§ 153.710 Data requirements.

(a) *Enrollment, claims, and encounter data.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS.

(b) *Claims data.* All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer (or payment of cost sharing by the enrollee).

(c) *Claims data from capitated plans.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving.

(d) *Final dedicated distributed data environment report.* Within 15 calendar days of the date of the final dedicated distributed data environment report from HHS, the issuer must, in a format specified by HHS, either:

(1) Confirm to HHS that the information in the final report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the benefit year specified in the report; or

(2) Describe to HHS any discrepancy it identifies in the final dedicated distributed data environment report.

(e) *Materiality threshold.* HHS will consider a discrepancy reported under paragraph (d)(2) of this section to be material if the amount in dispute is equal to or exceeds $100,000 or 1 percent of the total estimated transfer amount in the applicable State market risk pool, whichever is less.

(f) *Unresolved discrepancies.* If a discrepancy first identified in a final dedicated distributed data environment report in accordance with paragraph (d)(2) of this section remains unresolved after the issuance of the notification of risk adjustment payments and charges or reinsurance payments under § 153.310(e) or § 153.240(b)(1)(ii), respectively, an issuer of a risk adjustment covered plan or reinsurance-eligible plan may make a request for reconsideration regarding such discrepancy under the process set forth in § 156.1220(a) of this subchapter.

(g) *Evaluation of dedicated distributed data.* If an issuer of a risk adjustment covered plan fails to provide sufficient required data, such that HHS cannot apply the applicable methodology to calculate the risk adjustment payment transfer amount for the risk adjustment covered plan in a

timely or appropriate fashion, then HHS will assess a default risk adjustment charge under § 153.740(b). If an issuer of a reinsurance eligible plan fails to provide data sufficient for HHS to calculate reinsurance payments, the issuer will forfeit reinsurance payments for claims it fails to submit.

(1) *Data quantity.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan must provide, in a format and on a timeline specified by HHS, data on its total enrollment and claims counts by market, which HHS may use in evaluating whether the issuer provided access in the dedicated distributed data environment to a sufficient quantity of data to meet reinsurance and risk adjustment data requirements.

(2) *Data quality.* If, following the deadline for submission of data specified in § 153.730, HHS identifies an outlier that would cause the data that a risk adjustment covered plan or a reinsurance-eligible plan made available through a dedicated distributed data environment to fail HHS's data quality thresholds, the issuer may, within 10 calendar days of receiving notification of the outlier, submit an explanation of the outlier for HHS to consider in determining whether the issuer met the reinsurance and risk adjustment data requirements.

(h) *Risk corridors and MLR reporting.* Except as provided in paragraph (h)(3) of this section:

(1) Notwithstanding any discrepancy report made under paragraph (d)(2) of this section, any discrepancy filed under § 153.630(d)(2) or (3), or any request for reconsideration under § 156.1220(a) of this subchapter with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees and risk adjustment data validation adjustments; reinsurance payment; cost-sharing reduction payment or charge; or risk corridors payment or charge, unless the dispute has been resolved, an issuer must report, for purposes of the risk corridors and medical loss ratio (MLR) programs:

(i) The risk adjustment payment to be made or charge assessed, including an assessment of risk adjustment user fees, by HHS in the notification provided under § 153.310(e);

(ii) The reinsurance payment to be made by HHS in the notification provided under § 153.240(b)(1)(ii);

(iii) A cost-sharing reduction amount equal to the actual amount of cost-sharing reductions for the benefit year as calculated under § 156.430(c) of this subchapter, to the extent not reimbursed to the provider furnishing the item or service;

(iv) For medical loss ratio reporting only, the risk corridors payment to be made or charge assessed by HHS under § 153.510; and

(v) The risk adjustment data validation adjustment calculated by HHS in the applicable benefit year's Summary Report of Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers.

(2) An issuer must report during the current MLR and risk corridors reporting year any adjustment made or approved by HHS for any risk adjustment payment or charge, including an

assessment of risk adjustment user fees and risk adjustment data validation adjustments; any reinsurance payment; any cost-sharing reduction payment or charge; or any risk corridors payment or charge before August 15, or the next applicable business day, of the current MLR and risk corridors reporting year unless instructed otherwise by HHS. An issuer must report any adjustment made or approved by HHS for any risk adjustment payment or charge, including an assessment of risk adjustment user fees and risk adjustment data validation adjustments; any reinsurance payment; any cost-sharing reduction payment or charge; or any risk corridors payment or charge where such adjustment has not been accounted for in a prior MLR and Risk Corridors Annual Reporting Form, in the MLR and Risk Corridors Annual Reporting Form for the following reporting year.

(3) In cases where HHS reasonably determines that the reporting instructions in paragraph (h)(1) or (2) of this section would lead to unfair or misleading financial reporting, issuers must correct their data submissions in a form and manner to be specified by HHS.

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