Additionally, the website will be designed to support seamless handoffs (or redirections) to more appropriate websites. For example, if a consumer indicates he or she resides in a state with a State-based Exchange where a website for that State-based Exchange is available, the consumer will be re-directed to the appropriate website.

Mobile support is also a strong focus for the FFE. At a minimum, the website will be provided in a mobile-friendly format using responsive design techniques.

CMS is also funding Navigators in each FFE and State Partnership Exchange that will provide assistance to consumers as directed in 45 C.F.R. § 155.210. The duties of Navigators include maintaining expertise in eligibility, enrollment, and program specifications; conducting public outreach; providing information in a fair, impartial and accurate manner; facilitating selection of a QHP; making referrals to consumer assistance entities when appropriate; and providing information in a manner that is culturally and linguistically appropriate and that is accessible by individuals with disabilities.

SECTION 2. CONSUMER EDUCATION

CMS encourages QHP issuers to engage in consumer education efforts. Educational, marketing, and plan materials should comply with the requirements for meaningful access for limited English proficient individuals and for people with disabilities, as required by 45 C.F.R. §§ 155.230(b) and 156.250. In addition, CMS notes that QHPs are required to provide a Summary of Benefits and Coverage (SBC) and uniform glossary to current enrollees as well as to individuals and small employers seeking insurance in accordance with the rules set forth at 45 C.F.R. § 147.200.

SECTION 3. PROVIDER DIRECTORY

Pursuant to 45 C.F.R. § 156.230, CMS will require QHPs to make their provider directories available to the Exchange for publication online by providing the URL link to their network directory. CMS expects the directory to include location, contact information, specialty and medical group, and any institutional affiliations for each provider. CMS encourages issuers to include information such as whether the provider is accepting new patients, languages spoken, provider credentials, and whether the provider is an Indian provider.

SECTION 4. COMPLAINTS TRACKING AND RESOLUTION

CMS expects QHP issuers to investigate and resolve consumer complaints received directly from members or forwarded to the issuer by the state and/or CMS. Complaints may be forwarded within a CMS complaint tracking system developed by CMS or by other means as determined by

CMS and states. CMS expects issuers to resolve complaints in a timely and accurate manner to ensure consumers receive the highest level of service and to meet QHP issuer participation standards as outlined in 45 C.F.R. § 156.200.

In addition, issuers are expected to comply with all applicable state and federal laws related to consumer complaints, including advising consumers of their appeal rights. CMS intends to track complaints and use aggregated complaints information as a tool for directing oversight activities in FFEs and State Partnership Exchanges. To the greatest degree possible, CMS will collaborate with states in tracking complaints and sharing information suggestive of issuer performance problems. We intend to provide further information on issuer standards for consumer complaints in the future.

SECTION 5. COVERAGE APPEALS

QHPs are required to meet the standards for internal claims and appeals and external review established in 45 C.F.R. § 147.136, which implements section 2719 of the PHS Act, as added by the Affordable Care Act. Section 2719 of the PHS Act requires that all non-grandfathered group health plans and non-grandfathered health insurance issuers offering group or individual health insurance coverage implement an effective process for internal claims and appeals and external review. QHPs must fully comply with the requirements of 45 C.F.R. § 147.136 and any applicable guidance documents.

SECTION 6. MEANINGFUL ACCESS

In order to ensure meaningful access by limited-English proficient speakers and by people with disabilities, the Exchange Final Rule requires that QHP issuers provide all applications, forms, and notices to enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and individuals with limited English proficiency. *See* 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250. Additionally, 45 C.F.R. § 156.200(e) prohibits QHP issuers, with respect to QHPs, from discriminating on the basis of race, color, national origin, or disability, among other bases.

QHPs are reminded that these meaningful access requirements are independent of other obligations QHPs may have. In accordance with 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, providing meaningful access includes but is not limited to the following. For people with disabilities, providing meaningful access includes the use of accessible websites and the provision of auxiliary aids and services in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. For limited-English proficient speakers, providing meaningful access includes providing oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services. Furthermore, QHP issuers must inform individuals of the availability of the services described above, instruct

consumers how to access those same services, and indicate to applicants and enrollees that said services will be provided at no cost to them.

CMS remains open to proposals for how issuers plan to meet the regulatory meaningful access requirements.

CMS expects that QHP issuers will ensure meaningful access to at least the following essential documents:

- Applications (including the single streamlined application);
- Consent, grievance, and complaint forms, and any documents requiring a signature;
- Correspondence containing information about eligibility and participation criteria;
- Notices pertaining to the denial, reduction, modification, or termination of services, benefits, non-payment, and/or coverage;
- A plan's explanation of benefits or similar claim processing information;
- QHP ratings information, as applicable;
- Rebate notices; and
- Any other document that contains information that is critical for obtaining health insurance coverage or access to care through the QHP.

Documents related to appeals and SBC are not included in this list because they have their own regulatory standards with which issuers must comply.

We intend to further address and clarify the standards for ensuring meaningful access by limited-English-proficient speakers and by people with disabilities in the future. QHP issuers will be held to whatever standards will ultimately apply as a result of that guidance.

Chapter 7: Tribal Relations and Support

SECTION 1. MODEL CONTRACT ADDENDUM FOR TRIBAL ISSUERS WORKING WITH INDIAN PROVIDERS

The federal government has a historic and unique relationship with Indian tribes. In adhering to QHP certification standards, CMS encourages QHPs to engage with Indian health care providers, through which a significant portion of American Indians and Alaska Natives (AI/AN) access care. To promote contracting between issuers and Indian health care providers, CMS developed a Model QHP Addendum (Addendum) to facilitate the inclusion of Indian Health Service (IHS), tribal organization, and urban Indian organization providers (Indian health care providers) in QHP provider networks. The Addendum is a model standardized document for QHP issuers to use in contracting with Indian health care providers; the Addendum is also intended to help QHP issuers comply with the QHP certification standards set forth in part 156 of the Exchange Final Rule.

Although the Addendum is voluntary, it can assist QHP issuers in including Indian health care providers in their networks and provides an efficient way to establish contract relationships with such providers, while also helping to ensure that AI/ANs can continue to be served by their Indian provider of choice. The Model QHP Addendum is available on the CCIIO website, and a database of Indian health care providers compiled by the IHS should be available soon.

SECTION 2. TRIBAL SPONSORSHIP OF PREMIUMS

45 C.F.R. § 155.240(b) provides Exchanges with flexibility to permit Indian tribes, tribal organizations, and urban Indian organizations to pay QHP premiums—including aggregated payment—on behalf of members who are qualified individuals, subject to terms and conditions determined by the Exchange. During consultations with tribal governments, tribal leaders indicated the importance of tribes having the ability to pay premiums on behalf of their members. Over the course of several months, CMS assessed its various systems to determine how the FFEs could establish a process to facilitate Tribal Premium Sponsorship or the ability of Indian tribes, tribal organizations, and urban Indian organizations to pay premiums on behalf of AI/ANs. Because the FFEs will not collect premiums directly from individuals, CMS concluded that the FFEs will not be able to establish a process that would facilitate premium sponsorship, including Tribal Premium Sponsorship, for October 1, 2013. CMS recognizes that aggregating premium payments can be an effective mechanism for increasing the enrollment of AI/ANs in QHPs and will continue to work on this option for future years. It should be noted that tribes are able to work with issuers or tribal members directly to pay premiums. Additionally, this determination does not preclude State-based Exchanges from developing and implementing a process for Tribal Premium Sponsorship. CMS encourages tribes to continue to work closely with State-based Exchanges, including the option to explore tribal premium sponsorship.

Appendix A: Authorities Cited

Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26, 29 & 42 U.S.C.)

Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 26, 29 & 42 U.S.C.)

Internal Revenue Code, 26 U.S.C. § 1, *et seq*.

Public Health Service Act, 42 U.S.C. § 201, *et seq*.

Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq.*

Social Security Act, 42 U.S.C. § 301, *et seq*.

Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan Program, 76 Fed. Reg. 77392 (Dec. 13, 2011) (to be codified at 45 C.F.R. part 156)

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 C.F.R. parts 155, 156, & 157)

Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, 77 Fed. Reg. 42658 (Jul. 20, 2012) (to be codified at 45 C.F.R. part 156)

Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges, 78 Fed. Reg. 15559 (Mar. 11, 2012) (to be codified at 45 C.F.R. part 800)

Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834 (Feb. 25, 2013) (to be codified at 45 C.F.R. parts 147, 155, & 156)

Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13406 (Feb. 27, 2013) (to be codified at 45 C.F.R. parts 144, 147, 150, 154, & 156)

Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410 (Mar. 11, 2013) (to be codified at 45 C.F.R. parts 153, 155, 156, 157, & 158.).

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 15553 (Mar. 11, 2013) (to be codified at 45 C.F.R. parts 155 & 156)

Internal Revenue Serv., Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377 (May 23, 2012) (to be codified at 26 C.F.R. parts 1 & 602).

Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Serv., General Guidance on Federally-facilitated Exchanges (May 16, 2012), *available at* http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf.

Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Serv., Guidance on State Partnership Exchange Options in the Federally-facilitated Exchange (Jan. 3, 2013), *available at* http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf.

Ctr. Consumer Info. & Ins. Oversight, Ctrs. For Medicare & Medicaid Serv., Issuers of Stand-alone Dental Plans: Intent to Offer in FFE States (Jan. 28, 2013), *available at:* http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf.

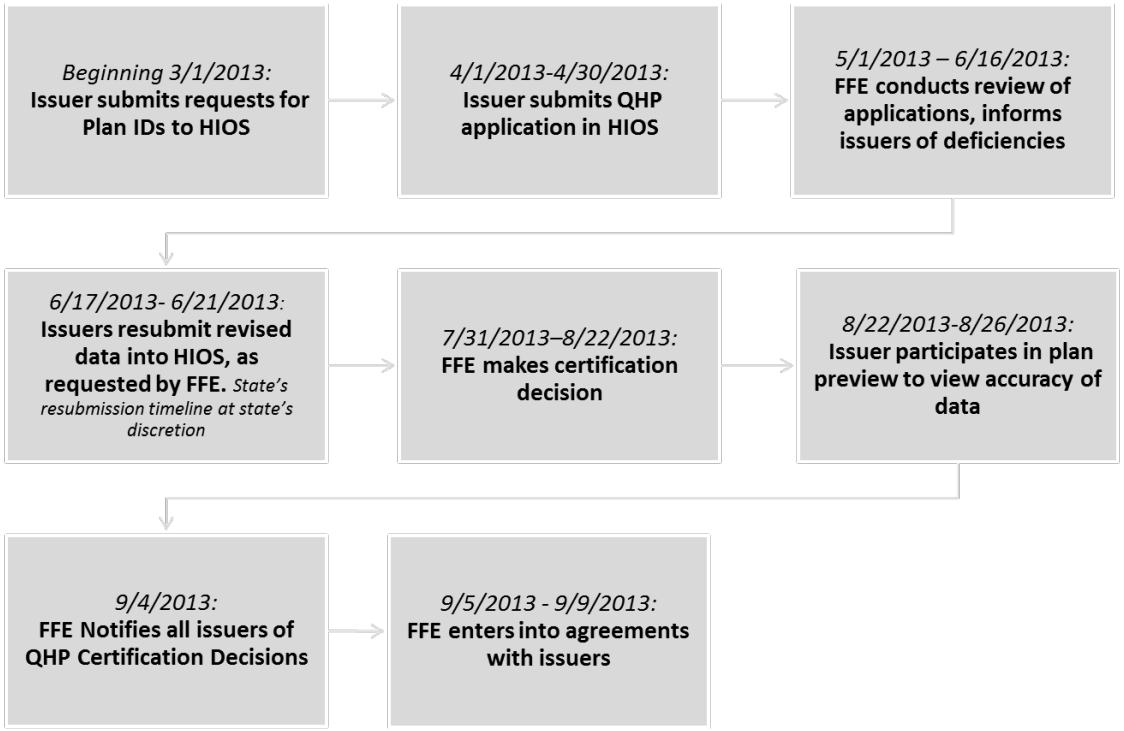
Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Serv., Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Exchange (FFE) (Jan. 31, 2013), *available at:* http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf.

Internal Revenue Serv., Rev. Proc. 2012-26, 26 C.F.R. §601.602, *available at* http://www.irs.gov/pub/irs-drop/rp-12-26.pdf.

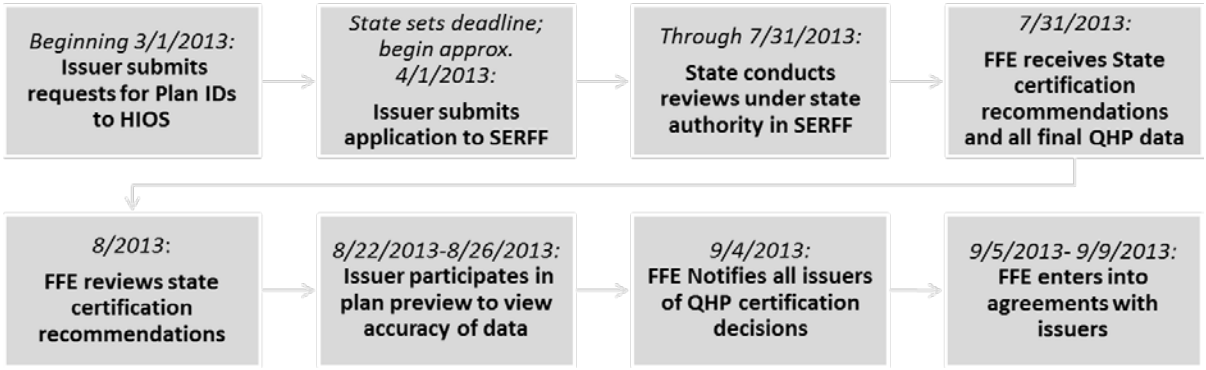
Appendix B: High-level Process Flows for QHP Certification
Note: all dates are subject to minor changes.

Non-Partnership FFE

Note: CMS expects the majority of states to enforce 2014 market reforms, including EHB and AV standards, for QHPs.



State Partnership Exchange



Appendix C: Additional Guidance on EHB Prescription Drug Coverage, Actuarial Value, and Cost Sharing

This appendix provides additional guidance and clarification on 45 CFR §§ 156.122, 156.130, and 156.135. Specifically, it address the drug count service CMS developed to compute the number of drugs per United States Pharmacopeial Convention (USP) category and class offered by an EHB-compliant formulary, the prescription drug exceptions process, calculating AV for health plans that are not compatible with the AV Calculator, and AV standards for the annual limitation on deductibles for health plans offered in the small group market.

EHB Prescription Drug Standards

i. Drug Count Service

45 C.F.R. § 156.122(a)(1) requires a health plan providing essential health benefits to cover at least the greater of 1) one drug in every USP category and class, or 2) the same number of prescription drugs in each USP category and class as the EHB-benchmark plan. A drug is considered covered regardless of tiers and cost sharing. The specific drugs covered on each health plan's formulary may vary as long as the minimum number in each USP category and class is met. For example, if a benchmark plan covers Lipitor (atorvastatin), a plan providing EHB could cover Zocor (simvastatin) because both of those drugs are in the same USP category or class. Similarly, if a benchmark plan covers five drugs in the statin class and a plan providing EHB covers five different drugs in the statin class, this plan would also meet the standard.

CMS computed the number of chemically distinct drugs covered by each EHB benchmark in each USP category and class by cross-walking National Drug Codes (NDCs) to categories and classes using the USP Model Guidelines version 5.0. Different dosages of the same drug, different concentrations of the same active ingredient, brands and their generic equivalents, extended release and non-extended release formulations, and different delivery methods of the same drug were counted as one drug within a USP category and/or class.

Table 1.1 Examples of Chemically Distinct and Not Chemically Distinct Drugs

Chemically Distinct (counted as two drugs)	Not Chemically Distinct (counted as one drug)
• Piroxicam oral tablet and Indomethacin oral capsule • Epivir (lamivudine) oral tablet and Epzicom (abacavir and lamivudine) oral tablet	• Brand name Aricept (donepezil hydrochloride) and generic donepezil hydrochloride • Ritalin LA (methylphenidate hydrochloride) 20 mg extended release capsule and Ritalin 20 mg oral tablet

	• Penicillin oral solution, Penicillin oral tablet

CMS has developed a count service that computes the number of drugs per USP category and class offered by an EHB-compliant formulary. The service is unable to distinguish between drugs covered under the plan's medical benefit and drugs covered under the plan's prescription drug benefit. The drug count service recognizes RxNorm Concept Unique Identifiers (RxCUIs) that successfully crosswalk to a USP category and class. States may elect to use CMS's drug count service to review plan formularies, if desired. CMS notes that formularies that include more than the minimum number of required drugs would not be considered to provide benefits in excess of EHB, because this scenario is similar to offering more generous coverage of the same benefit or a more robust provider network.

ii. Prescription Drug Exceptions Process

45 C.F.R. § 156.122(c) establishes that a health plan providing EHB must have procedures in place that allow an enrollee to request and access clinically appropriate drugs not covered by the health plan. The exceptions process outlined below is distinct from the coverage appeals process described in PHS Act section 2719.

CMS recognizes that most commercial health plans already have an exceptions process in place. Those plans may continue to use their current processes, so long as the existing processes allow an enrollee to request both an internal and an independent review of the exception request. Otherwise, CMS encourages issuers to use the following process:

- Step 1 – Internal review: The issuer would consider an exception request (made verbally or in writing within 60 calendar days following notification of the denial, by an enrollee, enrollee's representative, or prescriber on behalf of an enrollee) and provide verbal notification of its determination as expeditiously as an enrollee's health condition requires. CMS encourages issuers to provide a decision no later than 72 hours after the request is received. When an enrollee is suffering from a serious health condition, CMS encourages issuers to provide a decision no later than 24 hours after receiving the request. The issuer would provide its decision in writing no later than 48 hours after verbal notice has been given. The issuer would also advise the consumer about his or her ability to request an independent review.

- Step 2 – Independent review: If the issuer denies the exception request in Step 1, the enrollee (or enrollee's representative or prescriber) may request, orally or in writing, a second review, within 60 calendar days of the internal review decision. The independent review entity (IRE) contracted by the issuer to review the exception request denial would

make a decision within the same timeframes described in Step 1. The IRE's decision would be provided in writing no later than 48 hours after verbal notice has been given.

Consistent with the Medicare Part D program, CMS suggests that a drug is clinically appropriate, and should be covered, if an oral or written supporting statement is submitted from a prescriber, and establishes that the requested prescription drug is clinically appropriate to treat the enrollee's disease or medical condition, based on one or more of the following criteria:

i. All of the covered drugs on any tier of the plan's covered drug list for treatment for the same condition would not be as effective for the enrollee as the requested drug, and/or would have adverse effects for the enrollee, or
ii. The number of doses available under a dose restriction for the prescription drug:
    a. Has been ineffective in the treatment of the enrollee's disease or medical condition or,
    b. Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
iii. The prescription drug alternative(s) listed on the covered drug list or required to be used in accordance with step therapy requirements:
    a. Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
    b. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

As part of the required exceptions process, CMS strongly encourages plans offering EHB to allow the enrollee to have the medication in dispute during the entire exception request review process and, if the exception request is granted, to allow the enrollee to have access to the non-covered drug in subsequent plan/policy years should enrollment continue without interruption.

CALCULATING THE ACTUARIAL VALUE OF HEALTH PLANS THAT ARE NOT COMPATIBLE WITH THE AV CALCULATOR

Although the AV Calculator has been designed to accommodate the vast majority of plan designs, there is the possibility that the Calculator will not be able to accommodate a small percentage of plan designs.

For example, the following types of plan designs would not be compatible with the AV Calculator:

> **Example 1**: A plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10 percent coinsurance for the first $1,000 in consumer spending after the deductible, 20 percent coinsurance for the next $1,000 in consumer spending, and 40 percent coinsurance up to a $6,400 out-of-pocket maximum. This plan design would not be compatible because the current AV Calculator can accommodate only a single coinsurance rate for each benefit.
>
> **Example 2**: A plan with a multi-tiered provider or hospital network with substantial amounts of utilization expected in tiers other than the two lowest-priced tiers. This plan design would not be compatible because the current AV Calculator does not take into account utilization beyond the second network tier when computing AV.

Generally, a plan design that includes different cost sharing for services not included in the AV Calculator would be considered compatible with the AV Calculator. For example, advanced imaging is a single cost-sharing input in the Calculator; a plan design would not be considered incompatible because it assigns different copayment amounts to different types of imaging (e.g., MRI versus CT). Similarly, because the AV Calculator does not consider quantitative or qualitative limits for any benefit, the application of limits to a particular benefit would generally not necessitate one of the alternative methods for AV calculation.

Under 45 C.F.R. § 156.135(b), issuers with plan designs that are not compatible with the AV Calculator will need to use an alternate method to calculate AV. 45 C.F.R. § 156.135(b) provides two alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AV Calculator. Issuers of such plans must:

- Make adjustments to certain key plan design features to input a modified plan design that fits into the parameters of the AV Calculator, and have an actuary certify that the plan design was appropriately fit into the parameters of the AV Calculator; or

- Use the AV Calculator to determine the AV for plan provisions that do fit within its parameters, and then have an actuary calculate appropriate adjustments to the Calculator-generated AV to account for remaining plan features. For example, a plan with reference pricing for prescription drugs could use the Calculator to determine the AV for the medical benefits in its plan and then make adjustments to reflect its prescription drug benefits.

Both of the AV calculation methods for evaluating incompatible plans designs must be certified by a member of the American Academy of Actuaries, in accordance with generally accepted

actuarial principles and methodologies. If an issuer uses either of the two alternate methods for calculating AV just described, the issuer must submit an actuarial certification.

ii. Family Plan Design

The AV Calculator standard population and claims data were developed using claims data that did not include any family cost-sharing information. Issuers of plans with deductibles and/or out of pocket maximum costs that accumulate at the family rather than the individual level have several options depending on the specifics of the family plan.

In the case of a plan with a deductible and/or out-of-pocket maximum that accumulates first at the individual level and in addition at the family level, the plan enters the individual deductible and out-of-pocket maximum into the AV Calculator to determine AV. If deductible and out-of-pocket maximum accrue only at the family level and not at the individual level, the issuer may either include the family deductible and out-of-pocket maximum into that actuarial value calculator or, if the issuer believes that the family plan cost-sharing features of the plan's cost-sharing features will make a material difference in the AV produced by the calculator, the issuer may use one of the §156.135(b) exceptions described above to calculate AV and include plan-specific data on how the family-specific cost sharing is adjusted.

ANNUAL LIMITATIONS ON DEDUCTIBLES FOR EMPLOYER-SPONSORED HEALTH PLANS IN THE SMALL GROUP MARKET

Section 1302(c)(1) of the Affordable Care Act sets an annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) as part of the EHB package that non-grandfathered policies sold in the individual and small group markets must offer. As provided in 45 C.F.R. § 156.130(c), cost sharing for benefits provided outside of a health plan's network do not count towards the annual limitation on cost sharing when the health plan uses a provider network. For plan or policy years beginning after January 1, 2014, this limit will be the out-of-pocket limit for high deductible health plans (HDHP), adjusted by the Consumer Price Index (CPI-U), and set by the Internal Revenue Service (IRS) pursuant to section 223(c)(2)(A)(ii) of the Internal Revenue Code. Issuers of stand-alone dental plans should consult Chapter 4 of this Letter for more information on stand-alone dental plans.

EXHIBIT 6

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

Instructions: Please review and respond **Yes** or **No** to each of the attestations below and sign the Statement of Detailed Attestation Responses document. CMS may accept a **No** response, along with a justification for any of these **No** responses, to any of the individual attestations identified in the Supplemental "Updated QHP Attestation Instructions" (https://www.regtap.info/). Please be sure to reference the specific attestation in your justification discussion.

Program Attestations

General Issuer Attestations

1.) Applicant attests that it will adhere to all requirements contained in 45 CFR 156, and all applicable federal and state law.

○ Yes ◉ No

2.) Applicant attests that it will have a license by the end of the certification period, be in good standing, and be authorized to offer each specific type of insurance coverage offered in each State in which the issuer offers a QHP.

◉ Yes ○ No

3.) Applicant attests that it will be bound by 2 CFR 376 and that no individual or entity that is a part of the Applicant's organization is excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. This attestation includes any member of the board of directors, key management or executive staff or major stockholder of the applicant and its affiliated companies, subsidiaries or subcontractors.

○ Yes ◉ No

4.) Applicant attests that it will inform HHS, based on its best information, knowledge and belief, of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration against the applicant (under a current or former name), its principals, or any of its subcontractors. The applicant also attests that, based on its best information, knowledge and belief, none of its principals, nor any of its affiliates is presently debarred, suspended, proposed for debarment, or declared ineligible to participate in Federal programs by HHS or another Federal agency under 2 CFR 180.970 or any other applicable statute or regulation, and should such actions occur, it will inform HHS within 5 working days of learning of such action.

◉ Yes ○ No

5.) Applicant attests that it will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

6.) Applicant attests that it will market its QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.

◉ Yes ○ No

7.) Applicant attests that it will adhere to all non-renewal and decertification requirements in accordance with 45 CFR 156.290.

◉ Yes ○ No

8.) Applicant attests that it will adhere to requirements related to the segregation of funds for abortion services consistent with 45CFR 156.280 and all applicable guidance, as applicable.

◉ Yes ○ No

9.) Applicant attests that it will adhere to provisions addressing payment of federally-qualified health centers in 45 CFR 156.235(e).

◉ Yes ○ No

Compliance Plan

Applicant attests that it has a compliance plan that adheres to all applicable laws, regulations, and guidance, that the compliance plan is ready for implementation, and that the applicant agrees to reasonably adhere to the compliance plan provided. Any changes to the compliance plan will be submitted to HHS for review.

◉ Yes ○ No

If **Yes**, applicant should upload a copy of the applicant's compliance plan in the QHP Application Issuer Module.

Organizational Chart

Applicant attests that it is providing its organizational chart and that it will inform HHS of any significant changes to the organizational chart provided within 30 days of that change after the submission of this application.

◉ Yes ○ No

If **Yes**, applicant should upload a copy of the applicant's organizational chart in the QHP Application Issuer Module.

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

Operational Attestations

1.) Applicant attests that it will notify HHS of any pending change in ownership of the QHP issuer or that issuer's parent entities and will obtain approval for transfer of responsibility for its QHPs prior to making any change in ownership.

◉ Yes ○ No

2.) Applicant attests that it will comply with all QHP requirements, including technical requirements related to the use of FFE Plan Management system, on an ongoing basis and comply with Exchange systems, tools, processes, procedures, and requirements.

◉ Yes ○ No

3.) Applicant attests that it has in place an effective internal claims, grievance, and appeals process that complies with 45 CFR 147.136 as applicable, and agrees to act in accordance with all requirements for an external review process with respect to QHP enrollees in an applicable State or Federal external review process in compliance with 45 CFR 147.136 as applicable.

◉ Yes ○ No

Benefit Design Attestations

1.) Applicant attests that it will not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs or pre-existing conditions in QHPs in accordance with 45 CFR 156.225.

◉ Yes ○ No

2.) Applicant attests that it will comply with all benefit design standards, federal regulations and laws, and state mandated benefits for all services including: preventive services, emergency services, and formulary drug list.

◉ Yes ○ No

3.) Applicant attests that it will abide by all cost-sharing limits:

a.) the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) for emergency department services is the same regardless of provider network status, as applicable;

b.) it will make available enrollee cost sharing under an individual's plan or coverage for a specific item or service, consistent with 45 CFR 156.220.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

4.) Applicant attests that it will follow all Actuarial Value requirements.

◉ Yes ○ No

5.) Applicant attests that it will offer through the Exchange a minimum of one QHP at the silver coverage level and one QHP at the gold coverage level in accordance with 45 CFR 156.200(c), or a minimum of one plan at either a high or low coverage level for issuers of stand-alone dental plans.

◉ Yes ○ No

6.) Applicant attests that it will offer a child-only QHP(s) at the same level of coverage(s) as any QHP or stand-alone dental plans offered through the Exchange in accordance with 45 CFR 156.200(c).

◉ Yes ○ No

7.) Applicant attests that its catastrophic QHPs will only enroll individuals under the age of 30 or individuals deemed exempt from the individual mandate.

◉ Yes ○ No

8.) Applicant attests that its QHPs provide coverage for each of the 10 statutory categories of EHB in accordance with the applicable EHB benchmark plan and federal law:

a.) its QHPs provide benefits and limitation on coverage that are substantially equal to those covered by the EHB-benchmark plan;

b.) it complies with the requirements of 45 CFR 146.136 with regard to mental health and substance use disorder services, including behavioral services;

c.) it provides coverage for preventive services described in 45 CFR 147.130;

d.) it complies with EHB requirements with respect to prescription drug coverage;

e.) any benefits substituted in designing QHP plan benefits are actuarially equivalent to those offered by the EHB benchmark plan;

f.) it complies with the prohibition on discrimination with regard to EHB;

g.) its QHPs' benefits reflect an appropriate balance among the EHB categories, so that benefits are not unduly weighted toward any category;

h.) its QHPs include all applicable state required benefits.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

Stand-Alone Dental Attestations

1.) Applicant attests that it either offers no stand-alone dental plans, or that all stand-alone dental plans that it offers will comply with all benefit design standards and federal regulations and laws for stand-alone dental plans, as applicable, including that:

a.) the out-of-pocket maximum for its stand-alone dental plan is reasonable for the coverage of pediatric dental EHB;

b.) it offers the pediatric dental EHB;

c.) it does not include annual and lifetime dollar limits on the pediatric dental EHB.

◉ Yes ○ No

2.) Applicant attests that it either offers no stand-alone dental plans, or that any stand-alone dental plans it offers are limited scope dental plans.

◉ Yes ○ No

3.) Applicant attests that it either offers no stand-alone dental plans, or that any stand-alone dental plans it offers will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit.

◉ Yes ○ No

Rate Attestations

Applicant attests that it will comply with all rate requirements as applicable, including that it will:

a.) charge the same rates for each qualified health plan, or stand-alone dental plan, of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent;

b.) set rates for an entire benefit year, or for the SHOP, plan year and submit the rate and benefit information to the Exchange as required in 45 CFR 156.210;

c.) submit to the Exchange a justification for a rate increase prior to the implementation of an increase;

d.) prominently post rate increase justifications on its Web site;

e.) adhere to all rating area variation requirements pursuant to 45 CFR 156.255 for QHPs;

f.) comply with federal rating requirements or the state's Affordable Care Act compliant rating requirements, as applicable.

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

f.) comply with federal rating requirements or the state's Affordable Care Act compliant rating requirements, as applicable.

◉ Yes ○ No

Enrollment

1.) Applicant attests that it will meet the individual market requirement to:

a.) enroll a qualified individual during the initial and subsequent annual open enrollment periods and abide by the effective dates of coverage;

b.) make available, at a minimum, special enrollment periods (SEPs) established by the Exchange and abide by the effective dates of coverage determined by the Exchange.

◉ Yes ○ No

2.) Applicant attests that it will enable enrollees to make enrollment changes during open and special enrollment periods for which they are eligible.

◉ Yes ○ No

3.) Applicant attests that it will only terminate coverage as permitted by the Exchange and applicable State or federal law:

a.) the applicant will abide by the termination of coverage effective dates requirements;

b.) the applicant will maintain termination records in accordance with Exchange standards;

c.) the applicant will provide the enrollee with a notice of termination of coverage, consistent with the effective date required by applicable regulations, if terminating an enrollee's coverage for any reason. Notices must include an explanation of the reason for the termination. When applicable, the applicant will include in the notice an explanation of the enrollee's right to appeal;

d.) the applicant will establish a standard policy for the termination of coverage of enrollees due to non-payment of premium, provision of fraudulent application information or abuse of his or her benefit cards.

◉ Yes ○ No

4.) Applicant attests that it will provide enrollees with required documentation including: an enrollment information package, effective dates of coverage, summary of benefits and coverage, evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials, ID cards, and any notices as required by State or federal law.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

5.) Applicant attests that it will adhere to enrollment information collection and transmission requirements and will:

a.) accept enrollment information in an electronic format from the Exchange that is consistent with requirements;

b.) reconcile enrollment files with the Exchange no less than once a month;

c.) acknowledge receipt of enrollment information in accordance with Exchange standards and;

d.) timely, accurately and thoroughly process enrollment transactions and submit electronic 834 confirmation files to the Exchange to confirm the enrollees portion of the premium has been paid and coverage has been effectuated.

◉ Yes ○ No

6.) Applicant attests that if applicant utilizes Application Programming Interface (API) provided by the Exchange, the applicant will:

a.) direct individuals to the Exchange in order to initiate the eligibility process;

b.) enroll an individual only after receiving confirmation from the Exchange that the eligibility process is complete and the individual has been determined eligible for enrollment in a QHP, in accordance with the standards.

◉ Yes ○ No

7.) Applicant attests that the Issuer will follow the premium payment process requirements established by the Exchange in accordance with §156.265(d) and future guidance.

◉ Yes ○ No

8.) Applicant attests that it will provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid-in-full at least one month's premium. If an enrollee exhausts the grace period without submitting payment in full of outstanding premium due, the applicant will terminate the enrollee's coverage effective at the end of first month of the payment grace period.

◉ Yes ○ No

9.) Applicant attests that it will provide the enrollee with notice of payment delinquency if an enrollee is delinquent on premium payment.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

10.) Applicant attests that it will develop, operate and maintain viable systems, processes, procedures, and communication protocols for:

a.) the timely, accurate and valid enrollment and termination of enrollees' coverage within the exchange;

b.) the prompt resolution of urgent issues affecting enrollees, such as changes in enrollment and discrepancies identified during reconciliation.

◉ Yes ○ No

11.) Applicant attests that it will accept the total premium breakdown as determined by the Exchange and as specified in the electronic enrollment transmission. This includes:

a.) the total premium amount which is based on rate attestations submitted by the applicant;

b.) the APTC amount;

c.) any other payment amounts as depicted on the enrollment transmission.

◉ Yes ○ No

12.) Applicant attests that it will accept the advance CSR amount as determined by the Exchange and as specified in the electronic enrollment transmission.

◉ Yes ○ No

13.) Applicant attests that it will approve of the use of the following information for display on the FFE Web site for consumer education purposes: information on rates and premiums, information on benefits, the provider network URL(s) provided in this application, the URL(s) for the Summary of Benefits and Coverage provided in this application, the URL(s) for payment provided by this application, information on whether the issuer is a Medicaid managed care organization, and quality information, as applicable, derived from the accreditation survey, including accreditation status and CAHPS data.

◉ Yes ○ No

Financial Management

1.) Applicant attests that it will acknowledge and agree to be bound by Federal statutes and requirements that govern Federal funds. Federal funds include, but are not limited to, advance payments of the premium tax credit, cost-sharing reductions, and Federal payments related to the risk adjustment, reinsurance, and risk corridor programs.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

2.) Applicant attests that it will adhere to the risk corridor standards and requirements set by HHS as applicable for:

a.) risk corridor data standards and annual HHS notice of benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 CFR 153.510);

◉ Yes ○ No

b.) remit charges to HHS under the circumstances described in 45 CFR 153.510(c).

◉ Yes ○ No

3.) Applicant attests that it will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit and cost sharing reductions, including the provisions at 45 CFR 156.410, 156.425, 156.430, 156.440, 156.460, and 156.470.

◉ Yes ○ No

4.) Applicant attests that it will submit to HHS the applicable plan variations that adhere to the standards set forth by HHS at 45 CFR 156.420.

◉ Yes ○ No

5.) Applicant attests that it will pay all user fees in accordance with 45 CFR 156.200(b)(6).

◉ Yes ○ No

6.) Applicant attests that it will reduce premiums on behalf of eligible individuals if the Exchange notifies the QHP Issuer that it will receive an APTC on behalf of that individual pursuant to §156.460.

◉ Yes ○ No

7.) Applicant attests that it will adhere to the data standards and reporting for the CSR reconciliation process pursuant to 45 CFR 156.430(c) for QHPs.

◉ Yes ○ No

8.) The following applies to applicants participating in the risk adjustment and reinsurance programs inside and/or outside of the Exchange. Applicant attests that it will:

a.) adhere to the risk adjustment standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR Subparts G and H);

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

b.) remit charges to HHS under the circumstances described in 45 CFR 153.610;

◉ Yes ○ No

c.) adhere to the reinsurance standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR 153.400, 153.405, 153.410, 153.420);

◉ Yes ○ No

d.) remit contributions to HHS under the circumstances described in 45 CFR 153.400;

◉ Yes ○ No

e.) establish dedicated and secure server environments to host enrollee claims, encounter, and enrollment information for the purpose of performing risk adjustment and reinsurance operations for all plans offered;

◉ Yes ○ No

f.) allow proper interface between the dedicated server environment and special, dedicated CMS resources that execute the risk adjustment and reinsurance operations;

◉ Yes ○ No

g.) ensure the transfer of timely, routine, and uniform data from local systems to the dedicated server environment using CMS-defined standards, including file formats and processing schedules;

◉ Yes ○ No

h.) comply with all information collection and reporting requirements approved through the Paperwork Reduction Act of 1995 and having a valid OMB control number for approved collections. The Issuer will submit all required information in a CMS-established manner and common data format;

◉ Yes ○ No

i.) cooperate with CMS, or its designee, through a process for establishing the server environment to implement these functions, including systems testing and operational readiness;

◉ Yes ○ No

j.) use sufficient security procedures to ensure that all data available electronically are authorized and protect all data from improper access, and ensure that the operations environment is restricted to only authorized users;

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

k.) provide access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature to CMS or CMS' designee, if requested, for audit;

◉ Yes ○ No

l.) retain all original source documentation and medical records pertaining to any such particular claims data for a period of at least 10 years;

◉ Yes ○ No

m.) be responsible for all data submitted to CMS by itself, its employees, or its agents and based on best knowledge, information, and belief, submit data that are accurate, complete, and truthful;

◉ Yes ○ No

n.) all information, in any form whatsoever, exchanged for risk adjustment shall be employed solely for the purposes of operating the premium stabilization programs and financial programs associated with state markets, including but not limited to, the calculation of user fees to fund such programs, oversight, and any validation and analysis that CMS determines necessary.

◉ Yes ○ No

9.) The following attestation applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. 18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device, a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute. Applicant acknowledges the False Claims Act, 31 U.S.C., §§ 3729-3733.

◉ Yes ○ No

10.) The following applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Applicant attests to provide and promptly update when applicable changes occur in its Tax Identification Number (TIN) and associated legal entity name as registered with the Internal

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

Revenue Service, financial institution account information, and any other information needed by CMS in order for the applicant to receive invoices, demand letters, and payments under the APTC, CSR, user fees, reinsurance, risk adjustment, and risk corridors programs, as well as, any reconciliations of the aforementioned programs.

◉ Yes ○ No

11.) The following applies to applicants participating in the Exchanges and premium stabilization programs as defined in the Affordable Care Act and applicable regulations. Applicant attests that it will develop, operate and maintain viable systems, processes, procedures and communication protocols to accept payment-related information submitted by CMS.

◉ Yes ○ No

SHOP

1.) Applicant attests that it will adhere to the SHOP issuer requirements set by HHS in 45 CFR 156.285, or that it offers no SHOP plans.

◉ Yes ○ No

2.) Applicant attests that it will not vary premiums based on whether or not the employer offers employees a choice among QHPs, or that it offers no SHOP plans.

◉ Yes ○ No

3.) Applicant attests that it will issue SHOP QHP policies naming the qualified employer rather than the SHOP as the policyholder, or that it offers no SHOP plans.

◉ Yes ○ No

4.) Applicant attests that it waives the application of any minimum participation rates calculated at the issuer level that may be allowed under state law, or that it offers no SHOP plans.

◉ Yes ○ No

Reporting Requirements

1.) Applicant attests that it will provide to the Exchange the following information in the manner identified by HHS, as applicable: claims payment policies and practices; periodic financial disclosures; data on enrollment; data on disenrollment; data on the number of claims that are denied; data on rating practices; information on cost-sharing and payments with respect to any out-of-network coverage; and information on enrollee rights under title I of the Affordable Care Act.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses

2.) Applicant attests that it will report required data on prescription drug distribution and costs consistent with 45 CFR 156.295 and all applicable guidance.

◉ Yes ○ No

3.) Applicant attests that it will comply with the specific quality disclosure, reporting and implementation requirements of 45 CFR §156.200(b)(5) as will be detailed in future guidance.

◉ Yes ○ No

Federally-facilitated Marketplace Issuer Attestations:
Statement of Detailed Attestation Responses

Attestation Justification

Provide a justification for any attestation for which you indicated **No**. Be sure to reference the specific attestation in your justification.

1.) Applicant attests that it will adhere to all requirements contained in 45 CFR 156, and all applicable federal and state law.

In response: 1. It is always Blue Cross Blue Shield of North Carolina's intent to be fully-compliant with the law. We look forward to stating in full confidence that we are indeed fully compliant with the law as requested in Attestation 1. However, we are concerned that the General Issuer Attestation 1 is overly broad such that inadvertent noncompliance could occur. We are committed to working in good faith effort to understand and comply with the requirements; however, due to the number of new requirements and the compressed time frame for implementation, there may be instances in which full compliance, despite our reasonable and good faith efforts, is not realized.

3.) Applicant attests that it will be bound by 2 CFR 376 and that no individual or entity that is a part of the Applicant's organization is excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. This attestation includes any member of the board of directors, key management or executive staff or major stockholder of the applicant and its affiliated companies, subsidiaries or subcontractors.

In response: 3. Blue Cross and Blue Shield of North Carolina can affirmatively attest to General Issuer Attestation 3 with respect to its board of directors, key management and executive staff, affiliated companies and subsidiaries. However, we cannot so attest as to stockholders because we do not have stockholders. Finally, we cannot affirmatively attest to General Issuer Attestation 3 with regard to "subcontractors." The term "subcontractors" is not defined and it is uncertain how broadly the term is intended to reach. In any case, although we will certainly employ reasonable and good faith efforts to ensure that no "subcontractors" or other third parties place us in violation of this attestation, for obvious reasons we are unable to attest to the compliance of such third parties with the absolute certainty requested here. Instead, we would prefer to add immediately prior to the term "subcontractors" the same knowledge qualifier that is found in Attestation 4 (i.e., "the applicant attests based on its best information, knowledge and belief,...").

EXHIBIT 7

FEDERAL REGISTER

Vol. 76 Friday,
No. 136 July 15, 2011

Part III

Department of Health and Human Services

45 CFR Part 153
Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS–9975–P]

RIN 0938–AR07

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

AGENCY: Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement standards for States related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment consistent with title I of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. These programs will mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Affordable Insurance Exchanges (''Exchanges'') are implemented, starting in 2014. The transitional State-based reinsurance program serves to reduce the uncertainty of insurance risk in the individual market by making payments for high-cost cases. The temporary Federally-administered risk corridor program serves to protect against uncertainty in the Exchange by limiting the extent of issuer losses (and gains). On an ongoing basis, the State-based risk adjustment program is intended to provide adequate payments to health insurance issuers that attract high-risk populations (such as individuals with chronic conditions).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (E.S.T.) on September 28, 2011.

ADDRESSES: In commenting, please refer to file code CMS–9975–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 instructions under the ''More Search Options'' tab.

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–9975–P, P.O. Box 8010, Baltimore, MD 21244–8010.

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–9975–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

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, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

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

FOR FURTHER INFORMATION CONTACT:

Sharon Arnold at (301) 492–4415 for general information.

Wakina Scott at (301) 492–4393 for matters related to reinsurance and risk corridors.

Kelly O'Brien at (301) 492–4399 for matters related to risk adjustment.

Grace Arnold at (301) 492–4272 for matters related to the collection of information requirements.

Brigid Russell at (301) 492–4421 for matters related to the summary of preliminary regulatory impact analysis.

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)

CMS Centers for Medicare & Medicaid Services

HHS U.S. Department of Health and Human Services

HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)

MLR Medical Loss Ratio

PHS Act Public Health Service Act (42 U.S.C. 201 *et seq.*)

QHP Qualified Health Plan

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. Comments will be most useful if they are organized by the section of the proposed rule to which they apply. You can assist us by referencing the file code [CMS–9975–P] and the specific ''issue identifier'' that precedes the section on which you choose to comment.

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 electronic comments received before the close of the comment period on the following public 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 be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at Room 445–G, Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 1–800–743–3951.

establish and administer a program of risk corridors. In § 153.510, HHS proposes to establish risk corridors by specifying risk percentages above and below the target amount. In paragraph (a), we propose to require a QHP issuer to adhere to the requirements set by HHS for the establishment and administration of a risk corridor program for calendar years 2014 through 2016. We will issue guidance in the forthcoming annual Federal notice of benefits and payment parameters for QHPs regarding reporting and the administration of payments and charges similar to part 158. Risk corridors guidance will be plan specific and not issuer specific as indicated in part 158. We interpret the risk corridor provision to apply to all QHPs offered in the Exchange.

In § 153.510, we also establish the payment methodology for the risk corridor program, using the thresholds and risks-sharing levels specified in statute. The risk corridor thresholds are applied when a QHP's allowable costs reach plus or minus three percent of the target amount. Accordingly, HHS will pay a QHP issuer whose QHP incurred allowable costs for a benefit year that are greater than 103 percent of its target amount. Conversely, a QHP issuer must pay HHS if its QHP's allowable costs for a benefit year are less than 97 percent of its target amount. A QHP issuer whose QHP's allowable costs for a benefit year are greater than 97 percent but less than 103 percent of the target amount will neither make nor receive payments for risk corridors. For example, a QHP issuer with a QHP that has a target amount of $10 million will not receive or pay a risk corridor payment if its allowable charges range between $9.7 million and $10.3 million.

Paragraph (b) of this section describes the method for determining payment amounts to QHP issuers as well as the timing of those payments. For a QHP with allowable costs in excess of 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer 50 percent of the amount in excess of 103 percent of the target amount. For example, a QHP has a target amount of $10 million, and the QHP has allowable costs of $10.5 million, or 105 percent of the target amount. Since 103 percent of the target amount would equal $10.3 million, the amount of allowable costs that exceed 103 percent of the target amount is $200,000. Therefore, HHS would pay 50 percent of that amount, or $100,000 to the QHP issuer.

For QHPs that have allowable costs that exceed 108 percent of the target amount, the Affordable Care Act directs HHS to pay the QHP issuer an amount equal to 2.5 percent of the target amount plus 80 percent of the amount in excess of 108 percent of the target amount. For example, a QHP has a target amount of $10 million. The QHP has allowable costs of $11.5 million, or 115 percent of the target amount. Since 108 percent of the target amount would be $10.8 million, the amount of allowable costs that exceed 108 percent of the target amount is $700,000. Therefore, HHS pays 2.5 percent of the target amount, or $250,000, plus 80 percent of $700,000, or $560,000, for a total of $810,000.

Paragraph (c) describes the circumstances under which QHP issuers will remit charges to HHS, as well as the means by which HHS will determine those charge amounts. We propose that QHP issuers will begin to remit charges to HHS for the first dollar of allowable charges less than 97 percent of the target amount. For a QHP that has allowable costs that are less than 97 percent of the target amount but greater than 92 percent of the target amount, HHS will charge the QHP issuer an amount equal to 50 percent of the difference between 97 percent of the target amount and the actual value of allowable costs. For example, a QHP has a target amount of $10 million. The amount of allowable costs for this QHP is $9.3 million, or 93 percent of the target amount. The difference between 97 percent of the target amount, or $9.7 million, and the actual allowable charges is $400,000. The QHP issuer must pay HHS 50 percent of that amount, or $200,000.

For QHPs with allowable costs below 92 percent of the target amount, the QHP issuer will remit charges to HHS an amount equal to 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the actual value of allowable costs. For that same QHP with a $10 million target amount, assume the allowable charges are now $8.8 million, or 88 percent of the target amount. Ninety-two percent of the target amount would be $9.2 million, and the difference between 92 percent of the target amount and the actual value of allowed costs is $400,000. The QHP issuer will remit charges to HHS an amount equal to 2.5 percent of the target amount, or $250,000, plus 80 percent of $400,000, or $320,000, for a total of $570,000.

While we are not proposing deadlines at this time, HHS has considered timeframes for QHP issuers to remit charges to HHS. For example, a QHP issuer required to make a risk corridor payment may be required to remit charges within 30 days of receiving notice from HHS. Similarly, HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS within a 30-day period after HHS determines that a payment should be made to the QHP issuer. We believe that QHP issuers who are owed these amounts will want prompt payment, and also believe that the payment deadlines should be the same for HHS and QHP issuers. We invite comments as to the appropriate frequency QHP issuers should remit charges to HHS.

3. Risk Corridor Standards for QHP Issuers (§ 153.520)

To support the risk corridor program calculations, we propose in § 153.520 that all QHP issuers submit data needed to determine actual performance relative to their target amounts. The data would be collected in standard formats specified by HHS. We propose in paragraph § 153.520(a) that QHP issuers must submit data related to actual premium amounts collected by QHP issuers, including premium amounts paid by parties other than the enrollee in a QHP and specifically advance premium tax credits paid by the government. We also regard risk adjustment and reinsurance as an after-the-fact adjustment to premiums for purposes of determining risk corridor amounts. Medicare Advantage, Medicare Prescription Drug Benefit Program and Medicaid managed care risk adjustment programs similarly result in adjustments to total payments to plans. However, in these programs, the adjustment occurs concurrently with payments because they are made by the government (excluding monthly premium payments made by beneficiaries). For reinsurance, we anticipate health insurance issuers will reduce their premiums by an amount that would approximate the average reinsurance that they expect to receive, filling in the gap between the premium charged and the health insurance issuer's revenue needs.

Therefore, in paragraph (a)(1), we propose that the reported premium amounts must be increased by the amounts paid to the QHP issuer for risk adjustment and reinsurance. Similarly, we propose in paragraph (a)(2) that the reported premium amounts be reduced for any risk adjustment charges the QHP issuer pays on behalf of the plan, reinsurance contributions that the QHP issuer makes on behalf of the plan, and Exchange user fees that the QHP issuer pays on behalf of the plan. We invite comment on the treatment of reinsurance and risk adjustment as after-the-fact adjustments to premium for purposes of determining risk corridor amounts.

EXHIBIT 8

American Academy *of* Actuaries

Fact Sheet: ACA Risk-Sharing Mechanisms

The 3Rs (Risk Adjustment, Risk Corridors, and Reinsurance) Explained

While potentially tens of millions of Americans could gain health insurance under the Affordable Care Act (ACA), many for the first time, the law poses some financial risks for health insurers. To address these risks, the ACA includes some protections for insurers, known as risk-sharing provisions, especially in the early years of the new program. These risk-sharing provisions were included in the law with the intent of ensuring plans will be available to consumers and reducing incentives for insurers to avoid high-cost enrollees.

The risk-sharing mechanisms interact not only with each other, but also with other elements of the ACA. Any changes to these provisions should be made with careful consideration of these interrelationships and the impact of how revisions could affect insurer risks, insurance availability, and insurance premiums.

At the beginning of 2014, insurers will be prohibited from denying coverage to individuals and families, excluding pre-existing conditions, or varying premiums based on an individual's health status. This will be a dramatic change from the pre-2014 rules governing health insurance issue and rating rules in most states, especially in the individual market, resulting in uncertainty regarding who will sign up for coverage and, among the newly insured, what their medical spending will be. Due to this uncertainty, insurers will face several risks, including: what if a particular insurance plan enrolls a disproportionately large number of very sick beneficiaries; or what if a plan's average medical spending is higher than expected due perhaps to less-than-expected enrollment of lower-cost people?

The ACA includes three risk-sharing programs to mitigate these risks—a permanent risk-adjustment program, a transitional reinsurance program that will run from 2014-2016, and a temporary risk-corridor program that will run from 2014-2016.

Question: What is the permanent risk-adjustment provision?

Answer: The prohibition of denying coverage or charging higher premiums based on health status exposes insurers to adverse selection risk, which occurs when individuals or groups who anticipate high health care needs are more likely to purchase coverage than those who anticipate low health care needs. The ACA's individual mandate and premium subsidies will reduce the adverse selection effect, although some risk remains.

The permanent risk-adjustment program aims to reduce the incentives for health insurance plans to avoid enrolling people with higher-than-average costs by shifting money among insurers based on the risks of the people they enroll. Insurers with higher shares of low-cost enrollees are to contribute to a fund that will make payment to insurers with larger shares of high-cost enrollees. All non-grandfathered plans in the individual and small group market will participate in the risk-adjustment program, whether they are inside or outside of the exchanges. The risk-adjustment program is designed to be revenue neutral (i.e., no effect on the federal budget).

Q: What is the transitional reinsurance provision?

A: The transitional reinsurance program supplements the risk-adjustment program and compensates plans when they have enrollees with especially high claims. As the ACA was being drafted, it was recognized that high-cost individuals would have the greatest incentives to enroll in coverage. Therefore, during the first years of the law's implementation, this population could make up a greater share of enrollment than in subsequent years when the individual market risk pool is anticipated to be larger and more representative of the population as a whole.

The ACA transitional reinsurance program further reduces the incentives for plans to avoid high-cost individuals and helps to stabilize premiums during the initial years. The reinsurance program will offset a portion of the costs of high-cost enrollees in the individual market.

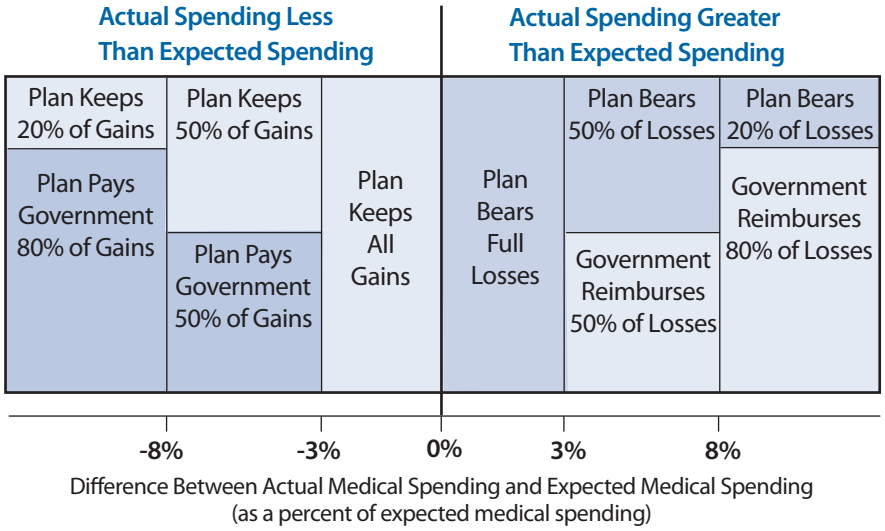
This will reduce the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans, including not only plans in the individual market, but also those in the small and large group markets, as well as self-insured plans.

These contributions are then used to make payments to non-grandfathered plans in the individual market.

In 2014, $10 billion will be collected from health plans, which will then be used to pay plans in the individual market when an individual's claims exceed $60,000.[1] Plans will be reimbursed for 80 percent of an individual's health claims between $60,000 and $250,000. The program is budget neutral; if necessary, the U.S. Department of Health and Human Services (HHS) will adjust reinsurance payments to ensure that payments do not exceed contributions collected from health plans.

Contributions to and reimbursements from the program will decline over time until the program expires after three years. The transitional nature of this program was designed to address the likelihood that the earliest enrollees in the individual market will be those with higher expected costs, including enrollees transitioning from high risk pools, whereas healthier individuals may delay enrolling.

Illustration of ACA Risk Corridors



Q: What is the temporary risk-corridor program?

A: Under the ACA, risk corridors have been established to mitigate the pricing risk that insurers face because they have very limited data to use to estimate who will enroll in plans operating under the new 2014 ACA rules and what their health spending will be. These temporary risk corridors limit insurer gains and losses—insurers receive a payment from HHS if their losses exceed a certain threshold; insurers pay the HHS if their gains exceed a certain threshold. An objective of risk corridors is to encourage health insurance competition by limiting the risk for insurers entering the exchange market during the early years of implementation. This provision applies to qualified health plans (QHPs) in the individual and small group markets.

The way the risk-corridor program works is that actual claims are compared to the expected claims that were assumed in the insurer's premiums. If actual claims are within 3 percent of expected, insurers either keep the gains or bear the losses. If actual claims exceed expected claims by more than 3 percent, HHS reimburses the plan for at least 50 percent of the excess loss. If actual claims fall below expected claims by more than 3 percent, the plan pays HHS at least 50 percent of the excess (see graph above).

The risk corridors are temporary since they are most appropriate during the first few years of the new program, when less expenditure data are available. As more data become available on the health spending patterns of the newly insured, the ability to set premiums accurately should improve, thereby reducing the need for risk corridors.

Q: Are risk-sharing provisions used in other programs?

A: The Medicare Part D program incorporates risk adjustment, reinsurance, and risk corridor provisions. The Medicare Advantage program uses risk adjustment.

For more information, see the Academy's issue brief, Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act.

[1]Proposed rules released by the Center for Consumer Information and Insurance Oversight (CCIIO) on Nov. 25 would reduce the 2014 attachment point from $60,000 to $45,000: http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf

EXHIBIT 9

FEDERAL REGISTER

Vol. 78 Monday,
No. 47 March 11, 2013

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.
Kelly Horney, (410) 786–0558, for matters related to the risk adjustment program generally.
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.
Rex Cowdry, (301) 492–4387, for matters related to the Small Business Health Options Program.
Carol Jimenez, (301) 492–4457, for matters related to the medical loss ratio program.

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

programs when practicable so that similar concepts in the two programs are handled in a similar manner, and similar policy goals are reflected. Consequently, our treatment of taxes for risk corridors purposes follows the approach of the MLR program, as outlined in section 3C of the model MLR regulation published by the National Association of Insurance Commissioners (NAIC).[23] We note that, because of the way profits is defined for the risk corridors calculation, no such circularity will occur with profits.

Comment: One commenter asked whether reinsurance contributions could be considered as ''taxes and regulatory fees'' when determining ''allowable administrative costs'' in the denominator of the risk corridors calculation.

Response: We note that other provisions of this final rule amend the MLR calculation so that reinsurance contributions are included in Federal and State licensing and regulatory fees paid with respect to the QHP as described in § 158.161(a), and are deducted from premiums for MLR purposes. Our proposed definition of ''taxes'' for purposes of the risk corridors program cross-referenced § 158.161(a) and similarly included reinsurance contributions. Thus, in response to these comments, and to maintain consistency with the MLR calculation and our proposed definition, which we are finalizing as proposed, we are making a conforming amendment to § 153.530(b)(1). In this final rule, we are deleting § 153.530(b)(1)(ii) and clarifying that reinsurance contributions are included in Federal and State licensing and regulatory fees paid with respect to the QHP as described in § 158.161(a), and thus are included in allowable administrative costs for risk corridors purposes. We are also making a conforming change to § 153.520(d) to remove the requirement that a QHP issuer must attribute reinsurance contributions to allowable costs for the benefit year. In addition, we are making a conforming modification to the proposed definition of ''taxes'' in § 153.500, by replacing the term ''taxes'' with ''taxes and regulatory fees.''

Comment: Nearly all those that commented on the risk corridors profit margin agreed with the 3 percent profit margin set in the proposed rule. One commenter suggested that a 2 percent profit margin would be more appropriate.

Response: Based on the comments received and the policy arguments outlined in our proposed rule, we are finalizing the definition of ''profits'' in § 153.500 as proposed.

Comment: One commenter expressed concern that an allowance for up to 3 percent profit could disrupt the budget neutrality of the risk corridors program, and asked for clarification on HHS's plans for funding risk corridors if payments exceed receipts.

Response: The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.

Comment: One commenter stated that the risk corridors calculation does not account for the credibility adjustment that is part of the MLR formula, and recommended setting maximum allowable administrative costs at 20 percent plus the allowed credibility adjustment for the carrier's block of business. The commenter believed that this change would be consistent with the MLR formula and make it more viable for carriers to maintain their smaller blocks of business, given the higher claims volatility that often characterizes these smaller blocks of business.

Response: Although we seek consistency with MLR where the risk corridors and MLR formulas contain similar parameters, we believe that the credibility adjustment is a unique parameter in the MLR formula. The MLR statute provides for a credibility adjustment through ''methodologies * * * designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans'' at section 2718(c) of the Affordable Care Act. No similar reference appears in section 1342 of the Affordable Care Act.

Comment: One commenter requested clarification on whether community benefit expenses would be included in the taxes of non-profit entities for the purposes of calculating the risk corridors target amount.

Response: We believe that accounting for these expenses as taxes when calculating the target amount would appropriately align the risk corridors formula with the MLR calculation. Our proposed definition of ''taxes'' in § 153.500 includes Federal and State taxes defined in § 158.162(b), which describes payments made by a tax-exempt issuer for community benefit expenditures. Consequently, we are clarifying that non-profit entities may account for community benefit expenditures as ''taxes and regulatory fees'' in a manner consistent with the MLR reporting requirements set forth in § 158.162 for the purposes of calculating the risk corridors target amount.

2. Risk Corridors Establishment and Payment Methodology

We proposed to add paragraph (d) to § 153.510, which would specify the due date for QHP issuers to remit risk corridors charges to HHS. Under this provision, an issuer would be required to remit charges within 30 days after notification of the charges. By June 30 of the year following an applicable benefit year, under § 153.310(e), QHP issuers will have been notified of risk adjustment payments and charges for the applicable benefit year. By that same date, under § 153.240(b)(1), QHP issuers also will have been notified of all reinsurance payments to be made for the applicable benefit year. As such, we proposed in § 153.530(d) that the due date for QHP issuers to submit all information required under § 153.530 of the Premium Stabilization Rule is July 31 of the year following the applicable benefit year. We also proposed that the MLR reporting deadline be revised to align with this schedule. We are finalizing this provision as proposed.

Comment: We received several supportive comments on our proposal to require issuers to submit risk corridors information by July 31 of the year following the applicable benefit year.

Response: We are finalizing § 153.530(d) as proposed, so that the due date for QHP issuers to submit all risk corridors information is July 31 of the year following the applicable benefit year. In section III.I.1. of this final rule, we also finalize our proposal to align the MLR reporting deadline with this schedule.

Comment: One commenter asked how payments made under the State supplemental reinsurance payment parameters are taken into account in the risk corridors calculation. Another commenter requested that HHS clarify the treatment of State ''wrap-around'' reinsurance payments under the risk corridors calculation, and asked for information on the way in which HHS analyzed the impact of the administrative burden associated with removing these costs.

Response: Under section 1342(c)(1)(B) of the Affordable Care Act, allowable costs are to be reduced by any risk adjustment and reinsurance payments received under sections 1341 and 1343. Supplemental reinsurance payments

[23] Section 3C of the NAIC model regulation, available at *http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf* states, ''[a]ll terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates provided for in sections 8, 9, and 10 [rebate calculation sections].''

EXHIBIT 10

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of October 14, 2015

Title 45 → Subtitle A → Subchapter B → Part 153 → Subpart F

Title 45: Public Welfare
PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

Subpart F—Health Insurance Issuer Standards Related to the Risk Corridors Program

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§153.500 Definitions.

The following definitions apply to this subpart:

Adjustment percentage means, with respect to a QHP:

(1) For benefit year 2014—

(i) For a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium in a transitional State, the percentage specified by HHS for such QHPs in the transitional State; and otherwise

(ii) Zero percent.

(2) For benefit year 2015, for a QHP offered by a health insurance issuer in any State, 2 percent.

(3) For benefit year 2016—

(i) For a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium, the percentage specified by HHS; and otherwise

(ii) Zero percent.

Administrative costs mean, with respect to a QHP, total non-claims costs incurred by the QHP issuer for the QHP, including taxes and regulatory fees.

After-tax premiums earned mean, with respect to a QHP, premiums earned with respect to the QHP minus taxes and regulatory fees.

Allowable administrative costs mean, with respect to a QHP, the sum of administrative costs of the QHP, other than taxes and regulatory fees, plus profits earned by the QHP, which sum is limited to the sum of 20 percent and the adjustment percentage of after-tax premiums earned with respect to the QHP (including any premium tax credit under any governmental program), plus taxes and regulatory fees.

Allowable costs means, with respect to a QHP, an amount equal to the pro rata portion of the sum of incurred claims within the meaning of §158.140 of this subchapter (including adjustments for any direct and indirect remuneration), expenditures by the QHP issuer for the QHP for activities that improve health care quality as set forth in §158.150 of this subchapter, expenditures by the QHP issuer for the QHP related to health information technology and meaningful use requirements as set forth in §158.151 of this subchapter, and the adjustments set forth in §153.530(b); in each case for all of the QHP issuer's non-grandfathered health plans in a market within a State, allocated to the QHP based on premiums earned.

Charge means the flow of funds from QHP issuers to HHS.

Direct and indirect remuneration means prescription drug rebates received by a QHP issuer within the meaning of §158.140(b)(1)(i) of this subchapter.

Payment means the flow of funds from HHS to QHP issuers.

Premiums earned mean, with respect to a QHP, all monies paid by or for enrollees with respect to that plan as a condition of receiving coverage, including any fees or other contributions paid by or for enrollees, within the meaning of §158.130 of this subchapter.

Profits mean, with respect to a QHP, the greater of:

(1) The sum of three percent and the adjustment percentage of after-tax premiums earned; and

(2) Premiums earned of the QHP minus the sum of allowable costs and administrative costs of the QHP.

Qualified health plan or *QHP* means, with respect to the risk corridors program only —

(1) A qualified health plan, as defined at §155.20 of this subchapter;

(2) A health plan offered outside the Exchange by an issuer that is the same plan as a qualified health plan, as defined at §155.20 of this subchapter, offered through the Exchange by the issuer. To be the same plan as a qualified health plan (as defined at §155.20 of this subchapter) means that the health plan offered outside the Exchange has identical benefits, premium, cost-sharing structure, provider network, and service area as the qualified health plan (as defined at §155.20 of this subchapter); or

(3) A health plan offered outside the Exchange that is substantially the same as a qualified health plan, as defined at §155.20 of this subchapter, offered through the Exchange by the issuer. To be substantially the same as a qualified health plan (as defined at §155.20 of this subchapter) means that the health plan meets the criteria set forth in paragraph (2) of this definition with respect to the qualified health plan, except that its benefits, premium, cost-sharing structure, and provider network may differ from those of the qualified health plan (as defined at §155.20 of this subchapter) provided that such differences are tied directly and exclusively to Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside an Exchange.

Risk corridors means any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount.

Target amount means, with respect to a QHP, an amount equal to the total premiums earned with respect to a QHP, including any premium tax credit under any governmental program, reduced by the allowable administrative costs of the plan.

Taxes and regulatory fees mean, with respect to a QHP, Federal and State licensing and regulatory fees paid with respect to the QHP as described in §158.161(a) of this subchapter, and Federal and State taxes and assessments paid with respect to the QHP as described in §158.162(a)(1) and (b)(1) of this subchapter.

Transitional State means a State that does not enforce compliance with §147.102, §147.104, §147.106, §147.150, §156.80, or subpart B of part 156 of this subchapter for individual market and small group health plans that renew for a policy year starting between January 1, 2014, and October 1, 2014, in accordance with the transitional policy outlined in the CMS letter dated November 14, 2013.

[77 FR 17248, Mar. 23, 2012, as amended at 78 FR 15530, 15550, Mar. 11, 2013; 78 FR 54133, Aug. 30, 2013; 79 FR 13835, Mar. 11, 2014; 79 FR 30341, May 27, 2014; 80 FR 10863, Feb. 27, 2015]

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§153.510 Risk corridors establishment and payment methodology.

(a) *General requirement.* A QHP issuer must adhere to the requirements set by HHS in this subpart and in the annual HHS notice of benefit and payment parameters for the establishment and administration of a program of risk corridors for calendar years 2014, 2015, and 2016.

(b) *HHS payments to health insurance issuers.* QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:

(1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and

(2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(c) *Health insurance issuers' remittance of charges.* QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:

(1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and

(2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

(d) *Charge submission deadline.* A QHP issuer must remit charges to HHS within 30 days after notification of such charges.

(e) A QHP issuer is not subject to the provisions of this subpart with respect to a stand-alone dental plan.

(f) *Eligibility under health insurance market rules.* The provisions of this subpart apply only for plans offered by a QHP issuer in the SHOP or the individual or small group market, as determined according to the employee counting method applicable under State law, that are subject to the following provisions: §§147.102, 147.104, 147.106, 147.150, 156.80, and subpart B of part 156 of this subchapter.

[77 FR 17248, Mar. 23, 2012, as amended at 78 FR 15530, Mar. 11, 2013; 78 FR 65094, Oct. 30, 2013; 79 FR 13836, Mar. 11, 2014]

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§153.520 Attribution and allocation of revenue and expense items.

(a) *Attribution to plans.* Each item of expense in the target amount with respect to a QHP must be reasonably attributable to the operation of the QHP issuer's non-grandfathered health plans in a market within a State, with the attribution based on a generally accepted accounting method, consistently applied. To the extent that a QHP issuer utilizes a specific method for allocating expenses for purposes of §158.170 of this subchapter, the method used for purposes of this paragraph must be consistent.

(b) *Allocation across plans.* Each item of expense in the target amount must reflect an amount equal to the pro rata portion of the aggregate amount of such expense across all of the QHP issuer's non-grandfathered health plans in a market within a State, allocated to the QHP based on premiums earned.

(c) *Disclosure of attribution and allocation methods.* A QHP issuer must submit to HHS a report, in the manner and timeframe specified in the annual HHS notice of benefit and payment parameters, with a detailed description of the methods and specific bases used to perform the attributions and allocations set forth in paragraphs (a) and (b) of this section.

(d) *Attribution of reinsurance and risk adjustment to benefit year.* A QHP issuer must attribute reinsurance payments and risk adjustment payments and charges to allowable costs for the benefit year with respect to which the reinsurance payments or risk adjustment calculations apply.

(e) *Maintenance of records.* A QHP issuer must maintain documents and records, whether paper, electronic, or in other media, sufficient to enable the evaluation of the issuer's compliance with applicable risk corridors standards, for each benefit year for at least 10 years, and must make those documents and records available upon request from HHS, the OIG, the Comptroller General, or their designees, to any such entity, for purposes of verification, investigation, audit or other review.

[77 FR 17248, Mar. 23, 2012, as amended at 78 FR 15530, 15550, Mar. 11, 2013; 78 FR 65094, Oct. 30, 2013]

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§153.530 Risk corridors data requirements.

(a) *Premium data.* A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in a manner specified by HHS.

(b) *Allowable costs.* A QHP issuer must submit to HHS data on the allowable costs incurred with respect to the QHP issuer's non-grandfathered health plans in a market within a State in a manner specified by HHS. For purposes of this subpart, allowable costs must be —

(1) Increased by any risk adjustment charges paid by the issuer for the non-grandfathered health plans under the risk adjustment program established under subpart D of this part.

(2) Reduced by —

(i) Any risk adjustment payments received by the issuer for the non-grandfathered health plans under the risk adjustment program established pursuant to subpart D of this part;

(ii) Any reinsurance payments received by the issuer for the non-grandfathered health plans under the transitional reinsurance program established pursuant to subpart C of this part; and

(iii) Any cost-sharing reduction payments received by the issuer for the QHP issuer's QHPs in a market within a State to the extent not reimbursed to the provider furnishing the item or service.

(c) *Allowable administrative costs.* A QHP issuer must submit to HHS data on the allowable administrative costs incurred with respect to the QHP issuer's non-grandfathered health plans in a market within a State in a manner specified by HHS.

(d) *Timeframes.* For each benefit year, a QHP issuer must submit all information required under paragraphs (a) through (c) of this section by July 31 of the year following the benefit year.

(e) *Requirement to submit enrollment data for risk corridors adjustment.* A health insurance issuer in the individual or small group market of a transitional State must submit, in a manner and timeframe specified by HHS, the following:

(1) A count of its total enrollment in the individual market and small group market; and

(2) A count of its total enrollment in individual market and small group market policies that meet the criteria for transitional policies outlined in the CMS letter dated November 14, 2013.

[77 FR 17248, Mar. 23, 2012, as amended at 78 FR 15531, Mar. 11, 2013; 78 FR 65094, Oct. 30, 2013; 79 FR 13836, Mar. 11, 2014; 79 FR 37662, July 2, 2014]

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§153.540 Compliance with risk corridors standards.

HHS or its designee may audit a QHP issuer to assess its compliance with the requirements of this subpart. HHS will conduct an audit in accordance with the procedures set forth in §158.402(a) through (e) of this subchapter.

[79 FR 13836, Mar. 11, 2014]

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EXHIBIT 11

FEDERAL REGISTER

Vol. 77 Friday,
No. 57 March 23, 2012

Part IV

Department of Health and Human Services

45 CFR Part 153
Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS–9975–F]

RIN 0938–AR07

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

AGENCY: Department of Health and Human Services.

ACTION: Final rule.

SUMMARY: This final rule implements standards for States related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment consistent with title I of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. These programs will mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Affordable Insurance Exchanges (''Exchanges'') are implemented, starting in 2014. The transitional State-based reinsurance program serves to reduce uncertainty by sharing risk in the individual market through making payments for high claims costs for enrollees. The temporary Federally administered risk corridors program serves to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the Federal government. The permanent State-based risk adjustment program provides payments to health insurance issuers that disproportionately attract high-risk populations (such as individuals with chronic conditions).

DATES: *Effective Date:* These regulations are effective on May 22, 2012.

FOR FURTHER INFORMATION CONTACT:

Sharon Arnold at (301) 492–4415 or Laurie McWright at (301) 492–4372 for general information.

Wakina Scott at (301) 492–4393 for matters related to reinsurance.

Grace Arnold at (301) 492–4272 for matters related to risk adjustment.

Jeff Wu at (301) 492–4416 for matters related to risk corridors.

SUPPLEMENTARY INFORMATION:

Abbreviations

CMS Centers for Medicare & Medicaid Services

HHS U.S. Department of Health and Human Services

HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)

MLR Medical Loss Ratio

PCIP Pre-existing Condition Insurance Plan

PHS Act Public Health Service Act (42 U.S.C. 201 *et seq.*)

QHP Qualified Health Plan

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I. Background

A. Legislative Overview

Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges.'' Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. In addition, Exchanges will give individuals and small businesses the same purchasing power as big businesses. The Departments of Health and Human Services, Labor, and the Treasury are working in close coordination to release guidance related to Exchanges in several phases. A Request for Comment relating to Exchanges was published in the **Federal Register** on August 3, 2010. An Initial Guidance to States on Exchanges was issued on November 18, 2010. A proposed rule for the application, review, and reporting process for waivers for State innovation was published in the **Federal Register** on March 14, 2011. Two proposed rules, including the proposed form of this rule, were published in the **Federal Register** on July 15, 2011 to implement components of Exchanges and health insurance premium stabilization programs (that is, reinsurance, risk corridors, and risk adjustment) from the Affordable Care Act. A proposed rule regarding eligibility for Exchanges was published in the **Federal Register** on August 17, 2011. A proposed rule on the Health Insurance Premium Tax Credit was published in the **Federal Register** on August 17, 2011. A proposed rule making changes to eligibility for the Medicaid program was published in the **Federal Register** on August 17, 2011. The final versions of the Exchange Establishment and Eligibility rules were made available for public inspection at the Office of the Federal Register on March 12, 2012. A final version of the Medicaid rule is being made available for public inspection at the Office of the Federal Register on the same date as this rule.

Section 1341 of the Affordable Care Act provides that each State must establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014 through 2016). Section 1342 provides that HHS must establish a temporary risk corridors program that will apply to QHPs in the individual and small group markets for the first three years of Exchange operation (2014 through 2016). Section 1343 provides that each State must establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges. These risk-spreading mechanisms, which will be implemented by HHS and the States, are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets. If a State chooses not to establish a transitional reinsurance program or a risk adjustment program, this final rule provides that HHS will do so on its behalf.

Section 1321(a) also provides broad authority for HHS to establish standards and regulations to implement the statutory requirements related to reinsurance, risk adjustment, and the other components of title I of the Affordable Care Act. Section 1321(a)(2) requires, in issuing such regulations, HHS to engage in stakeholder consultation in a way that ensures balanced representation among interested parties. We describe the consultation activities HHS has undertaken later in this introduction. Section 1321(c)(1) authorizes HHS to establish and implement reinsurance,

calculation take into account profits in a manner similar to the MLR rule. Some commenters requested that allowable administrative costs include profits, margin, or underwriting gain. This inclusion would be consistent with the MLR rule, which permits an issuer in certain circumstances to have administrative expenses and profits up to 20 percent of after-tax premium revenues before a rebate is due. Commenters also noted that section 1342(a) of the Affordable Care Act states that risk corridors calculations are to be based on a similar program under Medicare Part D, which includes return on investment, an analog to profits, in the definition of target amount.

Response: The proposed rule did not address profits in the risk corridors calculation. In the HHS notice of benefit and payment parameters, we intend to propose that profits be included within administrative costs for purposes of the risk corridors calculation, consistent with MLR.

Comment: A number of commenters requested that the risk corridors calculation take into account taxes in a manner similar to the MLR rule. The MLR rule requires reporting of a broad range of taxes, and deduction of certain taxes from premiums in the MLR denominator. One commenter noted that taxes may either be subtracted from premiums or added to allowable administrative costs.

Response: The proposed rule did not address taxes in the risk corridors calculation. In the HHS notice of benefit and payment parameters, we intend to propose that taxes and other expenses be included within administrative costs for purposes of the risk corridors calculation, with those Federal and State taxes and licensing and regulatory fees described in § 158.161(a), § 158.162(a)(1), and § 158.162(b)(1) exempt from the 20 percent cap on allowable administrative expenses.

Comments: Several commenters sought clarification as to whether any of the risk corridors elements were projections. Various commenters suggested that premiums or administrative costs should reflect projections. One commenter requested a clarification to confirm the intent to use projected costs as the targeted amount.

Response: Section 1342 of the Affordable Care Act does not allow the use of projections. Furthermore, because the temporary risk corridors program is designed to limit the extent of actual issuer losses (and gains) with respect to QHPs, the program will use actual data, not projected data.

2. Risk Corridors Establishment and Payment Methodology (§ 153.510)

In § 153.510 of the proposed rule, we proposed to establish risk corridors by specifying risk percentages above and below the target amount. In § 153.510(a), we proposed to require a QHP issuer to adhere to the requirements set by HHS for the establishment and administration of a risk corridors program for calendar years 2014 through 2016. The preamble to the proposed rule stated that we would issue guidance in the annual HHS notice of benefit and payment parameters for QHPs regarding reporting and the administration of payments and charges. The preamble also stated that risk corridors guidance will be plan-specific, and not issuer-specific, as is the case with respect to the MLR rule, and that we interpreted the risk corridors provisions to apply to all QHPs offered in the Exchange.

In § 153.510, we also established the payment methodology for the risk corridors program, using the thresholds and risk-sharing levels specified in statute. In § 153.510(b), we described the method for determining payment amounts to QHP issuers. For a QHP with allowable costs in excess of 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer 50 percent of the amount in excess of 103 percent of the target amount. For a QHP with allowable costs that exceed 108 percent of the target amount, the Affordable Care Act directs HHS to pay the QHP issuer an amount equal to 2.5 percent of the target amount plus 80 percent of the amount in excess of 108 percent of the target amount.

In § 153.510(c), we described the circumstances under which QHP issuers will remit charges to HHS, as well as the means by which HHS will determine those charge amounts. We proposed that QHP issuers will begin to remit charges to HHS for the first dollar of allowable charges less than 97 percent of the target amount. For a QHP with allowable costs that are less than 97 percent of the target amount but greater than 92 percent of the target amount, HHS will charge the QHP issuer an amount equal to 50 percent of the difference between 97 percent of the target amount and the actual value of allowable costs. For a QHP with allowable costs below 92 percent of the target amount, the QHP issuer will remit charges to HHS in an amount equal to 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the actual value of allowable costs.

While we did not propose deadlines in the proposed rule, we discussed in the preamble timeframes for QHP issuers to remit charges to HHS. We suggested, for example, that a QHP issuer required to make a risk corridors payment may be required to remit charges within 30 days of receiving notice from HHS, and that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers. We sought comment on these proposed payment deadlines in the preamble to the proposed rule.

Considering the comments received, we are finalizing this section as proposed, with a few clarifying modifications.

Comments: We received a number of comments suggesting that the risk corridors calculation should be performed at a less granular level than the plan level. The most common suggestion was aggregation at the issuer level, although other alternatives were suggested. One commenter suggested aggregation at the carrier, State and business line level, while another recommended applying the risk corridors calculation separately to an issuer's aggregate non-group QHP business and aggregate small group QHP business. One reason advanced for these alternatives was consistency with the MLR rules, which apply at the issuer level. Commenters also noted that issuers do not currently accumulate data at the plan level. Some commenters stated that issuer-level data would be more credible and reliable.

Response: We have carefully considered the commenters' suggestions, but are not making the requested change. The statutory language governing risk corridors does not afford the necessary flexibility. The statutory provision that governs risk corridors at section 1342(a) of the Affordable Care Act describes the risk corridors program as one in which ''a qualified health plan offered in the individual or small group market shall participate * * *''. By contrast, section 2718 of the PHS Act, which governs the MLR program, requires the calculation of a ratio with respect to an issuer.

Comment: One commenter requested that the risk corridors program may be based on targeted medical costs (net premiums) in addition to the premium rates.

Response: We are not making the changes proposed by the commenter because section 1342 of the Affordable Care Act does not provide the flexibility necessary to do so. That section requires

EXHIBIT 12

HealthCare.gov

Newsroom

Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) published a Notice of Proposed Rulemaking (NPRM) outlining a framework that will enable States to build Affordable Insurance Exchanges, State-based competitive marketplaces where individuals and small businesses will be able to purchase affordable private health insurance and have the same insurance choices as Members of Congress. This rule is a major step forward in implementing the Exchanges.

Exchanges will begin operating in 2014 and will make it easy for consumers and small businesses to compare health plans, get answers to questions, and enroll in or offer to their employees a health insurance plan that meets their needs. Individuals will be able to find out if they are eligible for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP); small businesses may be eligible for the small business tax credit for coverage purchased for employees through the Exchange.

Confidence and Stability in the New Marketplace

To help protect insurers against risk selection and market uncertainty, the Affordable Care Act establishes three programs, which begin in 2014: temporary reinsurance and risk corridor programs to give insurers payment stability as insurance market reforms begin, and an ongoing risk adjustment program that will make payments to health insurance issuers that cover higher-risk populations (e.g., those with chronic conditions) to more evenly spread the financial risk borne by issuers. These programs will ensure that health plans and issuers compete for coverage on the basis of price, quality and service. The proposed regulations provide standards to make the programs work and significant State flexibility for their implementation, while minimizing the burden on States and issuers. Well-designed reinsurance, risk corridors and risk adjustment programs can help encourage innovative care delivery that will slow the growth in our Nation's health care expenditures.

Risk Adjustment

The Affordable Care Act provides for a program of risk adjustment for all non-grandfathered plans in the individual and small group market both inside and outside of the Exchange. Under this provision, the Secretary of Health and Human Services, in consultation with the States, will establish criteria and methods to be used by States in determining the actuarial risk of plans within a State. The risk adjustment program serves to level the playing field, both inside and outside of the Exchange. Risk adjustment ends the incentive for issuers to avoid the sick and market only to the healthy by transferring excess payments from plans with lower risk enrollees to plans with higher risk enrollees. For this reason, plans will have to compete on the basis of price, quality and service. This allows consumers the ability to pick the plan that best meets his or her needs. The proposal suggests that a constant set of data for risk adjustment be considered, preventing a health insurer that offers qualified health plan in different States from having different reporting requirements. It proposes that risk adjustment calculations occur at the State, rather than plan or Federal level, given States' role in the system. And while a Federal risk adjustment methodology would be

developed, States could use an approved alternative. We welcome comments on the risk adjustment program design.

Reinsurance

The transitional reinsurance program is a critical element in helping to even out the health insurance market, moderate premium increases and set the foundation for the establishment of the Exchanges from 2014 through 2016. The Affordable Care Act provides that each State establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation. Under this provision, all health insurance issuers, and third-party administrators on behalf of self-insured group health plans, will make contributions to a nonprofit reinsurance entity to support reinsurance payments to individual market issuers that cover high risk individuals. The proposed rule would simplify the reinsurance program: rather than using a list of 50 to 100 conditions to set reinsurance policy, it would base reinsurance on high-cost enrollees' claims. This is similar to the private reinsurance market practice and the current Early Retiree Reinsurance Program. It also proposes flexibility for States, allowing them to run the reinsurance program regardless of its Exchange decision, supplement the payments, vary the thresholds for when reinsurance begins and ends, and contract with reinsurance entities to run the program.

Risk Corridors

In addition to risk adjustment and reinsurance, the risk corridor program is a third element of protection for qualified health plan issuers in the Exchange. Risk corridors create a mechanism for sharing risk for allowable costs between the Federal government and qualified health plan issuers. From 2014 through 2016, qualified health plan issuers with costs that are at least three percent less than the issuers' costs projections will remit charges for a percentage of those savings to HHS, while qualified health plan issuers with costs greater than three percent of cost projections will receive payments from HHS to offset a percentage of those losses. The Affordable Care Act directs HHS to administer the risk corridors program. The proposed rule aims to align the data and payment policies for this temporary program with other programs to promote simplicity and efficiency.

Posted on: July 11, 2011

EXHIBIT 13

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The General Counsel
Washington, D.C. 20201

MAY 20 2014

Julia C. Matta
Assistant General Counsel
for Appropriations Law
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Ms. Matta:

This is in response to your April 15, 2014 letter requesting information regarding budget authority available to operate the risk corridors program established in section 1342 of the Patient Protection and Affordable Care Act (PPACA)[1]. The responses to your questions are set forth below.

1. *Agencies may incur obligations and make expenditures only as permitted by an appropriation. U.S. Const., art. I, § 9, cl. 7; 31 U.S.C. §1341(a)(1); B-300192, Nov. 13, 2002. The making of an appropriation must be expressly stated in law. 31 U.S.C. §1301(d). A direction to an agency to pay funds without a designation of funds to be used for the payment does not make an appropriation. B-114808, Aug. 7. 1979. PPACA section 1342(b)(1) provides that, under some circumstances, HHS "shall pay" specified amounts to participating plans. Does any provision of law, be it PPACA section 1342 or another provision, currently provide HHS with an appropriation necessary to obligate and expend the payments specified in PPACA section 1342(b)(1)? Please explain.*

   Response: Section 1342 of PPACA requires the Secretary of Health and Human Services (HHS) 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 qualified health plans (QHPs). The risk corridors program applies only to participating plans defined to be qualified health plans (QHPs) at 45 CFR 153.500. Section 1342(b)(1) and (2) establishes the payment methodology for the payments in and the payments out, thereby establishing the formula to determine the amounts the QHPs must pay to the Secretary of HHS and the amounts the Secretary must pay to the QHPs if the risk corridors threshold is met.

   As section 1342 of PPACA requires the Secretary to establish and administer the risk corridors program and requires the Secretary to collect payments from and make payments to certain QHPs, section 1342 authorizes the collection and payment of user fees to and from

[1] Pub. L. No. 111-148, §1342, 124 Stat. 119, 211-212 (Mar.23, 2010), codified at 42 U.S.C. § 18062.

the QHPs. QHPs enjoy a special benefit resulting from the operation of the risk corridors program, in that the fees charged are ultimately utilized to balance risks among the QHPs, thus promoting stability in this sector of the market. This is consistent with OMB Circular A-25[2], which is intended to provide guidance to agencies regarding their assessment of user fees pursuant to 31 U.S.C. § 9701 and other statutes. Further, we view it as consistent with the definition of user fees as set forth in OMB's Fiscal Year 2015, *Analytical Perspectives*[3] and GAO's *Glossary of Terms Used in the Federal Budget Process*[4].

Section 1342 of PPACA requires the collection and payment of risk corridor user fees. The Centers for Medicare & Medicaid Services (CMS) Program Management (PM) appropriation for fiscal year 2014[5], which states ". . .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: . . .", appropriates the section 1342 user fees. Together, section 1342

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[2] "General policy: A user charge, as described below, will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. When the imposition of user charges is prohibited or restricted by existing law, agencies will review activities periodically and recommend legislative changes when appropriate. Section 7 gives guidance on drafting legislation to implement user charges.

a. Special benefits

1. Determining when special benefits exist. When a service (or privilege) provides special benefits to an identifiable recipient beyond those that accrue to the general public, a charge will be imposed (to recover the full cost to the Federal Government for providing the special benefit, or the market price). For example, a special benefit will be considered to accrue and a user charge will be imposed when a Government service:

(a) enables the beneficiary to obtain more immediate or substantial gains or values (which may or may not be measurable in monetary terms) than those that accrue to the general public (e.g., receiving a patent, insurance, or guarantee provision, or a license to carry on a specific activity or business or various kinds of public land use); or

(b) provides business stability or contributes to public confidence in the business activity of the beneficiary (e.g., insuring deposits in commercial banks); or . . ." Office of Mgmt. & Budget, Exec. Office of the President, OMB Cir. A-25, User Charges, section 6(1)(a)-(b)(2010).

[3] "In this chapter, user charges refer to fees, charges, and assessment levied on individuals or organizations directly benefiting from or subject to regulation by a Government program or activity, where the payers do not represent a broad segment of the public as those who pay taxes." Fiscal Year 2015 Analytical Perspectives, Budget of the U.S. Government, Office of Management and Budget, p. 192. Available on the Internet at *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/spec.pdf.*

[4] "A fee assessed to users for goods or services provided by the federal government. User fees generally apply to federal programs or activities that provide special benefits to identifiable recipients above and beyond what is normally available to the public. U.S. Government Accountability Office, GAO-05-734SP, *A Glossary of Terms Used in the Federal Budget Process* (2005), p. 100.

[5] Consolidated Appropriations Act, 2014, Div. H, Pub. L.113-76 (2014).

of PPACA and the CMS PM appropriation allows for the collection, retention, obligation and expenditure of the section 1342 user fees until September 30, 2019.

2. *PPACA section 1342(b)(2) provides that, under some circumstances, HHS will receive payments from participating plans. Absent specific statutory authority, agencies must deposit money for the government into the Treasury without deduction for any charge or claim, and such deposits are available for obligation and expenditure only as permitted by an appropriation. 31 U.S.C. §3302(b); B-271894, July 24, 1987; 22 Comp. Dec. 379 (1916). May HHS obligate and expend amounts that participating plans pay to HHS under PPACA section 1342(b)(2)? If so, please explain the statutory authority that permits HHS to obligate and expend these amounts and the permissible purposes of such obligations and expenditures.*

   Response: The CMS PM appropriation permits HHS to collect, retain, obligate, and expend the user fees in a manner consistent with section 1342.

3. *Has HHS made or received any payments under PPACA section 1342? If so, please explain the amount and source of any payments made or the amount and disposition of any payments received.*

   Response: To date, HHS has not made or received any payments under section 1342 of PPACA. HHS intends to begin collections and payments in fiscal year 2015 pursuant to continued CMS PM user fee authority.

Thank you for the opportunity to provide the Department's views on this matter.

Sincerely,

William B. Schultz

William B. Schultz
General Counsel

EXHIBIT 14

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 18, 2014

The Honorable Jeff Sessions
United States Senate
Washington, DC 20510

Dear Senator Sessions:

Thank you for your letter requesting information about the Department of Health and Human Services's (HHS) legal authority to make payments in connection with the risk corridors program. The temporary risk corridor provision in the Affordable Care Act is an important safety valve for consumers and insurers as millions of Americans transition to a new coverage in a brand new Marketplace. For consumers, the program will play an important role in mitigating premium increases in the early years as issuers gain more experience in setting their rates for this new program.

Section 1342 of the Affordable Care Act provides for a temporary risk corridors program from 2014 through 2016. The risk corridors program applies to qualified health plans (QHPs), both on and off the Marketplace, and certain substantially similar plans in the individual and small group markets. The temporary risk corridors program protects issuers of QHPs from uncertainty in rate setting from 2014 to 2016 by sharing in gains or losses resulting from inaccurate rate setting.

Modeled after a similar, permanent program established in the Medicare Modernization Act of 2003 for Medicare Part D, the temporary risk corridors program protects against uncertainty issuers face when estimating enrollment and costs resulting from the market reforms. The risk corridors program protects against uncertainty in rate-setting in the first three years of the Marketplace by creating a mechanism for sharing risk between the federal government and issuers of QHPs.

As established in statute, plans participating in the program with allowable costs that are at least three percent less than the plan's target amount will remit charges to HHS, while plans with allowable costs at least three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses. The risk corridors payment or charge amount will be calculated at the issuer level and then pro-rated based on the issuer's percentage of the market enrolled in QHPs, inside or outside the Marketplace, and plans that are substantially the same as a QHP.

In response to your questions regarding the legal analysis to make payments under the risk corridors program, enclosed please find HHS's response to the Government Accountability Office's request for information regarding budget authority available to operate the risk corridors program.

We appreciate your interest in this issue and do not hesitate to contact me if you have any further thoughts or concerns. We are providing the same response to Chairman Fred Upton, co-signer of your letter.

Sincerely,

Sylvia M. Burwell

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The General Counsel
Washington, D.C. 20201

MAY 20 2014

Julia C. Matta
Assistant General Counsel
for Appropriations Law
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Ms. Matta:

This is in response to your April 15, 2014 letter requesting information regarding budget authority available to operate the risk corridors program established in section 1342 of the Patient Protection and Affordable Care Act (PPACA)[1]. The responses to your questions are set forth below.

1. *Agencies may incur obligations and make expenditures only as permitted by an appropriation. U.S. Const., art. I, § 9, cl. 7; 31 U.S.C. §1341(a)(1); B-300192, Nov. 13, 2002. The making of an appropriation must be expressly stated in law. 31 U.S.C. §1301(d). A direction to an agency to pay funds without a designation of funds to be used for the payment does not make an appropriation. B-114808, Aug. 7. 1979. PPACA section 1342(b)(1) provides that, under some circumstances, HHS "shall pay" specified amounts to participating plans. Does any provision of law, be it PPACA section 1342 or another provision, currently provide HHS with an appropriation necessary to obligate and expend the payments specified in PPACA section 1342(b)(1)? Please explain.*

   Response: Section 1342 of PPACA requires the Secretary of Health and Human Services (HHS) 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 qualified health plans (QHPs). The risk corridors program applies only to participating plans defined to be qualified health plans (QHPs) at 45 CFR 153.500. Section 1342(b)(1) and (2) establishes the payment methodology for the payments in and the payments out, thereby establishing the formula to determine the amounts the QHPs must pay to the Secretary of HHS and the amounts the Secretary must pay to the QHPs if the risk corridors threshold is met.

   As section 1342 of PPACA requires the Secretary to establish and administer the risk corridors program and requires the Secretary to collect payments from and make payments to certain QHPs, section 1342 authorizes the collection and payment of user fees to and from

[1] Pub. L. No. 111-148, §1342, 124 Stat. 119, 211-212 (Mar.23, 2010), codified at 42 U.S.C. § 18062.

the QHPs. QHPs enjoy a special benefit resulting from the operation of the risk corridors program, in that the fees charged are ultimately utilized to balance risks among the QHPs, thus promoting stability in this sector of the market. This is consistent with OMB Circular A-25[2], which is intended to provide guidance to agencies regarding their assessment of user fees pursuant to 31 U.S.C. § 9701 and other statutes. Further, we view it as consistent with the definition of user fees as set forth in OMB's Fiscal Year 2015, *Analytical Perspectives*[3] and GAO's *Glossary of Terms Used in the Federal Budget Process*[4].

Section 1342 of PPACA requires the collection and payment of risk corridor user fees. The Centers for Medicare & Medicaid Services (CMS) Program Management (PM) appropriation for fiscal year 2014[5], which states ". . .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: . . .", appropriates the section 1342 user fees. Together, section 1342

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a. Special benefits

1. Determining when special benefits exist. When a service (or privilege) provides special benefits to an identifiable recipient beyond those that accrue to the general public, a charge will be imposed (to recover the full cost to the Federal Government for providing the special benefit, or the market price). For example, a special benefit will be considered to accrue and a user charge will be imposed when a Government service:

(a) enables the beneficiary to obtain more immediate or substantial gains or values (which may or may not be measurable in monetary terms) than those that accrue to the general public (e.g., receiving a patent, insurance, or guarantee provision, or a license to carry on a specific activity or business or various kinds of public land use); or

(b) provides business stability or contributes to public confidence in the business activity of the beneficiary (e.g., insuring deposits in commercial banks); or . . ." Office of Mgmt. & Budget, Exec. Office of the President, OMB Cir. A-25, User Charges, section 6(1)(a)-(b)(2010).

[3] "In this chapter, user charges refer to fees, charges, and assessment levied on individuals or organizations directly benefiting from or subject to regulation by a Government program or activity, where the payers do not represent a broad segment of the public as those who pay taxes." Fiscal Year 2015 Analytical Perspectives, Budget of the U.S. Government, Office of Management and Budget, p. 192. Available on the Internet at *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/spec.pdf.*

[4] "A fee assessed to users for goods or services provided by the federal government. User fees generally apply to federal programs or activities that provide special benefits to identifiable recipients above and beyond what is normally available to the public. U.S. Government Accountability Office, GAO-05-734SP, *A Glossary of Terms Used in the Federal Budget Process* (2005), p. 100.

[5] Consolidated Appropriations Act, 2014, Div. H, Pub. L.113-76 (2014).

of PPACA and the CMS PM appropriation allows for the collection, retention, obligation and expenditure of the section 1342 user fees until September 30, 2019.

2. *PPACA section 1342(b)(2) provides that, under some circumstances, HHS will receive payments from participating plans. Absent specific statutory authority, agencies must deposit money for the government into the Treasury without deduction for any charge or claim, and such deposits are available for obligation and expenditure only as permitted by an appropriation. 31 U.S.C. §3302(b); B-271894, July 24, 1987; 22 Comp. Dec. 379 (1916). May HHS obligate and expend amounts that participating plans pay to HHS under PPACA section 1342(b)(2)? If so, please explain the statutory authority that permits HHS to obligate and expend these amounts and the permissible purposes of such obligations and expenditures.*

   Response: The CMS PM appropriation permits HHS to collect, retain, obligate, and expend the user fees in a manner consistent with section 1342.

3. *Has HHS made or received any payments under PPACA section 1342? If so, please explain the amount and source of any payments made or the amount and disposition of any payments received.*

   Response: To date, HHS has not made or received any payments under section 1342 of PPACA. HHS intends to begin collections and payments in fiscal year 2015 pursuant to continued CMS PM user fee authority.

Thank you for the opportunity to provide the Department's views on this matter.

Sincerely,

William B. Schultz

William B. Schultz
General Counsel

EXHIBIT 15

FEDERAL REGISTER

Vol. 80 Friday,
No. 39 February 27, 2015

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:

Table of Contents

Response: We are maintaining the policy finalized in the 2015 Payment Notice under § 153.500 and § 153.530, which provides, for 2014, that the effect of the transitional adjustment will vary according to the member-month enrollment in a State, such that the 3 percent profit floor and 20 percent allowable administrative cost ceiling will apply in States that did not adopt the Federal transitional policy (QHP issuers in these States will receive a risk corridors transitional adjustment equal to zero). We believe that issuers in States that did not adopt the Federal transitional policy will not require the transitional adjustment to help mitigate mispricing that may have occurred due to unexpected changes in the risk pool resulting from the Federal transitional policy. We note that the adjustment will account for the effect of the Federal transitional policy in the entire market within a State that adopted the transitional policy, such that a QHP issuer in a transitional State will be eligible to receive an adjustment to its risk corridors calculation even if the issuer has not issued transitional policies.

b. Risk Corridors Payments for 2016

On April 11, 2014, we issued a bulletin titled ''Risk Corridors and Budget Neutrality,'' which described how we intend to administer risk corridors over the 3-year life of the program.[26] Specifically, we stated that if any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year. We also stated that we would establish in future guidance how we would calculate risk corridors payments in the event that cumulative risk corridors collections do not equal cumulative risk corridors payment requests.

In the proposed 2016 Payment Notice, we proposed that if, for the 2016 benefit year, cumulative risk corridors collections exceed cumulative risk corridors payment requests, we would make an adjustment to our administrative expense definitions (that is, the profit margin floor and the ceiling for allowable administrative costs) to account for the excess funds. That is, if, when the risk corridors program concludes, cumulative risk corridors collections exceed both 2016 payment requests under the risk corridors formula and any unpaid risk corridors amounts from previous years, we would increase the administrative cost ceiling and the profit floor in the risk corridors formula by a percentage calculated to pay out all collections to QHP issuers. The administrative cost ceiling and the profit floor would be adjusted by the same percentage.

We proposed to determine the percentage adjustment to the administrative cost ceiling and profit margin floor by evaluating the amount of excess risk corridors collections (if any) available after risk corridors payments for benefit year 2016 have been calculated. As stated in our bulletin on risk corridors and budget neutrality, after receiving charges from issuers for the 2016 benefit year, we would first prioritize payments to any unpaid risk corridors payments remaining from the 2015 benefit year. We would then calculate benefit year 2016 risk corridors payments for eligible issuers based on the 3 percent profit floor and 20 percent allowable administrative cost ceiling, as required by regulation. If, after making 2015 payments and calculating (but not paying) risk corridors payments for benefit year 2016, we determine that the aggregate amount of collections (including any amounts collected for 2016 and any amounts remaining from benefit years 2014 and 2015) exceed what is needed to make 2016 risk corridors payments, we would implement an adjustment to the profit floor and administrative cost ceiling to increase risk corridors payments for eligible issuers for benefit year 2016. We would examine data that issuers have submitted for calculation of their 2016 risk corridors ratios (that is, allowable costs and target amount) and determine, based on the amount of collections available, what percentage increase to the administrative cost ceiling and profit floor could be implemented for eligible issuers while maintaining budget neutrality for the program overall. Although all eligible issuers would receive the same percentage adjustment, we proposed that the amount of additional payment made to each issuer would vary based on the issuer's allowable costs and target amount. We proposed that, once HHS calculated the adjustment and applied it to eligible issuers' risk corridors formulas, it would make a single risk corridors payment for benefit year 2016 that would include any additional, adjusted payment amount.

Because risk corridors collections are a user fee to be used to fund premium stabilization under risk corridors and no other programs, we proposed to limit this adjustment to excess amounts collected. We also proposed to apply this adjustment to allowable administrative costs and profits for the 2016 benefit year only to plans whose allowable costs (as defined at § 153.500) are at least 80 percent of their after-tax premiums, because issuers under this threshold would generally be required to pay out MLR rebates to consumers.[27] For plans whose ratio of allowable costs to after-tax premium is below 80 percent, we proposed that the 3 percent risk corridors profit margin and 20 percent allowable administrative cost ceiling would continue to apply. Furthermore, we proposed that, to the extent that applying the proposed adjustment to a plan could increase its risk corridors payment and affect its MLR calculation, the MLR calculation would ignore these adjustments.

As previously stated, we anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In the unlikely event that risk corridors collections, including any potential carryover from the prior years, are insufficient to make risk corridors payments for the 2016 program year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.

We are finalizing this policy as proposed.

Comment: We received one comment on the proposed approach for allocating excess risk corridors collections at the end of the program. The commenter supported our approach. Another commenter supported language in the proposed Payment Notice that reaffirmed HHS's commitment to make full risk corridors payments if collections are insufficient to fund payments.

Response: We are finalizing the policy regarding allocation of excess risk corridors collections for 2016 as proposed.

[26] The Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. ''Risk Corridors and Budget Neutrality,'' April 11, 2014. Available at: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.*

[27] Because of some differences in the MLR numerator and the definition of allowable costs that applies with respect to the risk corridors formula, in a small number of cases, an issuer with allowable costs that are at least 80 percent of after-tax premium, may be required to pay MLR rebates to consumers.

EXHIBIT 16

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

July 21, 2015

Dear Commissioner,

Thank you for the work you and your teams did for the 2015 plan year to increase issuer competition and reduce premium rates, thus ensuring that coverage remained accessible and affordable for millions of Americans. In addition, thank you for the hard work you and your teams are investing to complete approval of final rates for the 2016 benefit year. With the availability of new Marketplace utilization experience data and the implementation of the reinsurance, risk adjustment, and risk corridor premium stabilization programs, we recognize that new information will need to be taken into account in reviewing rate proposals this year. We appreciate all that you and your staff do, and have the opportunity to do, to maintain affordability for consumers, while ensuring issuer solvency.

Based on preliminary filings for the coming year, we are confident that, overall, consumers will retain access to a wide range of affordable options in 2016. In addition, in the last few months, we have been meeting regularly with issuers and state officials from across the country to better understand key drivers of premium increases. These conversations have been encouraging and instructive, and we have distilled several findings that we would ask you to carefully consider as you make your final rate decisions:

1. **Recent claims data show healthier consumers**. Data show that consumers who signed up more recently are healthier than enrollees who were among the first to sign up during the first Open Enrollment Period. Further, recent experience may show an improved issuer medical loss ratio. For instance, Anthem CT announced on July 10 that it was proactively lowering its rates from its preliminary filings, which were based on claims from January 2014 through March 2015, because claims through May 2015 showed that their members' health care costs were lower than expected.

   In addition, risk pools are expected to continue to get healthier. Many issuers are assuming consumers who enroll in Marketplaces during the remainder of 2015 and into 2016 will exhibit even lower rates of utilization than 2014 enrollees. Already, many issuers are reporting a decline in pent-up demand for services. Further, the increase in the individual shared responsibility fee in 2016 and increased consumer experience with individual shared responsibility should motivate a new segment of uninsured who may not have a high need for health care to enroll for coverage. This was the experience in Massachusetts in the first years of their Exchange before the Affordable Care Act become law, and we expect a similar trend.

2. **Recent data show a continued moderate medical cost trend.** Available data suggest that underlying trends in overall medical costs remained moderate through the end of 2014 and into early 2015, even accounting for rapid growth in pharmaceutical costs. Because recent trend experience can often provide a useful guide to the near future, these data may be relevant when evaluating the reasonableness of trend assumptions for 2016.

3. **CMS will use a one hundred percent coinsurance rate for the 2014 reinsurance program.** As you know, the Centers for Medicare & Medicaid Services (CMS) recently announced that, consistent with its regulations for the transitional reinsurance program, all eligible claim expenses for the 2014 benefit year would be paid at a 100 percent coinsurance rate, instead of 80 percent. Initial filing by issuers were due before this announcement was made in June.

4. **CMS remains committed to the risk corridor program.** As stated in our final payment notice for 2016, "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." This spring, CMS announced that preliminary information about 2014 risk corridors payments and charges will be made available on August 14, 2015. We believe these payments should be taken into account before decisions are made on final rates.

5. **Public hearings are helpful.** Many states have found the use of public hearings helpful in rate evaluation. You and your staff undoubtedly have even more ideas to ensure that rates receive appropriate public scrutiny.

Like you, CMS is focused on both consumer affordability and issuer solvency. To that end, we ask that you consider these findings as you work to finalize rates for the 2016 plan year.

We appreciate all that you and your teams do to help us keep health insurance affordable and protect consumers. Please let us know of any ways we can be of further help.

Sincerely,

Kevin J. Counihan

Chief Executive Officer, Health Insurance Marketplace

Director, Center for Consumer Information & Insurance Oversight

EXHIBIT 17

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 19, 2015

From: Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Subject: **Risk Corridors Payments for the 2014 Benefit Year**

On October 1, 2015, the Centers for Medicare & Medicaid Services (CMS) announced that for the first year of the three year risk corridors program, qualified health plan (QHP) issuers will pay charges of approximately $362 million, and QHP issuers have requested $2.87 billion of 2014 payments, based on current data for the 2014 benefit year.[1] Consistent with prior guidance, assuming full collections of risk corridors charges for the 2014 benefit year, insurers will be paid an amount that reflects a proration rate of 12.6% of their 2014 benefit year risk corridors payment requests.[2] The remaining 2014 risk corridors payments will be made from 2015 risk corridors collections, and if necessary, 2016 collections.

In the event of a shortfall for the 2016 program year, the Department of Health and Human Services (HHS) will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments.

HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation of the United States Government for which full payment is required.

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[1] "*Risk Corridors Payment Proration Rate for 2014*." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf

[2] "*Risk Corridors and Budget Neutrality*." April 11, 2014. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf. "*Risk Corridors Payment Proration Rate*." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf

EXHIBIT 18

-----Original Message-----
From: Counihan, Kevin J. (CMS/CCIIO) [Kevin.Counihan@cms.hhs.gov]
Sent: Monday, November 02, 2015 04:17 PM Eastern Standard Time
To: Brad Wilson
Subject: 2014 Risk Corridors Payments

Mr. Wilson,
As we have discussed with your team, please find enclosed a letter from CMS reiterating that risk corridors payments are an obligation of the U.S. Government. Thank you again for your continued participation in the risk corridors program.

Kevin J. Counihan
Chief Executive Officer
Health Insurance Marketplaces
Director, CCIIO
202-260-6085

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

November 2, 2015

J. Bradley Wilson
Chief Executive Officer
Blue Cross Blue Shield of North Carolina
5901 Chapel Hill Road
Durham, NC 27707

Dear Mr. Wilson:

Thank you for your active, constructive participation in our recent discussions around Blue Cross Blue Shield of North Carolina's risk corridors payment.

As you know, on October 1, the Centers for Medicare & Medicaid Services (CMS) issued guidance stating that, based on current data for 2014, the first year of the three-year risk corridors program, issuers will pay 2014 risk corridors charges of approximately $362 million, and insurers have requested $2.87 billion of 2014 risk corridors payments. As a result, consistent with our prior guidance, insurers will be paid approximately 12.6% of their risk corridors payment requests at this time. We reiterated that the remaining 2014 risk corridors claims will be paid out of 2015 risk corridors collections, and if necessary, 2016 collections.

As I have previously written to you, we will not know the total loss or gain for the program until the fall of 2017, when the data from all three years of the program can be analyzed and verified. In the event of a shortfall for the 2016 program year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments.

According to our calculations, Blue Cross Blue Shield of North Carolina requested $147,421,876.38 in 2014 risk corridors payments for its individual market qualified health plans (QHPs), and requested approximately $53,091.97 in 2014 risk corridors payments for its small group QHPs. We estimate that, beginning in December 2015, we will pay out $18,601,495.60 in 2014 risk corridors payments for your individual market QHPs, and approximately $6,699.07 in

2014 risk corridors payments for your small group QHPs, with the shortfall being paid out of 2015 and, if necessary, 2016 risk corridors collections, as outlined above.

I wish to reiterate to you that the Department of Health and Human Services (HHS) recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligations of the United States Government for which full payment is required.

Thank you again for your participation in these discussions to date. Please do not hesitate to contact me if there is anything further we can do to support you in these efforts.

Sincerely,

Kevin J. Counihan
Chief Executive Officer, Health Insurance Marketplaces
Director, Center for Consumer Information & Insurance Oversight

EXHIBIT 19

FEDERAL REGISTER

Vol. 79 Tuesday,

No. 47 March 11, 2014

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:

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the reinsurance audit activities in this final rule would be covered through the reinsurance contribution rate, and that there would be no net budget impact for the Federal government as a result of the audit provision. Because this audit requirement would direct a State that establishes a reinsurance program to ensure that its applicable reinsurance entity and any relevant contractors, subcontractors, or agents cooperate with an audit, and would direct the State to provide to HHS for approval a written corrective action plan; implement the plan; and provide to HHS written documentation of the corrective actions once taken, if the audit resulted in a finding of material weakness or significant deficiency, the requirement does impose a cost on States operating reinsurance. However, we believe that State-operated reinsurance programs would already electronically maintain the information necessary for an audit as part of their normal business practices and as a result of the maintenance of records requirement set forth in § 153.240(c), no additional time or effort will be necessary to develop and maintain audit information. We estimate that it will take a compliance analyst (at an hourly labor cost of $53.75) 40 hours to gather the necessary information required for an audit, 5 hours to prepare a corrective action plan based on the audit findings and 64 hours to implement and document, if necessary, the corrective actions taken. We also estimate a senior manager (at an hourly labor cost of $77) will take 5 hours to oversee the transmission of audit information to HHS and to review the corrective action plan prior to submission to HHS, and 16 hours to oversee implementation of any corrective actions taken. Therefore, we estimate a total administrative cost of approximately $7,476 for each State-operated reinsurance program as a result of this audit requirement. For the one State that will operate reinsurance for the 2014 benefit year, we estimate a burden of approximately $7,476 as a result of this requirement. Although we have estimated the cost of a potential audit in this RIA, we note that we may not audit State-operated reinsurance programs.

In § 153.405(i) and § 153.410(d), we establish that HHS may audit contributing entities and issuers of reinsurance-eligible plans to assess compliance with reinsurance program requirements. We discuss the costs to contributing entities and issuers of reinsurance-eligible plans as a result of this requirement in the Collection of Information section of this proposed rule. We intend to combine issuer audits for the premium stabilization programs whenever practicable to reduce the financial burden of these audits on issuers. Consequently, we anticipate that, because issuers of reinsurance-eligible plans may also be subject to risk adjustment requirements, we would conduct these audits in a manner that avoids overlapping review of information that is required for both programs.

In this final rule, we are finalizing with modifications the definition of a contributing entity for the purpose of reinsurance contributions. Specifically, we exempt self-insured, self-administered plans that do not use a TPA to perform claims processing, claims adjudication, and enrollment functions from the requirement to make reinsurance contributions for the 2015 and 2016 benefit years. As stated earlier in this regulatory impact analysis, it is difficult to estimate the number of self-insured, self-administered group health plans that might be affected by this modification. We did not receive quantitative estimates in comments, although as previously stated, we expect that few entities will qualify for this exemption. Therefore, we have not changed our proposed 2015 reinsurance contribution rate.

Risk Corridors

The Affordable Care Act created a temporary risk corridors program for the years 2014, 2015, and 2016 that applies to QHPs, as defined in § 153.500. The risk corridors program is a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers. The Affordable Care Act established the risk corridors program as a Federal program; consequently, HHS will operate the risk corridors program under Federal rules with no State variation. The risk corridors program will help protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains. HHS intends to implement this program in a budget neutral manner.

As mentioned elsewhere in this rule, for the 2014 benefit year, we are making an adjustment to the risk corridors formula that would help mitigate potential QHP issuers' unexpected losses that are attributable to the effects of the transitional policy. We also estimate that this adjustment would result in direct administrative costs for individual and small group market issuers that are discussed in the Collection of Information section of this final rule. Because of the difficulty associated with predicting State enforcement of the 2014 market rules and estimating the enrollment in transitional plans and in QHPs, it is difficult to estimate the precise magnitude of this impact on aggregate risk corridors payments and charges at this time.

Our initial modeling suggests that this adjustment for the transitional policy could increase the total risk corridors payment amount made by the Federal government and decrease risk corridors receipts, resulting in an increase in payments. However, we estimate that even with this change, the risk corridors program is likely to be budget neutral or, will result in net revenue to the Federal government. The magnitude of this effect seems likely to be substantially smaller than the magnitude of the effect of the transitional policy itself (because risk corridors applies only to the extent of an issuer's QHP business), and the magnitude of the effect of the reduction of the reinsurance attachment point and potential increased coinsurance payout. Because reinsurance receipts are a parameter in the risk corridors calculation, the increase in reinsurance payments that would result from lowering the attachment point and potentially increasing the coinsurance rate would exert downward pressure on an issuer's risk corridors ratio. Consequently, while the transitional risk corridors adjustment will result in higher risk corridors payments than would occur if no transitional adjustment were in place, we believe that the risk corridors program as a whole will be budget neutral or, will result in net revenue to the Federal government in FY 2015 for the 2014 benefit year. We note that even with an estimated increase in outlays, CBO still projects the Premium Stabilization programs to reduce the deficit by approximately $8 billion over the budget window. HHS intends to implement this program in a budget neutral manner.

To ensure the integrity of risk corridors data reporting, we establish HHS authority in § 153.540(a) of this final rule to conduct post-payment audits of QHP issuers. We are contemplating several ways to reduce issuer burden, such as conducting the risk corridors audits using the existing MLR audit process or conducting risk corridors audits under an overall issuer audit program. Therefore, as described in the Collection of Information section of this rule, we believe that the cost for issuers that would result from this audit requirement is already accounted for as part of the MLR audit process.

EXHIBIT 20

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: **April 11, 2014**

Subject: **Risk Corridors and Budget Neutrality**

Q1: In the HHS Notice of Benefit and Payment Parameters for 2015 final rule (79 FR 13744) and the Exchange and Insurance Market Standards for 2015 and Beyond NPRM (79 FR 15808), HHS indicated that it intends to implement the risk corridors program in a budget neutral manner. What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as calculated under the risk corridors formula?

A1: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Example 1: For 2014, HHS collects $800 million in risk corridors charges, and QHP issuers seek $600 million risk corridors payments under the risk corridors formula. HHS would make the $600 million in risk corridors payments for 2014 and would retain the remaining $200 million for use in 2015 and potentially 2016 in case of a shortfall.

Example 2: For 2015, HHS collects $700 million in risk corridors charges, but QHP issuers seek $1 billion in risk corridors payments under the risk corridors formula. With the $200 million in excess charges collected for 2014, HHS would have a total of $900 million available to make risk corridors payments in 2015. Each QHP issuer would receive a risk corridors payment equal to 90 percent of the calculated amount of the risk corridors payment, leaving an aggregate risk corridors shortfall of $100 million for benefit year 2015. This $100 million shortfall would be paid for from risk corridors

charges collected for 2016 before any risk corridors payments are made for the 2016 benefit year.

Q2: What happens if risk corridors collections do not match risk corridors payments in the final year of risk corridors?

A2: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program. However, we will establish in future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program.

Q3: If HHS reduces risk corridors payments for a particular year because risk corridors collections are insufficient to make those payments, how should an issuer's medical loss ratio (MLR) calculation account for that reduction?

A3: Under 45 CFR 153.710(g)(1)(iv), an issuer should reflect in its MLR report the risk corridors payment to be made by HHS as reflected in the notification provided under §153.510(d). Because issuers will submit their risk corridors and MLR data simultaneously, issuers will not know the extent of any reduction in risk corridors payments when submitting their MLR calculations. As detailed in 45 CFR 153.710(g)(2), that reduction should be reflected in the next following MLR report. Although it is possible that not accounting for the reduction could affect an issuer's rebate obligations, that effect will be mitigated in the initial year because the MLR ratio is calculated based on three years of data, and will be eliminated by the second year because the reduction will be reflected. We intend to provide more guidance on this reporting in the future.

Q4: In the 2015 Payment Notice, HHS stated that it might adjust risk corridors parameters up or down in order to ensure budget neutrality. Will there be further adjustments to risk corridors in addition to those indicated in this FAQ?

A4: HHS believes that the approach outlined in this FAQ is the most equitable and efficient approach to implement risk corridors in a budget neutral manner. However, we may also make adjustments to the program for benefit year 2016 as appropriate.

EXHIBIT 21

of all funds used by the Centers for Medicare and Medicaid Services specifically for Health Insurance Marketplaces for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148) and the proposed uses for such funds for fiscal year 2016. Such information shall include, for each such fiscal year—

(1) the amount of funds used for each activity specified under the heading "Health Insurance Marketplace Transparency" in the explanatory statement described in section 4 (in the matter preceding division A of this Consolidated Act) accompanying this Act; and

(2) the milestones completed for data hub functionality and implementation readiness.

SEC. 227. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

SEC. 228. (a) Subject to the succeeding provisions of this section, activities authorized under part A of title IV and section 1108(b) of the Social Security Act shall continue through September 30, 2015, in the manner authorized for fiscal year 2014, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through September 30, 2015, at the level provided for such activities for fiscal year 2014, except as provided in subsections (b) and (c).

(b) In the case of the Contingency Fund for State Welfare Programs established under section 403(b) of the Social Security Act—

(1) the amount appropriated for section 403(b) of such Act shall be $608,000,000 for each of fiscal years 2015 and 2016;

(2) the requirement to reserve funds provided for in section 403(b)(2) of such Act shall not apply during fiscal years 2015 and 2016; and

(3) grants and payments may only be made from such Fund for fiscal year 2015 after the application of subsection (d).

42 USC 613 note.

(c) In the case of research, evaluations, and national studies funded under section 413(h)(1) of the Social Security Act, no funds shall be appropriated under that section for fiscal year 2015 or any fiscal year thereafter.

(d) Of the amount made available under subsection (b)(1) for section 403(b) of the Social Security Act for fiscal year 2015—

(1) $15,000,000 is hereby transferred and made available to carry out section 413(h) of the Social Security Act; and

(2) $10,000,000 is hereby transferred and made available to the Bureau of the Census to conduct activities using the Survey of Income and Program Participation to obtain information to enable interested parties to evaluate the impact of the amendments made by title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

EXHIBIT 22

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: October 1, 2015

Subject: Risk Corridors Payment Proration Rate for 2014

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

Under the risk corridors program, the federal government shares risk with QHP issuers – collecting charges from the issuer if the issuer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and making payments to the issuer if the issuer's premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments. On April 11, 2014, HHS issued a bulletin titled ''Risk Corridors and Budget Neutrality," which described how we intend to administer risk corridors over the three-year life of the program. We stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.

Today, HHS is announcing proration results for 2014 risk corridors payments. Based on current data from QHP issuers' risk corridors submissions, issuers will pay $362 million in risk corridors charges, and have submitted for $2.87 billion in risk corridors payments for 2014. **At this time, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent.**

HHS will begin collection of risk corridors charges in November, 2015, and will begin remitting risk corridors payments to issuers starting December, 2015.[1]

We thank QHP issuers for their hard work and timely responses to our data validation requests. We note that all QHP issuers submitted certifications or explanations and just over 50 percent of QHP issuers resubmitted their MLR/risk corridors filings on short notice as part of this important process.

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[1] We note that the risk corridor payment and charge amounts reflected in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 15, 2015, or the effect of subsequent appeals. Neither these amounts nor the proration rates reflected in this bulletin constitute specific obligations of federal funds to any particular issuer or plan.

EXHIBIT 23

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

April 1, 2016

VIA ELECTRONIC MAIL: David.Holmberg@highmarkhealth.com
Mr. David L. Holmberg
President and Chief Executive Officer
Highmark Health
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Dear David,

Thank you for your letter on March 17, 2016.

In 2014, issuers are liable for risk corridor charges of approximately $362 million, and issuers have requested $2.87 billion of 2014 risk corridor payments. CMS has stated that remaining risk corridor claims will be paid out of Calendar Year 2015 risk corridor collections, and, if necessary, Calendar Year 2016 collections.

As previously stated, we won't know the total loss or gain for the risk corridor program until the fall of 2017 when the charges and disbursements for all three years will be verified. In the event of a shortfall after Calendar Year 2016, HHS will explore other funding sources subject to the availability of appropriations. This includes engaging with Congress to secure funding.

We recognize and appreciate both the partnership and critical role Highmark plays in providing coverage and choice in Pennsylvania, Delaware, and West Virginia. We fully understand your concerns and recognize the seriousness of this issue.

I am always available to speak with you directly about these concerns at your convenience.

Sincerely,

Kevin J. Counihan
Chief Executive Officer, Health Insurance Marketplaces
Director, Center for Consumer Information & Insurance Oversight

EXHIBIT 24

ACA, and the amendments made by that Act, in the proposed fiscal year and each fiscal year since the enactment of the ACA.

(b) With respect to employees or contractors supported by all funds appropriated for purposes of carrying out the ACA (and the amendments made by that Act), the Secretary shall include, at a minimum, the following information:

(1) For each such fiscal year, the section of such Act under which such funds were appropriated, a statement indicating the program, project, or activity receiving such funds, the Federal operating division or office that administers such program, and the amount of funding received in discretionary or mandatory appropriations.

(2) For each such fiscal year, the number of full-time equivalent employees or contracted employees assigned to each authorized and funded provision detailed in accordance with paragraph (1).

(c) In carrying out this section, the Secretary may exclude from the report employees or contractors who—

(1) are supported through appropriations enacted in laws other than the ACA and work on programs that existed prior to the passage of the ACA;

(2) spend less than 50 percent of their time on activities funded by or newly authorized in the ACA; or

(3) work on contracts for which FTE reporting is not a requirement of their contract, such as fixed-price contracts.

SEC. 223. The Secretary shall publish, as part of the fiscal year 2017 budget of the President submitted under section 1105(a) of title 31, United States Code, information that details the uses of all funds used by the Centers for Medicare and Medicaid Services specifically for Health Insurance Exchanges for each fiscal year since the enactment of the ACA and the proposed uses for such funds for fiscal year 2017. Such information shall include, for each such fiscal year, the amount of funds used for each activity specified under the heading "Health Insurance Exchange Transparency" in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act).

SEC. 224. (a) The Secretary shall provide to the Committees on Appropriations of the House of Representatives and the Senate:

(1) Detailed monthly enrollment figures from the Exchanges established under the Patient Protection and Affordable Care Act of 2010 pertaining to enrollments during the open enrollment period; and

(2) Notification of any new or competitive grant awards, including supplements, authorized under section 330 of the Public Health Service Act.

(b) The Committees on Appropriations of the House and Senate must be notified at least 2 business days in advance of any public release of enrollment information or the award of such grants.

SEC. 225. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

EXHIBIT 25

Department of Health & Human Services

Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 19, 2015

Subject: Risk Corridors Payment and Charge Amounts for Benefit Year 2014

Background:

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. The program, which was modeled after a similar program implemented as part of the Medicare Part D prescription drug benefit program, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

HHS has previously stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.[1] On October 1, 2015, HHS announced the payment proration rate for 2014 will be approximately 12.6 percent, reflecting risk corridors charges of $362 million and payments of $2.87 billion requested by issuers.[2] This proration rate was based on the most current risk corridors data submitted by issuers and assumes full collection of charges from issuers.

Today, HHS is releasing issuer-level risk corridors payments and charges based on the most current risk corridors data submitted by issuers and assuming full collection of charges from issuers, by market and state, for the 2014 benefit year. The tables below include the risk corridors payment or charge amounts for the individual and small group markets, respectively, and the prorated risk corridors payment, if applicable. **Risk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated.** HHS will begin collection of risk corridors charges in November 2015 and will begin remitting risk corridors payments to issuers starting in December 2015.[3]

[1] "Risk Corridors and Budget Neutrality", published April 11, 2014 and posted at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf

[2] The exact proration rate for 2014 is 12.6178665287897%.

[3] We note that the risk corridor payment and charge amounts published in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 15, 2015 or any amount held back for appeals.

Table 1 – Alabama

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AL	44580	Humana Insurance Company	$ 947,116.86	$ -	$ 119,505.94	$ -
AL	46944	Blue Cross and Blue Shield of Alabama	$ 354,762.84	$ -	$ 44,763.50	$ -
AL	59809	UnitedHealthcare Life Insurance Company	$ -	$ (4,761.86)	$ -	$ (4,761.86)

Table 2 – Alaska

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AK	38344	Premera Blue Cross Blue Shield of Alaska	$ 8,126,435.92	$ 122,178.45	$ 1,025,382.84	$ 15,416.31
AK	73836	Moda Health Plan, Inc.	$ 1,237,418.79	$ 448,597.16	$ 156,135.85	$ 56,603.39

Table 3 – Arizona

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AZ	23307	Humana Health Plan, Inc.	$ 1,851,728.19	$ -	$ 233,648.59	$ -
AZ	51485	Health Net Life Insurance Company	$ 38,309,878.15	$ 6,528,368.90	$ 4,833,889.29	$ 823,740.87
AZ	53901	Blue Cross Blue Shield of Arizona, Inc.	$ 11,688,096.55	$ (216,623.22)	$ 1,474,788.42	$ (216,623.22)
AZ	60761	Meritus Health Partners	$ 3,401,552.97	$ 88,126.95	$ 429,203.41	$ 11,119.74

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AZ	70239	Health Choice Insurance Company	$ 1,258,219.04	$ -	$ 158,760.40	$ -
AZ	84251	Aetna Life Insurance Company	$ 60,071.04	$ -	$ 7,579.68	$ -
AZ	86830	Cigna Health and Life Insurance Company	$ 173,356.66	$ -	$ 21,873.91	$ -
AZ	88925	University of Arizona Health Plans-University Healthcare, Inc.	$ 645,097.22	$ -	$ 81,397.51	$ -
AZ	91450	Health Net of Arizona, Inc.	$ 44,674,893.78	$ 1,189,199.69	$ 5,637,018.47	$ 150,051.63
AZ	92045	Meritus Mutual Health Partners	$ 1,546,274.44	$ 327,316.81	$ 195,106.85	$ 41,300.40

Table 4 – Arkansas

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AR	62141	Celtic Insurance Company	$ (15,850,813.36)	$ -	$ (15,850,813.36)	$ -
AR	70525	QCA Health Plan, Inc.	$ 4,181,163.09	$ -	$ 527,573.58	$ -
AR	75293	USAble Mutual Insurance Company	$ -	$ -	$ -	$ -

Table 5 – California

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CA	18126	Molina Healthcare of California	$ -	$ -	$ -	$ -
CA	27603	Blue Cross of California	$ (8,679,121.40)	$ -	$ (8,679,121.40)	$ -
CA	40513	Kaiser Foundation Health Plan, Inc.	$ (65,768,044.51)	$ 36,933,195.21	$ (65,768,044.51)	$ 4,660,181.28
CA	47579	Chinese Community Health Plan	$ -	$ 712,789.33	$ -	$ 89,938.81
CA	67138	Health Net of California, Inc.	$ -	$ -	$ -	$ -
CA	70285	CA Physician's Service dba Blue Shield of CA	$ (106,990,058.09)	$ (136,577.80)	$ (106,990,058.09)	$ (136,577.80)
CA	84014	County of Santa Clara	$ -	$ -	$ -	$ -
CA	92499	Sharp Health Plan	$ -	$ 7,775.72	$ -	$ 981.13
CA	92815	Local Initiative Health Authority for Los Angeles County	$ 13,561,651.72	$ -	$ 1,711,191.11	$ -
CA	93689	Western Health Advantage	$ (228,695.71)	$ 138.73	$ (228,695.71)	$ 17.50
CA	99110	Health Net Life Insurance Company	$ -	$ 5,058,867.84	$ -	$ 638,321.19
CA	99483	Contra Costa Health Plan	$ -	$ -	$ -	$ -

Table 6 – Colorado

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CO	11555	New Health Ventures, Inc.	$ 106,520.81	$ -	$ 13,440.65	$ -
CO	20472	Colorado Health Insurance Cooperative, Inc.	$ 14,137,039.31	$ 163,367.72	$ 1,783,792.75	$ 20,613.52

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CO	21032	Kaiser Foundation Health Plan of Colorado	$ 14,160,790.95	$ -	$ 1,786,789.70	$ -
CO	49375	Cigna Health and Life Insurance Company	$ (632,444.16)	$ -	$ (632,444.16)	$ -
CO	63312	Colorado Choice Health Plans	$ 5,893,514.24	$ 114,299.01	$ 743,635.76	$ 14,422.10
CO	66699	Denver Health Medical Plan, Inc.	$ 287,542.11	$ -	$ 36,281.68	$ -
CO	74320	Humana Health Plan	$ 3,183,617.97	$ -	$ 401,704.67	$ -
CO	76680	HMO Colorado, Inc., dba HMO Nevada	$ 1,479,675.14	$ (21,811.05)	$ 186,703.43	$ (21,811.05)
CO	80208	Rocky Mountain Health Care Options	$ -	$ 440,553.54	$ -	$ 55,588.46
CO	92137	All Savers Insurance Company	$ (107,467.82)	$ -	$ (107,467.82)	$ -
CO	97879	Rocky Mountain HMO	$ 1,470,136.36	$ 578,003.29	$ 185,499.84	$ 72,931.68

Table 7 – Connecticut

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CT	49650	UnitedHealthcare Insurance Company	$ -	$ 11,299.51	$ -	$ 1,425.76
CT	76962	ConnectiCare Benefits, Inc.	$ (717,037.34)	$ -	$ (717,037.34)	$ -
CT	86545	Anthem Health Plans, Inc. (Anthem BCBS)	$ (863,733.24)	$ (26,699.38)	$ (863,733.24)	$ (26,699.38)
CT	91069	HealthyCT, Inc.	$ 1,561,247.18	$ 272,638.90	$ 196,996.09	$ 34,401.21

Table 8 - DC

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
DC	41842	UnitedHealthcare Insurance Company	$ -	$ (991,539.08)	$ -	$ (991,539.08)
DC	73987	Aetna Health, Inc. (a PA corp.)	$ -	$ (64,837.39)	$ -	$ (64,837.39)
DC	75753	Optimum Choice, Inc.	$ -	$ (254,567.86)	$ -	$ (254,567.86)
DC	77422	Aetna Life Insurance Company	$ (85,707.77)	$ (599,078.47)	$ (85,707.77)	$ (599,078.47)
DC	78079	Group Hospitalization and Medical Services, Inc.	$ -	$ -	$ -	$ -
DC	86052	CareFirst BlueChoice, Inc.	$ -	$ -	$ -	$ -
DC	94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$ 668,656.18	$ 592,476.32	$ 84,370.14	$ 74,757.87

Table 9 – Delaware

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
DE	13537	Coventry Health and Life	$ (98,081.56)	$ -	$ (98,081.56)	$ -
DE	76168	Highmark BCBSD, Inc.	$ 6,075,398.71	$ (90,018.42)	$ 766,585.70	$ (90,018.42)
DE	81914	Coventry Health Care of Delaware, Inc.	$ -	$ (83,436.61)	$ -	$ (83,436.61)

Table 10 – Florida

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
FL	16842	Blue Cross and Blue Shield of Florida	$ 14,407,419.27	$ 28,169.07	$ 1,817,908.93	$ 3,554.34
FL	23841	Aetna Life Insurance Company	$ -	$ -	$ -	$ -
FL	27357	Health First Health Plans, Inc.	$ -	$ 102,999.55	$ -	$ 12,996.35
FL	30252	Health Options, Inc.	$ 11,363,630.16	$ 18,103.08	$ 1,433,847.69	$ 2,284.22
FL	35783	Humana Medical Plan, Inc.	$ 41,231,083.98	$ -	$ 5,202,483.14	$ -
FL	48121	Cigna Health and Life Insurance Company	$ 4,068,246.94	$ -	$ 513,325.97	$ -
FL	51398	Preferred Medical Plan, Inc.	$ 34,777,521.17	$ -	$ 4,388,181.20	$ -
FL	54172	Molina Healthcare of Florida, Inc.	$ 39,035.74	$ -	$ 4,925.48	$ -
FL	56503	Florida Health Care Plan, Inc.	$ (1,687,550.49)	$ (123,177.85)	$ (1,687,550.49)	$ (123,177.85)
FL	57451	Coventry Health Care of Florida, Inc.	$ 30,600,508.00	$ -	$ 3,861,131.26	$ -
FL	77150	Health First Insurance, Inc.	$ 1,549,229.65	$ 303,120.12	$ 195,479.73	$ 38,247.29
FL	86382	Sunshine State Health Plan	$ (420,664.88)	$ -	$ (420,664.88)	$ -

Table 11 - Georgia

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
GA	45495	Peach State Health Plan	$ (675,263.76)	$ -	$ (675,263.76)	$ -
GA	49046	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	$ (5,981,961.36)	$ (3,041.08)	$ (5,981,961.36)	$ (3,041.08)
GA	83761	Alliant Health Plans	$ -	$ 125.18	$ -	$ 15.80
GA	89942	Kaiser Foundation Health Plan of Georgia	$ -	$ 2,003,716.30	$ -	$ 252,826.25
GA	93332	Humana Employers Health Plan of Georgia, Inc.	$ 83,973,253.40	$ -	$ 10,595,633.03	$ -

Table 12 – Hawaii

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
HI	18350	Hawaii Medical Service Association	$ -	$ -	$ -	$ -
HI	60612	Kaiser Foundation Health Plan, Inc.	$ 12,727,673.62	$ 6,060,129.80	$ 1,605,960.87	$ 764,659.09

Table 13 - Idaho

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
ID	26002	SelectHealth	$ 24,386,583.14	$ 1,574,917.17	$ 3,077,066.51	$ 198,720.95
ID	44648	Regence Blue Shield of Idaho	$ -	$ -	$ -	$ -
ID	59765	BridgeSpan Health Company	$ 27,918.21	$ -	$ 3,522.68	$ -
ID	60597	PacificSource Health Plans	$ 2,242,712.26	$ -	$ 282,982.44	$ -
ID	61589	Blue Cross of Idaho Health Service, Inc.	$ 39,437,313.04	$ 600,529.29	$ 4,976,147.52	$ 75,773.98

Table 14 – Illinois

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
IL	20129	Health Alliance Medical Plans, Inc.	$ 2,759,245.94	$ 14,837.77	$ 348,157.97	$ 1,872.21
IL	35670	Coventry Health & Life Company	$ 338,246.81	$ -	$ 42,679.53	$ -
IL	36096	Blue Cross Blue Shield of Illinois	$ 193,846,813.95	$ 3,325,244.33	$ 24,459,332.25	$ 419,574.89
IL	58288	Humana Health Plan, Inc.	$ 800,982.85	$ -	$ 101,066.95	$ -
IL	68303	Humana Insurance Company	$ 4,801,295.28	$ -	$ 605,821.03	$ -
IL	72547	Aetna Life Insurance Company	$ 156,532.35	$ -	$ 19,751.04	$ -
IL	79763	Land of Lincoln Mutual Health Insurance Company	$ 4,165,273.75	$ 326,970.05	$ 525,568.68	$ 41,256.64
IL	96601	Coventry Health Care of Illinois, Inc.	$ 3,177,608.98	$ -	$ 400,946.46	$ -

Table 15 – Indiana

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
IN	17575	Anthem Insurance Companies, Inc. (Anthem BCBS)	$ 812,580.18	$ (319.45)	$ 102,530.28	$ (319.45)
IN	35065	Coordinated Care Corporation Indiana	$ (263,623.41)	$ -	$ (263,623.41)	$ -
IN	50816	Physicians Health Plan of Northern Indiana, Inc.	$ 2,918,313.81	$ 386,940.55	$ 368,228.94	$ 48,823.64
IN	85320	MDwise, Inc.	$ (14,303,011.22)	$ -	$ (14,303,011.22)	$ -

Table 16 – Iowa

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
IA	18973	Aetna Health, Inc. (an IA corp.)	$ 2,707,707.64	$ -	$ 341,654.94	$ -
IA	27651	Gundersen Health Plan, Inc.	$ 105,688.49	$ 8,152.09	$ 13,335.63	$ 1,028.62
IA	71268	CoOportunity Health	$ 40,166,052.95	$ 15,838,758.46	$ 5,068,098.95	$ 1,998,513.40
IA	74980	Avera Health Plans, Inc.	$ 96,106.84	$ 4,805.45	$ 12,126.63	$ 606.35
IA	77638	Health Alliance Midwest, Inc.	$ -	$ -	$ -	$ -
IA	85930	Sanford Health Plan	$ -	$ 129,136.07	$ -	$ 16,294.22

Table 17 – Kansas

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
KS	18558	Blue Cross and Blue Shield of Kansas, Inc.	$ 13,740,981.12	$ 298,179.85	$ 1,733,818.66	$ 37,623.94
KS	61430	Coventry Health and Life	$ 22,889,994.47	$ -	$ 2,888,228.95	$ -
KS	65598	Coventry Health Care Of Kansas, Inc.	$ 9,497,537.20	$ -	$ 1,198,386.57	$ -
KS	94248	Blue Cross and Blue Shield of Kansas City	$ 1,261,531.48	$ (265,838.16)	$ 159,178.36	$ (265,838.16)

Table 18 - Kentucky

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
KY	15411	Humana Health Plan, Inc.	$ 6,029,009.18	$ -	$ 760,732.33	$ -
KY	23671	UnitedHealthcare of Kentucky, Ltd.	$ -	$ (26,994.08)	$ -	$ (26,994.08)
KY	36239	Anthem Health Plans of KY(Anthem BCBS)	$ (620,075.73)	$ (12,523.99)	$ (620,075.73)	$ (12,523.99)
KY	40586	Bluegrass Family Health, Inc.	$ -	$ 1,472,085.68	$ -	$ 185,745.81
KY	77894	Kentucky Health Cooperative	$ 77,074,941.10	$ (69,347.11)	$ 9,725,213.20	$ (69,347.11)

Table 19 - Louisiana

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
LA	19636	HMO Louisiana, Inc.	$ 2,638,100.44	$ 540,123.96	$ 332,871.99	$ 68,152.12
LA	44965	Humana Health Benefit Plan of Louisiana, Inc.	$ 414,666.60	$ -	$ 52,322.08	$ -
LA	67202	Louisiana Health Cooperative, Inc.	$ 11,945,268.95	$ 13,935.30	$ 1,507,238.09	$ 1,758.34
LA	67243	Vantage Health Plan, Inc.	$ -	$ 24,218.07	$ -	$ 3,055.80
LA	97176	Louisiana Health Service & Indemnity Company	$ 27,386,455.30	$ 7,951,249.65	$ 3,455,586.38	$ 1,003,278.07

Table 20- Maine

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
ME	33653	Maine Community Health Options	$ (2,045,819.48)	$ 241,717.00	$ (2,045,819.48)	$ 30,499.53
ME	48396	Anthem Health Plans of ME (Anthem BCBS)	$ -	$ (4,426.93)	$ -	$ (4,426.93)

Table 21 – Maryland

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MD	14468	Coventry Health Care of Delaware, Inc.	$ -	$ (3,504.62)	$ -	$ (3,504.62)
MD	23620	UnitedHealthcare Insurance Company	$ -	$ (2,371,783.62)	$ -	$ (2,371,783.62)

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MD	28137	CareFirst BlueChoice, Inc.	$ 17,927,378.59	$ (200,100.92)	$ 2,262,052.70	$ (200,100.92)
MD	31112	UnitedHealthcare of the Mid-Atlantic, Inc.	$ -	$ (552,561.24)	$ -	$ (552,561.24)
MD	36677	All Savers Insurance Company	$ 138,564.85	$ -	$ 17,483.93	$ -
MD	45532	CareFirst of Maryland, Inc.	$ 5,442,263.96	$ (52,255.73)	$ 686,697.60	$ (52,255.73)
MD	65635	MAMSI Life and Health Insurance Company	$ -	$ (1,511,616.91)	$ -	$ (1,511,616.91)
MD	68541	Coventry Health and Life	$ -	$ (3,959.56)	$ -	$ (3,959.56)
MD	72375	Optimum Choice, Inc.	$ -	$ (1,635,883.00)	$ -	$ (1,635,883.00)
MD	72564	Evergreen Health Cooperative, Inc.	$ 902,808.54	$ 3,232,843.21	$ 113,915.18	$ 407,915.84
MD	90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$ 220,063.25	$ 347,036.82	$ 27,767.29	$ 43,788.64
MD	94084	Group Hospitalization and Medical Services, Inc.	$ 1,021,545.92	$ (133,466.80)	$ 128,897.30	$ (133,466.80)

Table 22 – Massachusetts

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MA	29125	Tufts Associated HMO	$ -	$ -	$ -	$ -
MA	31234	CeltiCare Health Plan of MA	$ 191,649.92	$ -	$ 24,182.13	$ -
MA	34484	Health New England, Inc.	$ -	$ -	$ -	$ -
MA	36046	Harvard Pilgrim Health Care, Inc.	$ -	$ -	$ -	$ -
MA	41304	Neighborhood Health Plan	$ 7,389,737.55	$ 10,543,621.21	$ 932,427.22	$ 1,330,380.05

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MA	42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	$ -	$ -	$ -	$ -
MA	59763	Tufts Health Public Plans Inc.	$ -	$ -	$ -	$ -
MA	73331	Minuteman Health, Inc.	$ 1,138,642.67	$ -	$ 143,672.41	$ -
MA	82569	Boston Medical Center Health Plan, Inc.	$ 1,736,581.18	$ -	$ 219,119.50	$ -
MA	88806	Fallon Community Health Plan, Inc.	$ 200,285.65	$ 435,622.91	$ 25,271.78	$ 54,966.32
MA	95878	HPHC Insurance Company, Inc.	$ 255,319.27	$ 959,303.93	$ 32,215.84	$ 121,043.69

Table 23 – Michigan

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MI	15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	$ -	$ (676,390.04)	$ -	$ (676,390.04)
MI	20393	McLaren Health Plan	$ 532,813.30	$ -	$ 67,229.67	$ -
MI	29241	Priority Health Insurance Company (PHIC)	$ 1,049,112.59	$ 50,769.62	$ 132,375.63	$ 6,406.04
MI	29698	Priority Health	$ 452,162.74	$ 12,391.43	$ 57,053.29	$ 1,563.53
MI	37651	Health Alliance Plan (HAP)	$ (617,846.91)	$ (461,796.54)	$ (617,846.91)	$ (461,796.54)
MI	40047	Molina Healthcare of Michigan, Inc.	$ (33,005.69)	$ -	$ (33,005.69)	$ -
MI	41895	Consumers Mutual	$ 198,351.34	$ 1,442,311.90	$ 25,027.71	$ 181,988.99

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
		Insurance of Michigan				
MI	45002	UnitedHealthcare Life Insurance Company	$ -	$ 32.68	$ -	$ 4.12
MI	46275	Humana Medical Plan of Michigan, Inc.	$ 8,102,093.26	$ -	$ 1,022,311.31	$ -
MI	58594	Meridian Health Plan of Michigan, Inc.	$ (11,519.73)	$ -	$ (11,519.73)	$ -
MI	67183	Total Health Care USA, Inc.	$ -	$ -	$ -	$ -
MI	67577	Alliance Health and Life Insurance Company	$ 64,626.98	$ (176,039.32)	$ 8,154.55	$ (176,039.32)
MI	98185	Blue Care Network of Michigan	$ 17,193,568.72	$ (47,526.91)	$ 2,169,461.55	$ (47,526.91)

Table 24 – Minnesota

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MN	31616	Medica Insurance Company	$ -	$ 316,966.63	$ -	$ 39,994.43
MN	34102	Group Health Plan, Inc.	$ 2,612,104.28	$ -	$ 329,591.83	$ -
MN	49316	BCBSM, Inc.	$ 6,955,635.49	$ -	$ 877,652.80	$ -
MN	65847	Medica Health Plans of Wisconsin	$ -	$ -	$ -	$ -
MN	85736	UCare Minnesota	$ -	$ -	$ -	$ -
MN	88102	PreferredOne Insurance Company	$ 53,344,373.74	$ 176,995.83	$ 6,730,921.88	$ 22,333.10

Table 25 - Mississippi

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MS	48963	Humana Insurance Company	$ (900,401.14)	$ -	$ (900,401.14)	$ -
MS	61794	UnitedHealthcare Life Insurance Company	$ -	$ (1,130.50)	$ -	$ (1,130.50)
MS	94237	Magnolia Health Plan	$ (13,190,322.25)	$ -	$ (13,190,322.25)	$ -

Table 26 - Missouri

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MO	32753	Healthy Alliance Life Company (Anthem BCBS)	$ -	$ 22,591.92	$ -	$ 2,850.62
MO	34762	Blue Cross and Blue Shield of Kansas City	$ 2,807,773.67	$ (183,601.01)	$ 354,281.13	$ (183,601.01)
MO	44240	Coventry Health and Life	$ 29,076,804.73	$ -	$ 3,668,872.41	$ -

Table 27 – Montana

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MT	23603	PacificSource Health Plans	$ 1,938,055.47	$ -	$ 244,541.25	$ -
MT	30751	Blue Cross and Blue Shield of Montana	$ 23,457,847.95	$ 554,107.74	$ 2,959,879.94	$ 69,916.58
MT	32225	Montana Health Cooperative	$ 6,754,127.62	$ 62,383.51	$ 852,226.81	$ 7,871.47

Table 28 – Nebraska

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NE	15438	Coventry Health Care of Nebraska, Inc.	$ -	$ -	$ -	$ -
NE	29678	Blue Cross and Blue Shield of Nebraska	$ 14,143,024.12	$ (267,402.83)	$ 1,784,547.91	$ (267,402.83)
NE	43198	CoOportunity Health	$ 51,080,793.04	$ 22,870,010.14	$ 6,445,306.29	$ 2,885,707.35
NE	77931	Health Alliance Midwest, Inc.	$ (53,340.12)	$ 7,317.35	$ (53,340.12)	$ 923.29

Table 29 – Nevada

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NV	16698	Prominence HealthFirst	$ (71,742.47)	$ -	$ (71,742.47)	$ -
NV	34996	Nevada Health CO-OP	$ 10,388,059.14	$ 312,181.20	$ 1,310,751.44	$ 39,390.61
NV	60156	HMO Colorado, Inc., dba HMO Nevada	$ (53,370.48)	$ 2,715.74	$ (53,370.48)	$ 342.67
NV	95865	Health Plan of Nevada, Inc.	$ -	$ -	$ -	$ -

Table 30 – New Hampshire

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NH	96751	Matthew Thornton Health Plan (Anthem BCBS)	$ (2,966,744.60)	$ -	$ (2,966,744.60)	$ -

Table 31 – New Jersey

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NJ	10191	Freelancers CO-OP of New Jersey, Inc.	$ (2,895,760.17)	$ 150,164.60	$ (2,895,760.17)	$ 18,947.57
NJ	77606	AmeriHealth HMO, Inc.	$ 3,360,296.37	$ 138,744.96	$ 423,997.71	$ 17,506.65
NJ	91661	Horizon Healthcare Services, Inc.	$ (27,523,171.51)	$ 3,185,432.61	$ (27,523,171.51)	$ 401,933.64
NJ	91762	AmeriHealth Insurance Company of New Jersey	$ (2,318,123.55)	$ 1,157,648.85	$ (2,318,123.55)	$ 146,070.59

Table 32 – New Mexico

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NM	19722	Molina Health Care of New Mexico, Inc.	$ (628,432.85)	$ -	$ (628,432.85)	$ -
NM	52744	Presbyterian Insurance Company, Inc.	$ -	$ -	$ -	$ -
NM	57173	Presbyterian Health Plan, Inc.	$ 2,478,787.11	$ (82,897.17)	$ 312,770.05	$ (82,897.17)
NM	75605	Blue Cross Blue Shield of New Mexico	$ 6,563,110.63	$ 3,789.97	$ 828,124.54	$ 478.21

NM	93091	New Mexico Health Connections	$ 4,211,650.62	$ -	$ 531,420.45	$ -

Table 33 – New York

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NY	11177	MetroPlus Health Plan	$ 8,754,733.06	$ -	$ 1,104,660.53	$ -
NY	18029	Independent Health Benefits Corporation	$ (2,870,470.22)	$ (530,639.45)	$ (2,870,470.22)	$ (530,639.45)
NY	25303	New York State Catholic Health Plan, Inc.	$ (3,499,761.14)	$ -	$ (3,499,761.14)	$ -
NY	31808	American Progressive Life & Health Insurance Company of New York	$ (344,586.33)	$ -	$ (344,586.33)	$ -
NY	40064	HealthNow New York	$ (4,020,217.24)	$ (1,216,594.18)	$ (4,020,217.24)	$ (1,216,594.18)
NY	54235	UnitedHealthcare of New York, Inc.	$ (626,658.79)	$ -	$ (626,658.79)	$ -
NY	56184	MVP Health Plan, Inc.	$ (3,547,343.87)	$ 1,550,702.41	$ (3,547,343.87)	$ 195,665.56
NY	57165	Affinity Health Plan, Inc.	$ 1,179,368.76	$ -	$ 148,811.18	$ -
NY	71644	Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	$ 89,568,960.58	$ 59,765,898.72	$ 11,301,691.90	$ 7,541,181.33
NY	74289	Oscar Insurance Corporation	$ 9,342,723.93	$ -	$ 1,178,852.44	$ -
NY	78124	Excellus Health Plan, Inc.	$ (5,505,909.10)	$ 7,526,489.35	$ (5,505,909.10)	$ 949,682.38
NY	80519	Empire HealthChoice HMO, Inc.	$ -	$ -	$ -	$ -

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NY	82483	North Shore-LIJ Insurance Company, Inc.	$ 3,109,088.97	$ 407,827.19	$ 392,300.70	$ 51,459.09
NY	85629	Oxford Health Insurance, Inc.	$ -	$ -	$ -	$ -
NY	88582	Health Insurance Plan of Greater New York	$ -	$ -	$ -	$ -
NY	91237	Healthfirst PHSP, Inc.	$ 75,523.98	$ -	$ 9,529.51	$ -
NY	92551	CDPHP Universal Benefits, Inc.	$ -	$ 14,607,068.85	$ -	$ 1,843,100.45
NY	94788	CDPHP	$ (1,382,551.74)	$ -	$ (1,382,551.74)	$ -
NY	95456	Atlantis Health Plan	$ -	$ -	$ -	$ -

Table 34 – North Carolina

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NC	11512	Blue Cross and Blue Shield of NC	$ 147,421,876.38	$ 53,091.97	$ 18,601,495.60	$ 6,699.07
NC	56346	Coventry Health Care of the Carolinas, Inc.	$ 10,188,775.76	$ -	$ 1,285,606.13	$ -

Table 35 – North Dakota

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
ND	37160	Blue Cross Blue Shield of North Dakota	$ 458,378.00	$ -	$ 57,837.52	$ -
ND	73751	Medica Health Plans	$ 135,903.29	$ 104,395.86	$ 17,148.10	$ 13,172.53
ND	89364	Sanford Health Plan	$ (36,822.51)	$ (525,477.50)	$ (36,822.51)	$ (525,477.50)

Table 36 – Ohio

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OH	20126	HealthSpan Integrated Care	$ 11,010,446.61	$ 192,005.52	$ 1,389,283.46	$ 24,227.00
OH	28162	AultCare Insurance Company	$ (352,697.76)	$ 653,633.59	$ (352,697.76)	$ 82,474.61
OH	29276	Community Insurance Company (Anthem BCBS)	$ (1,827,325.84)	$ 16,036.90	$ (1,827,325.84)	$ 2,023.51
OH	41047	Buckeye Community Health Plan	$ (138,688.52)	$ -	$ (138,688.52)	$ -
OH	52664	Summa Insurance Company, Inc.	$ 1,029,971.11	$ 1,126,100.28	$ 129,960.38	$ 142,089.83
OH	64353	Molina Healthcare of Ohio	$ (59,275.67)	$ -	$ (59,275.67)	$ -
OH	66083	Humana Health Plan of Ohio, Inc.	$ 9,268,399.33	$ -	$ 1,169,474.26	$ -
OH	74313	Paramount Insurance Company	$ -	$ -	$ -	$ -
OH	77552	CareSource	$ (2,330,396.51)	$ -	$ (2,330,396.51)	$ -
OH	92036	HealthSpan	$ 4,984,820.40	$ 82,913.27	$ 628,977.98	$ 10,461.89
OH	98894	Coventry Health and Life	$ 572,626.39	$ -	$ 72,253.23	$ -
OH	99969	Medical Health Insuring Corporation of Ohio	$ 4,162,818.87	$ 814,705.62	$ 525,258.93	$ 102,798.47

Table 37 – Oklahoma

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OK	53524	Coventry Health and Life	$ 160,301.63	$ -	$ 20,226.65	$ -
OK	66946	Aetna Life Insurance Company	$ 430,044.89	$ -	$ 54,262.49	$ -
OK	76668	Coventry Health Care of Kansas, Inc.	$ 1,263,023.77	$ -	$ 159,366.65	$ -
OK	85408	GlobalHealth, Inc.	$ 2,789,907.94	$ 15,603.96	$ 352,026.86	$ 1,968.89
OK	87571	Blue Cross Blue Shield of Oklahoma	$ 51,750,597.82	$ 2,141,587.80	$ 6,529,821.36	$ 270,222.69
OK	87698	CommunityCare Life & Health Insurance Company	$ -	$ 153,238.12	$ -	$ 19,335.38
OK	98905	CommunityCare HMO, Inc.	$ (89,579.39)	$ 324,873.59	$ (89,579.39)	$ 40,992.12

Table 38 – Oregon

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OR	10091	PacificSource Health Plans	$ 3,007,808.62	$ -	$ 379,521.28	$ -
OR	10940	Health Net Health Plan of Oregon, Inc.	$ 2,355,054.51	$ -	$ 297,157.63	$ -
OR	32536	ATRIO Health Plans	$ 79,569.24	$ 38,865.04	$ 10,039.94	$ 4,903.94
OR	39424	Moda Health Plan, Inc.	$ 86,224,498.21	$ 1,515,915.79	$ 10,879,692.10	$ 191,276.23
OR	56707	Providence Health Plan	$ (884,714.62)	$ (14,562.34)	$ (884,714.62)	$ (14,562.34)
OR	63474	BridgeSpan Health Company	$ (10,125.33)	$ -	$ (10,125.33)	$ -
OR	71287	Kaiser Foundation Healthplan of the NW	$ -	$ (103,672.86)	$ -	$ (103,672.86)

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OR	85804	LifeWise Health Plan of Oregon	$ 4,825,921.49	$ -	$ 608,928.33	$ -
OR	95417	Trillium Community Health Plan	$ (4,991.57)	$ -	$ (4,991.57)	$ -
OR	96383	Health Republic Insurance Company	$ 4,206,407.40	$ 3,678,478.75	$ 530,758.87	$ 464,145.54
OR	99389	Community Care of Oregon, Inc.	$ 1,528,717.06	$ (53,520.17)	$ 192,891.48	$ (53,520.17)

Table 39 – Pennsylvania

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
PA	16481	UPMC Health Network, Inc.	$ -	$ 222,263.08	$ -	$ 28,044.86
PA	22444	Geisinger Health Plan	$ 17,817,403.51	$ 5,080,960.02	$ 2,248,176.19	$ 641,108.75
PA	31609	Independence Blue Cross (QCC Ins. Co.)	$ (1,308,105.69)	$ 10,769,563.46	$ (1,308,105.69)	$ 1,358,889.14
PA	33709	Highmark, Inc.	$ 158,255,675.15	$ 1,561,432.70	$ 19,968,489.86	$ 197,019.49
PA	33871	Keystone Health Plan East, Inc.	$ 14,274,873.45	$ 14,996,681.97	$ 1,801,184.48	$ 1,892,261.31
PA	33906	Aetna Life Insurance	$ 305,303.92	$ -	$ 38,522.84	$ -

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
		Company				
PA	52899	UPMC Health Plan, Inc.	$ -	$ 13,607.91	$ -	$ 1,717.03
PA	53789	Keystone Health Plan Central	$ 116,511.72	$ (10,554.40)	$ 14,701.29	$ (10,554.40)
PA	55957	First Priority Life Insurance Company, Inc.	$ 10,933,783.20	$ -	$ 1,379,610.17	$ -
PA	64844	Aetna Health Inc. (a PA corp.)	$ (345,573.38)	$ -	$ (345,573.38)	$ -
PA	70194	Highmark Health Insurance Company	$ 31,690,007.63	$ -	$ 3,998,602.87	$ -
PA	75729	Geisinger Quality Options	$ 3,707,248.35	$ 3,991,516.95	$ 467,775.65	$ 503,644.28
PA	82795	Capital Advantage Insurance Company CAIC	$ 235,466.09	$ 54,647.55	$ 29,710.80	$ 6,895.35
PA	91303	HealthAmerica Pennsylvania, Inc.	$ 2,042,302.79	$ -	$ 257,695.04	$ -

Table 40 – Rhode Island

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
RI	15287	Blue Cross & Blue Shield of Rhode Island	$ -	$ -	$ -	$ -
RI	77514	Neighborhood Health Plan of Rhode Island	$ (211,788.19)	$ (4,014.40)	$ (211,788.19)	$ (4,014.40)
RI	79881	UnitedHealthcare of New England, Inc.	$ -	$ 762.71	$ -	$ 96.24

Table 41 – South Carolina

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
SC	26065	Blue Cross and Blue Shield of South Carolina	$ (5,288,866.75)	$ (529,578.40)	$ (5,288,866.75)	$ (529,578.40)
SC	41614	Coventry Health Care of the Carolinas, Inc.	$ 5,095,926.05	$ -	$ 642,997.15	$ -
SC	49532	BlueChoice HealthPlan of South Carolina, Inc.	$ (2,329,264.72)	$ (21,230.33)	$ (2,329,264.72)	$ (21,230.33)
SC	65122	Consumers' Choice Health Insurance Company	$ 12,425,229.72	$ (1,019.57)	$ 1,567,798.90	$ (1,019.57)

Table 42 – South Dakota

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
SD	31195	Sanford Health Plan	$ 2,970,388.46	$ 566,171.13	$ 374,799.65	$ 71,438.72
SD	60536	Avera Health Plans, Inc.	$ 7,572,477.64	$ 394,223.31	$ 955,485.12	$ 49,742.57
SD	62210	South Dakota State Medical Holding Company, Inc.	$ 66,565.39	$ 12,552.90	$ 8,399.13	$ 1,583.91

Table 43 – Tennessee

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
TN	14002	BlueCross BlueShield of Tennessee	$ 78,721,051.43	$ -	$ 9,932,917.20	$ -
TN	66842	Community Health Alliance Mutual Insurance Company	$ 212,418.39	$ 155,095.17	$ 26,802.67	$ 19,569.70
TN	82120	Humana Insurance Company	$ 7,292,392.28	$ -	$ 920,144.32	$ -
TN	99248	Cigna Health and Life Insurance Company	$ (31,703.92)	$ -	$ (31,703.92)	$ -

Table 44 – Texas

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
TX	26539	SHA, LLC DBA FirstCare Health Plans	$ 1,675,416.16	$ 359,876.56	$ 211,401.77	$ 45,408.74
TX	27248	Community Health Choice, Inc.	$ (4,628.30)	$ -	$ (4,628.30)	$ -
TX	32673	Humana Health Plan of Texas, Inc.	$ 61,229,555.45	$ -	$ 7,725,863.58	$ -
TX	33602	Blue Cross Blue Shield of Texas	$ 275,081,527.88	$ 19,226,824.55	$ 34,709,420.03	$ 2,426,015.06
TX	40788	Scott and White Health Plan	$ 770,409.24	$ -	$ 97,209.21	$ -
TX	45786	Molina Healthcare of	$ (421,460.88)	$ -	$ (421,460.88)	$ -

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
		Texas				
TX	46224	Community First Health Plans, Inc.	$ 10,771.93	$ -	$ 1,359.19	$ -
TX	55409	Cigna Health and Life Insurance Company	$ 12,881,279.86	$ -	$ 1,625,342.70	$ -
TX	63141	Humana Insurance Company	$ 5,073,997.06	$ -	$ 640,230.18	$ -
TX	71837	Sendero Health Plans, Inc.	$ -	$ -	$ -	$ -
TX	87226	Superior Health Plan	$ (141,809.67)	$ -	$ (141,809.67)	$ -
TX	91716	Aetna Life Insurance Company	$ 1,101,457.25	$ -	$ 138,980.41	$ -

Table 45 – Utah

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
UT	18167	Molina Healthcare of Utah	$ (34,983.73)	$ -	$ (34,983.73)	$ -
UT	27619	Arches Mutual Insurance Company	$ 11,541,794.74	$ 475,006.15	$ 1,456,328.26	$ 59,935.64
UT	34541	BridgeSpan Health Company	$ 2,017,051.99	$ -	$ 254,508.93	$ -
UT	38927	Aetna Health of Utah, Inc.	$ 2,007,972.57	$ -	$ 253,363.30	$ -
UT	56764	Humana Medical Plan of Utah, Inc.	$ 9,670,212.71	$ -	$ 1,220,174.53	$ -
UT	66413	UnitedHealthcare of Utah, Inc.	$ -	$ (83,844.54)	$ -	$ (83,844.54)
UT	68781	SelectHealth	$ 62,294,564.39	$ 21,242,298.51	$ 7,860,244.99	$ 2,680,324.87

Table 46 – Vermont

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
VT	13627	Blue Cross Blue Shield of Vermont	$ (30,650.56)	$ (36,128.73)	$ (30,650.56)	$ (36,128.73)
VT	77566	MVP Health Plan, Inc.	$ 918,153.01	$ 644,843.45	$ 115,851.32	$ 81,365.49

Table 47 – Virginia

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
VA	10207	CareFirst BlueChoice, Inc.	$ 730,771.62	$ -	$ 92,207.79	$ -
VA	12028	Innovation Health Insurance Company	$ 426,857.46	$ -	$ 53,860.30	$ -
VA	20507	Optima Health Plan	$ -	$ -	$ -	$ -
VA	38234	Aetna Life Insurance Company	$ (659,270.22)	$ -	$ (659,270.22)	$ -
VA	40308	Group Hospitalization and Medical Services, Inc.	$ (64,661.14)	$ (1,025,296.29)	$ (64,661.14)	$ (1,025,296.29)
VA	88380	HealthKeepers, Inc.	$ -	$ (2,548.51)	$ -	$ (2,548.51)
VA	95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$ -	$ 178,089.11	$ -	$ 22,471.05
VA	99663	Coventry Health Care of Virginia, Inc.	$ -	$ -	$ -	$ -

Table 48 – Washington

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WA	18581	Community Health Plan of Washington	$ (753,546.87)	$ -	$ (753,546.87)	$ -
WA	23371	Kaiser Foundation Healthplan of the NW	$ (3,394,261.77)	$ (369,811.39)	$ (3,394,261.77)	$ (369,811.39)
WA	38498	LifeWise Health Plan of WA	$ (1,919,519.31)	$ -	$ (1,919,519.31)	$ -
WA	49831	Premera Blue Cross	$ (5,476,090.21)	$ -	$ (5,476,090.21)	$ -
WA	53732	BridgeSpan Health Company	$ (2,033,720.54)	$ -	$ (2,033,720.54)	$ -
WA	61836	Coordinated Care Corporation	$ -	$ -	$ -	$ -
WA	80473	Group Health Cooperative	$ (6,356,225.50)	$ -	$ (6,356,225.50)	$ -
WA	84481	Molina Healthcare of Washington, Inc.	$ (1,376,733.58)	$ -	$ (1,376,733.58)	$ -

Table 49 – West Virginia

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WV	31274	Highmark Blue Cross Blue Shield West Virginia	$ 14,385,457.00	$ 38,227.31	$ 1,815,137.76	$ 4,823.47

Table 50 – Wisconsin

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WI	35334	MercyCare Insurance Company	$ -	$ 355,607.79	$ -	$ 44,870.12
WI	37833	Unity Health Plans Insurance Corporation	$ -	$ -	$ -	$ -
WI	38166	Security Health Plan of Wisconsin, Inc.	$ -	$ 875,656.06	$ -	$ 110,489.11
WI	38345	Dean Health Plan	$ 15,750,038.55	$ -	$ 1,987,318.84	$ -
WI	47342	Health Tradition Health Plan	$ 297,680.24	$ 282,631.37	$ 37,560.90	$ 35,662.05
WI	52697	Molina Healthcare of Wisconsin, Inc.	$ (2,294,384.22)	$ -	$ (2,294,384.22)	$ -
WI	57637	Medica Insurance Company	$ -	$ 481,277.84	$ -	$ 60,727.00
WI	57845	Medica Health Plans of Wisconsin	$ (1,883,070.63)	$ -	$ (1,883,070.63)	$ -
WI	58326	MercyCare HMO, Inc.	$ 628,033.47	$ 555,110.94	$ 79,244.43	$ 70,043.16
WI	58564	Physicians Plus Insurance Corporation	$ (400,853.60)	$ -	$ (400,853.60)	$ -
WI	79475	Compcare Health Services Insurance Company (Anthem BCBS)	$ 4,931,489.14	$ -	$ 622,248.72	$ -
WI	84670	WPS Health Plan, Inc.	$ 6,415,135.24	$ -	$ 809,453.20	$ -
WI	87416	Common Ground Healthcare Cooperative	$ 44,457,568.86	$ 784,154.58	$ 5,609,596.70	$ 98,943.58
WI	91058	Gundersen Health Plan, Inc.	$ -	$ 2,074,673.03	$ -	$ 261,779.47
WI	94529	Group Health Cooperative-SCW	$ (214,772.33)	$ (487,586.65)	$ (214,772.33)	$ (487,586.65)

Table 51 – Wyoming

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WY	11269	Blue Cross Blue Shield of Wyoming	$ (3,909,210.30)	$ 607,415.77	$ (3,909,210.30)	$ 76,642.91
WY	53189	WINhealth Partners	$ 4,996,309.90	$ 70,330.08	$ 630,427.71	$ 8,874.16

EXHIBIT 26

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight 200
Independence Avenue SW
Washington, DC 20201

Date: November 18, 2016

Subject: Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year

Background:

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace.

HHS established a three-year payment framework for the risk corridors program and outlined the details of this payment framework in our April 11, 2014 guidance on *Risk Corridors and Budget Neutrality*.[1] As set forth in that guidance, if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall. Because risk corridors payments for the 2014 benefit year exceeded risk corridors collections for that benefit year, risk corridors collections for the 2015 benefit year will be used first towards remaining balances on 2014 benefit year risk corridors payments.

On September 9, 2016, HHS published guidance on *Risk Corridors Payments for 2015*, stating that we anticipated that all 2015 benefit year collections would be used toward remaining 2014 benefit year risk corridors payments, and that no funds would be available at this time for 2015 benefit year risk corridors payments.[2] Today, we are confirming that all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments.

We are also announcing issuer-level risk corridors payments and charges for the 2015 benefit year. The tables below show risk corridors payments and charges calculated for the 2015 benefit year, by State and issuer, and the additional amount based on anticipated 2015 risk corridors collections that HHS expects to pay towards the calculated 2014 benefit year payments.[3] Pursuant to 45 CFR

[1] *Risk Corridors and Budget Neutrality*, available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf
[2] *Risk Corridors Payments for 2015*, available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF
[3] Risk corridor payment and charge amounts published in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 30, 2016 or any amount held back for appeals.

153.510(g), the 2015 benefit year risk corridors amounts listed in this report include the direct adjustment for issuers that reported certified estimates of the cost-sharing reduction portion of advance payments that were lower than the actual CSRs provided for the 2014 benefit year (as calculated under CSR reconciliation for the 2014 benefit year). On November 17, 2016, HHS notified issuers subject to the direct adjustment to 2015 benefit year risk corridors amounts of the calculated adjustment amount, consistent with guidance issued on September 15, 2016.[4]

Risk corridors payments are reduced pro rata based on risk corridors collections received. HHS intends to collect the full 2015 risk corridors charge amounts indicated in the tables below. HHS is collecting 2015 risk corridor charges in November 2016, and will begin remitting risk corridors payments to issuers in December 2016, as collections are received.

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2015 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS 2015 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	EXPECTED PAYMENT TOWARD 2014 AMOUNTS
AK	38344	Premera Blue Cross Blue Shield of Alaska	$7,479,997.83	$716,228.92	$274,005.10
AK	73836	Moda Health Plan, Inc.	$28,630,662.11	$2,900,481.02	$56,006.61
AL	44580	Humana Insurance Company	$2,935,440.73	$0.00	$31,461.63
AL	46944	Blue Cross and Blue Shield of Alabama	$79,476,154.29	$10,341,860.76	$11,784.62
AL	59809	UnitedHealthcare Life Insurance Company	$0.00	$6,577.07	$0.00
AL	68259	UnitedHealthcare of Alabama, Inc.	$8,688,275.81	$0.00	N/A
AR	62141	Celtic Insurance Company	$1,812,823.37	$0.00	$0.00
AR	70525	QCA Health Plan, Inc.	$476,592.83	$0.00	$138,891.20
AR	75293	USAble Mutual Insurance Company	$15,919,592.28	-$7,883.38	$0.00
AR	37903	QualChoice Life & Health Insurance Company, Inc.	$4,524,487.98	$0.00	N/A
AZ	23307	Humana Health Plan, Inc.	$202,481.41	$0.00	$61,511.29
AZ	51485	Health Net Life Insurance Company	$95,219,226.99	$17,249,722.49	$1,489,451.17
AZ	53901	Blue Cross and Blue Shield of Arizona, Inc.	$51,990,665.22	$0.00	$388,258.91
AZ	60761	Meritus Health Partners	$54,694,644.83	$702,732.99	$115,921.29
AZ	70239	Health Choice Insurance Co.	$4,444,184.06	$0.00	$41,795.92
AZ	84251	Aetna Life Insurance Company	-$389,753.48	$0.00	$1,995.46
AZ	86830	Cigna Health and Life Insurance Company	$1,023,204.62	$0.00	$5,758.61
AZ	88925	University of Arizona Health Plans-University Healthcare, Inc.	$1,213,077.74	$0.00	$21,429.04
AZ	91450	Health Net of Arizona, Inc.	$38,681,654.46	$5,438,853.29	$1,523,528.06
AZ	92045	Meritus Mutual Health Partners	$11,438,590.03	$1,437,229.12	$62,237.55

[4] *Reporting of Risk Corridors Amounts Reflecting Certified Estimates of 2014 Cost-Sharing Reduction Amounts in Part 3, Line 1.7 of the Medical Loss Ratio Annual Reporting Form for the 2015 Benefit Year*, available at: https://www.regtap.info/uploads/library/RC_CSRandMLR_091516_v1_5CR_091516.pdf

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2015 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS 2015 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	EXPECTED PAYMENT TOWARD 2014 AMOUNTS
AZ	65441	Phoenix Health Plans, Inc.	$34,931.14	$0.00	N/A
AZ	80863	Time Insurance Company	$7,624,448.10	$0.00	N/A
AZ	98971	All Savers Insurance Company	$7,002,813.66	$0.00	N/A
CA	18126	MOLINA HEALTHCARE OF CALIFORNIA	$1,784,227.07	$0.00	$0.00
CA	27603	Blue Cross of California(Anthem BC)	-$808,605.43	$0.00	$0.00
CA	40513	Kaiser Foundation Health Plan, Inc.	$39,758,493.83	$47,233,593.74	$1,226,858.64
CA	47579	Chinese Community Health Plan	-$25,303.31	$0.00	$23,677.66
CA	67138	Health Net of California, Inc	$24,828,036.37	$0.00	$0.00
CA	70285	CA Physician's Service dba Blue Shield of CA	$29,839,109.20	-$217,494.36	$0.00
CA	84014	County of Santa Clara	$151,037.85	$0.00	$0.00
CA	92499	Sharp Health Plan	$0.00	$31,033.86	$258.29
CA	92815	Local Initiative Health Authority for Los Angeles County	$8,255,198.64	$0.00	$450,495.26
CA	93689	Western Health Advantage	$0.00	$171,678.94	$193.15
CA	99110	Health Net Life Insurance Company	$130,379,454.51	$10,868,970.44	$168,047.08
CA	99483	CONTRA COSTA HEALTH PLAN	$0.00	$0.00	$0.00
CO	11555	New Health Ventures Inc	$88,645.17	$0.00	$3,538.44
CO	20472	Colorado Health Insurance Cooperative, Inc.	$97,136,652.48	$1,558,715.85	$475,035.47
CO	21032	Kaiser Foundation Health Plan of Colo.	$52,928,909.77	$0.00	$470,397.66
CO	49375	Cigna Health and Life Insurance Company	$2,017,361.36	$0.00	$0.00
CO	63312	Colorado Choice Health Plans	$1,597,077.24	$60,789.09	$199,569.45
CO	66699	Denver Health Medical Plan, Inc	$141,372.24	$0.00	$9,551.66
CO	74320	Humana Health Plan	$2,856,524.81	$0.00	$105,754.43
CO	76680	HMO Colorado, Inc., dba HMO Nevada	$3,002,631.67	$38,482.92	$49,152.32
CO	80208	Rocky Mountain Health Care Options	$0.00	$0.00	$14,634.44
CO	92137	All Savers Insurance Company	$184,407.92	$0.00	$0.00
CO	97879	Rocky Mountain HMO	$32,345,160.48	$780,733.56	$68,035.75
CT	49650	UnitedHealthcare Insurance Company	$222,890.06	$265,020.43	$375.35
CT	76962	ConnectiCare Benefits, Inc.	$0.00	$0.00	$0.00
CT	86545	Anthem Health Plans Inc(Anthem BCBS)	-$691,198.86	$0.00	$0.00
CT	91069	HealthyCT, Inc.	$12,859,364.54	$1,723,783.09	$60,918.61
DC	41842	UnitedHealthcare Insurance Company	$0.00	$0.00	$0.00
DC	73987	Aetna Health Inc. (a PA corp.)	$0.00	$220,036.68	$0.00
DC	75753	Optimum Choice, Inc.	$0.00	-$240,089.45	$0.00
DC	77422	Aetna Life Insurance Company	$42,898.21	$112,048.45	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2015 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS 2015 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	EXPECTED PAYMENT TOWARD 2014 AMOUNTS
DC	78079	GHMSI	$0.00	$0.00	$0.00
DC	86052	CareFirst BlueChoice, Inc.	-$3,513.64	$0.00	$0.00
DC	94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$1,054,566.82	$1,802,662.82	$41,761.59
DC	21066	UnitedHealthcare of the Mid-Atlantic Inc	$0.00	$14,598.52	N/A
DE	13537	Coventry Health and Life	-$61,257.16	$0.00	$0.00
DE	76168	Highmark BCBSD Inc.	$21,566,965.70	$0.00	$201,814.53
DE	81914	Coventry Health Care of Delaware, Inc.	-$6,863.38	$0.00	$0.00
DE	29497	Aetna Life Insurance Company	$965,123.20	$0.00	N/A
DE	67190	Aetna Health Inc. (a PA corp.)	$528,909.73	-$12,042.12	N/A
FL	16842	Blue Cross and Blue Shield of Florida	$0.00	$0.00	$479,525.97
FL	23841	Aetna Life Insurance Company	-$7,303,625.54	$0.00	$0.00
FL	27357	Health First Health Plans, Inc.	$0.00	$0.00	$3,421.47
FL	30252	Health Options, Inc.	$0.00	$0.00	$378,082.04
FL	35783	Humana Medical Plan, Inc.	$45,750,026.92	$0.00	$1,369,627.28
FL	48121	Cigna Health and Life Insurance Company	$43,174,253.76	$0.00	$135,140.32
FL	51398	Preferred Medical Plan, Inc.	-$5,243,952.57	$0.00	$1,155,250.77
FL	54172	Molina Healthcare of Florida, Inc	$25,417,985.09	$0.00	$1,296.70
FL	56503	Florida Health Care Plan, Inc.	$719,021.99	-$114,905.82	$0.00
FL	57451	Coventry Health Care of Florida, Inc.	-$19,865,425.63	$0.00	$1,016,497.42
FL	77150	Health First Insurance, Inc.	-$142,937.08	$165,954.93	$61,531.94
FL	86382	Sunshine State Health Plan	$0.00	$0.00	$0.00
FL	18628	Aetna Health Inc. (a FL corp.)	$11,484,155.02	$0.00	N/A
FL	62662	Time Insurance Company	$61,174,353.15	$0.00	N/A
FL	68398	UnitedHealthcare of Florida, Inc.	$42,781,167.93	$39,290.23	N/A
GA	45495	Peach State Health Plan	$0.00	$0.00	$0.00
GA	49046	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	$2,761,214.17	$0.00	$0.00
GA	83761	Alliant Health Plans	$10,736,274.64	$0.00	$4.15
GA	89942	Kaiser Foundation Health Plan of Georgia	$9,263,922.53	$0.00	$65,821.65
GA	93332	Humana Employers Health Plan of Georgia, Inc.	$113,127,699.47	$0.00	$2,789,450.27
GA	20544	Time Insurance Company	$7,352,482.72	$0.00	N/A
GA	43802	UnitedHealthcare of Georgia, Inc.	$12,145,393.47	$0.00	N/A
GA	47783	Aetna Health Inc., a Georgia Corp	$18,355,167.74	$0.00	N/A
GA	50491	Cigna Health and Life Insurance Company	$560,890.22	$0.00	N/A
HI	18350	Hawaii Medical Service Association	$17,759,344.35	$0.00	$0.00
HI	60612	Kaiser Foundation Health Plan, Inc.	$18,747,151.44	$83,687.07	$618,200.26
IA	18973	Aetna Health of Iowa Inc.	$705,180.40	$0.00	$89,945.49
IA	27651	Gundersen Health Plan, Inc.	$110,467.33	$189,148.64	$3,781.59

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2015 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS 2015 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	EXPECTED PAYMENT TOWARD 2014 AMOUNTS
IA	71268	CoOportunity Health	$2,863,639.96	$3,779,496.69	$1,860,385.66
IA	74980	Avera Health Plans, Inc.	-$345,059.90	$829,146.07	$3,352.13
IA	77638	Health Alliance Midwest, Inc.	$0.00	$0.00	$0.00
IA	85930	Sanford Health Plan	$0.00	$0.00	$4,289.68
ID	26002	SelectHealth	$36,856,890.10	$2,127,750.55	$862,397.38
ID	44648	Regence Blue Shield of Idaho	$0.00	$0.00	$0.00
ID	59765	BridgeSpan Health Company	$939,702.69	$0.00	$927.39
ID	60597	PacificSource Health Plans	$2,063,613.63	$0.00	$74,499.13
ID	61589	Blue Cross of Idaho Health Service, Inc.	$43,056,603.68	$0.00	$1,329,989.79
ID	38128	Montana Health Cooperative	$22,795,348.35	$129,413.38	N/A
IL	20129	Health Alliance Medical Plans, Inc.	$8,788,291.05	$3,260.79	$92,150.39
IL	35670	Coventry Health & Life Co.	-$654,220.63	$0.00	$11,235.99
IL	36096	Blue Cross Blue Shield of Illinois	$288,419,830.50	$3,075,700.10	$6,549,724.23
IL	58288	Humana Health Plan, Inc.	$0.00	$0.00	$26,607.30
IL	68303	Humana Insurance Company	$3,149,288.79	$0.00	$159,490.95
IL	72547	Aetna Life Insurance Company	-$11,538.40	$0.00	$5,199.74
IL	79763	Land of Lincoln Mutual Health Insurance Company	$59,546,957.17	$12,286,293.83	$149,224.78
IL	96601	Coventry Health Care of Illinois, Inc.	$2,643,435.82	$0.00	$105,554.82
IL	16724	UnitedHealthcare of the Midwest, Inc.	$115,915.27	$0.00	N/A
IL	67807	Time Insurance Company	$1,111,551.75	$0.00	N/A
IL	68432	IlliniCare Health Plan, Inc.	-$4,500.83	$0.00	N/A
IN	17575	Anthem Ins Companies Inc(Anthem BCBS)	-$691,308.47	-$10,160.00	$26,992.54
IN	35065	Coordinated Care Corporation Indiana	$0.00	$0.00	$0.00
IN	50816	Physicians Health Plan of Northern Indiana, Inc.	$3,583,336.00	$35,701.79	$109,794.99
IN	85320	MDwise, Inc.	$0.00	$0.00	$0.00
IN	20855	Advantage Health Solutions, Inc.	$0.00	$0.00	N/A
IN	33380	Indiana University Health Plans, Inc.	$66,286.64	$88.16	N/A
IN	36373	All Savers Insurance Company	$11,449,513.89	$0.00	N/A
IN	54192	CareSource Indiana, Inc.	$1,293,422.26	$0.00	N/A
IN	62033	MDwise Marketplace, Inc.	$0.00	$0.00	N/A
IN	67920	Southeastern Indiana Health Organization	$21,739.31	$0.00	N/A
IN	76179	Celtic Insurance Company	-$1,443,802.06	$0.00	N/A
IN	91842	Time Insurance Company	$4,618,815.85	$0.00	N/A
KS	18558	Blue Cross and Blue Shield of Kansas, Inc.	$25,619,644.74	$910,894.46	$466,357.32
KS	61430	Coventry Health and Life	$22,585,325.23	$0.00	$760,367.12
KS	65598	Coventry Health Care Of Kansas Inc	$2,312,993.98	$0.00	$315,492.21

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KS	94248	Blue Cross and Blue Shield of Kansas City	$6,371,297.95	$408,600.97	$41,905.95
KS	27811	BlueCross BlueShield Kansas Solutions, Inc.	$12,789,305.41	$179,041.01	N/A
KY	15411	Humana Health Plan, Inc.	$2,482,523.85	$0.00	$200,273.54
KY	23671	UnitedHealthcare of Kentucky, Ltd.	$0.00	$13,606.24	$0.00
KY	36239	Anthem Health Plans of KY(Anthem BCBS)	$730,766.76	$0.00	$0.00
KY	40586	Baptist Health Plan, Inc.	$0.00	$3,214,861.78	$48,900.21
KY	47949	Golden Rule Insurance Company	$0.00	$0.00	$0.00
KY	77894	Kentucky Health Cooperative	$77,311,836.24	$0.00	$2,560,299.94
KY	45636	CareSource Kentucky Co.	$3,577,396.03	$0.00	N/A
KY	72001	WELLCARE HEALTH PLANS OF KENTUCKY, INC	$50,484.02	$0.00	N/A
LA	19636	HMO Louisiana, Inc.	$13,994,336.60	$1,372,994.63	$105,575.27
LA	44965	Humana Health Benefit Plan of Louisiana, Inc.	$3,073,966.60	$0.00	$13,774.52
LA	67202	Louisiana Health Cooperative, Inc.	$52,680,919.15	$693,646.35	$397,264.65
LA	67243	Vantage Health Plan, Inc.	-$2,699,673.78	-$22,641.24	$804.48
LA	97176	Louisiana Health Service & Indemnity Company	$37,710,617.93	$6,165,160.07	$1,173,859.13
LA	38499	UnitedHealthcare of Louisiana, Inc.	$4,251,825.74	$0.00	N/A
MA	29125	Tufts Associated Health Maintenance Org	$209,387.13	$76,520.57	$0.00
MA	31234	CeltiCare Health Plan of MA	-$192,735.20	$0.00	$6,669.56
MA	34484	Health New England, Inc.	-$7,531.80	$0.00	$0.00
MA	36046	Harvard Pilgrim Health Care Inc.	$0.00	$0.00	$0.00
MA	41304	Neighborhood Health Plan	$7,881,196.72	$6,922,012.85	$595,716.02
MA	42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	$1,943,171.80	$1,332,625.82	$0.00
MA	59763	Tufts Health Public Plans Inc.	$0.00	$0.00	$0.00
MA	73331	Minuteman Health, Inc	$1,903,857.27	$142,595.46	$37,823.79
MA	82569	Boston Medical Center Health Plan, Inc.	$0.00	$0.00	$57,686.30
MA	88806	Fallon Community Health Plan, Inc.	$295,987.67	$456,174.22	$18,616.80
MA	95878	HPHC Insurance Company Inc.	$8,829,688.42	$9,254,420.81	$40,347.74
MA	31779	UnitedHealthcare Insurance Company	$166,087.58	$0.00	N/A
MD	14468	Coventry Health Care of Delaware, Inc.	$0.00	$245,541.73	$0.00
MD	23620	UnitedHealthcare Insurance Company	$0.00	$0.00	$0.00
MD	28137	CareFirst BlueChoice, Inc.	$22,163,894.49	-$118,405.17	$595,517.37
MD	31112	UnitedHealthcare of the Mid-Atlantic Inc	$128,553.76	$0.00	$0.00

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MD	36677	All Savers Insurance Company	$179,551.18	$0.00	$4,602.89
MD	45532	CareFirst of Maryland, Inc.	$7,565,373.57	-$79,109.81	$180,782.85
MD	65635	MAMSI Life and Health Insurance Company	$0.00	$0.00	$0.00
MD	68541	Coventry Health and Life	$0.00	$83,456.08	$0.00
MD	72375	Optimum Choice, Inc.	$0.00	-$839,733.33	$0.00
MD	72564	Evergreen Health Cooperative, Inc.	$6,952,208.46	$14,571,500.47	$137,379.39
MD	90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$17,161,594.80	$0.00	$18,697.89
MD	94084	GHMSI	$3,594,558.80	-$62,678.93	$33,934.03
MD	32812	Cigna Health and Life Insurance Company	$256,315.80	$0.00	N/A
MD	66516	Aetna Health Inc. (a PA corp.)	$0.00	-$538.75	N/A
MD	70767	Aetna Life Insurance Company	$0.00	$0.00	N/A
ME	33653	Maine Community Health Options	$19,331,299.03	$301,696.58	$8,029.43
ME	48396	Anthem Health Plans of ME(Anthem BCBS)	-$31,628.48	$0.00	$0.00
ME	96667	Harvard Pilgrim Health Care Inc.	$0.00	$0.00	N/A
MI	15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	$22,247,616.11	$0.00	$0.00
MI	20393	McLaren Health Plan	$2,272,716.02	$3,253,857.07	$17,699.16
MI	29241	Priority Health Insurance Company (PHIC)	$4,777,255.18	$0.00	$35,939.76
MI	29698	Priority Health	$14,345,881.64	$0.00	$13,671.67
MI	37651	Health Alliance Plan (HAP)	$0.00	-$127,798.78	$0.00
MI	40047	Molina Healthcare of Michigan, Inc.	-$239,138.47	$0.00	$0.00
MI	41895	Consumers Mutual Insurance of Michigan	$12,524,722.48	$11,795,165.19	$60,797.86
MI	45002	UnitedHealthcare Life Insurance Company	$0.00	-$1,088.34	$1.08
MI	46275	Humana Medical Plan of Michigan, Inc.	$0.00	$0.00	$269,137.91
MI	58594	Meridian Health Plan of Michigan, Inc.	-$59,167.75	$0.00	$0.00
MI	67183	Total Health Care USA, Inc.	-$152,456.94	-$1,165,705.95	$0.00
MI	67577	Alliance Health and Life Insurance Company	$316,075.05	-$214,568.98	$2,146.80
MI	98185	Blue Care Network of Michigan	$4,131,999.44	-$981,975.51	$571,141.44
MI	34620	Harbor Health Plan, Inc.	-$8,559.18	$0.00	N/A
MI	60829	Physicians Health Plan	$0.00	$0.00	N/A
MI	71667	UnitedHealthcare Community Plan, Inc.	$144,054.47	$0.00	N/A
MI	89029	Time Insurance Company	$431,897.82	$0.00	N/A
MN	31616	Medica Insurance Company	$0.00	$0.00	$10,529.09
MN	34102	Group Health Plan, Inc.	$9,221,388.74	$0.00	$86,769.71
MN	49316	BCBSM, INC.	$174,955,826.46	$0.00	$231,054.51

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MN	65847	Medica Health Plans of Wisconsin	$5,655,753.07	$0.00	$0.00
MN	85736	UCare Minnesota	$10,464,932.43	$0.00	$0.00
MN	88102	PreferredOne Insurance Company	$0.00	$1,550,363.48	$1,762,670.15
MN	57129	HMO Minnesota	$5,872,656.21	$20,610.90	N/A
MO	32753	Healthy Alliance Life Co(Anthem BCBS)	-$1,003,114.69	$0.00	$750.46
MO	34762	Blue Cross and Blue Shield of Kansas City	$11,344,959.57	$157,134.97	$93,269.52
MO	44240	Coventry Health and Life	$7,567,905.73	$0.00	$965,882.56
MO	16049	All Savers Insurance Company	$6,697,668.39	$0.00	N/A
MO	30613	Humana Insurance Company	$2,475,780.80	$0.00	N/A
MO	74483	Cigna Health and Life Insurance Company	$0.00	$0.00	N/A
MS	48963	Humana Insurance Company	$0.00	$0.00	$0.00
MS	61794	UnitedHealthcare Life Insurance Company	$0.00	-$4,883.84	$0.00
MS	94237	Magnolia Health Plan	$0.00	$0.00	$0.00
MS	90714	Ambetter of Magnolia Inc.	-$2,810,643.19	$0.00	N/A
MS	97560	UnitedHealthcare of Mississippi, Inc.	$809,174.17	$0.00	N/A
MT	23603	PacificSource Health Plans	$11,649,353.31	$4,210,514.48	$64,378.94
MT	30751	Blue Cross and Blue Shield of Montana	$39,917,958.84	$3,150,150.04	$797,636.79
MT	32225	Montana Health Cooperative	$14,345,841.40	$410,809.41	$206,975.90
MT	24867	Time Insurance Company	$253,920.36	$0.00	N/A
NC	11512	Blue Cross and Blue Shield of NC	$214,485,108.80	$827,984.90	$4,898,870.47
NC	56346	Coventry Health Care of the Carolinas, Inc.	$16,459,753.99	$0.00	$338,453.99
NC	54332	UnitedHealthcare of North Carolina, Inc	$18,401,376.06	$0.00	N/A
ND	37160	Blue Cross Blue Shield of North Dakota	$0.00	$0.00	$15,226.54
ND	73751	Medica Health Plans	-$293,487.97	-$96,938.69	$7,982.33
ND	89364	Sanford Health Plan	$987,406.20	$0.00	$0.00
ND	39364	Medica Insurance Company	$0.00	$0.00	N/A
NE	15438	Coventry Health Care of Nebraska Inc.	$18,035,629.21	$0.00	$0.00
NE	29678	Blue Cross and Blue Shield of Nebraska	$24,733,023.87	$0.00	$469,807.48
NE	43198	CoOportunity Health	$12,853,762.71	$7,498,009.00	$2,456,521.33
NE	77931	Health Alliance Midwest Inc.	$0.00	$0.00	$243.07
NE	19524	Time Insurance Company	$4,045,974.64	$0.00	N/A
NH	96751	Matthew Thornton Hlth Plan(Anthem BCBS)	-$9,685,908.73	-$19,762.95	$0.00
NH	19304	Maine Community Health Options	$432,666.71	$2,673,543.16	N/A
NH	42260	Time Insurance Company	$925,446.08	$0.00	N/A
NH	59025	Harvard Pilgrim Health Care of NE	$0.00	$0.00	N/A
NH	61163	Minuteman Health, Inc	$3,131,228.08	$27,084.63	N/A

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NJ	10191	Freelancers CO-OP of New Jersey, Inc.	$21,700,609.51	$1,475,511.90	$4,988.21
NJ	77606	AmeriHealth HMO, Inc.	$5,486,703.07	$1,333,811.00	$116,232.27
NJ	91661	Horizon Healthcare Services, Inc.	-$3,703,866.20	$0.00	$105,814.71
NJ	91762	AmeriHealth Ins Company of New Jersey	$12,445,206.11	$2,462,716.68	$38,455.14
NJ	48834	Oxford Health Plans (NJ), Inc.	$1,357,526.59	$0.00	N/A
NJ	50221	Oscar Insurance Corporation of New Jersey	$2,132,615.32	$0.00	N/A
NM	19722	Molina Healthcare of New Mexico, Inc.	-$107,005.94	$0.00	$0.00
NM	52744	Presbyterian Insurance Company, Inc.	$0.00	$0.00	$0.00
NM	57173	Presbyterian Health Plan, Inc.	-$499,336.69	-$60,281.72	$82,341.14
NM	75605	Blue Cross Blue Shield of New Mexico	$18,627,474.95	$0.00	$218,141.39
NM	93091	New Mexico Health Connections	$14,280,094.79	$4,706,916.14	$139,903.95
NM	72034	CHRISTUS Health Plan	$134,369.02	$0.00	N/A
NV	16698	Prominence HealthFirst	$501,439.74	$0.00	$0.00
NV	34996	Nevada Health CO-OP	$29,901,096.25	$3,753,264.74	$355,443.99
NV	60156	HMO Colorado, Inc., dba HMO Nevada	$3,155,927.89	$0.00	$90.21
NV	95865	Health Plan of Nevada, Inc.	$643,589.93	$0.00	$0.00
NV	29211	Time Insurance Company	$7,321,151.53	$0.00	N/A
NY	11177	MetroPlus Health Plan	$8,797,440.70	$338,440.65	$290,817.51
NY	18029	Independent Health Benefits Corporation	$0.00	$868,523.25	$0.00
NY	25303	New York State Catholic Health Plan, Inc.	$0.00	$0.00	$0.00
NY	31808	American Progressive Life & Health Insurance Company of New York	$0.00	$0.00	$0.00
NY	40064	HealthNow New York	$1,448,976.32	$8,170,408.69	$0.00
NY	54235	UnitedHealthcare of New York, Inc.	$909,112.89	$0.00	$0.00
NY	56184	MVP Health Plan, Inc.	-$2,414,553.41	$1,447,961.39	$51,511.72
NY	57165	Affinity Health Plan, Inc.	$0.00	$0.00	$39,176.64
NY	71644	Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	$180,865,046.61	$133,175,392.41	$4,960,652.92
NY	74289	Oscar Insurance Corporation	$50,645,914.29	$0.00	$310,349.58
NY	78124	Excellus Health Plan, Inc.	$1,024,558.12	$23,738,013.87	$250,017.32
NY	80519	Empire HealthChoice HMO, Inc.	-$297,726.69	$0.00	$0.00
NY	82483	North Shore-LIJ Insurance Company Inc	$10,162,882.20	$4,911,774.19	$116,826.04
NY	85629	Oxford Health Insurance, Inc.	$0.00	$0.00	$0.00
NY	88582	Health Insurance Plan of Greater New York	$3,645,672.92	$17,504,832.79	$0.00
NY	91237	Healthfirst PHSP, Inc.	$697,039.60	$0.00	$2,508.78

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NY	92551	CDPHP Universal Benefits Inc.	$0.00	$35,536,715.61	$485,222.26
NY	94788	CDPHP	-$1,282,843.60	$0.00	$0.00
NY	95456	Atlantis Health Plan	$0.00	$0.00	$0.00
NY	39595	WellCare of New York	$162,701.86	$0.00	N/A
OH	20126	HealthSpan Integrated Care	$7,797,117.69	$4,745,409.18	$372,126.62
OH	28162	AultCare Insurance Company	-$9,718.54	$139,327.35	$21,712.60
OH	29276	Community Insurance Company(Anthem BCBS)	-$4,249,438.31	$0.00	$532.71
OH	41047	Buckeye Community Health Plan	$0.00	$0.00	$0.00
OH	52664	Summa Insurance Company, Inc.	-$463,101.73	$296,546.81	$71,621.06
OH	64353	Molina Healthcare of Ohio, Inc.	-$508,729.76	$0.00	$0.00
OH	66083	Humana Health Plan of Ohio, Inc.	$225,079.88	$0.00	$307,880.64
OH	74313	Paramount Insurance Company	$0.00	$0.00	$0.00
OH	77552	CareSource	$0.00	$0.00	$0.00
OH	92036	HealthSpan	$8,014,533.10	$644,630.91	$168,341.59
OH	98894	Coventry Health and Life	-$623,281.14	$0.00	$19,021.68
OH	99969	Medical Health Insuring Corp. of Ohio	$4,279,010.69	$0.00	$165,344.99
OH	14650	Time Insurance Company	$494,806.51	$0.00	N/A
OH	16204	Coordinated Health Mutual, Inc.	$37,187,153.00	$678,737.94	N/A
OH	26734	Premier Health Plan, Inc.	$2,572,926.75	$0.00	N/A
OH	33931	UnitedHealthcare of Ohio, Inc.	$902,297.30	$0.00	N/A
OH	67129	Aetna Life Insurance Company	$0.00	$0.00	N/A
OK	53524	Coventry Health and Life	-$502,544.02	$0.00	$5,324.95
OK	66946	Aetna Life Insurance Company	-$135,795.55	$0.00	$14,285.36
OK	76668	Coventry Health Care of Kansas, Inc.	$0.00	$0.00	$41,955.52
OK	85408	GlobalHealth, Inc.	$3,852,896.40	$13,731.93	$93,194.38
OK	87571	Blue Cross Blue Shield of Oklahoma	$115,115,001.13	$4,316,218.67	$1,790,207.78
OK	87698	CommunityCare Life & Health Insurance Co	$0.00	$634,317.06	$5,090.31
OK	98905	CommunityCare HMO Inc.	$0.00	$2,151,744.75	$10,791.75
OK	29176	Time Insurance Company	$568,168.32	$0.00	N/A
OR	10091	PacificSource Health Plans	$12,895,564.84	$1,492,522.43	$99,914.34
OR	10940	Health Net Health Plan of Oregon, Inc.	$0.00	$0.00	$78,230.95
OR	32536	ATRIO Health Plans	$491,055.00	-$7,359.48	$3,934.18
OR	39424	Moda Health Plan, Inc.	$88,433,164.06	$2,626,396.05	$2,914,589.01
OR	56707	Providence Health Plan	$5,718,501.21	$0.00	$63,203.86
OR	63474	BridgeSpan Health Company	$88,117.39	$0.00	$0.00
OR	71287	Kaiser Foundation Healthplan of the NW	$9,821,230.13	-$523,898.26	$0.00
OR	85804	LifeWise Health Plan of Oregon	$28,911,006.31	$0.00	$160,308.99
OR	95417	Trillium Community Health Plan	$0.00	-$418.63	$0.00
OR	96383	Health Republic Insurance Company	$8,052,058.67	$4,948,434.63	$261,922.66
OR	99389	Oregon's Health CO-OP	$12,246,711.70	$883,407.48	$50,781.41
PA	16481	UPMC Health Network, Inc.	-$38,755.23	$0.00	$7,383.20

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PA	22444	Geisinger Health Plan	$11,751,693.87	$6,179,883.41	$760,645.13
PA	31609	Independence Blue Cross (QCC Ins. Co.)	$7,891,991.13	$11,108,682.39	$357,746.79
PA	33709	Highmark Inc.	$168,580,028.14	$5,879,605.39	$5,308,855.59
PA	33871	Keystone Health Plan East, Inc	$17,725,832.87	$22,879,073.98	$972,351.85
PA	33906	Aetna Life Insurance Company	$1,872,197.90	$0.00	$10,141.68
PA	52899	UPMC Health Plan, Inc.	-$623,294.78	$679,452.52	$452.03
PA	53789	Keystone Health Plan Central	$431,670.61	$0.00	$3,870.32
PA	55957	First Priority Life Insurance Company, Inc.	$40,107,921.26	$263,953.76	$363,201.89
PA	64844	Aetna Health Inc. (a PA corp.)	$5,258,434.34	$0.00	$0.00
PA	70194	Highmark Health Insurance Company	$38,670,122.39	$406,775.20	$1,052,688.76
PA	75729	Geisinger Quality Options	$1,273,439.08	$689,409.22	$255,740.03
PA	82795	Capital Advantage Insurance Company CAIC	$0.00	$0.00	$9,637.08
PA	91303	HealthAmerica Pennsylvania, Inc.	$1,046,556.94	$0.00	$67,841.86
PA	16322	UPMC Health Options, Inc.	$24,615,139.76	$0.00	N/A
PA	19068	Time Insurance Company	$1,450,728.94	$0.00	N/A
PA	24872	UnitedHealthcare of Pennsylvania, Inc.	$5,937,531.25	$0.00	N/A
PA	45127	Capital Advantage Assurance Company	$2,500,772.16	$4,770.49	N/A
PA	62560	UPMC Health Coverage, Inc.	$0.00	$682,713.46	N/A
RI	15287	Blue Cross & Blue Shield of Rhode Island	$381,639.63	$0.00	$0.00
RI	77514	Neighborhood Health Plan of Rhode Island	-$5,233,486.30	-$138,066.87	$0.00
RI	79881	UnitedHealthcare of New England, Inc.	-$94,105.37	$0.00	$25.33
RI	70760	Guardian Life Insurance Company of America	$0.00	$0.00	N/A
SC	26065	Blue Cross and Blue Shield of South Carolina	$11,205,576.67	$0.00	$0.00
SC	41614	Coventry Health Care of the Carolinas, Inc.	$2,975,127.19	$0.00	$169,278.09
SC	49532	BlueChoice HealthPlan of South Carolina, Inc.	$6,375,309.45	$1,462,098.16	$0.00
SC	65122	Consumers' Choice Health Insurance Company	$81,078,167.44	$44,111.42	$412,745.23
SC	39996	Time Insurance Company	$1,451,025.54	$0.00	N/A
SD	31195	Sanford Health Plan	$3,972,231.55	$909,904.23	$117,478.56
SD	60536	Avera Health Plans, Inc.	$17,177,873.59	$2,309,953.60	$264,640.41
SD	62210	South Dakota State Medical Holding Company, Inc.	$12,926,212.21	$277,466.87	$2,628.17
TN	14002	BlueCross BlueShield of Tennessee	$83,199,959.16	$0.00	$2,614,980.96
TN	66842	Community Health Alliance Mutual Insurance Company	$29,930,892.43	$252,120.24	$12,208.18

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TN	82120	Humana Insurance Company	$1,354,405.83	$0.00	$242,241.01
TN	99248	Cigna Health and Life Insurance Company	$121,369.67	$0.00	$0.00
TN	60299	Time Insurance Company	$234,775.92	$0.00	N/A
TX	26539	SHA, LLC DBA FirstCare Health Plans	$4,623,491.00	$958,620.40	$70,795.54
TX	27248	Community Health Choice, Inc.	$2,042,945.29	$0.00	$0.00
TX	32673	Humana Health Plan of Texas, Inc.	$20,835,819.27	$0.00	$2,033,942.87
TX	33602	Blue Cross Blue Shield of Texas	$596,692,787.32	$25,767,249.27	$9,776,428.58
TX	40788	Scott and White Health Plan	$22,204,375.02	$0.00	$25,591.70
TX	45786	Molina Healthcare of Texas, Inc.	-$672,399.95	$0.00	$0.00
TX	46224	Community First Health Plans, Inc.	-$17,727.14	$0.00	$324.66
TX	55409	Cigna Health and Life Insurance Company	$25,063,932.77	$0.00	$427,894.45
TX	63141	Humana Insurance Company	$7,347,250.49	$0.00	$168,549.65
TX	71837	Sendero Health Plans, inc.	$2,200,617.89	$0.00	$22,751.14
TX	87226	Superior Health Plan	$0.00	$0.00	$0.00
TX	91716	Aetna Life Insurance Company	$8,680,426.35	$0.00	$36,588.55
TX	28020	Time Insurance Company	$7,661,197.18	$0.00	N/A
TX	63509	Allegian Insurance Company	$0.00	$0.00	N/A
TX	66252	CHRISTUS Health Plan	$0.00	$0.00	N/A
TX	85947	All Savers Insurance Company	$62,422,090.52	-$11,540.15	N/A
UT	18167	Molina Healthcare of Utah	$3,557,849.34	$0.00	$0.00
UT	27619	Arches Mutual Insurance Company	$43,467,274.22	$2,943,893.04	$399,177.92
UT	34541	BridgeSpan Health Company	$7,713,827.87	$0.00	$67,003.07
UT	38927	Aetna Health of Utah Inc.	$3,061,829.64	$0.00	$66,701.47
UT	56764	Humana Medical Plan of Utah, Inc.	$489,707.31	$0.00	$321,228.20
UT	66413	UnitedHealthcare of Utah, Inc.	$0.00	$6,697.41	$0.00
UT	68781	SelectHealth	$85,912,175.23	$25,143,079.57	$2,774,954.11
UT	40335	Educators Health Plans Life, Accident, and Health, Inc	$0.00	$0.00	N/A
VA	10207	CareFirst BlueChoice, Inc.	$1,952,573.46	$0.00	$24,275.00
VA	12028	Innovation Health Insurance Company	-$5,300,607.23	$0.00	$14,179.48
VA	20507	Optima Health Plan	$2,229,495.98	$0.00	$0.00
VA	38234	Aetna Life Insurance Company	-$2,260,494.69	$0.00	$0.00
VA	40308	Group Hospitalization and Medical Services Inc.	$155,508.63	$0.00	$0.00
VA	88380	HealthKeepers, Inc.	$0.00	$0.00	$0.00
VA	95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$33,418,222.77	$1,037,808.40	$5,672.26
VA	99663	Coventry Health Care of Virginia, Inc	-$4,505,742.80	$0.00	$0.00
VA	15668	Piedmont Community HealthCare, Inc.	$112,913.30	$11,151.45	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2015 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS 2015 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	EXPECTED PAYMENT TOWARD 2014 AMOUNTS
VT	13627	Blue Cross Blue Shield of Vermont	$2,096,136.84	$2,661,673.15	$0.00
VT	77566	MVP Health Plan, Inc.	$0.00	$0.00	$51,920.11
WA	18581	Community Health Plan of Washington	$1,187,131.21	$0.00	$0.00
WA	23371	Kaiser Foundation Healthplan of the NW	$0.00	-$152,819.47	$0.00
WA	38498	LifeWise Health Plan of WA	$11,748,045.56	$0.00	$0.00
WA	49831	Premera Blue Cross	$15,553,285.66	$0.00	$0.00
WA	53732	BridgeSpan Health Company	$3,849,576.58	$0.00	$0.00
WA	61836	Coordinated Care Corporation	$0.00	$0.00	$0.00
WA	80473	Group Health Cooperative	$521,384.24	$0.00	$0.00
WA	84481	Molina Healthcare of Washington, Inc.	$238,552.08	$0.00	$0.00
WA	65907	Moda Health Plan, Inc.	$11,360,459.83	$0.00	N/A
WI	35334	MercyCare Insurance Company	$0.00	$874,654.10	$11,812.69
WI	37833	Unity Health Plans Insurance Corporation	$11,131,237.20	$0.00	$0.00
WI	38166	Security Health Plan of Wisconsin, Inc.	$34,959,297.51	$1,198,009.90	$29,087.82
WI	38345	Dean Health Plan	$11,814,347.27	$0.00	$468,016.65
WI	47342	Health Tradition Health Plan	$0.00	$902,750.69	$19,276.97
WI	52697	Molina Healthcare of Wisconsin, Inc.	$21,340,461.88	$0.00	$0.00
WI	57637	Medica Insurance Company	$0.00	$1,140,492.00	$15,987.24
WI	57845	Medica Health Plans of Wisconsin	-$651,625.20	$0.00	$0.00
WI	58326	MercyCare HMO, Inc.	$888,775.53	$540,373.91	$39,302.06
WI	58564	Physicians Plus Insurance Corporation	$171,543.34	$0.00	$0.00
WI	79475	Compcare Health Serv Ins Co(Anthem BCBS)	-$93,143.86	$0.00	$163,815.77
WI	84670	WPS Health Plan, Inc.	$13,564,987.77	$220,591.15	$213,100.00
WI	87416	Common Ground Healthcare Cooperative	$27,770,382.35	$1,889,058.25	$1,502,853.97
WI	91058	Gundersen Health Plan, Inc.	$1,107,462.46	$3,261,542.62	$68,917.14
WI	94529	Group Health Cooperative of South Central Wisconsin	$0.00	-$758,698.27	$0.00
WI	32754	Managed Health Services Insurance Corporation	-$18,556.78	$0.00	N/A
WI	39924	All Savers Insurance Company	$7,972,985.11	-$182,309.24	N/A
WV	31274	Highmark Blue Cross Blue Shield West Virginia	$17,059,483.59	$0.00	$479,130.54
WY	11269	Blue Cross Blue Shield of Wyoming	$3,314,544.94	$0.00	$20,177.33
WY	53189	WINhealth Partners	$13,475,140.86	$108,220.90	$168,305.26

EXHIBIT 27

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 13, 2017

Subject: Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year

Background:

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of Exchange operations.

HHS established a three-year payment framework for the risk corridors program and outlined the details of this payment framework in our April 11, 2014 guidance entitled *Risk Corridors and Budget Neutrality*.[1] As set forth in that guidance, if risk corridors collections for a particular benefit year are insufficient to make full risk corridors payments as calculated for that benefit year, risk corridors payments are reduced pro rata to the extent of any shortfall. HHS then uses risk corridors collections for the subsequent benefit year toward risk corridors payment balances for the previous benefit years, until issuers have been reimbursed in full for the previous benefit year, before making payments for the current benefit year. Consistent with this framework, HHS announced on November 18, 2016 that all 2015 benefit year risk corridors collections would be applied toward 2014 benefit year risk corridors payment balances.[2]

Today, HHS is announcing issuer-level risk corridors payments and charges for the 2016 benefit year. Because 2015 benefit year collections were insufficient to pay 2014 benefit year payment balances in full, HHS will use 2016 benefit year risk corridors collections to make additional payments toward 2014 benefit year payment balances. The table below shows risk corridors payments and charges calculated for the 2016 benefit year, by State and issuer, and the amount of anticipated 2016 risk corridors collections that HHS expects to pay for issuers that have 2014 benefit year payment balances.[3]

HHS intends to collect the full 2016 risk corridors charge amounts indicated in the tables below, however, the 2014 payment amounts listed in the tables below will be reduced pro rata based on

[1] *Risk Corridors and Budget Neutrality*, available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf

[2] *Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year*, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf

[3] Risk corridor payment and charge amounts published in this bulletin reflect risk corridors data submitted to HHS by September 30, 2017 and do not account for amounts that may be held back for administrative appeals.

collections received. HHS is collecting 2016 risk corridor charges in November 2017 and will begin remitting risk corridors payments to issuers in January 2018, as collections are received.

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)[4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
AK	38344	Premera Blue Cross Blue Shield of Alaska	$0.00	$0.00	$71,752.90
AK	73836	Moda Health Plan, Inc.	$2,331,107.54	$2,535,475.85	$14,666.28
AL	44580	Humana Insurance Company	$5,347,297.70	$0.00	$8,238.76
AL	46944	Blue Cross and Blue Shield of Alabama	$31,253,329.90	$0.00	$3,086.00
AL	59809	UnitedHealthcare Life Insurance Company	N/A	N/A	$0.00
AL	68259	UnitedHealthcare of Alabama, Inc.	$4,226,662.97	$0.00	N/A
AR	37903	QualChoice Life & Health Insurance Company, Inc.	$6,742,797.09	$0.00	N/A
AR	62141	Celtic Insurance Company	-$435,672.31	$0.00	$0.00
AR	65817	UnitedHealthcare of Arkansas, Inc.	-$171,378.54	$0.00	N/A
AR	70525	QCA Health Plan, Inc.	$5,894,850.51	$0.00	$36,371.03
AR	75293	USAble Mutual Insurance Company	$19,022,135.87	-$1,727.51	$0.00
AZ	23307	Humana Health Plan, Inc.	$3,030,258.28	$0.00	$16,107.78
AZ	51485	Health Net Life Insurance Company	$6,406,342.85	$0.00	$390,038.18
AZ	53901	Blue Cross Blue Shield of Arizona, Inc.	$10,845,468.60	$0.00	$101,672.21
AZ	60761	Meritus Health Partners	N/A	N/A	$30,355.96
AZ	65441	Phoenix Health Plans, Inc.	$14,356,552.64	$0.00	N/A
AZ	70239	Health Choice Insurance Co.	$12,591,097.47	$0.00	$10,944.97
AZ	78611	Aetna Health Inc. (a PA corp.)	$2,200,505.68	$0.00	N/A
AZ	84251	Aetna Life Insurance Company	N/A	N/A	$522.54

[4] N/A indicates that the issuer was not required to submit risk corridors data for the benefit year referenced.
[5] $0.00 indicates that the issuer submitted risk corridors data for the 2014 benefit year but does not have a 2014 benefit year risk corridors payment balance.

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)[4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
AZ	86830	Cigna Health and Life Insurance Company	N/A	N/A	$1,507.99
AZ	88925	University of Arizona Health Plans-University Healthcare, Inc.	N/A	N/A	$5,611.56
AZ	91450	Health Net of Arizona, Inc.	$10,827,593.54	$1,688,379.12	$398,961.79
AZ	92045	Meritus Mutual Health Partners	N/A	N/A	$16,297.96
AZ	97667	Cigna HealthCare of Arizona, Inc	$1,709,445.01	$0.00	N/A
AZ	98971	All Savers Insurance Company	$2,787,630.49	-$49,087.07	N/A
CA	10544	Oscar Health Plan of California	$4,167,289.22	$0.00	N/A
CA	18126	MOLINA HEALTHCARE OF CALIFORNIA	$0.00	$0.00	$0.00
CA	27603	Blue Cross of California(Anthem BC)	$55,180,958.69	$0.00	$0.00
CA	37873	UnitedHealthcare Benefits Plan of California	$510,269.44	$0.00	N/A
CA	40513	Kaiser Foundation Health Plan, Inc.	$22,533,814.62	$133,003,881.28	$321,273.85
CA	47579	Chinese Community Health Plan	$523,908.24	$763,358.71	$6,200.40
CA	67138	Health Net of California, Inc	$0.00	$0.00	$0.00
CA	70285	CA Physician's Service dba Blue Shield of CA	$0.00	$0.00	$0.00
CA	84014	County of Santa Clara	$233,230.49	$0.00	$0.00
CA	92499	Sharp Health Plan	$652,496.53	$630,358.81	$67.63
CA	92815	Local Initiative Health Authority for Los Angeles County	$3,948,187.97	$0.00	$117,969.86
CA	93689	Western Health Advantage	$995,351.80	$700,089.44	$50.58
CA	99110	Health Net Life Insurance Company	$8,099,981.20	$0.00	$44,005.99
CA	99483	CONTRA COSTA HEALTH PLAN	N/A	N/A	$0.00
CO	11555	New Health Ventures Inc	N/A	N/A	$926.60
CO	20472	Colorado Health Insurance Cooperative, Inc.	N/A	N/A	$124,396.13

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)[4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
CO	21032	Kaiser Foundation Health Plan of Colo.	$76,429,472.92	$0.00	$123,181.64
CO	49375	Cigna Health and Life Insurance Company	$3,811,568.48	$0.00	$0.00
CO	59036	UnitedHealthcare of Colorado, Inc.	$719,427.07	$0.00	N/A
CO	63312	Colorado Choice Health Plans	$900,328.41	$4,055,983.33	$52,260.66
CO	66699	Denver Health Medical Plan, Inc	-$688,815.34	$0.00	$2,501.26
CO	74320	Humana Health Plan	$0.00	$0.00	$27,693.60
CO	76680	HMO Colorado, Inc., dba HMO Nevada	$2,015,531.53	$45,449.80	$12,871.37
CO	80208	Rocky Mountain Health Care Options	$0.00	$4,463,039.51	$3,832.28
CO	87269	Rocky Mountain Hospital and Medical Service, Inc., dba Anthem Blue Cross and Blue Shield	$14,813,129.30	$0.00	N/A
CO	92137	All Savers Insurance Company	-$422,444.96	$0.00	$0.00
CO	97879	Rocky Mountain HMO	$11,392,994.52	$3,230,381.44	$17,816.32
CT	49650	UnitedHealthcare Insurance Company	$793,529.41	-$34,355.06	$98.29
CT	76962	ConnectiCare Benefits, Inc.	$10,110,217.78	$0.00	$0.00
CT	86545	Anthem Health Plans Inc (Anthem BCBS)	$6,673,451.37	$0.00	$0.00
CT	91069	HealthyCT, Inc.	$22,557,147.20	$3,025,676.93	$15,952.57
DC	21066	UnitedHealthcare of the Mid-Atlantic Inc	$0.00	$53,160.65	N/A
DC	41842	UnitedHealthcare Insurance Company	$0.00	$0.00	$0.00
DC	73987	Aetna Health Inc. (a PA corp.)	$0.00	$236,018.31	$0.00
DC	75753	Optimum Choice, Inc.	$0.00	-$153,126.12	$0.00
DC	77422	Aetna Life Insurance Company	$0.00	$1,348,005.01	$0.00
DC	78079	GHMSI	$54,354.10	$379,836.03	$0.00
DC	86052	CareFirst BlueChoice, Inc.	$18,583.46	$120,537.46	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)[4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
DC	94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$643,071.50	$1,364,900.88	$10,935.98
DE	13537	Coventry Health and Life	N/A	N/A	$0.00
DE	29497	Aetna Life Insurance Company	$474,963.04	$0.00	N/A
DE	67190	Aetna Health Inc. (a PA corp.)	$0.00	$126,849.04	N/A
DE	76168	Highmark BCBSD Inc.	$15,159,604.02	$0.00	$52,848.57
DE	81914	Coventry Health Care of Delaware, Inc.	N/A	N/A	$0.00
FL	16842	Blue Cross and Blue Shield of Florida	$0.00	$0.00	$125,572.05
FL	18628	Aetna Health Inc. (a FL corp.)	$0.00	$0.00	N/A
FL	21663	Celtic Insurance Company	$0.00	$0.00	N/A
FL	23841	Aetna Life Insurance Company	N/A	N/A	$0.00
FL	27357	Health First Health Plans, Inc.	$1,432,717.01	$0.00	$895.97
FL	30252	Health Options, Inc.	$0.00	$0.00	$99,007.22
FL	35783	Humana Medical Plan, Inc.	$32,890,544.08	$173,712.62	$358,660.25
FL	48121	Cigna Health and Life Insurance Company	N/A	N/A	$35,388.79
FL	51398	Preferred Medical Plan, Inc.	N/A	N/A	$302,522.11
FL	54172	Molina Healthcare of Florida, Inc	$26,068,734.68	$0.00	$339.56
FL	56503	Florida Health Care Plan, Inc.	$0.00	$0.00	$0.00
FL	57451	Coventry Health Care of Florida, Inc.	$0.00	$0.00	$266,187.17
FL	68398	UnitedHealthcare of Florida, Inc.	$9,330,450.46	$0.00	N/A
FL	77150	Health First Insurance, Inc.	$0.00	$205,230.49	$16,113.18
FL	83883	Florida Health Solution HMO Company	$0.00	$0.00	N/A
FL	86382	Sunshine State Health Plan	N/A	N/A	$0.00
GA	43802	UnitedHealthcare of Georgia, Inc.	$4,356,433.40	$0.00	N/A
GA	45495	Peach State Health Plan	N/A	N/A	$0.00
GA	49046	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	$212,623.53	$0.00	$0.00

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)[4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
GA	50491	Cigna Health and Life Insurance Company	$1,901,757.01	$0.00	N/A
GA	70893	Ambetter of Peach State Inc.	$0.00	$0.00	N/A
GA	82824	Aetna Health Inc. (a GA corp.)	$780,032.71	$0.00	N/A
GA	83761	Alliant Health Plans	$4,529,064.09	$0.00	$1.08
GA	89942	Kaiser Foundation Health Plan of Georgia	$29,343,780.25	$667,124.28	$17,236.52
GA	93332	Humana Employers Health Plan of Georgia, Inc.	$102,932,298.50	$1,410,936.48	$730,465.11
GA	95852	Harken Health Insurance Company	$12,210,414.34	$0.00	N/A
HI	18350	Hawaii Medical Service Association	$14,609,115.03	$1,514,974.14	$0.00
HI	60612	Kaiser Foundation Health Plan, Inc.	$15,458,919.49	$714,193.48	$161,886.27
IA	18973	Aetna Health Inc. (a IA corp.)	$1,370,536.30	$0.00	$23,553.76
IA	27651	Gundersen Health Plan, Inc.	$75,831.31	$5,595.73	$990.27
IA	51902	UnitedHealthcare of the Midlands, Inc.	$1,351,512.14	$0.00	N/A
IA	71268	CoOportunity Health	N/A	N/A	$487,173.70
IA	74980	Avera Health Plans, Inc.	$155,933.71	$207,564.57	$877.81
IA	77638	Health Alliance Midwest, Inc.	N/A	N/A	$0.00
IA	85930	Sanford Health Plan	$0.00	$163,552.53	$1,123.32
IA	88678	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
IA	93078	Medica Insurance Company	$1,748,293.69	$0.00	N/A
ID	26002	SelectHealth	$51,028,512.58	$6,672,365.27	$225,833.45
ID	38128	Montana Health Cooperative	$13,010,336.93	$179,300.09	N/A
ID	44648	Regence Blue Shield of Idaho	N/A	N/A	$0.00
ID	59765	BridgeSpan Health Company	$847,275.91	$0.00	$242.85
ID	60597	PacificSource Health Plans	$1,205,143.84	$0.00	$19,508.86
ID	61589	Blue Cross of Idaho Health Service, Inc.	$14,535,162.34	$0.00	$348,280.50
IL	16724	UnitedHealthcare of the Midwest, Inc.	$157,038.37	$0.00	N/A

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)[4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
IL	20129	Health Alliance Medical Plans, Inc.	$21,342,103.01	$71,969.35	$24,131.15
IL	27833	Celtic Insurance Company	$1,846,059.24	$0.00	N/A
IL	35670	Coventry Health & Life Co.	$0.00	$0.00	$2,942.33
IL	36096	Blue Cross Blue Shield of Illinois	$112,457,984.78	$3,412,467.14	$1,715,156.95
IL	58288	Humana Health Plan, Inc.	$102,828.49	$0.00	$6,967.57
IL	68303	Humana Insurance Company	N/A	N/A	$41,765.42
IL	72547	Aetna Life Insurance Company	N/A	N/A	$1,361.64
IL	78463	Harken Health Insurance Company	$28,285,818.16	$0.00	N/A
IL	79763	Land of Lincoln Mutual Health Insurance Company	$42,901,843.98	$9,846,132.23	$39,077.05
IL	96601	Coventry Health Care of Illinois, Inc.	-$2,130,434.89	$0.00	$27,641.33
IL	99129	Aetna Health Inc. (a PA corp.)	$7,352,468.06	$0.00	N/A
IN	17575	Anthem Ins Companies Inc(Anthem BCBS)	$0.00	$0.00	$7,068.45
IN	20855	Advantage Health Solutions, Inc.	$0.00	$0.00	N/A
IN	33380	Indiana University Health Plans, Inc.	$403,177.29	$0.00	N/A
IN	35065	Coordinated Care Corporation Indiana	N/A	N/A	$0.00
IN	36373	All Savers Insurance Company	$6,211,732.83	$0.00	N/A
IN	50816	Physicians Health Plan of Northern Indiana, Inc.	$4,482,634.94	$0.00	$28,751.69
IN	54192	CareSource Indiana, Inc.	$10,568,031.40	$0.00	N/A
IN	62033	MDwise Marketplace, Inc.	$9,751,130.86	$0.00	N/A
IN	67920	Southeastern Indiana Health Organization	$105,200.90	$0.00	N/A
IN	76179	Celtic Insurance Company	-$1,099,796.09	$0.00	N/A
IN	85320	MDwise, Inc.	N/A	N/A	$0.00
KS	18558	Blue Cross and Blue Shield of Kansas, Inc.	$17,567,910.47	$408,112.19	$122,123.61

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2016 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)[4]	HHS 2016 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)[4]	EXPECTED PAYMENT TOWARD 2014 AMOUNTS[4,5]
KS	27811	BlueCross BlueShield Kansas Solutions, Inc.	$28,453,460.78	$142,714.94	N/A
KS	50274	UnitedHealthcare of the Midwest, Inc.	$0.00	$0.00	N/A
KS	61430	Coventry Health and Life	N/A	N/A	$199,115.09
KS	65598	Coventry Health Care Of Kansas Inc	N/A	N/A	$82,617.01
KS	94248	Blue Cross and Blue Shield of Kansas City	$11,222,745.35	$2,304,584.43	$10,973.78
KS	94968	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
KY	15411	Humana Health Plan, Inc.	$2,625,179.37	$0.00	$52,445.04
KY	23671	UnitedHealthcare of Kentucky, Ltd.	$0.00	$0.00	$0.00
KY	34822	Aetna Health Inc. (a PA corp.)	$0.00	$0.00	N/A
KY	36239	Anthem Health Plans of KY(Anthem BCBS)	$0.00	-$37,294.97	$0.00
KY	40586	Bluegrass Family Health, Inc.	$9,865,154.55	$2,898,208.49	$12,805.35
KY	45636	CareSource Kentucky Co.	$3,087,507.35	$0.00	N/A
KY	47949	Golden Rule Insurance Company	N/A	N/A	$0.00
KY	72001	WELLCARE HEALTH PLANS OF KENTUCKY, INC	-$13,574.40	$0.00	N/A
KY	77894	Kentucky Health Cooperative	N/A	N/A	$670,458.18
LA	19636	HMO Louisiana, Inc.	$4,490,022.42	$687,627.16	$27,646.68
LA	38499	UnitedHealthcare of Louisiana, Inc.	$200,537.78	$0.00	N/A
LA	44965	Humana Health Benefit Plan of Louisiana, Inc.	$3,092,925.82	$0.00	$3,607.09
LA	67202	Louisiana Health Cooperative, Inc.	N/A	N/A	$104,030.52
LA	67243	Vantage Health Plan, Inc.	$8,130,698.29	-$15,784.88	$210.66
LA	97176	Louisiana Health Service & Indemnity Company	$21,756,614.82	$1,822,667.19	$307,395.02
MA	29125	Tufts Associated Health Maintenance Org	$0.00	$0.00	$0.00

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MA	31234	CeltiCare Health Plan of MA	$0.00	$0.00	$1,746.54
MA	31779	UnitedHealthcare Insurance Company	$492,333.25	$0.00	N/A
MA	34484	Health New England, Inc.	$591,143.39	$1,823,346.74	$0.00
MA	36046	Harvard Pilgrim Health Care Inc.	$945,497.81	$7,745,516.62	$0.00
MA	41304	Neighborhood Health Plan	$0.00	$0.00	$155,998.39
MA	42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	$0.00	$0.00	$0.00
MA	59763	Tufts Health Public Plans Inc.	$0.00	$0.00	$0.00
MA	73331	Minuteman Health, Inc	$2,916,284.01	$311,545.12	$9,904.80
MA	82569	Boston Medical Center Health Plan, Inc.	$0.00	$0.00	$15,106.14
MA	88806	Fallon Community Health Plan, Inc.	$1,606,849.24	$328,544.25	$4,875.12
MA	95878	HPHC Insurance Company Inc.	$8,976,329.97	$9,268,445.40	$10,565.74
MD	14468	Coventry Health Care of Delaware, Inc.	N/A	N/A	$0.00
MD	23620	UnitedHealthcare Insurance Company	$0.00	$0.00	$0.00
MD	28137	CareFirst BlueChoice, Inc.	$41,057,486.62	-$46,498.46	$155,946.37
MD	31112	UnitedHealthcare of the Mid-Atlantic Inc	$0.00	-$27,309.80	$0.00
MD	32812	Cigna Health and Life Insurance Company	$743,128.94	$0.00	N/A
MD	36677	All Savers Insurance Company	$0.00	$0.00	$1,205.34
MD	45532	CareFirst of Maryland, Inc.	$11,539,940.12	$62,844.74	$47,341.07
MD	65635	MAMSI Life and Health Insurance Company	$0.00	-$117,035.51	$0.00
MD	66516	Aetna Health Inc. (a PA corp.)	$0.00	$0.00	N/A
MD	68541	Coventry Health and Life	$0.00	$0.00	$0.00
MD	70767	Aetna Life Insurance Company	$0.00	$34,442.90	N/A
MD	72375	Optimum Choice, Inc.	$0.00	$0.00	$0.00
MD	72564	Evergreen Health Cooperative, Inc.	$5,446,190.67	$15,614,288.59	$35,975.13

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MD	90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$31,064,359.51	$77,950.89	$4,896.36
MD	94084	GHMSI	$9,019,881.61	$0.00	$8,886.20
ME	33653	Maine Community Health Options	$21,050,424.64	$4,317,337.28	$2,102.64
ME	48396	Anthem Health Plans of ME(Anthem BCBS)	$0.00	$0.00	$0.00
ME	96667	Harvard Pilgrim Health Care Inc.	$747,510.63	$444,527.55	N/A
MI	15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	$5,296,176.54	$0.00	$0.00
MI	20393	McLaren Health Plan	$0.00	$781,057.65	$4,634.82
MI	29241	Priority Health Insurance Company (PHIC)	$7,075,598.39	$0.00	$9,411.44
MI	29698	Priority Health	$26,339,617.56	$0.00	$3,580.16
MI	37651	Health Alliance Plan (HAP)	$0.00	$0.00	$0.00
MI	40047	Molina Healthcare of Michigan, Inc.	-$39,105.84	$0.00	$0.00
MI	41895	Consumers Mutual Insurance of Michigan	N/A	N/A	$15,920.95
MI	45002	UnitedHealthcare Life Insurance Company	$0.00	-$906.46	$0.28
MI	46275	Humana Medical Plan of Michigan, Inc.	$9,529,350.76	$0.00	$70,478.35
MI	58594	Meridian Health Plan of Michigan, Inc.	$0.00	$0.00	$0.00
MI	60829	Physicians Health Plan	$277,579.39	$0.00	N/A
MI	63631	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
MI	67183	Total Health Care USA, Inc.	$0.00	-$2,047,580.25	$0.00
MI	67577	Alliance Health and Life Insurance Company	$846,068.00	$0.00	$562.17

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MI	71667	UnitedHealthcare Community Plan, Inc.	$0.00	$0.00	N/A
MI	74917	McLaren Health Plan Community	$0.00	$0.00	N/A
MI	98185	Blue Care Network of Michigan	$20,617,731.68	$0.00	$149,563.12
MN	31616	Medica Insurance Company	$0.00	$0.00	$2,757.22
MN	34102	Group Health Plan, Inc.	$14,052,643.55	$0.00	$22,722.12
MN	49316	BCBSM, INC.	$61,016,505.39	$7,923,542.86	$60,505.56
MN	57129	HMO Minnesota	$5,336,936.71	$504,528.26	N/A
MN	65847	Medica Health Plans of Wisconsin	$35,597,185.27	$0.00	$0.00
MN	85736	UCare Minnesota	$10,114,026.06	$0.00	$0.00
MN	88102	PreferredOne Insurance Company	N/A	N/A	$461,585.23
MO	16049	All Savers Insurance Company	$0.00	$0.00	N/A
MO	30613	Humana Insurance Company	$373,172.66	$0.00	N/A
MO	32753	Healthy Alliance Life Co(Anthem BCBS)	$0.00	$0.00	$196.52
MO	34762	Blue Cross and Blue Shield of Kansas City	$21,589,143.65	$49,355.14	$24,424.21
MO	44240	Coventry Health and Life	$0.00	$0.00	$252,932.81
MO	74483	Cigna Health and Life Insurance Company	$1,404,505.78	$0.00	N/A
MS	48963	Humana Insurance Company	$9,041,890.00	$0.00	$0.00
MS	61794	UnitedHealthcare Life Insurance Company	$0.00	$0.00	$0.00
MS	90714	Ambetter of Magnolia Inc.	$0.00	$0.00	N/A

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MS	94237	Magnolia Health Plan	N/A	N/A	$0.00
MS	97560	UnitedHealthcare of Mississippi, Inc.	$3,906,592.67	$0.00	N/A
MT	23603	PacificSource Health Plans	$9,717,931.78	$135,770.45	$16,858.72
MT	30751	Blue Cross and Blue Shield of Montana	$31,380,006.00	$3,027,515.02	$208,874.79
MT	32225	Montana Health Cooperative	$290,347.23	$355,758.03	$54,200.16
NC	11512	Blue Cross and Blue Shield of NC	$18,159,126.49	$0.00	$1,282,852.75
NC	54332	UnitedHealthcare of North Carolina, Inc	$0.00	$0.00	N/A
NC	56346	Coventry Health Care of the Carolinas, Inc.	N/A	N/A	$88,629.95
NC	61671	Aetna Health Inc. (a PA corp.)	$15,884,547.64	$0.00	N/A
ND	37160	Blue Cross Blue Shield of North Dakota	$0.00	$0.00	$3,987.33
ND	39364	Medica Insurance Company	$0.00	$19,371.92	N/A
ND	73751	Medica Health Plans	$0.00	$62,294.31	$2,090.31
ND	89364	Sanford Health Plan	$1,765,053.70	$108,586.34	$0.00
NE	15438	Coventry Health Care of Nebraska Inc.	$14,918,861.69	$0.00	$0.00
NE	20305	Medica Insurance Company	$7,670,841.68	$0.00	N/A
NE	29678	Blue Cross and Blue Shield of Nebraska	$25,923,663.23	$520,261.48	$123,027.09
NE	43198	CoOportunity Health	N/A	N/A	$643,281.99
NE	44751	UnitedHealthcare of the Midlands, Inc.	$6,406,781.24	$0.00	N/A
NE	68389	UnitedHealthcare Life Insurance Company	$0.00	$0.00	N/A
NE	73102	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
NE	77931	Health Alliance Midwest Inc.	N/A	N/A	$63.65
NH	19304	Maine Community Health Options	$5,826,502.09	$4,804,390.97	N/A
NH	59025	Harvard Pilgrim Health Care of NE	$291,440.74	$0.00	N/A

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NH	61163	Minuteman Health, Inc	$10,710,229.92	$9,045.97	N/A
NH	75841	Celtic Insurance Company	-$10,549,229.99	$0.00	N/A
NH	96751	Matthew Thornton Hlth Plan(Anthem BCBS)	$0.00	$0.00	$0.00
NJ	10191	Freelancers CO-OP of New Jersey, Inc.	$36,610,266.63	$7,789,387.27	$1,306.25
NJ	48834	Oxford Health Plans (NJ), Inc.	$4,561,830.04	$0.00	N/A
NJ	50221	Oscar Insurance Corporation of New Jersey	$3,064,840.14	$0.00	N/A
NJ	77606	AmeriHealth HMO, Inc.	$3,974,893.09	$105,954.94	$30,437.40
NJ	91661	Horizon Healthcare Services, Inc.	$16,478,389.42	$0.00	$27,709.38
NJ	91762	AmeriHealth Ins Company of New Jersey	$73,160,117.68	$344,230.91	$10,070.13
NM	19722	Molina Health Care of New Mexico, Inc.	$0.00	$0.00	$0.00
NM	52744	Presbyterian Insurance Company, Inc.	$0.00	$8,019,908.13	$0.00
NM	57173	Presbyterian Health Plan, Inc.	$2,450,553.68	$350,630.79	$21,562.43
NM	72034	CHRISTUS Health Plan	$2,352,154.70	$0.00	N/A
NM	75605	Blue Cross Blue Shield of New Mexico	$2,231,211.41	$653,200.67	$57,124.04
NM	93091	New Mexico Health Connections	$13,116,504.33	$10,319,090.60	$36,636.23
NV	16698	Prominence HealthFirst	$0.00	$0.00	$0.00
NV	33670	Rocky Mountain Hospital and Medical Service, Inc., dba Anthem Blue Cross and Blue Shield	$4,030,060.93	$0.00	N/A
NV	34996	Nevada Health CO-OP	N/A	N/A	$93,079.06
NV	60156	HMO Colorado, Inc., dba HMO Nevada	$0.00	-$7,237.91	$23.62
NV	95865	Health Plan of Nevada, Inc.	$3,326,339.65	$0.00	$0.00
NY	11177	MetroPlus Health Plan	$14,216,773.89	$820,311.63	$76,155.52
NY	18029	Independent Health Benefits Corporation	$2,527,441.24	$12,491,216.10	$0.00

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NY	25303	New York State Catholic Health Plan, Inc.	$3,996,255.02	$0.00	$0.00
NY	31808	American Progressive Life & Health Insurance Company of New York	N/A	N/A	$0.00
NY	39595	WellCare of New York	$442,366.09	$0.00	N/A
NY	40064	HealthNow New York	$5,597,212.16	$23,522,343.21	$0.00
NY	54235	UnitedHealthcare of New York, Inc.	$4,509,245.86	$0.00	$0.00
NY	56184	MVP Health Plan, Inc.	$5,120,950.13	$1,162,229.18	$13,489.22
NY	57165	Affinity Health Plan, Inc.	$20,735,006.33	$0.00	$10,259.07
NY	71644	Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	N/A	N/A	$1,299,031.53
NY	74289	Oscar Insurance Corporation	$107,138,699.40	$0.00	$81,270.32
NY	78124	Excellus Health Plan, Inc.	$0.00	$23,595,031.50	$65,471.29
NY	80519	Empire HealthChoice HMO, Inc.	$8,305,584.61	$0.00	$0.00
NY	82483	North Shore-LIJ Insurance Company Inc	$50,880,224.71	$62,252,325.98	$30,592.89
NY	85629	Oxford Health Insurance, Inc.	N/A	N/A	$0.00
NY	88582	Health Insurance Plan of Greater New York	$8,669,878.30	$1,686,044.58	$0.00
NY	91237	Healthfirst PHSP, Inc.	$6,891,430.55	$0.00	$656.96
NY	92551	CDPHP Universal Benefits Inc.	$0.00	$10,440,924.71	$127,063.72
NY	94788	CDPHP	$1,128,625.43	$0.00	$0.00
NY	95456	Atlantis Health Plan	N/A	N/A	$0.00
OH	16204	Coordinated Health Mutual, Inc.	$20,218,260.47	$310,347.28	N/A
OH	20126	HealthSpan Integrated Care	$1,619,850.19	$2,851,843.52	$97,447.70
OH	23340	Consumers Life Insurance Company	-$160,706.30	$0.00	N/A
OH	26734	Premier Health Plan, Inc.	$5,682,287.55	$0.00	N/A
OH	28162	AultCare Insurance Company	$0.00	$0.00	$5,685.81
OH	29276	Community Insurance Company(Anthem BCBS)	$0.00	$0.00	$139.50

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OH	33931	UnitedHealthcare of Ohio, Inc.	$3,833,592.57	$0.00	N/A
OH	41047	Buckeye Community Health Plan	$0.00	$0.00	$0.00
OH	52664	Summa Insurance Company, Inc.	$2,037,988.17	-$146,496.91	$18,755.19
OH	64353	MOLINA HEALTHCARE OF OHIO	$0.00	$0.00	$0.00
OH	66083	Humana Health Plan of Ohio, Inc.	$0.00	$0.00	$80,623.79
OH	67129	Aetna Life Insurance Company	$0.00	$0.00	N/A
OH	74313	Paramount Insurance Company	$267,351.46	$0.00	$0.00
OH	77552	CareSource	$32,086,445.80	$0.00	$0.00
OH	78726	All Savers Insurance Company	$446,164.50	$0.00	N/A
OH	92036	HealthSpan	$1,335,788.24	$211,049.76	$44,083.11
OH	98894	Coventry Health and Life	N/A	N/A	$4,981.15
OH	99969	Medical Health Insuring Corp. of Ohio	$13,342,648.57	-$8,758.40	$43,298.40
OK	45480	UnitedHealthcare of Oklahoma, Inc.	$3,012,668.48	$0.00	N/A
OK	53524	Coventry Health and Life	N/A	N/A	$1,394.42
OK	66946	Aetna Life Insurance Company	N/A	N/A	$3,740.86
OK	76668	Coventry Health Care of Kansas, Inc.	N/A	N/A	$10,986.77
OK	85408	GlobalHealth, Inc.	N/A	N/A	$24,404.54
OK	87571	Blue Cross Blue Shield of Oklahoma	$57,436,784.47	$787,973.67	$468,796.42
OK	87698	CommunityCare Life & Health Insurance Co	$0.00	$1,522,505.85	$1,332.98
OK	98905	CommunityCare HMO Inc.	$0.00	$677,742.83	$2,826.00
OR	10091	PacificSource Health Plans	$5,543,447.37	$1,501,673.38	$26,164.27
OR	10940	Health Net Health Plan of Oregon, Inc.	N/A	N/A	$20,486.10
OR	30969	ZOOM+Care Health Insurance	$1,045,273.45	$21,956.61	N/A
OR	32536	ATRIO Health Plans	$3,823,044.78	$0.00	$1,030.23
OR	39424	Moda Health Plan, Inc.	$33,246,324.18	$2,164,823.82	$763,234.82
OR	56707	Providence Health Plan	$66,897,686.23	$68,882.34	$16,551.00
OR	63474	BridgeSpan Health Company	$154,767.68	$0.00	$0.00

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OR	71287	Kaiser Foundation Healthplan of the NW	$15,251,167.48	$0.00	$0.00
OR	85804	LifeWise Health Plan of Oregon	$11,093,351.11	$0.00	$41,979.64
OR	95417	Trillium Community Health Plan	-$152,773.99	-$1,237.14	$0.00
OR	96383	Health Republic Insurance Company	N/A	N/A	$68,588.91
OR	99389	Community Care of Oregon, Inc.	$6,321,118.60	$4,270,863.90	$13,297.97
PA	16322	UPMC Health Options, Inc.	$59,842,450.12	$872,510.61	N/A
PA	16481	UPMC Health Network, Inc.	N/A	N/A	$1,933.41
PA	22444	Geisinger Health Plan	$13,244,631.61	$0.00	$199,187.89
PA	23489	UnitedHealthcare Insurance Company	$0.00	$2,903.41	N/A
PA	24872	UnitedHealthcare of Pennsylvania, Inc.	$2,254,922.55	$0.00	N/A
PA	31609	Independence Blue Cross (QCC Ins. Co.)	$9,763,812.15	$0.00	$93,682.09
PA	33709	Highmark Inc.	$13,432,627.24	$1,567,070.49	$1,390,214.34
PA	33871	Keystone Health Plan East, Inc	$8,955,428.25	$0.00	$254,626.90
PA	33906	Aetna Life Insurance Company	N/A	N/A	$2,655.77
PA	36247	Highmark Select Resources Inc.	$7,665,319.69	$0.00	N/A
PA	45127	Capital Advantage Assurance Company	$12,578,353.88	$6,463.00	N/A
PA	52899	UPMC Health Plan, Inc.	N/A	N/A	$118.37
PA	53789	Keystone Health Plan Central	$14,440,418.45	$60,166.33	$1,013.51
PA	55957	First Priority Life Insurance Company, Inc.	$15,373,532.92	$0.00	$95,110.60
PA	62560	UPMC Health Coverage, Inc.	$0.00	$281,136.83	N/A
PA	64844	Aetna Health Inc. (a PA corp.)	$7,165,507.59	$0.00	$0.00
PA	70194	Highmark Health Insurance Company	$13,156,877.36	-$406,467.62	$275,664.50
PA	75729	Geisinger Quality Options	$5,955,066.10	$0.00	$66,969.88

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PA	82795	Capital Advantage Insurance Company CAIC	N/A	N/A	$2,523.63
PA	91303	HealthAmerica Pennsylvania, Inc.	N/A	N/A	$17,765.54
RI	15287	Blue Cross & Blue Shield of Rhode Island	$6,723,928.86	$0.00	$0.00
RI	77514	Neighborhood Health Plan of Rhode Island	-$2,475,751.37	-$38,745.91	$0.00
RI	79881	UnitedHealthcare of New England, Inc.	$0.00	$0.00	$6.63
SC	26065	Blue Cross and Blue Shield of South Carolina	$21,882,021.95	$0.00	$0.00
SC	38408	Aetna Health Inc. (a PA corp.)	-$4,047,046.75	$0.00	N/A
SC	41614	Coventry Health Care of the Carolinas, Inc.	N/A	N/A	$44,328.35
SC	49532	BlueChoice HealthPlan of South Carolina, Inc.	$29,862,056.07	$1,524,317.55	$0.00
SC	57860	UnitedHealthcare Insurance Company	$486,864.50	$0.00	N/A
SC	65122	Consumers' Choice Health Insurance Company	N/A	N/A	$108,084.37
SD	31195	Sanford Health Plan	$11,217,457.61	$0.00	$30,763.76
SD	60536	Avera Health Plans, Inc.	$13,756,105.86	$311,636.34	$69,300.60
SD	62210	South Dakota State Medical Holding Company, Inc.	N/A	N/A	$688.23
TN	14002	BlueCross BlueShield of Tennessee	$64,972,431.35	$0.00	$684,777.34
TN	66842	Community Health Alliance Mutual Insurance Company	N/A	N/A	$3,196.92
TN	69443	UnitedHealthcare Insurance Company	$2,134,105.98	$0.00	N/A
TN	82120	Humana Insurance Company	$2,795,659.26	$0.00	$63,434.93
TN	99248	Cigna Health and Life Insurance Company	$6,667,000.07	$0.00	$0.00
TX	20069	Oscar Insurance Company of Texas	$35,085,745.70	$0.00	N/A

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TX	26539	SHA, LLC DBA FirstCare Health Plans	$7,590,347.71	$118,270.44	$18,539.02
TX	27248	Community Health Choice, Inc.	$3,212,369.47	$0.00	$0.00
TX	29418	Celtic Insurance Company	$0.00	$0.00	N/A
TX	32673	Humana Health Plan of Texas, Inc.	$15,164,712.65	$0.00	$532,622.61
TX	33602	Blue Cross Blue Shield of Texas	$157,277,306.72	$10,601,287.65	$2,560,124.49
TX	37392	Prominence HealthFirst of Texas, Inc.	$1,572,951.33	$0.00	N/A
TX	37755	Insurance Company of Scott & White	$75,429,033.03	$0.00	N/A
TX	40788	Scott and White Health Plan	$25,086,485.39	$0.00	$6,701.62
TX	45786	Molina Healthcare of Texas	$0.00	$0.00	$0.00
TX	46224	Community First Health Plans, Inc.	$0.00	$0.00	$85.01
TX	55409	Cigna Health and Life Insurance Company	$12,607,716.28	$0.00	$112,051.45
TX	63141	Humana Insurance Company	$1,157,247.50	$0.00	$44,137.59
TX	63509	Allegian Insurance Company	$6,758,866.06	$0.00	N/A
TX	66252	CHRISTUS Health Plan	$9,529,090.47	$0.00	N/A
TX	71837	Sendero Health Plans, inc.	$9,085,117.80	$0.00	$5,957.77
TX	76589	Cigna HealthCare of Texas, Inc.	$4,891,396.84	$0.00	N/A
TX	85947	All Savers Insurance Company	$37,545,522.88	$83,872.87	N/A
TX	87226	Superior Health Plan	N/A	N/A	$0.00
TX	91716	Aetna Life Insurance Company	$5,142,859.96	$0.00	$9,581.33
TX	98809	UnitedHealthcare Insurance Company	$0.00	$0.00	N/A
UT	18167	Molina Healthcare of Utah	$19,606,971.43	$0.00	$0.00
UT	27619	Arches Mutual Insurance Company	N/A	N/A	$104,531.54
UT	34541	BridgeSpan Health Company	$0.00	$0.00	$17,545.89
UT	38927	Aetna Health of Utah Inc.	N/A	N/A	$17,466.91
UT	42261	University of Utah Health Insurance Plans	$182,764.40	$0.00	N/A

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UT	56764	Humana Medical Plan of Utah, Inc.	$1,711,863.52	$0.00	$84,119.08
UT	66413	UnitedHealthcare of Utah, Inc.	$0.00	$53,669.11	$0.00
UT	68781	SelectHealth	$129,565,046.28	$14,423,772.02	$726,669.04
VA	10207	CareFirst BlueChoice, Inc.	$8,737,341.69	$0.00	$6,356.82
VA	12028	Innovation Health Insurance Company	$32,520,623.08	$0.00	$3,713.14
VA	15668	Piedmont Community HealthCare, Inc.	$636,028.99	$579,061.87	N/A
VA	20507	Optima Health Plan	$8,636,390.10	$0.00	$0.00
VA	37204	Piedmont Community HealthCare HMO, Inc.	$737,160.77	$0.00	N/A
VA	38234	Aetna Life Insurance Company	$0.00	$0.00	$0.00
VA	38599	UnitedHealthcare of the Mid-Atlantic Inc	$1,646,134.28	$0.00	N/A
VA	40308	Group Hospitalization and Medical Services Inc.	$4,073,508.25	-$602,890.46	$0.00
VA	86443	Innovation Health Plan, Inc.	$0.00	$75,765.11	N/A
VA	88380	HealthKeepers, Inc.	$0.00	$0.00	$0.00
VA	95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$35,656,640.04	$1,309,812.93	$1,485.37
VA	99663	Coventry Health Care of Virginia, Inc	$3,614,943.00	$0.00	$0.00
VT	13627	Blue Cross Blue Shield of Vermont	$2,552,850.56	$3,784,868.82	$0.00
VT	77566	MVP Health Plan, Inc.	$257,849.50	$226,463.69	$13,596.16
WA	18581	Community Health Plan of Washington	$492,042.87	$0.00	$0.00
WA	23371	Kaiser Foundation Healthplan of the NW	$6,553,058.03	$0.00	$0.00
WA	38229	Health Alliance Northwest Health Plan Inc.	$16,154.71	$0.00	N/A
WA	38498	LifeWise Health Plan of WA	$2,511,858.16	$0.00	$0.00
WA	43861	UnitedHealthcare of Washington, Inc.	$917,117.57	$457,090.26	N/A

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WA	49831	Premera Blue Cross	$27,211,442.78	$0.00	$0.00
WA	53732	BridgeSpan Health Company	$0.00	$0.00	$0.00
WA	61836	Coordinated Care Corporation	$0.00	$0.00	$0.00
WA	65907	Moda Health Plan, Inc.	$0.00	$264,613.60	N/A
WA	80473	Group Health Cooperative	$21,043,260.92	$0.00	$0.00
WA	84481	Molina Healthcare of Washington, Inc.	$2,547,925.84	$0.00	$0.00
WA	87718	Regence BlueShield	$0.00	$0.00	N/A
WI	32754	Managed Health Services Insurance Corporation	-$834,199.47	$0.00	N/A
WI	35334	MercyCare Insurance Company	$0.00	$690,228.89	$3,093.35
WI	37833	Unity Health Plans Insurance Corporation	$0.00	$0.00	$0.00
WI	38166	Security Health Plan of Wisconsin, Inc.	$24,508,429.21	$2,534,857.63	$7,617.14
WI	38345	Dean Health Plan	$5,406,793.42	$0.00	$122,558.13
WI	39924	All Savers Insurance Company	$925,020.38	$201,371.29	N/A
WI	47342	Health Tradition Health Plan	$733,565.54	$1,958,359.42	$5,048.00
WI	52697	Molina Healthcare of Wisconsin, Inc.	$27,554,627.62	$0.00	$0.00
WI	57637	Medica Insurance Company	$0.00	$573,305.09	$4,186.53
WI	57845	Medica Health Plans of Wisconsin	$0.00	$0.00	$0.00
WI	58326	MercyCare HMO, Inc.	$0.00	$1,966,338.04	$10,291.91
WI	58564	Physicians Plus Insurance Corporation	$464,542.33	$0.00	$0.00
WI	79475	Compcare Health Serv Ins Co(Anthem BCBS)	$0.00	$0.00	$42,897.95
WI	81413	Network Health Plan	$2,307,460.56	$0.00	N/A
WI	84670	WPS Health Plan, Inc.	$8,723,207.17	$663,495.55	$55,803.86
WI	87416	Common Ground Healthcare Cooperative	$26,987,917.60	$669,339.38	$393,547.93
WI	91058	Gundersen Health Plan, Inc.	$3,596,244.55	$53,602.89	$18,047.13
WI	94529	Group Health Cooperative-SCW	$385,820.36	-$126,846.57	$0.00

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WV	31274	Highmark Blue Cross Blue Shield West Virginia	$23,939,268.98	$0.00	$125,468.50
WV	50328	CareSource West Virginia Co.	$1,239,716.45	$0.00	N/A
WY	11269	Blue Cross Blue Shield of Wyoming	$6,400,796.86	$83,778.46	$5,283.77
WY	53189	WINhealth Partners	N/A	N/A	$44,073.60