IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HIGHMARK INC. f/k/a HIGHMARK HEALTH SERVICES, HMO OF NORTHEASTERN PENNSYLVANIA, INC. d/b/a FIRST PRIORITY HEALTH, HM HEALTH INSURANCE COMPANY d/b/a HIGHMARK HEALTH INSURANCE COMPANY, HIGHMARK BCBSD INC., HIGHMARK WEST VIRGINIA INC., HIGHMARK CHOICE COMPANY, HIGHMARK BENEFITS GROUP INC., and HIGHMARK COVERAGE ADVANTAGE INC.	)	
Plaintiffs,	)	No. 20-1686 Judge Kaplan
v.	)	
THE UNITED STATES OF AMERICA,	)	
Defendant.	)	

AMENDED COMPLAINT

Plaintiffs Highmark Inc. f/k/a Highmark Health Services, HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health, HM Health Insurance Company d/b/a Highmark Health Insurance Company, Highmark BCBSD Inc., Highmark West Virginia Inc., Highmark Choice Company, Highmark Benefits Group Inc., and Highmark Coverage Advantage Inc. (collectively, "Plaintiffs" or "Highmark"), by and through their undersigned counsel, bring this action against Defendant, the United States of America ("Defendant," "United States," or "Government"), and allege the following:

INTRODUCTION

1. This action seeks specific monetary relief for Defendant's breach of its statutory and regulatory obligations to make full and timely cost-sharing reduction ("CSR") payments to Plaintiffs, as mandated by Sections 1402 and 1412 of the Patient Protection and Affordable Care Act ("ACA"). The Government had made such monthly advance CSR payments to Plaintiffs for 45 consecutive months from January 2014 until October 12, 2017, when the Government announced it would stop making such mandatory CSR payments to Plaintiffs and other similarly situated qualified health plan issuers ("QHPs") that had been voluntarily participating on the ACA Exchanges.

2. As detailed below, Congress mandated in Section 1402 of the ACA that Defendant "shall make periodic and timely [CSR] payments" to QHPs as full reimbursement for the QHPs providing mandatory CSR discounts to certain of their middle- and low-income ACA customers. Congress designed those CSR discounts as a federally-funded subsidy to reduce eligible customers' out-of-pocket costs for health care.

3. In Section 1412 of the ACA, Congress expressly required Defendant to make the advance CSR payments to QHPs, such as Plaintiffs, in advance of when those QHPs would provide the CSR discounts to their eligible customers, to minimize the financial burden on those QHPs while they served as the Government's conduit for delivering the federal CSR subsidies to eligible enrollees.

4. Defendant has failed to honor its mandatory advance CSR payment obligation to Plaintiffs, but Plaintiffs remains financially obligated under Section 1402 to continue to provide CSR discounts to its eligible customers. Defendant unlawfully has shifted the financial burden entirely upon Plaintiffs, thwarting Congress's design, intent, and express payment mandate as set forth in the CSR statutory provisions.

5. This action seeks specific monetary relief from Defendant of the statutory CSR payments the Government was mandated to pay Plaintiffs in the amount of $186,049,979.00, which is the total amount of monthly CSR payments the Government owes Plaintiffs for discrepancies owed and approved by CMS for 2018 through 2021, but unlawfully has refused to pay.

6. The liability issues presented in this case are identical to those the Federal Circuit decided in favor of the appellee-health insurers in *Sanford Health Plan v. United States*, 969 F.3d 1370 (Fed. Cir. 2020), where it affirmed Judge Kaplan's ruling that "the government violated a statutory obligation created by Congress in the ACA when it failed to provide Sanford its full cost-sharing reduction payments." *Sanford Health Plan v. United States*, 139 Fed. Cl. 701, 702 (2018), *aff'd*, 969 F.3d 1370, *reh'g and reh'g en banc denied* (Fed. Cir. 2020).

7. In *Sanford Health Plan*, the Federal Circuit, relying on the U.S. Supreme Court's decision on ACA Risk Corridors payments the Government owed health insurers in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020), held that the ACA's "cost-sharing-reduction reimbursement provision imposes an unambiguous obligation on the government to pay money and that the obligation is enforceable through a damages action in the Court of Federal Claims under the Tucker Act." *Sanford Health Plan,* 969 F.3d at 1372. The Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's CSR liability in this case.

JURISDICTION AND VENUE

8. 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 Plaintiffs bring claims for monetary claims over $10,000 against the United States based on the Government's violations of money-mandating Acts of Congress, and money-mandating regulations of an executive department.

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

PARTIES

10. Plaintiff HIGHMARK INC. f/k/a HIGHMARK HEALTH SERVICES ("Highmark Inc.") is a health insurer and Pennsylvania nonprofit corporation with its principal place of business in Pittsburgh, Pennsylvania. Highmark Inc., an independent licensee of the Blue Cross Blue Shield Association, does business as Highmark Blue Cross Blue Shield or Highmark Blue Shield in the Commonwealth of Pennsylvania. Highmark Inc. was a QHP issuer on the Pennsylvania Health Insurance Marketplace for CY 2018, 2019, 2020, and 2021, the years relevant to Highmark Inc.'s claims in this case.

11. Plaintiff HMO OF NORTHEASTERN PENNSYLVANIA, INC. d/b/a FIRST PRIORITY HEALTH ("First Priority Health") is a Pennsylvania business corporation licensed as a health maintenance organization with its principal place of business in Wilkes-Barre, Pennsylvania. First Priority Health was a QHP issuer on the Pennsylvania Health Insurance Marketplace for CY 2018, 2019, 2020, and 2021, the years relevant to First Priority Health's claims in this case.

12. Plaintiff HM HEALTH INSURANCE COMPANY d/b/a HIGHMARK HEALTH INSURANCE COMPANY ("HHIC") is a Pennsylvania stock insurance company with its principal place of business in Pittsburgh, Pennsylvania. It is a wholly owned subsidiary of Highmark Inc. HHIC was a QHP issuer on the Pennsylvania Health Insurance Marketplace for CY 2018, 2019, 2020, and 2021, the years relevant to HHIC's claims in this case.

13. Plaintiff HIGHMARK BCBSD INC. ("Highmark Delaware") is a health insurer and Delaware nonprofit corporation with its principal place of business in Wilmington, Delaware. Highmark Delaware does business in Delaware as Highmark Blue Cross Blue Shield Delaware, an independent licensee of the Blue Cross Blue Shield Association. Highmark Delaware was a QHP issuer on the Delaware Health Insurance Marketplace for CY 2018, 2019, 2020, and 2021, the years relevant to Highmark Delaware's claims in this case.

14. Plaintiff HIGHMARK WEST VIRGINIA INC. ("Highmark West Virginia") is a health insurer and West Virginia nonprofit corporation with its principal place of business in Parkersburg, West Virginia. Highmark West Virginia does business in West Virginia as Highmark Blue Cross Blue Shield West Virginia, an independent licensee of the Blue Cross Blue Shield Association. Highmark West Virginia was a QHP issuer on the West Virginia Health Insurance Marketplace for CY 2018, 2019, 2020, and 2021, the years relevant to Highmark West Virginia's claims in this case.

15. Plaintiff HIGHMARK CHOICE COMPANY ("HCC") is a Pennsylvania non-profit corporation licensed as a health maintenance organization with its principal place of business in Pittsburgh, Pennsylvania. HCC was a QHP issuer on the Pennsylvania Health Insurance Marketplace for CY 2018, 2019, 2020, and 2021, the years relevant to HCC's claims in this case.

16. Plaintiff Highmark Benefits Group Inc. ("HBG") is a Pennsylvania nonprofit corporation with its principal place of business in Pittsburgh, Pennsylvania. HBG was a QHP issuer on the Pennsylvania Health Insurance Marketplace for CY 2020 and 2021, the years relevant to HBG's claims in this case.

17. Plaintiff Highmark Coverage Advantage Inc. ("HCA") is a Pennsylvania nonprofit corporation with its principal place of business in Pittsburgh, Pennsylvania. HCA was a QHP issuer on the Pennsylvania Health Insurance Marketplace for CY 2020 and 2021, the years relevant to HCA's claims in this case.

18. Defendant is THE UNITED STATES OF AMERICA. HHS, CMS, and Treasury are agencies of the Defendant United States of America.

FACTUAL ALLEGATIONS

Congress Enacts the Patient Protection and Affordable Care Act

19. Congress's enactment in 2010 of the ACA, Public Law 111-148, 124 Stat. 119, marked an historic shift in the United States health care market.

20. Through the ACA, Congress aimed to increase the number of Americans covered by health insurance and decrease the cost of health care in the U.S., and included a series of interlocking reforms designed to expand coverage in the individual health insurance market. The market reforms guaranteed availability of health care to all Americans, and prohibited health insurers from using factors such as health status, medical history, preexisting conditions, gender, and industry of employment to set premium rates or deny coverage.

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

22. Through the ACA, Congress created competitive statewide health insurance marketplaces – the ACA Exchanges – that offer health insurance options to consumers. Section 1311 of the ACA establishes the framework for the Exchanges. *See* 42 U.S.C. § 18031.

23. Collectively, Plaintiffs voluntarily participated and offered QHPs in the ACA Marketplaces in Pennsylvania, Delaware, and West Virginia in CY 2018, CY 2019, CY 2020, and CY 2021.

24. Upon the Government's and/or the state-level operator's evaluation and certification of Plaintiffs as QHPs, Plaintiffs were required to provide a package of "essential health benefits" on the ACA Exchange on which it voluntarily participated. 42 U.S.C. § 18021(a)(1).

25. In deciding to become and continue as a QHP each calendar year, Plaintiffs understood that in exchange for Plaintiffs complying with numerous obligations imposed on QHPs, the Government would comply with many reciprocal obligations imposed on it – including among others, the statutory obligation to make full and timely advance CSR payments to eligible QHPs, like Plaintiffs. The Government, however, unlawfully has failed to do so, as detailed below.

The ACA's Cost-Sharing Reduction Program

26. To make health insurance more affordable for low- and modest-income Americans, the ACA provides for funding from the Government to eligible enrollees. Those federal subsidies help offset the two kinds of costs that consumers must pay to obtain health insurance: (i) health insurance premiums, and (ii) out-of-pocket expenses for health care (such as deductibles, co-pays, co-insurance, the annual limitation on cost-sharing, and similar expenses). The latter are known as "cost-sharing" expenses.

27. Regarding cost-sharing expenses, Section 1402 of the ACA mandates that, after being notified by HHS that a customer is eligible for CSR discounts, a QHP "shall reduce" a specified portion of that customer's out-of-pocket health care costs for "deductibles, copayments, or similar charges." 42 U.S.C. § 18071(a)(2); § 18022(c)(3)(A).

28. Separately, regarding health insurance premiums, Section 1401 of the ACA amended the Internal Revenue Code by providing "premium tax credits" from the Government that reduce monthly health insurance premiums on ACA Exchange plans for individuals who earn between 100% and 400% of the federal poverty level, and who satisfy additional criteria. *See* 26 U.S.C. § 36B (ACA § 1401).

29. Congress intended CSR discounts to be available to enrollees who meet three criteria: (i) they are eligible to receive premium tax credits under Section 1401, (ii) their household income is less than 250% of the federal poverty level—in 2017, under $61,500 for a family of four—and (iii) they are enrolled in a "silver" plan offered by the QHP in an ACA Exchange's individual market. 42 U.S.C. § 18071(b), (c)(2), (f)(2); *Annual Update of the HHS Poverty Guidelines*, 82 FR 8831, 8832 (Jan. 31, 2017), attached hereto at Exhibit 01; CMS, *Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2016* at 6 (Dec. 27, 2016), attached hereto at Exhibit 02 (hereinafter, "CMS 2016 CSR Manual"). Section 1402(d) further provides special rules for QHPs that provide CSR discounts to American Indians and Alaska Natives. *See* 42 U.S.C. § 18071(d).

30. QHPs, like Plaintiffs, that are certified to voluntarily participate in an ACA Exchange must offer at least one "silver" health plan. *See* 42 U.S.C. § 18071(c)(2). Before applying CSR discounts, a "silver" plan is structured so that the QHP pays an estimated 70 percent of an enrollee's health care costs, leaving the enrollee responsible for a 30 percent share of their health care costs. *See* 42 U.S.C. § 18022(d)(1)(B). Congress intended for CSR discounts subsidized by the Government to further reduce eligible enrollees' health care costs, but not to increase costs for QHPs.

31. In CY 2018, about 53% of enrollees in the ACA exchanges received CSR discounts. In CY 2019, 52% of enrollees received CSR discounts. In CY 2020, 50% of enrollees received CSR discounts. In 2021, 48% of enrollees received CSR discounts. *See* CMS, *Early 2018 Effectuated Enrollment Snapshot* (July 2, 2018), attached hereto at Exhibit 03; CMS, *Early 2019 Effectuated Enrollment Snapshot* (August 12, 2019), attached hereto at Exhibit 04; CMS, *Early 2020 Effectuated Enrollment Snapshot* (July 23, 2020), attached hereto at Exhibit 05; CMS, *Early 2021 Effectuated Enrollment Snapshot* (June 5, 2021), attached hereto at Exhibit 06.

32. Although Congress's design called for eligible enrollees to receive CSR discounts directly from their health insurance QHPs, like Plaintiffs, Congress did not intend for QHPs to bear the expense of the CSR discounts. Instead, Congress intended and mandated in Sections 1402 and 1412 of the ACA that the Government "shall" fully reimburse QHPs for those CSR discounts through advance CSR payments from the Government to QHPs.

33. In Section 1402, Congress authorized and expressly required that the Government "***shall*** make periodic and timely [CSR] payments" directly to QHPs, in an amount "***equal to*** the value of the" CSR discounts, to reimburse QHPs for the CSR discounts that QHPs are statutorily required to make to eligible customers. 42 U.S.C. § 18071(c)(3)(A) (emphasis added).

34. Additionally, in Section 1412, Congress mandated HHS and Treasury to coordinate in providing CSR payments to QHPs in advance of the QHPs' provision of CSR discounts to eligible customers. *See* 42 U.S.C. § 18082(c)(3) ("Treasury ***shall*** make such advance [CSR] payment [to QHPs] at such time and in such amount as the [HHS] Secretary specifies ….") (emphasis added).

35. Congress purposefully used the word "***shall***" in Sections 1402 and 1412 to indicate clearly that advance CSR payments are a money-mandating obligation of the United States that the Government must make to QHPs, like Plaintiffs. *See Sanford Health Plan*, 969 F.3d at 1382 ("Under the background legal principles set forth in *Maine Community*, section 18071(c)(3) comfortably qualifies as a money-mandating provision[.]" Advance CSR payments are not subsidies for QHPs; they are mandatory advance payments owed by the Government to reimburse QHPs for the mandatory CSR discounts the ACA requires QHPs to provide to eligible customers for their out-of-pocket health care expenses.

36. Congress did not limit in any way the Government's obligation to make full advance CSR payments owed to QHPs, due to appropriations, restriction on the use of funds, the amount of premium tax credits provided to ACA enrollees under 26 U.S.C. § 36B or otherwise in Section 1402, Section 1412, or anywhere else in the ACA. *Sanford Health Plan,* at 1381 ("Section 18071(c)(3) uses 'shall make…payments' language…that is indistinguishable from the 'shall pay' language at issue in *Maine Community* and unmodified by limiting language."). The Government's obligation to make full advance CSR payments to QHPs is not, and has never been, subject to "budget neutrality."

37. Congress has not amended or repealed Section 1402 or Section 1412 since enactment of the ACA. Congress has never taken any legislative action regarding the Government's obligation to make advance CSR payments to QHPs. *Id*. (noting that the Government has not argued that there is a congressional repeal applicable to § 18071(c)(3)).

38. The Government lacks statutory authority to pay anything less than 100% of the CSR payments due to Plaintiffs.

39. Based on the language of Sections 1402 and 1412 and their implementing regulations, and the representations and conduct of the Government since the CSR program was initiated, when it agreed to commit each year to the ACA Exchanges, Plaintiffs understood that they would not bear the expense of the mandatory CSR discounts the ACA required it provide to eligible enrollees. Instead, Plaintiffs understood that the Government would pay Plaintiffs in advance for those CSR discounts through "periodic and timely" advance monthly CSR payments.

40. The Government has failed to honor its mandatory advance CSR payment obligation to Plaintiffs since October 12, 2017.

HHS's Cost-Sharing Reduction Regulations

41. The HHS Secretary formally delegated authority over the CSR program under Section 1402 and Section 1412 to the CMS Administrator on August 30, 2011, specifically directing that "CMS will consult with the Department of the Treasury." *See* 76 FR 53903, 53903-04 (Aug. 30, 2011), attached hereto at Exhibit 07. By authority of this delegation from the HHS Secretary, CMS issued implementing regulations for the CSR program at 45 C.F.R. Part 156.

42. The process for providing advance CSR payments and later reconciling those payments against CSR discounts is set forth at 45 C.F.R. § 156.430. *See* 45 C.F.R. § 156.430; CMS 2016 CSR Manual at 6 n.9, Ex. 02.

43. The CSR payment regulations state that QHPs "***will*** receive periodic ***advance*** payments based on the advance payment amounts calculated in accordance" with a regulatory formula. 45 C.F.R. § 156.430(b)(1) (emphasis added).

44. HHS and CMS determined that the Government would make "periodic" advance CSR payments monthly, and then in fact the Government made advance CSR payments to QHPs

each month from January 2014 until October 2017 – a total of 45 consecutive monthly advance CSR payments. As HHS explained when it first decided to make monthly CSR payments:

> We proposed to implement a payment approach under which we would make ***monthly*** advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts. ***This approach fulfills the Secretary's obligation to make "periodic and timely payments equal to the value of the reductions" under section 1402(c)(3) of the Affordable Care Act.*** We expect that this approach would not require issuers to fund the value of any cost-sharing reductions prior to reimbursement.

78 FR 15409, 15486 (Mar. 11, 2013) (Final Rule) (emphasis added) (internal footnote omitted), attached hereto at Exhibit 08.

45. Under the implementing regulations, an annual CSR reconciliation process occurs following the conclusion of each benefit year, with QHPs notifying the HHS Secretary of CSR discounts provided on behalf of eligible enrollees for actual essential health services. *See* 45 C.F.R. § 156.430(c); Bulletin, CMS, *Data submission deadline for cost-sharing reduction reconciliation* (Apr. 15, 2016), attached hereto at Exhibit 09 (hereinafter, "CMS CSR Data Submission Bulletin").

46. HHS then analyzes the relevant data and reconciles the amount of CSR discounts that eligible customers received from a QHP in the previous benefit year against the advance CSR payments that HHS made to the QHP for the same benefit year. *See* 45 C.F.R. § 156.430(d); CMS CSR Data Submission Bulletin, Ex. 09.

47. If a discrepancy exists between the previous benefit year's amount of CSR discounts and advance CSR payments, the discrepancy is resolved through either an additional Government reimbursement "for the difference" that HHS "will" provide to the QHP, or a repayment of "the difference" that the QHP "must" provide to HHS. 45 C.F.R. § 156.430(e); CMS 2016 CSR Manual at 36, Ex. 02.

48. Through this annual CSR reconciliation and reimbursement process, which historically has been completed by the end of June following the benefit year, HHS and QHPs ensure that the advance CSR payments from the Government to a QHP in a benefit year equal the actual amount of CSR discounts from the QHP to its eligible enrollees in that benefit year, consistent with Congress's mandate to the Government in Section 1402. *See* 42 U.S.C. § 18071(c)(3)(A) ("[T]he [HHS] Secretary shall make periodic and timely payments to the [QHP] equal to the value of the [CSR discount] reductions.").

Plaintiffs are QHPs for CYs 2018 to 2021

49. Based on Congress' statutory commitments set forth in the ACA, and the regulations implementing the ACA, including the CSR program, Plaintiffs agreed to offer QHPs on the ACA Exchanges and to enter into QHP Agreements either with CMS, a federal agency within HHS, or with the state-level operator of the ACA Exchange, after CMS and/or the state-level operator had exercised its discretion to certify Plaintiffs as QHPs in, respectively, Pennsylvania, Delaware, and West Virginia.

50. In 2017, Highmark Inc., First Priority Health, HHIC, Highmark Delaware, Highmark West Virginia, and HCC executed QHP Agreements with CMS regarding their participation on their respective State-level or ACA Exchanges for CY 2018.

51. In 2018, Highmark Inc., First Priority Health, HHIC, Highmark Delaware, Highmark West Virginia, and HCC executed QHP Agreements with CMS regarding their participation on their respective State-level or ACA Exchanges for CY 2019.

52. In 2019, Highmark Inc., First Priority Health, HHIC, Highmark Delaware, Highmark West Virginia, HCC, HBG, and HCA executed QHP Agreements with CMS regarding their participation on their respective State-level or ACA Exchanges for CY 2020.

53. In 2020, Highmark Inc., First Priority Health, HHIC, Highmark Delaware, Highmark West Virginia, HCC, HBG, and HAC executed QHP Agreements with CMS regarding their participation on their respective State-level or ACA Exchanges for CY 2021.

54. 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 10.

55. Had Plaintiffs known that the Government would fail to fully and timely make the mandatory advance statutory CSR payments owed to Plaintiffs, then Plaintiffs would not have agreed to the statutory obligation to provide CSR discounts to eligible members and Plaintiffs' annual premiums in the ACA Exchanges would necessarily have been higher than actually charged. Plaintiffs also would not have agreed to participate in the ACA Marketplace without adequate pricing had they known that the Government would have breached its statutory obligations regarding the CSR program.

HHS's and CMS's Interpretation of The Government's Cost-Sharing Reduction Payment Obligations

56. Starting in January 2014 and continuing uninterrupted until October 2017, the HHS and Treasury Secretaries made the Government's monthly advance CSR payments to QHPs, including Plaintiffs, as Congress required in the ACA and consistent with their interpretation of the Government's money-mandating payment obligations under the ACA. *See*

CMS 2016 CSR Manual at 36, Ex. 02 ("Payments to issuers for the cost-sharing reduction component of advance payments began in January 2014.").

57. In rulemaking as early as 2012, HHS and CMS publicly wrote in the Federal Register that "if the actual amounts of [CSR discounts provided from QHPs to eligible enrollees] exceed the advance [CSR] payment amounts provided to the [QHP by HHS] …, ***HHS would reimburse the issuer for the shortfall***, assuming that the [QHP] has submitted its actual [CSR] amount report to HHS in a timely fashion." 77 FR 73118, 73176 (Dec. 7, 2012) (Proposed Rule) (emphasis added), attached hereto at Exhibit 11.

58. Plaintiffs have always timely submitted their required CSR reports to HHS.

59. In final rulemaking of March 11, 2013, while QHPs like Plaintiffs were contemplating whether to commit to participating in the ACA Exchanges, HHS and CMS announced their interpretation that "***cost-sharing reductions are reimbursed by the Federal government***." 78 FR 15409, 15481 (Mar. 11, 2013) (Final Rule) (emphasis added), Ex. 08. In describing the CSR advance payment and reconciliation process, HHS and CMS expressly acknowledged "the [HHS] Secretary's ***obligation*** to make 'periodic and timely payments equal to the value of the reductions' under section 1402(c)(3) of the Affordable Care Act." *Id.* at 15486 (emphasis added). HHS and CMS expressed their understanding of the statutory requirement that "***QHP issuers will be made whole*** for the value of all cost-sharing reductions provided through the reconciliation process after the close of the benefit year." *Id.* at 15488 (emphasis added). Finally, HHS and CMS expressed their interpretation that "***Section 1402(c)(3) provides for the Secretary of HHS to make payments to QHP issuers equal to the value of the cost-sharing reductions.***" *Id.* at 15489 (emphasis added).

60. In final rulemaking of March 11, 2014, HHS and CMS stated their interpretation that:

> ***Section 1402(c)(3)*** of the Affordable Care Act directs a QHP issuer to notify the Secretary of cost-sharing reductions made under the statute, and ***directs the Secretary to make periodic and timely payments to the QHP issuer equal to the value of those reductions.*** Section 1412(c)(3) of the Affordable Care Act permits advance payments of cost-sharing reduction amounts to QHP issuers based upon amounts specified by the Secretary. Under these authorities, we established a payment approach in the 2014 Payment Notice under which monthly advance payments made to issuers to cover projected cost-sharing reduction amounts are reconciled after the end of the benefit year to the actual cost-sharing reduction amounts.

79 FR 13743, 13805 (Mar. 11, 2014) (Final Rule) (emphasis added), attached hereto at Exhibit 12.

61. In early 2015, in guidance issued to QHPs regarding the CSR reconciliation process, HHS and CMS stated that "[t]he [ACA] requires [QHPs] to provide cost-sharing reductions to eligible enrollees in such [silver] plans, ***and provides for issuers to be reimbursed for the value of those cost-sharing reductions***" by the Government. Bulletin, CMS, *Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year* at 1 (Feb. 13, 2015), attached hereto at Exhibit 13 (hereinafter, "CMS 2014 CSR Bulletin") (emphasis added).

62. In a December 2016 manual regarding CSR reconciliation, HHS and CMS again acknowledged that under Sections 1402 and 1412 of the ACA, "periodic and timely payments equal to the value of [QHPs' CSR] reductions ***are required to be made to issuers*** … in advance" by the Government. CMS 2016 CSR Manual at 6 & n.8 (emphasis added), Ex. 02.

63. In the middle of 2017, HHS and CMS implemented the CSR reconciliation process for CY 2016, and Plaintiffs timely submitted their CSR data to CMS and participated in the process. *See* CMS 2016 CSR Manual at 8-9 & 36, Ex. 02.

64. The Government continued making monthly mandatory advance CSR payments to QHPs, including Plaintiffs, from the inception of the CSR program in January 2014 through September 2017 (for October 2017 CSR discounts) as required by the ACA and its implementing regulations.

The Government Breaches its Statutory Cost-Sharing Reduction Payment Obligations

65. On October 12, 2017, the White House announced that the Government would no longer make CSR payments to QHPs. In a press statement, the White House stated that:

> Based on guidance from the Department of Justice, the Department of Health and Human Services has concluded that there is no appropriation for cost-sharing reduction payments to insurance companies under [the ACA]. In light of this analysis, the Government cannot lawfully make the cost-sharing reduction payments.

Dan Mangan, *Obamacare bombshell: Trump kills key payments to health insurers*, CNBC, Oct. 12, 2017, attached hereto at Exhibit 14.

66. HHS and CMS also issued a press release on October 12, 2017, stating:

> After a thorough legal review by HHS, Treasury, OMB, and an opinion from the Attorney General, we believe that ... Congress has not appropriated money for CSRs, and we will discontinue these payments immediately.

Press Release, HHS & CMS, *Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments* (Oct. 12, 2017), attached hereto at Exhibit 15.

67. Attached to the HHS and CMS press statement was an October 12, 2017 order from HHS Acting Secretary Eric Hargan to CMS Administrator Seema Verma, instructing that "CSR payments to issuers must stop, effective immediately. CSR payments are prohibited unless and until a valid appropriation exists." Letter from Eric Hargan, HHS Acting Secretary, to Seema Verma, CMS Administrator (Oct. 12, 2017), attached hereto at Exhibit 16.

68. Attached to Mr. Hargan's order was an October 11, 2017 legal opinion signed by then U.S. Attorney General Jeff Sessions and addressed to the Treasury Secretary and HHS

Acting Secretary. *See* Letter from Jefferson B. Sessions III, U.S. Attorney General, to Steven Mnuchin, Secretary of the Treasury & Don Wright, HHS Acting Secretary (Oct. 11, 2017), attached hereto at Exhibit 17.

69. Former U.S. Attorney General Sessions admitted that Section 1402 "***requires*** insurers offering policies through ACA exchanges to reduce co-payments and other out-of-pocket costs for certain policyholders (reductions referred to in the ACA as "Cost-Sharing Reductions")." *Id.* at 2 (citing ACA § 1402) (emphasis added).

70. U.S. Attorney General Sessions also admitted that Section 1412 "authorizes" advance CSR payments from the Government to QHPs for the cost of QHPs' CSR discounts to eligible customers. *Id.* Section 1402 mandates that HHS "shall" make CSR payments to QHPs, and Congress never made those money-mandating obligations subject to the availability of appropriations or limited the Government's CSR payment obligation in any way.

71. Pursuant to the Administration's decision to cease making required advance CSR monthly payments to QHPs, HHS and Treasury have not made any of the Government's advance CSR payments to QHPs, like Plaintiffs, in and after October 2017.

72. On October 13, 2017, CMS's Financial Management Coordination Center ("FMCC") emailed to Plaintiffs and other QHPs a letter stating that:

> [CMS] will discontinue payments of [CSR] to issuers effective in October. … For the October monthly payment cycle and beyond, CMS will withhold advance CSR payments for the current month of coverage and will not make any adjustments to CSR payment amounts related to retroactive enrollment data changes for prior months of 2017. Issuers will therefore receive no net payment of 2017 advance CSR in the October and future payment cycles. … CSR reconciliation payments for the 2016 benefit year, including any payments owed as the result of reported discrepancies, will not be made. CMS will collect CSR reconciliation charges that result from any discrepancies.

Email from CMS FMCC to Plaintiffs (Oct. 13, 2017).

73. On October 20, 2017, CMS sent an email to Plaintiffs and other QHPs including a notice that "CMS has published a supplemental FAQ document today related to the cessation of cost-sharing reductions to provide additional detail on the impacts of this change to issuers' enrollment and payment data processing," and provided a link to the referenced FAQ document. Email from CMS FMCC to Plaintiffs (Oct. 20, 2017).

74. CMS's FAQ document of October 20, 2017, confirmed that:

> For the October monthly payment cycle and beyond, CMS will not make advance CSR payments, and will not make any adjustments to CSR payment amounts related to retroactive enrollment data changes for prior months of 2017, unless Congress appropriates funding for these payments. Issuers will therefore receive no net payment of 2017 advance CSR in the October and future payment cycles.

Bulletin, CMS, *FAQ on Cessation of Payment of Cost-sharing Reductions* at 1 (Oct. 20, 2017), attached hereto at Exhibit 18.

75. Regarding payments and charges from the CSR reconciliation process established in the Government's implementing regulations, the FAQ document stated that:

> CSR reconciliation payments for the 2016 benefit year and prior year restatements previously scheduled for the October 2017 payment cycle or future cycles, including any payments calculated as the result of reported discrepancies, will not be made. However, if a discrepancy results in an overpayment to the issuer, CMS will proceed with the collection of those charges after the issuer has been notified of CMS's discrepancy decision.

Id.

76. The Government, in relying on the foregoing statements to stop making the statutorily-required CSR payments, however, ignored that "[i]t has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." *Prairie Cnty., Mont. v. United States*, 782 F.3d 685, 690 (Fed. Cir.), *cert. denied*, 136 S. Ct. 319 (2015); *see also Maine Community Health Options*, 140 S. Ct. at 1323;

Sanford Health Plan, 969 F.3d at 1381 ("It makes no difference to this conclusion that Congress did not specifically appropriate money to make the payments.").

77. The United States Supreme Court confirmed in *Maine Cmty. Health Options* that a similar ACA statutory obligation that HHS "shall" pay monies owed to insurers for the risk corridors program was itself (without express "budget authority") a binding, money-mandating government "obligation neither contingent on nor limited by the availability of appropriations or other funds." 140 S. Ct. at 1323; *cf.* ACA § 1412(c)(3) (the Treasury Secretary "shall make" advance CSR payment to QHPs). The Supreme Court also held the ACA's statutory payment obligation was unaffected by the Anti-deficiency Act because the "obligation was authorized" by the ACA's risk corridors statute. *Id*. at 1322.

78. Applying the Supreme Court's holding in *Maine Cmty. Health Options*, the Federal Circuit held that same ACA cost-sharing provision at issue in this case also is a binding, money-mandating Government obligation, regardless of whether Congress has specifically appropriated money to make those payments. *Sanford Health Plan*, 969 F.3d at 1381.

79. The Federal Circuit held in *Sanford Health Plan* that the Government is liable to QHPs, like Plaintiffs, for failure to pay the advance monthly CSR payments mandated by the statute. *Sanford Health,* 969 F.3d at 1372. The Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability for the CSR payments owed to Plaintiffs in this case.

80. The Federal Circuit's ruling in *Sanford Health Plan* is consistent with the rulings of every U.S. Court of Federal Claims Judge to have ruled on liability in a CSR case. *See Montana Health Co-Op v. United States*, 139 Fed. Cl. 213 (2018); *Sanford Health Plan*, 2018 WL 4939418, *aff'd*, 969 F.3d 1370; *Common Ground Healthcare Coop. v. United States*, 142 Fed. Cl. 38 (2019); *Cmty. Health Choice, Inc. v. United States*, 141 Fed. Cl. 744 (2019); *Local Initiative*

Health Auth. for L.A. Cty. v. United States, 142 Fed. Cl. 1 (2019); *Maine Cmty. Health Options v. United States*, 142 Fed. Cl. 53 (2019).

81. These rulings, which have held the Government liable for its CSR statutory payment obligations in all of these cases, are consistent with and bolstered by the Supreme Court's decision in *Maine Community Health Options*, 140 S. Ct. 1308, and the Federal Circuit's CSR liability ruling in *Sanford Health Plan*, 969 F.3d at 1381.

82. Since the Federal Circuit's ruling in *Sanford Health* holding that the Government is liable to QHPs like Plaintiffs, the Government has stipulated to liability and agreed to the entry of partial final judgment for CSR claims the Government owes to other QHPs for CY 2017 in numerous CSR cases before this Court. *See, e.g.*, *BridgeSpan v. United States*, No. 21-2316, ECF No. 8; *Highmark v. United States*, No. 20-1686, ECF No. 21; *Blue Cross of California v. United States*, No. 20-606, ECF No. 25; *Local Initiative Health Auth. for L.A. Cty. v. United States*, No. 17-1542, ECF No. 66.

83. The monetary relief Plaintiffs seek is specific—the statutorily mandated CSR payments to which Plaintiffs are entitled on and after January 1, 2018, but which were not paid by the Government.

Plaintiffs' Advance Cost-Sharing Reduction Payments Owed Since January 1, 2018

84. Between January 2014 and October 12, 2017, Defendant made monthly advance CSR payments to Plaintiffs on or about a date between the nineteenth and twenty-second of each month. *See* Decl. of Elizabeth Parish in Supp. of Defs.' Opp'n to Pls.' Mot. for a TRO, *Calif. v. Trump*, No. 3:17-cv-5895-VC, ECF No. 35-3, at ¶ 5 (Oct. 20, 2017), attached hereto at Exhibit 19 (CMS official declaring under oath that "monthly [advance CSR] payments [are] scheduled for a pre-established date between the nineteenth and twenty-second of each month").

85. The Administration announced its October 12, 2017 decision to stop making the Government's advance CSR payments before the Government made its expected October 20, 2017 monthly advance CSR payment to Plaintiffs. *See id.* ("October payments are being made without CSR payments according to this schedule on October 20, 2017.").

86. Defendant thus has made no statutorily-mandated CSR payments to Plaintiffs since September 2017.

87. In the October 13, 2017, CMS FMCC email to Plaintiffs and other QHPs, CMS stated that it would continue to report the amount of monthly advance CSR payments a QHP would have received from the Government in and after October 2017, but that the same monthly payment report "will also show a lump-sum issuer-level manual adjustment that reverses the total net advance CSR payment," resulting in no CSR payment being paid despite the Government's obligations to make such payments each month.

88. Plaintiffs are owed $46,556,124.00 in CSR payments for CY 2018, $39,936,614.00 in CSR payments for CY 2019, $50,558,654.00 in CSR payments for CY 2020, and $48,998,587.00 in CSR payments for CY 2021, following reconciliation of CSR payment amounts, but the Government has refused to pay these amounts in violation of its statutory and regulatory obligations.

89. Plaintiffs demand full and immediate payment from the United States of the total amount of CSR payments the Government owes Plaintiffs of $186,049,979.00.

COUNT I
Violation of Federal Statute and Regulation for 2018 CSRs
The Government Owes Plaintiffs

90. Plaintiffs reallege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

91. Plaintiffs are entitled to the CSR payments the Government owes them under § 1402's plain terms. Section 1402(c)(3)(A) of the ACA mandates compensation, expressly stating that a QHP issuer: "making reductions under this subsection shall notify the Secretary of such [cost-sharing] reductions and the Secretary *shall make periodic and timely payments* to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added).

92. Section 1412(c)(3) of the ACA likewise mandates compensation, expressly stating that the "Treasury [Secretary] shall make such advance [CSR] payment [to QHPs] at such time and in such amount as the [HHS] Secretary specifies." 42 U.S.C. § 18082(c)(3).

93. HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(a) also mandates compensation, expressly stating that "A QHP issuer will receive periodic advance [CSR] payments." 45 C.F.R. § 156.430(a).

94. Furthermore, HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(e)(1) mandates compensation, expressly stating that "If the actual amounts of cost-sharing reductions [provided by QHPs to enrollees] are – (1) More than the amount of advance payments provided [by HHS and Treasury to a QHP] and the QHP issuer has timely provided the actual amounts of cost-sharing reductions as required …, HHS will reimburse the QHP issuer for the difference." 45 C.F.R. § 156.430(e)(1).

95. HHS and CMS have long recognized "the [HHS] Secretary's ***obligation*** to make 'periodic and timely payments equal to the value of the [QHPs' CSR] reductions' under section 1402(c)(3) of the Affordable Care Act." 78 FR 15409, 15486 (Mar. 11, 2013) (Final Rule) (emphasis added).

96. Plaintiffs are entitled under Section 1402(c)(3)(A) of the ACA, Section 1412(c)(3) of the ACA, and 45 C.F.R. § 156.430(a) and (e)(1) to receive monthly advance CSR

payments from Defendant in an amount equal to the full amount of the monthly CSR discounts that Plaintiffs provide to their eligible customers for essential health benefits.

97. Plaintiffs have provided CSR discounts to its eligible customers for essential health benefits every month at issue since January 2018.

98. Every month between January 2014 and September 2017, Defendant complied with its obligations and made mandatory monthly advance CSR payments to Plaintiffs. *See* 42 U.S.C. § 18071(a).

99. Plaintiffs have not received any CSR payments from Defendant since October 2017, as a result of the Government's unlawful decision on October 12, 2017 to breach its statutory and regulatory obligations and stop making monthly advance CSR payments to Plaintiffs and other QHPs.

100. Congress did not repeal, amend or otherwise abrogate the statutory obligation created by Sections 1402 and 1412 to make full and timely advance CSR payments to QHPs, including Plaintiffs, that provide CSR discounts to their eligible customers for essential health benefits.

101. The Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in this case as the Government breached the identical statutory CSR payment obligation to Plaintiffs in this case.

102. The Government previously has acknowledged and accepted that the Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in other CSR cases, such as this one, because the Government breached the identical statutory CSR payment obligation.

103. The Government's failure to make full and timely advance CSR payments to Plaintiffs since January 1, 2018 constitutes a violation and breach of the Government's mandatory payment obligations under Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1).

104. Plaintiffs' statutory claims seek specific relief—the statutorily-mandated CSR payments to which they are entitled, and there is no statutory or other legal basis to undermine Plaintiffs' entitlement to those specific statutory CSR payments Plaintiffs are owed.

105. Section 1402 prescribes a precisely determinable CSR payment amount. Nothing in the ACA requires (or permits) the mandatory payments under §1402 to be reduced based on the amount of premiums charged by an insurer, an insurer's rate of return on sales, its overall profit, or any other market or external factors.

106. The ACA states that, entirely apart from the CSR payments owed, QHP issuers are entitled to a "[r]efundable [tax] credit for coverage under a qualified health plan." 26 U.S.C. § 36B. The ACA thus unconditionally requires the Government to make *both* CSR reimbursements and premium tax credits, and does not allow for reduction of one based on increase of the other.

107. The Government has not established that the statutorily-mandated CSR payments owed have been mitigated or are subject to offsets due to any additional premium tax credits received by Plaintiffs as the result of the Government's failure to pay CSRs owed for 2018, or otherwise. The ACA imposes no obligation of mitigation on QHPs, and no right of offset to the Government, with respect to the QHP issuers' unconditional right to receive the statutorily-mandated CSR payments due.

108. Plaintiffs' claims are for the statutorily-mandated CSR payments to which they are entitled are not based on expectancy damages. Therefore, the ultimate, indirect consequences of the Government's failure to pay the CSRs owed Plaintiffs under the statute are irrelevant to Plaintiffs' right to receive those unmade CSR payments as specific relief.

109. As a direct result of the United States' violation of Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1), Plaintiffs have not been paid the 2018 CSR payments owed and have been damaged in the amount of at least $46,556,124.00 as of the filing date of this Amended Complaint, together with post-judgment interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT II
Violation of Federal Statute and Regulation for 2019 CSRs
The Government Owes Plaintiffs

110. Plaintiffs reallege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

111. Plaintiffs are entitled to the CSR payments the Government owes them under § 1402's plain terms. Section 1402(c)(3)(A) of the ACA mandates compensation, expressly stating that a QHP issuer: "making reductions under this subsection shall notify the Secretary of such [cost-sharing] reductions and the Secretary *shall make periodic and timely payments* to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added).

112. Section 1412(c)(3) of the ACA likewise mandates compensation, expressly stating that the "Treasury [Secretary] shall make such advance [CSR] payment [to QHPs] at such time and in such amount as the [HHS] Secretary specifies." 42 U.S.C. § 18082(c)(3).

113. HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(a) also mandates compensation, expressly stating that "A QHP issuer will receive periodic advance [CSR] payments." 45 C.F.R. § 156.430(a).

114. Furthermore, HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(e)(1) mandates compensation, expressly stating that "If the actual amounts of cost-sharing reductions [provided by QHPs to enrollees] are – (1) More than the amount of advance payments provided [by HHS and Treasury to a QHP] and the QHP issuer has timely provided the actual amounts of cost-sharing reductions as required …, HHS will reimburse the QHP issuer for the difference." 45 C.F.R. § 156.430(e)(1).

115. HHS and CMS have long recognized "the [HHS] Secretary's ***obligation*** to make 'periodic and timely payments equal to the value of the [QHPs' CSR] reductions' under section 1402(c)(3) of the Affordable Care Act." 78 FR 15409, 15486 (Mar. 11, 2013) (Final Rule) (emphasis added).

116. Plaintiffs are entitled under Section 1402(c)(3)(A) of the ACA, Section 1412(c)(3) of the ACA, and 45 C.F.R. § 156.430(a) and (e)(1) to receive monthly advance CSR payments from Defendant in an amount equal to the full amount of the monthly CSR discounts that Plaintiffs provide to their eligible customers for essential health benefits.

117. Plaintiffs have provided CSR discounts to its eligible customers for essential health benefits every month at issue since January 2018.

118. Every month between January 2014 and September 2017, Defendant complied with its obligations and made mandatory monthly advance CSR payments to Plaintiffs. *See* 42 U.S.C. § 18071(a).

119. Plaintiffs have not received any CSR payments from Defendant since October 2017, as a result of the Government's unlawful decision on October 12, 2017 to breach its statutory and regulatory obligations and stop making monthly advance CSR payments to Plaintiffs and other QHPs.

120. Congress did not repeal, amend or otherwise abrogate the statutory obligation created by Sections 1402 and 1412 to make full and timely advance CSR payments to QHPs, including Plaintiffs, that provide CSR discounts to their eligible customers for essential health benefits.

121. The Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in this case as the Government breached the identical statutory CSR payment obligation to Plaintiffs in this case.

122. The Government previously has acknowledged and accepted that the Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in other CSR cases, such as this one, because the Government breached the identical statutory CSR payment obligation.

123. The Government's failure to make full and timely advance CSR payments to Plaintiffs since January 1, 2018 constitutes a violation and breach of the Government's mandatory payment obligations under Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1).

124. Plaintiffs' statutory claims seek specific relief—the statutorily-mandated CSR payments to which they are entitled, and there is no statutory or other legal basis to undermine Plaintiffs' entitlement to those specific statutory CSR payments Plaintiffs are owed.

125. Section 1402 prescribes a precisely determinable CSR payment amount. Nothing in the ACA requires (or permits) the mandatory payments under §1402 to be reduced based on the amount of premiums charged by an insurer, an insurer's rate of return on sales, its overall profit, or any other market or external factors.

126. The ACA states that, entirely apart from the CSR payments owed, QHP issuers are entitled to a "[r]efundable [tax] credit for coverage under a qualified health plan." 26 U.S.C. § 36B. The ACA thus unconditionally requires the Government to make *both* CSR reimbursements and premium tax credits, and does not allow for reduction of one based on increase of the other.

127. The Government has not established that the statutorily-mandated CSR payments owed have been mitigated or are subject to offsets due to any additional premium tax credits received by Plaintiffs as the result of the Government's failure to pay CSRs owed for 2019, or otherwise. The ACA imposes no obligation of mitigation on QHPs, and no right of offset to the Government, with respect to the QHP issuers' unconditional right to receive the statutorily-mandated CSR payments due.

128. Plaintiffs' claims are for the statutorily-mandated CSR payments to which they are entitled are not based on expectancy damages. Therefore, the ultimate, indirect consequences of the Government's failure to pay the CSRs owed Plaintiffs under the statute are irrelevant to Plaintiffs' right to receive those unmade CSR payments as specific relief.

129. As a direct result of the United States' violation of Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1), Plaintiffs have not been paid the 2019 CSR payments owed and have been damaged in the amount of at least $39,936,614.00 as

of the filing date of this Amended Complaint, together with post-judgment interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT III
Violation of Federal Statute and Regulation for 2020 CSRs
The Government Owes Plaintiffs

130. Plaintiffs reallege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

131. Plaintiffs are entitled to the CSR payments the Government owes them under § 1402's plain terms. Section 1402(c)(3)(A) of the ACA mandates compensation, expressly stating that a QHP issuer: "making reductions under this subsection shall notify the Secretary of such [cost-sharing] reductions and the Secretary *shall make periodic and timely payments* to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added).

132. Section 1412(c)(3) of the ACA likewise mandates compensation, expressly stating that the "Treasury [Secretary] shall make such advance [CSR] payment [to QHPs] at such time and in such amount as the [HHS] Secretary specifies." 42 U.S.C. § 18082(c)(3).

133. HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(a) also mandates compensation, expressly stating that "A QHP issuer will receive periodic advance [CSR] payments." 45 C.F.R. § 156.430(a).

134. Furthermore, HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(e)(1) mandates compensation, expressly stating that "If the actual amounts of cost-sharing reductions [provided by QHPs to enrollees] are – (1) More than the amount of advance payments provided [by HHS and Treasury to a QHP] and the QHP issuer has timely provided the actual amounts of cost-sharing reductions as required …, HHS will reimburse the QHP issuer for the difference." 45 C.F.R. § 156.430(e)(1).

135. HHS and CMS have long recognized "the [HHS] Secretary's ***obligation*** to make 'periodic and timely payments equal to the value of the [QHPs' CSR] reductions' under section 1402(c)(3) of the Affordable Care Act." 78 FR 15409, 15486 (Mar. 11, 2013) (Final Rule) (emphasis added).

136. Plaintiffs are entitled under Section 1402(c)(3)(A) of the ACA, Section 1412(c)(3) of the ACA, and 45 C.F.R. § 156.430(a) and (e)(1) to receive monthly advance CSR payments from Defendant in an amount equal to the full amount of the monthly CSR discounts that Plaintiffs provide to their eligible customers for essential health benefits.

137. Plaintiffs have provided CSR discounts to its eligible customers for essential health benefits every month at issue since January 2018.

138. Every month between January 2014 and September 2017, Defendant complied with its obligations and made mandatory monthly advance CSR payments to Plaintiffs. *See* 42 U.S.C. § 18071(a).

139. Plaintiffs have not received any CSR payments from Defendant since October 2017, as a result of the Government's unlawful decision on October 12, 2017 to breach its statutory and regulatory obligations and stop making monthly advance CSR payments to Plaintiffs and other QHPs.

140. Congress did not repeal, amend or otherwise abrogate the statutory obligation created by Sections 1402 and 1412 to make full and timely advance CSR payments to QHPs, including Plaintiffs, that provide CSR discounts to their eligible customers for essential health benefits.

141. The Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in this case as the Government breached the identical statutory CSR payment obligation to Plaintiffs in this case.

142. The Government previously has acknowledged and accepted that the Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in other CSR cases, such as this one, because the Government breached the identical statutory CSR payment obligation.

143. The Government's failure to make full and timely advance CSR payments to Plaintiffs since January 1, 2018 constitutes a violation and breach of the Government's mandatory payment obligations under Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1).

144. Plaintiffs' statutory claims seek specific relief—the statutorily-mandated CSR payments to which they are entitled, and there is no statutory or other legal basis to undermine Plaintiffs' entitlement to those specific statutory CSR payments Plaintiffs are owed.

145. Section 1402 prescribes a precisely determinable CSR payment amount. Nothing in the ACA requires (or permits) the mandatory payments under §1402 to be reduced based on the amount of premiums charged by an insurer, an insurer's rate of return on sales, its overall profit, or any other market or external factors.

146. The ACA states that, entirely apart from the CSR payments owed, QHP issuers are entitled to a "[r]efundable [tax] credit for coverage under a qualified health plan." 26 U.S.C. § 36B. The ACA thus unconditionally requires the Government to make *both* CSR reimbursements and premium tax credits, and does not allow for reduction of one based on increase of the other.

147. The Government has not established that the statutorily-mandated CSR payments owed have been mitigated or are subject to offsets due to any additional premium tax credits received by Plaintiffs as the result of the Government's failure to pay CSRs owed for 2020, or otherwise. The ACA imposes no obligation of mitigation on QHPs, and no right of offset to the Government, with respect to the QHP issuers' unconditional right to receive the statutorily-mandated CSR payments due.

148. Plaintiffs' claims are for the statutorily-mandated CSR payments to which they are entitled are not based on expectancy damages. Therefore, the ultimate, indirect consequences of the Government's failure to pay the CSRs owed Plaintiffs under the statute are irrelevant to Plaintiffs' right to receive those unmade CSR payments as specific relief.

149. As a direct result of the United States' violation of Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1), Plaintiffs have not been paid the 2020 CSR payments owed and have been damaged in the amount of at least $50,558,654.00 as of the filing date of this Amended Complaint, together with post-judgment interest, costs of suit, and such other relief as this Court deems just and proper.

COUNT IV
Violation of Federal Statute and Regulation for 2021 CSRs
The Government Owes Plaintiffs

150. Plaintiffs reallege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

151. Plaintiffs are entitled to the CSR payments the Government owes them under § 1402's plain terms. Section 1402(c)(3)(A) of the ACA mandates compensation, expressly stating that a QHP issuer: "making reductions under this subsection shall notify the Secretary of such

[cost-sharing] reductions and the Secretary *shall make periodic and timely payments* to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A) (emphasis added).

152. Section 1412(c)(3) of the ACA likewise mandates compensation, expressly stating that the "Treasury [Secretary] shall make such advance [CSR] payment [to QHPs] at such time and in such amount as the [HHS] Secretary specifies." 42 U.S.C. § 18082(c)(3).

153. HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(a) also mandates compensation, expressly stating that "A QHP issuer will receive periodic advance [CSR] payments." 45 C.F.R. § 156.430(a).

154. Furthermore, HHS's and CMS's implementing regulation at 45 C.F.R. § 156.430(e)(1) mandates compensation, expressly stating that "If the actual amounts of cost-sharing reductions [provided by QHPs to enrollees] are – (1) More than the amount of advance payments provided [by HHS and Treasury to a QHP] and the QHP issuer has timely provided the actual amounts of cost-sharing reductions as required …, HHS will reimburse the QHP issuer for the difference." 45 C.F.R. § 156.430(e)(1).

155. HHS and CMS have long recognized "the [HHS] Secretary's ***obligation*** to make 'periodic and timely payments equal to the value of the [QHPs' CSR] reductions' under section 1402(c)(3) of the Affordable Care Act." 78 FR 15409, 15486 (Mar. 11, 2013) (Final Rule) (emphasis added).

156. Plaintiffs are entitled under Section 1402(c)(3)(A) of the ACA, Section 1412(c)(3) of the ACA, and 45 C.F.R. § 156.430(a) and (e)(1) to receive monthly advance CSR payments from Defendant in an amount equal to the full amount of the monthly CSR discounts that Plaintiffs provide to their eligible customers for essential health benefits.

157. Plaintiffs have provided CSR discounts to its eligible customers for essential health benefits every month at issue since January 2018.

158. Every month between January 2014 and September 2017, Defendant complied with its obligations and made mandatory monthly advance CSR payments to Plaintiffs. *See* 42 U.S.C. § 18071(a).

159. Plaintiffs have not received any CSR payments from Defendant since October 2017, as a result of the Government's unlawful decision on October 12, 2017 to breach its statutory and regulatory obligations and stop making monthly advance CSR payments to Plaintiffs and other QHPs.

160. Congress did not repeal, amend or otherwise abrogate the statutory obligation created by Sections 1402 and 1412 to make full and timely advance CSR payments to QHPs, including Plaintiffs, that provide CSR discounts to their eligible customers for essential health benefits.

161. The Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in this case as the Government breached the identical statutory CSR payment obligation to Plaintiffs in this case.

162. The Government previously has acknowledged and accepted that the Federal Circuit's decision in *Sanford Health Plan* is dispositive of the Government's liability in other CSR cases, such as this one, because the Government breached the identical statutory CSR payment obligation.

163. The Government's failure to make full and timely advance CSR payments to Plaintiffs since January 1, 2018 constitutes a violation and breach of the Government's

mandatory payment obligations under Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1).

164. Plaintiffs' statutory claims seek specific relief—the statutorily-mandated CSR payments to which they are entitled, and there is no statutory or other legal basis to undermine Plaintiffs' entitlement to those specific statutory CSR payments Plaintiffs are owed.

165. Section 1402 prescribes a precisely determinable CSR payment amount. Nothing in the ACA requires (or permits) the mandatory payments under §1402 to be reduced based on the amount of premiums charged by an insurer, an insurer's rate of return on sales, its overall profit, or any other market or external factors.

166. The ACA states that, entirely apart from the CSR payments owed, QHP issuers are entitled to a "[r]efundable [tax] credit for coverage under a qualified health plan." 26 U.S.C. § 36B. The ACA thus unconditionally requires the Government to make *both* CSR reimbursements and premium tax credits, and does not allow for reduction of one based on increase of the other.

167. The Government has not established that the statutorily-mandated CSR payments owed have been mitigated or are subject to offsets due to any additional premium tax credits received by Plaintiffs as the result of the Government's failure to pay CSRs owed for 2021, or otherwise. The ACA imposes no obligation of mitigation on QHPs, and no right of offset to the Government, with respect to the QHP issuers' unconditional right to receive the statutorily-mandated CSR payments due.

168. Plaintiffs' claims are for the statutorily-mandated CSR payments to which they are entitled are not based on expectancy damages. Therefore, the ultimate, indirect consequences

of the Government's failure to pay the CSRs owed Plaintiffs under the statute are irrelevant to Plaintiffs' right to receive those unmade CSR payments as specific relief.

169. As a direct result of the United States' violation of Sections 1402(c)(3)(A) and 1412(c)(3) of the ACA and 45 C.F.R. § 156.430(a) and (e)(1), Plaintiffs have not been paid the 2021 CSR payments owed and have been damaged in the amount of at least $48,998,587.00 as of the filing date of this Amended Complaint, together with post-judgment interest, costs of suit, and such other relief as this Court deems just and proper.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs demand judgment against the Defendant, the United States of America, as follows:

(1) On Count I, awarding monetary damages sustained by Plaintiffs for the 2018 CSR payments owed by the Government, in the amount of at least $46,556,124.00, subject to proof at trial, as a result of the Defendant's violation of Sections 1402 and 1412 of the ACA and of 45 C.F.R. § 156.430;

(2) On Count II, awarding monetary damages sustained by Plaintiffs for the 2019 CSR payments owed by the Government, in the amount of at least $39,936,614.00, subject to proof at trial, as a result of the Defendant's violation of Sections 1402 and 1412 of the ACA and of 45 C.F.R. § 156.430;

(3) On Count III, awarding monetary damages sustained by Plaintiffs for the 2020 CSR payments owed by the Government, in the amount of at least $50,558,654.00, subject to proof at trial, as a result of the Defendant's violation of Sections 1402 and 1412 of the ACA and of 45 C.F.R. § 156.430;

(4) On Count IV, awarding monetary damages sustained by Plaintiffs for the 2021 CSR payments owed by the Government, in the amount of at least $48,998,587.00, subject to

proof at trial, as a result of the Defendant's violation of Sections 1402 and 1412 of the ACA and of 45 C.F.R. § 156.430;

(5) Awarding all available interest, including, but not limited to, post-judgment interest, to Plaintiff; and

(6) Awarding such other and further relief to Plaintiffs as the Court deems just and equitable.

Dated: September 23, 2022

Respectfully Submitted,

s/ Lawrence S. Sher

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CERTIFICATE OF SERVICE

I hereby certify that on September 23, 2022, a copy of the foregoing 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 INDEX

Exhibit No.	Description
01	*Annual Update of the HHS Poverty Guidelines*, 82 FR 8831 (Jan. 31, 2017)
02	CMS, *Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2016* (Dec. 27, 2016)
03	CMS, *2018 Effectuated Enrollment Snapshot* (July 2, 2018)
04	CMS, *2019 Effectuated Enrollment Snapshot* (August 12, 2019)
05	CMS, *2020 Effectuated Enrollment Snapshot* (July 23, 2020)
06	CMS, *2021 Effectuated Enrollment Snapshot* (June 5, 2021)
07	76 FR 53903 (Aug. 30, 2011)
08	78 FR 15409 (Mar. 11, 2013)
09	Bulletin, CMS, *Data submission deadline for cost-sharing reduction reconciliation* (Apr. 15, 2016)
10	Letter from CMS to Issuers on Federally-Facilitated Exchanges and State Partnership Exchanges (Apr. 5, 2013)
11	77 FR 73118 (Dec. 7, 2012)
12	79 FR 13743 (Mar. 11, 2014)
13	Bulletin, CMS, *Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year* (Feb. 13, 2015)
14	Dan Mangan, *Obamacare bombshell: Trump kills key payments to health insurers*, CNBC, Oct. 12, 2017
15	Press Release, HHS & CMS, *Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments* (Oct. 12, 2017)
16	Letter from Eric Hargan, HHS Acting Secretary, to Seema Verma, CMS Administrator (Oct. 12, 2017)
17	Letter from Jefferson B. Sessions III, U.S. Attorney General, to Steven Mnuchin, Secretary of the Treasury & Don Wright, HHS Acting Secretary (Oct. 11, 2017)

18	Bulletin, CMS, *FAQ on Cessation of Payment of Cost-sharing Reductions* at 1 (Oct. 20, 2017)
19	Decl. of Elizabeth Parish in Supp. of Defs.' Opp'n to Pls.' Mot. for a TRO, *Calif. v. Trump*, No. 3:17-cv-5895-VC, ECF No. 35-3 (Oct. 20, 2017)

EXHIBIT 1

Case 1:20-cv-01686-EDK Document 39-1 Filed 09/23/22 Page 4 of 206

Authority: Federal Advisory Committee Act, Pub. L. 92–463.

Dated: January 18, 2017.

Wendy M. Payne,

Executive Director.

[FR Doc. 2017–02028 Filed 1–30–17; 8:45 am]

BILLING CODE 1610–01–P

FEDERAL ELECTION COMMISSION

Sunshine Act Meetings

AGENCY: Federal Election Commission.

DATE AND TIME: Wednesday, February 1, 2017 at 10:00 a.m.

PLACE: 999 E Street NW., Washington, DC (Ninth Floor).

STATUS: This meeting will be open to the public.

FEDERAL REGISTER NOTICE OF PREVIOUS ANNOUNCEMENT: 82 FR 8613.

CHANGE IN THE MEETING: The February 1, 2017 Public Hearing on Internet Communication Disclaimers has been postponed.

PERSON TO CONTACT FOR INFORMATION: Judith Ingram, Press Officer, Telephone: (202) 694–1220.

Dayna C. Brown,

Acting Secretary and Clerk of the Commission.

[FR Doc. 2017–02090 Filed 1–27–17; 11:15 am]

BILLING CODE 6715–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than February 24, 2017.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. *Nicolet Bankshares, Inc.,* Green Bay, Wisconsin; to acquire 100 percent of First Menasha Bancshares, Inc., Neenah, Wisconsin, and thereby indirectly acquire The First National Bank—Fox Valley, Neenah, Wisconsin.

B. Federal Reserve Bank of Minneapolis (Jacquelyn K. Brunmeier, Assistant Vice President) 90 Hennepin Avenue, Minneapolis, Minnesota 55480–0291:

1. *Ameri Financial Group, Inc.,* Stillwater, Minnesota; to acquire 100 percent of First Resource Bank, Lino Lakes, Minnesota.

C. Federal Reserve Bank of San Francisco (Gerald C. Tsai, Director, Applications and Enforcement) 101 Market Street, San Francisco, California 94105–1579:

1. *BayCom Corp,* Walnut Creek, California; to merge with First ULB Corp., and thereby indirectly acquire United Business Bank, F.S.B., both of Oakland, California; and thereby engage in operating a savings association pursuant to 225.28(b)(4).

Board of Governors of the Federal Reserve System, January 25, 2017.

Yao-Chin Chao,

Assistant Secretary of the Board.

[FR Doc. 2017–01985 Filed 1–30–17; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the Department of Health and Human Services (HHS) poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Effective Date:* January 26, 2017 unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, state, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Suzanne Macartney, Office of the Assistant Secretary for Planning and Evaluation, Room 422F.3, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690–6143—or visit *http://aspe.hhs.gov/poverty/.*

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283.

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Health Resources and Services Administration Information Center at 1–800–275–4772. You also may visit *http://www.hrsa.gov/gethealthcare/affordable/hillburton/.*

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's Web site at *http://www.census.gov/hhes/www/poverty/poverty.html* or contact the Census Bureau's Customer Service Center at 1–800–923–8282 (toll-free) or visit *https://ask.census.gov* for further information.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price

Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by the Community Services Block Grant program and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2017 notice reflect the 1.3 percent price increase between calendar years 2015 and 2016. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. In rare circumstances, the rounding and standardizing adjustments in the formula result in small decreases in the poverty guidelines for some household sizes even when the inflation factor is not negative. In cases where the year-to-year change in inflation is not negative and the rounding and standardizing adjustments in the formula result in reductions to the guidelines from the previous year for some household sizes, the guidelines for the affected household sizes are fixed at the prior year's guidelines. As in prior years, these 2017 guidelines are roughly equal to the poverty thresholds for calendar year 2016 which the Census Bureau expects to publish in final form in September 2017.

The poverty guidelines continue to be derived from the Census Bureau's current official poverty thresholds; they are not derived from the Census Bureau's Supplemental Poverty Measure (SPM).

The following guideline figures represent annual income.

2017 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$12,060
2	16,240
3	20,420
4	24,600
5	28,780
6	32,960
7	37,140
8	41,320

For families/households with more than 8 persons add $4,180 for each additional person.

2017 Poverty Guidelines for Alaska

Persons in family/household	Poverty guideline
1	$15,060
2	20,290
3	25,520
4	30,750
5	35,980
6	41,210
7	46,440
8	51,670

For families/households with more than 8 persons, add $5,230 for each additional person.

2017 Poverty Guidelines for Hawaii

Persons in family/household	Poverty guideline
1	$13,860
2	18,670
3	23,480
4	28,290
5	33,100
6	37,910
7	42,720
8	47,530

For families/households with more than 8 persons, add $4,810 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines sometimes have been mistakenly referred to as the ''OMB'' (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as ''the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some federal programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-Federally-funded activities also may choose to use a percentage multiple of the guidelines.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as ''income'' or ''family,'' because there is considerable variation in defining these terms among the different programs that use the guidelines. These variations are traceable to the different laws and regulations that govern the various programs. This means that questions such as ''Is income counted before or after taxes?'', ''Should a particular type of income be counted?'', and ''Should a particular person be counted as a member of the family/household?'' are actually questions about how a specific program applies the poverty guidelines. All such questions about how a specific program applies the guidelines should be directed to the entity that administers or funds the program, since that entity has the responsibility for defining such terms as ''income'' or ''family,'' to the extent that these terms are not already defined for the program in legislation or regulations.

Dated: January 26, 2017.

Norris Cochran,

Acting Secretary of Health and Human Services.

[FR Doc. 2017–02076 Filed 1–27–17; 11:15 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and

EXHIBIT 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: December 27, 2016

From: Center for Consumer Information and Insurance Oversight (CCIIO)

Centers for Medicare & Medicaid Services (CMS)

Title: Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2016

Executive Summary

CMS is releasing this manual to all issuers offering a qualified health plan (QHP) through a health insurance Marketplace.[1] The manual provides information on the process for reconciling the cost-sharing reduction component of the advance payments that QHP issuers have been paid to reflect the cost-sharing reduction amounts those issuers provided to eligible Marketplace enrollees. The manual also provides QHP issuers with general instructions on using the standard, simplified, and actuarial value methodologies described at 45 CFR 156.430 for the purpose of determining the value of cost-sharing reduction amounts provided to eligible Marketplace enrollees, and describes the data elements issuers are required to submit when the annual cost-sharing reduction reconciliation process begins in April 2017.[2]

New for Benefit Year 2016:

- Testing and data submission timeline
- CMS guidance to issuers on how to restate cost-sharing reductions provided for a prior benefit year, and when such restatements are permitted
- CMS policy on outliers
- Frequently Asked Questions published on REGTAP during the 2014/2015 reconciliation cycle are incorporated into this 2016 manual.
- New section on when and how issuers file discrepancies and appeals
- Expanded section on the simplified actuarial value methodology
- Updated guidance on when issuers may estimate the Essential Health Benefit portion of claims
- Updated language on attestations
- Elimination of Attestation D, which is no longer required
- Updated language on technical specifications

CMS requested and received comments from the public on the draft of this manual, and is incorporating clarifications throughout this final version. For restatements of prior benefit year cost-sharing reduction

[1] Pursuant to 45 CFR 156.440, stand-alone dental plans and catastrophic health plans do not participate in the cost-sharing reductions program.
[2] The process for reconciling advanced payments for cost-sharing reductions is set forth at 45 CFR 156.430. Implementing regulations can be accessed at: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ce6315025f0c252a97ad1f092c705f38&r=PART&n=45y1.0.1.2.71#se45.1.156_1430

amounts, issuers should submit a full data file of all cost-sharing reductions provided for the benefit year being restated, including both restated cost-sharing reduction amounts and polices with unchanged cost-sharing reduction amounts that are not being restated. Also in this final manual, we add a data element for premium, which remains optional for the 2016 benefit year reconciliation, update the process to select a methodology, and revise language on discrepancies and appeals to reflect the final 2018 HHS Notice of Benefit and Payment Parameters.[3] Collection of these data elements is approved under OMB control number 0938-1266 and is valid until March 31, 2019.[4] On November 8, 2016, CMS submitted a revision to the collection for public comment and OMB approval, and in response to comment, CMS will retain (02) Plan Summary data elements as optional.[5] Draft technical guidance on actual submission of data is located on the CCIIO website at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#PremiumStabilization%20Programs under the heading of Premium Stabilization and the date of Dec. 5, 2016. CMS may update technical documents as needed. Associated forms may be found at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html#PremiumStabilization%20Programs under the headings of Premium Stabilization and Forms and the date of Dec. 5, 2016.

[3] The information provided in this manual is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This manual summarizes current policy and operations as of the date it was published. Links to certain source documents have been provided for your reference. We encourage interested parties to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them.

[4] See https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10526.html?DLPage=8&DLEntries=10&DLSort=1&DLSortDir=descending

[5] https://www.federalregister.gov/documents/2016/11/08/2016-26875/agency-information-collection-activities-proposed-collection-comment-request

Centers for Medicare & Medicaid Services (CMS)

Guidance Related to Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2016

December 2016

Table of Contents

Background

Reduced Cost Sharing for Eligible Enrollees

The Affordable Care Act requires issuers of qualified health plans (QHPs) to provide reduced cost sharing for essential health benefits (EHB) to eligible Marketplace enrollees. Cost sharing is defined at 45 CFR 155.20 as expenses on behalf of an enrollee for essential health benefits, including deductibles, copays, and coinsurance. Cost sharing does not include premiums, balance billing for out-of-network services, or out-of-pocket expenses for non-covered services. A cost-sharing reduction (CSR) plan is a variation of a standard plan that offers identical benefits and providers as the standard plan, except that the enrollee's out-of-pocket costs for essential health benefits are reduced depending on the consumer's eligibility.[6]

Reduced cost sharing must be available to eligible enrollees who are enrolled in a silver level plan through the Marketplace, or for Indians who are enrolled in any metal level plan through the Marketplace.[7] As set forth at 45 CFR 156.410, the QHP issuer must ensure any individual enrolled through the Marketplace who is eligible for cost-sharing reductions pays only the cost sharing required for the applicable covered service under the plan variation, and, in the case of improper assignment to a plan variation or improper cost sharing, the issuer must correct the plan variation assignment or refund the consumer.

Reconciliation of Advance Payment of Cost-sharing Reductions

QHP issuers are required to notify the Secretary of Health and Human Services of cost-sharing reductions provided on behalf of eligible enrollees. In addition, periodic and timely payments equal to the value of those reductions are required to be made to issuers. Those payments are made in advance.[8] Under the Affordable Care Act and implementing regulations, CMS reconciles the cost-sharing reduction portion of advance payment amounts by comparing what the enrollee in a cost-sharing reduction plan variation paid in cost sharing to what the enrollee would have paid if enrolled in a standard plan. In order to facilitate reconciliation of advance payments of cost-sharing reductions to reflect the amount provided to enrollees in cost-sharing reduction variation plans, issuers must report the amount they paid for each eligible medical claim, the amount enrollees paid for the claims, and the amount of cost sharing that would have been paid for the same services under the corresponding standard plan.[9] CMS uses this information to ensure payments reflect the cost-sharing amounts provided for each policy in a plan variation.

As set forth at 45 CFR 156.410(d)(3), issuers are not reimbursed for any cost-sharing reductions provided to enrollees who were erroneously assigned to a plan variation more generous than the one for which they are eligible. Any cost-sharing reductions, to the extent thereby or otherwise erroneously provided (such as cost-sharing reductions for non-EHB or non-covered services or cost-sharing reductions provided after

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[6] See 45 CFR 156.420(c) on network and service equivalence requirements in silver plans and variants.
[7] Eligible enrollees are defined at 45 CFR 155.305 (*Eligibility standards*), 45 CFR 155.330 (*Eligibility redetermination during a benefit year*), 45 CFR 155.335 (*Annual eligibility redetermination*,) and 45 CFR 155.350 (*Special Eligibility standard and process for Indians*).
[8] *See Generally*, section 1412 of the Affordable Care Act.
[9] The process for reconciling the cost-sharing reduction component of advanced payments is set forth at 45 CFR 156.430. Implementing regulations can be accessed at: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ce6315025f0c252a97ad1f092c705f38&r=PART&n=45y1.0.1.2.71#se45.1.156_1430

a policy has been terminated[10]), must be excluded from the reconciliation process. The only exception is provided under 45 CFR 156.430(f)(3), which permits issuers to seek reimbursement for cost-sharing reductions provided during a retroactive termination in which failure to terminate was not the fault of the QHP issuer, for example, when the QHP issuer receives a late termination notice from the Exchange.[11]

Issuers will not be reimbursed for cost-sharing reductions provided on services or drugs during the second or third months of an expired grace period (REGTAP FAQ 15456)[12] or for newborns who are later not enrolled (REGTAP FAQ 14883).[13] For services that cross benefit years, the issuer should adjudicate CSRs based on the year for which accumulators for the cost-sharing reductions applied (REGTAP FAQs 15454 and 15455).[14]

In the case of third-party non-profit or State subsidies to enrollees in cost-sharing reductions plans, the non-profit subsidy or State wrap subsidy amount should be included when reporting *the amount the enrollee paid*, but should be excluded from the value of cost-sharing reductions provided by the issuer. This reporting requirement is the same for SBM issuers and FFM issuers. Further, CMS expects issuers to adjudicate and re-adjudicate cost-sharing reductions separately from reconciliation of State advance payments for State subsidies that further reduce cost sharing for eligible enrollees in cost-sharing reduction plans, to ensure correct calculation of accumulators and re-adjudication of federal cost-sharing reductions provided.

In the case of claims with coordinated benefits (COB), issuers should apply the COB amounts consistently to standard plans and plan variations. When using either of the methodologies described below, the issuer would reflect adjustments for COB claims when reporting total allowed costs. However, the amount paid by the issuer or by the enrollee would be reduced, as applicable, in both the standard plan and the plan variation by any amounts that have been paid by a third party.[15] Issuers may wait to re-adjudicate complex claims until the complete cost of the benefit has been accounted for; however, in such a case, the issuer must re-state claims for the entire policy, including the complete COB claim, reducing total allowed costs for EHB by the amount paid by another issuer, as applicable, in both the standard plan and the plan variation, to ensure correct re-adjudication of cost-sharing reductions provided for that policy.[16] See CMS guidance below on Restatements of Cost-Sharing Reductions.

Issuers with little or no enrollment in a plan or enrollees with few claims for which cost-sharing reductions were provided may elect to reimburse CMS the full advance payment amount for those plans or policies rather than re-adjudicate such claims. Issuers that wish to return advance payments for all

[10] See 45 CFR 155.430(d)(4)).
[11] https://www.regtap.info/faq_viewu.php?id=15103
[12] https://www.regtap.info/faq_viewu.php?id=15456
[13] https://www.regtap.info/faq_viewu.php?id=14883
[14] https://www.regtap.info/faq_viewu.php?id=15454 and https://www.regtap.info/faq_viewu.php?id=15455
[15] For example, if a claim costs $500, and the auto insurer pays the issuer $250, the total allowed cost for the claim is $250 in both the standard plan and the CSR plan. If the auto issuer also pays the enrollee's $10 cost sharing, the total allowed cost remains the same at $250, of which the issuer pays $240 and the (auto insurer on behalf of the) enrollee paid $10.
[16] See REGTAP FAQ 15462 at https://www.regtap.info/faq_viewu.php?id=15462

plans in a HIOS ID should notify CMS at CSRreconquestions@cms.hhs.gov (REGTAP FAQ 15109 and 15270).[17]

Timing of Reconciliation Process

CMS anticipates that data submission for reconciliation of cost-sharing reductions provided to enrollees in the 2016 benefit year will begin on April 3, 2017. Issuers may include late claims from services provided in the 2016 benefit year as close to the June 2, 2017 data submission deadline as is practical, as long as the issuer recalculates and restates all claims for the associated policy as necessary using CMS methodologies and guidelines prior to a final re-adjudication of such claims for reconciliation.[18] CMS expects issuers to reconcile cost-sharing reductions under a permitted methodology promptly. However, CMS understands that not all claims with cost-sharing reductions provided can be submitted by the data submission deadline for the corresponding benefit year, for example because of coordination of benefits or the complexity of a medical service.

Therefore, consistent with CMS policy,[19] claims incurred in the 2016 benefit year that are not able to be submitted in time for the June 2, 2017 CSR reconciliation data submission deadline[20] for the 2016 benefit year may be submitted in the following year reconciliation cycle (2017 benefit year cycle), whether the reason for the non-submission was because they had not been paid in time, or because the issuer was not able to re-adjudicate the claim in time, or to correct situations in which the amount of cost-sharing provided has changed due to new information that was previously not available to the issuer at the time of CSR reconciliation data submission. Restatements of 2016 benefit year cost-sharing reductions will not be permitted after the 2017 benefit year reconciliation cycle.

Issuers that intend to submit restatements of previous year cost-sharing reductions provided must calculate and submit separate sets of cost-sharing reduction data for the 2016 benefit year and each benefit year that is being restated, by the data submission deadline of June 2, 2017.[21] Restated cost-sharing reduction amounts that are validated by CMS will be aggregated at the issuer level and the resulting payment or charge will be included in an issuer's June 2017 report of 2016 benefit year reconciled amounts.

2015 benefit year restatements: Claims incurred during the 2015 benefit year but which did not result in a final payment and re-adjudication using CMS methodologies by June 3, 2016, may be submitted in a separate file, as stated above.[22] Spring 2017 will be the final opportunity for issuers to restate cost-sharing reductions provided in the 2015 benefit year. Restatements of 2015 benefit year CSR reconciliation data will be submitted in a separate, full data file, according to the technical specifications to be provided by CMS via the CCIIO website, and will include each policy and subscriber ID for which the issuer provided reduced cost sharing in the 2015 benefit year, whether or not the policy is being restated.

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[17] https://www.regtap.info/faq_viewu.php?id=15109 and https://www.regtap.info/faq_viewu.php?id=15270
[18] See https://www.regtap.info/faq_viewu.php?id=14904
[19] See REGTAP FAQs 14904 and 15396
[20] CMS extended the data submission deadline to June in the 2014/2015 reconciliation cycle. See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-on-data-submission-deadlline-for-CSR-reconciliation-Final-4_15_16.pdf
[21] Issuers have until 11:59 p.m. Friday, June 2, 2017 to submit data.
[22] https://www.regtap.info/uploads/library/FT_CSRRecon_FAQClaimsRunOutDate_093015_v1_5CR_100115.pdf

2014 benefit year restatements: The 2014 benefit year reconciliation cycle ended June 3, 2016. CMS is permitting issuers to restate 2014 benefit year cost-sharing reduction reconciliation data only for data omitted because of outstanding appeals or unusual circumstances, as determined by CMS. (REGTAP FAQ 15396) [23] Issuers wishing to restate 2014 cost-sharing reductions data must request an exception by emailing CMS at CSRreconquestions@cms.hhs.gov. Please put "2014 restatement request" in the subject line. Restatements of 2014 benefit year data will be submitted to CMS through a special discrepancy process in the spring of 2017. CMS will provide additional instructions in future guidance.

For complete instructions on the process for restating and reconciling prior benefit year claims, see "Restatements of Cost-Sharing Reductions," on page 29, below.

Timing	Activity
November 2016	Draft Instructional manual and specifications guide published on CMS website for 30 day comment
January 2017	Final manual and specifications published
February 2017	Webinars and training for all issuers
February 2017	Testing begins for all issuers
April 3, 2017	Data submission window opens for benefit year 2016 reconciliation and 2015 restatements
June 2, 2017	Data submission window closes for benefit year 2016 reconciliation and 2015 restatements
June 30, 2017	CMS notifies issuers of reconciled amounts

Methodologies

Issuers may select one of two methodologies—the standard methodology or the simplified methodology—to calculate the value of cost-sharing reductions provided for each enrollee during the benefit year. CMS will compare the amount of cost-sharing reductions provided to eligible enrollees calculated using the applicable method to the amount of payments paid to the issuer for the benefit year.

Under the standard methodology, issuers re-adjudicate the actual complete set of claims incurred by an enrollee in the cost-sharing reduction plan variation as if they had been enrolled in the associated standard plan to determine the difference the enrollee would have paid in deductible payments, copays, coinsurance, and other out-of-pocket expenses for essential health benefits (other than premiums and balance billing). The difference equals the amount of cost-sharing reductions provided by the issuer. All issuers will use the standard methodology for reconciliation of benefit year 2017 claims.[24] (See page 13 for a detailed explanation of the standard methodology).

In response to issuers' concerns that they could not complete their technology updates to accomplish this level of re-adjudication in time for reconciliation, CMS is permitting issuers to use a simplified

[23] See https://www.regtap.info/faq_viewu.php?id=15396 and guidance at https://www.regtap.info/uploads/library/FT_FAQ2014CSRRecon_5CR_081716.pdf
[24] 45 CFR § 156.430(c)(3).

methodology to calculate the value of cost-sharing reduction for claims incurred in benefit years 2014, 2015, and 2016.[25] Under the simplified methodology, issuers first calculate estimated or effective cost-sharing parameters for their standard plans and then apply these to a policy's total allowed EHB claims to determine the value of cost-sharing reductions provided to enrollees. This method may be used only when there are sufficient enrollees in standard plan subgroups to make such calculations sufficiently reliable. (See page 16 for a detailed explanation of the simplified methodology).

If credibility cannot be established, the simplified actuarial value methodology (AV method) must be used.[26] The AV method requires issuers to compare the annual limitation on cost sharing for the standard plan to total allowed EHB claims for the policy to determine the amount of cost-sharing reductions provided. (See page 27 for a detailed explanation of the AV methodology).

Deadline for Selecting a Methodology

Issuers that used the simplified methodology for the 2015 benefit year must notify CMS that they intend to continue to use the simplified methodology or switch to the standard methodology for the 2016 benefit year by completing a web-based form by March 06, 2017. If an issuer does not submit a form, the issuer's methodology will default to the same methodology it used in 2015. Instructions and a link to the form will be announced via REGTAP. Consistent with CMS's goal of encouraging issuers to use the standard methodology, which will be required for all issuers beginning in the 2017 benefit year, and with CMS policy to extend the method selection deadline for the 2014/2015 CSR reconciliation cycle,[27] CMS will permit issuers to switch to the standard methodology for the 2016 benefit year at any time up to four business days prior to the data submission deadline on June 2, 2017. Issuers wishing to update the methodology they have selected after the March 06, 2017 initial methodology selection deadline may do so *in advance of data submission* no later than the close of business May 30, 2017.[28] CMS will provide instructions for updating methodologies during this period.

Under 45 CFR 156.430 (c)(3)(iii), issuers that previously selected the standard methodology may not switch back to the simplified methodology.

Determination of Total Allowed Essential Health Benefits

Issuers must identify allowed EHB claims for reconciliation, since they will not be reimbursed for reductions in out-of-pocket spending for benefits other than EHB Consistent with 45 CFR 156.430(c)(2)(i), CMS will permit issuers to use an alternate method to determine the total allowed EHB for certain plans, including capitated plans, whose cost sharing structure makes it difficult to distinguish between EHB and non-EHB claims without technology upgrades.[29] CMS intends to update the regulation, which governs 2014 and 2015 benefit years only, to reflect this policy in future rulemaking. These plans generally allow out-of-pocket spending for both EHB and non-EHB to accumulate toward deductibles

[25] 45 CFR § 156.430(c)(4).
[26] 45 CFR § 156.430(c)(4)(v).
[27] https://www.regtap.info/uploads/library/APTC_FAQ_2015MethodSelection_031615_5CR_031615.pdf
[28] Since the method selection deadline falls on Memorial Day 2017, CMS will permit issuers to update their methodology selection no later than close of business Tuesday, May 30, 2017, three days prior to the data submission deadline.
[29] See HHS Notice of Benefit and Payment Parameters for 2016, 80 FR 10842, (Feb 27, 2015). https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

and the reduced annual limitation on cost sharing. Issuers may calculate claims amounts attributable to EHB, including cost-sharing amounts attributable to EHB, by reducing total claims amounts for each policy by the plan-specific percentage estimate of non-EHB claims submitted on the Unified Rate Review Template (URRT) [30] for the corresponding benefit year, or use any other reasonable method to determine total allowed costs for EHB (REGTAP 14897).[31] Issuers should apply this percentage adjustment prior to re-adjudicating the policy's claims against the standard plan. To use this exception, issuers must attest that the non-EHB percentage estimate is less than 2 percent. These limitations help assure that the estimated percentage, which is calculated based on the proportion of claims attributable to EHB, does not overstate the proportion of reduced out-of-pocket spending associated with EHB, and that any inaccuracies in the estimate are unlikely to result in significant inaccuracies in total cost-sharing reduction reimbursement.

Identifying reimbursable EHB

Generally, all benefits in an EHB category that were required prior to December 31, 2011 are eligible for cost-sharing reduction reimbursement. Since each State defines EHB within the federal parameters, based on the base benchmark plan that they select, issuers may contact the State Based Exchange (SBE) in their State if applicable or if they are offering plans in an FFM, the State Department of Insurance, for a list of State EHB benchmarks. Additionally, the EHB benchmarks for each State are listed on the CMS website: https://www.cms.gov/cciio/resources/data-resources/ehb.html

Not all State-mandated benefits included in a State's EHB benchmark plan for that State are eligible for federal cost-sharing reduction reimbursement. Issuers may not seek reimbursement for EHB services not allowed under the cost-sharing reduction plan, even when these EHB services are included in a State benchmark plan and subsidized by a State (REGTAP FAQ 14882)**.**[32] Alternatively, some, supplemental EHB benefits such as habilitative services which were added by States to their EHB benchmark plans after Dec, 31, 2011 to meet federal requirements, may be eligible for reimbursement. See description in REGTAP FAQ 15105.[33]

Some non-formulary drugs or State mandates enacted after Dec. 31, 2011 are considered EHB, issuers may refer to REGTAP FAQ 15264 and 15105.[34]

In addition, out-of-network claims are generally not eligible for cost-sharing reductions and do not need to be included in total allowed EHB costs or the amount the issuer paid for EHB. However, if the plan variation provides cost-sharing reductions on covered out-of-network services, they should be included (for example, with the zero cost-sharing plan variation, cost-sharing reductions are required because the enrollee pays no cost sharing for EHB, in-network or out-of-network, as long as the associated standard plan also covers EHB out of network). If the standard plan does not cover EHB out of network, then CMS

[31] https://www.regtap.info/faq_viewu.php?id=14897
[31] https://www.regtap.info/faq_viewu.php?id=14897
[32] https://www.regtap.info/faq_viewu.php?id=14882
[33] https://www.regtap.info/faq_viewu.php?id=15105
[34] https://www.regtap.info/faq_viewu.php?id=15264 and https://www.regtap.info/faq_viewu.php?id=15105

will not reimburse issuers for any cost-sharing reduction provided to an enrollee for such non covered services (REGTAP 15117 and 15119).[35]

Total allowed costs for EHB do not include fees, charges, interest or any other administrative costs for the issuer, unless such fees and charges are included in a plan's benefit design for the standard plan and the plan variations (REGTAP FAQ 15453).[36]

Total allowed costs for EHB must be the same in the plan variation and the standard plan (REGTAP 15573).[37] Total allowed costs should not include claims that are 100 percent covered, such as primary care visits, except in the case of the actuarial value simplified methodology, since the actuarial value of a plan is calculated based on cost sharing for all services (REGTAP FAQ 15876).[38]

Issuer Reporting Requirements (all methodologies)

Issuer Summary Report: For each benefit year, all QHP issuers receiving the cost-sharing reduction portion of advance payments are required to report to CMS the actual value of cost-sharing reductions provided for all enrollees on a unique policy, calculated for each policy using the guidelines above. On the issuer summary report, the QHP issuer will report the total number of subscriber IDs in any plan variation throughout the year for which they are submitting a policy report, the total actual cost-sharing reductions provided to enrollees in all plan variations, and the methodology used to establish claims costs (standard or simplified).

Mergers and Acquisitions: An issuer that merged with or acquired another QHP issuer during the benefit year that selected a different methodology for calculating the value of cost-sharing reductions, must reconcile and report cost-sharing reductions separately, using the applicable methodology, enrollees, and time frame of each of the issuers respectively, under 45 CFR 156.430(c)(3)(iv). Likewise, in the case of a merger or acquisition during a benefit year, each party's cost-sharing reductions provided must be calculated separately using the applicable methodology. In a subsequent benefit year, an issuer that merged with or acquired a QHP issuer that used the simplified methodology may elect to reconcile all its plan variations under either methodology, as allowed under 45 CFR 156.430(c)(3)(ii), up through the 2016 benefit year, after which all issuers must use the standard methodology.

Issuer Attestations

Issuers must attest that cost-sharing reduction amounts represent only EHB cost-sharing for which Federal reimbursement is permitted, excluding certain benefits for which Federal funds may not be used, as described in Section 1303 of the Affordable Care Act and excluding amounts paid by enrollees, but including amounts reimbursed by issuers to fee-for-service providers.[39] If the issuer is estimating non-

[35] https://www.regtap.info/faq_viewu.php?id=15117 and https://www.regtap.info/faq_viewu.php?id=15119
[36] https://www.regtap.info/faq_viewu.php?id=15453
[37] https://www.regtap.info/faq_viewu.php?id=15573
[38] https://www.regtap.info/faq_viewu.php?id=15876
[39] See 45 CFR 156.430(c)(5) *Reimbursement of providers.* In the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid under the standard plan without cost-sharing reductions only to the extent the amount was either payable by the enrollee(s) as cost sharing under the plan variation or was reimbursed to the provider by the QHP issuer.

EHB as a percentage of claims, the issuer must attest that they used a reasonable method to determine total allowed EHB cost and that non-EHB represents less than 2 percent of EHB. As required under 45 CFR 156.430(c)(4)(iii)(E), if the issuer has selected the simplified methodology, the attestation document must include the effective parameters that were used to re-adjudicate claims for each standard plan and a description of how the issuer calculated effective cost-sharing parameters for each applicable subgroup in that standard plan. See Appendices for Attestation Forms A through C. Because many aspects of the claims re-adjudication process involve actuarial estimation or results, attestations must be signed by an actuary or senior company executive capable of financially binding the company. The issuer's actuary may delegate the signature to the chief executive officer or other senior company official capable of financially binding the company as an authorized representative.

The Standard Methodology

The standard methodology at 45 CFR 156.430(c)(2) compares the claim-specific cost-sharing amounts paid for each policy in a plan variation to the amount the eligible enrollee would have paid in the standard plan to determine the value of cost-sharing reductions provided to enrollees.

Issuers using this methodology must re-adjudicate actual claims incurred by each enrollee in a cost-sharing reduction plan as if he or she had been enrolled in the associated standard plan, to determine differences in deductible, copay, coinsurance, and other out-of-pocket expenses. The issuer first processes every claim using the cost-sharing structure of the enrollee's plan variation and then re-processes the claim applying the cost sharing in the corresponding standard plan in order to establish the cost-sharing reduction amount for each allowed EHB claim within a policy. This double adjudication – first to pay the claim and then to determine the claim's cost-sharing amount under the different cost structure of the standard plan – results in a dollar-for-dollar reconciliation of cost-sharing reductions.

In the case of a policy that switches from self-only to other than self-only or vice versa after a change in circumstances, such as marriage or death, and *remains in the same QHP plan variation*, or in the case of other changes of circumstance that result in multiple policies for the same subscriber in the same plan variation during the benefit year, e.g., because of a gap in coverage when the enrollee moved to another plan variation or Medicaid, an issuer using the standard methodology may aggregate the policies into one policy report as long as the issuer calculates cost-sharing reductions provided separately, as necessary, under the appropriate parameters for each policy for the period the policy was in effect. In either case, under 45 CFR 156.425 and CMS guidance (78 FR 15486), published March 11, 2013, accumulators must be carried over in both the plan variation and the associated standard plan, i.e., prior to adjudication, issuers must reduce the new plan variation deductibles by amounts paid into or accumulated in the old plan. Likewise, deductibles and copays in the associated standard plan should be reduced by the non-subsidized amount that would have been paid. For subscribers with multiple policies in the *same plan variation* (i.e., a gap in coverage), issuers should aggregate the policies and file one report under the plan variation using the first and last dates for which the policy was in effect. For example, issuers may report

one 05 plan variation policy record for an enrollee who moved from the 05 variant to 06 and back to the 05 variant. [40]

In the case of a subscriber who *changed plan variations* during the year, issuers must reconcile cost-sharing reductions provided to that subscriber separately for each plan variation, using the applicable subscriber IDs and Start and End dates for each plan variation. In such cases, under 45 CFR 156.425(b) and CMS guidance (78 FR 15486), published March 11, 2013, issuers are required to carry over accumulators when enrollees move back and forth through plan variations and between the issuer and Medicaid during a benefit year. Except for a gap caused by assignment to Medicaid/CHIP coverage, issuers are not required to (but may) carry over accumulators for an enrollee *who dropped coverage or was terminated and later re- enrolled* in the same or different plan variation or standard plan.[41]

We note that when transferring accumulators under 45 CFR 156.425(b), issuers should transfer an enrollee's accumulated cost sharing in the order in which cost sharing is required in the new plan; for example, if the original plan does not have a deductible and the new plan has a deductible, the issuer should first transfer amounts for any type of cost sharing incurred by the consumer in the original plan to the new plan's deductible.[42] CMS encourages issuers that voluntarily transfer accumulators to follow this same process.

Re-adjudication of claims

The goal of the claims re-adjudication process under the standard methodology is to calculate what the enrollee's cost-sharing would have been in a standard plan without cost-sharing reductions. Issuers using the standard methodology must follow HHS guidelines for determining the cost of claims in the standard plan.

Consistent with this goal, on November 17, 2014 HHS published guidance on the re-adjudication of claims which stated that when issuers re-adjudicate allowed costs[43] against the standard plan, issuers using the standard methodology are required to first set all accumulators to zero and then reprocess individual claims for each policy in their original order.[44]

Issuers using a third-party administrator (TPA) – which makes re-adjudication of claims in their natural order complex—may, after setting claims to zero, first adjudicate all medical claims and then all

[40] See also REGTAP 14889 and 15388 regarding when enrollees move between plan variations. Issuers may also file separate reports for multiple policies; see REGTAP FAQ 15387 at https://www.regtap.info/faq_viewu.php?id=14889 and https://www.regtap.info/faq_viewu.php?id=15388 and https://www.regtap.info/faq_viewu.php?id=15387

[41] SEE REGTAP FAQs 14891 at https://www.regtap.info/faq_viewu.php?id=14891

[42] See CMS guidance on Transfer of Accumulated Cost Sharing for Cost-Sharing Reduction Plans at https://www.regtap.info/uploads/library/FT_CSRcarryover_5CR_121616.pdf

[43] Allowed costs refer to the total allowed costs for benefits on a policy.

[44] HHS guidance on the re-adjudication of claims may be found at https://www.regtap.info/uploads/library/APTC_Claims_Readjudication_Guidance_110314_5CR_111714.pdf

pharmaceutical claims in a policy against the standard plan. These issuers may not process claims in any other order other than their original order.

The process described in the November 17, 2014 guidance also applies to TPAs for other subsets of benefits. As applicable, a TPA should first process medical claims, followed by pharmaceutical claims, and then any other subset of benefits, for example vision, dental, and substance use disorder benefits.[45] These additional categories of claims should be re-adjudicated in the order that best approximates the natural order in which they were incurred, so that, for example, if a preponderance of vision claims pre-date claims for dental care, the vision claims group should be re-adjudicated before the dental claims.

Finally, to ensure consistency for all enrollees from the claims re-adjudication process, when re-adjudicating claims under the standard methodology, issuers must re-adjudicate all of the enrollee's claims against a standard plan's total allowed costs and then determine the amount of cost sharing for EHB, rather than re-adjudicate cost sharing solely for EHB claims.

As stated above, issuers must first set accumulators to zero when re-calculating claims from multiple sources; however, 45 CFR146.425(b) and State laws that require issuers to carry over the policy holder's accumulators, if any, would continue to apply. [46] *Carryovers also must be reflected at the non-subsidized level in the standard plan to accurately determine how much the enrollee would have paid in the standard plan.*

CMS recognizes that claims processing is complex. Issuers handling complex circumstances should apply reasonable rules consistently and in such a way that the reconciliation calculation best captures the difference between the cost sharing that was required of the enrollee and the cost sharing that would have been required under the standard plan.

Fee-for-service plans: In the case of plans that compensate the applicable providers in whole or in part on a fee-for-service basis, cost-sharing reduction amounts recoverable do not include amounts of cost-sharing reductions that are not reimbursed to providers.[47]

Fully capitated plans or capitated pay arrangements within fee-for-service plans: The cost-sharing reduction amount is the difference between the out-of-pocket spending for essential health benefits the enrollee paid in the cost-sharing reduction variation and what the enrollee would have paid in the standard plan.

Zero cost-sharing and limited cost-sharing Qualified Health Plans: For each of its health plans at any level of coverage that an issuer offers, the issuer must submit a zero cost-sharing and limited cost-sharing plan variation.[48] Issuers are required to provide cost sharing reductions for in-network EHB and, provided the

[45] HHS guidance on third-party administration of additional benefit groups may be found at https://www.regtap.info/uploads/library/FT_CSR_FAQStandardMethodReadjudication_5CR__082415.pdf

[46] For example: Enrollee paid $500 toward a $1,000 deductible and, as required by State law, starts a new benefit year with $500 deductible rather than a $1,000 deductible. Issuer would still set accumulators to zero when re-adjudicating, but for this policy, the deductible would be met at $500 rather than the plan's original $1,000.
[47] See 45 CFR 156.430(d)(1).
[48] See 45 CFR 156.420(b).

standard plan covers it, for out-of-network EHB. [49] If the standard plan does not cover out-of-network EHB, the issuer should not reduce cost sharing for out-of-network EHB. As discussed in QHP Webinar Series FAQs #84 (April 25, 2013), this policy also applies to out-of-network EHB obtained from the Indian Health Service, Tribal or Urban Indian providers, collectively ITU providers. [50] Non-covered services or balance billing for covered out-of-network EHB are not included in the definition of cost sharing; therefore, issuers will not be reimbursed for any cost-sharing reduction on non-covered services or providers or balance billing.

Qualified Health Plans other than zero cost-sharing and limited cost-sharing plans: Issuers are not required to reduce cost sharing for covered out-of-network EHB in silver plan variations. However, a QHP *may* reduce cost sharing for covered out-of-network EHB to simplify plan design. If the issuer reduces cost sharing in this circumstance, it should include these out-of-network EHB claims when calculating cost-sharing reductions provided. [51]

In situations where the standard plan cost sharing is less than the cost-sharing reduction amount paid by the enrollee, issuers should enter a negative number for "CSR Provided" at the (03) Policy Detail Record. In the rare event that the standard methodology calculation of what enrollees would have paid in the standard plan suggests a negative amount of cost-sharing reductions was provided to all members across a plan variation, CMS will not subtract that amount from advance payments for cost-sharing reductions (REGTAP FAQ 15269)**.**[52]

The Simplified Methodology

In contrast to the claim-by-claim comparison that is used for the standard methodology, the simplified methodology (45 CFR 156.430(c)(4)) provides a way for issuers to compare the sum of all EHB claims incurred for a plan variation policy to the expected cost for the same claims in the standard plan.

When using the simplified methodology, issuers calculate the amount the enrollee would have paid under the standard plan by developing and then applying "effective" cost-sharing parameters for the standard plan to the total allowed costs for EHB for each plan variation policy. First, issuers must develop between two to six estimated or effective cost-sharing parameters for the standard plan using calculations provided by CMS.[53] These estimated or effective cost parameters are calculated based on the average claims experience of enrollees in the standard plan and its subgroups, if any. Then, issuers use CMS-developed mathematical formulas A, B, or C, to apply these cost-sharing parameters to the total allowed

[49] See Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, final rule, 78 FR 65074 (Oct. 30, 2013).
[50] Enrollee spending for non-covered services is not considered cost sharing. As a result, if a QHP does not cover certain services, (or all services) furnished by a provider outside the network, the spending for these non-covered services would not need to be eliminated for the zero or limited cost sharing plans, even if the service was furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization.
[51] See 78 FR 15481 (March 11, 2013) for discussion of 156.130(c) requirement that out-of-network cost sharing may not count toward the annual limitation or reduced annual limitation on cost sharing.
[52] https://www.regtap.info/faq_viewu.php?id=1526
[53] The following effective cost-parameters must be calculated for standard plan subgroups: Average deductible; Effective deductible; Effective pre-deductible coinsurance rate; Effective post-deductible coinsurance rate; Effective non-deductible cost sharing; and Effective claims ceiling.

cost for EHB claims for each policy or policy subgroup in a cost-sharing reduction plan variation to determine what the total cost sharing amount for these claims in the standard plan.[54]

Subgroups refer to the separate or different benefits provided within each plan, or populations under the plan. For example, one standard plan may have different out-of-pocket deductibles for individuals and families, and may also require enrollees in both groups to pay a $1,500 out-of-pocket deductible for medical benefits and a $250 deductible for pharmacy benefits. Such a standard plan would have four subgroups and require four sets of effective cost-sharing parameters.

- Individual (self-only) medical
- Individual (self-only) pharmacy
- Enrollment group (other than self-only) medical
- Enrollment group (other than self-only) pharmacy

If the plan has a combined deductible for medical and pharmacy claims, but different deductibles for individuals and families, the issuer would need to develop effective parameters for two standard plan subgroups:

- Individual (self-only) combined medical and pharmacy
- Enrollment group (other than self-only) combined medical and pharmacy

Each subgroup of the standard plan must have an adequate number of enrollee member months with a certain claims set in order for the estimated cost-sharing parameters under the simplified methodology to be credible. As set forth at 45 CFR 156.430(c)(4)(v), each of these standard plan subgroups must have enrollment of at least 12,000 member-month per benefit year with in-network EHB claims that are above the standard plan's effective deductible but below the annual limitation on cost sharing.[55] Therefore, it is possible for subgroups to meet or exceed 12,000 member months of enrollment but fall short of the claims set needed to conduct the analysis. (Because they lack sufficient in-network EHB claims above the standard plan's effective deductible but below the annual limitation on cost sharing.)

If a plan does meet the threshold for each subgroup, the issuer must use the following estimated standard plan parameters in one of three CMS formulas (A, B, or C) to calculate cost-sharing reductions provided: the effective deductible, the effective pre-deductible coinsurance rate, the effective post-deductible coinsurance rate, and the effective claims ceiling.

If any subgroup of the standard plan does not meet the credibility threshold, the issuer must use the simplified actuarial value methodology to establish costs for all subgroups of the standard plan. (See page 27.)

If a standard plan and its subgroups meets the membership credibility standard, but its benefit design does not require members to meet a deductible, meaning there are no claims in which the issuer can calculate

[54] For description of formulas A, B and C, see 45 CFR 156.430(c)(4)(i)(A-C)).
[55] Refers to plans with at least 80 percent of total allowed costs for EHB subject to a deductible. HMO-like plans use different claims sets.

the effective deductible and other parameters required for the simplified methodology, the issuer should use the simplified actuarial value methodology (REGTAP FAQ 15809).[56]

Definition of Member Months for the Credibility Threshold

As specified in the Program Integrity, Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 final rule, (78 FR 65098, Oct. 30, 2013), CMS requires issuers to have at least 12,000 member months in each of the subcategories of the standard plan for the entire benefit year to meet the credibility threshold for the simplified methodology.

QHP issuers must count both on and off-Marketplace members of a standard plan (that is, enrollees in the standard plan that purchase the plan through the Marketplace or directly from the issuer) when determining whether the standard plan meets the credibility standard.

2014 Benefit Year Credibility Threshold: To account for a delayed start to some enrollments in 2014, for the purpose of establishing the 12,000 member month credibility threshold for a standard plan or its subgroups, issuers may include enrollees who applied or tried to apply by March 31, 2014, but whose enrollments may not have been effective until May 30, 2014, as long as these enrollees remained in the plan until December 31, 2014. [57]

2015 Benefit Year Credibility Threshold: For the purpose of establishing the 12,000 member month credibility threshold for a standard plan or its subgroups for the 2015 benefit year, issuers may include enrollees who applied to the plan no later than February 22, 2015 and remained in the plan until the end of the benefit year on December 31, 2015. This time period allows issuers to include all individuals with coverage start dates on or before April 1, 2015, including those who applied by the February 15, 2015 open enrollment deadline and those who received a special enrollment period allowing them to apply by February 22, 2015. [58]

2016 Benefit Year Credibility Threshold: For the purpose of establishing the 12,000 member month credibility threshold for a standard plan or its subgroups for the 2016 benefit year, issuers may include enrollees who applied to the plan no later than January 31, 2016, and remained in the plan until the end of the benefit year on December 31, 2016.

Using the Simplified Methodology

Issuers using the simplified methodology must first determine how many subgroups are in the standard plan, and then determine whether each of these subgroups has at least the minimum member month enrollment. Issuers then calculate the first two effective cost-sharing parameters of the standard plan for each subgroup, and sort the policies in each subgroup by utilization to determine whether there are enough member months with claims that can be analyzed using this method. (Each subgroup would need claims for the benefit year that were incurred after the effective deductible (for the subgroup) but with in-network cost sharing that is less than the annual limitation on cost sharing.) Issuers then calculate the

[56] https://www.regtap.info/faq_viewu.php?id=15809
[57] See https://www.regtap.info/uploads/library/APTC_FAQ_CSRRecon_MemberMnths_5CR_011315.pdf
[58] See https://www.regtap.info/uploads/library/APTC_FAQ_CSRRecon_Methodology_5CR_040215.pdf

remaining effective parameters, and use the CMS-provided formula appropriate to the claims set for each policy or policy subgroup to calculate the value of cost-sharing reductions provided for that policy.

CMS issued guidance and provided examples of the simplified methodology, "Cost-Sharing Reductions Simplified Methodology Updated Examples," on March 11, 2014.[59]

We expand on that guidance below.

To use the simplified methodology, follow these five steps:

- **Step One:** Determine how many subgroups are in the standard plan (or its variation) for which the issuer must calculate separate cost-sharing parameters. For example, if the standard plan has separate parameters for self-only and for other than self-only, it would have at least two subgroups. If the plan also has separate medical and pharmacy deductibles, the plan would need to develop sets of cost-sharing parameters based on costs for enrollees in a total of four subgroups: self-only medical, self-only pharmacy, other than self-only medical and other than self-only pharmacy. For plans with separate medical and pharmaceutical deductibles but a combined annual limitation on cost sharing, issuers should develop separate effective cost sharing parameters for the medical and pharmaceutical claims. However, the total amount of cost sharing estimated under the standard plan for any policy must be limited to the combined annual limitation on cost sharing (REGTAP FAQ 15451).[60] (Note: The standard plan variation differs from the standard plan only in cost sharing; if a plan variation has no enrollees in a subgroup, issuers would not need to include this subgroup in its calculations on standard plan enrollees.)
- **Step Two:** Determine if one or more subgroups has a plan design similar to an HMO, in which 80 percent or more of total allowed costs for EHB is not subject to a deductible. For a plan or any portion of a plan with 80 percent of total allowed cost for EHB not subject to a deductible, issuers must use the separate calculation for such plans at 45 CFR 156.430(c)(4)(vi) and described on page 25, below.
- **Step Three:** For plan designs with 20 percent or more of total allowed costs for EHB that is subject to a deductible, calculate the number of enrollees (member months) in each subgroup in the standard plan. For this part of the credibility threshold test, issuers must have at least 12,000 member months in the standard plan subgroup for the entire benefit year. If one or more subgroup fails to meet the minimum 12,000-member month threshold, the issuer should proceed immediately to use the simplified actuarial value methodology. Otherwise, the issuer proceeds with this method to determine if the plan meets the credibility threshold for certain claims sets. [61] For the definition of credibility threshold, see page 18.
- **Step Four:** For all standard plans whose subgroups meet the 12,000 member month minimum, calculate the first two effective parameters (average and effective deductibles) for each subgroup

[59] See https://www.regtap.info/uploads/library/APTC_CSRSimpleMethodUpdate_5CR_031114.pdf and https://www.regtap.info/uploads/library/APTC_CSRSimpleMethodExample_5CR_031114.xlsx

[60] https://www.regtap.info/faq_viewu.php?id=15451

[61] Issuers may also sort allowed in-network EHB claims at this stage to assess whether the volume of claims is enough to make performing the calculations worthwhile.

using the instructions below. Next, sort policies in each standard plan subgroup into the following groups: policies with total allowed EHB claims less than/equal to the newly calculated effective deductible; policies above the effective deductible but for which in-network cost sharing is below the annual limitation of the standard plan, and policies with in-network cost sharing that is greater than/equal to the annual limitation on cost sharing. Determine whether for each standard plan subgroup there are at least 12,000 member months with claims incurred after the effective deductible for that subgroup but for which associated in-network cost sharing is below the annual limitation on cost sharing for the standard plan. If there are at least 12,000 member months with such claims in each subgroup, calculate the remaining effective parameters. For calculation of parameters, see below.

- **Step Five:** Select the CMS formula (A, B, and/or C) appropriate to the total claims of each subgroup in a policy. Using the formula for each subgroup, apply the effective parameters appropriate to the subgroup to the total allowed essential health benefits to find out what the policy holder would have paid for these same services in the standard plan. The value of cost-sharing reductions provided by the issuer for this policy is equal to the sum of amounts calculated for each subgroup on the policy, minus the cost sharing that the enrollee actually paid under the plan variation. For formulas see page 24.

Issuers whose plans meet the credibility threshold for the simplified method - with more than 12,000 member months in all subgroups, and 12,000 member months of claims falling after the effective deductible but before the annual limitation on cost sharing - would develop and submit effective cost-sharing parameters only for subgroups with actual enrollees in the plan variation. For instance, if a plan has separate self-only and other than self-only cost-sharing parameters, but all the plan variation's subscribers were enrolled in self-only coverage during the benefit year, the issuer does not need to calculate or report parameters for the other than self-only option.

In the case of a policy that switches from self-only to other than self-only or vice versa after a change in circumstances, such as marriage or death, and remains in the same QHP plan variation, an issuer may aggregate the two policies into one report if the issuer calculates separate effective cost-sharing parameters for self-only coverage and other than self-only coverage for the plan variation. In such a case, when a plan variation policy is self-only for part of the year, and then becomes other than self-only (or vice versa), the issuer should apply the set of effective cost-sharing parameters (or the AV method, one minus the actuarial value of the standard plan) for the type of coverage for which the plan variation policy was for the greatest number of coverage months. If the type of coverage of the policy was evenly split, the QHP issuer should default to the other than self-only coverage effective cost-sharing parameters. See FAQ 11901 (August 8, 2015). [62] Note: Issuers may aggregate policy reports after a change in circumstance regardless of whether the issuer calculates separate effective cost-sharing parameters for self-only coverage and other than self-only coverage (REGTAP 15390).[63]

[62] https://www.regtap.info/faq_viewu.php?id=11901
[63] https://www.regtap.info/faq_viewu.php?id=15390

For subscribers with multiple policies in the same plan variation (i.e., a gap in coverage), issuers should aggregate the policies and file one report under the plan variation using the first and last dates for which the policy was in effect.

In the case of a subscriber who changed plan variations during the year, issuers must reconcile cost-sharing reductions provided to that subscriber separately for each plan variation, using the applicable Start and End dates for each plan variation.[64]

CMS policy on carrying over accumulators when an enrollee switches to a new plan variation, or from a standard plan to a variation and back and forth to Medicaid must be followed for the simplified methodology as well as the standard methodology. In all cases, the deductible amount in the new plan must be reduced by the amount paid toward deductibles and co-pays in the old plan variation and by the amount that would have been paid toward deductibles and co-pays in the associated standard plan, prior to adjudication and re-adjudication, as required under 45 CFR 156.425.

We note that when transferring accumulators under 45 CFR 156.425(b), issuers should transfer an enrollee's accumulated cost sharing in the order in which cost sharing is required in the new plan; for example, if the original plan does not have a deductible and the new plan has a deductible, the issuer should first transfer amounts for any type of cost sharing incurred by the consumer in the original plan to the new plan's deductible.[65] CMS encourages issuers that voluntarily transfer accumulators to follow this same process.

Finally, we note that plans that use a capitated pay arrangement for certain specialty providers would follow the steps on page 25 for reconciling HMO-like plans for these provider claims, and add the result to the amount calculated in step 5, above, to obtain total cost-sharing reduction provided for the plan variation.

Calculation of Parameters for the Simplified Methodology

Average Deductible: For standard plans with only one deductible, the average deductible is that deductible. If a subgroup (self-only or other than self-only, etc.,) of the standard plan has more than one deductible, e.g. separate deductibles for in-network and out-of-network claims, the average deductible is the weighted average of the deductibles, that is, weighted by the allowed costs for EHB under the standard plan that are subject to each separate deductible. Exclude any service not subject to a deductible.

Using the example in the March 14 guidance, because the standard plan had separate deductibles for in-network and out-of-network claims, the average deductible would weighted by allowed costs for EHB

[64] Under 45 CFR 156.425(b) and CMS guidance (78 FR 15486), published March 11, 2013, issuers are required to carry over accumulators when enrollees move back and forth through plan variations and between the issuer and Medicaid during a benefit year. Except for a gap caused by assignment to Medicaid/CHIP coverage, issuers are not required to carry over accumulators for an enrollee who dropped coverage or was terminated and later re- enrolled in the same or different plan variation or standard plan.

[65] See CMS guidance on Transfer of Accumulated Cost Sharing for Cost-Sharing Reduction plans at https://www.regtap.info/uploads/library/FT_CSRcarryover_5CR_121616.pdf

under the standard plan that are subject to each separate deductible, excluding services that are not subject to any deductible.

In the "Standard Plan Example 1" tab of the appendix spreadsheet: (($1000*0.884+$2000*0.105)/0.989) = $1,107 (or cells (A2*N13/N10+A3*N16/N10)/((N13+N16)/N10).

This calculation is performed on all claims in the subgroup.

- Allowed costs for EHB for this calculation includes in-network and out-of-network EHB when both accumulate to the deductible.
- The Average Deductible refers to the average of in-network and out-of-network deductibles, weighted by the allowed costs for EHB subject to those deductibles.
- Average Deductible in a group plan is calculated on the other than self-only deductible: the simplified methodology does not account for embedded deductibles for individuals so these embedded deductibles should be ignored for the purpose of this analysis.

Effective Deductible: This is the sum of the Average Deductible (above) and the *average* total allowed costs for EHB that are *not* subject to any deductible for the standard plan for the benefit year.

The average total allowed costs for EHB that are not subject to any deductible must be calculated based only on standard plan policies with total allowed costs for EHB that are above the Average Deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

The QHP issuer must calculate the average total allowed costs for EHB for Group 1 policies that are not subject to any deductible. In the example, this amount is $114 (see cell O11 in the "Standard Plan Example 1" tab of the appendix spreadsheet.)

The effective deductible is equal to the sum of the average deductible and average total allowed costs for EHB that are not subject to any deductible, or in the example: [66]

$1,107 + $114 = $1,221

QHP issuers should only consider associated out-of-network cost sharing when determining whether or not the cost sharing incurred under a policy is less than the annual limitation if the issuer counts out-of-network cost sharing toward the annual limitation as allowed under 45 CFR 156.130(c).

Services that are not subject to a deductible, even if these services require co pays and coinsurance, may not be included in the calculation of the average deductible used in the Effective Deductible equation, above. If services are subject to a deductible to a limited extent, for example, after a set number of copays, such services may be included in the weighted average of the Effective Deductible. The weighted average of the Effective Deductible would be weighted by the allowed costs for EHB under the standard plan that are subject to each separate deductible – those with a limited deductible and those with no deductible.

[66] The average deductible is the weighted average of the deductibles, weighted by allowed costs for EHB under the standard plan for the benefit year that are subject to each separate deductible.

Classification of Policies

The remaining four effective cost-sharing parameter calculations and formulas are performed on certain claims sets; therefore, issuers must classify standard plan subgroup policies by utilization (establish the remaining claims sets) to use them.

The claims sets are:

- Policies with in-network cost sharing that is greater than or equal to the annual limitation on cost sharing (used in Formula C, below);
- Policies with total allowed costs for EHB that are less than or equal to the effective deductible;
- Policies with total allowed costs for EHB that are above the effective deductible, but for which associated in-network cost sharing is less than the annual limitation on cost sharing.

***Effective Pre-deductible Coinsurance Rate**:*

This rate must be calculated using only the standard plan policies with total allowed costs for EHB that are less than or equal to the Effective Deductible.

This rate is the proportion of the total allowed costs for EHB under the standard plan for the benefit year incurred for those standard plan (subgroup) enrollees and payable as cost sharing (including co pays and coinsurance on services not subject to the deductible).

In the example, the Effective Pre-Deductible Coinsurance Rate is:

567/630 = 90% (cells P20/P10 in the "Standard Plan Example 1" appendix spreadsheet)

***Effective Post-deductible Coinsurance Rate**:*

This rate must be calculated using only the subset of claims (cost data) from standard plan policies that have total allowed costs for EHB that are above the effective deductible, but for which associated cost sharing is less than the annual limitation on cost sharing.

This is the quotient of the portion of average EHB claims subject to a deductible during the benefit year and paid by enrollees as cost sharing other than through a deductible, over the average EHB costs subject to a deductible minus the average deductible. The calculation is provided in the formula below.

$$\text{Effective Post-Deductible Coinsurance rate} = \frac{\text{Average cost sharing other than deductible, for costs subject to a deductible}}{\text{Average EHB allowed costs subject to a deductible} — \text{Average Deductible}}$$

Using the same example, the Effective Post-Deductible Coinsurance Rate is:

425/(4250-1107) = 14% (cells (Q15+Q18)/(Q13+Q16-K2) in the "Standard Plan Example 1" tab of the appendix spreadsheet)

Effective non-deductible cost-sharing:

This amount equals the average portion of total allowed costs for EHB that are *not subject to any deductible* for the standard plan incurred for standard plan enrollees and payable by the enrollees as cost sharing.

This amount must be based only on policies in the standard plan with total allowed costs for EHB that are above the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

In the example provided, the effective non-deductible cost sharing is $9 (or Q12 in the "Standard Plan Example 1" tab of the appendix spreadsheet).

Effective claims ceiling:

This is the average amount of total allowed claims for a policy that results in cost sharing by an enrollee that meets the annual limitation on cost sharing. The calculation is provided in the formula below.

Effective claims ceiling =

The Effective Deductible +

$$\frac{\text{Annual limitation on cost sharing — average deductible} - \text{Effective non-deductible cost sharing}}{\text{Effective post-deductible coinsurance rate}}$$

In the example provided, the effective claims ceiling is equal to ($1,221 + (($6,350-$1,107-$9)/0.14)) = $39,935 (cells K3 + ($6,350 – K2 – K6)/K5))

Formulas to Calculate the Value of Cost Sharing in the Standard Plan

For each subgroup in a policy, use the formula appropriate to the claims set to establish what the enrollee would have paid in the standard plan and then calculate the value of cost-sharing reductions provided for that subgroup. (Further, issuers must use the subgroup's particular effective parameters when applying effective parameters under the formula. The last step is to add results from each subgroup calculation to determine the cost-sharing reductions provided for the policy.) (As discussed in, "Using the Simplified Methodology," above, the value of cost-sharing reductions provided is the amount the enrollee would have paid in the standard plan minus what the enrollee did pay.)

Use Formula A for *plan variation policies with total allowed costs for EHB that are less than or equal to the effective deductible*)

- The amount that the enrollees would have paid under the standard plan is equal to the total allowed cost for EHB under the policy for the benefit year multiplied by the effective pre-deductible coinsurance rate.

Use *Formula B* f*or plan variation policies with total allowed costs for EHB that are greater than the effective deductible but less than the effective claims ceiling:*

- The amount that the enrollees would have paid under the standard plan is equal to the sum of (x) the average deductible, plus (y) the effective non-deductible cost sharing, plus (z) the difference, if positive, between the total allowed costs under the policy for the benefit year for EHB that are subject to a deductible and the average deductible, multiplied by the effective post–deductible coinsurance rate.

Use *Formula C* *for plan variation policies with total allowed costs for EHB that are greater than or equal to the effective claims ceiling*

- The amount that the enrollees would have paid under the standard plan is equal to the annual limitation on cost sharing for the standard plan (as defined at 45 CFR 156.400), or, at the QHP issuer's election, on a policy by policy basis, the amount calculated pursuant to the standard methodology. (The option to use the standard methodology here allows issuers to recoup cost-sharing reductions provided to enrollees who incurred a significant amount of services from out-of-network providers for which enrollee cost sharing was payable even after reaching the annual limitation on cost sharing.)

The Simplified Methodology for HMO-like Plans[67]

Calculation of Parameters

The effective cost-sharing parameters below are for HMO-like plans or plans with HMO-like characteristics in certain specialties, for example when standard plans have a capitated model for transplant care. Issuers must follow the process provided at 45 CFR 156.430(c)(4)(vi) to calculate sets of parameters when more than 80 percent of a plan's total allowed costs for EHB is not subject to a deductible. Use the identical Steps 1 and 2 as described above for the simplified methodology on page 19 to determine how many sets of subgroups of effective cost-sharing parameters to calculate, and confirm whether for each subgroup, more than 80 percent of the plan's total EHB is not subject to a deductible. Then:

- **Step 3:** Calculate parameters for the standard plan. Issuers of HMO-like plans calculate only two parameters because for each subgroup of an HMO-like plan, the average deductible, the effective

[67] For the purpose of cost-sharing reduction reconciliation, an HMO-like plan is a plan or a provider pay arrangement within a plan in which 80 percent or more of total allowed costs for essential health benefits is not subject to a deductible.

non-deductible cost sharing, and the effective deductible will each equal zero, and the effective pre-deductible coinsurance rate is the same as the effective post-deductible insurance rate.

- **Step 4:** After calculating parameters, issuers must verify that each standard plan subgroup contains at least 12,000 member months in the standard plan in and out of the Exchange. Unlike other plan designs, HMO-like plans in which more than 80 percent of total allowed costs for EHB is not subject to a deductible are not required to meet the standard for claims above the effective deductible and below the annual limitation, since most claims will be at or near the annual limitation. Plans with insufficient member months in one or more subgroup must use the alternate simplified actuarial value methodology.
- **Step 5:** Select the CMS formula (A, B, and/or C) appropriate to the total claims of each and every subgroup in a policy. Use the appropriate formula to calculate for each policy subgroup that requires separate parameters the amount enrollees in the cost-sharing variation would have paid in the standard HMO plan. The value of cost-sharing reductions provided by the issuer is equal to the sum of amounts calculated for each subgroup on the policy, minus the cost sharing that the enrollee actually paid under the plan variation. *Issuers of HMO-like plans use Formulas A and C in these calculations.* See formulas on page 24.

Calculations for HMO-like Plans:

Average deductible = 0

Effective deductible = 0

Effective non-deductible = 0

Effective (pre and) post-deductible coinsurance rate = *Calculate the effective pre- and post-deductible insurance rate using all standard plan policies for the subgroup with associated cost sharing for EHB that is less than the annual limitation on cost sharing.*

The coinsurance rate(s) is equal to (=) the proportion of the total allowed costs for EHB under the standard plan for the benefit year incurred for standard plan enrollees and payable as cost sharing (including cost sharing payable through a deductible).

Effective Claims Ceiling

The effective claims ceiling is the same as for non-HMO plans; that is, the estimated average amount of total allowed cost for EHB for a policy that results in enrollee cost sharing that meets the annual limitation on cost sharing. The calculation is provided in the formula below.

Effective claims ceiling =

The Effective Deductible +

$$\frac{\text{Annual limitation on cost sharing} - \text{average deductible}}{\text{Effective non-deductible cost sharing}}$$

Effective post-deductible coinsurance rate

Formulas to Calculate Value of Cost Sharing in the Standard Plan for HMO-like Plans

Calculate the value of cost-sharing reductions provided by applying the effective cost-sharing parameters of the standard plan to the total allowed costs for EHB for the plan variation policy.

HMO-like plans use two of three formulas provided in the simplified methodology to calculate the cost sharing enrollees would have paid in the standard plan. For each policy in a plan variation, use the formula appropriate to the claims set to calculate the value of cost-sharing reductions provided.

For plan variation policies with total allowed costs for EHB for the benefit year that are **less than the effective claims ceiling,** use **Formula A** to calculate the amount the enrollees in the applicable subgroup would have paid under the standard plan.

- The amount that the enrollees would have paid under the standard plan is equal to the total allowed cost for EHB under the policy for the benefit year multiplied by the effective pre-deductible coinsurance rate.

For plan variation policies with total allowed costs for EHB for the benefit year that are **greater than or equal to the effective claims ceiling,** use **Formula C** to calculate the amount the enrollees in the applicable subgroup would have paid under the standard plan**:**

- The amount that the enrollees would have paid under the standard plan is equal to the annual limitation on cost sharing for the standard plan (as defined at 45 CFR 156.400, the particular standard plan's annual limitation), or, at the QHP issuer's election, on a policy by policy basis, the amount calculated pursuant to the standard methodology. (The option to use the standard methodology here allows issuers to recoup cost-sharing reductions provided to enrollees who incurred a significant amount of services from out-of-network providers for which enrollee cost sharing was payable even after reaching the annual limitation on cost sharing.)

Simplified Actuarial Value Methodology (AV method)

Issuers that selected the simplified methodology and whose standard plans lack sufficient enrollment to provide a credible estimate of average claims data must use a methodology derived from the standard plan actuarial value (from the Actuarial Value calculator) to estimate cost sharing under the standard plan. This methodology requires issuers to compare the annual limitation on cost sharing for the standard plan or a CMS calculation using the plan's actuarial value, whichever is less, to total allowed EHB claims for the policy to determine the actual amount of cost-sharing reduction provided. (As discussed in, "Using the Simplified Methodology," above, issuers must subtract the amount an enrollee paid in cost sharing from the amount the enrollee would have paid in the standard plan, here calculated according to the AV method, to obtain cost-sharing reduction provided.)

Under CFR 156.430(c)(4)(v), which sets forth the AV method, the amount enrollees in a plan variation policy would pay under the standard plan is the lesser of the annual limitation on cost sharing for the

standard plan, or the product of (x) one minus the standard plan's actuarial value, as calculated under 45 CFR 156.135, and (y) the total allowed cost for EHB.

The calculation to determine standard plan cost is provided in the formula below.

AV Method to determine Standard Plan Cost Sharing =

The lesser of:

The Annual Limitation of Cost Sharing for the Standard Plan, or,

{(1-AV) * actual allowed cost for EHB for the benefit year

Issuers then determine cost-sharing reductions provided using the formula below:

AV Method to calculate CSR Provided =

Amount the enrollee(s) paid in cost sharing – AV method standard plan cost

Example of the AV Method

The standard plan cost for a 70% AV silver plan with a $14,700 other than self-only maximum annual limitation on cost sharing and actual allowed costs for EHB services of $4,000 is the lesser of $14,700 or (1 - 0.70 = .30 x $4,000 = $1,200), or $1,200.

For a family that paid $600 in cost sharing, cost-sharing reduction provided is $1,200 - $600 = $600

When using this methodology, please note:

- The total allowed costs for EHB include cost-sharing reductions provided for covered out-of-network EHB.
- In the case of capitated or discounted services, issuers that report total allowed costs using their internal pricing mechanisms must ensure that total allowed costs for EHB in the standard plan are the same as total allowed costs in the plan variation (REGTAP FAQ 15573).[68]
- Actuarial value as calculated under 45 CFR 156.135(b)(4), does not include out-of-network costs.

[68] https://www.regtap.info/faq_viewu.php?id=15573

- Issuers must use the in-network annual limitation on cost sharing when a standard plan has separate in-network and out-of-network limitations on cost sharing.
- Issuers must use the other than self-only annual limitation on cost sharing for the standard plan for family plans with embedded individual limits. For single coverage, issuers should use the self-only annual limitation on cost sharing for the standard plan. (REGTAP FAQ 14873).[69]
- Issuers must use the full dollar value of the annual limitation on cost sharing for the standard plan in the equation for the AV methodology even if a member is enrolled for less than the full benefit year (REGTAP FAQ 15452).[70]
- In situations where the standard plan cost sharing is less than the cost-sharing reduction amount paid by the enrollee, issuers should enter a negative number for CSR Provided at the (03) Policy Detail Record. As discussed in the Program Integrity Rule (78 FR 65073, October 30, 2013) in the rare event that the simplified actuarial value methodology calculation of what enrollees would have paid in the standard plan suggests a negative amount of cost-sharing reductions were provided to all members across a plan variation, CMS will not subtract that amount from advance payments for cost-sharing reductions.

Restatements of Cost-Sharing Reductions

To ensure consistent and accurate results for restatements of cost-sharing reductions provided during a benefit year, and because the addition of data on missing or corrected claims may affect amounts of cost-sharing reductions provided for other claims on a policy, CMS is providing issuers this guidance on the restatement process for prior–year cost-sharing reductions. This process also should be used for current-year restatements, as when claims are presented after the issuer has re-adjudicated the policy but before the policy is submitted to CMS.

Notwithstanding any guidance provided below and because issuers reconciled 2014 benefit year cost-sharing reductions in the 2015 benefit-year reconciliation cycle, CMS is permitting issuers to restate 2014 cost-sharing reduction reconciliation data in the data submission cycle for the 2016 benefit year (Spring 2017) only arising from outstanding appeals or unusual circumstances (to be determined by CMS), as stated in REGTAP FAQ 15396.[71]

- A restatement of cost-sharing reductions provided for a benefit year must include all policies for which the issuer provided reduced cost sharing, whether or not cost-sharing reduction amounts for a policy are being amended.
- Issuers should use the current data file format to submit prior year restatements (i.e. 2015 restatement data must be submitted in the same file format as the 2016 data submission). The 2016 benefit year data file is substantially the same as the file format for 2014/2015 benefit years, but does contain differences that will affect the file structure.

[69] https://www.regtap.info/faq_viewu.php?id=14873
[70] https://www.regtap.info/faq_viewu.php?id=15452
[71] https://www.regtap.info/faq_viewu.php?id=15396

- Issuers may submit recalculations of existing policies, and policies that were not reported in the original benefit year CSR reconciliation data submission.
- Cost-sharing reductions are provided to eligible enrollees on a policy basis. As stated in the March 2014 guidance[72] on the re-adjudication of claims, the purpose of re-adjudication is to approximate the experience of the enrollee in the standard plan. Therefore, for each additional claim for which reduced cost sharing was provided, prior to re-calculating the value of cost-sharing reductions provided for any new claim, issuers must adjudicate and re-adjudicate all claims on the policy as applicable, and adjust the standard plan accumulators as applicable, to ensure correct calculation of cost-sharing reductions provided.
- If the new claim is added to a policy that has been aggregated with other policies under one Exchange-assigned subscriber ID, all claims and policies under the Exchange-assigned subscriber ID must be adjudicated and re-adjudicated, as applicable, to ensure proper accounting for accumulators in both the plan variation and standard plan and, finally, accurate calculations of cost-sharing reductions provided.
- For any restatement, when adjudicating and re-adjudicating the new claim and other claims on the policy(s) to determine cost-sharing reductions provided, the issuer must use the same CMS methodology that the issuer selected for the benefit year in which the claim occurred (the methodology used when the policy that is being restated was originally reconciled).
- Issuers must adjudicate the new claim in the order set out in the March 2014 CMS guidance on the re-adjudication of claims subject to cost sharing reductions,[73] (and comply with other claims re-adjudication requirements set forth in CMS guidance).
- If, after re-adjudication of the new claim(s) and associated cost-sharing reductions provided for the claim and subsequent claims or policies for a subscriber, the subscriber is determined to have paid an excess amount of cost sharing (more than what the subscriber would have paid under the restated amount of cost-sharing reductions for the policy), issuers must comply with refund requirements under 45 CFR 156.410(c).
- Restatements of cost-sharing reductions provided in a past year must be submitted in a separate data file and may not be aggregated with current year data. For example, for the 2016 benefit year reconciliation cycle in June 2017, issuers would submit one file of data for 2016 benefit year policies, and a second file of data restating 2015 benefit year cost-sharing reductions provided for policies with additional claims for which the issuer provided reduced cost sharing or additional reduced cost sharing on existing claims, and including claims with no changes in reduced cost sharing. (Issuers should refer to the Technical File Specifications for Submission of Cost-sharing Reduction Reconciliation Data that is published on the CCIIO website for the applicable CSR reconciliation reporting cycle for details on file structure, data elements, and format requirements.)
- Issuers must use the restatement process to claim reimbursements for cost-sharing reductions provided on medical services in a past year even if the claim was not presented or paid until after the year ended. For example, a claim received and paid in 2016 for a medical service provided in

[72] HHS guidance on the re-adjudication of claims may be found at https://www.regtap.info/uploads/library/APTC_Claims_Readjudication_Guidance_110314_5CR_111714.pdf
[73] HHS guidance on the re-adjudication of claims may be found at https://www.regtap.info/uploads/library/APTC_Claims_Readjudication_Guidance_110314_5CR_111714.pdf

2015 should be adjudicated and re-adjudicated with other claims on the 2015 policy, using the policy's 2015 parameters and the issuer's methodology for that plan and submitted as a restatement of 2015 cost-sharing reductions provided (REGTAP FAQ 15457). Such claims may not be re-adjudicated outside the associated policy or added to 2016 benefit year claims.

- Issuers must report the full cost-sharing reduction amount provided for restated policies for the benefit year, not just the incremental amount of cost-sharing reductions provided.
- CMS will permit issuers to file a discrepancy for a restated policy, as long as the restated information differs from the information provided for that policy in previous data and discrepancy submissions. Likewise, CMS will permit issuers to request a reconsideration of a final discrepancy report for restated policies as long as the restated information differs from the information provided in the prior year cost-sharing reduction submission. See appeals and discrepancies, below, on page 37.
- For restatements of cost-sharing reductions provided, CMS will calculate payments and charges to issuers by comparing the cost-sharing reductions provided in the original data submission for the benefit year to the restated amount for the benefit year as submitted by the issuer.

Reporting Requirements

Under 45 CFR 156.430(c)(1)(i)-(iii), Submission of actual amounts, issuers using any methodology are required to report to CMS, for each policy for the benefit year, the total allowed costs for essential health benefits charged for the policy for the benefit year, broken down by the amount the issuer paid, the amount the enrollee paid, and the amount enrollee(s) would have paid for the same benefits under the standard plan without cost-sharing reductions. The processes above provide issuers with dollar amounts they need to establish claims costs for cost-sharing reduction variation plan policies.

Description of reporting vehicles

As discussed in the data collection for cost-sharing reduction reconciliation approved under OMB control number 0938-1266, CMS requires issuers to report cost-sharing reduction reconciliation calculation amounts in an electronic file via the CMS Enterprise File Transfer (EFT) system. Technical specifications of this file will be provided separately. The structure of the file and order of elements is as follows:

Issuer Summary Information**:** Aggregate amounts of EHB claims, amounts paid by policy holders, the issuer, and actual cost-sharing reductions provided for all QHPs under this issuer.

Plan and Policy Information:

- For each plan, a summary, followed by reports for each policy (indicated by Exchange-assigned subscriber ID) under this plan.
- Issuers should list all QHPs with enrollment even if there are no policies with cost-sharing reduction claims for that QHP (enter zero for amounts).
- Issuers using the AV method must report the actuarial value of each standard plan.

CMS requires issuers to complete Attestation Forms listed in the Appendix, as appropriate, for each benefit year, and for any restated benefit year, and to upload attestations on the same timeline for submitting data elements. Instructions for submitting attestations are provided on each Attestation Form. Issuers would provide the following attestations:

- Attestation A: EHB for which Federal cost-sharing reductions are permitted, or—
- Attestation B: For issuers that estimate EHB, an estimate of EHB for which Federal cost-sharing reductions are permitted;
- Attestation C: Effective cost-sharing parameters calculated for the simplified methodology, if applicable. Issuers using the AV method *exclusively* do not complete this form.

Data elements

Issuer Summary Information

- **RECORD CODE:** Record code at the issuer level is always 01**.**
- **TRADING PARTNER ID**: The EDI Trading Partner number assigned.
- **ISSUER STATE CODE**: Enter the 2-letter State code for issuer's State of licensure.
- **HIOS ID**: The five-digit Health Insurance Oversight System (HIOS)–generated Issuer ID number.
- **ISSUER EXTRACT DATE**: Date information extracted by issuer.
- **ISSUER EXTRACT TIME**: Time information extracted by issuer.
- **BENEFIT YEAR**: The calendar benefit year (January to December). For restatements, enter the benefit year for which cost-sharing reductions are being restated.
- **TOTAL NUMBER OF SUBSCRIBER IDs in ALL CSR VARIANT PLANS UNDER THIS HIOS ID:** Count all subscriber IDs associated with a (03) Policy Detail Record in all plan variations for this QHP issuer. For restatement files, this is the total number of (03) Policy Detail Records, including restated policies and policies that are not being restated.
- **TOTAL NUMBER OF CSR VARIANT PLANS UNDER THIS QHP HIOS ID:** Total count of plan variations for the QHP issuer under this HIOS ID. This count should include only plan variations with enrollment, whether or not cost-sharing reductions were provided.
- **TOTAL ACTUAL CSR AMOUNT**: Total cost-sharing reduction amount provided by this QHP issuer to enrollees in all plan variations. For restatement files, this is the CSR amount provided by this QHP issuer to enrollees in all (03) Policy Detail Records, including restated policies and policies that are not being restated.
- **CSR AMOUNT ADVANCED TO THE ISSUER BY THE FEDERAL GOVERNMENT:** Optional. Amount the issuer shows received from the federal government for the benefit year January 1 to December 31. Issuers should include adjustments to advance payments for the applicable benefit year that were received by the closeout of advance payments in the April 2017 payment cycle. For restatements; the issuer should report the total amount of advance payments for the applicable benefit year as of the closeout payment cycle for that benefit year (this amount should match the original data file.)
- **RECONCILIATION METHODOLOGY**: The methodology – standard, simplified, or simplified AV method– previously selected by the issuer or, if applicable, the acquired issuer. Issuers using AV method exclusively must select the simplified AV methodology.
- **ACQUISITION: Y or N.** Has the issuer HIOS ID filing this reconciliation report been acquired by another issuer in the applicable benefit year?

- **ACQUIRING ISSUER**: HIOS ID of the acquiring issuer.
- **ACQUISITION EFFECTIVE DATE:** Date the acquisition was final.
- **MERGER: Y or N.** Has the issuer HIOS ID filing this reconciliation report merged with another issuer in the applicable benefit year?
- **MERGER ISSUER:** HIOS ID of the other issuer(s) party in the merger.
- **MERGER EFFECTIVE DATE:** Date the merger was final.
- **TECHNICAL POINT OF CONTACT First Name:** First name of the issuer's technical point of contact
- **TECHNICAL POINT OF CONTACT Last Name:** Last name of the issuer's technical point of contact
- **TECHNICAL POINT OF CONTACT Email address:** Email address of the issuer's technical point of contact
- **TECHNICAL POINT OF CONTACT Organization:** Organization of the issuer's technical point of contact
- **TECHNICAL POINT OF CONTACT Phone Number:** Phone number of the issuer's technical point of contact
- **BUSINESS POINT OF CONTACT First Name:** First name of the issuer's business point of contact
- **BUSINESS POINT OF CONTACT Last Name:** Last name of the issuer's business point of contact
- **BUSINESS POINT OF CONTACT Email Address:** Email of the issuer's business point of contact
- **BUSINESS POINT OF CONTACT Organization:** Organization of the issuer's business point of contact
- **BUSINESS POINT OF CONTACT Phone Number:** Phone number of the issuer's business point of contact

Plan and Policy Information

Plan Information (OPTIONAL)

- **RECORD CODE:** Record code at the plan level is always 02.
- **QHP PLAN ID:** The 16-digit HIOS-generated qualified health plan identification number. This includes the 14-digit standard plan ID plus the 2-digit variant ID.
- **TOTAL ANNUAL PREMIUM**: Aggregate billed premium for this plan.
- **TOTAL NUMBER OF EXCHANGE SUBCRIBER IDS IN THIS PLAN**: Enter the total count of Exchange subscriber IDs enrolled in this plan variation at any point during the benefit year.
- **TOTAL ALLOWED COSTS FOR EHB**: Aggregate total allowed costs for essential health benefits for all enrollees in this plan. (See, "Determination of Total Allowed Essential Health Benefits," page 10, above). For **Formula B** of the simplified methodology only, this means total allowed costs for EHB, subject to a deductible for the policy. Issuers, including issuers of capitated plans, may use plan-specific percentage estimates of non-EHB claims submitted on the

Unified Rate Review Template (URRT) or any other reasonable method to determine total allowed costs for EHB.

- **TOTAL ACTUAL AMOUNT THE ISSUER PAID FOR EHB**: The amount the issuer paid providers for EHB for all services to enrollees in this plan. This includes cost-sharing reduction reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability.
- **TOTAL ACTUAL AMOUNT PAID FOR EHB BY ENROLLEES**: Total amount all enrollees in this plan paid (or are liable for) in cost sharing for all EHB services.
- **TOTAL ACTUAL AMOUNT FOR EHB ENROLLEES WOULD HAVE PAID IN THE STANDARD PLAN**: The amount the enrollee(s) would have paid for the same claims had he/she/they been enrolled in the standard plan without cost-sharing reductions**.** *For the standard methodology*, dollar amounts entered here must be calculated in accordance with HHS guidance on re-adjudication of claims. Issuers should first equate all claims to zero and adjudicate claims as if the enrollee had been in the standard plan from the beginning of the year. (See discussion of claims re-adjudication on page 14, above.) *For the simplified methodology*, dollar amounts entered here must be calculated in accord with 45 CFR 156.430(c)(4).
- **TOTAL VALUE OF CSR PROVIDED:** The total amount (including restated amounts, if applicable) that all enrollees would have paid under the standard plan, minus the amount the enrollees did pay under the applicable plan variation (and reimbursed to fee-for-service providers, if applicable.) This is the amount that will be subtracted from payment for cost-sharing reductions to the issuer for the benefit year.

Policy Information

- **RECORD CODE:** Record code at the policy level is always 03.
- **EXCHANGE ASSIGNED SUBSCRIBER ID:** The subscriber identification number assigned by the Exchange. Issuers should list the State Based Exchange-assigned subscriber ID if applicable.
- **EXCHANGE ASSIGNED POLICY ID:** Optional. If this is an aggregated policy record, report the current Policy ID Number.
- **EXCHANGE ASSIGNED POLICY START DATE:** Optional. First date the subscriber enrolled in this policy. This is the start date for the most current Policy ID and may be different from the plan start date for this subscriber.
- **EXCHANGE ASSIGNED POLICY END DATE:** Optional. Last date the subscriber was enrolled in this policy.
- **QHP PLAN ID:** The 16-digit HIOS-generated qualified health plan identification number. This includes the 14-digit standard plan ID plus the 2-digit variant ID.
- **PLAN BENEFIT START DATE:** First date the subscriber was enrolled in this plan variation**.** If the issuer is filing more than one policy record for this subscriber, the start date may be different from the Policy Start Date.
- **PLAN BENEFIT END DATE:** Last date the subscriber was enrolled in this plan variation.
- **TOTAL MONTHLY PREMIUM**: Optional. The monthly premium amount billed for this policy. If the policy changed to self-only or other than self-only during the benefit year, or if the monthly premium amount changed during the benefit period as the result of other changes in

circumstance, enter the average monthly premium for this policy over the months in which it was in effect.

- **SELF ONLY/OTHER THAN SELF-ONLY**: For the simplified and simplified actuarial value methodology only, report whether coverage under this policy is self only, or other than self-only.
- **ANNUAL LIMITATION ON COST SHARING FOR THE STANDARD PLAN:** This is the annual limitation on cost sharing for the standard plan associated with this plan variation as reported to CMS for plan certification for the applicable benefit year**.** Required for the simplified and simplified actuarial value methodology only. If the policy is self-only, the annual limitation should be the self-only annual limitation.
- **ACTUARIAL VALUE of the STANDARD PLAN:** This is the actuarial value of the standard plan associated with this plan variation as reported to CMS for plan certification for the applicable benefit year. Required for the simplified actuarial value methodology only.
- **TOTAL ALLOWED COSTS FOR EHB:** Total allowed costs (including restated total allowed costs, if submitted as part of a restatement file) for essential health benefits incurred by the enrollee(s) on this policy. (See, "Determination of Total Allowed Essential Health Benefits," page 10, above). For **Formula B** of the simplified methodology only, this means total allowed costs for EHB, subject to a deductible for the policy**.** Issuers, including issuers of capitated plans, may use plan-specific percentage estimates of non-EHB claims submitted on the Unified Rate Review Template (URRT) or any other reasonable method to determine total allowed costs for EHB. Total allowed costs in the cost-sharing reduction plan variation must be the same as those in the associated standard plan.
- **ACTUAL AMOUNT THE ISSUER PAID FOR EHB:** This is the total dollar amount (including the restated total dollar amount, if submitted as part of a restatement file) the issuer paid to providers for all EHB services to enrollees on this policy. This includes cost-sharing reduction reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability. Note: Because of discounts and amounts paid by other insurers, total actual amounts paid for EHB by the issuer and by enrollees may not equal total allowed costs.
- **ACTUAL AMOUNT THE ENROLLEE(S) PAID FOR EHB:** The amount (including the restated amount, if submitted as part of a restatement file) all enrollees on this policy paid (or are liable for) in cost sharing for all EHB services.
- **ACTUAL AMOUNT THE ENROLLEE(S) WOULD HAVE PAID FOR EHB UNDER THE STANDARD PLAN**: The amount (including the restated amount, if submitted as part of a restatement file) the enrollee(s) would have paid for the same EHB claims had he/she/they been enrolled in the standard plan without cost-sharing reductions**.** *For the standard methodology*, dollar amounts entered here must be calculated in accordance with HHS guidance on re-adjudication of claims. Issuers should first equate all claims to zero and adjudicate claims as if the enrollee had been in the standard plan from the beginning of the year. (See discussion of claims re-adjudication on page 14, above.) *For the simplified methodology*, dollar amounts entered here must be calculated in accord with CFR 156.430(c)(4).
- **CSR PROVIDED:** The CSR Provided amount is the amount (including the restated amount, if submitted as part of a restatement file) enrollees would have paid under the standard plan, minus the amount the enrollees did pay under the applicable plan variation (and reimbursed to fee-for service providers, if applicable.) This is the amount that will be subtracted from payment for cost-sharing reductions to the issuer for the benefit year. *For the simplified actuarial value methodology*, CSR Provided is the amount remaining when actual enrollee EHB cost sharing is subtracted from the lesser of the annual limitation on cost-sharing for the standard plan or the

product of (x) one minus the standard plan's actuarial value, as calculated under 45 CFR 156.135, and (y) the total allowed costs for EHB. *For the simplified methodology*, CSR Provided is the sum of cost-sharing reduction amounts calculated for all subgroups on this policy; for example, if a policy has separate medical and pharmaceutical parameters, actual CSR Provided must be calculated separately and added together.

Data Elements for the Simplified Methodology Effective Parameters Report[74]

Issuers using the simplified methodology, including issuers of HMO-like plans, must list all standard plan subgroups and then report the effective parameters calculated for standard plan subgroups associated with each plan variation subgroup with claims sets in the plan variation, as appropriate. Issuers should use Attestation Form C to report effective parameters and to attest that the issuer applied the correct parameters and correct formula for each subgroup on the policy. Issuers using the AV methodology exclusively do not submit Attestation C.

Payment

Payments to issuers for the cost-sharing reduction component of advance payments began in January 2014. CMS will reconcile payments made to issuers according to the CMS formula for payments, as appropriate, for the particular benefit year, as provided under 45 CFR 156.430(d). Prior to issuing payment or invoices for reconciled data or reconciled restated data, CMS will validate data and perform outlier analysis. The amount of the cost-sharing reduction portion of advance payments to be reconciled is the amount provided to the issuer as of the final adjustment to advance payments for the benefit year. The final adjustment to advance payments for the 2016 benefit year will be made in the April 2017 payment cycle.[75]

Timing of payments and charges: CMS expects to issue a report showing, for validated data, cost-sharing reduction reconciliation payments and charges for the benefit year by June 30, 2017. As provided under 45 CFR 156.430(e), an issuer will be reimbursed any amounts necessary to reflect the cost-sharing reduction provided or, as appropriate, the issuer will be charged for excess amounts paid to it. Charges are subject to netting as appropriate in the next closest monthly payment cycle under 45 CFR 156.1215(b). As noted above, an issuer's annual reconciled amount will be adjusted up or down for validated restatement amounts.

For issuers that elect not to submit reconciliation data because of low enrollment or few claims, CMS will net the full amount of the cost-sharing component of advance payments made to that issuer in the August

[74] **Note**: This information is not required for issuers using the simplified actuarial value methodology. Such issuers should not report any effective parameters calculations they may have performed to determine whether to use the AV method and instead, they should report only the results of the AV method calculation.

[75] See **"**Final adjustment to the 2016 benefit year cost-sharing reduction portion of advance payments," available at https://www.regtap.info/uploads/library/FT_CSRFinalAdjustmentAP_5CR_121616.pdf

payment cycle following the June 30 report, and invoice the issuer for any remaining balance (REGTAP FAQ 15266).[76]

Determination of Outliers

CMS will conduct an analysis on issuer reported valid CSR amounts to determine whether they are within an expected range, based on an analysis of other issuers' submissions and a threshold derived from that analysis. Specifically, CMS will conduct a comparison against other metrics of issuer risk (e.g., risk adjustment and reinsurance data) adjusting for State characteristics (such as, differences in States' premiums in reflection of the CSR amounts provided) to determine if the issuers' reported amounts are within a reasonable range compared to other issuers. CMS will withhold CSR reconciliation payments to all issuers flagged as outliers based on our analysis until the outlier status is sufficiently and reasonably addressed by the issuer with an explanation or data resubmission. Issuers that do not provide such sufficient and reasonable explanation will be subject to CSR reconciliation payment withholding and CMS audits.

Appeals

As set forth in the HHS Notice of Benefit and Payment Parameters for the 2018 Benefit Year final rule, (2018 payment notice) under §156.430(h)(1),[77] issuers may file discrepancies to correct errors that directly affect the calculation of their reconciled cost-sharing reduction amount within 30 days of the date of notification of the results of the reconciliation of the cost-sharing reduction portion of advance payments (for example, subscriber ID errors or errors in calculation of amounts) Under §156.430(h)(2), issuers must have filed a discrepancy, where a discrepancy is identifiable, contesting a cost-sharing reduction reconciled amount (including reconciled restated amounts) for the applicable benefit year in order to appeal this amount under the process set forth in 45 CFR 156.1220. (CMS intends to update deadlines and the discrepancy submission process described in FAQ 16491 in spring 2017).[78]

Under 45 CFR 156.1220(a)(3)(v), as amended in the 2018 payment notice, issuers have 60 calendar days following the date of the notification provided by HHS of the cost-sharing reduction reconciliation discrepancy resolution decision to request a reconsideration to contest a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error of the amount to be paid for cost-sharing reductions for a benefit year.[79] Reconciliation of the cost-sharing reduction portion of advance payments to actual cost-sharing reductions provided by an issuer for a benefit year is the final determination of CSR payments for the benefit year. Therefore, any requests for reconsideration must be

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[76] https://www.regtap.info/faq_viewu.php?id=15266

[77] https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-benefit-and-payment-parameters-for-2018-amendments-to

[78] https://www.regtap.info/faq_viewu.php?id=16491 (Note: CMS intends to update this FAQ for the 2016 benefit year in spring 2017).

[79] See also "Administrative Appeal rights under 45 CFR 156.1220(a)(1)(v) for the Cost-Sharing Reduction Portion of the Advance Payments of the Premium Tax Credits at https://www.regtap.info/uploads/library/FT_CSRAppealsGuidance_5CR_121916.pdf

based on a final determination of the amount of advance payments.[80] For further information on the scope of an appeal, see 45 CFR 156.1220.

As noted in the section on restatements, issuers should only submit discrepancy reports for restated policies for a prior benefit year if the restated cost-sharing reduction amount has changed from the information provided in the prior year cost-sharing reduction submission. Issuers should not submit a discrepancy for a policy if the cost sharing reduction amount reported for that policy has not changed.

Discrepancy Process

After they have been notified of the results of cost-sharing reduction reconciliation, issuers that identify data discrepancies related to QHP ID errors, Exchange subscriber ID errors, or errors related to the amount of cost-sharing reductions that an issuer provided at the policy level, including, for example, flawed issuer calculations or lost data, are permitted to submit data related to their discrepancy in a pipe-delimited file through EFT. CMS will only accept data discrepancies for data that directly impacts the calculation of the issuer's reconciled CSR amounts. As noted above, issuers may file discrepancies within 30 days of the date of notification of the results of the reconciliation of the cost-sharing reduction portion of advance payments.

CMS will publish on the CCIIO website an updated specification document outlining the format of the file, which remains essentially unchanged for 2016. The technical specifications for discrepancy reporting contain many data elements and formatting elements that are identical to the file format used for submission of the CSR reconciliation data file, as well as some elements that are specific to discrepancy reporting. Issuers are only required to submit discrepancy data for policy records that they are disputing.

CMS will review discrepancy submissions and notify issuers of the resolution. If CMS accepts the issuer's discrepancy report for any policy record, CMS will request that the issuer resubmit its entire CSR reconciliation data file, with corrected amounts, as determined through the discrepancy resolution process. Consequently, issuers are strongly encouraged to maintain their most recent data file submission, so that it can be modified and resubmitted, if necessary. If a discrepancy results in a payment or charge adjustment, CMS will make this adjustment in a monthly payment cycle following the decision. Any issuer that does not file a discrepancy for a benefit year will be deemed as accepting their final data submission for CSR reconciliation for that benefit year. (REGTAP FAQ 16491).[81]

Audit and Retention of Records

Under 45 CFR 156.480, issuers are required to adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in §156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with the advance payment of cost-sharing reductions and premium tax credits.

[80] See https://www.regtap.info/uploads/library/FT_CSRFinalAdjustmentAP_5CR_121616.pdf
[81] https://www.regtap.info/faq_viewu.php?id=16491

Issuers must submit to CMS summary statistics on the administration of cost-sharing reduction program, including failure to adhere to any standards set forth under §156.410(a) through (d), §156.425(a) through (b), and §156.460(a) through (c) as required under 45 CFR 156.480 (b). CMS intends to provide instruction on that data submission and seek OMB data collection approval, if applicable, at a later date.

Additionally, as provided under 45 CFR 156.480(c), issuers that offer a QHP in the individual market through an Exchange are subject to audit by HHS or its designee to assess compliance with the relevant requirements regarding cost-sharing reductions.[82]

Definitions

Annual limitation on cost sharing means the annual in-network dollar limit on cost sharing required to be paid by an enrollee that is established by a particular qualified health plan.

Associated standard plan means the standard plan for which a QHP issuer has issued a cost-sharing reduction variation as required by 45 CFR 156.420. The standard plan and plan variations' benefits and cost-sharing structures are identical, but out-of-pocket spending under the standard plan is not reduced.

Cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but exclude premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Enrollee means a qualified individual or qualified employee enrolled in a QHP.

Essential health benefits package or EHB package means the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the ten statutory categories of benefits, as described in 45 CFR 156.110(a); provides the benefits in the manner described in 45 CFR 156.115; limits cost sharing for such coverage as described in 45 CFR 156.130; and subject to offering catastrophic plans

[82] The good faith compliance provision set forth at 45 CFR 156.800(c) for calendar years 2014 and 2015 does not apply to data submitted in the 2016 reporting cycle, even if data submitted is related to coverage provided in the 2015 benefit year (80 FR10843). However, in all our enforcement actions including the authority to impose civil money penalties on issuers that fail to comply with standards for the cost-sharing reduction portion of advance payments in Subpart E, including 45 CFR 156.430, CMS will continue to take into account all facts and circumstances, including the reasonable good faith action of issuers, and that this is the first year of CSR reconciliation.

as described in section 1302(e) of the Affordable Care Act, provides distinct levels of coverage as described in 45 CFR 156.140.

HMO-like plan: For the purposes of cost-sharing reduction reconciliation, a plan or a provider pay arrangement within a plan in which 80 percent or more of total allowed costs for essential health benefits is not subject to a deductible.

Percentage of the total allowed costs of benefits means the anticipated covered medical spending for EHB coverage (as defined in 45 CFR 156.110(a) paid by a health plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

Plan variation means a zero cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation as provided for in 45 CFR 156.420.

Standard plan means a QHP offered at one of the four levels of coverage, defined at 45 CFR 156.140, with an annual limitation on cost sharing that conforms to the requirements of 45 CFR 156.130(a). A standard plan at the bronze, silver, gold, or platinum level of coverage is referred to as a standard bronze plan, a standard silver plan, a standard gold plan, and a standard platinum plan, respectively.

ATTESTATION FORM A: Allowed Costs for Essential Health Benefits

Issuers must attest that cost-sharing reduction amounts provided to enrollees and submitted for reimbursement represent only cost sharing for essential health benefits for which Federal reimbursement is permitted, (in the case of fee-for-service providers, these amounts must have been passed through by the issuer to such providers, pursuant to 45 CFR 156.430(c)(5).)[83] NOTE: Issuers that are estimating essential health benefits must use Form B.

Instructions: Issuer must upload a signed copy of this form to an EFT folder by June 2, 2017. Signatures may simply be typed in the form. Please submit a separate attestation for each benefit year CSR payment was received.

Benefit year: _____

HIOS Issuer ID[84] _____

I certify in my capacity as actuary (or authorized delegate of actuary) of [(Issuer Name)] as indicated below:

- o I have reviewed the information on cost-sharing reduction amounts provided as calculated under the Standard or Simplified Methodology, as applicable, and submitted to the Centers for Medicare & Medicaid Services (CMS). I further certify that to the best of my knowledge, information, and belief, the information provided is accurate and that cost-sharing reduction amounts represent only cost-sharing reductions paid for essential health benefits for which Federal reimbursement is permitted, as described in Section 1303 of the Affordable Care Act, (in the case of fee-for-service providers, these amounts must have been passed through by the issuer to such providers, pursuant to 45 CFR 156.430(c)(5). I understand the information included in this submission is the basis for calculating cost-sharing reduction amounts provided by my organization to eligible enrollees.

Name of the Person Completing this form (Print or Type): Click here to enter text

Title: Click here to enter text

Organization: Click here to enter text

Telephone: Click here to enter text

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[83] See 45 CFR 156.430(c)(5) *Reimbursement of providers.* In the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid under the standard plan without cost-sharing reductions only to the extent the amount was either payable by the enrollee(s) as cost sharing under the plan variation or was reimbursed to the provider by the QHP issuer.

[84] *The five-digit Health Insurance Oversight System (HIOS)-generated issuer ID number*

Email Address: Click here to enter text

Signature: _____ Date: Click here to enter text

ATTESTATION FORM B: Estimate of Allowed Costs for Essential Health Benefits

Issuers that estimate total allowed essential health benefits must submit this form, instead of Form A. Attestation must be provided for each plan for which the issuer uses the plan-specific percentage estimate of non-essential health benefit claims submitted on the Uniform Rate Review Template or other reasonable method for the corresponding benefit year to calculate claims amounts attributable to essential health benefits. An issuer using this procedure is required to do so for all plan variations for which the criteria below are met, and must list each plan on this attestation.

Instructions: Issuer must upload a signed copy of this form to an EFT folder by June 2, 2017. Signatures may simply be typed in the form. Please submit a separate attestation for each benefit year CSR payment was received.

Benefit year: _____

HIOS Issuer ID[85] _____

Qualified Health Plan HIOS ID(s) [86]_____

(List all QHPs for which the issuer has estimated the percentage of essential health benefits for the purpose of calculating cost sharing reductions provided.)

I certify in my capacity as actuary (or authorized delegate of actuary) of [(Issuer Name)] as indicated below:

- o I have reviewed the information on cost-sharing reduction amounts provided as calculated under the Standard or Simplified Methodology, as applicable, and submitted to the Centers for Medicare & Medicaid Services (CMS). I further certify that to the best of my knowledge, information, and belief, the information provided is accurate and that cost-sharing reduction amounts represent only cost-sharing reductions paid for essential health benefits for which Federal reimbursement is permitted, as described in Section 1303 of the Affordable Care Act, (in the case of fee-for-service providers, these amounts must have been passed through by the issuer to such providers, pursuant to 45 CFR 156.430(c)(5).
- o I also certify that to the best of my knowledge, information, and belief, that the non-essential health benefit percentage estimate of total allowed costs for essential health benefits for (insert issuer name) is less than 2 percent, as required by CMS for an issuer to be able to calculate claims amounts attributable to essential health benefits for the purpose of cost-sharing reduction reconciliation using the plan-specific percentage estimate of non-essential health benefit claims

[85] *The five-digit Health Insurance Oversight System (HIOS)-generated issuer ID number*
[86] *The 16-digit HIOS-generated qualified health plan identification number*

submitted on the Uniform Rate Review Template for the corresponding benefit year, or other reasonable method (insert explanation); I understand that the information included in this submission is the basis for calculating cost-sharing reduction amounts provided by my organization to eligible enrollees.

Name of the Person Completing this form (Print or Type): Click here to enter text

Title: Click here to enter text

Organization: Click here to enter text

Telephone: Click here to enter text

Email Address: Click here to enter text

Signature: _____ Date: Click here to enter text

ATTESTATION FORM C: Simplified Methodology Effective Parameters and Formulas

ATTESTATION

Issuers using the simplified methodology must submit data for each standard plan with claims in the corresponding plan variation and attest to the accuracy of the effective cost-sharing parameters calculated for each standard plan and the formulas used in establishing cost-sharing reductions provided.

Actuarial attestation must include a written description by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies of how the issuer calculated the effective parameters for each applicable subgroup of a standard plan, for all plan variations with claims sets for which the issuer provided cost-sharing reductions. (Issuers should provide descriptions of individual standard plan calculations on "Simplified Method Effective Parameters" forms accompanying this attestation signature page.)

Instructions: Issuer must upload a signed copy of this form along with effective parameters reports for each standard plan to an EFT folder by June 2, 2017. Signatures may simply be typed in this form. Please submit a separate attestation and applicable effective parameters forms for each benefit year cost-sharing reduction payments were received.

Benefit Year _____

HIOS Issuer ID[87] _____

[87] *The five-digit Health Insurance Oversight System (HIOS)-generated issuer ID number*

I certify in my capacity as actuary (or authorized delegate of actuary) of [(Issuer Name)] as indicated below:

I have reviewed the information on each Simplified Methodology Effective Parameters Report submitted to the Centers for Medicare & Medicaid Services (CMS) for each standard plan with claims in the corresponding plan variation. I further certify that to the best of my knowledge, information, and belief, the information provided is accurate and that the effective parameters listed for each standard plan are calculated according to the methodology provided at 45 CFR 156.430. I certify that effective parameters have been calculated for all subgroups in each standard plan associated with plan variation subgroups for which this issuer has provided cost-sharing reductions. I certify that for each policy in each plan variation, (insert issuer name) has selected the CMS formula (A, B, and C) appropriate to each policy subgroup claims set and applied the appropriate effective parameters to calculate cost-sharing reductions provided for that policy.

I understand the information included in this submission is the basis for calculating cost-sharing reduction amounts provided by my organization to eligible enrollees.

Name of the Person Completing this form (Print or Type): Click here to enter text

Title: Click here to enter text

Organization: Click here to enter text

Telephone: Click here to enter text

Email Address: Click here to enter text

Signature: _____

Simplified Methodology Effective Parameters Report

Complete one form for each standard plan associated with a plan variation with claims. All issuers must provide a written description and list all subgroups. Fully capitated plans and fee-for-service plans with some capitated pay arrangements for certain subgroups, such as medical other than self-only, should provide parameters in the section of this form that applies to "HMO-like plans or plans with HMO-like payment arrangements."

Issuers also must list any QHPs under this HIOS ID for which the issuer calculated cost-sharing reductions using the simplified actuarial value method (and therefore have no parameters to report) on Tab 3 (Attestation C Count of QHPs using AV Method.)_

Qualified Health Plan ID (Plan Variation(s) [88]_____

[88] *The 16-digit HIOS-generated qualified health plan identification number for the plan variation for which CSRs were provided.*

Benefit Year _____

HIOS Issuer ID[89] _____

For the associated standard plan, provide written description here: (Describe the subgroups and how the issuer calculated effective parameters).

_____
_____
_____
_____

For the associated standard plan, report all subgroups:

PLAN SUBGROUPS with claims sets <80% of total allowed costs for essential health benefits under the standard plan are not subject to the deductible	Check or enter Yes for all that apply
Individual Medical	
Individual Pharmacy	
Individual Medical Pharmacy combined	
Enrollment Group Medical	
Enrollment Group Pharmacy	
Enrollment Group Medical Pharmacy combined	

For the associated standard plan, list Effective Parameters for each subgroup with claims sets in the corresponding Plan Variation.

PLAN SUBGROUP 1: Individual Medical <80% of total allowed costs for medical essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Average Deductible:	
Effective Deductible:	
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective non-deductible cost-sharing:	
Effective claims ceiling:	
PLAN SUBGROUP 2: Individual Pharmacy <80% of total allowed costs for pharmacy essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Average Deductible:	
Effective Deductible:	

[89] *The five-digit Health Insurance Oversight System (HIOS)-generated issuer ID number*

Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective non-deductible cost-sharing:	
Effective claims ceiling:	

PLAN SUBGROUP 3: Individual Medical & Pharmacy Combined <80% of total allowed costs for combined essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Average Deductible:	
Effective Deductible:	
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective non-deductible cost-sharing:	
Effective claims ceiling:	

PLAN SUBGROUP 4: Enrollment Group Medical <80% of total allowed costs for medical essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Average Deductible:	
Effective Deductible:	
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective non-deductible cost-sharing:	
Effective claims ceiling:	

PLAN SUBGROUP 5: Enrollment Group Pharmacy <80% of total allowed costs for pharmacy essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Average Deductible:	
Effective Deductible:	
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective non-deductible cost-sharing:	
Effective claims ceiling:	

PLAN SUBGROUP 6: Enrollment Group Medical & Pharmacy Combined <80% of total allowed costs for combined essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Average Deductible:	
Effective Deductible:	
Effective Pre-deductible Coinsurance Rate:	

Effective Post-deductible Coinsurance Rate:	
Effective non-deductible cost-sharing:	
Effective claims ceiling:	

HMO-like plans or plans with HMO-like payment arrangements

Fully capitated plans or plans with some HMO-like payment arrangements list subgroups and report Effective Parameters for each subgroup with claims sets in the corresponding Plan Variation here, as applicable.

PLAN SUBGROUPS with claims sets >80% of total allowed costs for essential health benefits under the standard plan are not subject to the deductible	Check or enter Yes for all that apply
Individual Medical	
Individual Pharmacy	
Individual Medical Pharmacy combined	
Enrollment Group Medical	
Enrollment Group Pharmacy	
Enrollment Group Medical Pharmacy combined	

PLAN SUBGROUP 1: Individual Medical >80% of total allowed costs for medical essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Effective Pre-deductible Coinsurance Rate: *	
Effective Post-deductible Coinsurance Rate:	
Effective claims ceiling:	

****Pre and post-deductible coinsurance rates are equal***

PLAN SUBGROUP 2: Individual Pharmacy >80% of total allowed costs for pharmacy essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective claims ceiling:	

PLAN SUBGROUP 3: Individual Medical & Pharmacy combined >80% of total allowed costs for combined essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective claims ceiling:	

PLAN SUBGROUP 4: Enrollment Group Medical >80% of total allowed costs for medical essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective claims ceiling:	

PLAN SUBGROUP 5: Enrollment Group Pharmacy >80% of total allowed costs for pharmacy essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective claims ceiling:	

PLAN SUBGROUP 6: Enrollment Group Medical & Pharmacy combined >80% of total allowed costs for combined essential health benefits under the standard plan are not subject to the deductible	EFFECTIVE PARAMETERS
Effective Pre-deductible Coinsurance Rate:	
Effective Post-deductible Coinsurance Rate:	
Effective claims ceiling:	

EXHIBIT 3

July 2, 2018

Early 2018 Effectuated Enrollment Snapshot

This report provides effectuated enrollment data for the 2017 plan year and for February 2018. The Centers for Medicare and Medicaid Services (CMS) publishes effectuated enrollment data semiannually to provide a more accurate picture of enrollment trends for the Exchanges than indicated by the number of individuals who simply selected a plan during Open Enrollment. For coverage to be considered effectuated, individuals generally must pay the first month's premium for the plan.

As of March 15, 2018, 10.6 million individuals had effectuated coverage through the Federal and State-Based Exchanges for February 2018, meaning that they selected a plan, paid their first month's premium, if applicable, and had coverage in February 2018. The total number of members with February 2018 coverage is about 9 percent lower than the number of individuals (11.8 million) who made plan selections during the 2018 Open Enrollment period, as reported in the 2018 Open Enrollment Final Report released by CMS in early April.[1] The number of individuals with effectuated coverage for February 2018 is approximately 3 percent higher than February 2017 effectuated enrollment of 10.3 million individuals, as of March 15, 2017.[2]

Based on historical enrollment trends for the Exchanges, CMS anticipates that a significant number of people who effectuated coverage in early 2018 will not stay in their plans for the full year. For example, while 10.3 million individuals had effectuated coverage for February 2017 (as of March 15, 2017), by the end of the year, only 8.9 million individuals remained in their plans, according to data released today. This is likely caused by consumers struggling to pay premiums as costs continue to increase. In addition, the numbers reported today may be revised in future months as additional data on new effectuations, terminations, and cancellations become available. CMS intends to publish later this year effectuated enrollment data for the first six months of 2018, which will include an updated snapshot of February 2018 enrollment.

This report also shows that the proportion of the population that enrolled on Federal and State-Based Exchanges and received advance premium tax credits (APTC) increased slightly for February 2018, to 87 percent, from an average of 84 percent for the 2017 plan year. The average total monthly premium per enrollee increased by 27 percent for February 2018 over the average total monthly premium per enrollee for the 2017 plan year; however, the average monthly amount of APTC per enrollee receiving APTC rose more sharply, by 39 percent, compared to the 2017 average monthly APTC per enrollee receiving APTC.

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[1] EXCHANGE 2018 OPEN ENROLLMENT PERIOD FINAL ENROLLMENT REPORT: Centers for Medicare & Medicaid Services, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html.

[2] 2017 Effectuated Enrollment Snapshot: Centers for Medicare & Medicaid Services, https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.

Background Information

The primary sources for the effectuated enrollment snapshot are payment and enrollment data. Effectuated enrollment is the total number of individuals who had an active policy in February 2018 and who paid their premium, if applicable, (thus effectuating their coverage) as of March 15, 2018. This data includes effectuated enrollment from both the Federal and State-Based Exchanges.

APTC enrollment is the total number of individuals who had an active policy in February 2018, who paid their premium, if applicable, (thus becoming effectuated), and who received an APTC. APTC is generally available if a consumer's household income is between 100 and 400 percent of the federal poverty level, and certain other criteria are met. A consumer was defined as having an APTC if the applied APTC amount was greater than $0; otherwise, a consumer was classified as not having APTC.

Cost-sharing reduction (CSR) enrollment is the total number of individuals who had an active policy in February 2018, who paid their premium, if applicable, (thus effectuating their coverage), and received cost-sharing reductions (CSR).[3] While CMS discontinued advance CSR payments to issuers in October 2017, issuers continue to provide reduced cost-sharing to eligible consumers in 2018 in compliance with Patient Protection and Affordable Care Act (PPACA) requirements. A consumer is generally eligible for CSR if the individual is eligible for APTC, has a household income between 100 percent and 250 percent of the federal poverty level, and enrolled in a health plan from the silver plan category. American Indians and Alaskan Natives are eligible for CSRs under different criteria.

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Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, February 2018					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
Total	**10,643,786**	**9,229,769**	**87%**	**5,612,435**	**53%**
AK	17,798	15,993	90%	6,930	39%
AL	158,024	149,528	95%	116,269	74%
AR	61,702	54,565	88%	35,872	58%
AZ	154,435	131,078	85%	79,014	51%
CA	1,405,714	1,222,093	87%	625,663	45%
CO	138,239	102,628	74%	42,492	31%
CT	106,475	79,977	75%	71,500	67%
DC	17,338	957	6%	550	3%
DE	20,760	18,043	87%	9,781	47%
FL	1,601,619	1,508,784	94%	1,052,757	66%
GA	409,510	368,795	90%	281,919	69%
HI	17,702	15,088	85%	8,247	47%
IA	45,882	41,678	91%	19,681	43%
ID	87,131	77,848	89%	40,353	46%

[3] On October 12, 2017, the Acting Secretary of HHS directed that cost-sharing reduction payments to issuers be discontinued until a valid appropriation exists. Therefore, CSR enrollment is provided in this report for informational purposes only.

Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, February 2018					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
IL	304,712	263,006	86%	135,755	45%
IN	147,270	102,375	70%	63,451	43%
KS	87,975	77,258	88%	40,043	46%
KY	81,023	63,671	79%	35,438	44%
LA	93,178	85,348	92%	48,772	52%
MA	242,413	193,173	80%	102,734	42%
MD	137,184	115,593	84%	70,676	52%
ME	68,609	61,324	89%	32,455	47%
MI	271,841	232,742	86%	117,542	43%
MN	106,492	68,500	64%	12,708	12%
MO	214,387	188,072	88%	125,769	59%
MS	74,678	72,063	96%	64,312	86%
MT	45,050	39,260	87%	15,089	33%
NC	478,021	450,007	94%	304,387	64%
ND	20,940	18,139	87%	9,695	46%
NE	83,255	79,354	95%	39,633	48%
NH	42,008	32,090	76%	17,486	42%
NJ	243,505	195,345	80%	120,352	49%
NM	40,398	32,655	81%	12,443	31%
NV	77,585	68,007	88%	39,287	51%
NY	221,699	126,253	57%	55,646	25%
OH	204,589	157,577	77%	77,636	38%
OK	130,902	124,280	95%	88,759	68%
OR	143,157	109,977	77%	52,084	36%
PA	359,272	319,360	89%	161,382	45%
RI	31,723	25,807	81%	16,071	51%
SC	197,699	184,579	93%	120,516	61%
SD	27,780	25,865	93%	14,411	52%
TN	209,499	188,745	90%	129,073	62%
TX	1,014,529	908,650	90%	601,156	59%
UT	177,535	163,675	92%	98,160	55%
VA	342,208	297,205	87%	203,234	59%
VT	27,906	22,803	82%	12,385	44%
WA	203,581	129,039	63%	73,505	36%
WI	200,557	176,410	88%	89,436	45%
WV	25,208	22,513	89%	12,406	49%
WY	23,089	21,994	95%	7,520	33%

Source: March 15th, 2018, CMS

Average total premium per month is the total premium (including APTC and any premium paid by the policyholder) for the month, divided by the number of individuals who had an active policy for the month. Average APTC per month is the total amount of APTC for the month for all individuals who received APTC, divided by the number of individuals who received APTC.

Average Total Premium and Average APTC by State, February 2018		
State	**Average Total Premium per Month**	**Average APTC per Month (for individuals receiving APTC)**
TOTAL	**$597.20**	**$519.89**
AK	$795.05	$717.92
AL	$677.62	$621.10
AR	$508.57	$379.83
AZ	$629.95	$551.17
CA	$547.36	$452.45
CO	$614.59	$514.03
CT	$689.26	$611.56
DC	$417.43	$268.80
DE	$750.17	$641.55
FL	$587.82	$527.99
GA	$611.78	$548.65
HI	$625.14	$493.29
IA	$988.41	$888.24
ID	$528.53	$480.53
IL	$643.70	$532.06
IN	$483.31	$343.91
KS	$623.30	$552.13
KY	$546.32	$457.84
LA	$649.25	$525.04
MA	$383.09	$236.41
MD	$630.57	$532.81
ME	$709.62	$654.01
MI	$493.43	$385.66
MN	$533.56	$391.89
MO	$644.00	$592.51
MS	$670.90	$621.78
MT	$637.40	$547.84
NC	$764.94	$699.35

Average Total Premium and Average APTC by State, February 2018		
State	**Average Total Premium per Month**	**Average APTC per Month (for individuals receiving APTC)**
ND	$452.28	$325.74
NE	$854.43	$802.31
NH	$642.66	$514.80
NJ	$570.10	$438.99
NM	$526.29	$468.17
NV	$506.90	$437.19
NY	$533.28	$287.81
OH	$504.55	$386.81
OK	$694.25	$665.46
OR	$525.39	$420.06
PA	$693.83	$625.34
RI	$416.92	$306.69
SC	$654.14	$581.61
SD	$624.45	$527.66
TN	$802.91	$790.90
TX	$538.07	$474.61
UT	$476.92	$437.65
VA	$640.26	$581.48
VT	$514.19	$334.39
WA	$511.04	$375.58
WI	$743.64	$665.15
WV	$842.65	$682.31
WY	$973.49	$919.64

Source: March 15th 2018, CMS

2017 Average Monthly Effectuated Enrollment

The average monthly effectuated enrollment in 2017 was 9.8 million individuals. CMS reports average monthly effectuated enrollment, in part, to create a single annual number that can be compared to other sources, such as the Congressional Budget Office (CBO). 2017 average monthly effectuated enrollment is consistent with CBO's September 2017 projection of 10 million individuals enrolled in individual coverage purchased through the Exchanges for 2017.[4] However, the September 2017 estimate had been revised downward from CBO's March 2016 Baseline projection of 15 million individuals enrolled for 2017.[5]

The primary sources for the 2017 average monthly effectuated enrollment are payment and enrollment data. These data represent the average monthly number of individuals who had an active policy in 2017 and who paid their premium, if applicable, (thus becoming effectuated) as of March 15, 2018. The average monthly effectuated enrollment number was calculated by adding total member months for the year and dividing by 12.

2017 average monthly APTC enrollment is the average number of individuals who had an active policy in 2017, who had paid their premium, if applicable, (thus becoming effectuated), and who received an APTC. APTC is generally available if a consumer's household income is between 100 and 400 percent of the federal poverty level, and certain other eligibility criteria are met.

2017 average monthly CSR enrollment is the total number of individuals who had an active policy in 2017, who paid their premiums, if applicable (thus effectuating their coverage), and who received CSR. While CMS discontinued advance CSR payments to issuers in October 2017, issuers continued to reduce cost sharing for eligible individuals through the remainder of the 2017 plan year in compliance with PPACA requirements. A consumer is generally eligible for CSR if the individual is eligible for APTC, has a household income between 100 percent and 250 percent of the federal poverty level, and enrolled in a health plan from the silver plan category. American Indians and Alaskan Natives are eligible for CSRs under different criteria.

[4] Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's September 2017 Projections, https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-09-healthinsurance.pdf.
[5] Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline, https://www.cbo.gov/sites/default/files/recurringdata/51298-2016-03-healthinsurance.pdf.

Total Average Monthly Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, 2017					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
Total	**9,763,076**	**8,228,479**	**84%**	**5,596,568**	**57%**
AK	14,626	13,442	92%	6,016	41%
AL	148,937	139,996	94%	113,794	76%
AR	54,530	46,711	86%	31,674	58%
AZ	137,296	119,467	87%	77,566	56%
CA	1,321,234	1,129,187	85%	649,793	49%
CO	140,012	91,335	65%	37,595	27%
CT	92,697	70,071	76%	39,387	42%
DC	17,849	886	5%	594	3%
DE	21,507	18,028	84%	10,122	47%
FL	1,334,172	1,229,240	92%	997,261	75%
GA	379,408	338,217	89%	269,277	71%
HI	16,316	13,583	83%	9,825	60%
IA	42,630	37,011	87%	22,522	53%
ID	82,517	73,142	89%	55,527	67%
IL	281,640	230,265	82%	136,421	48%
IN	139,001	101,588	73%	65,302	47%
KS	81,425	70,441	87%	45,635	56%
KY	70,652	54,449	77%	35,562	50%
LA	101,171	90,846	90%	56,787	56%
MA	242,020	180,598	75%	153,148	63%
MD	128,809	98,261	76%	74,042	57%
ME	66,880	57,984	87%	35,925	54%
MI	262,216	215,804	82%	128,431	49%
MN	88,562	61,932	70%	10,826	12%
MO	200,767	175,662	87%	114,437	57%
MS	61,519	57,172	93%	49,083	80%
MT	44,369	38,625	87%	18,928	43%
NC	434,083	407,524	94%	292,247	67%
ND	19,347	16,399	85%	9,039	47%
NE	71,357	66,602	93%	39,900	56%
NH	44,297	27,844	63%	15,820	36%
NJ	234,840	185,258	79%	121,655	52%
NM	42,474	31,066	73%	20,164	47%
NV	70,801	59,514	84%	39,601	56%
NY	211,693	120,407	57%	34,536	16%
OH	193,830	145,792	75%	87,645	45%

Total Average Monthly Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, 2017					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
OK	117,383	109,723	93%	75,107	64%
OR	126,528	95,919	76%	50,466	40%
PA	344,180	289,737	84%	198,035	58%
RI	29,361	23,376	80%	16,360	56%
SC	173,549	157,420	91%	124,864	72%
SD	25,789	23,796	92%	15,351	60%
TN	189,425	167,618	88%	113,113	60%
TX	897,182	778,233	87%	579,769	65%
UT	165,285	143,625	87%	101,298	61%
VA	339,387	281,606	83%	205,047	60%
VT	27,923	21,920	79%	11,649	42%
WA	182,365	112,775	62%	71,197	39%
WI	202,254	166,310	82%	103,022	51%
WV	25,826	22,799	88%	13,434	52%
WY	21,155	19,273	91%	11,769	56%

Source: March 15, 2018, CMS

Average monthly premium for 2017 is the total premium (including APTC and any premium paid by the policyholder) for the year, divided by the total number of member months for which individuals had active policies in 2017. Average monthly APTC for 2017 is the total amount of APTC for the year for all individuals who received APTC in 2017, divided by the number of member months for which individuals received APTC.

Average Total Premium and Average APTC by State, 2017		
State	**Average Total Premium per Month**	**Average APTC per Month (for individuals receiving APTC)**
TOTAL	**$470.52**	**$373.06**
AK	$1,040.46	$960.28
AL	$580.00	$517.79
AR	$424.27	$273.82
AZ	$628.07	$541.33
CA	$455.57	$347.97
CO	$461.81	$380.05
CT	$545.41	$438.99
DC	$349.55	$251.69
DE	$567.64	$420.30
FL	$447.09	$366.61
GA	$437.46	$360.28
HI	$475.68	$355.87
IA	$531.45	$426.24
ID	$428.16	$349.92
IL	$522.17	$371.27
IN	$418.45	$262.47
KS	$474.45	$377.17
KY	$412.08	$293.62
LA	$558.94	$437.54
MA*	$318.56	$177.17
MD	$437.96	$319.28
ME	$516.01	$413.15
MI	$404.14	$265.00
MN	$569.24	$431.35
MO	$484.76	$400.17
MS	$465.41	$383.17
MT	$578.33	$480.60
NC	$667.72	$592.09

Average Total Premium and Average APTC by State, 2017		
State	**Average Total Premium per Month**	**Average APTC per Month (for individuals receiving APTC)**
ND	$398.14	$286.47
NE	$595.63	$510.08
NH	$399.53	$249.84
NJ	$481.09	$350.87
NM	$374.06	$286.70
NV	$380.86	$289.02
NY	$476.35	$234.36
OH	$415.60	$267.80
OK	$619.14	$551.03
OR	$463.70	$347.80
PA	$534.88	$427.10
RI	$360.24	$245.78
SC	$520.21	$421.33
SD	$538.63	$441.17
TN	$592.13	$534.88
TX	$408.75	$336.92
UT	$313.89	$233.21
VA	$404.71	$318.14
VT	$487.01	$323.46
WA	$387.35	$253.21
WI	$517.97	$401.93
WV	$708.00	$566.27
WY	$609.24	$503.26

Source: March 15th, 2018, CMS

2017 Monthly Effectuated Enrollment by State												
State	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**
Total	**9,763,983**	**10,171,113**	**10,526,942**	**10,346,577**	**10,098,103**	**9,913,757**	**9,765,385**	**9,633,832**	**9,495,160**	**9,348,875**	**9,176,935**	**8,916,244**
AK	14,227	14,916	15,554	15,439	15,091	14,931	14,742	14,516	14,395	14,131	13,934	13,630
AL	145,501	153,607	159,718	157,449	154,011	151,582	148,941	146,965	145,232	143,302	141,839	139,099
AR	55,483	56,501	58,602	57,594	56,429	55,371	54,675	53,771	53,119	52,081	51,137	49,597
AZ	133,160	143,050	148,974	146,954	143,938	140,620	137,862	135,434	133,047	130,791	128,441	125,277
CA	1,294,998	1,338,971	1,391,014	1,373,853	1,351,385	1,340,816	1,330,261	1,318,958	1,308,695	1,292,415	1,272,411	1,241,025
CO	129,192	138,098	146,096	145,412	144,899	143,496	142,470	141,029	139,854	138,547	136,746	134,305
CT	92,171	98,035	101,325	97,298	95,126	93,724	92,591	91,290	89,891	88,579	86,657	85,682
DC	17,580	18,033	19,242	18,647	18,621	18,006	18,073	17,807	17,639	17,335	16,710	16,499
DE	22,227	22,713	23,167	22,791	22,296	21,867	21,541	21,208	20,823	20,412	19,928	19,110
FL	1,378,559	1,438,003	1,469,132	1,435,739	1,383,562	1,343,391	1,317,343	1,300,706	1,272,557	1,249,449	1,228,044	1,193,576
GA	377,877	403,378	422,046	411,314	396,643	386,502	378,096	371,006	364,191	356,863	348,547	336,429
HI	15,553	16,698	17,258	16,962	16,741	16,532	16,405	16,257	16,086	15,934	15,862	15,504
IA	44,382	45,602	46,382	45,524	44,447	43,511	42,635	41,708	40,831	39,935	39,066	37,542
ID	81,024	84,168	87,446	86,373	85,214	84,166	83,315	82,479	81,264	79,935	78,311	76,503
IL	288,116	297,758	306,667	300,461	292,340	287,112	282,020	277,025	271,359	265,151	259,517	252,153
IN	141,938	145,627	148,983	146,795	143,949	141,677	139,517	137,398	134,937	132,863	129,545	124,786
KS	81,587	84,956	87,519	86,441	84,572	83,266	81,902	80,780	79,243	77,863	76,071	72,904
KY	63,105	72,656	76,508	75,740	73,973	72,822	71,517	70,586	69,622	68,873	67,249	65,175
LA	116,605	111,182	113,122	110,162	105,759	100,920	98,178	96,281	93,759	91,730	89,768	86,581
MA	226,705	231,325	236,570	239,407	240,173	242,850	244,159	246,317	251,207	252,483	248,981	244,063
MD	129,619	131,294	138,630	135,354	134,301	130,467	130,094	126,659	124,998	124,325	121,363	118,604
ME	69,572	70,060	71,812	70,252	68,998	67,595	66,831	65,649	64,764	63,864	62,487	60,681
MI	273,360	278,016	282,499	277,469	270,541	265,051	260,605	256,270	252,390	248,388	244,289	237,710
MN	83,679	87,863	94,169	93,190	91,728	90,552	89,702	88,639	87,541	86,515	85,381	83,790
MO	199,906	210,883	220,933	216,806	210,496	205,821	201,685	197,012	192,833	188,985	184,995	178,853
MS	62,297	65,976	69,388	67,369	64,604	62,607	61,029	59,694	58,455	57,169	55,693	53,943
MT	45,357	46,364	47,019	46,293	45,434	44,715	44,175	43,785	43,280	42,744	42,165	41,094
NC	437,395	459,922	472,284	463,656	449,951	440,307	432,228	426,084	419,445	412,069	403,441	392,219
ND	19,328	19,969	20,333	20,107	19,775	19,547	19,388	19,074	18,927	18,824	18,596	18,301
NE	70,470	74,935	76,726	75,760	73,984	72,607	71,372	70,437	69,494	68,219	67,027	65,252
NH	45,712	46,376	47,255	46,449	45,693	44,998	44,470	43,913	43,176	42,496	41,488	39,532
NJ	232,893	243,284	251,574	248,097	243,269	240,181	236,468	232,907	229,332	225,131	220,461	214,487

2017 Monthly Effectuated Enrollment by State												
State	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**
NM	42,809	44,548	46,321	45,450	44,190	43,203	42,380	41,711	41,099	40,298	39,472	38,206
NV	72,965	75,526	77,547	76,178	73,865	72,167	70,710	69,265	67,925	66,434	64,894	62,139
NY	190,377	206,175	220,122	218,401	217,056	216,735	216,052	214,925	213,824	212,526	210,087	204,040
OH	197,370	204,320	208,939	205,297	200,848	197,463	194,081	190,894	187,262	184,537	180,215	174,733
OK	116,898	120,839	124,889	123,221	120,603	118,886	117,176	115,703	114,351	113,126	112,364	110,536
OR	125,774	130,937	135,269	133,146	130,234	128,275	126,746	125,307	124,006	122,670	119,846	116,127
PA	346,135	357,823	366,111	360,999	354,698	349,809	344,831	340,380	335,950	330,831	325,397	317,191
RI	26,298	29,183	30,419	30,308	30,031	29,680	29,451	29,493	29,553	29,527	29,651	28,736
SC	175,896	183,425	188,667	185,343	179,973	176,261	173,095	170,112	167,128	164,165	161,194	157,326
SD	25,603	26,575	27,130	26,857	26,416	26,210	25,806	25,609	25,365	25,032	24,711	24,152
TN	188,875	198,508	205,708	201,694	196,459	192,527	189,178	186,411	183,268	180,462	177,471	172,533
TX	898,715	938,625	993,647	969,519	936,911	912,811	894,019	877,828	862,538	847,050	830,196	804,325
UT	166,563	172,599	176,470	174,432	171,224	168,380	165,755	163,629	161,068	158,259	154,874	150,166
VA	341,673	355,290	369,456	362,774	353,814	346,186	340,207	334,510	329,001	322,800	314,758	302,170
VT	27,674	28,517	29,236	28,969	28,509	28,224	28,084	27,894	27,580	27,273	26,894	26,226
WA	173,284	186,117	193,363	190,830	188,344	186,383	184,414	183,196	181,476	178,935	175,087	166,951
WI	209,126	212,431	215,371	212,538	208,328	205,236	202,250	199,186	196,012	192,892	189,725	183,958
WV	26,934	27,390	27,819	27,265	26,784	26,245	25,722	25,213	24,751	24,412	23,982	23,398
WY	21,436	22,066	22,511	22,199	21,873	21,466	21,138	20,922	20,617	20,245	19,967	19,425

Source: March 15th, 2018, CMS

EXHIBIT 4

Fact sheet

Early 2019 Effectuated Enrollment Snapshot

Aug 12, 2019 Affordable Care Act, Eligibility & enrollment

Early 2019 Effectuated Enrollment Snapshot

This report provides effectuated enrollment, premium, and advance payments of the premium tax credit (APTC) data, for the Federally-facilitated and State-based Exchanges ("the Exchanges") for February 2019 and for the 2018 plan year.

As of March 15, 2019, 10.6 million consumers had effectuated coverage through the Exchanges for February 2019, meaning that they selected a plan, paid their first month's premium, if applicable, and had coverage in February 2019. This number represents approximately 92 percent of consumers who made plan selections during the 2019 Open Enrollment Period (11.4 million).[1] Total effectuated enrollment for February 2019 declined less than one percent from February 2018.[2]

The average total monthly premium for Exchange enrollees in February 2019 was $594.17, a decrease of one percent from the February 2018 average premium of $597.20. Approximately 9.3 million, or 87 percent of Exchange enrollees in February 2019 received APTC, consistent with the percentage of enrollees who received APTC in February 2018. The average monthly amount of APTC per enrollee receiving APTC also fell by approximately one percent from February 2018, to $514.01.

The numbers reported today may be revised in future months as additional data on new effectuations, terminations, and cancellations become available. Later this year, CMS intends to publish effectuated enrollment data for the first six months of 2019, which will include updated February 2019 enrollment data.

Background Information

The primary sources for the effectuated enrollment snapshot are payment and enrollment data. Effectuated enrollment for February 2019 is the total number of individuals who had an active policy in February 2019 and who paid their premium, if applicable, (thus effectuating their coverage) as of March 15, 2019. These data include effectuated enrollment from both the Federally-facilitated and State-based Exchanges.

APTC enrollment is the total number of individuals who had an active policy in February 2019, who paid their premium, if applicable, (thus effectuating their coverage), and who received an APTC. APTC is generally available if a consumer's household income is between 100 and 400 percent of the federal poverty level, and certain other criteria are met. A consumer was defined as receiving an APTC if the applied APTC amount was greater than $0; otherwise, a consumer was classified as not receiving APTC.

CSR enrollment is the total number of individuals who had an active policy in February 2019, who paid their premium, if applicable, (thus effectuating their coverage), and received cost-sharing reductions (CSRs). A consumer is generally eligible for CSR if the individual is eligible for APTC, has a household income between 100 percent and 250 percent of the federal poverty level, and is enrolled in a health plan from the silver plan category. American Indians and Alaskan Natives are eligible for CSRs under different criteria.

To see a breakdown of the data by state, click here: https://www.cms.gov/sites/default/files/2019-08/08-12-2019%20TABLE%20Early-2019-2018-Average-Effectuated-Enrollment.pdf

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[1] Health Insurance Exchanges 2019 Open Enrollment Report, available at: https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report.

[2] February 2018 effectuated enrollment and premium data in this section of the report are as of March 15, 2018. Complete February 2018 effectuated enrollment data are available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf.

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

7500 Security Boulevard, Baltimore, MD 21244

EXHIBIT 5

July 23, 2020

Early 2020 Effectuated Enrollment Snapshot

This report provides effectuated enrollment, premium, and advance payments of the premium tax credit (APTC) data for the Federally-facilitated and State-based Exchanges ("the Exchanges") for February 2020 and for the 2019 plan year.

February 2020 Effectuated Enrollment Snapshot Key Findings

As of March 15, 2020[1], 10.7 million consumers had effectuated coverage through the Exchanges for February 2020, meaning that they selected a plan, paid their first month's premium, if applicable, and had coverage in February 2020. This number represents approximately 94 percent of consumers who made plan selections during the 2020 Open Enrollment Period (11.4 million).[2] Although the number of plan selections through the Exchanges were approximately equal in the 2019 and 2020 Open Enrollment Periods (OEPs), a greater number of consumers had effectuated coverage in February 2020 compared to February 2019, as of March 15 of both years.[3] Total effectuated enrollment for February 2020 increased by approximately one percent from total effectuated enrollment for February 2019.

The average total monthly premium for Exchange enrollees in February 2020 was $576.16, a decrease of three percent from the February 2019 average premium of $594.17. Approximately 9.2 million, or 86 percent, of Exchange enrollees in February 2020 received APTC, which represents a decrease of approximately 1 percentage point from the share of Exchange enrollees who received APTC in February 2019. The average monthly amount of APTC per enrollee receiving APTC fell by approximately four percent from February 2019, to $491.53. The numbers reported today may be revised in future months as additional data on new effectuations, terminations, and cancellations become available. Later this year, CMS plans to publish effectuated enrollment data for the first six months of 2020, which will include updated February 2020 enrollment data.

2019 Average Monthly Effectuated Enrollment Snapshot Key Findings

On a monthly average basis, 9.8 million consumers had effectuated coverage through the Exchanges in the 2019 plan year. This is a decrease of slightly less than one percent from the average monthly effectuated enrollment of 9.9 million in the 2018 plan year.

The average total monthly premium for Exchange enrollees in 2019 was $591.26, consistent with the 2018

[1] February 2020 data for Minnesota are as of April 15, 2020. Due to Minnesota's transition to policy-based payments in 2020, the data for the April payment cycle (as of March 15, 2020) were incomplete.
[2] Health Insurance Exchanges 2020 Open Enrollment Report, available at: https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf.
[3] February 2019 and 2018 monthly effectuated enrollment and premium data in this report are as of March 15, 2019. Complete February 2019 and 2018 average monthly effectuated enrollment data are available at: https://www.cms.gov/sites/default/files/2019-08/08-12-2019%20TABLE%20Early-2019-2018-Average-Effectuated-Enrollment.pdf

average total monthly premium of $594.11. Approximately 87 percent of Exchange enrollees received APTC in 2019, consistent with the percentage of enrollees who received APTC in 2018. In 2019, the average monthly amount of APTC per enrollee receiving APTC fell by approximately one percent from 2018, to $512.11.

In 2019, monthly effectuated enrollment peaked in January at approximately 10.5 million consumers and fell to approximately 9.1 million by December, meaning that monthly effectuations and disenrollments followed a similar pattern as in 2018, when monthly effectuated enrollment fell from a high of approximately 10.5 million consumers in February to approximately 9.2 million at the end of the year.

Background Information

The primary sources for both the February 2020 effectuated enrollment snapshot and the 2019 average monthly effectuated enrollment data are payment and enrollment data, which include data from both the Federally-facilitated and State-based Exchanges. Effectuated enrollment for February 2020 is the total number of consumers who paid their premiums (if applicable)—thus effectuating their coverages—and who had active policies in February 2020 as of March 15, 2020. The 2019 average monthly effectuated enrollment is the average monthly number of consumers who paid their premiums (if applicable)—thus effectuating their coverages—and who had active policies in 2019 as of March 15, 2020. The average monthly effectuated enrollment number was calculated by adding total member months for 2019 and dividing by 12.

APTC enrollment for the February 2020 effectuated enrollment snapshot is the total number of consumers who paid their premiums (if applicable)—thus effectuating their coverages—and who received APTC in association with their active policies in February 2020. The 2019 average monthly APTC enrollment is the average number of consumers who paid their premiums (if applicable)—thus effectuating their coverages—and who received APTC in association with their active policies in 2019. APTC is *generally* available if a consumer's household income is between 100 percent and 400 percent of the federal poverty level. (Certain other criteria apply to APTC eligibility and must be met in order to receive APTC.) Consumers were defined as receiving APTC if the APTC amounts applied to their premiums were greater than $0; otherwise, consumers were classified as not receiving APTC.

Cost-sharing reduction (CSR) enrollment for the February 2020 effectuated enrollment snapshot is the total number of consumers who paid their premiums (if applicable)—thus effectuating their coverages—and who received CSRs in association with their active policies in February 2020. The 2019 average monthly CSR enrollment is the average number of consumers who paid their premiums (if applicable)—thus effectuating their coverages—and who received CSRs in association with their active policies in 2019. A consumer is *generally* eligible for a CSR if the consumer is eligible for APTC, has a household income between 100 percent and 250 percent of the federal poverty level, and is enrolled in a qualified health plan from the silver plan category. (American Indians and Alaskan Natives are eligible for CSRs under different criteria.)

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Table 1: Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, February 2020					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
TOTAL	**10,673,516**	**9,232,225**	**86%**	**5,348,201**	**50%**
AK	16,795	14,066	84%	3,773	22%
AL	149,133	141,355	95%	108,790	73%
AR	58,615	51,736	88%	34,432	59%
AZ	142,635	115,605	81%	64,947	46%
CA	1,477,329	1,254,947	85%	627,207	42%
CO	150,416	111,662	74%	45,250	30%
CT	103,955	72,767	70%	35,304	34%
DC	16,245	957	6%	328	2%
DE	22,497	19,359	86%	6,625	29%
FL	1,809,265	1,732,406	96%	1,201,618	66%
GA	433,086	392,670	91%	293,422	68%
HI	18,373	15,292	83%	6,756	37%
IA	52,542	47,850	91%	17,733	34%
ID	72,518	62,320	86%	22,037	30%
IL	273,180	233,361	85%	117,518	43%
IN	132,577	93,796	71%	55,869	42%
KS	79,847	71,167	89%	33,488	42%
KY	78,241	64,708	83%	32,400	41%
LA	80,471	73,016	91%	41,541	52%
MA	293,075	230,393	79%	215,147	73%
MD	135,474	110,478	82%	50,586	37%
ME	58,487	50,482	86%	19,762	34%
MI	247,075	211,708	86%	95,880	39%
MN*	105,677	58,707	56%	10,724	10%
MO	189,973	165,958	87%	113,478	60%
MS	91,483	89,982	98%	79,198	87%
MT	41,540	35,295	85%	12,309	30%
NC	471,781	439,497	93%	267,242	57%
ND	20,662	17,601	85%	7,686	37%
NE	86,805	82,709	95%	26,104	30%
NH	42,013	30,105	72%	15,189	36%
NJ	224,649	174,978	78%	107,972	48%
NM	39,762	30,680	77%	13,838	35%
NV	73,101	61,245	84%	31,205	43%
NY	235,526	130,858	56%	28,206	12%
OH	183,608	141,581	77%	61,493	33%

Table 1: Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, February 2020 (Cont.)					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
OK	148,474	140,704	95%	88,265	59%
OR	135,313	100,366	74%	43,187	32%
PA	307,100	267,191	87%	135,005	44%
RI	34,050	27,868	82%	14,266	42%
SC	199,657	185,788	93%	86,990	44%
SD	28,528	26,574	93%	13,190	46%
TN	186,021	166,243	89%	95,821	52%
TX	1,034,259	948,028	92%	615,642	60%
UT	190,514	176,459	93%	92,684	49%
VA	245,670	215,535	88%	98,278	40%
VT	25,834	21,528	83%	9,262	36%
WA	202,150	124,052	61%	64,845	32%
WI	185,652	161,942	87%	71,322	38%
WV	18,448	16,536	90%	8,997	49%
WY	23,435	22,114	94%	5,390	23%

Source: Data as of March 15, 2020, CMS

[*]Minnesota data are as of April 15, 2020. Due to Minnesota's transition to policy-based payments in 2020, the data for the April payment cycle (as of March 15, 2020) were incomplete

Table 2: Average Total Premium and Average APTC by State, February 2020		
State	**Average Total Premium per Month**	**Average APTC per Month**
TOTAL	**$576.16**	**$491.53**
AK	$735.89	$670.07
AL	$690.47	$624.55
AR	$519.99	$382.75
AZ	$584.14	$469.23
CA	$569.72	$454.20
CO	$481.52	$374.11
CT	$683.95	$633.21
DC	$516.96	$389.46
DE	$666.53	$571.96
FL	$592.44	$530.18
GA	$562.02	$493.22
HI	$628.07	$518.76
IA	$818.20	$803.16
ID	$525.23	$478.80
IL	$633.16	$498.38
IN	$537.68	$394.58
KS	$633.74	$544.35
KY	$588.02	$505.76
LA	$674.61	$562.96
MA	$402.87	$266.17
MD	$504.62	$443.17
ME	$634.64	$546.76
MI	$477.20	$364.35
MN*	$443.17	$294.02
MO	$631.34	$562.57
MS	$602.05	$558.44
MT	$568.84	$483.00
NC	$656.08	$605.18
ND	$446.10	$321.46

Table 2: Average Total Premium and Average APTC by State, February 2020 (Cont.)		
State	**Average Total Premium per Month**	**Average APTC per Month**
NE	$756.07	$707.86
NH	$525.39	$414.46
NJ	$553.24	$417.11
NM	$475.10	$373.56
NV	$492.40	$384.80
NY	$586.04	$335.00
OH	$517.82	$387.54
OK	$635.83	$593.36
OR	$554.71	$452.72
PA	$643.03	$514.29
RI	$432.39	$323.96
SC	$609.74	$539.42
SD	$678.80	$598.09
TN	$637.16	$576.78
TX	$527.77	$468.35
UT	$417.41	$369.87
VA	$636.24	$554.12
VT	$621.68	$463.29
WA	$506.65	$394.48
WI	$652.89	$566.21
WV	$984.40	$813.80
WY	$956.60	$914.18

Source: Data as of March 15, 2020, CMS

**Minnesota data are as of April 15, 2020. Due to Minnesota's transition to policy-based payments in 2020, the data for the April payment cycle (as of March 15, 2020) were incomplete*

Table 3: Total Average Monthly Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, 2019					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
TOTAL	**9,810,613**	**8,515,524**	**87%**	**5,036,544**	**51%**
AK	15,261	13,254	87%	4,026	26%
AL	140,678	132,717	94%	102,094	73%
AR	55,903	49,478	89%	33,224	59%
AZ	135,074	111,689	83%	64,675	48%
CA	1,348,547	1,174,764	87%	589,414	44%
CO	142,152	111,758	79%	43,666	31%
CT	97,272	66,966	69%	32,970	34%
DC	15,921	969	6%	332	2%
DE	19,352	17,276	89%	7,100	37%
FL	1,551,765	1,474,516	95%	1,042,724	67%
GA	373,049	337,826	91%	252,975	68%
HI	17,002	14,238	84%	6,479	38%
IA	44,799	41,179	92%	16,107	36%
ID	85,926	76,830	89%	36,147	42%
IL	262,714	226,065	86%	112,074	43%
IN	127,470	87,173	68%	55,981	44%
KS	77,880	69,688	89%	35,290	45%
KY	70,936	58,059	82%	30,819	43%
LA	77,579	69,942	90%	40,738	53%
MA	276,808	221,692	80%	208,202	75%
MD	134,775	114,189	85%	57,218	42%
ME	59,844	52,589	88%	22,757	38%
MI	234,530	202,809	86%	97,347	42%
MN	98,009	59,219	60%	11,400	12%
MO	179,171	156,258	87%	109,320	61%
MS	74,304	72,918	98%	66,373	89%
MT	39,684	34,241	86%	11,956	30%
NC	428,116	402,226	94%	255,709	60%
ND	19,848	17,224	87%	7,891	40%
NE	80,080	76,949	96%	29,927	37%
NH	38,889	28,665	74%	15,110	39%
NJ	211,462	162,892	77%	101,134	48%
NM	37,992	30,364	80%	12,829	34%
NV	67,052	58,503	87%	34,854	52%

Table 3: Total Average Monthly Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, 2019 (Cont.)					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
NY	241,576	140,173	58%	32,310	13%
OH	171,320	132,806	78%	61,381	36%
OK	138,015	131,110	95%	88,622	64%
OR	126,846	95,106	75%	43,787	35%
PA	303,134	266,152	88%	138,367	46%
RI	32,784	27,027	82%	14,490	44%
SC	180,113	167,649	93%	90,201	50%
SD	26,281	24,495	93%	13,135	50%
TN	174,568	155,951	89%	94,909	54%
TX	902,787	822,509	91%	537,175	60%
UT	179,518	165,977	92%	95,431	53%
VA	248,688	218,775	88%	114,764	46%
VT	25,730	21,506	84%	9,695	38%
WA	200,205	126,429	63%	62,937	31%
WI	178,865	157,413	88%	75,693	42%
WV	18,410	16,527	90%	9,147	50%
WY	21,929	20,794	95%	5,638	26%

Source: Data as of March 15, 2020, CMS

Table 4: Average Total Premium and Average APTC by State, 2019		
State	**Average Total Premium per Month**	**Average APTC per Month (for consumers receiving APTC)**
TOTAL	**$591.26**	**$512.11**
AK	$734.73	$659.28
AL	$671.51	$610.46
AR	$512.25	$395.00
AZ	$591.19	$496.51
CA	$578.78	$475.74
CO	$620.92	$538.25
CT	$618.35	$509.83
DC	$468.08	$368.48
DE	$832.12	$741.50
FL	$601.15	$541.60
GA	$595.16	$537.84
HI	$660.15	$559.18
IA	$910.97	$877.64
ID	$522.02	$479.08
IL	$645.58	$526.48
IN	$484.25	$339.19
KS	$653.98	$588.35
KY	$593.60	$506.81
LA	$613.26	$498.57
MA	$389.38	$247.71
MD	$557.02	$478.68
ME	$659.04	$587.79
MI	$496.29	$387.28
MN	$458.28	$309.82
MO	$645.95	$578.03
MS	$632.18	$595.26
MT	$662.92	$581.57
NC	$723.52	$674.62

Table 4: Average Total Premium and Average APTC by State, 2019 (Cont.)		
State	**Average Total Premium per Month**	**Average APTC per Month (for consumers receiving APTC)**
ND	$494.56	$388.64
NE	$848.11	$822.19
NH	$533.92	$412.33
NJ	$510.98	$365.20
NM	$483.08	$395.05
NV	$505.38	$422.64
NY	$561.35	$326.75
OH	$532.52	$400.96
OK	$657.42	$639.86
OR	$557.86	$452.45
PA	$650.11	$539.52
RI	$433.39	$326.67
SC	$662.30	$600.26
SD	$639.97	$554.32
TN	$659.43	$609.43
TX	$539.22	$482.63
UT	$447.24	$413.47
VA	$673.16	$597.78
VT	$569.66	$429.02
WA	$532.80	$409.66
WI	$696.73	$623.11
WV	$931.94	$764.91
WY	$942.01	$892.43

Source: Data as of March 15, 2020, CMS

Table 5: Monthly Effectuated Enrollment by State, 2019												
State	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
TOTAL	**10,498,207**	**10,433,850**	**10,316,078**	**10,159,035**	**9,965,987**	**9,797,989**	**9,675,407**	**9,583,119**	**9,490,318**	**9,395,866**	**9,292,314**	**9,119,195**
AK	16,389	16,327	16,081	15,808	15,460	15,187	14,966	14,856	14,718	14,621	14,435	14,281
AL	153,790	152,409	150,761	147,701	143,885	139,899	137,400	135,981	134,102	132,623	130,832	128,755
AR	60,707	59,761	58,863	58,105	56,814	55,861	55,187	54,688	53,814	53,137	52,435	51,466
AZ	147,299	144,485	142,035	139,685	136,796	134,351	132,763	131,501	130,235	128,854	127,591	125,288
CA	1,369,602	1,421,895	1,406,587	1,391,652	1,378,886	1,362,720	1,351,584	1,338,785	1,321,206	1,304,673	1,280,661	1,254,318
CO	142,008	150,708	148,887	146,639	144,835	143,213	141,761	140,447	139,073	137,512	136,038	134,701
CT	103,100	104,734	102,086	99,908	98,584	97,390	96,063	95,357	94,411	93,291	92,408	89,930
DC	16,582	16,516	16,882	16,482	16,403	15,794	15,864	15,621	15,458	15,499	15,019	14,932
DE	20,504	20,344	20,131	19,786	19,527	19,194	19,022	18,926	18,854	18,802	18,717	18,414
FL	1,674,068	1,649,067	1,627,923	1,599,372	1,563,387	1,534,290	1,516,869	1,507,011	1,501,162	1,495,128	1,491,272	1,461,633
GA	417,553	411,602	405,207	395,411	381,525	370,037	361,886	356,675	351,048	346,827	342,571	336,249
HI	18,571	18,002	17,831	17,521	17,201	16,829	16,645	16,525	16,464	16,337	16,176	15,924
IA	46,325	46,340	46,303	45,975	45,197	44,769	44,443	44,209	43,879	43,669	43,533	42,950
ID	89,347	88,870	88,330	87,669	86,969	86,222	85,768	85,199	84,514	83,861	82,801	81,559
IL	287,709	281,917	277,632	273,329	267,193	262,670	259,192	255,870	252,109	248,590	245,439	240,923
IN	138,525	135,903	133,721	131,934	129,829	127,989	126,088	124,477	122,987	121,335	119,607	117,248
KS	83,971	83,164	82,113	80,871	79,084	77,626	76,682	75,887	75,153	74,431	73,417	72,165

Table 5: Monthly Effectuated Enrollment by State, 2019 (Cont.)												
State	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
KY	77,939	76,338	75,118	73,586	72,057	70,725	69,617	68,857	68,005	67,187	66,517	65,291
LA	84,682	82,995	81,732	80,627	79,086	77,683	76,571	75,610	74,575	73,505	72,726	71,152
MA	260,174	269,683	273,558	274,889	276,969	278,868	279,225	281,143	283,645	284,372	279,973	279,199
MD	144,259	141,045	140,125	138,683	136,982	134,949	133,196	131,971	130,968	129,707	128,380	127,033
ME	66,702	65,323	64,466	62,827	61,390	59,775	58,953	57,656	56,593	55,774	54,781	53,890
MI	256,230	250,508	246,901	243,269	238,794	235,198	232,201	228,825	225,702	222,181	219,631	214,917
MN	97,648	103,500	102,322	101,203	99,979	99,061	98,056	97,274	96,190	95,147	93,545	92,187
MO	201,951	194,585	191,401	187,795	182,891	178,577	175,297	172,548	169,880	167,398	165,340	162,392
MS	81,823	81,409	80,640	78,285	75,266	73,159	71,660	71,012	70,106	69,951	69,585	68,747
MT	42,787	42,005	41,405	40,783	40,023	39,498	39,160	38,839	38,497	38,075	37,804	37,337
NC	464,050	459,406	453,877	446,637	435,765	426,120	419,018	415,846	411,826	407,079	402,332	395,440
ND	21,349	20,684	20,727	20,461	20,067	19,756	19,645	19,379	19,314	19,131	18,989	18,671
NE	83,584	83,669	83,343	82,546	81,133	79,995	79,101	78,701	78,231	77,537	77,028	76,091
NH	41,759	41,072	40,593	40,123	39,524	39,016	38,576	38,208	37,792	37,260	36,728	36,017
NJ	230,572	227,219	223,497	219,795	215,327	211,948	208,906	206,228	203,743	200,640	197,278	192,390
NM	43,303	41,206	40,525	39,705	38,790	37,997	37,211	36,465	36,064	35,474	34,985	34,178
NV	76,301	73,907	72,176	70,604	68,400	66,780	65,567	64,430	63,402	62,446	61,295	59,313
NY	221,424	234,772	247,364	246,767	246,304	245,932	245,631	245,117	244,331	243,031	241,151	237,089

Table 5: Monthly Effectuated Enrollment by State, 2019 (Cont.)												
State	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**
OH	190,420	185,275	181,344	178,063	174,393	171,404	168,737	166,113	164,008	161,388	158,983	155,707
OK	141,319	141,470	141,457	140,524	138,728	137,057	135,797	135,723	136,048	136,247	136,544	135,261
OR	137,998	135,731	133,423	131,288	128,737	126,733	125,176	123,753	122,410	120,857	119,235	116,809
PA	339,217	325,373	318,231	313,548	307,653	303,001	298,689	294,187	290,622	286,567	283,098	277,420
RI	31,277	33,852	33,816	33,674	33,706	33,261	33,061	32,791	32,539	32,218	31,997	31,216
SC	200,371	197,745	194,596	190,108	183,919	178,790	175,198	172,729	170,198	168,220	166,241	163,245
SD	27,728	27,583	27,274	26,936	26,630	26,243	26,098	25,860	25,665	25,420	25,141	24,794
TN	202,351	190,397	186,435	181,952	176,573	172,122	169,172	167,290	165,189	163,288	161,444	158,607
TX	989,953	977,570	962,516	943,250	917,862	897,282	881,388	871,667	862,364	853,911	845,684	829,991
UT	186,522	186,293	185,786	184,145	181,601	179,066	177,774	177,230	176,347	174,563	173,643	171,247
VA	291,116	270,634	264,695	259,010	252,794	246,935	242,209	238,628	234,958	231,571	228,481	223,225
VT	26,707	26,554	26,484	26,269	26,096	25,868	25,709	25,532	25,322	25,023	24,793	24,398
WA	214,336	211,124	209,232	207,053	204,298	201,994	199,660	197,097	194,778	192,249	188,964	181,672
WI	191,934	189,512	186,802	184,663	181,397	178,818	177,225	175,280	173,316	171,211	169,554	166,673
WV	20,692	20,137	19,785	19,402	18,949	18,532	18,139	17,693	17,301	17,037	16,814	16,443
WY	23,679	23,230	23,059	22,717	22,329	21,805	21,601	21,422	21,202	21,011	20,678	20,417

Source: Data as of March 15, 2020, CMS

EXHIBIT 6

June 5, 2021

Effectuated Enrollment: Early 2021 Snapshot and Full Year 2020 Average

This report provides effectuated enrollment, premium, advance payments of the premium tax credit (APTC), and cost sharing reduction (CSR) data for the Federally-facilitated and State-based Marketplaces ("the Marketplaces"), for February 2021 and for the entire 2020 plan year, as of March 15, 2021[1,2]

Key findings from this report include:

February 2021 Effectuated Enrollment, Financial Assistance, and Premiums

- *Effectuated Enrollment:* Effectuated enrollment through the Marketplaces for February 2021 was 11.3 million.[3] This is a six percent increase from 10.7 million consumers with effectuated coverage in February 2020.
- *Financial Assistance:* In February 2021, 86 percent of Marketplace enrollees received APTC, consistent with the percentage of enrollees who received APTC in February 2020.
- *Premiums:* The average total monthly premium for Marketplace enrollees in February 2021 was $574.59, compared to $576.16 for February 2020.

2020 Average Monthly Effectuated Enrollment, Financial Assistance, and Premiums

- *Effectuated Enrollment:* On monthly average, 10.4 million consumers had effectuated coverage through the Marketplaces in the 2020 plan year. This is a six percent increase from the average monthly effectuated enrollment of 9.8 million in the 2019 plan year.
- *Financial Assistance:* 86 percent of Marketplace enrollees received APTC on average each month in 2020. This represents a one-percentage point decrease from 87 percent in 2019.
- *Premiums:* The average total monthly premium for Marketplace enrollees in 2020 was $572.52, a three percent decrease from $591.26 in 2019.

[1] The data reported today may be revised in future months as additional data on new effectuations, terminations, and cancellations become available. CMS plans to publish effectuated enrollment data for the first six months of 2021, which will include updated February 2021 enrollment data.

[2] The February effectuated enrollment and premium data and methodology for plan years 2016-2021 are posted here: https://www.cms.gov/files/document/2016-2021-Feb-Effectuated-Enrollment-Tables.xls The average monthly effectuated enrollment and premium data and methodology for plan years 2016-2020 are posted here: https://www.cms.gov/files/document/2016-2020-Full-Year-Effectuated-Enrollment-Tables.xls

[3] February 2021 effectuated enrollment generally does not include enrollments during the 2021 Special Enrollment Periods (SEP) for the COVID-19 Public Health Emergency, because March 2021 was the earliest month that most enrollees could have coverage start, except for certain SEP types that allow retroactive start dates.

CONSUMERS EFFECTUATING COVERAGE THROUGH THE MARKETPLACES: FEBRUARY 2021

In February 2021, 11.3 million consumers had effectuated coverage through the Marketplaces, a six percent increase from 10.7 million consumers in February of 2020 (see Table 1).[4] This also represents 94 percent of consumers who made plan selections during the 2021 Open Enrollment Period (12.0 million). In five states (Florida, Georgia, Maryland, New Jersey and Texas), total effectuated enrollment increased by 10 percent or more from February 2020 to February 2021, while total effectuated enrollment fell by 10 percent or more in two states (Massachusetts and New York) over the same period.

In February 2021, 9.7 million, or 86 percent, of Marketplace enrollees received APTC, the same proportion of enrollees that received APTC in February 2020. The percentage of enrollees receiving CSR fell two percentage points from 50 percent in February 2020 to 48 percent in February 2021.

Table 1: Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State for February 2021

Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, February 2021					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
TOTAL	11,290,546	9,722,533	86%	5,449,070	48%
AK	16,780	13,680	82%	3,332	20%
AL	159,136	150,530	95%	115,554	73%
AR	60,258	53,415	89%	33,973	56%
AZ	143,964	114,335	79%	63,162	44%
CA	1,583,781	1,350,010	85%	671,745	42%
CO	161,342	112,498	70%	46,868	29%
CT	95,213	65,578	69%	31,461	33%
DC	15,822	1,091	7%	355	2%
DE	23,889	20,029	84%	6,280	26%
FL	2,018,631	1,930,320	96%	1,291,855	64%
GA	482,350	435,186	90%	316,299	66%
HI	20,191	16,620	82%	7,063	35%
IA	54,820	47,578	87%	14,271	26%
ID	66,422	54,757	82%	16,721	25%
IL	270,823	225,621	83%	112,835	42%
IN	124,979	90,340	72%	49,187	39%
KS	82,971	73,312	88%	37,121	45%
KY	70,680	57,610	82%	25,579	36%

[4] Centers for Medicare and Medicaid Services, Early 2020 Effectuated Enrollment Snapshot (July 23, 2020), at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Early-2020-2019-Effectuated-Enrollment-Report.pdf

Total Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, February 2021					
State	Total Enrollment	APTC Enrollment	Percentage of Enrollment with APTC	CSR Enrollment	Percentage of Enrollment with CSR
LA	76,289	69,609	91%	38,560	51%
MA	259,677	198,471	76%	184,482	71%
MD	154,815	118,622	77%	46,338	30%
ME	55,502	45,452	82%	18,052	33%
MI	249,353	208,070	83%	92,014	37%
MN	106,138	53,582	50%	9,335	9%
MO	200,588	174,902	87%	113,214	56%
MS	99,897	97,730	98%	78,595	79%
MT	41,842	34,467	82%	11,650	28%
NC	501,252	462,765	92%	252,075	50%
ND	21,822	18,710	86%	6,528	30%
NE	83,275	78,540	94%	22,275	27%
NH	44,228	28,761	65%	14,644	33%
NJ	257,819	203,687	79%	123,143	48%
NM	38,922	29,180	75%	12,868	33%
NV	79,976	67,811	85%	39,482	49%
NY	197,083	94,970	48%	18,087	9%
OH	187,869	142,568	76%	58,777	31%
OK	161,639	152,766	95%	92,704	57%
OR	129,436	92,802	72%	38,534	30%
PA	315,334	270,385	86%	121,602	39%
RI	30,670	24,260	79%	11,580	38%
SC	217,292	199,052	92%	83,812	39%
SD	29,974	27,928	93%	13,365	45%
TN	196,626	174,547	89%	94,548	48%
TX	1,210,431	1,113,267	92%	687,642	57%
UT	198,037	181,268	92%	88,813	45%
VA	243,598	209,320	86%	90,383	37%
VT	23,700	19,521	82%	7,794	33%
WA	202,546	124,765	62%	58,221	29%
WI	180,328	153,123	85%	63,055	35%
WV	17,217	15,437	90%	8,039	47%
WY	25,319	23,685	94%	5,198	21%

Source: Data as of March 15, 2021, CMS

PREMIUMS AND FINANCIAL ASSISTANCE FOR EFFECTUATED COVERAGE THROUGH THE MARKETPLACES: FEBRUARY 2021

The average monthly premium for Marketplace enrollees in February 2021 was $574.59, relatively constant in comparison to $576.16 in February 2020. The average monthly APTC for February 2021 was $485.67, a one percent decrease from $491.53 in February 2020.

Table 2: Average Total Premium and Average APTC by State, February 2021

Average Total Premium and Average APTC by State, February 2021		
State	**Average Total Premium per Month**	**Average APTC per Month (for consumers receiving APTC)**
TOTAL	$574.59	$485.67
AK	$691.86	$627.64
AL	$730.77	$672.59
AR	$545.40	$419.72
AZ	$577.45	$465.27
CA	$570.16	$450.73
CO	$462.98	$341.11
CT	$693.73	$650.30
DC	$524.92	$385.29
DE	$673.84	$570.27
FL	$595.08	$525.62
GA	$580.90	$509.90
HI	$622.32	$537.55
IA	$647.95	$576.14
ID	$516.08	$458.61
IL	$621.60	$465.95
IN	$578.95	$426.85
KS	$625.86	$521.11
KY	$600.97	$508.49
LA	$741.00	$627.60
MA	$439.22	$289.84
MD	$442.44	$374.38
ME	$556.52	$458.19
MI	$478.41	$354.79

Average Total Premium and Average APTC by State, February 2021 (Cont.)		
State	**Average Total Premium per Month**	**Average APTC per Month**
MN	$439.88	$277.84
MO	$637.94	$553.29
MS	$619.78	$544.85
MT	$568.46	$467.02
NC	$631.08	$566.18
ND	$482.63	$417.89
NE	$714.86	$670.32
NH	$443.65	$326.73
NJ	$575.39	$440.90
NM	$461.15	$369.17
NV	$505.57	$414.13
NY	$592.87	$322.84
OH	$520.47	$377.24
OK	$619.53	$569.08
OR	$561.40	$450.60
PA	$621.23	$515.30
RI	$455.74	$350.88
SC	$578.77	$505.33
SD	$694.07	$621.85
TN	$615.20	$532.21
TX	$545.48	$477.63
UT	$398.83	$350.62
VA	$591.35	$506.45
VT	$637.21	$465.80
WA	$482.60	$385.14
WI	$628.84	$533.33
WV	$1,036.03	$831.76
WY	$864.90	$817.43

Source: Data as of March 15, 2021, CMS

CONSUMERS EFFECTUATING COVERAGE THROUGH THE MARKETPLACES: PLAN YEAR 2020

Below is information on consumers with effectuated coverage for the 2020 plan year. On a monthly average basis, 10.4 million consumers had effectuated coverage through the Marketplaces in the 2020 plan year. This is a six percent increase from 9.8 million in the 2019 plan year. In eight states (California, Delaware, Florida, Georgia, Iowa, Maryland, Mississippi and Texas), total effectuated enrollment increased by 10 percent or more from the 2019 plan year to the 2020 plan year, while total effectuated enrollment fell by 10 percent or more in one state (Idaho) over the same period.

On average, 9.0 million, or 86 percent, of Marketplace enrollees received APTC each month in plan year 2020, a one-percentage point decrease from 87 percent of enrollees that received APTC each month in plan year 2019. The monthly average percentage of enrollees receiving CSR fell one percentage point from 51 percent in the 2019 plan year to 50 percent in the 2020 plan year.

Table 3: Total Average Monthly Effectuated Enrollment and Enrollees Receiving APTC and CSR by State for 2020

Total Average Monthly Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, 2020					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
TOTAL	10,408,982	8,977,593	86%	5,227,170	50%
AK	15,544	13,062	84%	3,491	22%
AL	143,075	135,199	94%	104,313	73%
AR	56,071	49,236	88%	32,653	58%
AZ	135,366	108,932	80%	61,920	46%
CA	1,514,297	1,290,296	85%	640,439	42%
CO	156,196	114,103	73%	44,978	29%
CT	100,626	69,561	69%	32,978	33%
DC	16,195	1,176	7%	402	2%
DE	22,338	18,984	85%	6,408	29%
FL	1,757,882	1,678,022	95%	1,175,366	67%
GA	413,122	372,405	90%	280,353	68%
HI	18,528	15,395	83%	6,792	37%
IA	51,519	46,923	91%	17,182	33%
ID	68,878	59,929	87%	20,605	30%
IL	259,519	220,326	85%	111,934	43%

Total Average Monthly Effectuated Enrollment and Enrollees Receiving APTC and CSR by State, 2020 (Cont.)					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
IN	125,261	88,391	71%	52,464	42%
KS	76,702	68,336	89%	32,328	42%
KY	71,430	58,853	82%	29,212	41%
LA	75,432	68,441	91%	38,867	52%
MA	286,857	227,691	79%	211,854	74%
MD	149,367	122,196	82%	52,961	35%
ME	55,388	47,512	86%	18,452	33%
MI	234,780	199,550	85%	90,013	38%
MN	105,327	57,668	55%	10,528	10%
MO	183,019	158,998	87%	109,677	60%
MS	86,736	84,740	98%	74,858	86%
MT	40,183	33,947	84%	11,928	30%
NC	452,638	420,823	93%	256,463	57%
ND	19,976	17,003	85%	7,369	37%
NE	82,649	78,861	95%	24,669	30%
NH	40,671	28,847	71%	14,505	36%
NJ	215,129	167,203	78%	103,480	48%
NM	37,176	28,682	77%	12,960	35%
NV	66,538	56,628	85%	58,428	88%
NY	238,377	136,335	57%	28,948	12%
OH	174,882	133,979	77%	57,866	33%
OK	143,361	135,854	95%	85,154	59%
OR	127,448	93,949	74%	40,026	31%
PA	290,571	250,848	86%	126,317	43%
RI	32,754	26,611	81%	13,248	40%
SC	188,907	174,952	93%	81,767	43%
SD	27,786	25,995	94%	12,900	46%
TN	178,195	158,678	89%	91,981	52%
TX	1,010,181	924,035	91%	604,699	60%
UT	185,925	171,630	92%	89,910	48%
VA	232,867	202,952	87%	91,512	39%
VT	24,732	20,600	83%	8,636	35%
WA	201,436	122,594	61%	62,776	31%
WI	176,820	153,445	87%	66,878	38%
WV	17,567	15,704	89%	8,518	48%
WY	22,758	21,513	95%	5,204	23%

Source: Data as of March 15, 2021, CMS

The average monthly premium for Marketplace enrollees in 2020 was $572.52, compared to the 2019 average monthly premium of $591.26. The average monthly APTC for consumers receiving APTC was $489.71, a decrease of four percent from $512.11 in 2019.

Table 4: Average Total Premium and Average APTC by State for 2020

Table 4: Average Total Premium and Average APTC by State, 2020		
State	**Average Total Premium per Month**	**Average APTC per Month (for consumers receiving APTC)**
TOTAL	$572.52	$489.71
AK	$725.27	$662.55
AL	$680.46	$619.57
AR	$517.36	$381.30
AZ	$581.09	$467.76
CA	$563.42	$450.16
CO	$471.26	$365.05
CT	$677.88	$628.42
DC	$512.58	$374.33
DE	$660.87	$567.12
FL	$592.87	$531.87
GA	$560.59	$493.87
HI	$626.94	$518.78
IA	$814.29	$799.66
ID	$515.58	$469.33
IL	$631.24	$497.80
IN	$534.63	$392.62
KS	$630.99	$543.11
KY	$588.41	$507.24
LA	$676.45	$564.82
MA	$402.80	$268.31
MD	$497.40	$439.54
ME	$630.17	$542.53
MI	$467.02	$361.28
MN	$433.42	$286.64
MO	$629.42	$560.94
MS	$601.92	$559.18
MT	$560.44	$477.31

Table 4: Average Total Premium and Average APTC by State, 2020 (Cont.)		
State	**Average Total Premium per Month**	**Average APTC per Month (for consumers receiving APTC)**
NC	$656.32	$606.83
ND	$442.11	$318.39
NE	$754.29	$707.66
NH	$523.32	$412.26
NJ	$553.13	$417.33
NM	$475.20	$373.38
NV	$487.76	$389.06
NY	$579.05	$335.98
OH	$511.79	$385.19
OK	$633.51	$595.83
OR	$550.54	$451.01
PA	$639.59	$513.41
RI	$428.46	$321.99
SC	$608.35	$539.93
SD	$672.36	$592.40
TN	$635.41	$576.52
TX	$526.22	$468.31
UT	$412.42	$365.88
VA	$635.61	$554.10
VT	$620.04	$462.33
WA	$497.81	$389.06
WI	$651.86	$566.17
WV	$981.06	$810.33
WY	$951.41	$908.80

Source: Data as of March 15, 2021, CMS

Table 5 includes the monthly effectuated enrollment by state for the 2020 plan year. In 2020, monthly effectuated enrollment peaked in February at 10.6 million consumers and fell to 9.9 million by December. Effectuated enrollment was much more stable throughout the year in 2020 compared to 2019, when enrollment declined from a high of 10.5 million consumers in January to 9.1 million consumers at the end of the year.

Table 5: Monthly Effectuated Enrollment by State for 2020

Monthly Effectuated Enrollment by State, 2020												
State	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**
TOTAL	10,514,296	10,592,901	10,533,727	10,506,296	10,518,508	10,526,138	10,506,231	10,466,271	10,409,652	10,250,309	10,135,819	9,947,574
AK	16,535	16,339	16,177	15,948	15,808	15,567	15,382	15,264	15,172	14,926	14,820	14,585
AL	148,905	147,478	146,005	144,083	143,857	143,967	143,151	142,674	141,742	139,509	138,593	136,941
AR	58,057	57,077	56,795	56,614	56,686	56,939	56,770	55,933	55,472	54,670	54,253	53,583
AZ	142,215	140,187	138,986	137,722	136,992	136,459	135,561	134,162	133,021	131,411	129,985	127,687
CA	1,353,866	1,506,786	1,493,427	1,519,227	1,537,121	1,543,069	1,553,335	1,565,348	1,564,054	1,535,182	1,509,882	1,490,270
CO	144,359	154,000	153,123	157,113	160,649	160,065	159,462	159,153	158,519	157,612	156,369	153,933
CT	101,050	104,580	103,943	104,624	103,442	101,949	101,209	100,684	99,195	97,967	96,551	92,313
DC	15,696	15,538	16,084	16,085	16,120	16,204	16,283	16,485	16,571	16,537	16,422	16,320
DE	22,472	22,411	22,684	22,818	22,911	23,055	23,179	22,932	22,007	21,484	21,262	20,835
FL	1,811,441	1,804,495	1,794,230	1,768,666	1,769,429	1,777,277	1,772,151	1,755,765	1,746,136	1,717,850	1,707,220	1,669,921
GA	431,365	425,362	420,840	416,403	417,956	419,268	417,062	412,284	410,083	401,308	396,230	389,307
HI	18,758	18,364	18,415	18,406	18,444	18,275	18,433	18,605	18,858	18,594	18,720	18,469
IA	51,980	51,903	52,017	51,927	51,985	52,067	51,976	52,054	51,756	50,696	50,309	49,557
ID	72,800	72,126	71,844	70,926	69,857	69,320	68,732	67,826	67,023	66,310	65,487	64,283

Monthly Effectuated Enrollment by State, 2020 (Cont.)												
State	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**
IL	273,988	268,579	265,326	262,969	262,396	261,712	260,466	258,560	255,575	251,656	248,903	244,099
IN	131,906	130,459	128,956	128,295	127,838	127,347	126,272	123,965	122,610	120,562	118,870	116,053
KS	80,704	78,614	77,831	77,279	77,187	77,288	76,863	76,246	75,866	75,004	74,432	73,107
KY	77,174	75,970	75,395	74,474	73,381	72,198	71,468	70,677	69,072	67,174	65,947	64,232
LA	80,311	78,901	78,256	77,403	76,556	76,302	75,709	75,154	74,016	72,156	71,097	69,320
MA	278,256	287,298	292,632	293,995	288,826	288,067	291,301	293,502	291,691	285,123	278,145	273,445
MD	144,542	141,108	141,103	147,876	150,216	152,539	153,677	154,208	155,523	152,101	150,325	149,185
ME	58,540	57,354	57,181	56,804	56,402	55,830	55,420	54,941	54,485	53,778	52,446	51,470
MI	247,628	242,504	240,346	239,037	237,433	236,561	236,105	234,785	231,940	227,272	224,113	219,639
MN	105,052	104,526	104,532	109,857	108,333	107,247	106,800	106,407	105,519	103,597	102,106	99,942
MO	190,217	187,407	185,565	183,849	184,126	184,486	184,311	184,029	183,250	179,586	176,171	173,234
MS	91,348	89,800	88,415	86,973	87,640	88,423	87,285	86,147	85,669	83,907	83,291	81,931
MT	41,532	41,042	40,884	40,685	40,518	40,430	40,351	40,229	39,842	39,275	39,011	38,394
NC	471,204	462,741	460,091	459,583	461,376	459,795	452,426	450,195	447,341	440,490	436,946	429,462
ND	20,815	20,341	20,266	20,117	20,131	20,089	20,015	19,947	19,862	19,610	19,394	19,119
NE	86,715	84,403	83,806	83,310	83,290	83,144	82,944	82,957	82,228	80,850	79,860	78,277
NH	42,102	41,570	41,301	41,002	41,118	41,126	41,066	40,611	40,288	39,745	39,385	38,733
NJ	223,890	221,634	219,326	218,534	218,046	217,368	215,797	214,882	212,511	209,943	207,293	202,318
NM	40,166	38,917	38,389	37,873	37,465	37,221	36,909	36,634	36,250	35,840	35,537	34,911

Monthly Effectuated Enrollment by State, 2020 (Cont.)												
State	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**
NV	69,061	66,809	65,579	66,236	67,297	68,047	67,382	66,767	66,042	65,731	65,311	64,188
NY	220,403	234,781	250,844	251,180	246,789	240,823	239,923	239,449	238,945	237,119	234,112	226,155
OH	183,942	181,019	179,228	177,849	176,697	176,024	174,964	173,420	172,158	170,115	168,251	164,918
OK	147,856	141,274	140,782	139,859	141,481	143,067	144,034	144,809	144,884	144,449	144,717	143,116
OR	133,821	132,479	131,757	130,890	129,593	128,520	127,767	127,020	125,790	123,000	120,705	118,032
PA	307,591	299,887	296,840	296,121	294,868	293,216	291,217	287,821	285,622	282,576	278,506	272,591
RI	30,934	34,173	34,403	34,384	33,524	33,365	32,826	32,744	32,513	32,063	31,501	30,622
SC	198,196	194,616	191,709	188,590	188,567	189,508	189,390	189,229	188,145	184,721	183,342	180,875
SD	28,365	28,282	28,185	28,020	28,018	28,072	27,985	27,872	27,638	27,249	27,094	26,655
TN	186,197	182,491	180,849	178,644	178,406	178,916	178,610	178,154	177,037	174,807	173,571	170,660
TX	1,036,650	1,022,310	1,012,110	1,000,500	1,007,295	1,017,046	1,019,575	1,015,205	1,012,758	1,003,166	996,680	978,873
UT	191,113	189,115	188,143	186,726	186,973	187,032	186,913	186,584	185,415	182,989	181,401	178,696
VA	247,883	240,739	238,025	236,054	236,031	234,096	232,634	231,584	230,060	226,052	222,639	218,602
VT	25,939	25,724	25,562	25,239	24,741	24,595	24,638	24,610	24,473	24,137	23,802	23,325
WA	204,063	205,270	203,521	205,302	205,407	204,604	202,830	201,253	200,043	198,729	195,880	190,326
WI	184,886	182,753	180,987	179,440	178,644	177,979	177,084	176,014	174,856	172,276	169,880	167,035
WV	18,370	18,150	17,967	17,916	17,794	17,686	17,642	17,565	17,374	17,089	16,967	16,281
WY	23,437	23,215	23,065	22,869	22,848	22,888	22,946	22,926	22,752	22,316	22,085	21,749

Source: Data as of March 15, 2021, CMS

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EXHIBIT 7

TABLE—ESTIMATED ANNUALIZED BURDEN

Instrument	Type of respondent	Number of respondents	Number of responses per respondent	Average burden hours per response	Total annual burden hours
Evaluation of Adolescent Pregnancy Prevention Approaches Household Survey.	Youth aged 15–19	9,000	1	45/60	6,750

Mary Forbes,

Office of the Secretary, Paperwork Reduction Act Clearance Officer.

[FR Doc. 2011–22166 Filed 8–29–11; 8:45 am]

BILLING CODE 4150–32–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Delegation of Authorities

Notice is hereby given that I have delegated to the Administrator, Centers for Medicare & Medicaid Services (CMS), or his or her successor, the authorities vested in the Secretary for the following provisions of Titles I, II, and X of the Affordable Care Act, including Title XXVII of the Public Health Service Act insofar as such parts pertain to CMS' mission, as described in section F.00 of CMS' Statement of Organization, Functions, and Delegations of Authority, last published at 55 FR 9363 (March 13, 1990).

Title I—Quality, Affordable Health Care for All Americans

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Section 1101—The authorities pursuant to section 1101 [42 U.S.C. 18001], as amended, to establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

Section 1102—The authorities pursuant to section 1102 [42 U.S.C. 18002], as amended, to establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014. The authority to accept and review appeals of adverse reimbursement determinations under the reinsurance program is, however, delegated to the Chair of the Departmental Appeals Board, Office of the Secretary, who will designate one or more Board Members to decide each appeal. The Board's decision on an appeal will be final and binding unless reopened and revised pursuant to 45 CFR 149.610.

Section 1103—The authorities pursuant to section 1103 [42 U.S.C. 18003], as amended, to establish a mechanism, including an Internet Web site, through which a resident of any State may identify affordable health insurance coverage options in that State.

Subtitle C—Quality Health Insurance Coverage for All Americans

Part II—Other Provisions

Section 1251—The authorities pursuant to section 1251 [42 USC 18011], as amended, to preserve the right of individuals and groups to maintain existing health insurance coverage.

Section 1252—The authorities pursuant to section 1252 [42 USC 18012], as amended, to uniformly apply rate reforms to all health insurance issuers and group health plans.

Subtitle D—Available Coverage Choices for All Americans

Part I—Establishment of Qualified Health Plans

Section 1301—The authorities pursuant to section 1301 [42 U.S.C. 18021], as amended, pertaining to defining qualified health plans.

Section 1302—The authorities pursuant to section 1302 [42 U.S.C. 18022], as amended, pertaining to essential health benefits requirements, including a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in Section 1302(b)(2) [42 U.S.C. 18022(b)(2)].

Section 1303—The authorities pursuant to section 1303 [42 U.S.C. 18023], as amended, pertaining to State opt-out of abortion coverage, special rules relating to coverage of abortion services, applying State and Federal laws regarding abortion, and applying emergency services.

Section 1304—The authorities pursuant to section 1304 [42 U.S.C. 18024], as amended, pertaining to definitions related to quality, affordable health care for all Americans.

Part II—Consumer Choices and Insurance Competition Through Health Benefit Exchanges

Section 1311—The authorities pursuant to section 1311 [42 USC 18031], as amended, pertaining to affordable choices of health benefit plans, in particular, the American Health Benefit Exchanges (AHBE). CMS will coordinate with the Department of Labor under section 1311(e)(3)(B) [42 USC 18031(e)(3)(B)].

Section 1312—The authorities pursuant to section 1312 [42 USC 18032], as amended, pertaining to consumer choice, payment of premiums by qualified individuals, single risk pool, enrollment through agents or brokers, and qualified individuals and employers (access limited to citizens and lawful residents).

Section 1313(a)—The authorities pursuant to section 1313(a) [42 USC 18033(a)], as amended, pertaining to financial integrity involving accounting for expenditures, investigations, audits, pattern of abuse, protections against fraud and abuse, and applying the False Claims Act. CMS will coordinate with the Office of the Inspector General to investigate the affairs of an AHBE, to examine the properties and records of an AHBE, and to require periodic reports in relation to activities undertaken by an AHBE under section 1313(a)(2) [42 USC 18033(a)(2)].

Part III—State Flexibility Relating to Exchanges

Section 1321—The authorities pursuant to section 1321 [42 U.S.C. 18041], as amended, pertaining to the State's flexibility in operation and enforcement of AHBE and related requirements. CMS will consult with the National Association of Insurance Commissioners under section 1321(a)(2) [42 U.S.C. 18041(a)(2)].

Sections 1322(a)–(b)(1) and (2), (c)–(g) and (h)(1)—The authorities pursuant to sections 1322(a)–(b)(1) and (2), (c)–(g) [42 USC 18042] and (h)(1) [26 U.S.C. 501(c)(29)], as amended, to establish the Consumer Operated and Oriented Plan Program to assist establishment and operation of non-profit, member-run

health insurance issuers. CMS will coordinate with the Department of the Treasury to establish criteria and procedures for tax exemption under section 501(c)(29) of the Internal Revenue Code of 1986 [26 U.S.C. 501(c)(29)] for qualified nonprofit health insurance issuers.

Section 1323—The authorities pursuant to section 1323 [42 U.S.C. 18043], as amended, to fund territories that elect to establish an AHBE.

Section 1324—The authorities pursuant to section 1324 [42 U.S.C. 18044], as amended, pertaining to health insurance coverage offered by a private health insurance issuer, which would not be subject to the Federal or State laws described in section 1324(b) [42 U.S.C. 18044(b)] if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322 [42 U.S.C. 18042] or a multi-State qualified health plan under section 1334 [42 USC 18054] were not subject to such laws.

Part IV—State Flexibility to Establish Alternative Programs

Section 1331—The authorities pursuant to section 1331 [42 USC 18051], as amended, to establish basic health programs for low-income individuals not eligible for Medicaid, and allowing States the flexibility to establish alternative programs by entering into contracts to offer one or more standard health plans providing at least the essential health benefits described in section 1302(b) [42 U.S.C. 18022(b)] to eligible individuals in lieu of offering such individuals coverage through an Exchange. The Chief Actuary in the Office of the Actuary, CMS, will certify whether the methodology used to make determinations pursuant to section 1331(d)(3) (A)(iii) [42 U.S.C. 18051(d)(3)(A)(iii)], and such determinations, meet the requirements of section 1331(d)(3)(A)(ii) [42 U.S.C. 18051(d)(3)(A)(ii)] in consultation with the Office of Tax Analysis of the Department of the Treasury.

Section 1332—The authorities pursuant to section 1332 [42 U.S.C. 18052], as amended, pertaining to waivers for State innovations with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2017. CMS will coordinate with the Department of the Treasury to publish regulations pursuant to section 1332(a)(4)(B) [42 U.S.C. 18052(a)(4)(B)].

Section 1333—The authorities pursuant to section 1333 [42 U.S.C. 18053], as amended, pertaining to offering plans in more than one State. CMS will coordinate with the National Association of Insurance Commissioners to publish regulations pursuant to section 1333(a)(1) [42 U.S.C. 18053(a)(1)].

Part V—Reinsurance and Risk Adjustment

Section 1341—The authorities pursuant to section 1341 [42 U.S.C. 18061], as amended, pertaining to the transitional reinsurance program for individual and small group markets in each State. CMS will coordinate with the National Association of Insurance Commissioners to publish regulations pursuant to section 1321(a) [42 U.S.C. 18041].

Section 1342—The authorities pursuant to section 1342 [42 U.S.C. 18062], as amended, to establish and administer a program of risk corridors 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 health plan to the health plan's aggregate premiums based on the program for regional participating provider organizations under part D of Title XVIII of the Social Security Act.

Section 1343(b)—The authorities pursuant to section 1343(b) [42 U.S.C. 18063(b)], as amended, to establish criteria and methods used in carrying out risk adjustment activities pursuant to section 1343 [42 USC 18063] with respect to health insurance plans and coverage.

Subtitle E—Affordable Coverage Choices for All Americans

Part I—Premium Tax Credits and Cost-Sharing Reductions

Subpart A—Premium Tax Credits and Cost-Sharing Reductions

Section 1401(a)—The authorities pursuant to section 1401(a) [26 USC 36B], as amended, pertaining to refundable credit for coverage under a qualified health plan. CMS will consult with the Department of the Treasury pursuant to the Internal Revenue Code of 1986 section 36B(e)(3) [26 U.S.C. 36B(e)(3)] to prescribe rules setting forth the methods by which calculations of family size and household income are made, and carry out the activities set out pursuant to 26 U.S.C. 36B [26 U.S.C. 36B], such as determinations of premiums.

Section 1402—The authorities pursuant to section 1402 [42 U.S.C. 18071], as amended, pertaining to reduced cost-sharing for individuals enrolling in qualified health plans. CMS will consult with the Department of the Treasury pursuant to section 1402(e)(3) [42 U.S.C. 18071(e)(3)].

Section 1411—The authorities pursuant to section 1411 [42 U.S.C. 18081], as amended, to determine eligibility for exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions. CMS will consult with: (1) The Department of Homeland Security pursuant to section 1411(b)(2)(B) [42 U.S.C. 18081(b)(2)(B)]; 2) the Departments of the Treasury, and Homeland Security, and the Social Security Administration pursuant to sections 1411(c)(4)(A) [42 U.S.C. 18081(c)(4)(A)] and 1411(f)(1) [42 U.S.C. 18081(f)(1)]; and 3) the Department of the Treasury pursuant to section 1411(i)(1) [42 U.S.C. 18081(i)(1)].

Section 1412—The authorities pursuant to section 1412 [42 U.S.C. 18082), as amended, pertaining to advance determinations made pursuant to section 1411 [42 U.S.C. 18081] with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the AHBE for the premium tax credit allowable pursuant to section 1401(a) [26 U.S.C. 36B] and the cost-sharing reductions under section 1402 [42 U.S.C. 18071]. CMS will consult with the Department of the Treasury.

Section 1413—The authorities pursuant to section 1413 [42 U.S.C. 18083), as amended, to streamline procedures for enrollment through an AHBE and State Medicaid, CHIP, and health subsidy programs.

Section 1414(a)(1)—The authorities pursuant to section 6103(l)(21) of the Internal Revenue Code of 1986 [26 U.S.C. 6103(l)(21)], as amended, pertaining to disclosure of taxpayer return information and Social Security numbers.

Section 1414(a)(2)—The authorities pursuant to section 205(c)(2)(C)(x) of the Social Security Act [42 U.S.C. 405(c)(2)(C)(x)], as amended, to collect and use the names and Social Security account numbers of individuals as required to administer the provisions of the Social Security Act and amendments made by the Affordable Care Act.

Section 1415—The authorities pursuant to section 1415 [42 U.S.C. 18084], as amended, pertaining to premium tax credit and cost-sharing reduction payments disregarded for Federal and federally-assisted programs.

Subtitle F—Shared Responsibility for Health Care

Part I—Individual Responsibility

Sections 1501(a) and (b)—The authorities pursuant to section 1501(a) [42 U.S.C. 18091(a)], as amended, and

pursuant to section 1501(b) [26 U.S.C. 5000A], as amended, to maintain minimal essential coverage for health care, except for the last paragraph of 26 U.S.C. 5000A(e)(4).

Part II—Employer Responsibilities

Section 1511—The authorities pursuant to 29 USC 218A, as amended, to automatically enroll employees of large employers that have more than 200 full-time employees, and that offer employees enrollment in 1 or more health benefits plans (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer.

Section 1512—The authorities pursuant to 29 U.S.C. 218B, as amended, to provide notice to employees of coverage options.

Section 1513(a)—The authorities pursuant to section 1513(a) [26 U.S.C. 4980H], as amended, pertaining to shared responsibility for employers regarding health coverage. CMS will consult with the Department of Labor pursuant to 26 U.S.C. 4980H(c)(4)(B) to determine the hours of service of an employee necessary to qualify under 26 U.S.C. 4980H(c)(4) as a ''full-time employee'' for purposes of coverage under the Affordable Care Act.

Section 1514(a)—The authorities pursuant to section 6056 [26 U.S.C. 6056] of the Internal Revenue Code of 1986, as amended, to review the accuracy of health insurance information provided by large employers who are required to report on health insurance coverage.

Subtitle G—Miscellaneous Provisions

Section 1558—The authority pursuant to section 1558 [29 U.S.C. 218C], as amended, to prohibit employers from discharging or in any manner discriminating against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has: (1) Received a credit pursuant to section 36B of the Internal Revenue Code of 1986 or a subsidy pursuant to section 1402 of the Affordable Care Act; (2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title); (3) testified or is about to testify in a proceeding concerning such violation; (4) assisted or participated, or is about to assist or participate, in such a proceeding; or (5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of Title 29 of the United States Code (or amendment), or any order, rule, regulation, standard, or ban pursuant to Title 29 of the United States Code (or amendment).

Title II—Role of Public Programs

Subtitle C—Medicaid and CHIP Enrollment Simplification

Section 2201—The authority pursuant to section 2201 [42 U.S.C. 1396w–3, section 1943 of the Social Security Act], as amended, pertaining to enrollment simplification and coordination with State Health Insurance Exchanges.

Subtitle K—Protections for American Indians and Alaska Natives

Sections 2901(a) and (b)—The authorities pursuant to section 2901(a) and (b) [25 U.S.C. 1623(a) and (b)], as amended, pertaining to special rules relating to Indians. CMS will coordinate with the Indian Health Service pursuant to section 2901(b) [25 U.S.C. 1623(b)].

Title X—Strengthening Quality, Affordable Health Care for All Americans

Section 10108(a)–(e)—The authorities under section 10108(a)–(e) [42 USC 18101(a)–(e)], as amended, pertaining to an offering employer providing free choice vouchers to each qualified employee through an employer-sponsored health insurance plan.

Title XXVII of the Public Health Service Act, as amended, including the authority to conduct studies and demonstration projects, as directed by Congress, relating to Title XXVII of the Public Health Service Act. The delegation includes, but does not limit the authority to, directing performance, entering into contracts or cooperative agreements, making grants, approving payments for contracts, cooperative agreements, and grants, and approving authorized waivers of compliance with certain requirements of Title XXVII of the Public Health Service Act when such authorities are for the purpose of conducting studies and demonstration projects.

This delegation of authorities excludes the authorities to issue regulations, to submit reports to Congress, and the following authorities, as amended by the indicated sections of the Affordable Care Act:

(1) *Section 1302(b)(2)(A) and (B)*—The authority to conduct a survey of employer-sponsored coverage pursuant to section 1302(b)(2)(A) [42 U.S.C.18022(b)(2)(A)] to determine the benefits typically covered by employers, including multi-employer plans and the authority to submit a report pursuant to section 1302(b)(2)(B) [42 U.S.C. 18022(b)(2)(B)] to the appropriate committees of Congress.

(2) *Section 1311(e)(3)(D)*—The authority to update and harmonize rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established pursuant to section 1311(e)(3)(D) [42 U.S.C. 18031(e)(3)(A)].

(3) *Sections 1322(b)(4)*—The authority to appoint 15 members to the Consumer Operated and Oriented Plan Advisory Board pursuant to section 1322(b)(4) [42 U.S.C. 18042(b)(4)].

(4) *Section 1332*—The authorities with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, pursuant to section 1332(a)(2)(D) [42 U.S.C. 18052(a)(2)(D)] including sections 36B [26 U.S.C. 36B], 4980H [26 U.S.C. 4980H], and 5000A [26 U.S.C. 5000A] of the Internal Revenue Code of 1986, pertaining to reports to Congress pursuant to section 1332(a)(4)(C) [42 U.S.C. 18052(a)(4)(C)], and to notify the appropriate committees of Congress pursuant to section 1332(d)(2)(B) [42 U.S.C. 18052(d)(2)(B)].

(5) *Section 1411(i)(2)*—The authority under section 1411(i)(2) [42 U.S.C. 18081(i)(2)] of the Affordable Care Act to issue a report of the results of the study conducted under section 1411(i)(1) [42 U.S.C. 18081(i)(1)], including any recommendations for legislative changes to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate, and the Committees of Education and Labor and Ways and Means of the House of Representatives.

(6) *Section 1412(c)(2)*—The authority under section 1412(c)(2) [42 U.S.C. 18082(c)(2)] to make advance payments under section 1412 [42 U.S.C. 18082] of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 [26 U.S.C. 36B] to the issuer of a qualified health plan on a monthly basis.

(7) *Section 1414(a)(1)*—The authority to prescribe regulations to disclose return information indicating whether the taxpayer is eligible for a tax credit or reduction (and the amount thereof) pursuant to 26 U.S.C. 6103(l)(21)(A)(v).

(8) *Section 1501(b)*—The authority to prescribe rules for the collection of the penalty imposed in cases where

continuous periods include months in more than one taxable year pursuant to the last paragraph of 26 U.S.C. 5000A(e)(4).

This delegation of authorities supersedes the authorities delegated under Title XXVII of the Public Health Service Act that were published in the **Federal Register** notice on June 23, 1998 (63 FR 34190).

This delegation of authorities is effective immediately.

These authorities may be re-delegated.

These authorities shall be exercised under the Department's policy on regulations and the existing delegation of authority to approve and issue regulations.

I hereby affirm and ratify any actions taken by the Administrator, CMS, or his or her subordinates, which involved the exercise of the authorities under Titles I, II, and X of the Affordable Care Act, including Title XXVII of the Public Health Service Act delegated herein prior to the effective date of this delegation of authorities.

Authority: 44 U.S.C. 3101.

Dated: August 2, 2011.

Kathleen Sebelius,

Secretary.

[FR Doc. 2011–22042 Filed 8–29–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[ATSDR–270]

Availability of Final Toxicological Profile for RDX

AGENCY: Agency for Toxic Substances and Disease Registry (ATSDR), Department of Health and Human Services (HHS).

ACTION: Notice of availability.

SUMMARY: This notice announces the availability of one toxicological profile, prepared by ATSDR for the Department of Defense, on Royal Demolition eXplosive (RDX), chemical name hexahydro-1,3,5-trinitro-1,3,5-triazine, also known as cyclonite.

FOR FURTHER INFORMATION CONTACT: Ms. Delores Grant, Division of Toxicology and Environmental Medicine, Agency for Toxic Substances and Disease Registry, Mailstop F–62, 1600 Clifton Road, NE., Atlanta, Georgia 30333, telephone (770) 488–3351.

SUPPLEMENTARY INFORMATION: The Superfund Amendments and Reauthorization Act (SARA) of 1986 (Pub. L. 99–499) amended the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA or Superfund). Section 211 of SARA also amended Title 10 of the U.S. Code, creating the Defense Environmental Restoration Program. Section 2704 of Title 10 of the U.S. Code directs the Secretary of Defense to notify the Secretary of Health and Human Services (HHS) of not less than 25 of the most commonly found unregulated hazardous substances at defense facilities. The Secretary of HHS is to prepare toxicological profiles of these substances. Each profile is to include an examination, summary and interpretation of available toxicological information and epidemiologic evaluations. This information is used to ascertain the level of significant human exposure for the substance and the associated health effects. The toxicological profile includes a determination of whether adequate information on the health effects of each substance is available or in the process of development. When adequate information is not available, ATSDR, in cooperation with the National Toxicology Program (NTP), may plan a program of research designed to determine these health effects.

Notice of the availability of the draft profile for public review and comment was published in the **Federal Register** on August 26, 2010, (75 FR 52535), with notice of a 90-day public comment period starting from the actual release date. Following the close of the comment period, chemical-specific comments were addressed, and, where appropriate, changes were incorporated into each profile. The public comments and other data submitted in response to the **Federal Register** notice bears the docket control number ATSDR–266. This material is available for public inspection at the Agency for Toxic Substances and Disease Registry, 4700 Buford Highway, Building 106, Second Floor, Chamblee, Georgia 30341 between 8 a.m. and 4:30 p.m., Monday through Friday, except legal holidays.

Availability

This notice announces the availability of one updated final toxicological profile, RDX, prepared by ATSDR for the Department of Defense. Electronic access to this document is available at the ATSDR Web site: *http://www.atsdr.cdc.gov/toxprofiles/index.asp.*

A printed copy of this toxicological profile is available through the U.S. Department of Commerce, National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, Virginia 22161, telephone 1–800–553–6847. There is a charge for this profile as determined by NTIS.

Hazardous substance	NTIS Order No.	CAS Number
RDX	PB2011–xxx	121–82–4

Dated: August 24, 2011.

Ken Rose,

Director, Office of Policy, Planning and Evaluation, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry.

[FR Doc. 2011–22080 Filed 8–29–11; 8:45 am]

BILLING CODE 4163–70–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Title: ORR State Plan for Grants to States for Refugee Resettlement.

OMB No. 0970–0351.

Description: A State Plan is required by 8 U.S.C. 1522 of the Immigration and Nationality Act (the Act) [Title IV, Sec. 412 of the Act] for each State agency requesting Federal funding for refugee resettlement under 8 U.S.C. 524 [Title IV, Sec. 414 of the Act], including Refugee Cash and Medical Assistance, Refugee Social Services, and Targeted Assistance program funding. The State Plan is a comprehensive narrative description of the nature and scope of a States programs and provides assurances that the programs will be administered in conformity with the specific requirements stipulated in 45 CFR 400.4–400.9. The State Plan must

EXHIBIT 8

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 9

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: April 15, 2016

Subject: Data submission deadline for cost-sharing reduction reconciliation

The Affordable Care Act requires issuers of qualified health plans (QHPs) to provide reduced cost sharing for essential health benefits (EHB) to eligible Marketplace enrollees. Pursuant to 45 CFR 156.430(c), issuers of QHPs must notify the Secretary of Health and Human Services annually of cost-sharing reductions provided on behalf of eligible enrollees for actual essential health services. The amount of cost-sharing reductions provided to enrollees is then reconciled to payments that have been made to the issuer for the applicable benefit year.

Data submission to determine the reconciliation of cost-sharing reductions provided for the 2014 and 2015 benefit years began on April 1, 2016. To ensure the accuracy of data submission, and to accommodate issuers that are submitting data for both the 2014 and 2015 benefit years for the first time, **CMS will extend the final deadline for submission of 2014 and 2015 cost-sharing reduction reconciliation data to Friday, June 3, 2016 at 11:59 pm EDT.**

Additionally, to help ensure that issuers will be able to submit their CSR reconciliation data successfully by the Friday, June 3, 2016 deadline, **we are establishing an interim data submission deadline of Monday, May 2, 2016, 11:59 pm EDT**, by which time we are requiring all issuers to have submitted a data file to CMS. If an issuer has submitted a data file that has been processed by the interim deadline, the issuer will be deemed to be in compliance with the interim deadline, even if the file submitted fails CMS validations.

EXHIBIT 10

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.

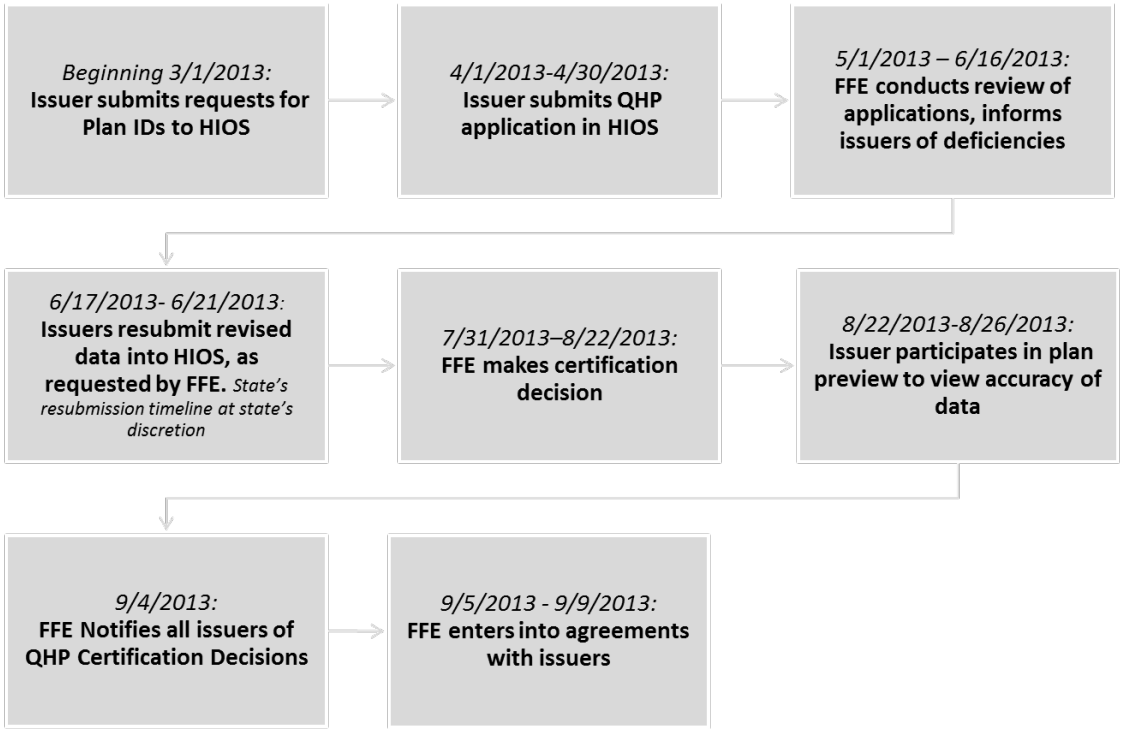
Ctr. Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Serv., Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Exchange (FFE) (Jan. 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.

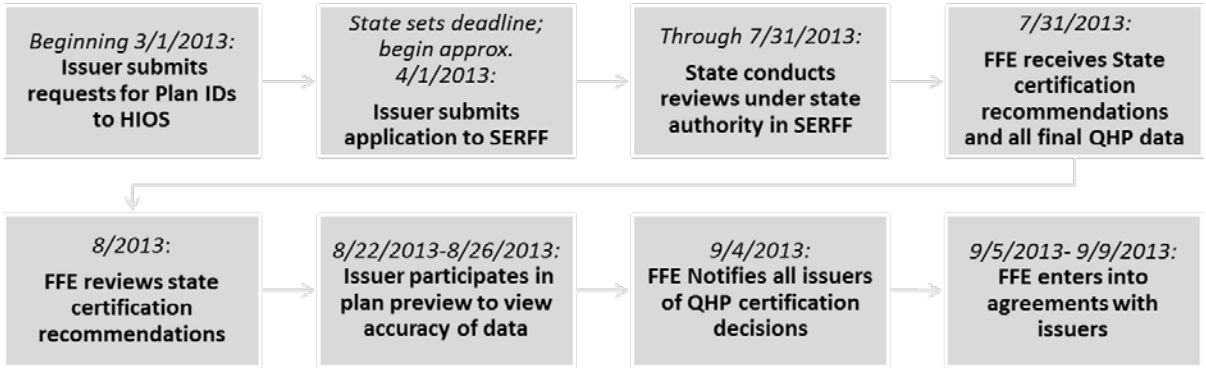
Appendix B: High-level Process Flows for QHP Certification
Note: all dates are subject to minor changes.

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 11

FEDERAL REGISTER

Vol. 77 Friday,
No. 236 December 7, 2012

Part II

Department of Health and Human Services

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

[CMS–9964–P]

RIN 0938–AR51

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

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

ACTION: Proposed rule.

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

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

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

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

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

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

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9964–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

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

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9964–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

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

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

FOR FURTHER INFORMATION CONTACT: Sharon Arnold at (301) 492–4286, Laurie McWright at (301) 492–4311, or Jeff Wu at (301) 492–4305 for general information.

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

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

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

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

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

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

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

SUPPLEMENTARY INFORMATION:

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

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

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taxes, and profits earned, which sum is limited to 20 percent of after-tax premiums earned (including any premium tax credit under any governmental program), plus taxes. This definition reflects the inclusion of profits and taxes discussed above, and clarifies that the 20 percent cap on allowable administrative costs applies to taxes, other than taxes deductible from premium revenue under the MLR rules, a result that is consistent with the way these taxes are accounted for by the MLR rules.

The following example illustrates the operation of the risk corridors calculation as proposed in this proposed rule:

- *Premiums earned:* Assume a QHP with premiums earned of $200.
- *Allowable costs:* Assume allowable costs of $140, including expenses for health care quality and health information technology, and other applicable adjustments. Risk adjustment and reinsurance payments are after-the-fact adjustments to allowable costs for purposes of determining risk corridors amounts, and allowable costs must be reduced by the amount of any cost-sharing reductions received from HHS.
- *Non-Claims Costs:* Assume that the QHP has non-claims costs of $50, of which $15 are properly allocable to licensing and regulatory fees and taxes and assessments described in § 158.161(a), § 158.162(a)(1), and § 158.162(b)(1) (that is, ''taxes'').

The following calculations result:

- *Taxes:* Under the proposed definition of taxes, the QHP's taxes will be $15.
- *Administrative costs* are proposed to be defined as non-claims costs. In this case, those costs would be $50. Administrative costs other than taxes would be $35.
- *After-tax premiums earned* are proposed to be defined as premiums earned minus taxes, or in this case $200 − $15 = $185.
- *Profits* are proposed to be defined as the greater of: 3 percent of premiums earned, or 3 percent * $200 = $6; and premiums earned by the QHP minus the sum of allowable costs and administrative costs, or $200—($140 + $50) = $200 − $190 = $10. Therefore, profits for the QHP would be $10, which is greater than $6.
- *Allowable administrative costs* are proposed to be defined as the sum of administrative costs, other than taxes, plus profits earned by the QHP, which sum is limited to 20 percent of after-tax premiums earned by the QHP (including any premium tax credit under any governmental program), plus taxes.

= ($35 + $10), limited to 20 percent of $185, plus $15
= $45, limited to $37, plus $15
= $37, plus $15
= $52.

- *The target amount* is defined as premiums earned reduced by allowable administrative costs, or $200 − $52 = $148.
- *The risk corridors ratio* is the ratio of allowable costs to target amount, or the ratio of $140 to $148, or approximately 94.6 percent (rounded to the nearest one-tenth of one percent), meaning that the QHP issuer would be required to remit to HHS 50 percent of approximately (97 percent − 94.6 percent) = 50 percent of 2.4 percent, or approximately 1.2 percent of the target amount, or approximately 0.012 * $148, or approximately $1.78.

We propose these amendments to account for taxes and profits in a manner broadly consistent with the MLR calculation. As described in the Premium Stabilization Rule, we seek alignment between the MLR and risk corridors program when practicable so that similar concepts in the two programs are handled in a similar manner, and similar policy goals are reflected. Otherwise, there would be the potential for the Federal government to subsidize MLR rebate payments, or for an issuer to make risk corridors payments even though no MLR rebates would have been required.

We welcome comments on these proposals.

2. Risk Corridors Establishment and Payment Methodology

We propose 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.

We propose a schedule for the risk corridors program, as follows. By June 30 of the year following an applicable benefit year, under the redesignated § 153.310(e), issuers of QHPs will have been notified of risk adjustment payments and charges for the applicable benefit year. By that same date, under proposed § 153.240(b)(1), QHP issuers also would have been notified of all reinsurance payments to be made for the applicable benefit year. As such, we propose 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 note that in section III.I. of this proposed rule, we are proposing that the MLR reporting deadline be revised to align with this schedule.

We welcome comments on these proposals.

3. Risk Corridors Data Requirements

In § 153.530 of the Premium Stabilization Rule, we stated that to support the risk corridors program calculations, a QHP must submit data related to actual premium amounts collected, including premium amounts paid by parties other than the enrollee in a QHP, specifically advance premium tax credits. We further specified that risk adjustment and reinsurance payments be regarded as after-the-fact adjustments to allowable costs for purposes of determining risk corridors amounts, and allowable costs be reduced by the amount of any cost-sharing reductions received from HHS. For example, if a QHP incurred $200 in allowable costs for a benefit year, but received a risk adjustment payment of $25, made reinsurance contributions of $10, received reinsurance payments of $35, and received cost-sharing reduction payments of $15, its allowable costs would be $135 ($200 allowable costs − $25 risk adjustment payments received + $10 reinsurance contributions made − $35 reinsurance payments received − $15 cost-sharing reduction payments).

As noted in section III.E. of this proposed rule, we are proposing an approach to reimbursement of cost-sharing reductions that would add an additional reimbursement requirement for cost-sharing reductions by providers with whom the issuer has a fee-for-service compensation arrangement. As described in section III.E., we propose that issuers be reimbursed for, in the case of a benefit for which the issuer compensates the provider in whole or in part on a fee-for-service basis, the actual amount of cost-sharing reductions provided to the enrollee for the benefit and reimbursed to the provider by the issuer. However, cost-sharing reductions on benefits rendered by providers for which the issuer provides compensation other than on a fee-for-service arrangement (such as a capitated system) would not be held to this standard.

It is our understanding that, in most fee-for-service arrangements, cost-sharing reductions will be passed through to the fee-for-service provider, and as such a QHP's allowable costs should not include either enrollee cost sharing or cost-sharing reductions reimbursed by HHS. However, in contrast in capitated arrangements, cost-sharing reduction payments should be accounted for as a deduction from

EXHIBIT 12

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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required in the QHP with no cost-sharing reductions.

We are finalizing the provisions as proposed, with one modification. To ensure continuity across the plan variations, we clarify in § 156.420(d) that the out-of-pocket spending required of enrollees in the zero cost sharing plan variation of a QHP for a benefit that is not an EHB from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the limited cost sharing plan variation of the QHP and the corresponding out-of-pocket spending required in the silver plan variation of the QHP for individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i), in the case of a silver QHP. This modification responds to commenters' concerns that issuers may use this flexibility to selectively attract certain enrollees, and is consistent with our general policy that an enrollee in a cost-sharing reduction plan variation be provided with plan features, including out-of-pocket spending, provider network, and benefits, that are at least as good as those offered under the standard plan or any other plan variation designed to be less generous.

We also clarify that in the case of an issuer participating in an Exchange that only requires issuers to submit one zero cost sharing plan variation with the lowest premium for a set of standard plans, as described in the 2014 Payment Notice at 78 FR 15494, the issuer must ensure that the out-of-pocket spending requirement for each non-EHB benefit of the submitted zero cost sharing plan variation is less than or equal to the lowest out-of-pocket spending requirement for the same benefit of a silver plan variation for individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i), if the silver plan is included in the set of standard plans.

Under these provisions, each cost-sharing reduction plan variation will continue to provide the most cost savings for which an enrollee is eligible; however, QHP issuers will be able to—though are not required to—reduce out-of-pocket spending for benefits that are not EHB for enrollees in plan variations in order to offer simpler cost-sharing designs that are consistent across EHB and benefits that are not EHB. We note, however, that in accordance with section 1402(d)(4) of the Affordable Care Act, any reductions in out-of-pocket spending for benefits that are not EHB will not be reimbursed by the Federal government because payments for cost-sharing reductions only apply to EHB.

Comment: One commenter strongly supported the proposal, stating that it will allow issuers the flexibility to develop plans that best meet the needs of the low-income population. Conversely, another commenter stated that issuers may use this flexibility to design plans that attract healthier beneficiaries and may offset any costs through premium increases. Several logistical concerns were also raised by commenters about how HHS would ensure that Federal reimbursement is not provided for these reductions, and how issuers would report and implement these reductions.

Response: As described in § 156.430(c), issuers may only submit information on reductions in cost sharing for EHB, and HHS will not provide reimbursement for reductions in out-of-pocket spending for benefits other than EHB. In addition, our changes to § 156.420(d) and (e) provide additional flexibility only with respect to different plan variations, and those provisions do not permit issuers to selectively lower cost sharing in a manner that disadvantages low-income consumers. As a result, we do not believe issuers will have any additional opportunity to attract healthy enrollees. Therefore, we are finalizing this provision as proposed, with the minor modification discussed above. We will provide additional guidance in the future for issuers on how to report out-of-pocket spending for benefits that are not EHB for purposes of QHP certification.

d. Advance Payments of Cost-Sharing Reductions

Section 1402(c)(3) of the Affordable Care Act directs a QHP issuer to notify the Secretary of cost-sharing reductions made under the statute, and directs the Secretary to make periodic and timely payments to the QHP issuer equal to the value of those reductions. Section 1412(c)(3) of the Affordable Care Act permits advance payments of cost-sharing reduction amounts to QHP issuers based upon amounts specified by the Secretary. Under these authorities, we established a payment approach in the 2014 Payment Notice under which monthly advance payments made to issuers to cover projected cost-sharing reduction amounts are reconciled after the end of the benefit year to the actual cost-sharing reduction amounts.

To implement this approach, we specified in § 156.430(a) that a QHP issuer must provide to the Exchange an estimate of the dollar value of the cost-sharing reductions to be provided over the benefit year, calculated in accordance with the methodology specified by HHS in the annual HHS notice of benefit and payment parameters. We further specified in the 2014 Payment Notice that QHP issuers did not need to submit an estimate of the dollar value of the cost-sharing reductions for the 2014 benefit year, except in the case of a limited cost sharing plan variation.[46] Instead, the Exchange sent the data that issuers submitted under §§ 156.420 and 156.470, including the AV of the standard plan and plan variation, and the EHB portion of expected allowed claims costs, to HHS for the calculation of the cost-sharing reduction advance payment rates. HHS then approved the rates and sent them back to the Exchange so that the cost-sharing reduction advance payment amounts could be reported as part of the 834 enrollment transactions, pursuant to § 156.340(a). HHS then provided advance payments to QHP issuers.

Based on our experience implementing this process for the 2014 benefit year, we proposed certain modifications to §§ 155.1030, 156.430, and 156.470. We believe these modifications will simplify the process and improve the accuracy of the calculations. Specifically, we proposed to remove the requirement detailed in § 156.430(a) that issuers develop estimates of the dollar value of the cost-sharing reductions to be provided, and instead proposed to modify § 155.1030(b)(3) to provide that an Exchange be required to use the methodology specified in the annual HHS notice of benefit and payment parameters to calculate advance payment amounts for cost-sharing reductions. We also proposed to modify § 155.1030(b)(4) so that the Exchange would no longer be required to submit issuers' advance payment estimates to HHS for approval prior to the start of the benefit year. The Exchange would simply calculate the advance payment amounts and transmit the amounts to HHS via the 834 enrollment transaction, pursuant to § 156.340(a). We then proposed in § 156.430(b)(1) that HHS provide periodic advance payments to QHP issuers based on the amounts transmitted by the Exchange. Lastly, we proposed conforming modifications to §§ 155.1030(b)(1) and 156.470(a), to remove the obligation for QHP issuers to submit, and Exchanges to review, the EHB allocation of the expected allowed

[46] If an issuer sought advance payments for the cost-sharing reductions provided under the limited cost sharing plan variation of a health plan it offers, we specified in § 156.430(a)(2) that the issuer was required to submit an estimate of the dollar value of the cost-sharing reductions to be provided.

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 13

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: February 13, 2015

Subject: Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year

To enhance the accuracy of reconciliation of cost-sharing reduction payments to issuers, and to fully reimburse issuers for reductions in out-of-pocket expenses provided to eligible low- and moderate-income enrollees, and American Indian/Alaska Native enrollees in 2014, the Centers for Medicare & Medicaid Services (CMS) will reconcile 2014 benefit year cost-sharing reductions for all issuers in April 2016, rather than in April 2015.

The Affordable Care Act requires issuers of qualified health plans (QHPs) to provide cost-sharing reductions to eligible enrollees in such plans, and provides for issuers to be reimbursed for the value of those cost-sharing reductions. Under implementing regulations, monthly advance cost-sharing reduction payments to issuers were authorized starting in 2014, and a process was provided for issuers to reconcile these advance payments to actual cost-sharing reductions provided to these enrollees.[1]

Advanced payments of cost-sharing reductions are reconciled by comparing the cost sharing that an enrollee pays under a cost-sharing reduction plan variation of the QHP to the cost sharing the enrollee would have paid under the standard plan. The cost sharing that would have been paid under the standard plan is most accurately calculated by adjudicating an enrollee's claims history for the year through the standard plan cost-sharing parameters, a process sometimes referred to as "double adjudication," and referred to under CMS regulations as the "standard methodology." Under CMS regulations, as a transitional measure, issuers were permitted to elect either to calculate cost sharing that an enrollee would have paid under the standard plan using the standard methodology – the most accurate approach – or to estimate that cost sharing using a simplified methodology based on actuarial estimates of certain key cost-sharing parameters.

When enrollment in a QHP standard plan is insufficient (under CMS regulations, 12,000 member months among a particular subset of enrollees within the standard plan is the minimum required enrollment) to derive statistically credible estimates of these actuarially derived cost-sharing parameters, issuers that elected the simplified methodology must use a formula based on the plan variation's actuarial value to calculate cost-sharing reductions provided. This formula, known as the actuarial value methodology or "AV methodology" may result in inaccurate payments to issuers compared to the amount of cost-sharing reductions they actually provided to enrollees.

[1] The process for reconciling advanced payments for cost-sharing reductions is detailed at 45 CFR 156.430. We established standards for the administration and payment of cost-sharing reductions in the HHS Notice of Benefit and Payment Parameters for 2014 final rule published in the March 11, 2013 **Federal Register** (78 FR 15410) and in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, published in the March 11, 2013 **Federal Register** (78 FR 15541). The provisions established in the interim final rule were finalized in the second Program Integrity Rule published in the October 30, 2013 **Federal Register** (78 FR 65046).

It has come to our attention that many issuers using the simplified methodology are falling short of the 12,000 member month credibility threshold for a particular subgroup more frequently than anticipated – and will be required to use the simplified "AV methodology," which may yield inaccurate estimates of cost-sharing reductions provided to eligible enrollees in those plans. It has also come to our attention that many issuers using the standard methodology are continuing to have difficulty upgrading their systems in time for reconciliation of advanced payments of cost-sharing reductions under this "double adjudication" method, putting at risk the accuracy of those calculations.

Therefore, to enhance the accuracy of reconciliation of reductions in out-of-pocket expenses that issuers provided to eligible low- and moderate-income enrollees and American Indian/Alaska Native enrollees, **CMS will permit issuers that selected the simplified methodology to switch to the more accurate standard methodology, and will reconcile 2014 benefit year cost-sharing reductions for all issuers beginning on April 30, 2016.** This new reconciliation deadline for all issuers will promote accurate reimbursement of cost-sharing reductions by permitting issuers that switch to, or previously selected, the more accurate standard methodology to complete their operational upgrades.

Issuers that are switching from the simplified methodology to the standard methodology will be permitted to notify CMS of that switch upon submission of the required cost-sharing reduction reconciliation files on April 30, 2016. Issuers that do not switch to the standard methodology must use the simplified methodology, including using the "AV methodology," as applicable. Issuers that selected the standard methodology last year may not switch to the simplified methodology. Because these changes will help promote accurate payments for cost-sharing reductions, they will not alter the ultimate liability for cost-sharing reductions from issuers or the federal government.

CMS provided the data elements for cost-sharing reduction reconciliation in June 2014, via a collection of information authorized under the Paperwork Reduction Act titled, "Cost-Sharing Reduction Reconciliation, (CMS-10526)," approved by the Office of Management and Budget in December 2014. We continue to provide technical assistance to issuers and, in advance of pilot testing for 2016 cost-sharing reduction reconciliation data submission for benefit years 2014 and 2015, we will provide technical data submission standards and appropriate instruction.

This guidance supersedes earlier guidance on the submission of data for cost-sharing reduction reconciliation.

EXHIBIT 14

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Obamacare bombshell: Trump kills key payments to health insurers

- The payments reimburse insurers for discounts in health costs offered to low- and middle-income Obamacare customers.
- Insurers were projected to receive $10 billion in subsidies in 2018.
- Some premiums for 2018 are already higher because insurers feared the Trump administration would end the payments.

Dan Mangan | @_DanMangan
Published 10:53 PM ET Thu, 12 Oct 2017 | Updated 8:48 AM ET Fri, 13 Oct 2017

The Trump administration will immediately stop making critically important payments to insurers who sell Obamacare health plans, a bombshell move that is expected to spike premium prices and potentially lead many insurers to exit the marketplace.

The decision to end the billions of dollars worth of so-called cost-sharing reduction (CSR) payments came after months of threats by

President Donald Trump to do just that. The news came only hours after Trump signed an executive order that Obamacare advocates said could badly harm the individual insurance marketplaces.

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Advocates, along with insurers, health-care provider groups, patient groups and officials in many states, have expressed concerns for months that the cost-sharing reimbursements would be cut off by Trump.

Senate Minority Leader Chuck Schumer, D-N.Y., sharply criticized Trump in a series of Twitter posts late Thursday.

Chuck Schumer
@SenSchumer

Sadly, instead of working to lower health costs for Americans, it seems @POTUS will singlehandedly hike Americans' health premiums.

10:17 PM - Oct 12, 2017

1,878 7,140 14,632

Chuck Schumer @SenSchumer 12 Oct
Replying to @SenSchumer @POTUS
It is a spiteful act of vast, pointless sabotage leveled at working families and the middle class in every corner of America.

Chuck Schumer
@SenSchumer

Make no mistake about it, @POTUS will try to blame the Affordable Care Act, but this will fall on his back and he will pay the price for it.

10:18 PM - Oct 12, 2017

710 947 2,569

Two months ago, the Congressional Budget Office estimated that individual health plan premiums would be 20 percent higher than originally projected if the payments ceased. It also projected that premiums would be 25 percent higher than they otherwise would be by 2020, and that the federal deficit would be increased by almost $200 billion if the subsidies ended.

The payments, worth $7 billion or so to insurers this year and up to $10 billion or more next year, reimburse insurers for discounts in out-of-pocket health costs they give to low-income Obamacare customers. The discounts must be offered by law.

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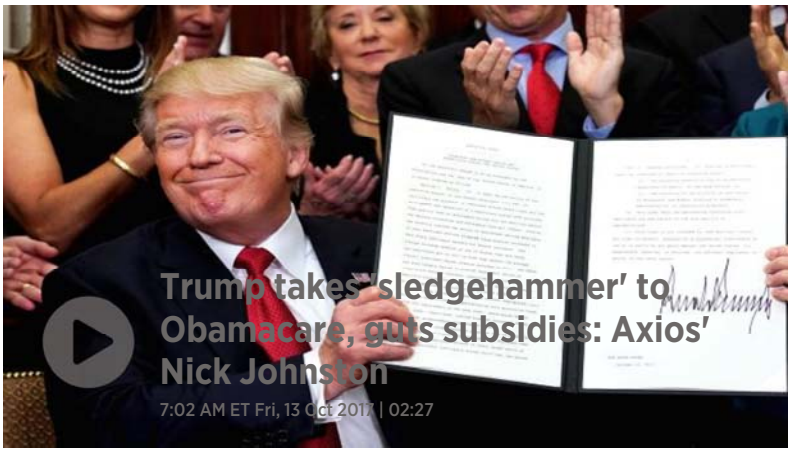

However, congressional Republicans successfully challenged in a lawsuit the Obama administration's decision to make the reimbursement payments to insurers without getting the express budgetary authorization from Congress.

Now, both California Attorney General Xavier Becerra and New York State Attorney General Eric Schneiderman said they would file lawsuits seeking to prevent Trump from ending the subsidies.

The two were part of a group of 18 state attorneys general who were given permission this year to intervene in the pending appeal of the federal court decision that had ruled the payments were illegal given their lack of congressional authorization.

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Overall Effects

As a result of the increase in total subsidies under the policy, CBO and JCT project these outcomes, compared with what would occur if the CSR payments were continued:

- The fraction of people living in areas with no insurers offering nongroup plans would be greater during the next two years and about the same starting in 2020;
- Gross premiums for silver plans offered through the marketplaces would be 20 percent higher in 2018 and 25 percent higher by 2020—boosting the amount of premium tax credits according to the statutory formula;
- Most people would pay net premiums (after accounting for premium tax credits) for nongroup insurance throughout the next decade that were similar to or less than what they would pay otherwise—although the share of people facing slight increases would be higher during the next two years;
- Federal deficits would increase by $6 billion in 2018, $21 billion in 2020, and $26 billion in 2026; and
- The number of people uninsured would be slightly higher in 2018 but slightly lower starting in 2020.

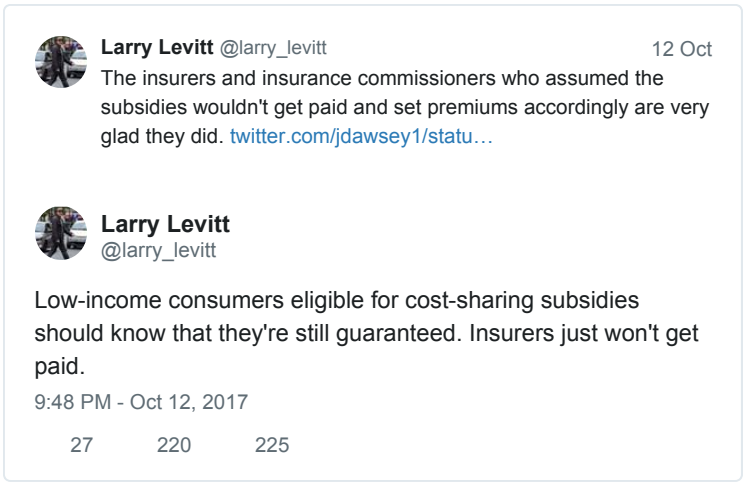
Those effects are uncertain and would depend on how the policy was implemented.

Source: Congressional Budget Office analysis "The Effects of Terminating Payments for Cost-Sharing Reductions," August 2017

More than half of the people who buy Obamacare plans on government-run exchanges qualify for reduced out-of-pocket health charges that the CSRs subsidize. Those customers have relatively low incomes.

A greater number of people, about 85 percent of all Obamacare exchange customers, qualify for subsidies that reduce their monthly plan premiums. Those subsidies, in the form of federal tax credits, are not at risk from the Trump administration action on CSRs.

In fact, those premium subsidies will offset the price hikes that are expected from the CSR cutoff for millions of people. That is, the value of the tax credit-based subsidy rises in step with premium prices — so if premiums go up, so do the subsidies.



Customers of Obamacare plans who do not receive premium subsidies, however, will be hit with the full effect of the CSR-related price hikes.

Still, the relationship between the two subsidies is why Trump's decision to kill the CSRs will cost the federal government more than if he had continued making the payments.

Here's what the White House said on the subsidies:

> Based on guidance from the Department of Justice, the Department of Health and Human Services has concluded that there is no appropriation for cost-sharing reduction payments to insurance companies under Obamacare. In light of this analysis, the Government cannot lawfully make the cost-sharing reduction payments. The United States House of Representatives sued the previous administration in Federal court for making these payments without such an appropriation, and the court agreed that the payments were not lawful. The bailout of insurance companies through these unlawful payments is yet another example of how the previous administration abused taxpayer dollars and skirted the law to prop up a broken system. Congress needs to repeal and replace the disastrous Obamacare law and provide real relief to the American people.

Without the reimbursements, insurers are expected to raise the prices of their health plans significantly to offset the loss of the money they have received for years.

Trump's threat to end the CSRs had already led insurers in a number of states to request higher premiums for 2018 plans than they otherwise would have requested. On Wednesday, California's Obamacare marketplace imposed an average 12.5 percent surcharge on many health plans for next year because of the potential cutoff for the CSRs.

A leading Obamacare advocacy group, the Protect Our Care Campaign, said, "The President of the United States is now running a daily campaign to sabotage the health care of the American people."

"Nonpartisan analysts say canceling these payments means making people pay 20% higher premiums," said Brad Woodhouse, campaign director at Protect Our Care.

"The Trump administration and every Republican in Congress who lets him do this is now responsible for every rate hike people see for the foreseeable future. They broke it, they own it."

Daniel Liebman
@D_Liebman

This is the policy equivalent of tossing a live hand grenade into the insurance marketplace. twitter.com/sarahkliff/sta…

8:54 PM - Oct 12, 2017

1 14 6

Dan Mangan
Reporter

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EXHIBIT 15

HHS.gov U.S. Department of Health & Human Services

FOR IMMEDIATE RELEASE

October 12, 2017

Contact: HHS Press Office

202-690-6343

media@hhs.gov

Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments

U.S. Health and Human Services Acting Secretary Eric Hargan and Centers for Medicare & Medicaid Services Administrator Seema Verma released the following statement announcing that cost-sharing reductions payments will be discontinued immediately based on a legal opinion from the Attorney General:

"It has been clear for many years that Obamacare is bad policy. It is also bad law. The Obama Administration unfortunately went ahead and made CSR payments to insurance companies after requesting - but never ultimately receiving - an appropriation from Congress as required by law. In 2014, the House of Representatives was forced to sue the previous Administration to stop this unconstitutional executive action. In 2016, a federal court ruled that the Administration had circumvented the appropriations process, and was unlawfully using unappropriated money to fund reimbursements due to insurers. After a thorough legal review by HHS, Treasury, OMB, and an opinion from the Attorney General, we believe that the last Administration overstepped the legal boundaries drawn by our Constitution. Congress has not appropriated money for CSRs, and we will discontinue these payments immediately."

Read CSR Payment Memo - PDF

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/news.

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Last revised: October 15, 2017

EXHIBIT 16

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

To: Seema Verma, Administrator
Centers for Medicare and Medicaid Services

From: Eric Hargan
Acting Secretary

Date: October 12, 2017

Re: Payments to Issuers for Cost-Sharing Reductions (CSRs)

The Attorney General of the United States has provided the U.S. Department of Health & Human Services (HHS) and the U.S. Department of the Treasury with the attached legal opinion regarding CSR payments made to issuers of qualified health plans. In light of that opinion—and the absence of any other appropriation that could be used to fund CSR payments—CSR payments to issuers must stop, effective immediately. CSR payments are prohibited unless and until a valid appropriation exists.

EXHIBIT 17

Office of the Attorney General
Washington, D. C. 20530

October 11, 2017

The Hon. Steven Mnuchin, Secretary of the Treasury
U.S Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Don Wright, M.D., M.P.H., Acting Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Mnuchin and Acting Secretary Wright:

You have asked for my legal opinion as to whether the permanent appropriation for "refunding internal revenue collections," 31 U.S.C. § 1324, is available to fund the cost-sharing reduction (CSR) payments authorized by section 1402 of the Affordable Care Act, 42 U.S.C. § 18071. As you are aware, the prior administration originally sought an appropriation to fund CSR payments—suggesting it believed such an appropriation was necessary—but then later concluded that section 1324's permanent appropriation was available. The U.S. House of Representatives sued, contending that Congress had not appropriated funds for CSR payments. The U.S. District Court for the District of Columbia agreed, holding that section 1324 does not appropriate funds for CSR payments. *U.S. House of Reps. v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016). The district court "enjoin[ed] any further reimbursements under Section 1402 until a valid appropriation is in place," but "stay[ed] its injunction pending any appeal by the parties." *Id.* at 189. The prior administration appealed that decision, and the D.C. Circuit has held the appeal in abeyance to allow time for a resolution that would obviate the need for judicial determination of the appeal, including potential legislative action.

The Department of Justice has consulted with your Departments, as well as the Office of Management and Budget, all of which have now expressed the view that section 1324 does not appropriate funds for the CSR program. Although the Department of Justice has previously defended in court the government's decision to use the permanent appropriation in section 1324 for CSR payments, I have concluded that the best interpretation of the law is that the permanent appropriation for "refunding internal revenue collections," 31 U.S.C. § 1324, cannot be used to fund the CSR payments to insurers authorized by 42 U.S.C. § 18071.

First, "[i]f the statutory language is plain," it must be enforced "according to its terms." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). Here, the plain reading of the text is that the ACA permanently appropriated money for section 1401 premium tax credits, but not for section 1402

CSR payments to insurers. As relevant here, the ACA created two distinct programs that both have the broad purpose of providing government funding for the cost of health insurance obtained through ACA exchanges. Section 1401(a) created a program to reduce the health insurance premiums of qualified individuals by providing those individuals with refundable tax credits. Congress appropriated funds for this program in the ACA by: (1) amending the Internal Revenue Code to add a new refundable tax credit provision (§ 36B, entitled "Refundable Credit for Coverage Under a Qualified Health Plan"), *see* ACA § 1401(a); and (2) amending 31 U.S.C. § 1324—a preexisting funding provision that provides a permanent appropriation "for refunding internal revenue collections as provided by law," *id.* § 1324(a)—to include the new Internal Revenue Code § 36B credit in its list of permanently funded tax credits, *see* ACA § 1401(d)(1). That is, Congress amended the funding provision to provide for payment of "refunds due … from section … 36B." 31 U.S.C. § 1324(b)(2).

Separately, the ACA created the section 1402 CSR program, which Congress did not include in the Internal Revenue Code. Section 1402 (1) requires insurers offering policies through ACA exchanges to reduce co-payments and other out-of-pocket costs for certain policyholders (reductions referred to in the ACA as "Cost-Sharing Reductions"), *see* ACA § 1402, codified at 42 U.S.C. § 18071; and (2) authorizes the federal government to make payments directly to insurers to offset the lost revenue these reductions cause, *see* ACA § 1412(c)(3). But unlike with section 1401's refundable tax credit, the ACA did not itself provide an appropriation to directly fund the section 1402 CSR program. The ACA's amendment to the permanent appropriation in 31 U.S.C. § 1324 refers only to section 1401 tax credits (i.e., "refunds due … from [Internal Revenue Code] section … 36B"), and makes no reference to section 1402 payments (i.e., 42 U.S.C. § 18071 payments). As amended by the ACA, that appropriation provision thus supplies funding for Internal Revenue Code § 36B tax credits to insureds, but not for 42 U.S.C. § 18071 CSR payments to insurers.

Second, although the "meaning—or ambiguity—of certain words or phrases may only become evident when placed in context," *King*, 135 S. Ct. at 2489, the statutory context of these provisions is consistent with their plain meaning. As noted above, while the two payment provisions appear sequentially within the ACA, only the section 1401 tax credits are included in the Internal Revenue Code (consistent with their status as tax credits for taxpayers). It is logical that the permanent appropriation in 31 U.S.C. § 1324—which funds a variety of tax expenditures—would fund the ACA's tax credits. But it would make little sense for a provision that appropriates funds for "refunding internal revenue collections," 31 U.S.C. § 1324(a), to also (and without saying so) permanently fund a non-tax program that provides payments to insurers.

The prior administration contended that CSR payments should be deemed "refunds due … from section … 36B" on the ground that both types of payments are essentially two parts of a single program. But the two programs are distinct. Each is authorized by a separate provision in a separate title of the U.S. Code; each has a different focus (tax credits for premiums, CSR payments for out-of-pocket costs); each functions differently; and each has a different eligibility formula. It is true that ACA section 1402(f)(2) provides CSRs are not "allowed … unless … a credit is allowed to the insured … under section 36B," but that provision means only that individuals who are ineligible for a tax credit are likewise ineligible for CSRs. It does not mean that CSR payments are the same as tax credits under section 36B—or even that they have the same

eligibility requirements. *Compare* 26 U.S.C. § 36B(c)(1)(A) (policyholder is eligible for tax credits if household income is between 100 and 400 percent of the federal poverty level), *with* 42 U.S.C. § 18071 (complex CSR formula providing for income-based reductions, adjustments to reductions to maintain actuarial levels, and additional reductions for lower-income insureds); *see also House of Reps.*, 185 F. Supp. 3d at 176. Indeed, the distinction between the programs is reflected throughout the ACA, including in the section providing for advance payments of both tax credits and CSRs to insurers—a provision that bundles the two types of payments together but nonetheless carefully distinguishes between the two programs. *See generally* 42 U.S.C. § 18082.

The issue here is quite different from the statutory question in *King*. There, the Supreme Court held that certain language within the ACA seemed unambiguous in isolation, but did not make sense in the context of the rest of the Act because "the most natural reading of the pertinent statutory phrase" would have prevented two of the ACA's "three major" policy changes from being applicable in certain States—something the Court saw as a "calamitous result that Congress plainly meant to avoid." 135 S. Ct. 2493, 2495-96. Here, the two programs in the ACA that provide government funding for insurance costs function properly when operated according to their terms. Unlike in *King*, practical difficulties do not result from any conflict or inconsistency within the ACA; rather, practical difficulties result, if at all, from Congress's post-ACA decision to not appropriate money for CSR payments. Nothing in *King* suggested that the ACA's plain text can be ignored in order to override the intentional legislative decisions of subsequent Congresses.

Congress has the power of the purse, and it is up to Congress to decide which programs it will and will not fund. *See, e.g.*, *House of Reps.*, 185 F. Supp. 3d at 184 (recounting instance when Congress conferred "permanent authority" on Treasury "to permit prepayment ... to territorial treasuries of estimates of moneys to be collected" but made "no subsequent appropriation," such that "no such money could be spent"). There is no more fundamental power granted to the Legislative Branch than its exclusive power to appropriate funds. And the Executive Branch cannot unilaterally spend money that Congress has not appropriated. Congress's repeated choice to deny funding for CSR payments is thus Congress's prerogative. When Congress refuses to appropriate money for a program, the Executive is required to respect that decision.

Third, the contemporary evidence is consistent with this straightforward interpretation of the ACA's text. The prior administration, in the President's *Fiscal Year 2014 Budget of the U.S. Government*, and in the HHS-submitted House and Senate *Justification of Estimates for Appropriations Committees*, sought an appropriation for section 1402 CSR payments. *See House of Reps.*, 185 F. Supp. 3d at 186. These requests suggest that the prior administration initially believed that—unlike with section 1401 tax credits—it needed an appropriation from Congress to fund section 1402 CSR payments to insurers. It was only months after these submissions that the prior administration adopted an interpretation of the ACA that authorized funding CSR payments out of the permanent appropriation in 31 U.S.C. § 1324.

Finally, it is not surprising the Congress chose to retain the power of the purse, even for an important component of the ACA. After all: "Most current appropriations are adopted on an annual basis and must be re-authorized for each fiscal year. Such appropriations are an integral part of our constitutional checks and balances, insofar as they tie the Executive Branch to the Legislative Branch via purse strings." *House of Reps.*, 185 F. Supp. 3d at 169-70.

In sum, it is my opinion that the best interpretation of the law is that section 1324 does not appropriate funds for the Affordable Care Act's Cost-Sharing Reduction program.

Sincerely,

Jefferson B. Sessions III
Attorney General of the United States

EXHIBIT 18

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: October 20, 2017

FAQ on Cessation of Payment of Cost-sharing Reductions

Question: How will CMS operationalize discontinuation of advance cost-sharing reduction (CSR) payments?

Answer: For the October monthly payment cycle and beyond, CMS will not make advance CSR payments, and will not make any adjustments to CSR payment amounts related to retroactive enrollment data changes for prior months of 2017, unless Congress appropriates funding for these payments. Issuers will therefore receive no net payment of 2017 advance CSR in the October and future payment cycles.

Question: How will CSR transactions be displayed on issuers' October payment reports?

Answer: Issuers will see detailed advance CSR payments appear as in prior months on their payment reports. Issuers in Federally-facilitated Exchange (FFE) states paid through policy-based payments (PBP) will see policy-level detail showing CSR payments, and issuers in states paid through manual workbooks will see issuer-level CSR payments as in prior months. Payment reports for all issuers will also show a lump-sum issuer-level manual adjustment that reverses the total net advance CSR payment.

Question: How will payments and charges from reconciliation of cost-sharing reductions be treated?

Answer: CSR reconciliation payments for the 2016 benefit year and prior year restatements previously scheduled for the October 2017 payment cycle or future cycles, including any payments calculated as the result of reported discrepancies, will not be made. However, if a discrepancy results in an overpayment to the issuer, CMS will proceed with the collection of those charges after the issuer has been notified of CMS's discrepancy decision.

Question: How will advance CSR amounts be reflected in enrollment reporting from CMS, including 834s, pre-audit file, and RCNO files?

Answer: CMS is not making any changes to CSR data in the Federally-Facilitated Exchange (FFE) database at this time as a result of this change. 834s, pre-audit, and RCNO files will continue to show CSR amounts for all coverage years, including for 2018 BAR/alternate enrollment and 2018 active enrollments. Issuers should continue to populate their RCNI files for all coverage years with CSR amounts. CSR payments to issuers will be netted out using issuer-level manual adjustments as described above to prevent payment. CMS will notify SBEs in advance of any changes to these files or processes.

Question: Should issuers continue to submit payment or enrollment disputes of advance CSR amounts?

Answer: To avoid operational disruption, CMS is not making any changes to its dispute processing at this time as a result of this change. Issuers may continue to dispute advance CSR calculated amounts for 2017 and CMS will process these disputes as before. However, CMS does not have the authority to make any further cost-sharing reduction reconciliation payments as a result of reported discrepancies or appeals, so that any resulting changes to the FFE enrollment data will not impact CSR payment. CMS will notify SBEs in advance of any changes to this process.

Question: Will this change affect PROD-R reports distributed to State-Based Exchanges (SBEs) and their issuers preparing for the policy-based payments transition?

Answer: No. PROD-R EPS extracts and PPRs distributed to SBEs and their issuers will show CSR payments as usual in October. CMS will notify SBEs in advance of any changes to PROD-R data or reporting.

EXHIBIT 19

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

STATE OF CALIFORNIA, *et al.*, Plaintiffs, v. DONALD J. TRUMP, President of the United States, *et al.*, Defendants.	No. 3:17-cv-5895 (VC) **DECLARATION OF ELIZABETH PARISH IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER**

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Parish, declare under penalty of perjury that the following is true and correct:

1. I am the Acting Director of the Payment Policy and Financial Management Group ("PPFMG") for the Center for Consumer Information and Insurance Oversight ("CCIIO"), one of the centers in the Centers for Medicare & Medicaid Services ("CMS"), a component agency within the U.S. Department of Health and Human Services ("HHS"). I make this declaration based on my own personal knowledge, on information contained in the records of CMS or HHS, or on information provided to me by CMS or HHS employees.

2. CCIIO oversees implementation of major provisions of the Patient Protection and Affordable Care Act ("ACA"), including administration of the federally facilitated Exchanges (including collection of user fees), the advance payments for the premium tax credit and cost-sharing reduction ("CSR") programs, the Consumer Operated and Oriented Plan ("CO-OP") program, and the risk adjustment, reinsurance, and risk corridors programs (collectively the "3Rs" or "premium stabilization" programs). CCIIO also coordinates with other CMS divisions, notably the Office of Financial Management ("OFM") and the U.S. Department of the Treasury, to make payments to insurance companies ("issuers") that offer Qualified Health Plans ("QHPs") on the Exchanges.

3. I have served in this capacity and/or as Deputy Director of PPFMG since 2015. I oversee CCIIO's policy development and implementation activities related to federal payment programs that impact issuers (QHP and non-QHP).

4. CMS has advance payments made to and collects charges from issuers under the premium tax credit and CSR programs, along with payments to and from issuers for other ACA programs, as part of a monthly payment cycle.

5. The statute allows CMS flexibility in determining the timing of the payments, *see* 42 U.S.C. §18082(c), and neither regulations nor guidance require specific timing. It has been CMS's

practice to run a fixed payment cycle each month with specified activities for each date. These activities include controls to validate data throughout the cycle, with monthly payments scheduled for a pre-established date between the nineteenth and twenty-second of each month. October payments are being made without CSR payments according to this schedule on October 20, 2017.

6. Future payment cycles will not include payments to issuers of advance CSRs or reconciled CSR payment amounts for prior benefit years.

7. Payment for the November monthly payment cycle is scheduled for November 21, 2017. If the Court were to order CMS to make CSR payments, under typical operations CMS could include in that monthly cycle payments of advance CSRs and CSR reconciliations for the months of October and November. CMS would need to be notified of the Court's order by November 6, 2017, in order to include these payments in the November payment cycle.

8. If ordered to make payment before November 21, it will take CMS a minimum of eight business days to facilitate CSR payments to issuers outside of this cycle. The payment process involves coordinated activities initiated or completed by CCIIO, OFM, and the Treasury Department. In general, if the aggregate amount of a payment is over $50 million, then Treasury requires that CMS provide Treasury with two business days' notice of the amount of a payment before Treasury can send the payment. If the aggregate amount of the payment is over $500 million, then Treasury requires five business days' notice. CMS operational processes typically require additional notice to change the amount of a previously noticed payment, depending on the nature of the change.

9. If the Court were to order CMS to make an off-cycle payment of October advance CSRs and CSR reconciliation, CMS would go through the following steps, as set forth in paragraphs 10 through 13, below. Depending on the date of such an order, it is possible that payments previously scheduled for

other CMS programs could require CMS to add an additional day of processing to the schedule below to make an off-cycle payment.

10. Business Day One. On the first business day of this process, CCIIO needs approximately seven hours to process, validate, approve, and create a file detailing the payments to be made, in order to initiate payment to issuers. This first step can be taken in advance of setting a payment date that would be more than seven business days later.

11. Business Days Two and Three. On the second business day, CCIIO sends a total payment amount to OFM to start the Treasury process for a payment over $500 million—and OFM notifies Treasury of the greater-than-$500 million payment—by 9:00 a.m. Eastern time. During the second and third business days, CCIIO transmits the file of payment data to the Exchange section of CMS's payment system and begins its process of file reconciliation, transfer into the central section of CMS's accounting system, reconciliation of that data, and funds certification. CCIIOO conducts its funds certification briefing and transmits a Funds Certification Memo to OFM by the end of business day three.

12. Business Days Four and Five. By the morning of business day four, OFM has the validated payment file and will hold a Funds Certification Briefing. OFM needs forty-eight hours to process the payment certified by CCIIO. The payment processing includes an accounting process, an internal fund certification process, the creating of payment transactions, and the creating of payment file(s) electronically sent to Treasury.

13. Business Days Six through Eight. On business day six, OFM sends the payment file(s) to Treasury. On business day seven, Treasury certifies the funds; and on business day eight, the funds are sent to issuers via electronic fund transfers.

14. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on October 20, 2017 in Baltimore, Maryland.

Elizabeth Parish