§ 156.430 Payment for cost-sharing reductions.

(a) [Reserved]

(b) *Advance payments for cost-sharing reductions.* (1) When there is an appropriation to make cost-sharing reduction payments to QHP issuers, a QHP issuer will receive periodic advance payments from HHS to the extent permitted by the appropriation and calculated in accordance with § 155.1030(b)(3) of this subchapter.

(2) HHS may adjust the advance payment amount for a particular QHP during the benefit year if the QHP issuer provides evidence, certified by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, that the advance payments for a particular QHP are likely to be substantially different than the cost-sharing reduction amounts that the QHP provides that will be reimbursed by HHS.

(c) *Submission of actual amounts*—(1) *General.* For each plan variation that a QHP issuer offers on the Exchange, it must submit to HHS, in the manner and timeframe established by HHS, for each policy, the total allowed costs for essential health benefits charged for the policy for the benefit year, broken down by all of the following:

(i) The amount the issuer paid.

(ii) The amount the enrollee(s) paid.

(iii) The amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions.

(2) *Standard methodology.* A QHP issuer must calculate the value of the amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions by applying the actual cost-sharing requirements for the standard plan to the allowed costs for essential health benefits under the enrollee's policy for the benefit year.

(i) For reconciliation of cost-sharing reduction amounts advanced for the 2014 and 2015 benefit years, an issuer of a QHP using the standard or simplified methodology may calculate claims amounts attributable to EHB, including cost sharing amounts attributable to EHB, by reducing total claims amounts by the plan-specific percentage estimate of non-essential health benefit claims submitted on the Uniform Rate Review Template for the corresponding benefit year, if the following conditions are met:

(A) The non-essential health benefits percentage estimate is less than 2 percent; and

(B) Out-of-pocket expenses for non-EHB benefits are included in the calculation of amounts subject to a deductible or annual limitation on cost sharing, but copayments and coinsurance rates on non-EHB benefits are not reduced under the plan variation.

(ii) [Reserved]

(3) *Selection of methodology.* For benefit years 2014 through 2016, notwithstanding paragraph (c)(2) of this section, a QHP issuer may choose to calculate the amounts that would have been paid under the standard plan without cost-sharing reductions using the simplified methodology described in paragraph (c)(4) of this section.

(i) The QHP issuer must notify HHS prior to the start of each benefit year, in the manner and timeframe established by HHS, whether or not it selects the simplified methodology for the benefit year.

(ii) If the QHP issuer selects the simplified methodology, it must apply the simplified methodology to all plan variations it offers on the Exchange for a benefit year.

(iii) The QHP issuer may not select the simplified methodology for a benefit year if the QHP issuer did not select the simplified methodology for the prior benefit year.

(iv) Notwithstanding paragraphs (c)(3)(ii) and (iii) of this section, if a QHP issuer merges with or acquires another issuer of a QHP on the Exchange, or acquires a QHP offered on the Exchange from another QHP issuer, and if one, but not all, of the merging, acquiring, or acquired parties had selected the simplified methodology for the benefit year, then for the benefit year in which the merger or acquisition took place, the QHP issuer must calculate the amounts that would have been paid using the methodology (whether the standard methodology described in paragraph (c)(2) of this section or the simplified methodology described in paragraph (c)(4) of this section) selected with respect to the plan variation prior to the start of the benefit year (even if the selection was not made by that QHP issuer). For the next benefit year (if such benefit year is 2015 or 2016), the QHP issuer may select the simplified methodology (subject to paragraph (c)(3)(ii) of this section but, for that benefit year, not paragraph (c)(3)(iii) of this section) or the standard methodology.

(4) *Simplified methodology.* Subject to paragraph (c)(4)(v) of this section, a QHP issuer that selects the simplified methodology described in this paragraph (c)(4) must calculate the amount that the enrollees would have paid under the standard plan without cost-sharing reductions for each policy that was assigned to a plan variation for any portion of the benefit year by applying each set of the standard plan's effective cost-sharing parameters (as calculated under paragraphs (c)(3)(ii) and (iii) of this section) to the corresponding subgroup of total allowed costs for EHB for the policy (as described in paragraph (c)(4)(i) of this section).

(i) For plan variation policies with total allowed costs for EHB for the benefit year that are:

(A) 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 costs for EHB under the policy for the benefit year multiplied by the effective pre-deductible coinsurance rate.

(B) 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.

(C) 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 described in paragraph (c)(2) of this section,

(ii) The QHP issuer must calculate one or more sets of effective cost-sharing parameters, as described in paragraph (c)(4)(iii) of this section, based on policies assigned to the standard plan without cost-sharing reductions for the entire benefit year and must separately apply each set of effective cost-sharing parameters to the corresponding subgroup of total allowed costs for EHB for each plan variation policy, as described in paragraph (c)(4)(i) of this section, as follows:

(A) If the standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage, but does not have separate cost-sharing parameters for pharmaceutical and medical services, the QHP issuer must calculate and apply separate sets of effective cost-sharing parameters based on the costs of enrollees in the standard plan with self-only coverage, and based on the costs of enrollees in the standard plan with other than self-only coverage.

(B) If the standard plan has separate cost-sharing parameters for pharmaceutical and medical services, but does not have separate cost-sharing parameters for self-only coverage and other than self-only coverage, the QHP issuer must calculate and apply separate sets of effective cost-sharing parameters based on the medical costs of the enrollees in the standard plan, and based on the pharmaceutical costs of the enrollees in the standard plan.

(C) If the standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage, and also has separate cost-sharing parameters for pharmaceutical and medical services, the QHP issuer must calculate and apply separate sets of effective cost-sharing parameters based on the medical costs of enrollees in the standard plan with self-only coverage, based on the pharmaceutical costs of enrollees in the standard plan with self-only coverage, based on the medical costs of enrollees in the standard plan with other than self-only coverage, and based on the pharmaceutical costs of enrollees in the standard plan with other than self-only coverage.

(iii) The effective cost-sharing parameters for the standard plan without cost-sharing reductions must be calculated based on policies assigned to the standard plan for the entire benefit year for each of the required subgroups under paragraph (c)(4)(ii) of this section as follows:

(A) If the standard plan has only one deductible (for the applicable subgroup), the average deductible of the standard plan is that deductible amount. If the standard plan has more than one deductible (for the applicable subgroup), 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. Services that are not subject to any deductible (including

services subject to copayments or coinsurance but not any deductible) are not to be incorporated into the calculation of the average deductible.

(B) The effective non-deductible cost sharing for the applicable subgroup is the average portion of total allowed costs for EHB that are not subject to any deductible for the standard plan for the benefit year incurred for standard plan enrollees and payable by the enrollees as cost sharing. The effective non-deductible cost sharing must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are above the effective deductible but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(C) The effective deductible for the applicable subgroup is equal to the sum of the average deductible 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 for the standard plan for the benefit year must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are above the average deductible but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(D) The effective pre-deductible coinsurance rate for the applicable subgroup is 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. The effective pre-deductible coinsurance rate must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible.

(E) The effective post-deductible coinsurance rate for the applicable subgroup is the quotient of (x) the portion of average allowed costs for EHB subject to a deductible incurred for enrollees for the benefit year, and payable by the enrollees as cost sharing other than through a deductible, over the difference of (y) the average allowed costs for EHB subject to a deductible incurred for enrollees for the benefit year, and (z) the average deductible. The effective post-deductible coinsurance rate must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are above the effective deductible but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(F) The effective claims ceiling for the applicable subgroup is calculated as the effective deductible plus the quotient of (x) the difference between the annual limitation on cost sharing and the sum of the average deductible and the effective non-deductible cost sharing, divided by (y) the effective post-deductible coinsurance rate.

(iv) If a QHP issuer uses the simplified methodology described in this paragraph (c)(4), and the QHP issuer's standard plan does not meet any of the criteria in paragraphs (c)(4)(v)(A) through (D) of this section, the QHP issuer must also submit to HHS, in the manner and timeframe established by HHS, the following information for each standard plan offered by the QHP issuer in the individual market through the Exchange for each of the required subgroups described in paragraph (c)(4)(ii) of this section:

(A) The average deductible for each applicable subgroup;

(B) The effective deductible for each applicable subgroup;

(C) The effective non-deductible cost sharing amount for each applicable subgroup;

(D) The effective pre-deductible coinsurance rate for each applicable subgroup;

(E) The effective post-deductible coinsurance rate for each applicable subgroup;

(F) The effective claims ceiling for each applicable subgroup; and

(G) A memorandum developed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies that describes how the QHP issuer calculated the effective cost-sharing parameters for each applicable subgroup for the standard plan.

(v) Notwithstanding paragraphs (c)(4)(i) through (iii) of this section, if a QHP issuer's standard plan meets the criteria in any of the following subparagraphs, and the QHP issuer has selected the simplified methodology described in this paragraph (c)(4), then the QHP issuer must calculate the amount that the enrollees in the plan variation would have paid under the standard plan without cost-sharing reductions as the lesser of the annual limitation on cost sharing for the standard plan or the amount equal to 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 benefit year under each policy that was assigned to a plan variation for any portion of the benefit year.

(A) The standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage, does not have separate cost-sharing parameters for pharmaceutical and medical services, and has an enrollment during the benefit year of fewer than 12,000 member months for coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing, in either of the following categories -

(1) Self-only coverage; or

(2) Other than self-only coverage.

(B) The standard plan has separate cost-sharing parameters for pharmaceutical and medical services, does not have separate cost-sharing parameters for self-only coverage and other than self-only coverage, and has an enrollment during the benefit year of fewer than 12,000 member months for coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing, in either of the following categories:

(1) Coverage of medical services; or

(2) Coverage of pharmaceutical services.

(C) The standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage and for pharmaceutical and medical services, and has an enrollment during the

benefit year of fewer than 12,000 member months for coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing, in any of the following categories:

(1) Self-only coverage of medical services;

(2) Self-only coverage of pharmaceutical services;

(3) Other than self-only coverage of medical services; or

(4) Other than self-only coverage of pharmaceutical services.

(D) The standard plan does not have separate cost-sharing parameters for pharmaceutical and medical services, or for self-only coverage and other than self-only coverage, and has an enrollment during the benefit year of fewer than 12,000 member months with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(vi) Notwithstanding paragraphs (c)(4)(i)(A) and (B) of this section, and paragraphs (c)(4)(iii)(A) through (E) of this section, if more than eighty percent of the total allowed costs for EHB for the benefit year under a standard plan for a subgroup that requires a separate set of effective cost-sharing parameters pursuant to paragraph (c)(4)(ii) are not subject to a deductible, then:

(A) The average deductible, the effective non-deductible cost sharing, and the effective deductible for the subgroup equal zero;

(B) The effective pre-deductible coinsurance rate for the subgroup is equal to the effective post-deductible coinsurance rate for the subgroup, which is determined based on all standard plan policies for the applicable subgroup for which associated cost sharing for EHB is less than the annual limitation on cost sharing, and calculated for the applicable subgroup as 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); and

(C) The amount that enrollees in the applicable subgroup in plan variation policies with total allowed costs for EHB for the benefit year that are less than the effective claims ceiling would have paid under the standard plan must be calculated using the formula in paragraph (c)(4)(i)(A).

(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.

(d) *Cost-sharing reductions data submissions.* HHS will periodically provide a submission window for issuers to submit cost-sharing reduction data documenting cost-sharing reduction amounts issuers paid, as specified in paragraphs (d)(1) and (2) of this section, in a form and manner specified by HHS in guidance, calculated in accordance with paragraph (c) of this section. When HHS makes cost-sharing reduction payments to QHP issuers, HHS will notify QHP issuers that the submission of the cost-sharing data is mandatory for those issuers having received cost-sharing reduction payments for any part of the benefit year and voluntary for other issuers, and HHS will use the data to reconcile advance cost-sharing reduction payments to issuers against the actual amounts of cost-sharing reductions QHP issuers provided, as determined by HHS based on amounts specified in paragraphs (d)(1) and (2) of this section, as calculated in accordance with paragraph (c) of this section. In the absence of an appropriation to make cost-sharing reduction payments to issuers, HHS will notify QHP issuers that the submission of the cost-sharing data is voluntary. The cost-sharing data that must be submitted in either a voluntary or mandatory submission includes:

(1) The actual amount of cost-sharing reductions provided to enrollees and reimbursed to providers by the QHP issuer for benefits for which the QHP issuer compensates the applicable providers in whole or in part on a fee-for-service basis; and

(2) The actual amount of cost-sharing reductions provided to enrollees for benefits for which the QHP issuer compensates the applicable providers in any other manner.

(e) *Cost-sharing reductions payments and charges.* If the actual amounts of cost-sharing reductions determined by HHS based on amounts described in paragraphs (d)(1) and (2) of this section are—

(1) More than the amount of advance payments HHS provided, and the QHP issuer has timely provided the data of actual amounts of cost-sharing reductions as required under paragraph (c) of this section, if an appropriation is available to make cost-sharing payments to QHP issuers, HHS will make a payment to the QHP issuer for the difference; or

(2) Less than the amount of advance payments provided, the QHP issuer must repay the difference to HHS in the manner and timeframe specified by HHS.

(f) *Cost-sharing reductions during special periods.* (1) Notwithstanding the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will not be eligible for reimbursement of any cost-sharing reductions provided following a termination of coverage effective date with respect to a grace period as described in § 155.430(b)(2)(ii)(A) or (B) of this subchapter. However, the QHP issuer will be eligible for reimbursement of cost-sharing reductions provided prior to the termination of coverage effective date. Advance payments of cost-sharing reductions will be paid to a QHP issuer prior to a determination of termination (including during any grace period, but the QHP issuer will be required to repay any advance payments made with respect to any month after any termination of coverage effective date during a grace period).

(2) Notwithstanding the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the termination (or the late determination thereof) is the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will not be eligible for advance payments and reimbursement for cost-sharing reductions provided during the period following the termination of coverage effective date and prior to the determination of the termination.

(3) Subject to the requirements of the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the reason for the termination (or late determination thereof) is not the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during such period.

(4) Subject to the requirements of the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during any period of coverage pending resolution of inconsistencies in information required to determine eligibility for enrollment under § 155.315(f) of this subchapter.

(g) *Prohibition on reduction in payments to Indian health providers.* If an Indian is enrolled in a QHP in the individual market through an Exchange and is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, the QHP issuer may not reduce the payment to any such entity for such item or service by the amount of any cost sharing that would be due from the Indian but for the prohibitions on cost sharing set forth in § 156.410(b)(2) and (3).

(h) *Reconciliation of the cost-sharing reduction portion of advance payments discrepancies and appeals.* (1) If an issuer reports a discrepancy and seeks to dispute the notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments, it must report the discrepancy to HHS within 30 calendar days of notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments as described in paragraph (e) of this section, in the manner set forth by HHS.

(2) An issuer may appeal the amount of reconciliation of the cost-sharing reduction portion of advance payments, under the process set forth in § 156.1220.

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