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paragraph (g)(1) of this section any group health plan that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act, that only provides benefits related to prescription drugs, or that is a health reimbursement arrangement, health savings account, or health flexible spending arrangement.

(4) *Procedures for counting covered lives for multiple group health plans treated as a single group health plan.* The rules in this paragraph (g)(4) govern the determination of the average number of covered lives in a benefit year for any set of multiple self-insured group health plans or health insurance plans (or a combination of one or more self-insured group health plans and one or more health insurance plans) that are treated as a single group health plan under paragraph (g)(1) of this section.

(i) *Multiple group health plans including an insured plan.* If at least one of the multiple plans is an insured plan, the average number of covered lives of reinsurance contribution enrollees must be calculated using one of the methods specified in either paragraph (d)(1) or (2) of this section, applied across the multiple plans as a whole. The following information must be determined by the plan sponsor:

(A) The average number of covered lives calculated;

(B) The counting method used; and

(C) The names of the multiple plans being treated as a single group health plan as determined by the plan sponsor and reported to HHS.

(ii) *Multiple group health plans not including an insured plan.* If each of the multiple plans is a self-insured group health plan, the average number of covered lives of reinsurance contribution enrollees must be calculated using one of the methods specified either in paragraph (e)(1) or (2) of this section, applied across the multiple plans as a whole. The following information must be determined by the plan sponsor:

(A) The average number of covered lives calculated;

(B) The counting method used; and

(C) The names of the multiple plans being treated as a single group health plan as determined by the plan sponsor.

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(h) *Maintenance of records.* A contributing entity must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the enrollment count submitted pursuant to this section for a period of at least 10 years, and must make those documents and records available upon request from HHS, the OIG, the Comptroller General, or their designees, to any such entity, for purposes of verification, investigation, audit, or other review of reinsurance contribution amounts.

(i) *Audits.* HHS or its designee may audit a contributing entity to assess its compliance with the requirements of this subpart. A contributing entity that uses a third party administrator, administrative services-only contractor, or other third party to assist with its obligations under this subpart must ensure that the third party administrator, administrative services-only contractor, or other third party cooperates with any audit under this section.

[78 FR 15528, Mar. 11, 2013, as amended at 78 FR 66655, Nov. 6, 2013; 78 FR 65094, Oct. 30, 2013; 78 FR 66655, Nov. 6, 2014; 79 FR 13835, Mar. 11, 2014; 80 FR 10862, Feb. 27, 2015; 81 FR 12334, Mar. 8, 2016]

§ 153.410 Requests for reinsurance payment.

(a) *General requirement.* An issuer of a reinsurance-eligible plan may make a request for payment when that issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth in subpart B of this part and the HHS notice of benefit and payment parameters and State notice of benefit and payment parameters for the applicable benefit year, if applicable.

(b) *Manner of request.* An issuer of a reinsurance-eligible plan must make requests for payment in accordance with the requirements of the annual HHS notice of benefit and payment parameters for the applicable benefit year or the State notice of benefit and payment parameters described in subpart B of this part, as applicable.

(c) *Maintenance of records.* An issuer of a reinsurance-eligible plan must maintain documents and records, whether paper, electronic, or in other

media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least 10 years, and must make those documents and records available upon request from HHS, the OIG, the Comptroller General, or their designees, or, in a State where the State is operating reinsurance, the State or its designee, to any such entity, for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(d) *Audits and compliance reviews.* HHS or its designee may audit or conduct a compliance review of an issuer of a reinsurance-eligible plan to assess its compliance with the applicable requirements of this subpart and subpart H of this part. Compliance reviews conducted under this section will follow the standards set forth in §156.715 of this subchapter.

(1) *Notice of audit.* HHS will provide at least 30 calendar days advance notice of its intent to conduct an audit of an issuer of a reinsurance-eligible plan.

(i) *Conferences.* All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the initial audit findings will be discussed.

(ii) [Reserved]

(2) *Compliance with audit activities.* To comply with an audit under this section, the issuer must:

(i) Ensure that its relevant employees, agents, contractors, subcontractors, downstream entities, and delegated entities cooperate with any audit or compliance review under this section;

(ii) Submit complete and accurate data to HHS or its designees that is necessary to complete the audit, in the format and manner specified by HHS, no later than 30 calendar days after the initial audit response deadline established by HHS at the entrance conference described in paragraph (d)(1)(i) of this section for the applicable benefit year;

(iii) Respond to all audit notices, letters, and inquiries, including requests for supplemental or supporting information, as requested by HHS, no later than 15 calendar days after the date of the notice, letter, request, or inquiry; and

(iv) In circumstances in which an issuer cannot provide the requested data or response to HHS within the timeframes under paragraph (d)(2)(ii) or (iii) of this section, as applicable, the issuer may make a written request for an extension to HHS. The extension request must be submitted within the timeframe established under paragraph (d)(2)(ii) or (iii) of this section, as applicable, and must detail the reason for the extension request and the good cause in support of the request. If the extension is granted, the issuer must respond within the timeframe specified in HHS's notice granting the extension of time.

(3) *Preliminary audit findings.* HHS will share its preliminary audit findings with the issuer, who will then have 30 calendar days to respond to such findings in the format and manner specified by HHS.

(i) If the issuer does not dispute or otherwise respond to the preliminary findings, the audit findings will become final.

(ii) If the issuer responds and disputes the preliminary findings, HHS will review and consider such response and finalize the audit findings after such review.

(4) *Final audit findings.* If an audit results in the inclusion of a finding in the final audit report, the issuer must comply with the actions set forth in the final audit report in the manner and timeframe established by HHS, and the issuer must complete all of the following:

(i) Within 45 calendar days of the issuance of the final audit report, provide a written corrective action plan to HHS for approval.

(ii) Implement that plan.

(iii) Provide to HHS written documentation of the corrective actions once taken.

(5) *Failure to comply with audit activities.* If an issuer fails to comply with the audit activities set forth in this subsection in the manner and timeframes specified by HHS:

(i) HHS will notify the issuer of reinsurance payments received that the issuer has not adequately substantiated; and

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(ii) HHS will notify the issuer that HHS may recoup any payments identified in paragraph (5)(i) of this section.

[77 FR 17248, Mar. 23, 2012, as amended at 78 FR 15530, Mar. 11, 2013; 78 FR 65094, Oct. 30, 2013; 79 FR 13835, Mar. 11, 2014; 86 FR 24286, May 5, 2021]

§ 153.420 Data collection.

(a) *Data requirement.* To be eligible for reinsurance payments, an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State, or by HHS on behalf of the State.

(b) *Deadline for submission of data.* An issuer of a reinsurance-eligible plan must submit or make accessible data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year.

[78 FR 15530, Mar. 11, 2013]

Subpart F—Health Insurance Issuer Standards Related to the Risk Corridors Program

§ 153.500 Definitions.

The following definitions apply to this subpart:

Adjustment percentage means, with respect to a QHP:

(1) For benefit year 2014—

(i) For a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium in a transitional State, the percentage specified by HHS for such QHPs in the transitional State; and otherwise

(ii) Zero percent.

(2) For benefit year 2015, for a QHP offered by a health insurance issuer in any State, 2 percent.

(3) For benefit year 2016—

(i) For a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium, the percentage specified by HHS; and otherwise

(ii) Zero percent.

Administrative costs mean, with respect to a QHP, total non-claims costs incurred by the QHP issuer for the

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QHP, including taxes and regulatory fees.

After-tax premiums earned mean, with respect to a QHP, premiums earned with respect to the QHP minus taxes and regulatory fees.

Allowable administrative costs mean, with respect to a QHP, the sum of administrative costs of the QHP, other than taxes and regulatory fees, plus profits earned by the QHP, which sum is limited to the sum of 20 percent and the adjustment percentage of after-tax premiums earned with respect to the QHP (including any premium tax credit under any governmental program), plus taxes and regulatory fees.

Allowable costs means, with respect to a QHP, an amount equal to the pro rata portion of the sum of incurred claims within the meaning of §158.140 of this subchapter (including adjustments for any direct and indirect remuneration), expenditures by the QHP issuer for the QHP for activities that improve health care quality as set forth in §158.150 of this subchapter, expenditures by the QHP issuer for the QHP related to health information technology and meaningful use requirements as set forth in §158.151 of this subchapter, and the adjustments set forth in §153.530(b); in each case for all of the QHP issuer's non-grandfathered health plans in a market within a State, allocated to the QHP based on premiums earned.

Charge means the flow of funds from QHP issuers to HHS.

Direct and indirect remuneration means prescription drug rebates received by a QHP issuer within the meaning of §158.140(b)(1)(i) of this subchapter.

Payment means the flow of funds from HHS to QHP issuers.

Premiums earned mean, with respect to a QHP, all monies paid by or for enrollees with respect to that plan as a condition of receiving coverage, including any fees or other contributions paid by or for enrollees, within the meaning of §158.130 of this subchapter.

Profits mean, with respect to a QHP, the greater of:

(1) The sum of three percent and the adjustment percentage of after-tax premiums earned; and