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: November 2, 2016

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

Centers for Medicare & Medicaid Services (CMS)

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

Executive Summary

CMS is releasing this draft 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 reductions 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 draft manual.
- New section on when and how issuers file discrepancies
- 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 to reflect changes in the manual

CMS requests comments on this draft manual. Please submit comments to CSRreview@cms.hhs.gov by 5 p.m. on December 2, 2016. When submitting comments, please indicate the section of the draft manual to

[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

which the comment pertains. After carefully considering comments received, CMS intends to publish a final version of this manual prior to data submission for the 2016 benefit year.[3] Collection of these data elements is approved under OMB control number 0938-1266 and is valid until March 31, 2019.[4] Draft technical guidance on actual submission of data and associated forms will be posted separately.

Centers for Medicare & Medicaid Services (CMS)

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

November 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

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.[5]

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.[6] 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.[7] 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.[8] 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

---

[5] See 45 CFR 156.420(c) on network and service equivalence requirements in silver plans and variants.

[6] 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*).

[7] *See Generally*, section 1412 of the Affordable Care Act.

[8] 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[9]), 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.[10]

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)[11] or for newborns who are later not enrolled (REGTAP FAQ 14883).[12] 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).[13]

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.[14] 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.[15] 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

---

[9] See 45 CFR 155.430(d)(4)).

[10] https://www.regtap.info/faq_viewu.php?id=15103

[11] https://www.regtap.info/faq_viewu.php?id=15456

[12] https://www.regtap.info/faq_viewu.php?id=14883

[13] https://www.regtap.info/faq_viewu.php?id=15454 and https://www.regtap.info/faq_viewu.php?id=15455

[14] 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.

[15] 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).[16]

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.[17] 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,[18] 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[19] for the 2016 benefit year may be submitted in the following year reconciliation cycle (June 2018), 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 2018 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 for which it is restating, by the data submission deadline of June 2, 2017.[20] 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.[21] 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

[16] https://www.regtap.info/faq_viewu.php?id=15109 and https://www.regtap.info/faq_viewu.php?id=15270

[17] See https://www.regtap.info/faq_viewu.php?id=14904

[18] See REGTAP FAQs 14904 and 15396

[19] 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

[20] Issuers have until 11:59 p.m. Friday, June 2, 2017 to submit data.

[21] https://www.regtap.info/uploads/library/FT_CSRRecon_FAQClaimsRunOutDate_093015_v1_5CR_100115.pdf

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.

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) [22] 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 28, 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

[22] See https://www.regtap.info/faq_viewu.php?id=15396 and guidance at https://www.regtap.info/uploads/library/FT_FAQ2014CSRRecon_5CR_081716.pdf

balance billing). The difference equals the amount of cost-sharing reductions provided by the issuer. All issuers must use the standard methodology starting with benefit year 2017 claims.[23] (See page 12 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 methodology to calculate the value of cost-sharing reduction for claims incurred in benefit years 2014, 2015, and 2016.[24] 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 15 for a detailed explanation of the simplified methodology).

If credibility cannot be established, the simplified actuarial value methodology (AV method) must be used.[25] 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 26 for a detailed explanation of the AV methodology).

Deadline for Selecting a Methodology

Issuers that used the simplified methodology for the 2015 benefit year may notify CMS that they intend to switch to the standard methodology for the 2016 benefit year by emailing CMS at CSRreconcilationAttestationsview@cms.hhs.gov as soon as possible. Please use the subject line of "CSR reconciliation methodology selection." Consistent with CMS' 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,[26] 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 of June 2, 2017.

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.[27] 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 and the reduced annual limitation on cost sharing. Issuers may calculate claims amounts attributable to

[23] 45 CFR § 156.430(c)(3).
[24] 45 CFR § 156.430(c)(4).
[25] 45 CFR § 156.430(c)(4)(v).
[26] https://www.regtap.info/uploads/library/APTC_FAQ_2015MethodSelection_031615_5CR_031615.pdf
27 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[29]
https://www.regtap.info/faq_viewu.php?id=14897

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 Uniform Rate Review Template (URRT) [28] for the corresponding benefit year, or use any other reasonable method to determine total allowed costs for EHB (REGTAP 14897).[29] 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)**.**[30] 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.[31]

Some non-formulary drugs or state mandates enacted after Dec. 31, 2011 are considered EHB, issuers may refer to REGTAP FAQ 15264 and 15105.[32]

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 will not reimburse issuers for any cost-sharing reduction provided to an enrollee for such non covered services (REGTAP 15117 and 15119).[33]

---

[29] https://www.regtap.info/faq_viewu.php?id=14897

[29] https://www.regtap.info/faq_viewu.php?id=14897

[30] https://www.regtap.info/faq_viewu.php?id=14882

[31] https://www.regtap.info/faq_viewu.php?id=15105

[32] https://www.regtap.info/faq_viewu.php?id=15264 and https://www.regtap.info/faq_viewu.php?id=15105

[33] https://www.regtap.info/faq_viewu.php?id=15117 and https://www.regtap.info/faq_viewu.php?id=15119

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).[34]

Total allowed costs for EHB must be the same in the plan variation and the standard plan (REGTAP 15573).[35] 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).[36]

Issuer Reporting Requirements (all methodologies)

Issuer Summary Report: For each benefit year, all QHP issuers receiving advance payments of cost-sharing reductions 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.[37] If the issuer is estimating non-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

[34] https://www.regtap.info/faq_viewu.php?id=15453
[35] https://www.regtap.info/faq_viewu.php?id=15573
[36] https://www.regtap.info/faq_viewu.php?id=15876
[37] 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.

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, 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. [38]

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.[39]

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[40] 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.[41]

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 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,

[38] 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

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

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

[41] 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

and then any other subset of benefits, for example vision, dental, and substance use disorder benefits.[42] 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. [43] *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.[44]

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.[45] Issuers are required to provide cost sharing reductions for in-network EHB and, provided the standard plan covers it, for out-of-network EHB. [46] 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

[42] 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

[43] 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.

[44] See 45 CFR 156.430(d)(1).

[45] See 45 CFR 156.420(b).

[46] See Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, final rule, 78 FR 65074 (Oct. 30, 2013).

Indian Health Service, Tribal or Urban Indian providers, collectively ITU providers. [47] 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. [48]

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 Policy Detail (03) level. 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)**.**[49]

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.[50] 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 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.[51]

[47] 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.

[48] 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.

[49] https://www.regtap.info/faq_viewu.php?id=15269

[50] 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.

[51] For description of formulas A, B and C, see 45 CFR 156.430(c)(4)(i)(A-C)).

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.[52] 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 26.)

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 the effective deductible and other parameters required for the simplified methodology, the issuer should use the simplified actuarial value methodology (REGTAP FAQ 15809).[53]

---

[52] 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.

[53] https://www.regtap.info/faq_viewu.php?id=15809

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. [54]

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. [55]

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 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.

[54] See https://www.regtap.info/uploads/library/APTC_FAQ_CSRRecon_MemberMnths_5CR_011315.pdf

[55] See https://www.regtap.info/uploads/library/APTC_FAQ_CSRRecon_Methodology_5CR_040215.pdf

CMS issued guidance and provided examples of the simplified methodology, "Cost-Sharing Reductions Simplified Methodology Updated Examples," on March 11, 2014.[56]

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).[57] (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 24, 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. [58] For the definition of credibility threshold, see page 17.
- **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 using the instructions below. Next, sort policies in each standard plan subgroup into the

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

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

[58] 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.

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 23.

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) [59] 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).[60]

[59] https://www.regtap.info/faq_viewu.php?id=11901

[60] 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.[61]

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.

Finally, we note that plans that use a capitated pay arrangement for certain specialty providers would follow the steps on page 24 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 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.

[61] 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.

- 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: [62]

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

QHP issuers should only consider associated in-network cost sharing when determining whether or not the cost sharing incurred under a policy is less than the annual limitation. This is because out-of-network cost sharing does not accumulate toward the annual limitation on cost sharing for 2014 and 2015.

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.

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);

[62] 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

- 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[63]

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 18 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 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

[63] 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.

enrollee actually paid under the plan variation. *Issuers of HMO-like plans use Formulas A and C in these calculations.* See formulas on page 23.

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 +

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

- Effective non-deductible cost sharing

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).[64]
- Actuarial value as calculated under 45 CFR 156.135(b)(4), does not include out-of-network costs.
- 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).[65]
- 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).[66]
- 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 Policy Record (03) level. 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.

[64] https://www.regtap.info/faq_viewu.php?id=15573
[65] https://www.regtap.info/faq_viewu.php?id=14873
[66] https://www.regtap.info/faq_viewu.php?id=15452

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.[67]

- 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[68] 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,[69] (and comply with other claims re-adjudication requirements set forth in CMS guidance).

[67] https://www.regtap.info/faq_viewu.php?id=15396

[68] 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

[69] 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

- 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. (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 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.
- 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.
- 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 policy to the restated amount for the policy as submitted by the issuer. The resulting payment or charge will be aggregated to the issuer's 2016 reconciled amount.

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 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 Policy Level record.
- **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 CSR AMOUNT**: Total cost-sharing reduction amount provided by this QHP issuer to enrollees in all plan variations. For restatements, this is the cost-sharing reduction amount provided by this QHP issuer to enrollees in all plan variations for which one or more Subscriber ID CSR amount is restated.

- **CSR AMOUNT ADVANCED TO THE ISSUER BY THE FEDERAL GOVERNMENT:** Amount the issuer shows received from the federal government for the benefit year January 1 to December 31. Issuers should include retroactive adjustments to advance payments for the applicable benefit year that were made after the close of the benefit year but before or by June 2,, 2017.
- **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

- **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 NUMBER OF EXCHANGE SUBCRIBER IDS IN THIS PLAN**: Enter the total count of unique Exchange subscriber IDs in this plan variation for 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 9, 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 Uniform 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 13, 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 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. For restatements, this is the cost-sharing reduction amount provided by this QHP issuer to enrollees in all plan variations for which one or more Subscriber ID CSR amount is restated.

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 for 2016. If this is an aggregated policy record, report the current Policy ID Number.
- **EXCHANGE ASSIGNED POLICY START DATE:** Optional for 2016. First date the subscriber enrolled in this policy. This is the start date for the most current Policy ID.

- **EXCHANGE ASSIGNED POLICY END DATE:** Optional for 2016. 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**.**
- **PLAN BENEFIT END DATE:** Last date the subscriber was enrolled in this plan variation.
- **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 for essential health benefits incurred by the enrollee(s) on this policy. (See, "Determination of Total Allowed Essential Health Benefits," page 9, 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 Uniform 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 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 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 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 13, 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 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[70]

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.

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 payment cycle following the June 30 report, and invoice the issuer for any remaining balance (REGTAP FAQ 15266).[71]

Determination of Outliers

CMS will conduct an analysis on issuer reported valid CSR amounts provided data to determine whether the valid CSR amounts reflect a substantially higher amount due to a data reporting anomaly. 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

[70] **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.

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

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

Consistent with CMS policy for the 2014 and 2015 benefit year cost-sharing reduction reconciliation, 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) (FAQ 16491).[72] Issuers must have filed a discrepancy 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.

Under 45 CFR 156.1220(a)(3)(v), issuers have 60 calendar days following the date of the notification provided by HHS of the cost-sharing reduction reconciliation amount 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. For further information on the scope of an appeal, see 45 CFR 156.1220.

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

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

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).[73]

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.

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.[74]

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.

---

[73] https://www.regtap.info/faq_viewu.php?id=16491

[74] 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.

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 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).)[75] 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[76] _____

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

[75] 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.

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

Telephone: Click here to enter text

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[77] _____

Qualified Health Plan HIOS ID(s) [78]_____

(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:

- 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 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

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

[78] *The 16-digit HIOS-generated qualified health plan identification number*

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 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[79] _____

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

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

Complete one form for each plan variation with claims in the associated standard plan. 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) [80]_____

Benefit Year _____

HIOS Issuer ID[81] _____

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.

[80] *The 16-digit HIOS-generated qualified health plan identification number for the plan variation for which CSRs were provided*
[81] *The five-digit Health Insurance Oversight System (HIOS)-generated issuer ID number*

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:	
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:	

o