

Proposed HHS Notice of Benefit and Payment Parameters for 2014 Overview

Center for Consumer Information and Insurance Oversight

The Department of Health and Human Services (HHS) published a proposed notice of benefit and payment parameters for 2014 (“proposed 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 (at 77 FR 17220, March 23, 2012) and the Exchange Establishment Rule (at 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 (at 76 FR 74864, December 1, 2010) and final rule (at 76 FR 76574, December 7, 2011). The proposed Payment Notice provides further detail and parameters related to: the risk adjustment, reinsurance and 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.

Provisions of the proposed Payment Notice are summarized below. The proposed Payment Notice may be viewed in its entirety at: <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf>.

State Notice of Benefit and Payment Parameters

State Notice Timing (§153.100)

In the proposed Payment Notice, we propose a new deadline for States to publish an annual State notice of benefit and payment parameters for benefit year 2014 that is 30 days after the final HHS Payment Notice is published or March 1, 2013, whichever is later. We believe the new deadline would provide States additional time to develop and publish their State notice for benefit year 2014.

Provisions and Parameters for the Permanent Risk Adjustment Program

The permanent risk adjustment program transfers funds from plans with relatively lower-risk enrollees to plan with relatively higher-risk enrollees to protect against potential effects of adverse selection.

Standards and Approval of State-Operated Risk Adjustment (§153.310)

States that establish an Exchange are eligible to operate a risk adjustment program or may defer risk adjustment operation to HHS. In the proposed Payment Notice, we propose standards for HHS approval of a State-operated risk adjustment program for benefit year 2015 and beyond. We also propose that States 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. Given the time constraints for benefit year 2014, we request that a State that elects to operate a risk adjustment program consult with HHS to determine readiness. For benefit year 2015 and subsequent years, all States operating risk adjustment would need formal HHS approval.

Risk Adjustment Methodology (§153.20 & §153.360)

The methodology that HHS proposes to use when operating a risk adjustment program on behalf of a State would calculate a plan average risk score for each covered plan based upon the relative risk of the plan’s enrollees, and apply 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 proposed risk

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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 proposed risk adjustment methodology developed by HHS:

- Is developed on commercial claims data for a population similar to the expected population to be risk adjusted;
- Employs 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 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 propose to risk adjust catastrophic plans in their own risk pool – that is, we would transfer funds between catastrophic plans, but not between catastrophic plans and other metal level plans. In addition, we propose that a risk adjustment covered plan would be subject to risk adjustment in the State in which the policy is filed and approved.

State Alternate Methodology (§153.330)

Our proposals would clarify that States operating a risk adjustment program can use the HHS risk adjustment methodology, or submit an alternate methodology to HHS for certification. We also propose to 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 in 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
- Components are aligned with each other.

We propose to 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. For a number of plans, such as student health plans and plans not subject to the market reform rules, we have proposed not to transfer payments under the HHS risk adjustment methodology. However, we believe that States should have the flexibility to submit a methodology that transfers funds between these types of plans, either in their own risk pool or with the other metal levels.

Risk Adjustment Data Validation (§153.630)

To promote confidence in the risk adjustment program, we propose risk adjustment data validation standards for risk adjustment covered plans under HHS operated risk adjustment. We propose that issuers 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 would then submit data and documentation from

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the initial audit to HHS for a second validation audit. HHS would perform the second audit to confirm the findings of the initial auditor. HHS would provide an administrative process to dispute audit findings. For 2014 and 2015, we propose that an initial and second validation audit be conducted, but that we would not adjust payments and charges based on the results of this validation. For the 2016 benefit year and later, HHS would prospectively adjust payments and charges using information from the data validation process.

Provisions and Parameters for the Transitional Reinsurance Program

The transitional reinsurance program is a three-year program designed to stabilize premiums for coverage in the individual market from 2014 through 2016.

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

To improve efficiency and reduce administrative burdens on issuers and group health plans, we have modified several provisions of the transitional reinsurance program set forth in the Premium Stabilization Rule. In particular, we propose that:

- In order to heighten efficiency and reduce administrative burden, HHS would collect contributions from all health insurance issuers and self-insured group health plans;
- To ensure fair and equitable distribution of funds, reinsurance payments would be determined based on the total pool of all reinsurance contributions collected and total paid eligible claims nationally;
- Contributions would be collected once annually beginning in late 2014;
- Reinsurance payments would be made once annually, based on a uniform HHS coinsurance rate, attachment point, and reinsurance cap for each benefit year;
- A State may supplement the HHS reinsurance payment parameters, but would pay for those supplementary parameters with additional State reinsurance collections or state funds (instead of funds collected by HHS under the national contribution rate); and
- A State that seeks additional reinsurance funds for administrative expenses and/or supplemental reinsurance payments would have its applicable reinsurance entity collect those funds.

In addition, in order to maximize the program's net impact on premiums, we propose uniform payment parameters that would result in fair and more equitable access to the full reinsurance pool. This approach would allocate 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)

We propose that all reinsurance contributions be collected and reinsurance payments be disbursed on a uniform schedule. For benefit year 2014, contributing entities would be required to submit their enrollment counts to HHS by November 15, 2014. HHS would invoice each contributing entity based on its enrollment count within 30 days or by December 15, 2014, whichever is later, and the contributing entity would then have 30 days to remit the contribution. We propose that HHS or a State operated program notify issuers of the total amount of reinsurance payments that would be made no later than June 30, 2015. We further propose that the HHS operated and State operated reinsurance programs would provide reinsurance payments only to those reinsurance-eligible plans that are subject to the 2014 market reform rules.

Entities Excluded from Contributions and Payments (§153.400)

We clarify that reinsurance contributions are not required for coverage that is not "major medical coverage." We would not require contributions for health insurance coverage (other than self-insured

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group health plans) that is not part of a commercial book of business or that is not filed with and regulated by a State department of insurance. With respect to self-insured group health plans, the plan is liable, 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)

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 plans that must make reinsurance contributions. Section 1341 of the Affordable Care Act sets the 2014 national reinsurance pool 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 would be \$20.3 million (which translates to a national per capita contribution rate of \$0.11 annually) for administrative expenses. Based on HHS's estimate of the number of enrollees in plans that must make reinsurance contributions, the national reinsurance contribution rate would be set at \$5.25 per enrollee per month for benefit year 2014.

Calculation, Collection, and Disbursement of Reinsurance Contributions (§153.220, §153.240, §153.400, §153.405)

We propose that each contributing entity make reinsurance contributions annually at the national per capita contribution rate, in a manner specified by HHS, or the State when the State is collecting any additional contributions from health insurance issuers. The reinsurance contribution amount would 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. We propose a number of methods that a contributing entity may use to determine the number of covered lives of reinsurance contribution enrollees under a health insurance plan for a benefit year for purposes of the annual enrollment count. These methods are based on the methods under the Patient-Centered Outcomes Research Trust Fund (PCORTF) Rule (77 FR 72721, December 6, 2012).

National Reinsurance Payment Parameters and Uniform Payment Adjustments (§153.230)

We propose to amend the policy described in the Premium Stabilization Rule by establishing uniform reinsurance payment parameters that would apply to the reinsurance program for each State, whether or not operated by the State. We propose that in each State the transitional reinsurance program begin to pay claims at an attachment point of \$60,000, and stop paying claims after \$250,000, the reinsurance cap. We are also proposing to set a uniform coinsurance rate of 80 percent, which would reimburse a proportion of claims between the attachment point and reinsurance cap, while giving issuers an incentive to contain costs. We further propose that HHS would adjust reinsurance payments by a uniform rate in the event that HHS determines that all requests for reinsurance payments under the uniform reinsurance payment parameters exceed reinsurance contributions collected under the national contribution rate.

Supplemental State Reinsurance Parameters (§153.232)

We propose that if a State establishes a 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 payments 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). Supplemental reinsurance payments with respect to a health insurance issuer's claims costs for an individual enrollee's paid claims for covered benefits must be calculated by taking the sum of: (1) the product of such claims paid between the supplemental State attachment point and the national attachment point multiplied by the national coinsurance rate (or applicable State supplemental coinsurance rate); (2) the product of such paid claims between the national reinsurance cap and the supplemental State reinsurance cap multiplied by the national coinsurance rate (or applicable State supplemental State

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coinsurance rate); and (3) the product of such paid claims between the national attachment point and the national reinsurance cap multiplied by the difference between the supplemental coinsurance rate and the national coinsurance rate.

Reinsurance Data Collection Standards (§153.240)

We propose that a State ensure that its applicable reinsurance entity either collect or be provided access to the data necessary to determine reinsurance payments from these plans. We also propose that States 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. When HHS operates reinsurance on behalf of a State, HHS would utilize the same distributed data collection approach that we propose to use for risk adjustment.

Distributed Data Environment for Reinsurance and Risk Adjustment

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. Under the proposed Payment Notice, issuers would be required to provide access to "masked" enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data through a dedicated, secure data environment for the reinsurance and risk adjustment programs operated by HHS on behalf of the State. The data environment would be issuer-owned and operated. HHS would access the issuer's data environment to install and update common software. The software would edit data submitted for risk adjustment and reinsurance in order to provide summary level information to HHS and detailed information to issuers, with the detailed information remaining in the issuer's environment.

Provisions for the Temporary Risk Corridors Program

The temporary risk corridors program protects qualified health plans from uncertainty in rate setting from 2014 to 2016 by having the Federal government share risk in losses and gains. HHS proposes to account for profits and taxes in the calculations and to align this program with the MLR program.

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

Under the Premium Stabilization Rule, risk corridors calculations compare a qualified health plan's (QHP) allowable costs (claims costs) with its target amount (premiums less allowable administrative (non-medical) costs). In the proposed rule, we further propose to account for profits and taxes in the risk corridors calculations in a manner that is consistent with the MLR program. Specifically, we propose to define "taxes" as Federal and State licensing and regulatory fees and Federal and State taxes and assessments paid to align with the corresponding MLR definitions. We also propose to define "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 specify 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 propose to define "after tax premiums earned" as premiums earned minus taxes.

In order to conform to the newly added definitions set forth above, we also propose to revise the definition of "administrative costs" to mean the total non-claims costs incurred by the issuer for the QHP, including taxes. Finally, we propose to revise the definition of "allowable administrative costs" to include the sum of administrative costs (other than taxes) and profits earned, which sum is limited to 20 percent of after tax premiums earned (including any premium tax credit under any governmental program), plus taxes.

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

We propose in other sections of the Payment Notice that no later than June 30, 2015, QHP issuers would receive an annual notification concerning reinsurance and risk adjustment payments and charges. By July 31, 2015, QHP issuers would report to HHS risk corridor data, including premiums, allowable costs, and allowable administrative costs. We further propose that 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. In this proposed Payment Notice, we supplement previous rulemaking on advance payments of the premium tax credit (APTCs) and cost-sharing reductions (CSRs), including the Exchange Establishment Final Rule and the IRS' Health Insurance Premium Tax Credit Final Rule.

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)

As discussed in previous rulemaking, 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 APTC amount. In this proposed Payment Notice, we propose standards for Exchanges when recalculating an enrollee's APTC amount after a change in eligibility during a benefit year, with the goal of minimizing any projected discrepancies between the advance payments and the final premium tax credit amount, as determined by the IRS after the close of the tax year. We also propose 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 would ensure that enrollees automatically receive the subsidy for which they are eligible. Lastly, we propose that issuers of QHPs and stand-alone dental plans 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 would be used by the Exchange to calculate APTC amounts.

New Standards Related to Cost-Sharing Reductions

To implement requirements in the Affordable Care Act, we propose that QHP issuers 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 (§156.215, §156.400, §156.410, §156.420, §156.425 and §156.440)

To implement the cost-sharing reduction program, we propose that QHP issuers 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 would be paid by the federal government, and the remainder would be paid by the enrollee. In the proposed 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 would be required to assign eligible enrollees to the appropriate plan variation based on an eligibility determination made by the Exchange. This approach would ensure that eligible enrollees receive the

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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 would 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. To fulfill this requirement, we propose to implement 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. In this proposed Payment Notice, we propose that QHP issuers 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 propose a simplified methodology for calculating these estimates for benefit year 2014. After the close of the benefit year, QHP issuers would submit to HHS information on the actual value of the cost-sharing reductions. HHS would then reconcile the advance payments and the actual cost-sharing reductions.

Federally Facilitated Exchange User Fees (§156.50)

In order to fund the operation of the Federally-facilitated Exchange (FFE), issuers participating in an FFE would be required to pay a monthly user fee to support the operation of the FFE. In general, for the 2014 benefit year, we propose a monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer. We seek to align this rate with rates charged by State-based Exchanges, and may adjust this rate to conform with State-based Exchange rates in the final Payment Notice. This policy does not affect the ability of a State to use grants described in section 1311 of the Affordable Care Act to develop functions that a State elects to operate under a Partnership Exchange, and to support State activities to build interfaces with a Federally-facilitated Exchange.

Provisions for the Small Business Health Options Program (SHOP)

Employee Choice in a Federally-Facilitated SHOP (FF-SHOP) (§155.705)

In FF-SHOPS, we propose that qualified employers will choose a level of coverage (bronze, silver, gold, or platinum) and a contribution, and employees can then choose any QHP at that level. For a FF-SHOP, we continue to consider whether to allow a qualified employer to offer their employees only a single QHP on a transitional basis or as a permanent feature of the FF-SHOP, and we seek comment on adding an additional employer option in a FF-SHOP that would allow a qualified employer to make available to employees all QHPs at the level of coverage selected by the employer plus any QHPs at the next higher level of coverage that a QHP issuer agrees to make available under this option. We also seek comment on a transitional policy in which Federally-facilitated SHOPS would provide employers a single option: the choice of a single QHP from among those offered through SHOP.

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 propose using the full-time equivalent method used

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in section 4980H(c)(2)(e) 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 propose to 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 would, take no action if other methods allowable under State law are used. However, the definitions as proposed would be effective for operations of a FF-SHOP on October 1, 2013.

Methods for Employer Contributions in a FF-SHOP (§155.705)

We propose that FF-SHOPs would 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 the employees' premiums and qualify for the small business premium tax credit prior to 2014.

Minimum Participation Rate in a FF-SHOP (§155.705)

Subject to sections 2703 and 2704 of the Public Health Service Act, which are the subject of a proposed rule published November 26, 2012, we propose here a minimum participation rate for the FF-SHOP of 70 percent, calculated based on the level of enrollment through the FF-SHOP. Because State law, regulation, and market practices vary from State to State, we also propose 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 (§155.200)

We propose 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.

Broker Compensation for Coverage Sold Through the FFE or FF-SHOP & Broker Listing (§155.200)

We propose 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).

Provisions for Medical Loss Ratio Requirements

MLR accounting for the payments and receipts related to risk adjustment, reinsurance and risk corridors (§158.130(b), §158.140(b), and §158.240(c))

We propose to direct health insurance issuers subject to MLR requirements to 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 would direct issuers to include premium stabilization payments and receipts in total earned premium. Premium stabilization payments and receipts would then be excluded from an issuer's earned premium in calculating an issuer's MLR and rebates.

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Premium stabilization payments and receipts would 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 propose to extend MLR reporting and rebate deadlines to accommodate the reporting schedule for the premium stabilization programs, which would allow the use of actual premium stabilization program amounts in the MLR and rebate calculations and ensure accurate rebates. We propose to extend the filing deadline for annual MLR reports for reporting years 2014 and later from June 1 to July 31 of the year following the reporting year. We propose to 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 propose to 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, 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. The proposed amendment would place not-for-profit issuers on a level playing field with for-profit issuers with regard to federal income taxes. The proposed rule would cap the deduction to avoid waste, fraud and abuse at the higher of the applicable state premium tax rate or 3 percent.