HHS Notice of Benefit and Payment Parameters for 2014

Center for Consumer Information and Insurance Oversight

The Department of Health and Human Services (HHS) published a notice of benefit and payment parameters for 2014 ("Payment Notice") to help ensure that every American has access to high-quality, affordable health insurance by implementing sections 1311, 1341, 1342, 1343, 1401, 1402, 1411, and 1412 of the Affordable Care Act, expanding on standards set forth in the Premium Stabilization Rule (77 FR 17220, March 23, 2012) and the Exchange Establishment Rule (77 FR 18310, March 27, 2012), and amending the Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act interim final rule in (75 FR 74864, December 1, 2010) and final rule (76 FR 76574, December 7, 2011). The Payment Notice provides further detail and parameters related to: the permanent risk adjustment, transitional reinsurance and temporary risk corridors programs (together referred to as the premium stabilization programs), cost-sharing reductions, user fees for Federally-facilitated Exchanges, advance payments of the premium tax credit, the Small Business Health Option Program (SHOP), and the medical loss ratio (MLR) program.

HHS is also releasing an interim final rule with comment (IFC) and a proposed rule (NPRM) amending certain provisions of the Payment Notice. In the IFC, we establish provisions to align the risk corridors program with the single risk pool requirement and an alternative approach to calculating the amount of cost-sharing reductions provided. In the proposed rule, we propose certain amendments to the SHOP provisions of the payment notice.

Provisions of the Payment Notice and amendments to the Payment Notice are summarized below. The Payment Notice may be viewed in its entirety at: http://ofr.gov/OFRUpload/OFRData/2013-04902_PI.pdf. The interim final rule with comment can be viewed here: http://ofr.gov/OFRUpload/OFRData/2013-04904_PI.pdf. The proposed rule can be found here: http://ofr.gov/OFRUpload/OFRData/2013-04952_PI.pdf.

State Notice of Benefit and Payment Parameters State Notice Timing (§153.100)

In the Payment Notice, we clarify that States must publish an annual State notice of benefit and payment parameters for benefit year 2014 within 30 days after the final HHS Payment Notice is published. The new deadline provides States additional time to develop and publish their State notice for benefit year 2014.

Provisions and Parameters for the Permanent Risk Adjustment Program

Section 1343 of the Affordable Care Act provides for a permanent risk adjustment program that applies to non-grandfathered individual and small group plans inside and outside Exchanges. Risk adjustment funds are transferred from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees (such as individuals with chronic conditions) to protect against potential effects of adverse selection.

HHS-developed Risk Adjustment Methodology (§153.20 & §153.360)

We finalized a methodology for use when operating a risk adjustment program on behalf of a State. The methodology calculates a plan average risk score for each covered plan based upon the relative risk of the plan's enrollees, and applies a payment transfer formula in order to determine risk adjustment payments and charges between plans within a risk pool within a market within a State. The risk adjustment methodology addresses three considerations: (1) the newly insured population; (2) plan metal level differences and permissible rating variation; and (3) the need for risk adjustment transfers that net to zero. The risk adjustment methodology developed by HHS:

- Was developed on commercial claims data for a population similar to the expected population to be risk adjusted;
- Uses the hierarchical condition category ("HCC") grouping logic used in the Medicare risk adjustment program, with HCCs refined and selected to reflect the expected risk adjustment population;

- Establishes 15 concurrent risk adjustment models, one for each combination of metal level (platinum, gold, silver, bronze, catastrophic) and age group (adult, child, infant);
- Results in payment transfers that net to zero within a risk pool within a market within a State;
- Adjusts payment transfers for plan metal level, geographic rating area, induced demand, and age rating, so that transfers reflect health risk and not other cost differences; and
- Transfers funds between plans within a risk pool within a market within a State.

We finalized our proposal to risk adjust catastrophic plans in their own risk pool – that is, we will transfer funds between catastrophic plans, but not between catastrophic plans and other metal level plans. In addition, a risk adjustment covered plan in the small group market will be subject to risk adjustment in the State in which the employer's policy is filed and approved.

Standards and Approval of State-Operated Risk Adjustment (§153.310)
States that establish an Exchange may operate a risk adjustment program if it is approved by HHS or may defer risk adjustment operation to HHS. In the Payment Notice, we finalized proposed standards for HHS approval of a State-operated risk adjustment program for benefit year 2015 and beyond. We also finalized that States must submit information to HHS demonstrating compliance with these standards, which include the operational readiness to implement the applicable Federally certified risk adjustment methodology, including readiness to process payments and charges and conduct oversight and monitoring.

State Alternate Methodology (§153.330)
The States operating a risk adjustment program can use the HHS risk adjustment methodology, or submit an alternate methodology to HHS for certification. The Payment Notice clarifies that we will evaluate the extent to which an alternate risk adjustment methodology:

- Explains the variation in health care costs of a given population;
- Links risk factors to daily clinical practices and is clinically meaningful to providers;
- Encourages favorable behavior among providers and health plans and discourages
- unfavorable behavior;
- Uses data that is complete, high quality, and available in a timely fashion;
- Is easy for stakeholders to understand and implement;
- Provides stable risk scores over time and across plans;
- Minimizes administrative costs;
- Complies with subpart D of part 153;
- Accounts for risk selection across metal levels; and
- Each of the elements of the methodology are aligned.

We provide States the flexibility to select the adjustments used for the calculation of payments and charges in their alternate methodologies. States may also add or remove factors from the basic payment transfer formula as long as these factors are normalized, so that transfers net to zero.

Federally Certified Risk Adjustment Methodology
In addition to finalizing the methodology HHS will use when operating risk adjustment on behalf of a State, we have approved as a Federally certified methodology Massachusetts' alternate methodology. The Massachusetts risk adjustment methodology uses four concurrent models to predict plan liability. The Massachusetts model includes an adjustment for duration of enrollment and is based on HCC grouping logic, but the number and makeup of individual HCCs differ from the HHS model. Massachusetts will use the HHS payment transfer formula with modifications to several cost factors. The

data used to calibrate and operate the program are from the State's all payer claims database (APCD); calibration data were supplemented with MarketScan® New England data.

Risk Adjustment User Fees (§153.610)

To fund the HHS-operated risk adjustment program, HHS is finalizing the proposed risk adjustment user fees for issuers of risk adjustment covered plans in HHS-operated risk adjustment programs. Issuers will remit to HHS a per member per month fee of $0.96 per enrollee when risk adjustment payments and charges are processed.

Risk Adjustment Data Validation (§153.630)

To promote confidence in the risk adjustment program, we finalized the risk adjustment data validation standards for risk adjustment covered plans under the HHS-operated risk adjustment program. Issuers will be required to hire independent auditors to perform the initial validation audit of risk adjustment data for an HHS-provided audit sample of enrollees in their plans. Issuers will then need to submit data and documentation from the initial audit to HHS for a second validation audit. We will perform the second audit to confirm the findings of the initial auditor. We will provide an administrative process to appeal data validation findings. For 2014 and 2015, an initial and second validation audit will be conducted, but the findings will not be used to adjust payments and charges based on the results of this validation. For the 2016 benefit year and later, we plan to prospectively adjust 2017 payments and charges using information from the data validation process. We anticipate consulting with stakeholders on this approach to data validation.

Provisions and Parameters for the Transitional Reinsurance Program

Section 1341 of the Affordable Care Act provides for a transitional reinsurance program in each State from 2014 through 2016. The reinsurance program is designed to reduce the costs of high-risk enrollees and thereby reduce premiums for enrollees in the individual market to ensure market stability with the implementation of new market reform rules in 2014.

State Standards Related to the Reinsurance Program (§153.210 through §153.250)

To improve efficiency and reduce administrative burdens on issuers and self-insured group health plans, we finalized in the Payment Notice several provisions of the transitional reinsurance program amending provisions set forth in the Premium Stabilization Rule. In particular, we establish that:

- To increase efficiency and reduce administrative burden, HHS will collect contributions from all health insurance issuers and self-insured group health plans;
- To ensure fair and equitable distribution of funds, reinsurance payments will be determined based on the total reinsurance contributions collected and total eligible claims paid nationally by eligible issuers;
- Contributions will be collected annually beginning in late 2014;
- Reinsurance payments will be made annually, based on a uniform HHS coinsurance rate, attachment point, and reinsurance cap for the applicable benefit year;
- A State may supplement the HHS reinsurance payment parameters, but must fund those supplemental payments with additional State reinsurance collections or State funds (not with reinsurance funds collected by HHS under the national contribution rate);
- A State that seeks additional reinsurance funds for administrative expenses or supplemental reinsurance payments must have its applicable reinsurance entity collect those funds; and
- A State is required to set forth the additional contribution rate in its State notice of benefit and payment parameters, but we are not finalizing a provision that the State must notify HHS of its intent to collect additional contributions prior to the State's notice of benefit and payment notice.

In addition, to maximize the program's net impact on premiums, we finalized uniform payment parameters that result in fair and more equitable access to the reinsurance funds. This approach allocates reinsurance contributions where they are most needed, to reimburse issuers with enrollees with high claims cost in the individual market in 2014, 2015, and 2016. This policy is consistent with the goal of the transitional reinsurance program – to stabilize premiums in the initial years of market reform and Exchange implementation.

Uniform Collections and Payment Calendar (§153.400 and §153.410)
All reinsurance contributions will be collected and reinsurance payments disbursed on a uniform schedule. For benefit year 2014, contributing entities must submit their enrollment counts to HHS by November 15, 2014. HHS will invoice each contributing entity based on its enrollment count within 30 days or by December 15, 2014, whichever is later, and the contributing entity will have 30 days to remit the contribution. HHS or a State-operated program will notify issuers of the total amount of reinsurance payments to be made no later than June 30, 2015. Only those reinsurance-eligible plans that are subject to the 2014 market reform rules will be eligible to receive reinsurance payments.

Entities Excluded from Contributions and Payments (§153.400)
We clarify in the Payment Notice that reinsurance contributions are not required for coverage that is not "major medical coverage." We will not require contributions for health insurance coverage (other than self-insured group health plans) that is not part of a commercial book of business. We also will not require contributions for HSAs, integrated HRAs, and expatriate coverage (as defined by the Secretary). With respect to self-insured group health plans, the plan is liable for reinsurance contributions, although a third-party administrator or administrative-services-only contractor may be utilized for transfer of reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion.

National Contribution Rate and Federal Administrative Fees (§153.220)
Section 1341 of the Affordable Care Act requires the collection of reinsurance contributions for the 2014 benefit year at $10 billion and the contribution to the U.S. Treasury at $2 billion. The amount to be collected for administrative expenses for benefit year 2014 is $20.3 million (which translates to a national per capita contribution rate of $0.11 annually). The national per capita contribution rate is calculated by dividing the sum of the national reinsurance pool, the U.S. Treasury contribution, and administrative costs by the estimated number of enrollees in contributing entities. Based on HHS's estimate of the number of enrollees in plans that must make reinsurance contributions, the national reinsurance contribution rate is $63.00 per enrollee per year for benefit year 2014.

Calculation, Collection, and Disbursement of Reinsurance Contributions (§153.220, §153.240, §153.400, §153.405)
We are finalizing the proposal that each contributing entity must make reinsurance contributions annually at the national per capita contribution rate, in a manner specified by HHS. States may elect to collect additional contributions from health insurance issuers. The reinsurance contribution amount for a contributing entity will be calculated by multiplying the number of covered lives of reinsurance contribution enrollees during the benefit year for all of the contributing entity's plans and coverage that are required to pay reinsurance contributions, by the national contribution rate for the applicable benefit year. Contributing entities must use one of several methods based on the methods under the Patient-Centered Outcomes Research Trust Fund (PCORTF) Rule (77 FR 72721, December 6, 2012) to determine the number of covered lives of reinsurance contribution enrollees for a benefit year.

National Reinsurance Payment Parameters and Uniform Payment Adjustments (§153.230)
We have amended the policy described in the Premium Stabilization Rule by establishing uniform reinsurance payment parameters that apply to the reinsurance program, whether or not operated by the State. The Payment Notice finalizes the uniform reinsurance payment parameters. In each State, the

transitional reinsurance program will begin to pay claims at an attachment point of $60,000, and stop paying claims after $250,000, the reinsurance cap. We also finalized the proposal to set a uniform coinsurance rate of 80 percent. We will adjust reinsurance payments by a uniform rate in the event that we determines that the total amount requested for reinsurance payments under the uniform reinsurance payment parameters exceed reinsurance contributions collected under the national contribution rate.

Supplemental State Reinsurance Parameters (§153.232)

If a State establishes the reinsurance program and collects supplemental funds for reinsurance payments or uses State funds to supplement the funds collected under the national contribution rate, the State may set State supplemental reinsurance payment parameters by: (1) decreasing the national attachment point; (2) increasing the national reinsurance cap; and/or (3) increasing the national coinsurance rate (not to exceed the issuer's total paid amount for the reinsurance-eligible claims). States' supplemental payment parameters will not affect the amount of reinsurance payments made under the uniform payment parameters.

Reinsurance Data Collection Standards (§153.240)

We are finalizing our proposal that, when HHS operates reinsurance on behalf of a State, HHS will utilize the same distributed data collection approach that we will use for risk adjustment. When a State operates reinsurance, it must ensure that its applicable reinsurance entity either collects or accesses the data necessary to determine reinsurance payments from reinsurance-eligible plans. States must provide a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims in the normal course of business (e.g., a capitated plan) may request reinsurance payments (or submit data to be considered for reinsurance payments) based on estimated costs of encounters for the plan.

Requirements for a Distributed Data Environment (§153.700 through §153.730)

Protecting the privacy and confidentiality of an individual's personal health information continues to be among HHS's highest priorities. In the Payment Notice, issuers are required to use a "masked enrollee identification number" when loading enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data to a dedicated, secure data environment for the reinsurance and risk adjustment programs operated by HHS. The data server will reside with the issuer. HHS will access the issuer's data server to install and update common software. The software will verify claim and enrollment data submitted for risk adjustment and reinsurance and provide summary level information to HHS as well as detailed information to issuers, with the detailed information remaining in the issuer's server.

Provisions for the Temporary Risk Corridors Program

Section 1342 of the Affordable Care Act directs HHS to establish and administer a temporary risk corridors program from 2014 through 2016. The risk corridors program applies to qualified health plans (QHPs) in the individual and small group markets. The temporary risk corridors program protects QHPs from uncertainty in rate setting from 2014 to 2016 by limiting the extent of issuer losses and gains.

Accounting for Profits and Taxes in Risk Corridors Calculation (§153.500)

In the Payment Notice, we defined "taxes and regulatory fees" as Federal and State licensing and regulatory fees and Federal and State taxes and assessments paid to align with the corresponding MLR definitions. We defined "profits" to mean the greater of: (1) three percent of after tax premiums earned; and (2) premiums earned minus the sum of allowable costs and administrative costs. We specified that allowable costs would be reduced by any cost-sharing reduction payments received by the issuer for the QHP to the extent they would not be reimbursed to the provider furnishing the item or service. We further define "after tax premiums earned" as premiums earned minus taxes and regulatory fees.

In addition, we defined "administrative costs" to mean the total non-claims costs incurred by the QHP issuer for the QHP, including taxes and regulatory fees. We have also revised the definition of "allowable administrative costs" to mean the sum of administrative costs of the QHP (other than taxes and regulatory fees) and profits earned by the QHP, including reinsurance contributions, which sum is limited to 20 percent of after tax premiums earned with respect to the QHP (including any premium tax credit under any governmental program), plus taxes and regulatory fees.

Aligning Risk Corridors with the Single Risk Pool (§153.20 in the IFC)

We received a number of comments on the proposed Payment Notice urging us to change the risk corridors calculation so that the risk corridors calculation is made at the issuer level instead of at the QHP level. In response to these comments, we are modifying the definition of "allowable costs" for the risk corridors calculation, so that the QHP's allowable costs are determined on the basis of its pro-rata share of a pooled claims cost amount of the QHP issuer for all of its non-grandfathered health plans in a market within a State. Under the modified approach, allowable costs would be allocated to and among an issuer's QHPs in proportion to the amount of the QHPs' premiums. Finally, we are modifying the attribution and allocation of revenue and expense items in §153.520 to align with our policy that requires issuers to allocate allowable costs to their QHPs in proportion to the QHP's premium.

Risk Corridor Data Submission Dates and Requirements (§153.510, §153.520, and §153.530)

In the Payment Notice, we finalize that by July 31, 2015, QHP issuers will report to HHS risk corridor data, including premiums, allowable costs, and allowable administrative costs. An issuer of a QHP must remit risk corridor charges to HHS within 30 days after notification from HHS. We will release further risk corridors data submission guidance in the future.

Provisions for the Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions Programs

Beginning in 2014, individuals who enroll in QHPs through Exchanges may receive premium tax credits to make health insurance more affordable, and financial assistance to help reduce out-of-pocket costs for health care services.

New Standards Related to Advance Payments of the Premium Tax Credit (§155.305, §155.330, §155.340, §155.1030, §156.440, §156.460, and §156.470)

Exchanges will make advance determinations of premium tax credit eligibility for individuals enrolling in coverage through the Exchange, and will notify the QHP issuer of the enrollee's advanced payment of the premium tax credit (APTC) amount. In the case of an eligibility redetermination during the benefit year, the Payment Notice directs Exchanges to account for any advance payments already made on behalf of the tax filer in that benefit year to minimize, to the extent possible, any projected discrepancies between the advance payments and the tax filer's projected premium tax credit for the benefit year.

In the Payment Notice, we allow Exchanges greater flexibility in allocating the APTC if one or more individuals in a tax household enroll in more than one policy through the Exchange. We also finalized that after an Exchange notifies a QHP issuer of an enrollee's APTC amount, the issuer must reduce the premium charged to the individual by the APTC amount. This policy ensures that enrollees automatically receive the subsidy for which they are eligible. Lastly, we established that issuers of QHPs and stand-alone dental plans must determine the portion of their premium allocable to essential health benefits and submit this information, along with an actuarial memorandum explaining the methods used to perform the allocation, to the Exchange for review and approval. This information will be used by the Exchange to calculate APTC amounts.

New Standards Related to Cost-Sharing Reductions

To implement requirements in the Affordable Care Act, QHP issuers must reduce cost sharing for individuals with household incomes between 100 percent and 250 percent of the Federal poverty level (FPL), who are enrolled in a silver level QHP in the individual market on an Exchange. In addition, issuers must eliminate cost sharing for Indians with household incomes under 300 percent of FPL who are enrolled in a QHP in the individual market on an Exchange. Finally, issuers must eliminate cost sharing for Indians enrolled in a QHP in the individual market on the Exchange, regardless of income, when services are provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.

Plan Variations (§155.305, §156.215, §156.400, §156.410, §156.420, §156.425 and §156.440)

We finalized our proposal that QHP issuers must develop variations of their QHPs. These variations would not be separate QHPs, but rather, variations of the QHP under which a portion of the cost sharing is to be paid by the Federal government, with the remainder being paid by the enrollee. In the Payment Notice, we provide specific instructions to QHP issuers for developing the plan variations and submitting the variations to the Exchange for approval. QHP issuers will be required to assign eligible enrollees to the appropriate plan variation based on an eligibility determination made by the Exchange. This approach ensures that eligible enrollees receive the appropriate cost-sharing reductions at the point of service. QHP issuers may not create a system in which an eligible enrollee is required to pay the full cost-sharing requirement and apply for a reimbursement or refund. We also clarify that if an Exchange notifies a QHP issuer of a change in an enrollee's eligibility for cost-sharing reductions, the QHP issuer must reassign the enrollee to the appropriate plan variation. Following such a reassignment, the QHP issuer must ensure that any cost sharing paid by enrollee under the previous plan variation is accounted for in the calculation of deductibles and annual limitations on cost sharing in the enrollee's new plan variation for the remainder of the benefit year – in other words, cost-sharing amounts would "carry over" to the new plan variation. An issuer will not be required to "carry over" cost sharing following a change in QHP.

Payments for Cost-Sharing Reductions (§155.1030, §156.430, and §156.470)

The Affordable Care Act directs the Secretary to make periodic and timely payments to QHP issuers to offset the cost-sharing reductions. In the Payment Notice, we finalized a payment approach under which HHS would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts. We also establish that QHP issuers must submit to the Exchange, for approval by HHS, estimates of the value of the cost-sharing reductions to be provided over the benefit year. Given the lack of data on costs associated with coverage offered through an Exchange, we finalize a simplified approach for calculating these estimates for benefit year 2014. We also finalize a modification which allows us to adjust the advance payments if the QHP issuer provides information demonstrating that the cost-sharing reductions provided differ significantly from the advance payment amounts. After the close of the benefit year, QHP issuers must submit to HHS information on the actual value of the cost-sharing reductions provided. We would then reconcile the advance payments and the actual cost-sharing reduction amounts.

Alternative Approach for Calculating Cost-Sharing Reduction Amounts (§156.430(c) in IFC)

We received comments on the proposed Payment Notice suggesting that the proposed methodology for calculating the cost-sharing reduction amounts would place a large administrative burden on issuers. In response to these comments, we are permitting issuers to choose one of two methodologies for determining the amount of cost-sharing reductions provided. The first methodology (referred to as the "standard methodology") was finalized in the Payment Notice. Under that methodology, QHP issuers calculate the cost sharing that the enrollee would have paid under the standard plan without cost-sharing

reductions by applying the cost-sharing requirements for the standard plan to the allowed costs for each policy. Under the second methodology (referred to as the "simplified methodology"), set forth in the IFC, QHP issuers calculate the amount that the enrollee would have paid under the standard plan by applying certain summary cost-sharing parameters for the standard plan to the total allowed costs for each policy. This approach will allow QHP issuers to choose the methodology that best aligns with their operational practices, which should reduce the administrative burden on issuers in the initial years of the Exchanges.

The standards related to this policy are set forth in the IFC, published in the same issue of the Federal Register as the final Payment Notice. We believe it is important to establish these amendments through an IFC, rather than a final rule, to allow the public the opportunity to comment on the modifications. However, these provisions do not substantially change the underlying policy approach to the cost-sharing reductions program; and, we believe it is important to provide clear standards through an IFC, which QHP issuers can use to develop the rates for their plans in a timely manner for 2014.

Federally-Facilitated Exchange User Fees (§156.50)
In order to fund the operation of the Federally-facilitated Exchange (FFE) and Federally-facilitated SHOP (FF-SHOP), issuers participating in an FFE or FF-SHOP will be required to pay a monthly user fee to support the operation of the FFE or FF-SHOP. For the 2014 benefit year, we establish a monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer for policies that it offers through the FFE. An issuer will be required to pool the cost of the FFE user fee across all non-grandfathered plans that it offers in a market in a State, pursuant to the single risk pool requirement at 45 CFR 156.80.

Provisions for the Small Business Health Options Program (SHOP)
Employee Choice in a Federally-Facilitated SHOP (FF-SHOP) (§155.705)
In a FF-SHOP, we proposed that qualified employers would choose a metal level of coverage and a contribution, and employees could then choose any QHP at that level. We also sought comment on two additional options that the FF-SHOP might offer employers, one in which the employee would have a choice among the QHPs at two levels of coverage and a second transitional option in which the employer would offer a single QHP either as an additional employer option or as the only employer option. We finalized the policy of providing two employer options: offer all QHPs at a given level of coverage (metal level) or offer a single QHP. Because of the comments received in response to the proposed Payment Notice, we are publishing a separate NPRM simultaneously with the Payment Notice in which we propose delaying the date on which a SHOP must offer all QHPs at a single level until plan years beginning in 2015, and in which we further propose that the FF-SHOP not offer that option until 2015.

Definitions of Full-time Employee, Small Employer, and Large Employer (§155.20)
For the purposes of determining whether an employer is a small or large employer to determine eligibility as a qualified employer to participate in a SHOP, we will use the full-time equivalent method used in section 4980H(c)(2) of the Internal Revenue Code, as added by section 1513 of the Affordable Care Act. For the purpose of determining a full-time employee for purposes of determining compliance with the Affordable Care Act requirement that qualified employers make coverage available to all full-time employees, we will use the method in section 4980H(c)(4) of the Internal Revenue Code, as provided in forthcoming Treasury regulations. The definitions are proposed to become effective January 1, 2016; under this proposal, we discuss a transitional enforcement policy under which HHS will take no action if other methods allowable under State law are used. However, the definitions as proposed will be effective for operations of a FF-SHOP on October 1, 2013.

Methods for Employer Contributions in a FF-SHOP (§155.705)
We finalized the proposal that FF-SHOPs base the employer contribution methods on the cost of a reference plan chosen by the qualified employer. A qualified employer may define its contribution toward an employee's coverage as a percentage of the premium for the reference plan. We discuss the

use of either composite premiums or premiums that vary with age, based on the approaches described in section III(G) of IRS Notice 2010-82 regarding allowable ways an employer may contribute to employees' premiums and qualify for the small business premium tax credit prior to 2014.

Minimum Participation Rate in a FF-SHOP (§155.705)
We finalized the minimum participation rate for the FF-SHOP of 70 percent, calculated based on the level of enrollment through the FF-SHOP, and describe how the rate is calculated. Because State law, regulation, and market practices vary from State to State, we also finalize an option for a FF-SHOP to adopt a different minimum participation rate in a State with a FF-SHOP if there is evidence that the State law sets the rate or a higher or lower rate is customarily used by the majority of QHP issuers in that State.

Linking Issuer Participation in the FFE with Participation in a FF-SHOP (§156.200)
We proposed a QHP certification standard specific to the FFE that would permit an FFE to certify a QHP in the individual market of the FFE only if the QHP issuer meets one of the following conditions: (1) the issuer offers through a FF-SHOP serving that State at least one small group market QHP at the silver level and gold level of coverage; (2) the QHP issuer does not offer small group market plans in that State, but another issuer in the same issuer group offers at least one small group market QHP at the silver and gold coverage levels through a FF-SHOP serving that State; or (3) neither the issuer nor any issuer in the same issuer group offers a small group market product in the State. We finalized these provisions, but modify condition (3) so that the certification standard is also met if neither the issuer nor another issuer in the same issuer group has a market share of the State's small group market larger than 20 percent.

Broker Compensation for Coverage Sold Through the FFE or FF-SHOP & Broker Listing (§155.200)
We establish a QHP certification standard ensuring that issuers pay the same broker compensation for QHPs in the FFE or FF-SHOP that the issuer pays for similar plans in the outside market. We propose allowing Exchanges and SHOPs to selectively list only brokers registered with the Exchange or SHOP (and adopting that policy for Federally-facilitated Exchanges and FF-SHOPs).

SHOP Enrollment Periods (§155.725; §156.285)
In the NPRM published simultaneously with the final Payment Notice, we propose to amend current §155.725 to align the duration of special enrollment periods applicable to the group market under HIPAA – generally 30 days – to the coverage through the SHOP. We propose this change because there was no rationale for having a different special enrollment period in the SHOP. We also propose another change intended to align the SHOP special enrollment periods with HIPAA: we propose to create a 60-day special enrollment period in SHOP for people who become ineligible for Medicaid or CHIP or who become eligible for Medicaid or CHIP premium assistance. We also propose a conforming amendment to §156.285.

Provisions for Medical Loss Ratio Requirements
The medical loss ratio (MLR) program requires health insurance issuers to pay rebates when their MLRs fall below certain thresholds (generally, 80 percent in the individual and small group markets and 85 percent in the large group market).

MLR accounting for the payments and receipts related to risk adjustment, reinsurance and risk corridors (§158.130(b), §158.140(b), §158.161(a), §158.221(c), and §158.240(c))
Health insurance issuers subject to MLR requirements must account for payments and receipts related to the premium stabilization programs in MLR and rebate calculations. Beginning with the 2014 MLR reporting year, the annual MLR reporting form will direct issuers to include premium stabilization payments and receipts in total earned premium. Total earned premium will not be reduced by the amount of contributions under the transitional reinsurance program. Premium stabilization payments and receipts, other than reinsurance contributions, will then be excluded from an issuer's earned premium so that these

amounts will not have a net impact on the adjusted earned premium used in calculating an issuer's MLR and rebates. Contributions under the transitional reinsurance program will be included with the Federal regulatory fees that are deducted from earned premium in MLR and rebate calculations. Premium stabilization payments and receipts other than reinsurance contributions will be included as an adjustment to incurred claims in calculating an issuer's MLR.

MLR deadlines (§158.110(b), §158.240(d), and §158.241(a)(2))
We extend the MLR reporting and rebate deadlines to accommodate the reporting schedule for the premium stabilization programs, which will allow the use of actual premium stabilization programs amounts in the MLR and rebate calculations and ensure accurate rebates. We extend the filing deadline for annual MLR reports for 2014 and later reporting years from June 1 to July 31 of the year following the reporting year. We extend the rebate payment deadline from August 1 to September 30 of the year following the reporting year.

MLR Treatment of Community Benefit Expenditures (§158.162(b)(1))
We allow tax-exempt not-for-profit (NFP) issuers who make community benefit expenditures in lieu of Federal income taxes to deduct both community benefit expenditures (CBEs) and State premium tax from premium in calculating their MLR and rebates. Currently, tax-exempt not-for-profit issuers may only deduct either CBE or State premium tax from premium in MLR calculations, although they are required to make CBE to maintain their tax-exempt status. This amendment to the MLR regulation places tax-exempt not-for-profit issuers on a level playing field with issuers that are subject to Federal income taxes with regard to Federal income taxes. In order to avoid waste, fraud and abuse, the new standard caps the CBE deduction at the higher of the State's highest premium tax rate or 3 percent.